IC 27

TITLE 27. INSURANCE

IC 27-1

ARTICLE 1. DEPARTMENT OF INSURANCE

IC 27-1-1

Chapter 1. Department Created

IC 27-1-1-1

Creation; functions

Sec. 1. There is hereby created a department in the state government of the state of Indiana which shall be known as the department of insurance. Said department shall have charge of the organization, supervision, regulation, examination, rehabilitation, liquidation, and/or conservation of all insurance companies to which this title is applicable, shall have charge of the enforcement, administration, and execution of the provisions of this title and the provisions of any other statute applicable to insurance companies, to the insurance department, or to the insurance commissioner, and shall exercise such other powers and perform such other duties as may at any time be imposed or conferred on the department by law. Wherever by any of the provisions of any statute any right, power, or duty is imposed or conferred on the department, the right, power, or duty so imposed or conferred shall be possessed and exercised by the insurance commissioner, unless otherwise provided in that statute, or unless any such right, power, or duty is delegated to the duly appointed deputies, assistants, or employees of the department, or any of them, by an appropriate rule or order of the insurance commissioner.

(Formerly: Acts 1945, c.351, s.1.) As amended by P.L.252-1985, SEC.1.

IC 27-1-1-2

Insurance commissioner

Sec. 2. (a) The powers, duties, management and control of the department of insurance are hereby conferred on and vested in the "insurance commissioner". The insurance commissioner shall be appointed by the governor, and shall be familiar with and known to possess a knowledge of the subject of insurance and be skilled in matters pertaining thereto and shall be chosen solely for fitness, irrespective of political beliefs or affiliations. The commissioner shall serve and may be removed at the pleasure of the governor, and shall be the chief executive and administrative officer of the department. The commissioner shall take an oath of office and give bond in the sum of fifty thousand dollars ($50,000) with surety to be approved by the governor for the faithful performance of his duties.

(b) The commissioner is authorized to attend and participate in the meetings of the national convention of insurance commissioners and of the committees thereof and may require the deputies, actuaries, and assistants that the commissioner may designate to attend and participate in such meetings. If the commissioner deems it advisable, the commissioner may request the attorney general or a deputy attorney general to attend and participate in such meetings. The commissioner and the deputies, actuaries, assistants, and attorneys of the department of insurance shall aid in promoting improvements in the insurance laws and the uniformity thereof in the several states. The expense of such attendance by the commissioner, and the deputies, actuaries, assistants, and attorneys shall be paid by the treasurer of state upon the warrant of the commissioner certifying that the commissioner has examined and approved the charges for such expenses.

(Formerly: Acts 1945, c.351, s.2; Acts 1959, c.351, s.1.) As amended by P.L.100-2012, SEC.62.

IC 27-1-1-3

Personnel

Sec. 3. The commissioner shall appoint a chief deputy, an actuary, a securities deputy, and such other deputies, examiners, assistants and other employees as may be necessary to carry on the work of the department. With respect to all of such positions, aptitude, previous training and experience, intelligence and moral and physical qualifications shall be carefully considered and such employees shall be chosen for their fitness, either professional or practical, as the nature of the position may require, irrespective of their political beliefs or affiliations; it being the responsibility of the commissioner to develop and maintain a highly trained and effective personnel within the insurance department. The actuary of the department shall have had at least five (5) years experience in a responsible actuarial position in a life or casualty insurance company, in consulting actuarial practice, or in a comparable actuarial position in a state or federal agency; however, only two (2) years experience of the type aforesaid shall be required (a) if the applicant is a fellow or associate of the society of actuaries or the casualty actuarial society, or (b) if said applicant has completed courses in actuarial mathematics or theory in an accredited college or university. The technical or professional qualifications of any applicant shall be determined by examination, professional rating or otherwise, as the commissioner shall determine. The securities deputy and any securities clerk shall each give bond in the sum fixed by the governor, but not less than twenty-five thousand dollars ($25,000) surety, for the faithful performance of their duties.

(Formerly: Acts 1945, c.351, s.3; Acts 1959, c.351, s.2.) As amended by P.L.100-2012, SEC.63.

IC 27-1-1-4
Repealed

(Formerly: Acts 1945, c.351, s.4; Acts 1959, c.351, s.3; Acts 1963(ss), c.8, s.1. Repealed by P.L.100-2012, SEC.64.)

IC 27-1-1-5
Repealed

(Repealed by P.L.4-1988, SEC.17.)

IC 27-1-2

Chapter 2. Application of Article; Definitions

IC 27-1-2-1

Citation

Sec. 1. IC 27-1-2 through IC 27-1-20 shall be known and may be cited as the Indiana Insurance Law.

(Formerly: Acts 1935, c.162, s.1.) As amended by P.L.252-1985, SEC.3.

IC 27-1-2-2

Application of article

Sec. 2. This article shall be applicable to all persons, firms, partnerships, corporations, associations, orders, societies, and systems and to associations operating as Lloyds, interinsurers, or individual underwriters authorized as of March 8, 1935, to make insurance under the provisions of any statute enacted prior to March 8, 1935, or organized or incorporated before or after March 8, 1935, under the provisions of any statute of this state, or which are doing or attempting to do, or which are representing that they are doing an insurance business in this state, or which are in process of organization for the purpose of doing or attempting to do such business. All domestic, foreign, and alien companies authorized to do business in this state shall be subject to this article; however, any not-for-profit corporation which pays death benefits to the owner of a valuable registered horse on the death of said horse shall for that purpose not be subject to this article.

(Formerly: Acts 1935, c.162, s.2; Acts 1973, P.L.269, SEC.1.) As amended by P.L.252-1985, SEC.4; P.L.8-1993, SEC.408.

IC 27-1-2-2.3

Captive insurers

Sec. 2.3. (a) As used in this section, "captive insurer" means a foreign company or an alien company:

(1) that is supervised in the foreign or alien jurisdiction;

(2) that is owned by a person that conducts business in Indiana;

(3) whose exclusive purpose is to insure property and casualty risks of:

(A) the parent entity described in subdivision (2);

(B) affiliates of the parent entity; or

(C) a controlled unaffiliated business;

which may include reinsuring (through risk-sharing arrangements) property and casualty risks insured by other foreign companies or alien companies described in subdivision (1); and

(4) that:

(A) is owned or controlled by a state educational institution (as defined by IC 21-7-13-32); or

(B) has made an election under Section 831(b) of the Internal Revenue Code if that election is in effect.

(b) As used in this section, "controlled unaffiliated business" means a business:

(1) that:

(A) is not an affiliate of; and

(B) has a contractual relationship with;

a parent entity described in subsection (a)(2) or an affiliate of the parent entity; and

(2) the risks of which are managed by a captive insurer.

(c) Except as provided in this section, this article does not apply to a captive insurer.

(d) A captive insurer that is doing business in Indiana:

(1) is not required to obtain a certificate of authority in Indiana under IC 27-1-6 for domestic formation or under IC 27-1-17 for foreign company admission;

(2) shall register with the commissioner; and

(3) shall, for each calendar year after 2012 in which the captive insurer is doing business in Indiana, pay into the treasury of this state a tax of two thousand five hundred dollars ($2,500).

(e) A captive insurer that is required to pay the tax imposed for a calendar year under subsection (d)(3) shall pay the tax as follows:

(1) For a tax imposed under subsection (d)(3) for calendar year 2013, the captive insurer shall pay the tax before July 1, 2014.

(2) For a tax imposed under subsection (d)(3) for a calendar year after 2013, the captive insurer shall pay the tax before April 15 of the following calendar year.

(f) The state and a political subdivision of the state shall not impose a license fee or privilege or other tax on a captive insurer, except the following:

(1) The tax described in subsection (d)(3).

(2) An applicable tax on real and tangible personal property of the captive insurer.

As added by P.L.129-2014, SEC.3. Amended by P.L.242-2015, SEC.42.

IC 27-1-2-2.5

Health insurance providers; registration

Sec. 2.5. A person or other entity that provides coverage in Indiana for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, optometric, or podiatric expenses, whether coverage is by direct payment, reimbursement, or other means, shall:

(1) register with the commissioner; and

(2) indicate in the registration if the coverage provided by the person or other entity is an employee benefit plan subject to the Employee Retirement Income Security Act (29 U.S.C. 1001 et seq.).

As added by P.L.147-1990, SEC.1.

IC 27-1-2-3
Definitions

Sec. 3. As used in this article, and unless a different meaning appears from the context: (a) "Insurance" means a contract of insurance or an agreement by which one (1) party, for a consideration, promises to pay money or its equivalent or to do an act valuable to the insured upon the destruction, loss or injury of something in which the other party has a pecuniary interest, or in consideration of a price paid, adequate to the risk, becomes security to the other against loss by certain specified risks; to grant indemnity or security against loss for a consideration.

(b) "Commissioner" means the "insurance commissioner" of this state.

(c) "Department" means "the department of insurance" of this state.

(d) The term "company" or "corporation" means an insurance company and includes all persons, partnerships, corporations, associations, orders or societies engaged in or proposing to engage in making any kind of insurance authorized by the laws of this state.

(e) The term "domestic company" or "domestic corporation" means an insurance company organized under the insurance laws of this state.

(f) The term "foreign company" or "foreign corporation" means an insurance company organized under the laws of any state of the United States other than this state or under the laws of any territory or insular possession of the United States or the District of Columbia.

(g) The term "alien company" or "alien corporation" means an insurance company organized under the laws of any country other than the United States or territory or insular possession thereof or of the District of Columbia.

(h) The term "person" includes individuals, corporations, associations, and partnerships; personal pronoun includes all genders; the singular includes the plural and the plural includes the singular.

(k) The term "insurance solicitor" means any natural person employed to aid an insurance producer in any manner in soliciting, negotiating, or effecting contracts of insurance or indemnity other than life.

(l) The term "principal office" means that office maintained by the corporation in this state, the address of which is required by the provisions of this article to be kept on file in the office of the department.

(m) The term "articles of incorporation" includes both the original articles of incorporation and any and all amendments thereto, except where the original articles of incorporation only are expressly

referred to, and includes articles of merger, consolidation and reinsurance, and in case of corporations, heretofore organized, articles of reorganization filed in the office of the secretary of state, and all amendments thereto.

(n) The term "shareholder" means one who is a holder of record of shares of stock in a corporation, unless the context otherwise requires.

(o) The term "policyholder" means one who is a holder of a contract of insurance in an insurance company.

(p) The term "member" means one who holds a contract of insurance or is insured in an insurance company other than a stock corporation.

(q) The term "capital stock" means the aggregate amount of the par value of all shares of capital stock.

(r) The term "capital" means the aggregate amount paid in on the shares of capital stock of a corporation issued and outstanding.

(s) The term "life insurance company" means any company making one or more of the kinds of insurance set out and defined in class 1(a) of IC 27-1-5-1.

(t) The term "casualty insurance company" means any company making the kind or kinds of insurance set out and defined in class 2 of IC 27-1-5-1.

(u) The term "fire and marine insurance company" means any company making the kind or kinds of insurance set out and defined in class 3 of IC 27-1-5-1.

(v) The term "certificate of authority" means an instrument in writing issued by the department to an insurer, which sets out the authority of such insurer to engage in the business of insurance or activities connected therewith.

(w) The term "premium" means money or any other thing of value paid or given in consideration to an insurer, insurance producer, or solicitor on account of or in connection with a contract of insurance and shall include as a part but not in limitation of the above, policy fees, admission fees, membership fees and regular or special assessments and payments made on account of annuities.

(x) The term "insurer" means a company, firm, partnership, association, order, society or system making any kind or kinds of insurance and shall include associations operating as Lloyds, reciprocal or inter-insurers, or individual underwriters.

(y) The terms "assessment plan" and "assessment insurance" mean the mode or plan and the business of a corporation, association or society organized and limited to the making of insurance on the lives of persons and against disability from disease, bodily injury or death by accident, and which provides for the payment of policy claims, accumulation of reserve or emergency funds, and the expenses of the management and prosecution of its business by payments to be made either at stated periods named in the contract or upon assessments, and wherein the insured's liability to contribute is not limited to a

fixed sum.

(z) "Agency billed" refers to a system in which an insured pays a premium directly to an insurance agency.

(aa) "Reinsurer" means an insurer that:

(1) is principally engaged in the business of reinsurance;

(2) does not conduct a significant amount of direct insurance as a percentage of the insurer's net premiums; and

(3) is not engaged on an ongoing basis in the business of soliciting direct insurance.

(Formerly: Acts 1935, c.162, s.3; Acts 1963, c.203, s.1.) As amended by Acts 1977, P.L.280, SEC.1; P.L.8-1993, SEC.409; P.L.48-2000, SEC.1; P.L.178-2003, SEC.13; P.L.11-2011, SEC.3.

IC 27-1-2-4

Violation of Indiana Insurance Law

Sec. 4. A person who recklessly violates the Indiana Insurance Law (chapters 2 through 20 of this article) commits a Class A misdemeanor, except as otherwise provided.

As added by Acts 1978, P.L.2, SEC.2701. Amended by P.L.82-1998, SEC.1.

IC 27-1-2.1

Chapter 2.1. Health Care Sharing Ministries

IC 27-1-2.1-1

"Health care sharing ministry"

Sec. 1. (a) As used in this chapter, "health care sharing ministry" means a nonprofit organization that:

(1) is comprised only of participants who share similar and sincerely held religious beliefs;

(2) is tax exempt under Section 501(c)(3) of the Internal Revenue Code;

(3) acts as a facilitator among participants who have financial or medical needs that are qualified in accordance with the organization's criteria, matching those participants with other participants who have the present ability to assist with financial or medical needs;

(4) provides for the financial or medical needs of a participant through contributions from one (1) participant to another participant;

(5) provides information about amounts that participants, with no assumption of risk or promise to pay, may contribute for distribution:

(A) among the participants; or

(B) by the organization to participants;

(6) provides a written monthly statement to all participants that specifies:

(A) the total dollar amount of qualified needs submitted to the organization; and

(B) the amount actually published or assigned to participants for their contribution; and

(7) includes the following statement, in writing, on or accompanying all applications and guideline materials:

"Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Any assistance you receive with your medical bills will be totally voluntary. Neither the organization nor any other participant can be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Whether or not you receive any payments for medical expenses and whether or not this organization continues to operate, you are always personally responsible for the payment of your own medical bills.".

(b) The term does not include a fraternal benefit society described in IC 27-11-1-1.

As added by P.L.13-2012, SEC.1.

IC 27-1-2.1-2

Health care sharing ministry not engaged in the business of insurance

Sec. 2. A health care sharing ministry is not considered to be engaged in the business of insurance under this title or any other provision of Indiana law.

As added by P.L.13-2012, SEC.1.

IC 27-1-3

Chapter 3. General Powers and Duties of the Department

IC 27-1-3-1

Exemption from individual liability

Sec. 1. Neither the insurance commissioner nor the several officers and employees of the department shall be liable, in their individual capacity, except to the state of Indiana, for any act done or omitted in connection with the performance of their respective duties under the provisions of this article.

(Formerly: Acts 1935, c.162, s.8.) As amended by P.L.252-1985, SEC.5.

IC 27-1-3-2

Conflicts of interest

Sec. 2. Neither the insurance commissioner, during his term of office, nor any deputy, actuary, securities clerk, examiner or employee shall be directly or indirectly interested in any insurance company, except as an ordinary policyholder.

(Formerly: Acts 1935, c.162, s.9.)

IC 27-1-3-3

Seal of department

Sec. 3. The department of insurance shall have an official seal of such design as may be approved by the insurance commissioner.

(Formerly: Acts 1935, c.162, s.10.)

IC 27-1-3-4

Business practices of insurance companies

Sec. 4. Every insurance company to which this article is applicable:

(1) shall conduct and transact its business in a safe and prudent manner;

(2) shall maintain such company in a safe and solvent condition; and

(3) shall establish and maintain safe and sound methods for the conduct of such insurance company and its business and prudential affairs.

(Formerly: Acts 1935, c.162, s.11.) As amended by P.L.252-1985, SEC.6.

IC 27-1-3-5

Certified copies of documents and commissioner's certification of facts as prima facie evidence

Sec. 5. Copies of all certificates, documents, reports, or other papers lawfully received and filed by the department pursuant to this article or any other law of this state, when duly certified by the commissioner or any deputy and authenticated by the official seal of

the department, shall be taken and received in all courts and places as prima facie evidence of the facts therein stated, and a certificate from the commissioner under the official seal of the department as to the existence or nonexistence of the facts relating to any insurance company which would not appear from a certified copy of any paper lawfully filed with the department shall be taken and received in all courts and places as prima facie evidence of the existence or nonexistence of the facts therein stated.
(Formerly: Acts 1935, c.162, s.12.) As amended by P.L.252-1985, SEC.7.

IC 27-1-3-6
Commissioner's annual report

Sec. 6. During December the commissioner shall report to the governor the names of all insurance companies which are in the charge of the department for rehabilitation, liquidation or conservation and such information in regard to those companies as the commissioner may deem pertinent.
(Formerly: Acts 1935, c.162, s.13.) As amended by Acts 1979, P.L.17, SEC.54.

IC 27-1-3-7
Rules and regulations

Sec. 7. (a) The department may promulgate rules and regulations for any of the following enumerated purposes:

(1) For the conduct of the work of the department.

(2) Prescribing the methods and standards to be used in making the examinations and prescribing the forms of reports of the several insurance companies to which IC 27-1 is applicable.

(3) Defining what is a safe or an unsafe manner and a safe or an unsafe condition for conducting business by any insurance company to which IC 27-1 is applicable.

(4) For the establishment of safe and sound methods for the transaction of business by such insurance companies and for the purpose of safeguarding the interests of policyholders, creditors, and shareholders respecting the withdrawal or payment of funds by any life insurance company in times of emergency. Any rule or regulation promulgated under this subdivision may apply to one (1) or more insurance companies as the department may determine.

(5) For the administration and termination of the affairs of any such insurance company which is in involuntary liquidation or whose business and property have been taken possession of by the department for the purpose of rehabilitation, liquidation, conservation, or dissolution under IC 27-1.

(6) For the regulation of the solicitation or use of proxies, in general and as they concern consents or authorizations, in respect of securities issued by any domestic stock company for

the purpose of protecting investors by prescribing the form of proxies, including such consents or authorizations, and by requiring adequate disclosure of information relevant to such proxies, including such consents or authorizations, and relevant to the business to be transacted at any meeting of shareholders with respect to which such proxies, including such consents or authorizations, may be used, which regulations may, in general, conform to those prescribed by the National Association of Insurance Commissioners.

(7) For regulation related to a health benefit exchange established under the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and operating in Indiana.

(b) The department may adopt a rule under IC 4-22-2 to provide reasonable simplification of the terms and coverage of individual and group Medicare supplement accident and sickness insurance policies and individual and group Medicare supplement subscriber contracts in order to facilitate public understanding and comparison and to eliminate provisions contained in those policies or contracts which may be misleading or confusing in connection either with the purchase of those coverages or with the settlement of claims and to provide for full disclosure in the sale of those coverages.

(Formerly: Acts 1935, c.162, s.14; Acts 1965, c.178, s.1.) As amended by Acts 1978, P.L.2, SEC.2702; Acts 1980, P.L.168, SEC.1; Acts 1981, P.L.233, SEC.1; Acts 1982, P.L.159, SEC.1; P.L.114-1991, SEC.8; P.L.278-2013, SEC.19.

IC 27-1-3-8
Repealed

(Repealed by P.L.26-1991, SEC.28.)

IC 27-1-3-9
Repealed

(Repealed by P.L.26-1991, SEC.28.)

IC 27-1-3-10
Power to revoke or suspend certificate of authority

Sec. 10. The commissioner shall have power:

(1) to revoke or suspend the authority to do business in this state of any company which refuses to permit an examination under IC 27-1-3.1; and

(2) to revoke or suspend any certificate of authority when any condition prescribed by law for granting it no longer exists.

(Formerly: Acts 1935, c.162, s.17.) As amended by P.L.26-1991, SEC.3.

IC 27-1-3-10.5

Disclosure of information

Sec. 10.5. (a) As used in this section, "confidential information" means information that has been designated as confidential by statute, rule, or regulation issued under a statute.

(b) The commissioner may not:

(1) disclose; or

(2) subject to subpoena;

financial information regarding material transactions disclosed by an insurer under IC 27-2-18.

(c) The commissioner may not disclose any information, including any document or report received from:

(1) the National Association of Insurance Commissioners; or

(2) an insurance department of another state;

if the information is designated as confidential information in the other jurisdiction.

(d) The commissioner may share confidential information with:

(1) the National Association of Insurance Commissioners; or

(2) an insurance department of another state;

on the condition that the National Association of Insurance Commissioners and the other state agree to maintain the same level of confidentiality that is provided to the information under Indiana law.

(e) The commissioner may share confidential information related to a health benefit exchange established under the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), with the health benefit exchange if the health benefit exchange:

(1) agrees to maintain the same level of confidentiality that is provided to the confidential information under Indiana law; and

(2) complies with all applicable confidentiality requirements under federal law.

As added by P.L.251-1995, SEC.1. Amended by P.L.278-2013, SEC.20.

IC 27-1-3-11

Confidential information

Sec. 11. (a) The commissioner or any deputy, actuary, assistant, examiner, or employee or any other person having access to any information obtained through an examination conducted under IC 27-1-3.1 may not disclose to any person, other than officially to the department, by the report made to it, or to the board of directors, trustees, partners, attorney-in-fact, or owners, or in compliance with an order of a court, any information concerning the affairs of any insurance company as shown by the report of the examination of such company by the department. However, this prohibition against disclosure does not apply after the report of the examiners has been submitted to the department and the department has in turn submitted

the report with its recommendations, if any, to the board of directors, trustees, partners, attorney-in-fact, or owners.

(b) This section does not prohibit the publication by any company of the facts contained in its own examination.

(Formerly: Acts 1935, c.162, s.18; Acts 1969, c.164, s.6.) As amended by Acts 1978, P.L.2, SEC.2703; P.L.17-1984, SEC.7; P.L.159-1986, SEC.1; P.L.26-1991, SEC.4.

IC 27-1-3-12

Acceptance of examination made by another state

Sec. 12. The department may in its discretion accept any examination of any insurance company made by the commissioners' convention or by the proper authority of the state in which a foreign or alien company is domiciled in lieu of the examination made under the provisions of this article.

(Formerly: Acts 1935, c.162, s.19.) As amended by P.L.252-1985, SEC.9.

IC 27-1-3-13

Blanks for annual statement; separate exhibit

Sec. 13. (a) Each company authorized to conduct business in Indiana and required to file an annual statement with the department under IC 27-1-20-21 shall submit the company's statement on the National Association of Insurance Commissioners (NAIC) Annual Statement Blank prepared in accordance with NAIC Annual Statement Instructions, and following practices and procedures prescribed by the most recent NAIC Accounting Practices and Procedures Manual.

(b) To the extent that the NAIC Annual Statement Instructions require disclosure under subsection (a) of compensation paid to or on behalf of an insurer's officers, directors, or employees, the information may be filed with the department as an exhibit separate from the annual statement blank. The compensation information described under this subsection shall be maintained by the department as confidential and may not be made public.

(Formerly: Acts 1935, c.162, s.20; Acts 1963, c.154, s.1.) As amended by P.L.130-1994, SEC.1; P.L.116-1994, SEC.5; P.L.251-1995, SEC.2.

IC 27-1-3-14

Notice of insolvency, failure, or suspension of operations; failure to give notice

Sec. 14. If any domestic insurance company is insolvent, or in imminent danger of insolvency, or fails or suspends operation between the periods of examination authorized, it is a Class B misdemeanor for the highest officer then actively in charge of such domestic insurance company to knowingly fail to notify the department immediately, of such condition, failure, or suspension.

(Formerly: Acts 1935, c.162, s.21.) As amended by Acts 1978, P.L.2, SEC.2704.

IC 27-1-3-15
Filing fees; collection

Sec. 15. (a) Except as provided in subsections (f) and (h), the commissioner shall collect the following filing fees:

Document	Fee
Articles of incorporation	$350
Amendment of articles of incorporation	$ 10
Filing of annual statement and consolidated statement	$100
Annual renewal of company license fee	$ 50
Withdrawal of certificate of authority	$ 25
Certified statement of condition	$ 5
Any other document required to be filed by this article	$ 25

The commissioner shall deposit fees collected under this subsection into the department of insurance fund established by section 28 of this chapter.

(b) The commissioner shall collect a fee of ten dollars ($10) each time process is served on the commissioner under this title.

(c) The commissioner shall collect the following fees for copying and certifying the copy of any filed document relating to a domestic or foreign corporation:

Per page for copying	As determined by the commissioner but not to exceed actual cost
For the certificate	$10

(d) Each domestic and foreign insurer and each health maintenance organization shall remit annually to the commissioner for deposit into the department of insurance fund established by section 28 of this chapter one thousand dollars ($1,000) as an internal audit fee. All assessment insurers, farm mutuals, and fraternal benefit societies shall remit to the commissioner for deposit into the department of insurance fund two hundred fifty dollars ($250) annually as an internal audit fee.

(e) Beginning July 1, 1994, each insurer shall remit to the commissioner for deposit into the department of insurance fund established by section 28 of this chapter a fee of thirty-five dollars ($35) for each policy, rider, rule, rate, or endorsement filed with the state, including subsequent filings. Except as provided in subsection (f), each policy, rider, rule, rate, or endorsement that is filed as part of a particular product filing or in association with a particular

product filing is an individual filing subject to the fee under this subsection. However, the total amount of fees paid under this subsection by each insurer for a particular product filing may not exceed one thousand dollars ($1,000).

(f) Beginning July 1, 2009, a policy, rider, rule, rate, or endorsement that is filed as part of a particular product filing or in association with a particular product filing for a commercial product described in:

(1) Class 2(b), Class 2(c), Class 2(d), Class 2(e), Class 2(f), Class 2(g), Class 2(h), Class 2(i), Class 2(j), Class 2(k), Class 2(l), or Class 2(m) of IC 27-1-5-1; or

(2) Class 3 of IC 27-1-5-1;

is considered to be part of a single filing for which the insurer is subject only to one (1) thirty-five dollar ($35) fee under subsection (e).

(g) The commissioner shall pay into the state general fund by the end of each calendar month the amounts collected during that month under subsections (b) and (c).

(h) The commissioner may not collect fees for quarterly statements filed under IC 27-1-20-33.

(i) The commissioner may adopt rules under IC 4-22-2 to provide for the accrual and quarterly billing of fees under this section.

(Formerly: Acts 1935, c.162, s.22.) As amended by P.L.31-1988, SEC.9; P.L.130-1994, SEC.2; P.L.116-1994, SEC.6; P.L.91-1998, SEC.3; P.L.268-1999, SEC.1; P.L.203-2001, SEC.4; P.L.173-2007, SEC.6; P.L.234-2007, SEC.188; P.L.3-2008, SEC.207.

IC 27-1-3-16

Disposition of taxes and fees accrued

Sec. 16. All taxes provided by this article and all fees accruing to the department as provided in this article shall be paid into the state treasury monthly.

(Formerly: Acts 1935, c.162, s.23.) As amended by P.L.252-1985, SEC.10; P.L.146-2015, SEC.2.

IC 27-1-3-17

Repealed

(Repealed by P.L.4-1988, SEC.17.)

IC 27-1-3-18

Solicitation for political assessments or contributions; violations

Sec. 18. It is a Class A misdemeanor for a person to knowingly solicit from any officer or employee of the department any money or other property for political assessments or contributions.

(Formerly: Acts 1935, c.162, s.25.) As amended by Acts 1978, P.L.2, SEC.2705.

IC 27-1-3-19

Order to correct improper practices or remedy deficiencies; actions to compel compliance

Sec. 19. (a) Whenever the commissioner determines that any insurance company to which this article is applicable:

(1) is conducting its business contrary to law or in an unsafe or unauthorized manner;

(2) has had its capital or surplus fund impaired or reduced below the amount required by law; or

(3) has failed, neglected, or refused to observe and comply with any order or rule of the department or commissioner;

then the commissioner may, by an order in writing addressed to the board of directors, board of trustees, attorney in fact, partners, or owners of or in any such insurance company, to direct the discontinuance of any such illegal, unauthorized, or unsafe practice, the restoration of an impairment to the capital or the surplus fund, or the compliance with any such law, order, or rule of the department or commissioner. The order shall be mailed to the last known principal office of the insurance company by certified or registered mail or delivered to an officer of the company and shall be considered to be received by the insurance company three (3) days after mailing or on the date of delivery.

(b) If the insurance company fails, neglects, or refuses to comply with the terms of that order within thirty (30) days after its receipt by the insurance company, or within a shorter period set out in the order if the commissioner determines that an emergency exists, the commissioner may, in addition to any other remedy conferred upon the department or the commissioner by law, bring an action against any such insurance company, its officers, and agents to compel that compliance.

(c) The action shall be brought by the commissioner in the Marion County circuit court. The action shall be commenced and prosecuted in accordance with the Indiana Rules of Trial Procedure, and relief for noncompliance of the order includes any remedy appropriate under the facts, including injunction, preliminary injunction, and temporary restraining order. In that action, a change of venue from the judge, but no change of venue from the county, is permitted.

(Formerly: Acts 1935, c.162, s.26.) As amended by P.L.252-1985, SEC.12; P.L.31-1988, SEC.10.

IC 27-1-3-20

Certificate of authority; issuance; necessity; removal of unqualified officers or directors; violations; civil penalties

Sec. 20. (a) The commissioner may issue a certificate of authority to any company when it shall have complied with the requirements of the laws of this state so as to entitle it to do business herein. The certificate shall be issued under the seal of the department authorizing and empowering the company to make the kind or kinds of insurance specified in the certificate. No certificate of authority

shall be issued until the commissioner has found that:

(1) the company has submitted a sound plan of operation; and

(2) the general character and experience of the incorporators, directors, and proposed officers is such as to assure reasonable promise of a successful operation, based on the fact that such persons are of known good character and that there is no good reason to believe that they are affiliated, directly or indirectly, through ownership, control, management, reinsurance transactions, or other insurance or business relations with any person or persons known to have been involved in the improper manipulation of assets, accounts, or reinsurance.

No certificate of authority shall be denied, however, under subdivision (1) or (2) until notice, hearing, and right of appeal has been given as provided in IC 4-21.5.

(b) Every company possessing a certificate of authority shall notify the commissioner of the election or appointment of every new director or principal officer, within thirty (30) days thereafter. If in the commissioner's opinion such a new principal officer or director does not meet the standards set forth in this section, the commissioner shall request that the company effect the removal of such persons from office. If such removal is not accomplished as promptly as under the circumstances and in the opinion of the commissioner is possible, then upon notice to both the company and such principal officer or director and after notice, hearing, and right of appeal pursuant to IC 4-21.5, and after a finding that such person is incompetent or untrustworthy or of known bad character, the commissioner may order the removal of such person from office and may, unless such removal is promptly accomplished, suspend the company's certificate of authority until there is compliance with such order.

(c) No company shall transact any business of insurance or hold itself out as a company in the business of insurance in Indiana until it shall have received a certificate of authority as prescribed in this section.

(d) No company shall make, issue, deliver, sell, or advertise any kind or kinds of insurance not specified in the company's certificate of authority.

(e) Notwithstanding IC 27-1-2-4, a director or officer of a company who knowingly, intentionally, or recklessly violates subsection (c) or (d) commits a Level 6 felony.

(f) The commissioner shall impose a civil penalty of not more than twenty-five thousand dollars ($25,000) on a director or officer of a company that violates subsection (c) or (d). The amount imposed must be proportionate to the costs incurred by the department of insurance, other governmental entities, and the courts in regulating the activity of the director, officer, or company who violates subsection (c) or (d). A civil penalty imposed under this subsection may be enforced in the same manner as a civil judgment.

(Formerly: Acts 1935, c.162, s.27; Acts 1967, c.127, s.1; Acts 1975, P.L.278, SEC.1.) As amended by P.L.7-1987, SEC.135; P.L.67-1998, SEC.1; P.L.158-2013, SEC.296.

IC 27-1-3-21
Execution of instruments or documents

Sec. 21. All rules, regulations, notices, orders, deeds, assignments and other instruments or documents issued, executed or promulgated by the department shall be executed in the name of "the department of insurance," on its behalf, by the insurance commissioner, or, in case of his absence or disability, by a deputy insurance commissioner, and shall be sealed with the official seal of the department; but the commissioner may authorize the execution of such deeds, assignments, releases, petitions, notices or any other instruments or documents issued or executed by the department in connection with the rehabilitation, liquidation or conservation of any insurance company by such department in the name of "the department of insurance," by any special deputy commissioner duly appointed in charge of rehabilitation, liquidation or conservation of any insurance company; and all such documents so executed by the special deputy insurance commissioner need not bear the official seal of the department.
(Formerly: Acts 1935, c.162, s.28.)

IC 27-1-3-22
Fraudulent insurance act; definition; liability

Sec. 22. (a) As used in this section, "fraudulent insurance act" means:

(1) the preparation or presentation of a written statement as part of, or in support of:

(A) a fraudulent application for the issuance or rating of a policy of commercial insurance; or

(B) a fraudulent claim under a policy of commercial or personal insurance; or

(2) the concealment, for the purpose of misleading, of information concerning any fact material to an application or claim described in subdivision (1).

(b) As used in this section, "fraudulent insurance act" includes the act or omission of a person who, knowingly and with intent to defraud, does any of the following:

(1) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, a reinsurer, a purported insurer or reinsurer, a broker, or an agent of an insurer, reinsurer, purported insurer or reinsurer, or broker, an oral or written statement that the person knows to contain materially false information as part of, in support of, or concerning any fact that is material to:

(A) an application for the issuance of an insurance policy;

(B) the rating of an insurance policy;
(C) a claim for payment or benefit under an insurance policy;
(D) premiums paid on an insurance policy;
(E) payments made in accordance with the terms of an insurance policy;
(F) an application for a certificate of authority;
(G) the financial condition of an insurer, a reinsurer, or a purported insurer or reinsurer; or
(H) the acquisition of an insurer or a reinsurer;

or conceals any information concerning a subject set forth in clauses (A) through (H).

(2) Solicits or accepts new or renewal insurance risks by or for an insolvent insurer, reinsurer, or other entity regulated under this title.

(3) Removes or attempts to remove:
(A) the assets;
(B) the record of assets, transactions, and affairs; or
(C) a material part of the assets or the record of assets, transactions, and affairs;

of an insurer, a reinsurer, or another entity regulated under this title, from the home office, other place of business, or place of safekeeping of the insurer, reinsurer, or other regulated entity, or conceals or attempts to conceal from the department assets or records referred to in clauses (A) through (C).

(4) Diverts, attempts to divert, or conspires to divert funds of an insurer, a reinsurer, another entity regulated under the Indiana Code, or other persons, in connection with any of the following:
(A) The transaction of insurance or reinsurance.
(B) The conduct of business activities by an insurer, a reinsurer, or another entity regulated under this title.
(C) The formation, acquisition, or dissolution of an insurer, a reinsurer, or another entity regulated under this title.

(c) A person who acts without malice, fraudulent intent, or bad faith is not subject to civil liability for filing a report or furnishing, orally or in writing, other information concerning a suspected, anticipated, or completed fraudulent insurance act if the report or other information is provided to or received from any of the following:

(1) The department or an agent, an employee, or a designee of the department.

(2) Law enforcement officials or an agent or employee of a law enforcement official.

(3) The National Association of Insurance Commissioners.

(4) Any agency or bureau of federal or state government established to detect and prevent fraudulent insurance acts.

(5) Any other organization established to detect and prevent fraudulent insurance acts.

(6) An agent, an employee, or a designee of an entity referred to in subdivisions (3) through (5).

(d) This section does not abrogate or modify in any way any common law or statutory privilege or immunity.

As added by P.L.159-1986, SEC.2. Amended by P.L.121-1992, SEC.1.

IC 27-1-3-23

Civil actions; substantial justification

Sec. 23. (a) For the purposes of this section, a party is "substantially justified" in initiating a civil action if the action had a reasonable basis in law or fact at the time the action was initiated.

(b) If:

(1) a person or entity referred to in section 22(c) of this chapter, or an employee or agent of a person or entity referred to in section 22(c), is the prevailing party in a civil action for libel, slander, or any other relevant tort arising out of the filing of a report or the furnishing of information under section 22(c) of this chapter; and

(2) the party who initiated the action was not substantially justified in initiating the action;

the person, entity, employee, or agent referred to in subdivision (1) is entitled to an award of attorney's fees and costs.

As added by P.L.121-1992, SEC.2.

IC 27-1-3-24

Declaration of dividend other than from earned surplus; approval

Sec. 24. (a) As used in this section, "earned surplus" means an amount equal to the unassigned funds of an insurer as set forth in the most recent annual statement of the insurer that is submitted to the commissioner, excluding surplus arising from unrealized capital gains or revaluation of assets.

(b) A domestic insurer may not:

(1) declare; or

(2) pay;

a dividend from any source of money other than earned surplus unless the commissioner approves the payment of the dividend before the dividend is paid.

As added by P.L.130-1994, SEC.3 and P.L.116-1994, SEC.7.

IC 27-1-3-25

Review of ordinary shareholder dividends to determine reasonableness

Sec. 25. The department shall establish and maintain a procedure under which the department, at least one (1) time each year, reviews the ordinary shareholder dividends paid by each domestic insurer to determine whether dividends paid by the insurer are reasonable in relation to the following:

(1) The adequacy of the level of surplus as regards policyholders of the insurer remaining after the payment of dividends.

(2) The quality of the earnings of the insurer and the extent to which the reported earnings of the insurer include extraordinary items, such as surplus relief, reinsurance transactions, and reserve destrengthening.

As added by P.L.130-1994, SEC.4 and P.L.116-1994, SEC.8.

IC 27-1-3-26

Order to limit ordinary shareholder dividends

Sec. 26. The department shall establish and follow a practice under which the department issues an order to a domestic insurer to limit the payment of ordinary shareholder dividends by the insurer if the department determines that the surplus of the insurer as regards policyholders:

(1) is not reasonable in relation to the outstanding liabilities of the insurer; and

(2) is not adequate to the financial needs of the insurer.

As added by P.L.130-1994, SEC.5 and P.L.116-1994, SEC.9.

IC 27-1-3-27

Order to limit or disallow payment of ordinary shareholder dividends

Sec. 27. The department shall establish and follow a practice under which the department issues an order to limit or disallow the payment of ordinary shareholder dividends by a domestic insurer if the domestic insurer is found to be financially distressed or troubled.

As added by P.L.130-1994, SEC.6 and P.L.116-1994, SEC.10.

IC 27-1-3-28

Department of insurance fund; establishment; deposits

Sec. 28. (a) The department of insurance fund is established for the following purposes:

(1) To provide supplemental funding for the operations of the department of insurance.

(2) To pay the costs of hiring and employing staff.

(3) To enable the department of insurance to maintain accreditation by the National Association of Insurance Commissioners.

(4) To carry out any other purpose determined necessary by the department of insurance to carry out the department's duties under this title.

(b) The fund shall be administered by the commissioner. The following shall be deposited in the department of insurance fund:

(1) Audit fees remitted by insurers to the commissioner under section 15(d) of this chapter.

(2) Filing fees remitted by insurers to the commissioner under

section 15(a) or 15(e) of this chapter.

(3) Any other amounts remitted to the commissioner or the department that are required by rule or statute to be deposited into the department of insurance fund.

(c) The expenses of administering the fund shall be paid from money in the fund.

(d) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. Interest that accrues from these investments shall be deposited in the fund.

(e) Money in the fund at the end of a particular fiscal year does not revert to the state general fund.

(f) There is annually appropriated to the department of insurance, for the purposes set forth in subsection (a), the entire amount of money deposited in the fund in each year.

As added by P.L.130-1994, SEC.7 and P.L.116-1994, SEC.11. Amended by P.L.252-1995, SEC.1; P.L.91-1998, SEC.4; P.L.173-2007, SEC.7; P.L.234-2007, SEC.189; P.L.100-2012, SEC.65.

IC 27-1-3-29

Enforceability of policies exceeding authority of insurer or violating statute or rule

Sec. 29. (a) Except as otherwise provided by statute, a policy is enforceable against the insurer according to its terms, even if the policy exceeds the authority of the insurer.

(b) A policy that violates a statute or rule is enforceable against the insurer as if the policy conformed to the statute or rule.

(c) Upon the written request of the policyholder or the insured whose rights under the policy are continuing and not transitory, an insurer shall reform and reissue its written policy to comply with the requirements of the law existing at the date of issue or last renewal of the policy.

As added by P.L.268-1999, SEC.2.

IC 27-1-3-30

Expired

(As added by P.L.166-2003, SEC.1. Amended by P.L.28-2004, SEC.165; P.L.125-2005, SEC.1. Expired 12-31-2010 by P.L.125-2005, SEC.1.)

IC 27-1-3-31

Expired

(As added by P.L.144-2009, SEC.1. Expired 12-31-2009 by P.L.144-2009, SEC.1.)

IC 27-1-3-32

Posting of life insurance and other financial information

Sec. 32. The department shall develop, post, and maintain on the department's Internet web site information related to life insurance, including the manner in which an individual may do the following:

(1) Obtain information concerning the existence of a life insurance policy.

(2) File a claim for life insurance benefits.

(3) Make provision for resolution of financial affairs after the individual's death, including notification of life insurance beneficiaries and making financial documents known and accessible to survivors.

As added by P.L.166-2015, SEC.1.

IC 27-1-3-33

Publication of grievance related information on Internet

Sec. 33. The department shall develop, post, and maintain on the department's Internet web site information concerning the internal and external grievance procedures for accident and sickness insurance policies and health maintenance organization contracts. The department shall include on the web site:

(1) information concerning the process that a consumer should follow in filing an internal grievance or an external grievance; and

(2) a telephone number for the department where consumers may call to obtain additional information.

As added by P.L.18-2016, SEC.1.

IC 27-1-3.1

Chapter 3.1. Examinations

IC 27-1-3.1-1

Commissioner

Sec. 1. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

As added by P.L.26-1991, SEC.5.

IC 27-1-3.1-2

Company

Sec. 2. As used in this chapter, "company" means any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative, regulatory, or taxing authority of the commissioner.

As added by P.L.26-1991, SEC.5.

IC 27-1-3.1-3

Department

Sec. 3. As used in this chapter, "department" refers to the department of insurance of Indiana.

As added by P.L.26-1991, SEC.5.

IC 27-1-3.1-4

Examiner

Sec. 4. As used in this chapter, "examiner" means any individual or firm authorized by the commissioner to conduct an examination under this chapter.

As added by P.L.26-1991, SEC.5.

IC 27-1-3.1-5

Insurer

Sec. 5. As used in this chapter, "insurer" has the meaning set forth in IC 27-1-2-3.

As added by P.L.26-1991, SEC.5.

IC 27-1-3.1-6

NAIC examiner's handbook

Sec. 6. As used in this chapter, "NAIC examiner's handbook" means the Examiners' Handbook adopted by the National Association of Insurance Commissioners.

As added by P.L.26-1991, SEC.5.

IC 27-1-3.1-7

Person

Sec. 7. As used in this chapter, "person" means any individual, aggregation of individuals, trust, association, partnership, limited

liability company, or corporation, or any affiliate of these entities.
As added by P.L.26-1991, SEC.5. Amended by P.L.8-1993, SEC.410.

IC 27-1-3.1-8
Procedure

Sec. 8. (a) The commissioner or any of the commissioner's examiners:

(1) may conduct an examination under this chapter of any company as often as the commissioner, in the commissioner's sole discretion, considers appropriate; and

(2) shall, at a minimum, conduct an examination of every insurer licensed in Indiana at least once every five (5) years.

(b) In scheduling and determining the nature, scope, and frequency of the examinations, the commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, and other criteria as set forth in the NAIC examiner's handbook.

(c) For purposes of completing an examination of any company under this chapter, the commissioner may examine or investigate any person, or the business of any person, in so far as such examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the company.

(d) In lieu of an examination under this chapter of any foreign or alien insurer licensed in Indiana, the commissioner may accept an examination report on such company as prepared by the insurance department of the company's state of domicile or port-of-entry state until January 1, 1994. After January 1, 1994, those reports may only be accepted if:

(1) the insurance department that prepared the report was at the time of the examination accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program; or

(2) the examination is performed with the participation of one (1) or more examiners who are employed by an accredited State Insurance Department and who after a review of the examination work papers and report state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

As added by P.L.26-1991, SEC.5. Amended by P.L.1-1992, SEC.144.

IC 27-1-3.1-9
Warrant; access to information; refusal; penalties; subpoenas; oaths; order to appear; evidence

Sec. 9. (a) Upon determining that an examination should be conducted, the commissioner or the commissioner's designee shall issue an examination warrant appointing one (1) or more examiners

to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the NAIC examiner's handbook. The commissioner may also employ such other guidelines or procedures as the commissioner considers appropriate. The commissioner is not required to issue an examination warrant for a data call.

(b) Every company or person from whom information is sought, and the officers, directors, and agents of the company or person, must provide to the examiners appointed under subsection (a) timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business, and affairs of the company being examined. The officers, directors, employees, and agents of the company or person must facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees, or agents within the company's control, to submit to examination or to comply with any reasonable written request of the examiners, or the failure of any company to make a good faith effort to require compliance with such a request, is grounds for:

(1) suspension;
(2) refusal; or
(3) nonrenewal;

of any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. The commissioner may proceed to suspend or revoke a license or authority upon the grounds set forth in this subsection under IC 27-1-3-10 or IC 27-1-3-19.

(c) The commissioner and the commissioner's examiners may issue subpoenas, administer oaths, and examine under oath any person as to any matter pertinent to an examination conducted under this chapter. Upon the failure or refusal of any person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter any order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order is punishable as contempt of court.

(d) When making an examination under this chapter, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners. The cost of retaining these examiners shall be borne by the company that is the subject of the examination.

(e) This chapter does not limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to this title. Findings of fact and conclusions made pursuant to any examination shall be prima facie

evidence in any legal or regulatory action.
As added by P.L.26-1991, SEC.5. Amended by P.L.130-1994, SEC.8; P.L.116-1994, SEC.12; P.L.111-2008, SEC.1.

IC 27-1-3.1-10
Reports

Sec. 10. (a) All examination reports shall be comprised of only:

(1) facts:

(A) appearing upon the books, records, or other documents of the company; and

(B) ascertained from the agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning the affairs of the company; and

(2) conclusions and recommendations that the examiners find reasonably warranted from those facts.

(b) No more than sixty (60) days after the completion of the examination, the examiner in charge shall file with the department a verified written report of examination under oath. Upon receipt of the verified report, the department shall transmit the report to the company examined, together with a notice that affords such company examined a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to any matters contained in the examination report. The thirty (30) day period may be extended if the commissioner, in the commissioner's sole discretion, determines that an extension is appropriate or necessary.
As added by P.L.26-1991, SEC.5. Amended by P.L.130-1994, SEC.9; P.L.116-1994, SEC.13.

IC 27-1-3.1-11
Review of report; order

Sec. 11. (a) Within thirty (30) days after the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers, and enter an order:

(1) adopting the examination report as filed or with modification or corrections;

(2) rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and refiling the report under this chapter; or

(3) calling for an investigatory hearing with no less than twenty (20) days notice to the company for purposes of obtaining additional documentation, data, information and testimony.

(b) If the examination report reveals that the company is operating in violation of any law, regulation, or prior order of the commissioner, the commissioner may order the company to take any

action the commissioner considers necessary and appropriate to cure that violation.
As added by P.L.26-1991, SEC.5.

IC 27-1-3.1-12
Orders; findings and conclusions; appeal; hearing

Sec. 12. (a) All orders entered under section 11(a) of this chapter shall be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner workpapers, and any written submissions or rebuttals.

(b) Any order entered under section 11(a) of this chapter shall be considered a final administrative decision that may be appealed under IC 4-21.5-5, and shall be served upon the company by certified mail, together with a copy of the adopted examination report. Within thirty (30) days of the issuance of the adopted report, the company shall file an affidavit stating that each director has received a copy of the adopted report and related orders.

(c) Any hearing conducted under section 11(a)(3) of this chapter by the commissioner or an authorized representative shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies, or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the commissioner's review of relevant workpapers or by the written submission or rebuttal of the company. Within twenty (20) days of the conclusion of the hearing, the commissioner shall enter an order under section 11 of this chapter.
As added by P.L.26-1991, SEC.5. Amended by P.L.130-1994, SEC.10; P.L.116-1994, SEC.14.

IC 27-1-3.1-13
Hearing

Sec. 13. (a) The commissioner may not appoint an examiner as authorized representative to conduct a hearing. The hearing shall proceed expeditiously with discovery by the company limited to the examiner's workpapers which tend to substantiate any assertions set forth in any written submission or rebuttal. The commissioner or the commissioner's representative may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation whether under the control of the department, the company, or other persons. The documents produced shall be included in the record and testimony taken by the commissioner or the commissioner's representative shall be under oath and preserved for the record.

(b) This section does not require the department to disclose any information or records which would indicate or show the existence or content of any investigation or activity of a criminal justice

agency.

(c) The hearing shall proceed with the commissioner or the commissioner's representative posing questions to the persons subpoenaed. Thereafter, the company and the department may present testimony relevant to the investigation. The commissioner, the department, and the company may cross-examine witnesses. The company and the department shall be permitted to make closing statements and may be represented by counsel of their choice.

As added by P.L.26-1991, SEC.5. Amended by P.L.130-1994, SEC.11; P.L.116-1994, SEC.15.

IC 27-1-3.1-14

Confidentiality of report; public inspection; disclosures

Sec. 14. (a) Upon the adoption of an examination report under section 11(a)(1) of this chapter, the commissioner shall continue to hold the content of the examination report as confidential information for a period of thirty (30) days except to the extent provided in section 10(b) of this chapter. Thereafter, the report shall be open for public inspection.

(b) This chapter does not prevent or prohibit the commissioner from disclosing the content of an examination report, preliminary examination report, or results, or any matter relating thereto, to the National Association of Insurance Commissioners, the insurance department of any other state or country, or to law enforcement officials of Indiana or any other state or agency of the federal government at any time, if the agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this chapter.

(c) If the commissioner determines that regulatory action is appropriate as a result of any examination, the commissioner may initiate any proceedings or actions authorized by law.

(d) This chapter does not limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company work papers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action that the commissioner may, in the commissioner's sole discretion, consider appropriate.

As added by P.L.26-1991, SEC.5. Amended by P.L.130-1994, SEC.12; P.L.116-1994, SEC.16; P.L.11-2011, SEC.4.

IC 27-1-3.1-15

Confidential information; use in court proceedings

Sec. 15. (a) All working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the commissioner or any other person in the course of an examination under this chapter (including trade secrets and information obtained from a federal agency, a foreign country, or the National Association

of Insurance Commissioners, or under another state law):

(1) are confidential and privileged;

(2) are not subject to public inspection or copying under IC 5-14-3-3;

(3) are not subject to subpoena;

(4) are not subject to discovery or admissible in evidence in a private civil action; and

(5) may not be made public by the commissioner or any other person, except to the extent provided in section 14 of this chapter.

(b) The commissioner may use the materials and information described in subsection (a) in relation to a regulatory or legal action brought as part of the commissioner's duties. Access to the materials and information described in subsection (a) may also be granted to the National Association of Insurance Commissioners. A party receiving materials or information under this subsection must agree in writing prior to receiving the materials or information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

(c) A court order requiring a release or production of materials or information described in subsection (a) that is not authorized under this section is null and void unless the commissioner has been served, in accordance with the Indiana Rules of Trial Procedure, with a pleading or motion requesting the court to order release or production of the materials or information.

As added by P.L.26-1991, SEC.5. Amended by P.L.11-2011, SEC.5; P.L.276-2013, SEC.1.

IC 27-1-3.1-16

Appointment of examiner; conflict of interest; support staff

Sec. 16. (a) No examiner may be appointed by the commissioner if that examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this chapter. However, this section does not automatically preclude an examiner from being:

(1) a policyholder or claimant under an insurance policy;

(2) a grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;

(3) an investment owner in shares of regulated diversified investment companies; or

(4) a settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed.

(b) Notwithstanding the requirements of this section, the commissioner may periodically retain on an individual basis qualified actuaries, certified public accountants, and other similar individuals who are independently practicing their professions, even

though those persons may from time to time be similarly employed or retained by persons subject to examination under this chapter.
As added by P.L.26-1991, SEC.5.

IC 27-1-3.1-17
Liability of commissioner, authorized representative, or examiner; attorney's fees

Sec. 17. (a) No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this chapter.

(b) No cause of action may arise, and no liability be imposed against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this chapter, if that act of communication or delivery is performed in good faith and without fraudulent intent or the intent to deceive.

(c) This section does not abrogate or modify in any way any common law or statutory privilege or immunity enjoyed by any person identified in subsection (a).

(d) A person identified in subsection (a) is entitled to an award of attorney's fees and costs if that person is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of that person's activities in carrying out the provisions of this chapter and if the court finds the action was frivolous, unreasonable, groundless, or litigated in bad faith.
As added by P.L.26-1991, SEC.5.

IC 27-1-3.1-18
Financial analysis ratios; written requests; examination synopses; confidentiality

Sec. 18. (a) The commissioner shall provide any financial analysis ratios computed by the Insurance Regulatory Information System of the National Association of Insurance Commissioners within five (5) business days after receiving a written request for those ratios.

(b) All examination synopses concerning insurance companies that are submitted to the department by the Insurance Regulatory Information System of the National Association of Insurance Commissioners are confidential and may not be disclosed by the department.
As added by P.L.26-1991, SEC.5.

IC 27-1-3.5

Chapter 3.5. Annual Audited Financial Reports

IC 27-1-3.5-0.5

"Audit committee"

Sec. 0.5. (a) As used in this chapter, "audit committee" means a body established by the board of directors of a domestic insurer or group of insurers for the purpose of overseeing:

(1) the accounting and financial reporting processes;

(2) external audits of financial statements; and

(3) the internal audit function;

of a domestic insurer or group of insurers.

(b) For purposes of this chapter, the audit committee of an insurance holding company system is considered to be the audit committee of a group of insurers that are members of the insurance holding company system, at the election of the insurance holding company system.

(c) For purposes of this chapter, if a board of directors does not establish an audit committee, the entire board of directors constitutes the audit committee.

As added by P.L.146-2015, SEC.3.

IC 27-1-3.5-1

"Commissioner"

Sec. 1. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

As added by P.L.244-1989, SEC.2.

IC 27-1-3.5-2

"Domestic insurer"

Sec. 2. (a) As used in this chapter, "domestic insurer" means an insurer organized under the laws of Indiana.

(b) If a domestic insurer is a member of an "insurance holding company system" (as defined in IC 27-1-23-1), the term "domestic insurer" also includes:

(1) any person in immediate control of the domestic insurer; and

(2) any affiliate:

(A) in which the domestic insurer has invested; or

(B) that is indebted to the domestic insurer.

As added by P.L.244-1989, SEC.2.

IC 27-1-3.5-2.6

"Group of insurers"

Sec. 2.6. As used in this chapter, "group of insurers" means two (2) or more insurers that are part of an insurance holding company system.

As added by P.L.146-2015, SEC.4.

IC 27-1-3.5-3
"Independent auditor"

Sec. 3. As used in this chapter, "independent auditor" means a certified public accountant or a certified public accounting firm that conducts an annual audit of a domestic insurer as required by this chapter.

As added by P.L.244-1989, SEC.2.

IC 27-1-3.5-3.1
"Insurance holding company system"

Sec. 3.1. As used in this chapter, "insurance holding company system" has the meaning set forth in IC 27-1-23-1.

As added by P.L.146-2015, SEC.5.

IC 27-1-3.5-3.2
"Internal audit function"

Sec. 3.2. As used in this chapter, "internal audit function" means a process that provides independent, objective, and reasonable assurance that is designed to:

(1) add value to and improve a domestic insurer's or group of insurers' operations; and

(2) accomplish the domestic insurer's or group of insurers' objectives;

through introduction of a systematic, disciplined approach to the evaluation and improvement of the effectiveness of risk management, control, and governance processes.

As added by P.L.146-2015, SEC.6.

IC 27-1-3.5-3.3
"Internal control over financial reporting"

Sec. 3.3. As used in this chapter, "internal control over financial reporting" means a process effected by a domestic insurer's board of directors, management, or other personnel that is designed to provide reasonable assurance regarding the reliability of financial statements of the domestic insurer, including the following:

(1) The items specified in section 7(c)(2) through section 7(c)(6) and section 7(d) of this chapter.

(2) Policies and procedures that do the following:

(A) Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect transactions and deposit of assets.

(B) Provide reasonable assurance that:

(i) transactions are recorded as necessary to permit preparation of the financial statements; and

(ii) receipts and expenditures are made only in accordance with the authorization of management and the board of directors.

(C) Provide reasonable assurance regarding prevention or

timely detection of unauthorized acquisition, use, or disposition of assets that may have a material effect on the financial statements.

As added by P.L.146-2015, SEC.7.

IC 27-1-3.5-3.4
"Section 404"

Sec. 3.4. As used in this chapter, "Section 404" refers to Section 404 of the federal Sarbanes-Oxley Act of 2002 (Public Law 107-204).

As added by P.L.146-2015, SEC.8.

IC 27-1-3.5-3.5
Repealed

(As added by P.L.251-1995, SEC.3. Repealed by P.L.146-2015, SEC.9.)

IC 27-1-3.5-3.6
"Section 404 report"

Sec. 3.6. As used in this chapter, "Section 404 report" means a domestic insurer's or group of insurers' management's report on internal control over financial reporting (as defined by the federal Securities and Exchange Commission) and the related attestation report of an independent auditor.

As added by P.L.146-2015, SEC.10.

IC 27-1-3.5-3.7
"SOX compliant entity"

Sec. 3.7. As used in this chapter, "SOX compliant entity" means an entity that is required to be compliant, or is voluntarily compliant, with all of the following provisions of the federal Sarbanes-Oxley Act of 2002 (Public Law 107-204):

(1) The preapproval requirements of Section 201.

(2) The audit committee independence requirements of Section 301.

(3) The internal control over financial reporting requirements of Section 404.

As added by P.L.146-2015, SEC.11.

IC 27-1-3.5-4
"Work papers"

Sec. 4. (a) As used in this chapter, "work papers" means the records kept by the independent auditor of the procedures followed, the tests performed, the information obtained, and the conclusions reached by the independent auditor's audit of the financial statements of a domestic insurer.

(b) The term includes any audit planning documentation, work programs, analyses, memoranda, letters of confirmation and

representation, abstracts of company documents, and schedules or commentaries that:

(1) are prepared or obtained by the independent auditor in the course of any audit of the financial statements of a domestic insurer; and

(2) support the independent auditor's opinion on the domestic insurer's financial statements.

As added by P.L.244-1989, SEC.2. Amended by P.L.251-1995, SEC.4.

IC 27-1-3.5-5

Application of chapter; exemptions

Sec. 5. (a) Except as provided in subsections (b) and (c), this chapter applies to all domestic insurers.

(b) A domestic insurer that has:

(1) direct written premiums of less than one million dollars ($1,000,000) in any calendar year;

(2) less than one thousand (1,000) policyholders or certificate holders of directly written policies nationwide at the end of a calendar year; and

(3) assumed premiums under contracts or treaties of reinsurance of less than one million dollars ($1,000,000);

is exempt from this chapter with respect to that year. However, the commissioner may require compliance with this chapter upon a finding that compliance with this chapter is necessary for the commissioner to carry out a statutory responsibility.

(c) A foreign or an alien insurer that files an audited financial report in another state or country pursuant to that state's or country's requirement for audited financial reports is exempt, with respect to the year of that audited financial report, from the requirement to file an audited financial report with the commissioner under this chapter, if:

(1) the commissioner has found the other state's or country's requirement for audited financial reports to be substantially similar to the requirements of this chapter;

(2) copies of the audited financial report, a communication of internal control related matters noted in an audit, and the accountant's letter of qualifications filed with the other state or country are filed with the commissioner in accordance with the filing requirements set forth in sections 6, 8, and 12 of this chapter; and

(3) a copy of a notification of an adverse financial condition report that is filed with the other state is filed with the commissioner within the time specified in section 11 of this chapter.

This subsection does not prevent the commissioner from ordering, conducting, or performing examinations of foreign or alien insurers under the rules, regulations, and practices of the department.

As added by P.L.244-1989, SEC.2. Amended by P.L.251-1995, SEC.5; P.L.146-2015, SEC.12.

IC 27-1-3.5-6
Annual audit; filing; time; extension

Sec. 6. (a) A domestic insurer shall have an audit by an independent auditor every year and shall file an audited financial report with the commissioner every year before June 1 immediately following the December 31 that ends the year reported on in the financial report. The commissioner may require a domestic insurer to file an audited financial report earlier than June 1 if the commissioner gives the domestic insurer ninety (90) days advance notice of the earlier filing date.

(b) An extension of the June 1 filing date may be granted by the commissioner for thirty (30) days upon a showing by the insurer and its independent auditor of the reasons for requesting the extension and a determination by the commissioner that there is good cause for an extension. The request for an extension must be submitted in writing at least ten (10) days before the due date, and must include sufficient detail to permit the commissioner to make an informed decision with respect to the requested extension.

As added by P.L.244-1989, SEC.2. Amended by P.L.251-1995, SEC.6.

IC 27-1-3.5-6.5
Filing annual audited financial reports by domestic insurer

Sec. 6.5. Except as provided in this chapter, a domestic insurer shall file the annual audited financial reports required under this chapter for the calendar year ending December 31, 1989, and for every calendar year after 1989.

As added by P.L.220-2011, SEC.420.

IC 27-1-3.5-7
Contents of report

Sec. 7. (a) The annual audited financial report filed by a domestic insurer under this chapter shall report:

(1) the financial position of the domestic insurer as of the end of the most recently ended calendar year; and

(2) the results of the domestic insurer's operations, cash flow, and changes in capital and surplus for that year;

in conformity with statutory accounting practices prescribed, or otherwise permitted, by the department of insurance.

(b) The financial statements included in the annual audited financial report filed by a domestic insurer under this chapter shall be examined by an independent auditor. The independent auditor shall conduct its examination of the domestic insurer's financial statements in accordance with generally accepted auditing standards, and shall consider such other procedures illustrated in the Financial

Condition Examiner's Handbook published by the National Association of Insurance Commissioners as the independent auditor considers necessary.

(c) An annual audited financial report filed by a domestic insurer under this chapter must include the following:

(1) The report of the insurer's independent auditor.

(2) A balance sheet reporting admitted assets, liabilities, capital, and surplus.

(3) A statement of operations.

(4) A statement of cash flow.

(5) A statement of changes in capital and surplus.

(6) Notes to financial statements. The notes must be those required by the National Association of Insurance Commissioners' annual statement instructions and any other notes required by statutory accounting practices, which must include a reconciliation of differences, if any, between the financial statements included in the audited financial report and the annual statement filed by the insurer under IC 27-1-20-21, including a written description of the nature of these differences.

(d) The financial statements included in a domestic insurer's audited financial report shall be prepared in the same form, and using language and groupings substantially the same, as the relevant sections of the annual statement of the insurer filed with the commissioner under IC 27-1-20-21.

(e) The financial statements included in a domestic insurer's audited financial report must be comparative, presenting the amounts as of December 31 of the year of the report and comparative amounts as of the immediately preceding December 31. However, in the first year in which an insurer is required to file an audited financial report under this chapter, the comparative data may be omitted.

As added by P.L.244-1989, SEC.2. Amended by P.L.251-1995, SEC.7; P.L.146-2015, SEC.13.

IC 27-1-3.5-8

Independent auditor

Sec. 8. (a) A domestic insurer that is required by this chapter to file annual audited financial reports shall, not more than sixty (60) days after becoming subject to the requirement, register in writing with the commissioner the name and address of the independent auditor retained by the insurer to conduct the annual audits required by this chapter. The domestic insurer shall continuously ensure that the information provided to the commissioner under this section is accurate, and shall inform the commissioner in writing of any change in the identity or address of its independent auditor.

(b) A domestic insurer shall obtain a letter from its independent auditor that:

(1) states that the independent auditor is aware of the provisions

of IC 27 and the administrative rules of the department of insurance that relate to auditing, accounting, and financial matters; and

(2) affirms that the independent auditor will express its opinion on the financial statements of the domestic insurer in the terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by the department, specifying such exceptions as the independent auditor may believe appropriate.

The domestic insurer shall file a copy of this letter with the commissioner.

(c) If an independent auditor that audited the most recent financial report filed by the insurer with the commissioner under this chapter subsequently ceases to be the independent auditor for the insurer, the insurer shall:

(1) not more than five (5) business days after the cessation of the independent auditor's services, notify the commissioner in writing of the identity and address of the new independent auditor;

(2) not more than ten (10) business days after the notification given in subdivision (1), furnish the commissioner with a separate letter that states whether in the twenty-four (24) months preceding the engagement of the new independent auditor there were any disagreements between the insurer and its former independent auditor on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, which, if not resolved to the satisfaction of the former independent auditor, would have caused the former independent auditor to make reference to the subject matter of the disagreement in the former independent auditor's statement of its opinion on the insurer's financial report, and, if there was such a disagreement, provides a description of the disagreement. Disagreements required to be reported under this subdivision include those at the decision making level that were resolved:

(A) to the former accountant's satisfaction; and

(B) not to the former accountant's satisfaction; and

(3) comply with subsection (d).

For the purposes of this subsection, "decision making level" refers to the personnel of the insurer who are responsible for the presentation of the insurer's financial statements and the personnel of the independent auditor who are responsible for rendering the opinion of the auditor on the insurer's financial report.

(d) A domestic insurer subject to the provisions of subsection (c) shall:

(1) provide its former independent auditor with a copy of the letter furnished to the commissioner under subsection (c)(2); and

(2) request in writing its former independent auditor to furnish a letter addressed to the insurer stating whether the former independent auditor agrees with the statements contained in the letter furnished to the commissioner under subsection (c)(2) and, if not, stating the reasons for the former independent auditor's disagreement.

The domestic insurer shall furnish the commissioner with a copy of any responsive letter it receives from its former independent auditor within five (5) business days after the insurer receives the letter.

As added by P.L.244-1989, SEC.2. Amended by P.L.251-1995, SEC.8.

IC 27-1-3.5-9

Qualifications of independent auditor

Sec. 9. (a) For the purposes of this chapter, the commissioner may not recognize as an independent auditor any individual or firm that is not:

(1) a certified public accountant (if an individual) or made up of certified public accountants (if a firm); or

(2) in good standing with:

(A) the American Institute of Certified Public Accountants; and

(B) all of the authorities that license certified public accountants and certified public accounting firms in the states in which the individual or firm is licensed to practice.

(b) A partner or other individual responsible for rendering a report may not act in that capacity for more than five (5) consecutive years. An individual who has been responsible for rendering a report for five (5) years is disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for five (5) years. A domestic insurer may apply to the commissioner and request to be exempted from the five (5) year rotation requirement on the basis of unusual circumstances. The commissioner may consider the following factors in determining if relief should be granted:

(1) The number of partners, expertise of the partners, or number of insurance clients in the currently registered firm.

(2) The premium volume of the domestic insurer.

(3) The number of jurisdictions in which the domestic insurer transacts business.

(c) The commissioner may not recognize as an independent auditor or accept an annual audited financial report prepared in whole or part by a person who:

(1) has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act under federal law (18 U.S.C. 1961 through 1968) or state law (IC 35-45-6) or any dishonest conduct or practices under federal or state law;

(2) has been found to have violated the insurance law of this state with respect to any previous reports submitted under this chapter; or

(3) has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under this chapter.

(d) The commissioner shall not recognize as a qualified independent certified public accountant, or accept an annual audited financial report prepared in whole or in part by an accountant that provides to a domestic insurer, contemporaneously with the audit, any of the following nonaudit services:

(1) Bookkeeping or other services related to the accounting records or financial statements of the domestic insurer.

(2) Financial information systems design or implementation.

(3) Appraisal or valuation services, fairness opinions, or contribution-in-kind reports.

(4) Actuarially oriented advisory services involving the determination of amounts recorded in the financial statements. This does not include the following:

(A) The accountant assisting the domestic insurer to understand the methods, assumptions, and inputs used in the determination of amounts recorded in the financial statement if it is reasonable to conclude that the assistance provided is not subject to audit procedures during an audit of the domestic insurer's financial statements.

(B) An accountant's actuary issuing an actuarial opinion or certification concerning the domestic insurer's reserves if the following apply:

(i) The accountant and the accountant's actuary have not performed any management functions or made any management decisions.

(ii) The domestic insurer has competent personnel, or engages a third party actuary, to estimate the reserves for which management takes responsibility.

(iii) The accountant's actuary tests the reasonableness of the reserves after the domestic insurer's management has determined the amount of the reserves.

(5) Internal audit outsourcing services.

(6) Management or human resources functions.

(7) Broker, dealer, investment adviser, or investment banking services.

(8) Legal services or expert services unrelated to the audit.

(9) Any other services that the commissioner determines to be impermissible in rules adopted under IC 4-22-2.

(e) In making a determination under subsection (d), the commissioner shall generally consider whether the accountant's independence has been impaired by any of the following, in which case the commissioner shall not recognize the accountant or accept

the annual audited financial report from the accountant:

(1) Functioning in the role of management for the domestic insurer.

(2) Auditing the accountant's own work.

(3) Serving as an advocate for the domestic insurer.

(f) The commissioner may conduct a hearing under IC 4-21.5 to determine whether an independent auditor engaged by a domestic insurer is sufficiently independent of that domestic insurer to be capable of exercising independent judgment and expressing an objective opinion on the financial statements in the annual financial report filed by the insurer under this chapter. If the commissioner determines that the auditor is not sufficiently independent of the insurer, the commissioner shall require the insurer to replace the auditor with another that is sufficiently independent of the insurer.

As added by P.L.244-1989, SEC.2. Amended by P.L.251-1995, SEC.9; P.L.11-2011, SEC.6; P.L.146-2015, SEC.14.

IC 27-1-3.5-10

Consolidated returns

Sec. 10. A domestic insurer may apply in writing to the commissioner for approval to satisfy the requirements of this chapter by filing audited consolidated or combined financial statements instead of separate annual audited financial statements if the insurer is part of a group of insurance companies that utilizes a pooling or one hundred percent (100%) reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer cedes all of the insurer's direct and assumed business to the pool. If a domestic insurer whose application is approved elects to file a consolidated return, the insurer shall file, with its financial statements, a columnar consolidating or combining schedule, which must meet the following requirements:

(1) Amounts shown on the consolidated or combined audited financial report shall be shown on the schedule.

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

(3) Noninsurance operations shall be shown on the schedule on an individual basis.

(4) Explanations of consolidating and eliminating entries shall be included.

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

As added by P.L.244-1989, SEC.2. Amended by P.L.130-1994, SEC.13; P.L.116-1994, SEC.17.

IC 27-1-3.5-11

Report from independent auditor of financial condition

irregularities; subsequent facts

Sec. 11. (a) A domestic insurer required to file annual audited financial reports under this chapter shall require its independent auditor to report in writing to the board of directors or the board of director's audit committee, not more than five (5) business days after making a determination, the independent auditor's determination that:

(1) the domestic insurer has materially misstated to the commissioner the financial condition of the insurer as of the date of the balance sheet being examined by the independent auditor; or

(2) the domestic insurer does not meet the minimum capital and surplus requirements of Indiana as of the date of the balance sheet being examined by the independent auditor.

The domestic insurer who has received a report under this section shall forward a copy of the report to the commissioner within five (5) business days after receipt of the report and shall provide the independent accountant making the report with evidence of the report being furnished to the commissioner. An independent auditor who does not receive the evidence that the report was filed with the commissioner within the required five (5) business days shall furnish the commissioner a copy of the report within the next five (5) business days. An independent auditor may not be liable to any person for a statement made in connection with this subsection, if the statement is made in good faith compliance with this subsection.

(b) If the independent auditor of a domestic insurer, after the filing of the insurer's audited financial report under this chapter, becomes aware of facts that, if the independent auditor had been aware of the facts when writing its report, might have affected the independent auditor's report that was included in the insurer's audited financial report, the independent auditor shall take such action as is prescribed in the Professional Standards of the American Institute of Certified Public Accountants.

As added by P.L.244-1989, SEC.2. Amended by P.L.251-1995, SEC.10.

IC 27-1-3.5-12

Report of unremediated material weaknesses in internal control over financial reporting

Sec. 12. (a) A domestic insurer required by this chapter to file an annual audited financial report with the commissioner shall also furnish the commissioner with a written communication describing any unremediated material weaknesses (as defined by the NAIC Statement on Auditing Standard 60, Communication of Internal Control Related Matters Noted in an Audit) in the domestic insurer's internal control over financial reporting as of the December 31 immediately preceding the audit (coinciding with the domestic insurer's annual audited financial report), noted during the audit. If no unremediated material weaknesses are noted during the audit, the

communication must reflect that fact.

(b) The written communication required under subsection (a) must be prepared not later than sixty (60) days after the filing of the annual audited financial report.

(c) If a description of remedial actions taken or proposed to correct unremediated material weaknesses described under subsection (a) is not provided by the independent auditor, the domestic insurer shall provide a description of the remedial actions. *As added by P.L.244-1989, SEC.2. Amended by P.L.251-1995, SEC.11; P.L.146-2015, SEC.15.*

IC 27-1-3.5-12.1
Audit committee; members; duties; waiver

Sec. 12.1. (a) As used in this section, "independent", with respect to a member of an audit committee, means that the member, other than in the member's capacity as a member of the audit committee, the board of directors, or another board committee:

(1) does not accept a consulting fee, an advisory fee, or another compensatory fee from the domestic insurer or group of insurers; and

(2) is not an affiliate of the domestic insurer or group of insurers.

(b) This section does not apply to any of the following:

(1) A foreign insurer or an alien insurer that possesses a certificate of authority.

(2) A domestic insurer that is a SOX compliant entity.

(3) A wholly-owned subsidiary of a SOX compliant entity.

(c) The audit committee of a domestic insurer or group of insurers is directly responsible for the:

(1) appointment;

(2) compensation; and

(3) oversight of the work;

of the domestic insurer's or group of insurers' accountant, including resolution of disagreements between management and the accountant concerning financial reporting, for the purpose of preparing or issuing an annual audited financial report or related work under this chapter. Each accountant reports directly to the audit committee.

(d) The audit committee of a domestic insurer or group of insurers is responsible for:

(1) oversight of the domestic insurer's or group of insurers' internal audit function; and

(2) granting the person that performs the internal audit function suitable authority and resources to fulfill the person's responsibilities if required by section 12.3 of this chapter.

(e) The following apply to the membership of an audit committee:

(1) Each member shall be:

(A) a member of the board of directors of the domestic insurer; or

(B) if the audit committee of the entity that controls a group of insurers serves as the audit committee of the domestic insurer or group of insurers, a member of the audit committee of the entity that controls the group of insurers.

(2) The percentage of independent members must meet the following minimum requirements:

(A) If the domestic insurer had direct written and assumed premiums during the immediately preceding calendar year of less than three hundred million dollars ($300,000,000), no minimum requirement applies.

(B) If the domestic insurer had direct written and assumed premiums during the immediately preceding calendar year of at least three hundred million dollars ($300,000,000) and less than five hundred million dollars ($500,000,000), at least fifty percent (50%) of the members must be independent members.

(C) If the domestic insurer had direct written and assumed premiums during the immediately preceding calendar year of at least five hundred million dollars ($500,000,000), at least seventy-five percent (75%) of the members must be independent members.

(f) If:

(1) state or federal law requires that a board of directors of a domestic insurer or group of insurers include otherwise nonindependent members; and

(2) an otherwise nonindependent member is not an officer or employee of the domestic insurer, group of insurers, or an affiliate of the domestic insurer or group of insurers;

the nonindependent member may serve as a member of an audit committee and be considered to be independent for audit committee purposes.

(g) If:

(1) a member of an audit committee of a domestic insurer ceases to be independent for reasons beyond the member's reasonable control; and

(2) the domestic insurer notifies the department of the cessation of independence;

the member may continue to serve as an audit committee member until the next annual meeting of the domestic insurer or one (1) year after the date on which the member's independence ceased, whichever occurs first.

(h) The ultimate controlling person of a domestic insurer may designate the audit committee of the domestic insurer by providing written notice to each commissioner responsible for regulation of each affected insurer. The written notice must:

(1) be timely provided before the issuance of the annual audited financial report; and

(2) include a description of the basis for the designation.

(i) A designation:

(1) under subsection (h) may be changed with written notice from the domestic insurer to the commissioner, including a description of the basis for the designation; and

(2) under subsection (h) or this subsection remains in effect unless rescinded or changed.

(j) A domestic insurer's audit committee shall require the accountant that performs an audit required by this chapter to report to the audit committee in accordance with the requirements of AICPA Statements on Auditing Standards (SAS) 61, Communication with Audit Committees, or its replacement, including the following:

(1) All significant accounting policies and material permitted practices.

(2) All:

(A) material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the domestic insurer; and

(B) ramifications of the use of the alternative disclosures and treatments.

(3) The treatment described in subdivision (2) that is preferred by the accountant.

(4) Any other material written communication between the accountant and the management of the domestic insurer, including any management letter or schedule of unadjusted differences.

(k) If:

(1) a domestic insurer is a member of an insurance holding company system; and

(2) any substantial differences among insurers in the insurance holding company system are identified to the audit committee;

the reports required by subsection (j) may be provided to the audit committee on an aggregate basis for insurers in the holding company system.

(l) If a domestic insurer has direct written and assumed premiums (excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program) of less than five hundred million dollars ($500,000,000), the domestic insurer may apply to the commissioner for a waiver from the audit committee requirements of this section based on hardship.

(m) A domestic insurer that receives a waiver under subsection (l) shall file the waiver, with the domestic insurer's annual statement filing, with the:

(1) commissioners of insurance in the states in which the domestic insurer is licensed or doing insurance business; and

(2) National Association of Insurance Commissioners.

If another state has access to electronic filing with the National Association of Insurance Commissioners, the domestic insurer shall

file the waiver with the other state electronically in accordance with National Association of Insurance Commissioners electronic filing specifications.
As added by P.L.146-2015, SEC.16.

IC 27-1-3.5-12.3
Internal audit function

Sec. 12.3. (a) This section does not apply to a domestic insurer that meets the following requirements:

(1) The domestic insurer has annual direct written and unaffiliated assumed premiums (including international direct and assumed premiums and excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program) of less than five hundred million dollars ($500,000,000).

(2) If the domestic insurer is a member of a group of insurers, the group has annual direct written and unaffiliated assumed premiums (including international direct and assumed premiums and excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program) of less than one billion dollars ($1,000,000,000).

A domestic insurer or group of insurers described in this subsection shall comply with the requirements of this section not later than one (1) year after the year in which the domestic insurer's or group's annual direct written and unaffiliated assumed premiums described in subdivisions (1) and (2) exceed the applicable maximum amount specified in subdivision (1) or (2).

(b) A domestic insurer shall establish an internal audit function to:

(1) provide independent, objective, and reasonable assurance to the domestic insurer's audit committee and management concerning the domestic insurer's governance, risk management, and internal controls;

(2) perform general and specific audits, reviews, and tests; and

(3) use other techniques considered necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations.

(c) An internal audit function established under subsection (b) must be organizationally independent, as follows:

(1) Ultimate judgment concerning audit matters must be made by the department responsible for the internal audit function.

(2) The department responsible for the internal audit function shall appoint an individual:

(A) to be responsible for the internal audit function; and

(B) to have direct and unrestricted access to the board of directors of the domestic insurer.

The internal audit function's organizational independence does not preclude dual reporting relationships.

(d) The director of the internal audit function shall report to the

audit committee of a domestic insurer on a regular basis, at least annually, concerning the following:

(1) The internal audit function's periodic audit plan.

(2) Factors that may adversely affect the internal audit function's independence or effectiveness.

(3) Material findings from completed audits.

(4) The appropriateness of corrective actions implemented by management as a result of audit findings.

(e) If a domestic insurer is a member of an insurance holding company system or a member of a group of insurers, the domestic insurer may satisfy the internal audit function requirements of this section at the ultimate controlling person level, an intermediate holding company level, or an individual legal entity level.

As added by P.L.146-2015, SEC.17. Amended by P.L.72-2016, SEC.7.

IC 27-1-3.5-12.5

Management's report of internal control over financial reporting

Sec. 12.5. (a) A domestic insurer that is required to file an annual audited financial report under this chapter that has annual direct written and assumed premiums (excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program) of at least five hundred million dollars ($500,000,000) shall prepare a report of the domestic insurer's or group of insurers' management's internal control over financial reporting as of the immediately preceding December 31. The report shall be filed with the commissioner along with the communication of internal control related matters noted in an audit.

(b) The commissioner may require a domestic insurer that is:

(1) not described in subsection (a); and

(2) in a RBC level event described in IC 27-1-36 or considered by the commissioner to be in hazardous financial condition (as defined in rules adopted under IC 27-1-3-7);

to file a report of management's internal control over financial reporting.

(c) If:

(1) a domestic insurer or group of insurers is:

(A) directly subject to Section 404;

(B) part of an insurance holding company system whose parent is directly subject to Section 404;

(C) not directly subject to Section 404, but is a SOX compliant entity; or

(D) part of an insurance holding company system whose parent is not directly subject to Section 404, but is a SOX compliant entity; and

(2) the domestic insurer's or group of insurers' internal controls over financial reporting that have a material impact on the preparation of the domestic insurer's or group of insurers'

annual audited financial statements are included in the Section 404 report;

the domestic insurer or group of insurers may satisfy the requirement of this section to file a report of management's internal control over financial reporting by including with the domestic insurer's or group of insurers' Section 404 report an addendum described in subsection (d).

(d) An addendum described in subsection (c) must be a positive statement by the domestic insurer's or group of insurers' management that no internal controls over financial reporting that have a material impact on the preparation of the domestic insurer's or group of insurers' annual audited financial statements exist, other than the internal controls that are included in the Section 404 report.

(e) If:

(1) a domestic insurer or group of insurers is described in subsection (c)(1); and

(2) the domestic insurer's or group of insurers' internal controls over financial reporting that have a material impact on the preparation of the domestic insurer's or group of insurers' annual audited financial statements are not all included in the Section 404 report;

the domestic insurer or group of insurers shall file a report of management's internal control over financial reporting as required by this section for the internal controls that have a material impact and are not included in the Section 404 report.

(f) A domestic insurer's or group of insurers' report of management's internal control over financial reporting required by this section must include the following:

(1) A statement that management is responsible for establishment and maintenance of adequate internal control over financial reporting.

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

(3) A statement that briefly describes the approach or processes by which management evaluated the effectiveness of management's internal control over financial reporting.

(4) A statement that briefly describes the scope of work that is included in the report and whether any of management's internal controls over financial reporting were excluded.

(5) Disclosure of any unremediated material weaknesses in the management's internal control over financial reporting identified by management as of the immediately preceding December 31. The management may not conclude that the

internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of annual audited financial statements in accordance with statutory accounting principles if one (1) or more unremediated material weaknesses exist in the management's internal control over financial reporting.

(6) A statement regarding the inherent limitations of the management's internal control over financial reporting.

(7) Signatures of the chief executive officer and the chief financial officer, or equivalent position, of the domestic insurer or group of insurers.

(g) A domestic insurer's or group of insurers' management shall document and make available upon financial condition examination the basis on which the management's assertions described in subsection (f) are made. The management's assertions may be based, in part, upon the management's review, monitoring, and testing of internal controls over financial reporting that are undertaken in the normal course of the management's activities. The management may determine the nature of the internal control framework used and the nature and extent of documentation to make the management's assertion in a cost effective manner, including assembly of or reference to existing documentation.

(h) A report of management's internal control over financial reporting required by this section, and any supporting documentation provided during the course of a financial condition examination, is confidential.

As added by P.L.251-1995, SEC.12. Amended by P.L.146-2015, SEC.18.

IC 27-1-3.5-13

Independent audit work papers and communications; review by department examiners

Sec. 13. (a) A domestic insurer required to file an audited financial report under this chapter shall require its independent auditor to make available for review by department examiners:

(1) all work papers prepared in the conduct of the independent auditor's examination; and

(2) any record of significant communications related to the audit between the independent auditor and the insurer that took place at:

(A) the offices of the insurer;

(B) the department;

(C) the offices of the independent auditor; or

(D) any other reasonable place designated by the commissioner.

The insurer shall require the independent auditor to retain the audit work papers and communications until the department has filed a report on the examination covering the period of the audit but not

later than seven (7) years after the date of the audit report.

(b) Department examiners, in conducting a review of an independent auditor's work papers, may make and retain copies of the work papers and communications. A review of an independent auditor's work papers and communications shall be considered an investigation and all work papers and communications obtained or copied during the course of that investigation are confidential under IC 27-1-3.1-15.

As added by P.L.244-1989, SEC.2. Amended by P.L.251-1995, SEC.13.

IC 27-1-3.5-14
Exemption application; hearing

Sec. 14. (a) In response to a written application from a domestic insurer, the commissioner may grant an exemption from compliance with this chapter if the commissioner finds, upon review of the application, that compliance with this chapter would constitute a financial or an organizational hardship upon the domestic insurer. An exemption may be granted at any time for a specified period.

(b) Within ten (10) days after the denial of a domestic insurer's written request for an exemption from this chapter, the insurer may, in writing, request a hearing on its application for an exemption. The hearing shall be held under IC 4-21.5.

As added by P.L.244-1989, SEC.2. Amended by P.L.251-1995, SEC.14.

IC 27-1-3.5-15
Repealed

(Repealed by P.L.251-1995, SEC.22.)

IC 27-1-3.5-16
Penalty for noncompliance

Sec. 16. A domestic insurer that fails to file an audited annual financial report before July 1 or any other deadline established by the commissioner for the insurer under this chapter without having obtained an extension is subject to a civil penalty of fifty dollars ($50) per day until the report is received by the commissioner.

As added by P.L.244-1989, SEC.2.

IC 27-1-3.5-17
Effect of chapter on examinations under IC 27-1-3.1

Sec. 17. This chapter does not prohibit or in any way restrict the commissioner from ordering, conducting, or performing examinations of insurers under IC 27-1-3.1.

As added by P.L.244-1989, SEC.2. Amended by P.L.26-1991, SEC.6.

IC 27-1-3.5-18
British or Canadian insurers

Sec. 18. (a) In the case of a British or Canadian insurer, the annual audited financial report refers to the annual statement of total business on the form filed by the company with its domiciliary supervision authority audited by an independent auditor.

(b) For a British or Canadian insurer, the letter required under section 8 of this chapter shall state that the accountant is aware of the requirement relating to the annual audited statement filed with the commissioner under section 6 of this chapter and shall affirm that the opinion expressed is in conformity with those requirements.

As added by P.L.251-1995, SEC.15.

IC 27-1-4
Repealed

(Repealed by Acts 1979, P.L.255, SEC.3.)

IC 27-1-4.1

Chapter 4.1. Corporate Governance Annual Disclosure

IC 27-1-4.1-1

Application and scope of chapter

Sec. 1. (a) This chapter applies beginning January 1, 2016.

(b) This chapter does not do the following:

(1) Impose corporate governance standards or internal procedures that are not otherwise required under IC 27.

(2) Limit the commissioner's authority, or the rights and obligations of third parties, under IC 27-1-3.1.

As added by P.L.146-2015, SEC.19.

IC 27-1-4.1-2

"Corporate governance annual disclosure"; "CGAD"

Sec. 2. As used in this chapter, "corporate governance annual disclosure" or "CGAD" means a confidential report filed by an insurer or insurance group under this chapter.

As added by P.L.146-2015, SEC.19.

IC 27-1-4.1-3

"Insurance group"

Sec. 3. As used in this chapter, "insurance group" means insurers and affiliates of an insurance holding company system (as defined in IC 27-1-23-1).

As added by P.L.146-2015, SEC.19.

IC 27-1-4.1-4

"Insurer"

Sec. 4. As used in this chapter, "insurer" has the same meaning as set forth in IC 27-1-2-3, except that the term:

(1) refers only to domestic insurers (as defined in IC 27-1-36-8); and

(2) does not include agencies, authorities, or instrumentalities of the United States, possessions and territories of the United States, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

As added by P.L.146-2015, SEC.19.

IC 27-1-4.1-5

"NAIC"

Sec. 5. As used in this chapter, "NAIC" refers to the National Association of Insurance Commissioners.

As added by P.L.146-2015, SEC.19.

IC 27-1-4.1-6

Annual submission of CGAD

Sec. 6. (a) An insurer or insurance group of which the insurer is

a member shall, not later than June 1 of each calendar year, submit:

(1) to the commissioner; or

(2) if the insurer is a member of an insurance group, to the lead state commissioner of the insurance group (as determined by the procedures in the most recent Financial Analysis Handbook adopted by the NAIC) according to the law of the lead state;

a CGAD.

(b) An insurer that is a member of an insurance group and not required to submit a CGAD to the commissioner under subsection (a) shall submit a CGAD to the commissioner upon the commissioner's request.

(c) A CGAD submitted under this section must include the signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting that to the best of the chief executive officer's or corporate secretary's knowledge the insurer has:

(1) implemented corporate governance procedures; and

(2) provided a copy of the CGAD to the insurer's board of directors or the appropriate committee of the board of directors.

As added by P.L.146-2015, SEC.19.

IC 27-1-4.1-7

Level of disclosure

Sec. 7. (a) Subject to subsection (b), an insurer or insurance group may complete a CGAD using corporate governance information at the level of disclosure at which the insurer's or insurance group's system of corporate governance is structured, as follows:

(1) The ultimate controlling parent level.

(2) An intermediate holding company level.

(3) The individual legal entity level.

(b) An insurer or insurance group may, but is not required to, choose the level of disclosure at which to complete a CGAD under subsection (a) according to one (1) of the following criteria:

(1) The level at which the insurer's or insurance group's risk tolerance is determined.

(2) The level at which the insurer's or insurance group's earnings, capital, liquidity, operations, and reputation are:

(A) collectively overseen; and

(B) supervised.

(3) The level at which legal liability for failure of general corporate governance would be placed.

(c) If the insurer or insurance group chooses the level of disclosure at which to complete a CGAD under subsection (a) according to a criterion described in subsection (b), the insurer or insurance group shall:

(1) indicate which of the three (3) criteria was used to determine the level of disclosure; and

(2) explain any change in the level of disclosure that is subsequently used.

As added by P.L.146-2015, SEC.19.

IC 27-1-4.1-8
CGAD submitted by insurance group member

Sec. 8. If a CGAD is submitted by an insurer as a member of an insurance group, the lead state commissioner of the insurance group (as determined by the procedures in the most recent Financial Analysis Handbook adopted by the NAIC) shall:

(1) review a CGAD submitted under section 6 of this chapter; and

(2) make any requests for additional information.

As added by P.L.146-2015, SEC.19.

IC 27-1-4.1-9
Nonduplication of other filings

Sec. 9. If an insurer or insurance group:

(1) submits, in other:

(A) documents submitted to the commissioner, including proxy statements filed with registration statements required by IC 27-1-23-3; or

(B) state or federal filings provided to the department;

information that is substantially similar to the information required by this chapter; and

(2) cross references in the CGAD the document or filing that contains the substantially similar information;

the insurer or insurance group is not required to duplicate the information in the CGAD.

As added by P.L.146-2015, SEC.19.

IC 27-1-4.1-10
Additional information; CGAD preparation requirements

Sec. 10. (a) If a CGAD contains the material information necessary to allow the reviewing commissioner to understand the insurer's or insurance group's corporate governance structure, policies, and procedures, the insurer or insurance group may determine whether to respond to a request from the reviewing commissioner for additional information.

(b) If the reviewing commissioner considers additional information to be material and necessary to provide a clear understanding of an insurer's or insurance group's:

(1) corporate governance structure, policies, and procedures;

(2) reporting or information system; or

(3) controls implementing subdivisions (1) and (2);

the commissioner may request the additional information.

(c) A CGAD must be:

(1) prepared in a manner consistent with the NAIC's Corporate Governance Annual Disclosure Model Regulation; and

(2) made available to the commissioner upon:

(A) examination under IC 27-1-3.1; or
(B) request of the commissioner.

As added by P.L.146-2015, SEC.19.

IC 27-1-4.1-11

Confidentiality; privilege; use of information; sharing and disclosure

Sec. 11. (a) Documents, materials, and other information related to a CGAD, including the CGAD, that are in the possession or control of the department and obtained by, created by, or disclosed to the commissioner or another person under this chapter, are:

(1) considered to be proprietary and contain trade secrets;
(2) confidential and privileged;
(3) not subject to subpoena; and
(4) not subject to discovery or admissible in evidence in a private civil action.

(b) The commissioner may:

(1) use the documents, materials, and other information described in subsection (a) in relation to a regulatory or legal action brought as part of the commissioner's duties; and
(2) otherwise make the documents, materials, and other information public only with the prior written consent of the insurer.

(c) The commissioner, and any other person:

(1) who receives documents, materials, or other information related to a CGAD while acting under the authority of the commissioner; or
(2) with whom the documents, materials, or other information are shared;

under this chapter is not permitted or required to testify in a private civil action concerning any documents, materials, or other information described in subsection (a).

(d) The commissioner may, in the performance of the commissioner's duties, do the following:

(1) Upon request, share all documents, materials, and other information described in subsection (a) with the following if the recipient agrees in writing, and provides written verification that the recipient has the legal authority, to maintain the confidential and privileged status of the documents, materials, and other information:
    (A) Other state, federal, and international financial regulatory agencies.
    (B) The NAIC.
    (C) Members of a supervisory college (as defined in IC 27-1-23-1).
    (D) A third party consultant under section 12 of this chapter.
(2) Receive all documents, materials, and other information described in subsection (a) from:

(A) other state, federal, and international financial regulatory agencies;

(B) members of a supervisory college (as defined in IC 27-1-23-1); and

(C) the NAIC;

if the commissioner maintains the confidential or privileged status of the documents, materials, and other information that are received with notice or the understanding that the documents, materials, and other information are confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials, and other information.

(e) The sharing of information by the commissioner under this chapter is not a delegation of regulatory authority. The commissioner is solely responsible for the administration, implementation, and enforcement of this chapter.

(f) Disclosure to or sharing by the commissioner of documents, materials, or other information under this chapter is not a waiver of any applicable privilege or claim of confidentiality in the documents, materials, or other information.

As added by P.L.146-2015, SEC.19.

IC 27-1-4.1-12

Third party consultants; confidentiality; sharing of information

Sec. 12. (a) The commissioner may, at the insurer's expense, retain third party consultants, including attorneys, actuaries, accountants, and others who are not part of the commissioner's staff, that:

(1) the commissioner considers necessary to review a CGAD, related information, or the insurer's or insurance group's compliance with this chapter; and

(2) have verified, with notice to the insurer, that the third party consultant:

(A) has no conflict of interest affecting the commissioner's retention of the third party consultant; and

(B) has internal procedures to:

(i) monitor whether a conflict of interest arises after the third party consultant has been retained; and

(ii) comply with the confidentiality requirements of this chapter.

(b) A third party consultant who is retained under subsection (a) is under the direction and control of the commissioner and acts only in an advisory capacity.

(c) The NAIC and a third party consultant who is retained under subsection (a) are subject to the same confidentiality requirements as the confidentiality requirements that apply to the commissioner under this chapter. The NAIC may share information received under this chapter only with state regulators from states in which insurers that are members of an insurance group are domiciled.

(d) The commissioner shall enter into a written agreement with the NAIC or a third party consultant governing sharing and use of information provided under this chapter, including the following:

(1) Procedures and protocols concerning the confidentiality and security of information shared:

(A) with the NAIC or third party consultant under this chapter; and

(B) by the NAIC with regulators of other states in which insurers that are members of an insurance group are domiciled.

(2) A statement that the recipient:

(A) agrees in writing; and

(B) provides written verification that the recipient has the legal authority;

to maintain the confidential and privileged status of the documents, materials, and other information.

(3) A statement that, with respect to information shared with the NAIC or third party consultant under this chapter:

(A) the commissioner maintains ownership of the information; and

(B) the use of the information is subject to the direction of the commissioner.

(4) A statement that the NAIC or third party consultant may not store information shared under this chapter in a permanent data base after the underlying analysis is completed.

(5) A requirement that, if CGAD related information of an insurer that is in the possession of the NAIC or third party consultant under this chapter is subject to a request or subpoena to the NAIC or third party consultant for production or disclosure, the NAIC or third party consultant will provide prompt notice to the commissioner and to the insurer or insurance group.

(6) A requirement that the NAIC or third party consultant will allow intervention by an insurer in a judicial or administrative action under which the NAIC or third party consultant may be required to disclose confidential information concerning the insurer that has been shared with the NAIC or third party consultant under this chapter.

(7) An express requirement that the written consent of the insurer or insurance group is required before the NAIC or third party consultant makes public any information shared under this chapter.

As added by P.L.146-2015, SEC.19.

IC 27-1-4.1-13

Failure to timely file; penalty; waiver

Sec. 13. (a) An insurer that fails, without just cause (as determined by the commissioner), to timely file a CGAD as required

by this chapter shall, after notice and hearing under IC 4-21.5, pay a civil penalty of one hundred dollars ($100) for each day of noncompliance, not to exceed ten thousand dollars ($10,000).

(b) The commissioner may reduce a penalty imposed under subsection (a) if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

(c) A civil penalty collected under this section shall be deposited in the department of insurance fund established by IC 27-1-3-28.

As added by P.L.146-2015, SEC.19.

IC 27-1-4.1-14

Nonseverability

Sec. 14. Notwithstanding IC 1-1-1-8, section 11 of this chapter is not severable.

As added by P.L.146-2015, SEC.19.

IC 27-1-4.1-15

Rulemaking

Sec. 15. The commissioner may adopt rules under IC 4-22-2 to implement this chapter.

As added by P.L.146-2015, SEC.19.

IC 27-1-5

Chapter 5. Classification of Insurance

IC 27-1-5-1

Authority to write one or more kinds of insurance; restrictions on assessment plan companies; classes of insurance

Sec. 1. A company, including a foreign or alien company authorized to transact business in Indiana, may make all or any one (1) or more of the kinds of insurance and reinsurance comprised in any one (1) of the following classes, subject to the provisions of IC 27-1. However, insurance on the assessment plan is limited to the making of insurance on the lives of persons and against disability from disease, bodily injury or death by accident.

CLASS 1. INSURANCE APPERTAINING TO PERSONS ONLY:

(a) To insure the lives of persons, including insurance against permanent mental or physical disability resulting from accident or disease, or against accidental death combined with a policy for life insurance, and to grant, purchase or dispose of annuities;

(b) To insure against bodily injury or death by accident and against disablement resulting from sickness and every insurance appertaining thereto, including contracts between an insurer and policyholder providing for the indemnification of the policyholder (or the other party) obligated to pay benefits resulting from bodily injury, death by accident, or disablement from sickness in accordance with the provisions of a benefit plan; however, for purposes of Class 2(1) of this section, this provision does not apply;

(c) Within the meaning of "Insurance Appertaining to Persons Only," generally described in Class 1 of this section, are to be included, among other things:

(1) contracts providing for immediate or future life insurance and/or annuity benefits, fundable and/or computable as to cost or payment or both; and

(2) contracts providing for insurance against bodily injury or sickness, a portion of which may be funded;

out of or on the basis of assets in a segregated investment account; the assets being those received by the company from or in relation to contributions, premiums or considerations received by it under such contracts. The establishment of such account shall in no way affect the company's absolute ownership of the investment items to which the account from time to time pertains. A company issuing contracts of the nature described may as to them establish one (1) or more segregated accounts, dependent upon the company's plan of operation.

A segregated investment account established as contemplated in this paragraph (c) shall not be chargeable with liabilities arising out of any other business the company may conduct and which has no specific relation to or dependence upon such account. Any surplus or

deficit which may arise in any such segregated investment account by virtue of any guarantee by the company of the value of the assets allocated to the account, their investment or income, or mortality experience shall be adjusted by withdrawals from or additions to such account so that the assets of such account shall always equal the assets required to satisfy all liabilities arising under contracts fundable by such account.

CLASS 2.

(a) To insure any persons against bodily injury, disablement or death resulting from accident and against disablement resulting from disease and every insurance appertaining thereto;

(b) To insure against loss or damage resulting from accident to, or injury sustained by, an employee or other person for which accident or injury the insured is liable;

(c) To insure against loss or damage by burglary, theft or housebreaking;

(d) To insure glass, its fittings or lettering thereon, against breakage or damage;

(e) To insure against loss from injury to persons or property which results accidentally from steam-boilers, elevators, electrical devices, engines and all machinery and appliances used in connection therewith or operated thereby; and to make inspection of and issue certificates of inspection upon such boilers, elevators, electrical devices, engines, machinery and appliances;

(f) To insure against any loss, expense and/or liability resulting from the ownership, maintenance, use and/or operation of any automobile or other motor vehicle, including complete line coverage on automobiles or other motor vehicles;

(g) To insure against loss or damage by water to any goods or premises arising from the breakage or leakage of sprinklers and/or water-pipes;

(h) To insure against any loss or damage resulting from accident to or injury suffered by any person, for which loss or damage the insured is liable; excepting employer's liability insurance as authorized under subsection (b) of Class 2 of this section;

(i) To insure persons, associations or corporations against loss or damage by reason of the giving or extending of credit;

(j) To insure against loss or damage on account of encumbrances upon or defects in the title to real estate and against loss by reason of the nonpayment of the principal or interest of bonds, mortgages or other evidences of indebtedness;

(k) To become surety or guarantor for any person, partnership or corporation in any position or place of trust or as custodian of money or property, public or private; to become a surety or guarantor for the performances by any person, copartnership or corporation of any lawful obligation, undertaking, agreement or contract of any kind, except contracts or policies of insurance, to become surety or guarantor for the performance of insurance contracts where surety

bonds are required by states or municipalities. The business covered by this subsection (k) shall be considered as fidelity and surety obligations and construed as such regardless of any other classification contained in this chapter to the contrary;

(l) To insure against any other casualty or insurance risk specified in the articles of incorporation which lawfully may be made the subject of insurance and for which specific provision is not made in this chapter.

(m) To insure against legal expenses, such as attorneys fees, court costs, witness fees and incidental expenses incurred in connection with the use of the professional services of attorneys at law, in consideration of a specified payment for an interval of time, regardless of whether payment is made by the beneficiaries individually or by a third person for them, so that the total cost incurred by assuming the obligation is spread directly or indirectly among the group, except those expenses resulting from the following:

(1) Retainer contracts made with a single client with the fee based on an estimate of the nature and the amount of services that will be provided to that client, and similar contracts made with a group of clients involved in the same or closely related legal matters (such as class actions).

(2) Plans providing no benefits other than a limited amount of consultation and advice on simple matters either alone or in combination with referral services or the promise of fee discounts for other matters.

(3) Plans providing limited benefits on simple legal matters on a voluntary and informal basis, not involving a legally binding promise, in the context of an employment or educational or similar relationship.

(4) Legal services provided by unions or employee associations to its members in matters solely relating to employment or occupation, and provided, further, that nothing in this chapter shall prohibit group legal services of any other kind.

(5) Payment of fines, penalties, judgments or assessments.

CLASS 3.

(a) To make insurance on buildings and personal property of every description against loss or damage, including loss of use or occupancy, caused by fire, smoke or smudge, lightning or other electrical disturbance, earthquake, windstorm, cyclone, tornado, tempest, hail, frost or snow, ice, sleet, weather or climatic conditions, including excess or deficiency of moisture, flood, rain or drought, rising of the waters of the ocean, or its tributaries, bombardment, invasion, insurrection, riot, civil war or commotion, military or usurped power, and by explosion, whether fire ensues or not, except explosion of steam-boilers;

(b) To insure against loss or damage from any cause, to crops or farm products and loss of rental value of land used in producing such

crops or products;

(c) To insure against loss or damage by water or other fluid to any goods or premises arising from the breakage or leakage of sprinklers, pumps, or other apparatus erected for extinguishing fires or of other conduits or containers or by water entering through leaks or openings in buildings and/or water-pipes, and against accidental injury to such sprinklers, pumps, or other apparatus, conduits, containers or water-pipes;

(d) To insure vessels, boats, cargoes, goods, merchandise, freight, specie, bullion, jewels, profits, commissions, bank notes, bills of exchange, other evidences of debt, bottomry and respondentia interests, and other property against loss or damage by any or all of the risks of lake, river, canal and inland navigation and transportation, and other insurances appertaining to or connected with marine risks, including complete line coverage automobile insurance, and also insurance on any other property or risk, or the use thereof, by reason of any contingency unless the granting of such insurance is contrary to public policy. However, such companies may not grant or make insurance against:

(1) losses arising from explosion of steam boilers;

(2) losses arising from breakage of plate or other glass, except when caused by fire, wind, or hail storm, and except when the loss occurs to glass which is a part of any dwelling house;

(3) risks of the classes commonly known as fidelity insurance and surety bonds;

(4) risks of the classes commonly known as burglary or theft insurance, except as above specifically permitted, and except for the risks to any dwelling house; and

(5) the risk of legal liability by reason of bodily injury to the person except as such liability may result from the ownership, maintenance, use or operation of an automobile.

(Formerly: Acts 1935, c.162, s.59; Acts 1957, c.265, s.1; Acts 1959, c.87, s.1; Acts 1961, c.138, s.2.) As amended by Acts 1978, P.L.129, SEC.1; Acts 1982, P.L.160, SEC.1; P.L.260-1983, SEC.5.

IC 27-1-5-2

Management of segregated investment account

Sec. 2. Notwithstanding any other provisions of this article, any company which has established or establishes on or after March 8, 1935, a segregated investment account of assets as authorized in Class 1(c) of section 1 of this chapter may provide that such segregated investment account of assets shall be managed by a committee, board, or similarly designated body, the members of which need not be otherwise affiliated with such company or its board of directors and the members of which may be elected solely by the owners of the contracts issued and outstanding under such account, and may further provide that each contract owner under such account shall have the right, with respect to the election of

members of such committee, board, or body and with respect to other matters pertaining only to such account, to vote a number of votes proportionate to the value of the contract owner's interest in the account in the manner provided by such rules as may be adopted by such committee, board, or body.
(Formerly: Acts 1935, c.162, s.59a; Acts 1967, c.127, s.6.) As amended by P.L.252-1985, SEC.13.

IC 27-1-5-3
"Property" and "property interests" defined

Sec. 3. "Property" and "property interests", as used in section 1 of this chapter, shall include real and personal property, chattels real, currency, coin, bank notes, bullion, postage or revenue stamps, express, postal, pension or bank money orders, bonds, debentures, checks, coupons, demand or time drafts, bills of exchange, acceptances, promissory notes, certificates of deposit, certificates of stock, warehouse receipts, bills of lading, and all other choses in action.
(Formerly: Acts 1935, c.162, s.60.) As amended by P.L.252-1985, SEC.14.

IC 27-1-5-4
Repealed

(Repealed by P.L.255-1995, SEC.15.)

IC 27-1-6
Chapter 6. Formation of Domestic Companies

IC 27-1-6-1
Authority to incorporate; excluded kinds of insurance

Sec. 1. Any number of natural persons, not less than seven (7), all of whom are eighteen (18) years of age or older, at least a majority of whom are residents of the state of Indiana and citizens of the United States, may form a corporation under the provisions of this chapter for the purpose of making any kind or kinds of insurance described in any one class set out in IC 27-1-5-1, other than reciprocal, farm mutual, fraternal, and assessment insurance, by complying with the provisions of this chapter.

(Formerly: Acts 1935, c.162, s.61; Acts 1973, P.L.270, SEC.1.) As amended by P.L.252-1985, SEC.15.

IC 27-1-6-2
Applicable rights, powers, privileges, duties, obligations, and liabilities

Sec. 2. Any insurance company incorporated as such under this chapter, and its successors shall have the rights and powers, shall be entitled to the privileges, and shall be subject to the duties, obligations, and liabilities as prescribed in this article.

(Formerly: Acts 1935, c.162, s.62.) As amended by P.L.252-1985, SEC.16.

IC 27-1-6-3
Names; required and prohibited words; similarity of names; change of name

Sec. 3. The name of any company organized under this article shall contain the word "insurance" and the word "company," "corporation" or "incorporated," or shall end with an abbreviation of one of these words, except that the word "company" or the abbreviation "Co." may be used only if that word or abbreviation is not immediately preceded by the word "and," or any substitute therefor.

No company organized under this article shall:

(a) Use as a part of its corporate name the words "United States," "Federal," "government," "official," or any word that would imply that the company was an administrative agency of the state of Indiana or of the United States, or is subject to supervision of any department other than the department of insurance of the state of Indiana.

(b) Take or assume a corporate name the same as, or confusingly similar to, the name of any other insurance company then existing under the laws of this state or authorized to transact business in this state, unless at the same time (1) such other company shall change its corporate name or withdraw from transacting business in this state, and (2) the written consent of such company, signed and verified

under oath by its secretary, shall be filed with the department.

Any company organized under this article may change its corporate name at any time by amending its articles of incorporation in the manner hereinafter provided. The provisions of this section shall not affect the right of any insurance company which is existing under the laws of this state on March 8, 1935, or of any such company which thereafter reorganizes or reincorporates under this article or of any company authorized to transact business in this state on March 8, 1935, to continue the use of its corporate name.

(Formerly: Acts 1935, c.162, s.63.) As amended by Acts 1977, P.L.281, SEC.3; P.L.1-2009, SEC.145.

IC 27-1-6-4

Articles of incorporation; contents

Sec. 4. The incorporators shall execute articles of incorporation, not inconsistent with the provisions of this article, setting forth the following:

(a) The name of the proposed corporation.

(b) The post office address of its principal office.

(c) A precise and accurate statement of the purpose or purposes for which the company is organized, which shall be restricted to the kind or kinds of insurance comprised within one (1) of the classes of insurance specified in IC 27-1-5-1, and that it is organized under this article.

(d) The term for which it is to continue as a corporation, which may be perpetual.

(e) In the case of a stock company, the amount of its capital and the aggregate number of shares which the company shall have authority to issue and the par value thereof.

(f) The amount of paid-in capital with which the company will begin business.

(g) The plan or principle upon which the business is to be transacted.

(h) The name, occupation, and post office address of each of the incorporators.

(i) The names of the first officers and directors, their post office addresses, and their terms of office.

(j) Any other provisions, consistent with the laws of this state, for the regulation of the business and conduct of the affairs of the company and creating, defining, limiting, or regulating the powers of the company, of the directors, or of the shareholders or any class or classes of shareholders.

(Formerly: Acts 1935, c.162, s.64.) As amended by P.L.252-1985, SEC.17.

IC 27-1-6-5

Publication of notice of intention to organize

Sec. 5. At least ten (10) and not more than twenty (20) days prior

to the presentation of the articles of incorporation to the department as provided in section 6 of this chapter, the incorporators shall publish at least once in a newspaper of general circulation, printed and published in the English language, in the county in which the principal office of the proposed company is to be located, and at least once in a newspaper of general circulation, printed and published in the English language, in the city of Indianapolis, Marion County, Indiana, a notice of intention to organize such a corporation, which publication shall contain the following:

(a) The name of the proposed company.

(b) A statement that the proposed company is to be organized under the provisions of this article.

(c) The general character and class or classes of insurance to be transacted by the proposed company.

(d) The time when the articles of incorporation will be presented to the department.

(e) The names, occupations, and addresses of the incorporators.

(Formerly: Acts 1935, c.162, s.65.) As amended by P.L.252-1985, SEC.18.

IC 27-1-6-6

Articles of incorporation; form; execution

Sec. 6. The form of the articles of incorporation shall be prescribed and furnished by the department. The articles of incorporation shall be:

(1) prepared and signed in triplicate originals by all of the incorporators, or, in the case of a redomestication under IC 27-1-6.5, by the corporate officers if the original incorporators are no longer available;

(2) acknowledged by at least three (3) of the incorporators or corporate officers before a notary public; and

(3) presented in triplicate originals to the department at the office of the department.

(Formerly: Acts 1935, c.162, s.66.) As amended by P.L.116-1994, SEC.18.

IC 27-1-6-7

Articles of incorporation; submission to department; proof of publication

Sec. 7. At the time of presenting the articles of incorporation for approval, the incorporators shall file with the department the proof of publication required by section 5 of this chapter. The department shall determine whether the proof of publication conforms with the provisions of section 5 of this chapter and is hereby authorized to approve or disapprove the same. If the department shall disapprove the proof of publication, it shall endorse its disapproval thereon and return the proof of publication and the articles of incorporation to the incorporators. If the department approves the proof of publication, it

shall then consider the articles of incorporation.
(Formerly: Acts 1935, c.162, s.67.) As amended by P.L.252-1985, SEC.19.

IC 27-1-6-8
Articles of incorporation; approval or disapproval by department

Sec. 8. The department is hereby authorized, in its discretion, to approve or disapprove the articles of incorporation of the proposed company. If the department shall approve the articles of incorporation of the proposed company, the department shall write or stamp, in an appropriate place on each of said triplicate copies of such articles of incorporation, the:

(1) words "Approved by the department of insurance of the state of Indiana";
(2) date of the approval;
(3) impression of the seal of the department; and
(4) signature of the commissioner.

(Formerly: Acts 1935, c.162, s.68.) As amended by P.L.146-2015, SEC.20.

IC 27-1-6-9
Articles of incorporation; submission to attorney general

Sec. 9. In the event the department approves the articles of incorporation of the proposed company, it shall then submit the proposed articles of incorporation to the attorney general for the state of Indiana, who shall examine said articles. If the attorney general finds that the articles of incorporation conform to the provisions of this article and are not inconsistent with the constitution of this state, and of the United States, he shall so certify and shall thereupon return the articles of incorporation to the department with his approval endorsed thereon.
(Formerly: Acts 1935, c.162, s.69.) As amended by P.L.252-1985, SEC.20.

IC 27-1-6-10
Articles of incorporation; submission to secretary of state; filing

Sec. 10. When the articles of incorporation have been approved by the attorney-general and returned to the department, then the department shall present the same to the secretary of state for the state of Indiana. If the secretary of state finds that the articles of incorporation conform to law, he shall indorse his approval upon each of the triplicate copies of the articles, and when all fees have been paid as required by law, he shall file one (1) copy in his office and return the other two (2) copies to the incorporators or their representatives.
(Formerly: Acts 1935, c.162, s.70.)

IC 27-1-6-11

Articles of incorporation; filing certified copy with department; surety bond; permit for completion of organization; procedure

Sec. 11. (a) When the articles of incorporation are returned to the incorporators or their representatives bearing the endorsement of the approval of the secretary of state, as provided in section 10 of this chapter, the incorporators or their representatives shall obtain a certified copy of the articles of incorporation from the secretary of state and file such certified copy with the department.

(b) The incorporators shall also file with the department a surety bond payable to the state of Indiana in the sum of ten thousand dollars ($10,000), with surety to be approved by the commissioner or collateral in the sum of ten thousand dollars ($10,000), as approved by the commissioner, and conditioned upon the faithful accounting to the department on completion of organization and receipt of its certificate of authority from the department, or to its shareholders, members, applicants for policies and creditors, or the trustee, receiver, or assignee of the proposed company duly appointed in any proceedings in any court of competent jurisdiction in the state in accordance with their respective rights in case the organization of the proposed company should not be completed and a certificate of authority should not be procured from the department.

(c) Whenever the incorporators have filed their certified copy of the articles of incorporation and bond as provided in this section, then the department may issue a permit for completion of organization. The company shall have authority under such permit to solicit subscriptions and payments for capital stock, if a stock company, and applications and advance premiums for insurance, if a mutual company, and to exercise such powers, subject to the limitations in this article prescribed, as may be necessary and proper in completing its organization and qualifying itself for a certificate of authority from the department to make the kind or kinds of insurance proposed in its articles of incorporation, provided that such company shall not issue policies or enter into contracts of insurance until it shall have received the certificate of the department authorizing it so to do.

(Formerly: Acts 1935, c.162, s.71.) As amended by P.L.252-1985, SEC.21.

IC 27-1-6-12

Commencement of corporate existence; powers

Sec. 12. Upon the issuance of the permit for completion of organization by the department, the corporate existence shall begin, and thereupon such incorporators and their associates shall become a body corporate with power to sue and be sued, contract and be contracted with, adopt a seal, and do such other acts, subject to the provisions and to the restrictions of this article, as shall be needful to accomplish the purpose of completing its organization, provided, that such company shall not issue policies or enter into contracts of

insurance until it shall have received the certificate of the department authorizing it so to do.
(Formerly: Acts 1935, c.162, s.72.) As amended by P.L.252-1985, SEC.22.

IC 27-1-6-13
Requirements for commencing business or incurring indebtedness; liability for violations

Sec. 13. Any company organized under this article shall not transact any business or incur any indebtedness until:

(a) one (1) of the triplicate copies of the articles of incorporation, bearing the approval of the department and the attorney general and the endorsement of the approval of the secretary of state, as provided in section 10 of this chapter has been filed for record with the county recorder of the county in which the principal office is located; and

(b) a certified copy of the permit for completion of organization, issued pursuant to section 11 of this chapter, shall be filed for record with the county recorder of the county in which the principal office is located, which certified copy shall be evidence only that the company has been authorized to proceed in the completion of its organization.

If a company transacts any business or incurs any indebtedness in violation of this section, the officers who participated therein and the directors, except those who dissented therefrom and caused their dissent to be filed at the time in the principal office of the company or who, being absent, filed their dissent upon learning of the action, shall be severally liable for the debts or liabilities of the company so incurred or arising therefrom.
(Formerly: Acts 1935, c.162, s.73.) As amended by P.L.252-1985, SEC.23.

IC 27-1-6-14
Stock companies; capital stock and surplus requirements

Sec. 14. (a) A domestic capital stock company that organized before March 7, 1967, must maintain a paid-in capital stock of not less than:

(1) two hundred thousand dollars ($200,000), if it markets one (1) or more kinds of insurance under Class I;

(2) two hundred thousand dollars ($200,000), if it markets one (1) kind of insurance under Class II, other than Class II(k) insurance;

(3) three hundred thousand dollars ($300,000), if it markets two (2) kinds of insurance under Class II, other than Class II(k) insurance;

(4) four hundred thousand dollars ($400,000), if it markets three (3) or more kinds of insurance under Class II, other than Class II(k) insurance;

(5) four hundred thousand dollars ($400,000), if it markets one (1) or more kinds of insurance under Class III;

(6) seven hundred fifty thousand dollars ($750,000), if it markets one (1) or more kinds of insurance under both Class II and Class III; or

(7) seven hundred fifty thousand dollars ($750,000), if it markets one (1) or more kinds of insurance under Class II, including Class II(k) insurance.

(b) A domestic capital stock company that organized after March 6, 1967, and before July 1, 1977, must maintain a paid-in capital stock of not less than:

(1) four hundred thousand dollars ($400,000), if it markets one (1) or more kinds of insurance under Class I;

(2) four hundred thousand dollars ($400,000), if it markets one (1) or more kinds of insurance under Class II, other than Class II(k) insurance;

(3) four hundred thousand dollars ($400,000), if it markets one (1) or more kinds of insurance under Class III;

(4) seven hundred fifty thousand dollars ($750,000), if it markets one (1) or more kinds of insurance under both Class II and Class III; or

(5) seven hundred fifty thousand dollars ($750,000), if it markets one (1) or more kinds of insurance under Class II, including Class II(k) insurance.

(c) A domestic capital stock company that organized after June 30, 1977, must maintain a paid-in capital stock of not less than one million dollars ($1,000,000).

(d) A domestic capital stock company must deposit with the department the following percentage of its paid-in capital stock requirement under this section in cash or in obligations of the United States:

(1) Twenty-five percent (25%), if it organized before July 1, 1977.

(2) Ten percent (10%), if it organized after June 30, 1977.

(e) A domestic capital stock company must maintain a surplus of not less than two hundred fifty thousand dollars ($250,000). However, when it organizes, it must have a surplus of not less than one million dollars ($1,000,000).

(f) If the commissioner determines that the continued operation of a domestic capital stock company may be hazardous to the policyholders or the general public, the commissioner may, upon the commissioner's determination, issue an order requiring the insurer to increase the insurer's capital and surplus based on the type, volume, and nature of the business transacted.

(Formerly: Acts 1935, c.162, s.74; Acts 1955, c.316, s.1; Acts 1959, c.13, s.1; Acts 1967, c.127, s.2.) As amended by Acts 1977, P.L.282, SEC.1; Acts 1980, P.L.169, SEC.1; P.L.130-1994, SEC.14; P.L.116-1994, SEC.19.

IC 27-1-6-15

Mutual companies; initial subscriptions and premiums; deposits; surplus

Sec. 15. (a) Except as provided in subsection (b), a domestic mutual company that organized before July 1, 1977, must maintain a surplus of not less than two hundred fifty thousand dollars ($250,000). This subsection does not apply to a standard farm mutual insurance company that is organized under IC 27-5 (before its repeal) or IC 27-5.1.

(b) A domestic mutual company that organized before July 1, 1977, must maintain a surplus of not less than:

(1) seven hundred fifty thousand dollars ($750,000), if it markets one (1) or more kinds of insurance under both Class II and Class III, other than Class II(k) insurance;

(2) one million dollars ($1,000,000), if it markets one (1) or more kinds of insurance under Class II, including Class II(k) insurance; or

(3) one million dollars ($1,000,000), if it markets one (1) or more kinds of insurance under both Class II and Class III, including Class II(k) insurance.

(c) A domestic mutual company that organized after June 30, 1977, must maintain a surplus of not less than one million two hundred fifty thousand dollars ($1,250,000). However, when it organizes, it must:

(1) have a surplus of not less than two million dollars ($2,000,000);

(2) for the one (1) or more kinds of insurance under Class I that it intends to market, have received applications for insurance from not less than four hundred (400) persons, each application for an amount not less than one thousand dollars ($1,000), and have received the first year's premium due on a policy to be issued on each such application; and

(3) for the one (1) or more kinds of insurance under Class II or Class III that it intends to market, have received applications for insurance covering not less than eight hundred (800) separate risks in not less than forty (40) policies to be issued to not less than forty (40) members, and have received premiums amounting to not less than one hundred thousand dollars ($100,000) for those policies.

(d) A domestic mutual company must deposit with the department in cash or in obligations of the United States:

(1) twenty-five thousand dollars ($25,000), if it organized before June 30, 1955;

(2) fifty thousand dollars ($50,000), if it organized after June 29, 1955, and before March 7, 1967; or

(3) one hundred thousand dollars ($100,000), if it organized after March 6, 1967.

This subsection does not apply to a standard farm mutual insurance

company that is organized under IC 27-5 (before its repeal) or IC 27-5.1.

(e) If the commissioner determines that the continued operation of a domestic mutual company may be hazardous to the policyholders or the general public, the commissioner may, upon the commissioner's determination, issue an order requiring the insurer to increase the insurer's capital and surplus based on the type, volume, and nature of the business transacted.

(Formerly: Acts 1935, c.162, s.75; Acts 1955, c.316, s.2; Acts 1967, c.127, s.3.) As amended by Acts 1977, P.L.282, SEC.2; P.L.130-1994, SEC.15; P.L.116-1994, SEC.20; P.L.129-2003, SEC.1.

IC 27-1-6-16

Extension of charter powers and licenses; limitation of actions

Sec. 16. (a) The charter powers and licenses of any domestic insurers authorized to market one or more kinds of insurance or reinsurance under Class II or Class III and meeting the requirements set out in section 14 or 15 of this chapter may be broadened and extended hereunder to include the right, power and authority to make any one or more of the kinds of insurance and reinsurance specified in both Class II and Class III of IC 27-1-5-1.

(b) Any domestic company authorized to insure against loss or damage by fire, which has been actively engaged in the fire insurance business continuously for ten (10) years or more, or whose predecessor or predecessors, if any prior to merger or consolidation, shall have been so engaged for such period, may, if it complies with the provisions of this subsection and without complying with the capitalization and surplus requirements of section 14 or section 15 of this chapter, insure against loss or damage to dwellings and appurtenant structures and to the contents thereof and any other personal property of a similar nature of the insured or of the members of his household, resulting from any peril, and may, in connection with making such insurance, also make insurance against the legal liability of the insured or of the members of his household, and for any medical, surgical and hospital expenses of any person other than the insured or such members, arising out of nonbusiness pursuits of the insured or such members or out of the condition of, or acts performed by the insured or such members on such dwellings and appurtenant structures and the real estate on which each is located. Where a company is entitled to make such additional insurance solely by virtue of this subsection, it shall not make such insurance unless it has made reinsurance arrangements satisfactory to the commissioner whereby all of such additional insurance is reinsured with a company which is qualified under IC 27-1 to make reinsurance of such additional kind of insurance. The charter powers and licenses of any domestic insurer meeting the requirements set out in this subsection may be broadened and extended hereunder to

include the right, power and authority to make any one or more of the kinds of insurance permitted by this subsection.

(c) No policy issued by a mutual company including a farm mutual insurance company, shall be required to contain a provision limiting the time within which suit against the insurer on such policy must be filed.

(Formerly: Acts 1935, c.162, s.75 1/2; Acts 1947, c.50, s.1; Acts 1957, c.265, s.2; Acts 1967, c.233, s.2.) As amended by Acts 1977, P.L.282, SEC.3; P.L.129-2003, SEC.2.

IC 27-1-6-17

Examination of proposed companies; revocation and renewal of permit and insurance producer's authority

Sec. 17. The commissioner may, personally or through the commissioner's deputies and assistants, examine into the affairs of any such proposed company and inspect its books and papers, and may summon and examine under oath any officer or insurance producer or any person who is or has been connected with such company, and if the commissioner finds the company is violating the law, or if the company shall not be qualified for a certificate of authority within one (1) year from date of its permit, the commissioner may revoke its permit; and if the commissioner finds an insurance producer of such company has violated the law, the commissioner may revoke the insurance producer's authority, and the commissioner may for the insurance producer's violation revoke the company's permit. Any revocation shall be after notice and hearing. The commissioner may renew any company's permit or agent's authority which the commissioner has revoked.

(Formerly: Acts 1935, c.162, s.76.) As amended by P.L.178-2003, SEC.14.

IC 27-1-6-18

Certificate of authority; issuance; recording

Sec. 18. When the provisions of sections 2 through 17 of this chapter have been complied with, and the department has made an investigation and examination as required in section 17, then the commissioner may issue a certificate of authority under IC 27-1-3-20, which shall license the company to transact only the kind or kinds of insurance specified in its articles of incorporation. The company shall file a certified copy of such certificate of authority for record with the county recorder of the county wherein the principal office is located, which certified copy shall be evidence only that the company is authorized and licensed to transact the class or classes of insurance set out therein.

(Formerly: Acts 1935, c.162, s.77.) As amended by Acts 1977, P.L.283, SEC.1.

IC 27-1-6-19

Bylaws; procedure for adoption

Sec. 19. (a) If the articles of incorporation provide for the adoption of the bylaws by the shareholders, members, or policyholders, the incorporators or a majority of them after the issuance of the certificate of authority, shall call a meeting of the shareholders, members, or policyholders for the purpose of adopting the bylaws, giving at least ten (10) days' notice by mail to each shareholder, member, or policyholder entitled to vote at the time and place of such meeting, unless the giving of such notice be waived in writing by any or all of such shareholders, members, or policyholders, in which case notice shall be given only to such shareholders, members, or policyholders who have not so waived such notice. Such shareholders, members, or policyholders shall meet at the time and place designated and shall adopt the bylaws. After the adoption of such bylaws, the directors named in the articles of incorporation as the first board of directors shall meet at the call of a majority thereof and shall elect officers and transact such other business as may properly come before such board.

(b) If the articles of incorporation do not provide for the adoption of the bylaws by the shareholders, members, or policyholders, then, after the issuance of the certificate of authority, the directors named in the articles as the first board of directors shall meet at the call of a majority thereof, adopt the bylaws, elect officers, and transact such other business as may properly come before such board.

(Formerly: Acts 1935, c.162, s.78.) As amended by P.L.252-1985, SEC.24.

IC 27-1-6-20

Repealed

(Repealed by P.L.108-1985, SEC.1.)

IC 27-1-6-21

Company domiciled in Indiana; requirements

Sec. 21. (a) A company that is approved by the department after June 30, 2000, to be domiciled in Indiana, must have and maintain in Indiana the following:

(1) A physical presence that provides economic benefit to the state.

(2) Complete records of the company's assets, transactions, and affairs in accordance with methods and systems that are customary or suitable to the kind or kinds of insurance transacted by the company, including all records required under IC 27-1-7-16. Records may be maintained in a form that is physically or electronically available to the department within Indiana.

(b) The commissioner shall determine whether the requirements of subsection (a) are met. In making a determination under subsection (a)(1), the commissioner shall compare and consider the

following:

(1) The economic benefit to Indiana and Indiana communities offered by the domestication of the company.

(2) The costs that may be incurred by the state in regulating the company as a domestic company versus a foreign company.

(c) If a domestic company subject to this section fails to comply with the provisions of subsection (a), the commissioner may:

(1) require the company to transfer its domicile under IC 27-1-6.5-2; or

(2) annually impose an additional administrative fee on the company in an amount equal to the difference between the cost of regulating the company as a domestic company and the cost of regulating the company as a foreign company. The fee shall be deposited in the department of insurance fund established by IC 27-1-3-28.

(d) In the case of a company that is part of an insurance holding company system (as defined in IC 27-1-23-1) whose presence provides an economic benefit to the state, the commissioner shall consider the insurance holding company system and any domestic company in the aggregate when making the determination required under subsection (b).

As added by P.L.144-2000, SEC.1.

IC 27-1-6.5

Chapter 6.5. Redomestication of Insurers

IC 27-1-6.5-1

Foreign insurers; qualification as domestic insurer; requirements

Sec. 1. (a) Any foreign insurance company which is admitted to transact business in Indiana may, upon complying with the requirements for formation of a domestic company under IC 27-1-6, become a domestic insurer. When those requirements have been met, the commissioner may issue a certificate of authority, under IC 27-1-3-20, to permit the company to transact business in the state as a domestic company.

(b) A company which changes its status from foreign to domestic under subsection (a) has all the rights, titles, and interests in the assets of the original corporation, as well as all of its liabilities and obligations. The company shall be recognized as a company formed under the laws of this state as of the date of its incorporation in its original domiciliary state.

As added by Acts 1980, P.L.170, SEC.1.

IC 27-1-6.5-2

Domestic insurers; transfer of domicile to another state; approval

Sec. 2. Any domestic insurance company may, upon the approval of the commissioner, transfer its domicile from this state to any other state in which it is admitted to transact business. The commissioner shall approve the proposed transfer of domicile, unless he determines that the transfer is contrary to the best interests of the company's policyholders. If the commissioner does not approve the transfer, he shall give the company written notice of the refusal and the reasons for it within thirty (30) days after the date the request for transfer was made. If the request for transfer is granted, and the company is otherwise qualified, it may operate in this state as a foreign insurer without interruption in licensing.

As added by Acts 1980, P.L.170, SEC.1.

IC 27-1-6.5-3

Foreign insurers; change of domicile to another foreign state; merger or consolidation conditions

Sec. 3. Any foreign insurance company admitted to transact business in this state may, upon proper notice to the commissioner, change its domicile by merger, consolidation, or otherwise to another foreign state without interruption of its licensing and without reapplying as a foreign insurer if:

(1) the change in domicile does not result in a reduction in the company's assets or surplus below the requirements for admission as a foreign insurer under IC 27-1-17-5;

(2) there is no substantial change in the lines of insurance to be written by the company; and

(3) the change in domicile has been approved by the supervising regulatory officials of both the former and new state of domicile.

As added by Acts 1980, P.L.170, SEC.1.

IC 27-1-6.5-4

Transfer of domicile to another state; requisites

Sec. 4. Each insurer admitted to transact business in this state that transfers its domicile to any other state shall notify the commissioner of the proposed transfer and shall file promptly with him any necessary amendments to articles of incorporation, charters, bylaws, and other corporate documents.

As added by Acts 1980, P.L.170, SEC.1.

IC 27-1-6.5-5

Transfer of domicile to this or another state; effectiveness of certificate of authority

Sec. 5. When any insurer admitted to transact business in this state transfers its domicile to this or any other state, its certificate of authority, insurance producers' appointments and licenses, policy forms, rates, authorizations, and other filings and approvals which existed at the time of the transfer, remain in effect after the transfer of domicile occurs.

As added by Acts 1980, P.L.170, SEC.1. Amended by P.L.178-2003, SEC.15.

IC 27-1-6.5-6

Regulations

Sec. 6. The commissioner may develop and promulgate regulations, under IC 4-22-2, to carry out the purposes of this chapter.

As added by Acts 1980, P.L.170, SEC.1.

IC 27-1-7

Chapter 7. General Corporate Powers and Responsibilities of Insurance Companies

IC 27-1-7-1

"Corporation" defined

Sec. 1. The term "corporation", as used in this chapter and IC 27-1-8, means any company organized or reorganized under the provisions of this article and any company organized or reorganized under the provisions of any statute of this state enacted prior to March 8, 1935.

(Formerly: Acts 1935, c.162, s.79.) As amended by P.L.252-1985, SEC.25.

IC 27-1-7-2

Capacity and authority to act; general rights, privileges, and powers; excluded powers

Sec. 2. (a) Every corporation has the capacity to act that is possessed by natural persons, but has the authority to perform only those acts that are necessary, convenient, or expedient to accomplish the purposes for which it is formed and that are not repugnant to law.

(b) Subject to any limitations or restrictions imposed by law or the articles of incorporation, each corporation has the following general rights, privileges, and powers:

(1) To continue as a corporation, under its corporate name, for the period set forth in its articles of incorporation.

(2) To sue and be sued in its corporate name.

(3) To have a corporate seal and to alter the same at pleasure.

(4) To acquire, own, hold, lease, mortgage, pledge, convey, or otherwise dispose of property, real and personal, tangible and intangible.

(5) To acquire, subscribe for, own, hold, vote, mortgage, lend, pledge, convey, or otherwise dispose of, and to guarantee or otherwise deal in and with, shares or other interests in, or obligations of, any entity, including itself, except as otherwise prohibited or limited by this article.

(6) To be a promoter, partner, member, associate, or manager of any partnership, joint venture, trust, or other entity.

(7) To borrow money, and to issue its notes or debentures to evidence such borrowings, but any debentures so issued shall be subordinate to the rights of policyholders, members, or creditors of such corporations.

(8) To conduct business in this state and elsewhere; to have one (1) or more offices out of this state; to acquire, own, hold and use, and to lease, mortgage, pledge, sell, convey, or otherwise dispose of property, real and personal, tangible and intangible, out of this state.

(9) To appoint such officers and agents as the business of the

corporation may require, and to define their duties and fix their compensation.

(10) To lend money, invest and reinvest its funds, and receive and hold real estate and personal property as security for repayment, except as otherwise limited in this title.

(11) To pay pensions and establish and administer pension plans, pension trusts, profit sharing plans, share bonus plans, share option plans, welfare plans, qualified and nonqualified retirement plans, and benefit or incentive plans for any or all of its current or former directors, officers, employees, and agents.

(12) To make donations for the public welfare or for charitable, scientific, or education purposes.

(13) To make bylaws for the government and regulation of its affairs.

(14) To cease doing business and to dissolve and surrender its corporate franchise and authority and license to transact an insurance business in this state.

(15) To do all acts and things necessary, convenient, or expedient to carry out the purposes for which it is formed.

(16) To become a member of any federal home loan bank; to purchase stock therein, to borrow money or obtain advances from any such bank and to transfer, assign, and pledge property to or with such bank as security for the payment of such loans or advances, to do and perform all acts required of members of a federal home loan bank, and to possess and exercise all rights, powers, and privileges conferred upon such members under the provisions of the act of Congress entitled Federal Home Loan Bank Act.

(c) No corporation shall, by any implication or construction, be deemed to possess the power of carrying on the business of receiving deposits of money, bullion, or foreign coins, or receiving deposits of securities or other personal property from any person or corporation or acting as a safe deposit company, or of issuing bills, notes, or other evidences of debt for circulation as money.

(d) A corporation that is a stock company may establish one (1) or more procedures by which it regulates transactions that would, when consummated, result in a change of control of such corporation.

(e) For purposes of this section "control" means:

(1) for any corporation having one hundred (100) or more shareholders, the beneficial ownership, or the direct or indirect power to direct the voting, of no less than ten percent (10%) of the voting shares of a corporation's outstanding voting shares; or

(2) for any corporation having fewer than one hundred (100) shareholders, the beneficial ownership, or the direct or indirect power to direct the voting, of no less than fifty percent (50%) of the voting shares of the corporation's outstanding voting

shares.

(f) A procedure established under this section may be adopted:

(1) in a corporation's original articles of incorporation or bylaws;

(2) by amending the articles of incorporation; or

(3) notwithstanding that a vote of the shareholders would otherwise be required by any other provision of this article or the articles of incorporation for the adoption or implementation of all or any portion of the procedure, by amending the bylaws.

(Formerly: Acts 1935, c.162, s.80; Acts 1939, c.63, s.1; Acts 1973, P.L.271, SEC.1.) As amended by P.L.266-1987, SEC.1.

IC 27-1-7-3

Principal office; change of location

Sec. 3. Each corporation shall maintain an office or place of business in this state, to be known as the "Principal Office." The post-office address of the principal office shall be stated in the original articles of incorporation at the time of incorporating. Thereafter, the location of the principal office, may be changed at any time or from time to time when authorized by the board of directors by:

(1) filing with the department and secretary of state, on or before the day any change is to take effect, a certificate signed by the president or a vice-president and the secretary or an assistant secretary of the corporation, and verified under oath, stating the change to be made and reciting that such change is made pursuant to authorization by the board of directors; and

(2) notifying each policyholder of the address and telephone number of the new location.

(Formerly: Acts 1935, c.162, s.81.) As amended by P.L.94-1999, SEC.1.

IC 27-1-7-4

Shares of stock; classes; sale for less than par; shareholders' liability; preemptive rights

Sec. 4. (a) Every stock company organized under this article shall have the right, when authorized by its articles of incorporation, to issue one (1) or more classes or kinds of shares of capital stock, any or all of which classes or kinds may consist of shares with par value or shares without par value, with full, limited, or no voting powers as provided in the articles of incorporation and with such designations, and such relative rights, preferences, qualifications, limitations, or restrictions as shall be stated and expressed in the articles of incorporation.

(b) No stock company organized under this article shall issue or sell any of its shares of stock having a par value for less than the par value thereof.

(c) The shareholders of any stock company organized under this

article shall be liable for the debts of such stock company only to the extent of any unpaid portion of their subscriptions for shares of such company or any unpaid portion of the consideration for the issuance to them of shares of such stock company.

(d) The shareholders of such stock company shall not have preemptive rights to subscribe to any additional issues of shares of the capital stock of such company, except to the extent, if any, that such rights shall be fixed and prescribed in the articles of incorporation, or in a bylaw adopted by the board of directors of such stock company.

(Formerly: Acts 1935, c.162, s.82; Acts 1969, c.164, s.3.) As amended by P.L.252-1985, SEC.26.

IC 27-1-7-5

Stock certificate; contents; transferability

Sec. 5. In the case of a stock company, every shareholder shall be entitled to a certificate, or other evidence of stock ownership, signed by the president or a vice president and by the secretary or an assistant secretary, which shall state the name of the registered holder, the number of shares represented thereby and the par value of each share. Where such certificate is also signed by a transfer agent or registrar, or both, the signatures of any such president, vice president, secretary or assistant secretary may be facsimiled. The shares represented thereby shall be transferable on the books of the company in such manner and under such regulations, not inconsistent with the laws of this state relating to the transfer of shares of stock in corporations, as may be provided in the by-laws. If such company is authorized to issue shares of more than one (1) class, every certificate shall state the kind and class of shares represented thereby, and the relative rights, interests, preferences and restrictions of such class, or a summary thereof.

(Formerly: Acts 1935, c.162, s.83; Acts 1963, c.144, s.1.)

IC 27-1-7-6

Bylaws

Sec. 6. Unless otherwise provided in the articles of incorporation, the power to make, alter, amend or repeal the bylaws of a company is hereby vested in the board of directors. The bylaws so adopted may contain any provision for the regulations and management of the affairs of the corporation which is not inconsistent with this article or of any law of this state or with the articles of incorporation and may include provisions concerning:

(a) the time and place of holding, and the manner of conducting meetings of the shareholders, members, or policyholders, and of directors;

(b) the manner of calling special meetings of shareholders, members, or policyholders and directors;

(c) the powers, duties, tenure, and qualifications of the officers

of the corporation and the time, place, and manner of electing them;

(d) the creation and appointment of executive or other committees and the number of members thereof and prescribing their powers;

(e) the classification of its risks and of its members, the payment of dividends and the creation of a surplus fund or funds, if other than a stock company; and

(f) the form of stock certificates or other evidences of stock ownership and the manner of transferring shares of capital stock if a stock company, and the manner of creating and exercising proxies.

(Formerly: Acts 1935, c.162, s.84.) As amended by P.L.252-1985, SEC.27.

IC 27-1-7-7

Meetings of shareholders, members, or policyholders; location; annual meeting; special meetings; notice; quorum; actions taken without meeting

Sec. 7. (a) All meetings of shareholders, members, or policyholders shall be held within this state and at the principal office of the corporation, unless otherwise provided in the articles of incorporation.

(b) An annual meeting of shareholders, members, or policyholders shall be held within five (5) months after the close of each fiscal year of the corporation and at such time within that period as the bylaws may provide. The failure to hold the annual meeting at the designated time shall not work any forfeiture or a dissolution of the corporation. The time and place of such annual meeting of a mutual company may be stated in the policies thereof or notice of such meeting shall be given as provided in subsection (d).

(c) Special meetings of the shareholders, members, or policyholders may be called by the president, by the board of directors, by shareholders, members, or policyholders holding not less than one-fourth (1/4) of all of the shares or policies outstanding and entitled by the articles of incorporation to vote on the business proposed to be transacted thereat, or by such other officers or persons as the bylaws may provide.

(d) A written or printed notice stating the place, day, and hour of the meeting, and in case of a special meeting, the purpose or purposes for which the meeting is called, shall be delivered or mailed by the secretary, or by the officers or persons calling the meeting, to each shareholder, member, or policyholder of record, entitled by the articles of incorporation and by this article to vote at such meeting, at such address as appears upon the records of the corporation, at least thirty (30) days before the date of the meeting. Notice of any meeting of the shareholders, members, or policyholders may be waived in writing by any shareholder, member, or policyholder if the

waiver sets forth in reasonable detail the purpose or purposes for which the meeting is called and the time and place thereof. Attendance at any meeting in person or by proxy shall constitute a waiver of notice of such meeting.

(e) Unless otherwise provided in the articles of incorporation or by the provisions of this article or the bylaws, at any meeting of the shareholders, members, or policyholders, a majority of the shares of the outstanding capital stock entitled by the articles of incorporation to vote at such meeting or in the case of a company other than a stock company, not less than ten percent (10%) of the policyholders or members entitled to vote at such meeting, represented in person or by proxy, shall constitute a quorum.

(f) Unless otherwise provided in the articles of incorporation or bylaws, action to be taken at a meeting of shareholders, members, or policyholders may be taken without a meeting if the action is taken by all the shareholders, members, or policyholders entitled to vote on the action. The action must be evidenced by one (1) or more written consents that:

(1) describe the action taken;

(2) are signed by all the shareholders, members, or policyholders entitled to vote on the action; and

(3) are delivered to the corporation for inclusion in the minutes or for filing with the corporate records.

(g) The record date for determining shareholders, members, or policyholders entitled to take action without a meeting is the date the first shareholder, member, or policyholder signs the consent under subsection (f).

(h) Action taken under subsection (f) is effective when the last shareholder, member, or policyholder signs the consent, unless the consent specifies a different prior or subsequent effective date.

(i) A consent signed under subsection (f) has the effect of a meeting vote and may be described as a meeting vote in any document.

(Formerly: Acts 1935, c.162, s.85; Acts 1965, c.6, s.1.) As amended by P.L.252-1985, SEC.28; P.L.185-1997, SEC.1.

IC 27-1-7-8

Voting rights of shareholders; shares that cannot be voted; voting by particular shareholders; proxy votes

Sec. 8. (a) Except as otherwise provided in the articles of incorporation or in this section, every shareholder in a stock insurance company shall have the right, at every shareholders' meeting, to one (1) vote for each share of stock standing in his name on the books of the corporation. No share shall be voted at any meeting:

(1) which shall have been transferred on the books of the corporation within such number of days, not exceeding fifty (50), next preceding the date of such meeting as the board of

directors shall determine, or, in the absence of such determination, within ten (10) days next preceding the date of such meeting; or

(2) which belongs to the corporation that issued it.

(b) Shares standing in the name of a corporation, other than the issuing corporation, may be voted by such officer, agent or proxy as the board of directors of such corporation may appoint or as the by-laws of such corporation may prescribe.

(c) Shares held by fiduciaries may be voted by the fiduciaries in such manner as the instrument or order appointing such fiduciaries may direct. In the absence of such direction, or the inability of the fiduciaries to act in accordance therewith, the following provisions shall apply:

(1) Where shares are held jointly by three (3) or more fiduciaries, such shares shall be voted in accordance with the will of the majority.

(2) Where the fiduciaries, or a majority of them, can not agree, or where they are equally divided upon the question of voting such shares, any court having general equity jurisdiction may, upon petition filed by any of such fiduciaries, or by any party in interest, direct the voting of such shares as it may deem to be for the best interest of the beneficiaries, and such shares shall be voted in accordance with such direction.

(d) Unless otherwise provided in the agreement of pledge, or in the by-laws of the corporation, shares that are pledged may be voted by the shareholder pledging such shares until the shares shall have been transferred to the pledgee on the books of the corporation, and thereafter such shares may be voted by the pledgee.

(e) Shares issued and held in the names of two (2) or more persons shall be voted in accordance with the will of the majority, and if a majority of them can not agree, or if they are equally divided as to the voting of such shares, the shares shall be divided equally between or among such persons for voting purposes.

(f) A shareholder, including any fiduciary, may vote either in person or by proxy executed in writing by the shareholder or a duly authorized attorney in fact. Unless a longer time is expressly provided therein, no proxy shall be valid after eleven (11) months from the date of its execution.

(Formerly: Acts 1935, c.162, s.86.) As amended by Acts 1981, P.L.234, SEC.1.

IC 27-1-7-9

Voting rights of policyholders and members; proxy votes

Sec. 9. Except as otherwise provided in the articles of incorporation every policyholder or member, in all companies other than stock companies, shall have the right to one (1) vote at every policyholders' or members' meeting, regardless of the number of policies or amount of insurance he may have with such company.

Any policyholder or member may vote either in person or by proxy executed in writing by the policyholder or by a duly authorized attorney in fact. Unless a longer time is expressly provided therein, no proxy hereafter given shall be valid after eleven (11) months from the date of its execution.
(Formerly: Acts 1935, c.162, s.87.)

IC 27-1-7-9.5
Shareholders' derivative proceedings; procedure

Sec. 9.5. (a) As used in this section, "shareholder" includes:

(1) with respect to a stock company formed under this article, a shareholder or a beneficial owner whose shares are held in a voting trust or held by a nominee on the owner's behalf; and

(2) with respect to a mutual company formed under this article, a member or policyholder.

(b) A person may not commence a proceeding in the right of a corporation unless the person was a shareholder of the corporation when the transaction complained of occurred or unless the person became a shareholder through transfer by operation of law from one who was a shareholder at that time. The derivative proceeding may not be maintained if it appears that the person commencing the proceeding does not fairly and adequately represent the interests of the shareholders in enforcing the right of the corporation.

(c) A complaint in a proceeding brought in the right of a corporation must be verified and allege with particularity the demand made, if any, to obtain action by the board of directors, and either that the demand was refused or ignored or why the shareholder did not make the demand. Whether or not a demand for action was made, if the corporation commences an investigation of the charges made in the demand or complaint (including an investigation commenced under subsection (e)), the court may stay any proceeding until the investigation is completed.

(d) A proceeding commenced under this section may not be discontinued or settled without the court's approval. If the court determines that a proposed discontinuance or settlement will substantially affect the interest of the corporation's shareholders or a class of shareholders, the court shall direct that notice be given the shareholders affected. On termination of the proceeding, the court may require the plaintiff to pay any defendant's reasonable expenses (including attorney's fees) incurred in defending the proceeding if it finds that the proceeding was commenced without reasonable cause.

(e) Unless prohibited by the articles of incorporation, the board of directors may establish a committee consisting of three (3) or more disinterested directors or other disinterested persons to determine:

(1) whether the corporation has a legal or equitable right or remedy; and

(2) whether it is in the best interests of the corporation to pursue that right or remedy, if any, or to dismiss a proceeding that

seeks to assert that right or remedy on behalf of the corporation.

(f) In making a determination under subsection (e), the committee is not subject to the direction or control of or termination by the board. A vacancy on the committee may be filled by the majority of the remaining members by selection of another disinterested director or other disinterested person.

(g) If the committee determines that pursuit of a right or remedy through a derivative proceeding or otherwise is not in the best interests of the corporation, the merits of that determination shall be presumed to be conclusive against any shareholder making a demand or bringing a derivative proceeding with respect to such right or remedy, unless such shareholder can demonstrate that:

(1) the committee was not disinterested, as described in subsection (h); or

(2) the committee's determination was not made after an investigation conducted in good faith.

(h) For purposes of this section, a director or other person is disinterested if the director or other person:

(1) has not been made a party to a derivative proceeding seeking to assert the right or remedy in question, or has been made a party but only on the basis of a frivolous or insubstantial claim or for the sole purpose of seeking to disqualify the director or other person from serving on the committee;

(2) is able under the circumstances to render a determination in the best interests of the corporation; and

(3) is not an officer, employee, or agent of the corporation or of a related corporation. However, an officer, employee, or agent of the corporation or a related corporation who meets the standards of subdivisions (1) through (2) shall be considered disinterested in any case in which the right or remedy under scrutiny is not assertable against a director or officer of the corporation or the related corporation.

As added by P.L.266-1987, SEC.2.

IC 27-1-7-10

Board of directors; general provisions; management of business; executive committee; removal of directors

Sec. 10. (a) The business of every corporation shall be managed by a board of directors, composed of not less than five (5) nor more than the maximum number fixed in the articles of incorporation. The exact number of directors to serve for each year shall be determined from time to time, in such manner as the bylaws prescribe.

(b) The first board of directors shall be elected by the incorporators and shall hold office until the first annual meeting of the shareholders, members or policyholders. At the first annual meeting of the shareholders, members or policyholders, and at each annual meeting thereafter, directors shall be elected by the shareholders, members or policyholders for the term or terms

hereinafter prescribed.

(c) The articles of incorporation or the bylaws may provide that the directors may be divided into two (2) or more classes whose terms of office expire at different times, but no term shall continue longer than six (6) years. In the absence of such provision, each director, except members of the first board of directors, shall be elected for a term of one (1) year and shall hold office until the director's successor is elected and has qualified.

(d) Any vacancy which may occur in the membership of the board of directors, caused by an increase in the number of directors or otherwise (except death, resignation, or disqualification), shall be filled by a majority vote of the remaining members of the board, until the next annual meeting of the shareholders, members or policyholders. A vacancy in the membership in the board of directors caused by death, resignation or disqualification of a member shall be filled by a majority vote of the remaining membership of the board for the unexpired term of the directorship.

(e) A majority of the whole board of directors is necessary to constitute a quorum for the transaction of any business except the filling of vacancies, and the act of a majority of the board of directors present at any meeting at which a quorum is present is the act of the board of directors, unless a greater number is required by this article, or by the articles of incorporation or the bylaws.

(f) The board of directors may, by a resolution adopted by a majority of the whole board, pursuant to a provision of the bylaws, designate two (2) or more of their number to constitute an executive committee, which, to the extent provided in that resolution or in the bylaws, has all of the authority of the board of directors in the management of the corporation, during the interval between the meetings of the board, but the designation of the committee and the delegation to the committee of such authority does not operate to relieve the board of directors or any member of the board of directors of any responsibility imposed upon it or the member by this article. The minutes of each meeting of the executive committee shall be read at the next succeeding meeting of the board of directors.

(g) Meetings of the board of directors may be held at such time at the principal office of the corporation or at such other place as may be unanimously designated by the board of directors, and upon the notice provided in the bylaws. Unless otherwise provided by the articles of incorporation or bylaws, a member of the board of directors or of a committee designated by the board may participate in a meeting of the board or committee by means of a conference telephone or similar communications equipment by which all persons participating in the meeting can communicate with each other, and participation by these means constitutes presence in person at the meeting.

(h) Unless otherwise provided in the articles of incorporation or bylaws, an action required or permitted to be taken at a meeting of

the board of directors or of a committee of the board may be taken without a meeting if:

(1) before the action is taken, a written consent to the action is signed by all members of the board or of the committee; and

(2) the written consent is filed with the minutes of the proceedings of the board or the committee.

(i) Every director, when elected, shall take and subscribe an oath that he will, insofar as the duty devolves upon him, faithfully, honestly and diligently administer the affairs of such corporation, and that he will not knowingly violate or willingly permit to be violated any of the provisions of law applicable to any such corporation.

(j) A director may be removed in any manner provided by the articles of incorporation. Unless the articles of incorporation provide otherwise, a director may be removed, with or without cause, by a majority vote of:

(1) the shareholders of a stock company;

(2) the members or policyholders of a mutual company qualified to elect directors; or

(3) the directors.

(k) A director may be removed under this subsection:

(1) only at a meeting called for the purpose of removing the director; and

(2) the meeting notice must state that the purpose, or one (1) of the purposes, of the meeting is removal of the director.

(Formerly: Acts 1935, c.162, s.88; Acts 1969, c.164, s.4; Acts 1971, P.L.1, SEC.7.) As amended by Acts 1982, P.L.161, SEC.1; P.L.266-1987, SEC.3.

IC 27-1-7-11

Citizenship and residence qualifications of directors

Sec. 11. A majority of directors must, during their entire terms of service, be citizens of the United States or Canada. At least one (1) of the directors must reside in Indiana.

(Formerly: Acts 1935, c.162, s.89; Acts 1941, c.127, s.1; Acts 1947, c.18, s.1; Acts 1969, c.164, s.5.) As amended by P.L.245-1989, SEC.1.

IC 27-1-7-12

Directors; attendance record and report; record of communications; annual examination and report of condition

Sec. 12. In addition to such other duties as may be imposed upon the directors by any other provisions of this article, such directors shall keep a record of the attendance of directors at meetings of the board, and shall make a report showing the names of the directors, the number of meetings of the board, regular and special, the number of meetings attended, and the number of meetings from which each director was absent, which report shall be read at and incorporated

in the minutes of the annual meeting of the shareholders, members, or policyholders. Such directors, at such times as they are meeting as a board of directors, shall also require the secretary of such board, or some other duly designated agent, to make such communications from the department as the department designates a matter of record in the minutes of the meetings of such board of directors. The board of directors, a committee therefrom, or the auditor, actuary, or comptroller of such corporation shall examine the corporation once each year and submit a complete statement of the condition of such corporation to the department. Such report of examination, if made by other than the board of directors or a committee thereof, shall be approved by the board of directors before the same is submitted to the department.

(Formerly: Acts 1935, c.162, s.90.) As amended by P.L.252-1985, SEC.29.

IC 27-1-7-12.5

Directors; good faith discharge of duties; liability; conflict of interest; authorization of unlawful payments to shareholders

Sec. 12.5. (a) A director shall, based on facts then known to the director, discharge the duties as a director, including the director's duties as a member of a committee:

(1) in good faith;

(2) with the care an ordinarily prudent person in a like position would exercise under similar circumstances; and

(3) in a manner the director reasonably believes to be in the best interests of the corporation.

(b) In discharging the director's duties, a director is entitled to rely on information, opinions, reports, or statements, including financial statements and other financial data, if prepared or presented by:

(1) one (1) or more officers or employees of the corporation whom the director reasonably believes to be reliable and competent in the matters presented;

(2) legal counsel, public accountants, or other persons as to matters the director reasonably believes are within the person's professional or expert competence; or

(3) a committee of the board of directors of which the director is not a member if the director reasonably believes the committee merits confidence.

(c) A director is not acting in good faith if the director has knowledge concerning the matter in question that makes reliance otherwise permitted by subsection (b) unwarranted.

(d) A director may, in considering the best interests of a corporation, consider the effects of any action on shareholders, members, policyholders, agents, employees, suppliers, and customers of the corporation, and the communities in which offices or other facilities of the corporation are located, and any other factors the director considers pertinent.

(e) A director is not liable for any action taken as a director, or any failure to take any action, unless:

(1) the director has breached or failed to perform the duties of the director's office under subsections (a) through (d); and

(2) the breach or failure to perform constitutes willful misconduct or recklessness.

(f) A conflict of interest transaction is a transaction with the corporation in which a director of the corporation has a direct or indirect interest. A conflict of interest transaction is not voidable by the corporation solely because of the director's interest in the transaction if any one (1) of the following is true:

(1) The material facts of the transaction and the director's interest were disclosed or known to the board of directors or a committee of the board of directors and the board of directors or committee authorized, approved, or ratified the transaction.

(2) The material facts of the transaction and the director's interest were disclosed or known to the shareholders entitled to vote and they authorized, approved, or ratified the transaction.

(3) The transaction was fair to the corporation.

(g) For purposes of subsection (f), a director of the corporation has an indirect interest in a transaction if:

(1) another entity in which the director has a material financial interest or in which the director is a general partner is a party to the transaction; or

(2) another entity of which the director is a director, officer, or trustee is a party to the transaction and the transaction is, or is required to be, considered by the board of directors of the corporation.

(h) For purposes of subsection (f)(1), a conflict of interest transaction is authorized, approved, or ratified if it receives the affirmative vote of a majority of the directors on the board of directors (or on the committee) who have no direct or indirect interest in the transaction, but a transaction may not be authorized, approved, or ratified under this section by a single director. If a majority of the directors who have no direct or indirect interest in the transaction vote to authorize, approve, or ratify the transaction, a quorum is present for the purpose of taking action under this section. The presence of, or a vote cast by, a director with a direct or indirect interest in the transaction does not affect the validity of any action taken under subsection (f)(1) if the transaction is otherwise authorized, approved, or ratified as provided in subsection (f)(1).

(i) For purposes of subsection (f)(2), shares owned by or voted under the control of a director who has a direct or indirect interest in the transaction, and shares owned by or voted under the control of an entity described in subsection (g), may be counted in a vote of shareholders to determine whether to authorize, approve, or ratify a conflict of interest transaction.

(j) Subject to subsection (e), a director who votes for or assents to

a payment in the form of a dividend or otherwise to the corporation's shareholders made in violation of this article or the articles of incorporation is personally liable to the corporation for the amount of the payment that exceeds what could have been paid without violating this article or the articles of incorporation.

(k) A director held liable for an unlawful payment under subsection (j) is entitled to contribution:

(1) from every other director who voted for or assented to the distribution, subject to subsection (e); and

(2) from each shareholder for the amount the shareholder accepted.

(l) The purchase and holding of a contract of insurance or annuity or a certificate in a group policy by a director does not constitute a conflict of interest.

As added by P.L.266-1987, SEC.4.

IC 27-1-7-13

Officers; secretary; duties; resignation; removal; contract rights

Sec. 13. (a) A corporation has the officers described in its bylaws. However, a corporation must have at least one (1) officer.

(b) An officer of a corporation may appoint one (1) or more officers or assistant officers if authorized to do so by the bylaws or the board of directors.

(c) The bylaws or the board of directors must delegate to one (1) of the officers responsibility for preparing minutes of the directors' and shareholders' meetings and for authenticating records of the corporation, and that officer is the secretary for purposes of this article. The same individual may simultaneously hold more than one (1) office in the corporation.

(d) Each officer of a corporation has the authority and shall perform the duties set forth in the bylaws, to the extent consistent with the bylaws or, the duties prescribed by the board of directors or by direction of an officer authorized by the board of directors to prescribe the duties of other officers.

(e) An officer of a corporation may resign at any time by delivering notice to the board of directors, its chairman, the secretary of the corporation or, if the articles of incorporation or bylaws so provide, to another designated officer. A resignation is effective when the notice is delivered unless the notice specifies a later date. If a resignation is made effective at a later date and the corporation accepts the future effective date, its board of directors may fill the pending vacancy before the effective date if the board of directors provides that the successor does not take office until the effective date.

(f) The board of directors of a corporation may remove an officer of the corporation at any time with or without cause. An officer who appoints another officer or assistant officer may remove the appointed officer or assistant officer at any time with or without

cause.

(g) The election or appointment of an officer of a corporation does not itself create contract rights.

(h) The removal of an officer of a corporation does not affect the officer's contract rights, if any, with the corporation. An officer's resignation does not affect the corporation's contract rights, if any, with the officer.

(Formerly: Acts 1935, c.162, s.91.) As amended by P.L.266-1987, SEC.5.

IC 27-1-7-14

Bonding officers having access to money or securities; blanket bond

Sec. 14. All officers and home office employees of every corporation having control of or access to moneys or securities of such corporation in the regular discharge of their duties, shall, before entering upon the performance of their duties, execute their individual bonds with adequate surety payable to the corporation to indemnify the corporation for any pecuniary loss it shall sustain of money or other personal property by any act or acts of fraud, dishonesty, forgery, theft, embezzlement, wrongful abstraction, or willful misapplication. The amount and form of such bonds and the sufficiency of the sureties thereon shall be approved by the board of directors of the corporation and by the department and shall be filed with the department within such time as it may prescribe. In lieu of individual bonds, a blanket bond covering all such officers and employees may be used, subject to the same approval as individual bonds. No officer or director of the corporation shall sign the bond of any other person as surety thereon required by this article. If any bonds required by this section are signed by individuals as sureties, the bonds must contain separate affidavits as to the net worth of each surety.

(Formerly: Acts 1935, c.162, s.92.) As amended by P.L.252-1985, SEC.30.

IC 27-1-7-15

Loans to or borrowing by directors or officers; offense; exceptions

Sec. 15. A board of directors, director, or officer of any insurance company doing business in this state who lends any of its money or other property, to any director or officer of the insurance company commits a Class B misdemeanor. A director or officer who borrows from the insurance company any money or other property commits a Class B misdemeanor. However, this section does not apply to:

(1) the continuation to maturity of any loan that did not violate this section when it was made; or

(2) a loan made by a life insurance company to any director or officer of the company in an amount not greater than the net cash surrender value of, and secured by, a policy with the

company held by the borrower; or

(3) a loan made by any insurance company to an officer, other than a director, secured by a first mortgage loan upon a single-family dwelling, condominium unit or cooperative apartment unit, which is the borrower's personal residence acquired on account of the officer's relocation or initial employment.

(Formerly: Acts 1935, c.162, s.93.) As amended by Acts 1978, P.L.2, SEC.2707; Acts 1981, P.L.235, SEC.1.

IC 27-1-7-16
Books and records to be kept at principal office

Sec. 16. Every corporation shall keep correct and complete books of account and minutes of the proceedings of its shareholders, members or policyholders, directors, executive and/or finance committees, and it shall likewise keep, at its principal office, an original or a duplicate stock transfer book and/or records giving the names and addresses of all shareholders, members or policyholders, and if a stock company the number of shares held by each.

(Formerly: Acts 1935, c.162, s.94.)

IC 27-1-7-17
Restrictions on dividend payments

Sec. 17. No domestic company shall make any payments in form of dividends or otherwise to its shareholders, for or on account of any interest in or relation to the company as shareholders, unless it possesses assets in the amount of such payment, in excess of its liabilities, including its capital stock: Provided, That in no instance shall such dividend reduce the surplus below an amount equal to fifty per cent (50%) of the capital stock of such company; and no domestic company shall make any payments to its members or policyholders for or on account of any interest in or relation to the company as members or policyholders, except for matured claims or other policy obligations and in the purchase of surrender values, unless it possesses assets in the amount of such payments in excess of its liabilities.

(Formerly: Acts 1935, c.162, s.95.)

IC 27-1-7-18
Repealed

(Repealed by P.L.260-1983, SEC.8.)

IC 27-1-7-19
Mutual or stock companies; borrowing for surplus funds

Sec. 19. (a) A mutual or stock company organized under this article may borrow or assume a liability for the repayment of a sum of money to provide itself with surplus funds with the prior approval of the department. The rate of interest on any loan or advance may

not exceed the following:

(1) The corporate base rate in effect on the first business day of the month in which the loan document is executed, as reported by the bank or branch with the greatest amount of assets in Indiana, plus three percent (3%) per annum.

(2) A variable rate determined by a formula that:

(A) is specified in the loan document;

(B) is based on objective data or information that is reasonably related to commercial lending rates;

(C) provides an initial rate that is not more than the corporate base rate in effect on the first business day of the month in which the loan document is executed, as reported by the bank or branch with the greatest amount of assets in Indiana, plus two percent (2%) per annum; and

(D) is approved by the department as reasonable and appropriate in relation to the company's financial condition.

The company shall elect and state in the written agreement whether the interest rate is to be fixed or floating for the term of the agreement. The agreement shall be submitted to and approved by the department before the agreement's execution.

(b) The loan or advance, with interest at a rate not exceeding the maximum rate of interest as defined in subsection (a), shall be repaid only out of the surplus of the company. Repayment of principal or payment of interest may be made only when approved by the department whenever in its judgment the financial condition of the company shall warrant. However, the department may not withhold approval if:

(1) the company has and submits to the department satisfactory evidence that a surplus that is equal to or greater than the surplus existing immediately after the issuance of the loan or advance will exist after the repayment; and

(2) the surplus that will exist immediately after repayment of principal or payment of interest is:

(A) reasonable in relation to the company's outstanding liabilities; and

(B) adequate to the company's financial needs;

in light of the factors set forth in IC 27-1-23-4(f).

(c) A loan or advance made under this section, or interest accruing on the loan or advance, may not form a part of the legal liabilities of the company until authorized for payment by the department. However, until a loan or an advance is repaid, all statements published by the company or filed with the department must show the amount of the loan or advance then remaining unpaid, including any accrued and unpaid interest charges.

(Formerly: Acts 1935, c.162, s.97.) As amended by P.L.138-1984, SEC.1; P.L.253-1985, SEC.1; P.L.184-1996, SEC.1; P.L.111-2000, SEC.1.

IC 27-1-7-20

Authority of corporations, boards, and associations to insure with mutual insurance company

Sec. 20. Any public or private corporation, board or association in this state or elsewhere may make applications, enter into agreements for, and hold policies in, any mutual insurance company. Any officer, stockholder, trustee or legal representative of any such company, board, association, or estate may be recognized as acting for or on its behalf for the purposes of such membership, but shall not be personally liable upon such contract of insurance by reason of acting in such representative capacity.

(Formerly: Acts 1935, c.162, s.97a.)

IC 27-1-7-21

Mutual companies; statement of maximum premium in policy; limitation of liability for single risk; reinsurance requirements

Sec. 21. (a) The maximum premium shall be expressed in the policy of a mutual company and shall be solely a cash premium without contingent premium but no such company other than a life insurance company shall issue any policy providing limits of liability for any one (1) risk under any one (1) line of insurance in an amount exceeding five percent (5%) of its surplus, including contingent reserves, if any, until and unless it either possesses a surplus, including contingent reserves, if any, of at least four hundred thousand dollars ($400,000), or has reinsured in a reinsurer (or reinsurers) admitted to do business in this state and authorized to make such kind or kinds of reinsurance in this state all of such liability in excess of such amount or such greater amount as the commissioner may authorize and such reinsurance contract or contracts shall have been submitted to and approved by the commissioner. Such reinsurance contract or contracts shall be in such form as to enable the insured under such policy or the holder of a judgment against the insured for which such company is liable under such policy to maintain an action on such reinsurance contract or contracts against such reinsured company jointly with the reinsurer and, upon recovering judgment, to have recovery against such reinsurer or reinsurers for payment to the extent to which it or they may be liable under such reinsurance contract (or contracts) and in discharge thereof. In no event shall the unreinsured liability assumed under this section on any one (1) risk exceed the amount otherwise authorized by this article to be written upon any one (1) risk.

(b) Any determination of permissible limits of liability and amount of surplus pursuant to the provisions of subsection (a) shall be made as of December 31 immediately preceding except that in the case of a newly formed company such determination shall be made as of the date it receives the certificate of the department authorizing it to commence business.

(c) Any reinsurance contract submitted to and approved by the

commissioner in accordance with the requirements of this section shall continue in full force and effect until notice of its termination or amendment has been filed with the commissioner, and in the case of an amendment has been approved by him.

(d) Subsection (a) shall apply only to companies organized under this article after July 26, 1967, except that any company in existence on July 26, 1967, under any of the insurance statutes of this state and to which subsection (a) would otherwise apply may, by appropriate action of its policyholders and board of directors, elect to comply with subsection (a).

(e) This section shall not affect nor invalidate any policy of any mutual insurance company in existence on July 26, 1967, issued pursuant to Acts 1935, c.162, s.98. Any such policy issued on or after July 26, 1967, by a mutual insurance company in existence on July 26, 1967, and the rights and obligations thereunder shall continue to be subject to the provisions of Acts 1935, c.162, s.98 until such company has exercised the right of election provided in this section and has complied with the provisions of this section.

(Formerly: Acts 1935, c.162, s.98; Acts 1967, c.233, s.1.) As amended by P.L.252-1985, SEC.31.

IC 27-1-7-22

Vouchers for disbursements

Sec. 22. No domestic insurance corporation shall make any disbursement of one hundred dollars ($100) or more unless the same be evidenced by a voucher signed by or on behalf of the person, firm, limited liability company, or corporation receiving the money and correctly describing the consideration for the payment, and if the same be for services and disbursements, setting forth the services rendered and an itemized statement of the disbursements made, and if it be in connection with any matter pending before any legislative or public body or before any department or officer of any government, correctly describing in addition the nature of the matter and of the interest of such corporation therein, or, if such a voucher can not be obtained by an affidavit stating the reasons therefor and setting forth the particulars above mentioned.

(Formerly: Acts 1935, c.162, s.99.) As amended by P.L.8-1993, SEC.411.

IC 27-1-7-23

Annual or other required statements; material false statement

Sec. 23. A director, officer, agent, or employee of any company who knowingly subscribes, makes, or concurs in making or publishing any annual or other statement required by law, containing any material statement which is false, commits a Class A misdemeanor.

(Formerly: Acts 1935, c.162, s.100.) As amended by Acts 1978, P.L.2, SEC.2708.

IC 27-1-7.5

Chapter 7.5. Indemnification of Directors

IC 27-1-7.5-1

"Corporation" defined

Sec. 1. As used in this chapter, "corporation" has the meaning set forth in IC 27-1-2-3. The term also includes any domestic or foreign predecessor entity of a corporation in a merger or other transaction in which the predecessor's existence ceased upon consummation of the transaction.

As added by P.L.266-1987, SEC.6.

IC 27-1-7.5-2

"Director" defined

Sec. 2. As used in this chapter, "director" means an individual who is or was a director of a corporation or an individual who, while a director of a corporation, is or was serving at the corporation's request as a director, officer, partner, trustee, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, employee benefit plan, or other enterprise, whether for profit or not. A director is considered to be serving an employee benefit plan at the corporation's request if the director's duties to the corporation also impose duties on, or otherwise involve services by, the director to the plan or to participants in or beneficiaries of the plan. The term includes, unless the context requires otherwise, the estate or personal representative of a director.

As added by P.L.266-1987, SEC.6.

IC 27-1-7.5-3

"Expenses" defined

Sec. 3. As used in this chapter, "expenses" includes counsel fees.

As added by P.L.266-1987, SEC.6.

IC 27-1-7.5-4

"Liability" defined

Sec. 4. As used in this chapter, "liability" means the obligation to pay a judgment, settlement, penalty, fine (including an excise tax assessed with respect to an employee benefit plan), or reasonable expenses incurred with respect to a proceeding.

As added by P.L.266-1987, SEC.6.

IC 27-1-7.5-5

"Official capacity" defined

Sec. 5. (a) As used in this chapter, "official capacity" means:

(1) when used with respect to a director, the office of director in a corporation; and

(2) when used with respect to an individual other than a director, as contemplated in section 13 of this chapter, the office

in a corporation held by the officer or the employment or agency relationship undertaken by the employee or agent on behalf of the corporation.

(b) The term does not include service for any other foreign or domestic corporation or any partnership, joint venture, trust, employee benefit plan, or other enterprise, whether for profit or not.
As added by P.L.266-1987, SEC.6. Amended by P.L.5-1988, SEC.141.

IC 27-1-7.5-6
"Party" defined

Sec. 6. As used in this chapter, "party" includes an individual who was, is, or is threatened to be made a named defendant or respondent in a proceeding.
As added by P.L.266-1987, SEC.6.

IC 27-1-7.5-7
"Proceeding" defined

Sec. 7. As used in this chapter, "proceeding" means any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative and whether formal or informal.
As added by P.L.266-1987, SEC.6.

IC 27-1-7.5-8
Conditional indemnification of director against liability

Sec. 8. (a) A corporation may indemnify an individual made a party to a proceeding because the individual is or was a director against liability incurred in the proceeding if:

(1) the individual's conduct was in good faith;

(2) the individual reasonably believed:

(A) in the case of conduct in the individual's official capacity with the corporation, that the individual's conduct was in its best interests; and

(B) in all other cases, that the individual's conduct was at least not opposed to its best interests; and

(3) in the case of any criminal proceeding, the individual either:

(A) had reasonable cause to believe the individual's conduct was lawful; or

(B) had no reasonable cause to believe the individual's conduct was unlawful.

(b) A director's conduct with respect to an employee benefit plan for a purpose the director reasonably believed to be in the interests of the participants in and beneficiaries of the plan is conduct that satisfies the requirement of subsection (a)(2).

(c) The termination of a proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent is not, of itself, determinative that the director did not

meet the standard of conduct described in this section.
As added by P.L.266-1987, SEC.6.

IC 27-1-7.5-9
Mandatory indemnification of director for expenses incurred in successful defense

Sec. 9. Unless limited by its articles of incorporation, a corporation shall indemnify a director who was wholly successful, on the merits or otherwise, in the defense of any proceeding to which the director was a party because the director is or was a director of the corporation against reasonable expenses incurred by the director in connection with the proceeding.
As added by P.L.266-1987, SEC.6.

IC 27-1-7.5-10
Advancement of expenses before final disposition; conditions

Sec. 10. (a) A corporation may pay for or reimburse the reasonable expenses incurred by a director who is a party to a proceeding in advance of final disposition of the proceeding if:

(1) the director furnishes the corporation a written affirmation of the director's good faith belief that the director has met the standard of conduct described in section 8 of this chapter;

(2) the director furnishes the corporation a written undertaking, executed personally or on the director's behalf, to repay the advance if it is ultimately determined that the director did not meet the standard of conduct; and

(3) a determination is made that the facts then known to those making the determination would not preclude indemnification under this chapter.

(b) The undertaking required by subsection (a)(2) must be an unlimited general obligation of the director but need not be secured and may be accepted without reference to financial ability to make repayment.

(c) Determinations and authorizations of payments under this section shall be made in the manner specified in section 12 of this chapter.
As added by P.L.266-1987, SEC.6.

IC 27-1-7.5-11
Court ordered indemnification; determination

Sec. 11. Unless a corporation's articles of incorporation provide otherwise, a director of the corporation who is a party to a proceeding may apply for indemnification to the court conducting the proceeding or to another court of competent jurisdiction. On receipt of an application, the court, after giving any notice the court considers necessary, may order indemnification if it determines that:

(1) the director is entitled to mandatory indemnification under section 9 of this chapter, in which case the court shall also order

the corporation to pay the director's reasonable expenses incurred to obtain court ordered indemnification; or

(2) the director is fairly and reasonably entitled to indemnification in view of all the relevant circumstances, whether or not the director met the standard of conduct set forth in section 8 of this chapter.

As added by P.L.266-1987, SEC.6.

IC 27-1-7.5-12

Determination of permissible indemnification; authorization of indemnification and evaluation as to reasonableness of expenses

Sec. 12. (a) A corporation may not indemnify a director under section 8 of this chapter unless authorized in the specific case after a determination has been made that indemnification of the director is permissible in the circumstances because the director has met the standard of conduct set forth in section 8 of this chapter.

(b) The determination shall be made by any one (1) of the following procedures:

(1) By the board of directors by majority vote of a quorum consisting of directors not at the time parties to the proceeding.

(2) If a quorum cannot be obtained under subdivision (1), by majority vote of a committee duly designated by the board of directors (in which designation directors who are parties may participate), consisting solely of two (2) or more directors not at the time parties to the proceeding.

(3) By special legal counsel:

(A) selected by the board of directors or its committee in the manner prescribed in subdivision (1) or (2); or

(B) if a quorum of the board of directors cannot be obtained under subdivision (1) and a committee cannot be designated under subdivision (2), selected by majority vote of the full board of directors (in which selection directors who are parties may participate).

(c) Authorization of indemnification and evaluation as to reasonableness of expenses shall be made in the same manner as the determination that indemnification is permissible, except that if the determination is made by special legal counsel, authorization of indemnification and evaluation as to reasonableness of expenses shall be made by those entitled under subsection (b)(3) to select counsel.

As added by P.L.266-1987, SEC.6.

IC 27-1-7.5-13

Indemnification of corporate employees other than directors

Sec. 13. The following apply unless a corporation's articles of incorporation provide otherwise:

(1) An officer of the corporation, whether or not a director, is entitled to mandatory indemnification under section 9 of this

chapter and is entitled to apply for court ordered indemnification under section 11 of this chapter, in each case to the same extent as a director.

(2) The corporation may indemnify and advance expenses under this chapter to an officer, employee, or agent of the corporation, whether or not a director, to the same extent as to a director.

(3) A corporation may also indemnify and advance expenses to an officer, employee, or agent, whether or not a director, to the extent, consistent with public policy, that may be provided by its articles of incorporation, bylaws, general or specific action of its board of directors, or contract.

As added by P.L.266-1987, SEC.6.

IC 27-1-7.5-14

Liability insurance purchased and maintained by corporation

Sec. 14. A corporation may purchase and maintain insurance on behalf of an individual who is or was a director, officer, employee, or agent of the corporation, or who, while a director, officer, employee, or agent of the corporation, is or was serving at the request of the corporation as a director, officer, partner, trustee, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, employee benefit plan, or other enterprise, against liability asserted against or incurred by the individual in that capacity or arising from the individual's status as a director, officer, employee, or agent, whether or not the corporation would have power to indemnify the individual against the same liability under section 8 or 9 of this chapter.

As added by P.L.266-1987, SEC.6.

IC 27-1-7.5-15

Limitation of remedies; effect of chapter

Sec. 15. (a) The indemnification and advance for expenses provided for or authorized by this chapter does not exclude any other rights to indemnification and advance for expenses that a person may have under:

(1) a corporation's articles of incorporation or bylaws;

(2) a resolution of the board of directors or of the shareholders of a stock company, or members or shareholders of a mutual company qualified to elect directors; or

(3) any other authorization, whenever adopted, after notice, by a majority vote of all the voting shares then issued and outstanding of a stock company or of all the members or policyholders of a mutual company authorized to elect directors.

(b) If the articles of incorporation, bylaws, resolutions of the board of directors or of the shareholders, or other duly adopted authorization of indemnification or advance for expenses limit indemnification or advance for expenses, indemnification and

advance for expenses are valid only to the extent consistent with the articles, bylaws, resolution of the board of directors or of the shareholders, members, or directors or other duly adopted authorization of indemnification or advance for expenses.

(c) This chapter does not limit a corporation's power to pay or reimburse expenses incurred by a director, officer, employee, or agent in connection with the person's appearance as a witness in a proceeding at a time when the person has not been made a named defendant or respondent to the proceeding.

As added by P.L.266-1987, SEC.6.

IC 27-1-8

Chapter 8. Procedures for Amending Articles of Incorporation

IC 27-1-8-1

Authority to amend

Sec. 1. Any corporation may, at any time, amend its articles of incorporation without limitation so long as the articles as amended would have been authorized by this article as original articles, by complying with the provisions of this chapter.

(Formerly: Acts 1935, c.162, s.101.) As amended by P.L.252-1985, SEC.32.

IC 27-1-8-2

Proposal of amendment

Sec. 2. Every amendment to the articles of incorporation shall first be proposed by the board of directors, by the adoption of a resolution setting forth the proposed amendment and directing that it be submitted to a vote of the shareholders, members, or policyholders entitled to vote in respect thereof at a designated meeting of such shareholders, members, or policyholders which may be an annual meeting of the shareholders, members, or policyholders or a special meeting of the shareholders, members, or policyholders entitled to vote in respect thereof. If the resolution shall direct that the proposed amendment is to be submitted at an annual meeting, notice of the submission of the proposed amendment shall be included in the notice of such annual meeting. If the said resolution shall direct that the proposed amendment is to be submitted to a special meeting of the shareholders, members, or policyholders entitled to vote thereon, such special meeting shall be called by the resolution proposing the amendment, and notice of such meeting shall be given at the time in the manner provided in IC 27-1-7-7.

(Formerly: Acts 1935, c.162, s.102.) As amended by P.L.252-1985, SEC.33.

IC 27-1-8-3

Vote of shareholders, policyholders, or members; exceptions; notice of corporation name change

Sec. 3. (a) Except as provided in subsection (b), an amendment to the articles of incorporation so proposed shall be submitted to a vote of the shareholders, members, or policyholders at the annual or at the special meeting directed by the resolution of the board of directors proposing the amendment, and the proposed amendment shall be adopted upon receiving the affirmative votes of at least a majority of the stock, or such greater portion as the articles of incorporation may require, of the outstanding shares of stock entitled to vote, if a stock company; and upon receiving the affirmative votes of at least two-thirds (2/3) of the members or policyholders voting at such

annual or special meeting, if other than a stock company.

(b) Unless the articles of incorporation provide otherwise, a corporation's board of directors may adopt one (1) or more amendments to the corporation's articles of incorporation without shareholder, member, or policyholder action to:

(1) extend the duration of the corporation, if the corporation was incorporated at a time when limited duration was required by law;

(2) delete the names and addresses of the initial directors, officers, or incorporators;

(3) delete the name and address of the initial registered agent or registered or principal office, if a statement of change is on file with the secretary of state;

(4) change each issued and unissued authorized share of an outstanding class into a greater number of whole shares or a lesser number of whole shares and fractional shares if the corporation has only shares of that class outstanding;

(5) reduce the number of authorized shares solely as the result of a cancellation of treasury shares; or

(6) change the corporate name, if the new name complies with IC 27-1-6-3.

(c) If a corporation changes its name under subsection (b)(6), the corporation shall, not more than thirty (30) days after the effective date of the amendment changing the corporate name, mail or deliver a written or printed notice of the new corporate name to each shareholder, member, or policyholder of record of the corporation.
(Formerly: Acts 1935, c.162, s.103.) As amended by P.L.185-1997, SEC.2.

IC 27-1-8-4
Form and content of articles of amendment

Sec. 4. Upon the proposal and adoption of any amendment to the articles of incorporation, there shall be executed articles of amendment setting forth the following:

(a) The amendment so adopted;

(b) The manner of its adoption and the vote by which it was adopted;

(c) In the case of a stock corporation;

(1) If the total authorized amount or number of shares is increased by such amendment, a statement of the shares theretofore authorized and a statement of the additional shares authorized by the amendment;

(2) If the total authorized amount or number of shares is reduced by such amendment, a statement of the shares theretofore authorized and the amount thereof that has been issued, and a statement of the reduction authorized by the amendment and the manner in which the reduction shall be effected; and

(3) If any change is made in the shares without increasing or

reducing the total authorized amount or number of shares, a statement of the shares theretofore authorized and the amount thereof that has been issued, and a statement of the change to be made by the amendment and the manner in which the change shall be effected.
(Formerly: Acts 1935, c.162, s.104.)

IC 27-1-8-5
Execution and presentation of articles of amendment to department

Sec. 5. The form of the articles of amendment shall be prescribed and furnished by the department. The articles of amendment shall be prepared and signed in triplicate originals by the president or a vice-president and by the secretary or an assistant secretary of the corporation, and shall be acknowledged before a notary public by the officers signing the articles and shall be presented in triplicate originals to the department at its office, for the approval or disapproval of the department.
(Formerly: Acts 1935, c.162, s.105.)

IC 27-1-8-6
Approval or disapproval of articles of amendment by department

Sec. 6. The department is hereby authorized to approve or disapprove such articles of amendment, and the approval of them, if given, shall be evidenced in the manner prescribed in IC 27-1-6-8.
(Formerly: Acts 1935, c.162, s.106.) As amended by P.L.252-1985, SEC.34.

IC 27-1-8-7
Submission of articles of amendment to attorney general

Sec. 7. In the event the department approves the articles of amendment, they shall then be submitted to the attorney general for the state of Indiana who shall examine said articles. And his approval, if given, shall be evidenced in the manner provided in IC 27-1-6-9, and he shall return the same to the department.
(Formerly: Acts 1935, c.162, s.107.) As amended by P.L.252-1985, SEC.35.

IC 27-1-8-8
Presentation of articles of amendment to secretary of state; duties of secretary of state

Sec. 8. When the articles of amendment have been approved by the attorney-general and returned to the department, then the department shall present the same to the secretary of state for the state of Indiana. If the secretary of state finds that the articles conform to law, he shall indorse his approval upon each of the triplicate copies of the articles, and when all fees have been paid as required by law, he shall file one (1) copy in his office and shall return the other two (2) copies of the articles of amendment bearing

the indorsement of his approval, to the corporation, one (1) of which copies the corporation shall file with the department.
(Formerly: Acts 1935, c.162, s.108.)

IC 27-1-8-9
Amended certificate of authority

Sec. 9. When the provisions of sections 2 through 8 of this chapter have been complied with, then the commissioner may issue an amended certificate of authority, which shall license the company to transact the kind or kinds of insurance specified in its articles of incorporation and in the amendment to its articles of incorporation, and which shall expire at midnight, April 30, next following the date of issuance.
(Formerly: Acts 1935, c.162, s.109.) As amended by P.L.252-1985, SEC.36.

IC 27-1-8-10
Effect of amendment

Sec. 10. Upon the issuance of the amended certificate of authority by the commissioner, the amendment shall become effective and the articles of incorporation shall be deemed to be amended accordingly. No amendment shall effect any existing cause of action in favor of or against such corporation, or any pending suit in which such corporation shall be a party, or the existing rights of persons other than shareholders of a stock company, or the members or policyholders in companies other than stock companies; and in the event the corporate name shall be changed by any amendment, no suit brought against such corporation under its former name shall be abated for that reason.
(Formerly: Acts 1935, c.162, s.110.)

IC 27-1-8-11
Prerequisites to corporate acts under amendment

Sec. 11. (a) A corporation whose articles of incorporation have been amended in accordance with the provisions of this chapter shall not exercise any power, right, or authority conferred by, or take any action pursuant to, such amendment until:

(1) the corporation shall have filed one (1) of the triplicate copies of the articles of amendment, bearing the endorsement of the approval of the secretary of state as provided in section 8 of this chapter, for record in the office of the county recorder of the county in which the articles of incorporation of such corporation were or should have been filed for record as provided in IC 27-1-6-13; and

(2) the company shall have filed a certified copy of such amended certificate of authority for record with the county recorder of the county wherein the principal office is located, which certified copy shall be evidence only that the company is

authorized and licensed to transact the kind or kinds of insurance set out therein, for the period stated therein.

(b) If a corporation exercises any such power, right, or authority, or takes any such action, in violation of this section, the officers and directors who participated therein shall be severally liable for any debts or liabilities of the corporation incurred thereby or arising therefrom.

(Formerly: Acts 1935, c.162, s.111.) As amended by P.L.252-1985, SEC.37.

IC 27-1-8-12

Restrictions on amendments; decreasing capital stock

Sec. 12. A company may amend its articles by providing for a decrease of its capital stock to an amount not less than the minimum capital required for the kind or kinds of insurance theretofore transacted by the company. The department shall not approve or issue its certified copy of such amendment to the company if it shall be of the opinion that the interests of policyholders or creditors may be prejudiced thereby. No distribution of the assets of the company shall be made to shareholders upon any such decrease of capital which shall reduce the surplus of its assets over its liabilities, including capital, to less than the minimum surplus required by this article. Upon any such amendment so decreasing the capital, such company may require each shareholder to return his certificate of stock and accept a new certificate for such proportion of the amount of its original stock as the reduced capital shall bear to the original capital.

(Formerly: Acts 1935, c.162, s.113.) As amended by P.L.252-1985, SEC.38.

IC 27-1-8-13

Repealed

(Formerly: Acts 1935, c.162, s.113a; Acts 1969, c.164, s.1. As amended by P.L.252-1985, SEC.39; P.L.7-1987, SEC.136. Repealed by P.L.94-1999, SEC.4.)

IC 27-1-9
Chapter 9. Merger, Consolidation, and Reinsurance

IC 27-1-9-1
Authority to merge, consolidate, or reinsure

Sec. 1. Subject to the provisions of this article and IC 27-6-1.1, any domestic corporation is authorized and empowered to:

(1) merge or consolidate with any other domestic company;

(2) merge or consolidate with any foreign company, including any foreign company organized as a stock, mutual, nonstock, nonprofit, fraternal benefit, mutual benefit, or medical or hospital service company under the insurance or other laws of the foreign company's state of domicile, if the surviving company meets the requirements for authorization to engage in the insurance business in this state, and provided such merger or consolidation is authorized by the laws of the state, or territory in which such foreign company is organized;

(3) subject to the requirements of IC 27-6-1.1-5, reinsure under an agreement of assumption reinsurance all or a portion of its risks with another domestic company or with any foreign or alien company authorized to engage in the insurance business in this state; and

(4) subject to the requirements of IC 27-6-1.1-5, reinsure under an agreement of assumption reinsurance all or a portion of the risks of another domestic company or of a foreign or alien company whether such company is or is not authorized to engage in the insurance business in this state.

(Formerly: Acts 1935, c.162, s.114; Acts 1941, c.115, s.1; Acts 1969, c.164, s.2.) As amended by P.L.260-1983, SEC.2; P.L.185-1997, SEC.3.

IC 27-1-9-2
Effect of article on corporate powers and kinds of business

Sec. 2. Nothing contained in this chapter shall be construed to enlarge the corporate powers of any insurance company, nor to authorize any insurance company to engage in any kind or kinds of insurance business not authorized by its articles of incorporation, nor to authorize any foreign insurance company to engage in any kind or kinds of insurance business in this state not covered by its certificate of authority to do business in this state.

(Formerly: Acts 1935, c.162, s.115.) As amended by P.L.252-1985, SEC.40.

IC 27-1-9-2.5
Definitions relating to merger

Sec. 2.5. (a) As used in section 3 of this chapter, "participating shares" means shares that entitle the shareholders to participate without limitation in distributions.

(b) As used in section 3 of this chapter, "voting members" means members or policyholders entitled to vote unconditionally in the election of directors.

(c) As used in section 3 of this chapter, "voting shares" means shares that entitle the shareholders to vote unconditionally in the election of directors.

As added by P.L.185-1997, SEC.4.

IC 27-1-9-3

Procedure for merger

Sec. 3. (a) Any domestic corporation may merge with any other corporation or corporations, subject to the provisions of sections 1 and 2 of this chapter, in the following manner. The board of directors of each corporation shall, by a resolution adopted by a majority vote of the members of such board, approve a joint agreement of merger setting forth:

(1) the names of the corporations proposed to merge, and the name of the corporation into which they propose to merge, which is designated in this section as the surviving corporation;

(2) the terms and conditions of the proposed merger and the mode of carrying the same into effect;

(3) the manner and basis, if any, of converting the shares of each stock corporation, other than the surviving corporation into shares or other securities or obligations of the surviving corporation, or, in whole or in part, into cash, property, shares, or other securities or obligations of any corporation;

(4) a restatement of such provisions of the articles of incorporation of the surviving corporation as may be deemed necessary or advisable to give effect to the proposed merger; and

(5) such other provisions with respect to the proposed merger as are deemed necessary or desirable.

Unless shareholder, member, or policyholder approval is not required by subsection (i), the resolution of the board of directors of each corporation approving the agreement shall direct that the agreement be submitted to a vote of the shareholders, members, or policyholders of such corporation entitled to vote in respect thereof at a designated meeting thereof, which may be an annual meeting of shareholders, members, or policyholders, or a special meeting of the shareholders, members, or policyholders entitled to vote in respect thereof. If the designated meeting of any corporation at which the agreement is to be submitted is an annual meeting, notice of the submission of the agreement shall be included in the notice of such annual meeting. If the designated meeting of any corporation at which the agreement is to be submitted is a special meeting of the shareholders, members, or policyholders entitled to vote in respect thereof, such special meeting shall be called by the resolution designating the meeting, and notice of such meeting shall be given at the time and in the manner provided

in IC 27-1-7-7.

(b) Unless shareholder, member, or policyholder approval is not required by subsection (i), the agreement of merger so approved shall be submitted to a vote of the shareholders, members, or policyholders of each corporation entitled to vote in respect thereof at the meeting directed by the resolution of the board of directors of such corporation approving the agreement, and the agreement shall be adopted by such corporation upon receiving the affirmative vote of such proportion of the shareholders, members, or policyholders as provided in section 8 of this chapter.

(c) Unless shareholder, member, or policyholder approval is not required by subsection (i), within five (5) days after the agreement of merger shall be adopted by any corporation, the secretary of such corporation shall mail or deliver a written or printed notice of the adoption of the agreement to each shareholder, member, or policyholder of record of such corporation who was not present in person or represented by proxy at the meeting at which the agreement was adopted. And the corporation shall file an affidavit with the department, signed by the president and secretary of such corporation, that such notice was given.

(d) Unless shareholder, member, or policyholder approval is not required by subsection (i), any shareholder, member, or policyholder of any such corporation who did not vote in favor of the adoption of the agreement of merger may object to such merger in the manner and with the effect provided in sections 9 and 10 of this chapter.

(e) Unless shareholder, member, or policyholder approval is not required by subsection (i), as soon as practicable after the expiration of a period of thirty (30) days after the adoption of the agreement of merger by the shareholders, members, or policyholders of that one (1) of the merging corporations which is the last, in point of time, to adopt the same, the agreement shall again be considered by the board of directors of each corporation a party thereto, at a regular or special meeting of such board, and if the board of directors of each such corporation, by a majority vote of the members of such board, shall again approve the agreement and shall authorize the execution thereof, the agreement shall be signed on behalf of each such corporation by its president or a vice president and its secretary or an assistant secretary and shall have the corporate seal of each such corporation thereto affixed.

(f) Upon the execution of the agreement of merger by all of the corporations parties thereto, there shall be executed and filed, in the manner provided in this section, articles of merger setting forth the agreement of merger, the signatures of the several corporations parties thereto, the manner of its adoption, and the vote, if any, by which adopted by each of such corporations. The articles of merger shall be signed on behalf of each such corporation by its president or a vice president and its secretary or an assistant secretary, and acknowledged before a notary public by the officers signing the

same, in such multiple copies as shall be required to enable the corporations to comply with the provisions of this chapter with respect to filing and recording the articles of merger, and shall then be presented to the department at its office. The department is hereby authorized to approve or disapprove the articles of merger. In the event that the department shall approve the articles of merger, it shall endorse its approval thereon in the manner provided in IC 27-1-6-8, and it shall present the same to the secretary of state of the state of Indiana at his office.

(g) Upon the presentation of the articles of merger, the secretary of state, if he finds that they conform to law, shall endorse his approval on each of the multiple copies of the articles and, when all fees have been paid as required by law, shall file one (1) copy of the articles of merger in his office and issue a certificate of merger and shall return the remaining copies of the articles bearing the endorsement of his approval, together with the certificate of merger, to the surviving corporation or its representatives.

(h) The surviving corporation shall obtain a certified copy of the certificate of merger from the secretary of state and file the same with the department, accompanied by a copy of the articles of merger bearing the endorsement and approval of the secretary of state.

(i) If a domestic corporation is the surviving corporation, action by the shareholders, members, or policyholders is not required if the articles of incorporation of the surviving corporation will not differ (except for amendments enumerated in IC 27-1-8-3(b)) from its articles before the merger and:

(1) if the corporation is a stock corporation:

(A) each shareholder of the surviving corporation whose shares were outstanding immediately before the merger will hold the same proportionate number of shares relative to the number of shares held by all shareholders (except for shares of the surviving corporation received solely as a result of the shareholder's proportionate shareholdings in the other corporations participating in the merger) with identical designations, preferences, limitations, and relative rights, immediately after the merger;

(B) the number of voting shares outstanding immediately after the merger, including the number of voting shares issuable as a result of the merger (either by the conversion of securities issued under the merger or the exercise of rights and warrants issued under the merger), will not exceed by more than twenty percent (20%) the total number of voting shares (adjusted to reflect any forward or reverse share split that occurs under the plan of merger) of the surviving corporation outstanding immediately before the merger; and

(C) the number of participating shares outstanding immediately after the merger, including the number of participating shares issuable as a result of the merger (either

by conversion of securities issued under the merger or the exercise of rights and warrants issued under the merger), will not exceed by more than twenty percent (20%) the total number of participating shares (adjusted to reflect any forward or reverse share split that occurs under a plan of merger) outstanding immediately before the merger; or

(2) if the surviving corporation is an insurance company other than a stock corporation:

(A) each member or policyholder of the surviving corporation will retain the same contractual and other rights to which the member or policyholder was entitled before the merger; and

(B) the number of votes of voting members immediately after the merger, including the number of votes of voting members added as a result of the merger, will not exceed by more than twenty percent (20%) the total number of votes of voting members of the surviving corporation immediately before the merger.

(Formerly: Acts 1935, c.162, s.116; Acts 1973, P.L.272, SEC.1.) As amended by P.L.252-1985, SEC.41; P.L.185-1997, SEC.5.

IC 27-1-9-4

Procedure for consolidation

Sec. 4. Any domestic corporation may consolidate with any other corporation or corporations, subject to the provisions of sections 1 and 2 of this chapter, in the following manner:

(a) Agreement of Consolidation. The board of directors of each corporation shall, by a resolution adopted by a majority vote of the members of such board, approve a joint agreement of consolidation setting forth:

(1) The names of the corporations proposing to consolidate, and the name of the new corporation into which they proposed to consolidate, which is hereinafter designated as the new corporation;

(2) The terms and conditions of the proposed consolidation and the mode of carrying the same into effect;

(3) The manner and basis, if any, of converting the shares of each stock corporation into shares of other securities or obligations of the new corporation, or, in whole or in part, into cash, property, shares, or other securities or obligations of any other corporation;

(4) With respect to the new corporation, all of the statements required by IC 1971, 27-1-6-4 to be set forth in original articles of incorporation for corporations formed under this article; and

(5) Such other provisions with respect to the proposed consolidation as are deemed necessary or desirable;

(b) Adoption of Agreement. The agreement of consolidation shall then be submitted to a vote of the shareholders, members or policyholders entitled to vote in respect thereof of each corporation in the same manner as provided in section 3 of this chapter and this

agreement shall be adopted by such corporation upon receiving the affirmative vote of such proportion of the shareholders, members or policyholders, as provided in section 8 of this chapter; and the adoption thereof by directors and by the shareholders, members or policyholders shall be followed by the same notice to shareholders, members or policyholders as hereinabove provided in paragraphs (a), (b) and (c) of section 3 of this chapter in case of a merger.

(c) Objections. Any shareholder, member or policyholder, of any such corporation who did not vote in favor of the adoption of the agreement of consolidation, may object to such consolidation in the manner and with the effect provided in sections 9 and 10 of this chapter.

(d) Reapproval and Execution of Agreement. Upon the adoption of the agreement of consolidation it shall again be considered by the board of directors of each corporation a party to the agreement, and, if again approved and the execution of the agreement authorized by such board, the agreement shall be signed and filed, all in the same manner and within the same time as provided in subsection (e) of section 3 of this chapter.

(e) Articles of Consolidation. Under the execution of the agreement of consolidation by all of the corporations parties thereto, articles of consolidation shall be executed and filed, accompanied by the fees prescribed by law in the same manner and form and in such multiple copies as provided in subsection (f) of section 3 of this chapter.

(f) Certificate of Consolidation and Incorporation. Upon the presentation of the articles of consolidation, the secretary of state, if he finds that they conform to law, shall indorse his approval on each of the multiple copies of the articles, and, when all fees have been paid as required by law, shall file one (1) copy of the articles of consolidation in his office and issue a certificate of consolidation and incorporation, and shall return the remaining copies of the articles bearing the indorsement of his approval, together with the certificate of consolidation and incorporation, to the new corporation, or its representatives.

(g) Filing Certificate. The surviving corporation shall obtain a certified copy of the certificate of consolidation and incorporation from the secretary of state and file the same with the department, accompanied by a copy of the articles of consolidation bearing the indorsement of the approval of the secretary of state.

(Formerly: Acts 1935, c.162, s.117; Acts 1973, P.L.272, SEC.2.)

IC 27-1-9-5

Effective time of merger or consolidation

Sec. 5. Upon the issuance of a certificate of merger or a certificate of consolidation and incorporation by the secretary of state, the merger or consolidation, as the case may be, shall be effected, subject to the rights of dissenting shareholders, members, or

policyholders, as provided in sections 9 and 10 of this chapter.
(Formerly: Acts 1935, c.162, s.118.) As amended by P.L.252-1985, SEC.42.

IC 27-1-9-6
Recording certified copies of certificate of merger or consolidation

Sec. 6. The surviving or new corporation, as the case may be, resulting from a merger or consolidation, shall within ten (10) days after such merger or consolidation has become effective as hereinabove provided, file for record with the county recorder of each county in which the principal office of any of the corporations parties to the agreement is located, and of each county in this state in which any of such corporations shall have real property at the time of such merger or consolidation the title to which will be transferred by the merger or consolidation, a certified copy of the certificate of merger or certificate of consolidation and incorporation, as the case may be, accompanied by one (1) of the copies of the articles of merger or articles of consolidation, bearing the indorsement of the approval of the secretary of state, as the case may be.
(Formerly: Acts 1935, c.162, s.119.)

IC 27-1-9-7
Repealed

(Repealed by P.L.260-1983, SEC.8.)

IC 27-1-9-8
Voting at meeting of shareholders, policyholders, or members; proxies; vote required

Sec. 8. At any meeting of the shareholders, members, or policyholders held pursuant to the resolution of the board of directors for the purpose of adopting an agreement of merger or consolidation, as provided for in sections 3 and 4 of this chapter, the shareholders, members, or policyholders entitled to vote in respect thereof may vote in person or by proxy. Each shareholder entitled to vote at such meeting shall have one (1) vote for each share of voting stock held by him, and each member or policyholder entitled to vote at such meeting shall have one (1) vote regardless of the amount of insurance or number of policies held by him. The affirmative votes representing two-thirds (2/3) of all outstanding capital stock in case of purely stock companies, or two-thirds (2/3) of all outstanding capital stock, if any, and two-thirds (2/3) of the votes cast by the members or policyholders represented at the meeting in person or by proxy in the case of other companies, shall be necessary for the adoption of such proposed articles of merger or consolidation.
(Formerly: Acts 1935, c.162, s.122; Acts 1941, c.115, s.4.) As amended by P.L.252-1985, SEC.43.

IC 27-1-9-9

Dissenting shareholders; payment of value of shares; appraisal

Sec. 9. (a) If any shareholder of any corporation a party to a merger or consolidation who did not vote in favor of such merger or consolidation at the meeting at which the agreement of merger or consolidation was adopted by the shareholders of such corporation shall, at any time within thirty (30) days after the filing of the affidavit of notice of the adoption of the agreement of merger or consolidation as provided for in sections 3 and 4 of this chapter, object thereto in writing and demand payment of the value of his shares, the surviving or new corporation shall, in the event that the merger or consolidation shall be made effective, pay to such shareholder upon surrender of his certificates therefor, the value of such shares at the effective date of the merger or consolidation. If within thirty (30) days after such effective date, the value of such shares is agreed upon between the shareholder and the surviving or new corporation, as the case may be, payment therefor may be made within ninety (90) days after the effective date. If, within thirty (30) days after such effective date, the surviving or new corporation, as the case may be, and the shareholder do not so agree, either such corporation or the shareholder may, within ninety (90) days after such effective date, petition the judge of the circuit or superior court of the county in which the principal office of the corporation is located, to appraise the value of such shares, and payment of the appraised value thereof shall be made within sixty (60) days after the entry of the judgment or order finding such appraised value. The practice, procedure, and judgment in the circuit or superior court upon such petition shall be the same, so far as practicable, as that under the eminent domain laws in this state, and the judgment of such circuit or superior court in such matter shall be final.

(b) Upon the effective date of the merger or consolidation, any shareholder who has made such objection and demand shall cease to be a shareholder and shall have no rights with respect to such shares except the right to receive payment therefor. Every shareholder who did not vote in favor of such merger or consolidation and who does not object in writing and demand payment of the value of his shares at the time and in the manner provided in this section shall be conclusively presumed to have assented to such merger or consolidation.

(Formerly: Acts 1935, c.162, s.123; Acts 1941, c.115, s.5.) As amended by P.L.252-1985, SEC.44.

IC 27-1-9-10

Hearing on petition of members or policyholders of mutual company in opposition to merger or consolidation; revocation of approval

Sec. 10. If not less than five percent (5%) of the members or policyholders in a mutual corporation who did not vote in favor of such merger or consolidation at the meeting at which the agreement

of merger or consolidation was adopted by the members or policyholder of such corporation shall, at any time within thirty (30) days after the filing of the affidavit of notice of the adoption of the agreement of merger or consolidation as provided for in sections 3 and 4 of this chapter, file a petition with the department for a hearing upon the adoption of such agreement or merger or consolidation, the department shall order a hearing upon said petition and give notice fixing the time and place of such hearing to the corporations which are parties to the merger or consolidation fifteen (15) days before the date of such hearing. The company whose policyholders file such petition shall give notice by mail to each member or policyholder of such company, at least ten (10) days before such hearing. At the time and place fixed in such notice, or at the time or times and place or places to which such hearing shall be adjourned, the commissioner shall proceed with the hearing and make or order such examination into the affairs and condition of each of such corporations as he may deem proper. The commissioner shall have the power to summon and compel the attendance and testimony of witnesses and the production of books and papers before him at such hearing. Any member or policyholder, as the case may be, of the corporation so petitioning may appear before the commissioner and be heard with reference to said contract. If, upon such hearing being had, the commissioner is not satisfied that the interests of the members or policyholders, as the case may be, of such company are properly protected, or if he finds that any reasonable objection exists to such contract, he shall revoke the approval already given, and the said agreement of merger or consolidation shall thereupon become null and void. The commissioner shall have like power to revoke any approval of any such agreement of merger or consolidation if any officer, director, or employee of either corporation party to such agreement of merger or consolidation shall, after reasonable notice, fail or refuse to attend and testify at such hearing, or to produce any books or papers called for by said commissioner.

(Formerly: Acts 1935, c.162, s.124; Acts 1941, c.115, s.6.) As amended by P.L.252-1985, SEC.45.

IC 27-1-9-11

Effect of merger or consolidation

Sec. 11. When such merger or consolidation has been effected as provided in this chapter, the following apply:

(a) The several corporations parties to the agreement of merger or consolidation shall be a single corporation, which shall be:

(1) in case of a merger, the surviving corporation a party to the agreement of merger into which it has been agreed the other corporations parties to the agreement shall be merged, which surviving corporation shall survive the merger; or

(2) in case of a consolidation, the new corporation into which it has been agreed the corporations parties to the

agreement of consolidation shall be consolidated.

(b) The separate existence of all of the corporations parties to the agreement of merger or consolidation, except the surviving corporation in the case of a merger, shall cease.

(c) Such single corporation shall have all of the rights, privileges, immunities, and powers and shall be subject to all of the duties and liabilities of a corporation organized under this article.

(d) Such single corporation shall thereupon and thereafter possess all the rights, privileges, immunities, powers, and franchises of a public as well as of a private nature of each of the corporations so merged or consolidated, and all property, real, personal, and mixed, and all debts due on whatever account, including subscriptions to shares of capital stock, and all other choses in action and all and every other interest, of or belonging to or due to each of the corporations so merged or consolidated shall be taken and deemed to be transferred to and vested in such single corporation without further act or deed, and the title to any real estate, or any interest therein, under the laws of this state vested in any of such corporations shall not revert or be in any way impaired by reason of such merger or consolidation.

(e) Such single corporation shall thenceforth be responsible and liable for all the liabilities and obligations of each of the corporations so merged or consolidated in the same manner and to the same extent as if such single corporation had itself incurred the same or contracted therefor; any claim existing or action or proceeding pending by or against any of such corporations may be prosecuted to judgment as if such merger or consolidation had not taken place, or such single corporation may be substituted in its place. Neither the rights of creditors nor any liens upon the property of any of such corporations shall be impaired by such merger or consolidation, but such liens shall be limited to the property upon which they were liens immediately prior to the time of such merger or consolidation, unless otherwise provided in the agreement of merger or consolidation.

(f) In case of a merger, the articles of incorporation of the surviving corporation shall be supplanted and superseded to the extent, if any, that any provision or provisions of such articles shall be restated in the agreement of merger as provided by section 3 of this chapter, and such articles of incorporation shall be deemed to be thereby and to that extent amended; and in case of a consolidation, the statements set forth in the agreement of consolidation as provided in section 4 of this chapter shall be deemed to be articles of incorporation of the new corporation formed by such consolidation.

(Formerly: Acts 1935, c.162, s.125.) As amended by P.L.252-1985,

SEC.46.

IC 27-1-9-12

Execution of articles of merger or consolidation by foreign corporations; approval by foreign regulatory authority; appointment of commissioner as attorney for service of process on foreign corporation

Sec. 12. (a) In case of a merger or consolidation between a domestic and a foreign company, the articles of merger or consolidation shall be regarded as executed by the proper officers of said foreign company when such officers are duly authorized to execute same through such action on the part of the directors, shareholders, members, or policyholders of said foreign company as may be required by the laws of the state where the same is incorporated; and upon execution, said articles of merger or consolidation shall be submitted to the commissioner of insurance or other officer at the head of the insurance department of the state where such foreign company is incorporated. No such merger or consolidation shall take effect until it shall have been approved by the insurance official of the state where said foreign company is incorporated nor until a certificate of his approval has been filed in the office of the department of insurance of the state of Indiana. Such submission to and approval by the proper official of such other state shall not be required unless the same are required by the laws of such foreign state. The domestic company involved in such merger or consolidation shall not through anything contained in this section be relieved of any of the procedural requirements enumerated in the preceding sections of this article.

(b) No merger or consolidation between a domestic and a foreign company shall take effect, unless and until the surviving or new company, if such is a foreign company, shall file with the department a power of attorney appointing the commissioner and his successors in office, the attorney for service of said foreign company, upon whom all lawful process against said company may be served. Said power of attorney shall be irrevocable so long as said foreign company has outstanding in this state any contract of insurance, or other obligation whatsoever, and shall by its terms so provide. Service upon the commissioner shall be deemed sufficient service upon the company.

(Formerly: Acts 1935, c.162, s.127; Acts 1941, c.115, s.8.) As amended by P.L.260-1983, SEC.3.

IC 27-1-9-13

Transfer of deposit covering policies assumed by foreign corporation to foreign state

Sec. 13. If the state in which a foreign, new, surviving or accepting company, is incorporated or organized, shall require the maintenance with any official of such state of a deposit of the legal

reserve on the policies so assumed and such foreign company shall maintain such deposit, then the commissioner is authorized to deliver to the proper custodian of such funds in the state in which the said foreign company is incorporated or organized, such deposits as he may hold pertaining to the policies so assumed by the new, surviving or accepting company. If a surviving, new or accepting domestic company assumes all or a substantial number of the risks of a foreign company incorporated in a state which requires the maintenance with a state official of a deposit of the legal reserve on policies so assumed, then the commissioner is hereby authorized to receive from such official such deposits as he may hold pertaining to the policies so assumed. Such surviving, new or accepting company shall, within sixty (60) days after the transfer of such deposit, notify the holder of every policy secured by such transferred deposit that the transfer has been made; and the president and secretary of such company shall, within thirty (30) days thereafter, file with the commissioner an affidavit of the fact that due notification to policyholders, as provided for herein, has been given. The amount of deposit to be maintained from time to time for each policy on which liability is assumed shall be at least equal to the amount which would be required in the state where such deposit has theretofore been maintained.
(Formerly: Acts 1935, c.162, s.128.)

IC 27-1-9-14
Statement of compensation to persons securing, aiding, promoting, or assisting in merger, consolidation, or reinsurance

Sec. 14. Whenever articles of merger, consolidation or reinsurance are filed with the department, there shall also be filed a certificate, executed by the president or a vice-president and attested by the secretary or an assistant secretary, and under the corporate seal of each of the corporations parties to the agreement of merger, consolidation and reinsurance, verified by the affidavits of all such officers, setting forth all fees, commissions or other compensations, or valuable considerations paid or to be paid, directly or indirectly, to any person or persons, firm or firms, limited liability company or limited liability companies, corporation or corporations whomsoever, which in any manner secured, aided, promoted or assisted in any such merger, consolidation or reinsurance.
(Formerly: Acts 1935, c.162, s.129.) As amended by P.L.8-1993, SEC.412.

IC 27-1-9-15
Undisclosed compensation; violations

Sec. 15. (a) No director, officer, or member of any such corporation or corporations, except as fully expressed in the affidavits described in section 14 of this chapter, may receive any money or other property for aiding, promoting, or assisting in such

a merger, consolidation, or reinsurance.

(b) A person who violates this section commits a Class A misdemeanor.

(Formerly: Acts 1935, c.162, s.130.) As amended by Acts 1978, P.L.2, SEC.2709.

IC 27-1-10
Chapter 10. Voluntary Dissolution

IC 27-1-10-1
Surrender of certificate of incorporation; time; procedure

Sec. 1. With the approval in writing of the department, the incorporators named in the articles of incorporation of any corporation organized under the provisions of this article may surrender the certificate of incorporation and all of the corporate rights and franchises of the corporation at any time within one (1) year from the date of the issuance of the certificate and before the issuance of any of the shares of capital stock of the corporation and before the beginning by it of the business for which it was formed, by presenting to the secretary of state at his office, accompanied by the fees prescribed by law, a certificate in triplicate, signed and verified by the joint and several oaths of a majority of the incorporators in the form prescribed by the secretary of state, showing that no shares of the capital stock of the corporation have been issued and that the amount, if any, actually paid in on the shares, less any part thereof disbursed for necessary expenses, had been returned to those entitled thereto, that such business has not been begun, that no debts remain unpaid, and that they surrender all rights and franchises.

(Formerly: Acts 1935, c.162, s.131.) As amended by P.L.252-1985, SEC.47.

IC 27-1-10-2
Submission of question of dissolution; vote of shareholders, members, or policyholders

Sec. 2. Any corporation organized under the provisions of this article may liquidate its affairs and dissolve in the following manner:

(1) Whenever the board of directors by a resolution adopted by a majority vote of the members of such board shall deem it advisable to submit the question of dissolution, or whenever the board of directors shall be required in writing by the holders of a majority of the outstanding shares of capital stock, if a stock company, or a majority of the members or policyholders, if other than a stock company, to submit the question of dissolution, the board of directors shall submit the question of dissolving the company to a vote of the shareholders, members, or policyholders of a company entitled to vote in respect thereof at such meeting thereof as may be designated in such request, or, in the absence of such request or of such designation, in such resolution, the designated meeting may be an annual meeting of shareholders, members or policyholders, entitled to vote in respect thereof. If the designated meeting is an annual meeting, notice of the submission of the question of dissolution shall be included in the notice of such annual meeting. If the designated meeting is a special meeting of the shareholders, members, or

policyholders entitled to vote in respect thereof, such special meeting shall be called by the board of directors, and notice of such meeting shall be given at the time and in the manner as provided in IC 27-1-7-7.

(2) The question of dissolving the corporation shall be submitted to a vote of the shareholders, members, or policyholders entitled to vote in respect thereof at the meeting designated as provided in this section, and the dissolution shall be authorized upon receiving the affirmative votes of the holders of two-thirds (2/3) of the outstanding shares entitled to vote in respect thereof, if a stock company, or not less than two-thirds (2/3) of the members or policyholders entitled to vote, if other than a stock company. The shareholders, members, or policyholders of a corporation entitled to vote in respect to dissolution of the corporation shall be the shareholders entitled to vote under IC 27-1-7-8 and the members or policyholders entitled to vote under IC 27-1-7-9.

(Formerly: Acts 1935, c.162, s.132.) As amended by P.L.252-1985, SEC.48.

IC 27-1-10-3

Reinsurance of noncancellable policies

Sec. 3. Nothing contained in this article shall authorize or be construed to authorize the dissolution of any life insurance company or health and accident insurance company having noncancellable policies in force, after the same shall have commenced business, unless and until all of its policies shall have been reinsured, to the satisfaction of the commissioner, in a solvent life insurance company or health and accident insurance company respectively.

(Formerly: Acts 1935, c.162, s.133.) As amended by P.L.252-1985, SEC.49.

IC 27-1-10-4

Publication of notice of dissolution; payment of debts and liabilities; distribution of remaining assets; disposal of unclaimed distributive shares

Sec. 4. Upon authorization of the dissolution, the board of directors shall then proceed to:

(a) Cause a notice that the corporation is about to be dissolved to be published at least once in a newspaper of general circulation, printed and published in the English language, in the county in which the principal office of the corporation is located, and at least once in a newspaper of general circulation, printed and published in the English language in the city of Indianapolis, Marion County, Indiana, and to be mailed to each creditor of the corporation;

(b) Collect all of the corporate assets;

(c) Pay and discharge all of the corporate debts and liabilities; and

(d) After the expiration of a period of thirty (30) days following the publication and mailing of said notice, distribute the remaining

corporate assets and property among the shareholders, members or policyholders according to their respective interests.

In case the holders of shares or policies are unknown or shall fail or refuse to accept their distributive shares in such property and assets, or are under any disability, or can not be found, after diligent inquiry or in case the ownership of any shares or policies is in dispute, the board of directors shall deposit the distributive portions of such shares of stock or policies with the clerk of the circuit court in the county in which the principal office is located for the use and benefit of those who may be lawfully entitled thereto, and such deposit shall have the same force and effect as if payment had been made directly to and accepted by the persons lawfully entitled thereto. Such distributive shares shall be paid over by such clerk to such shareholders or policyholders, respectively, or to the lawful owner of the shares or policies, the ownership of which has been in dispute, or to their respective legal representatives, upon satisfactory proof being made to such clerk of their respective rights thereto.
(Formerly: Acts 1935, c.162, s.134.)

IC 27-1-10-5
Articles of dissolution; contents; executions; approval

Sec. 5. The corporation shall then execute and file, in the manner provided in this chapter, articles of dissolution, setting forth the following:

(a) The name of the corporation.

(b) The place where its principal office is located.

(c) The date of the meeting of the shareholders, members, or policyholders at which the dissolution was authorized and a copy of the notice of such meeting.

(d) A copy of the resolution of the shareholders, members, or policyholders authorizing the dissolution.

(e) The manner of its adoption and the vote by which it was adopted.

(f) A copy of the notice published and mailed as provided in this chapter.

(g) The names and addresses of the then existing directors and officers of the corporation.

(h) A complete itemized list of all the corporate debts and liabilities of the corporation existing at the time of the adoption of such resolution and thereafter incurred, and the date and manner of payment of each such debt and liability.

(i) A complete itemized list of all the corporate assets and property distributed to its shareholders, members, or policyholders, the name of each such shareholder, member, or policyholder, the amount distributed to each, and the date of distribution.

The articles of dissolution shall be executed in triplicate originals, in the form prescribed by the department, and signed by the president

or a vice president and the secretary or an assistant secretary of the corporation, and verified by the oaths of the officers signing the same, and shall be presented in triplicate originals to the department at its office accompanied by the proof of publication of the notice required by section 4 of this chapter. The department is hereby authorized, in its discretion, to approve or disapprove the articles of dissolution and proof of publication. If the department shall approve the articles of dissolution and proof of publication, it shall endorse its approval thereon as required in IC 27-1-6-8 and present the same to the attorney general of the state of Indiana for examination. In the event the attorney general approves the articles of dissolution and proof of publication he shall certify his approval thereon as required in IC 27-1-6-9 and return the same to the department when the articles of dissolution and proof of publication have been approved by the attorney general and returned to the department.
(Formerly: Acts 1935, c.162, s.135.) As amended by P.L.252-1985, SEC.50.

IC 27-1-10-6
Articles of dissolution; duties of secretary of state

Sec. 6. Then the department shall present the same to the secretary of state for the state of Indiana. If the secretary of state finds that the articles of dissolution and proof of publication conform to law he shall indorse his approval upon each of the triplicate copies of the articles, and the proof of publication, and when all fees have been paid as required by law, he shall file one (1) copy of the articles of dissolution and the proof of publication in his office and issue a certificate of dissolution to the corporation, and shall return the certificate of dissolution to the corporation together with the two (2) remaining copies of the articles of dissolution, bearing the indorsement of his approval, to the corporation or its representatives.
(Formerly: Acts 1935, c.162, s.136.)

IC 27-1-10-7
Articles of dissolution; filing certified copies; surrender of certificate of authority; recording

Sec. 7. (a) The corporation shall then file a certified copy of the articles of dissolution with the department, and present to the department its certificate of authority issued or renewed under IC 27-1-6-18 for cancellation. The department shall file the certified copy of the articles of dissolution and shall cancel the said certificate of authority and endorse the cancellation thereon, and return the cancelled certificate of authority to the corporation or its representatives.

(b) The corporation shall then file for record with the county recorder of the county in which the articles of incorporation were or should have been recorded, as provided in IC 27-1-6-13, one (1) of the triplicate originals of the articles of dissolution bearing the

endorsement of the approval of the secretary of state as provided for in section 6 of this chapter.
(Formerly: Acts 1935, c.162, s.137.) As amended by P.L.252-1985, SEC.51.

IC 27-1-10-8
Final dissolution; pending liabilities

Sec. 8. (a) Upon the issuance of the certificate of dissolution and the recording of the articles of dissolution, as provided in section 7 of this chapter, the corporation shall be dissolved and its existence shall cease.

(b) The dissolution of any corporation in accordance with the provisions of this article shall not take away or impair any remedy against such corporation, its directors, officers, or shareholders, for any liability incurred by the corporation previous to its dissolution if suit is brought and service of process is had, as provided by the laws of this state, within two (2) years after the date of such dissolution.
(Formerly: Acts 1935, c.162, s.138.) As amended by P.L.252-1985, SEC.52.

IC 27-1-11
Chapter 11. Reorganization of Existing Insurance Companies

IC 27-1-11-1
Authority to reorganize; reorganization of mutual company as stock company unauthorized

Sec. 1. Any stock company or mutual company organized before March 8, 1935, under any of the laws of this state may reorganize under the provisions of this article and thereafter avail itself of the rights, privileges, immunities, and franchises provided by this article by complying with the provisions of this chapter. Nothing in this chapter shall be construed or interpreted as permitting or authorizing the reorganization of a mutual company as a stock company.
(Formerly: Acts 1935, c.162, s.139.) As amended by P.L.252-1985, SEC.53.

IC 27-1-11-2
Articles; approval by directors

Sec. 2. The board of directors of such company desiring to reorganize under this article shall, by resolution adopted by a majority vote of the members of such board, approve the articles of reorganization setting forth:

(1) the name of the corporation;
(2) the location of its principal office;
(3) the date of its incorporation or organization;
(4) a designation of the statute under which it was organized;
(5) a declaration that it accepts all of the terms and provisions of this article; and
(6) a restatement of such provisions of its articles of incorporation or association as may be deemed desirable so long as the provisions restated would have been authorized by this article as provisions of original articles of incorporation for a corporation organized under this article.

(Formerly: Acts 1935, c.162, s.140.) As amended by P.L.252-1985, SEC.54.

IC 27-1-11-3
Articles; submission to shareholders, members, or policyholders; vote required; eligibility to vote

Sec. 3. (a) The resolution of the board of directors approving the articles of reorganization shall direct that the articles be submitted to a vote of the shareholders, members, or policyholders of such corporation entitled to vote in respect thereof, at a designated meeting thereof, which may be an annual meeting of shareholders, members, or policyholders or a special meeting of the shareholders, members, or policyholders, entitled to vote in respect thereof. If the designated meeting is an annual meeting, notice of the submission of the articles of reorganization shall be included in the notice of such

annual meeting. If the designated meeting is a special meeting of the shareholders, members, or policyholders entitled to vote in respect thereof, such meeting shall be called by the resolution designating the meeting, and notice of such meeting shall be given at the time and in the manner as provided in IC 27-1-7-7.

(b) The articles of reorganization so approved shall be submitted to a vote of the shareholders, members, or policyholders entitled to vote in respect thereof at the meeting directed by the resolution of the board of directors approving the articles, and shall be adopted upon receiving the affirmative vote of the holders of two-thirds (2/3) of the outstanding shares entitled to vote in respect thereof, if a stock company, or not less than two-thirds (2/3) of the members or policyholders present and voting at such meeting, if other than a stock company. The shareholders, members, or policyholders of a corporation entitled to vote in respect of the organization of such corporation shall be the shareholders entitled to vote under IC 27-1-7-8 and the members or policyholders entitled to vote under IC 27-1-7-9.

(Formerly: Acts 1935, c.162, s.141.) As amended by P.L.252-1985, SEC.55.

IC 27-1-11-4

Articles; execution; approval or disapproval by department

Sec. 4. (a) Upon the approval and adoption thereof, the articles of reorganization shall be filed in triplicate originals, in the form prescribed by the department, by the president or a vice president and the secretary or an assistant secretary of the corporation, and acknowledged and sworn to before a notary public by the officer signing the same and shall be presented in triplicate to the department at its office.

(b) The department is hereby authorized, in its discretion, to approve or disapprove the articles of reorganization, and if the department shall approve the articles of reorganization it shall endorse its approval thereon as required in IC 27-1-6-8 and present the same to the secretary of state for the state of Indiana for his approval.

(Formerly: Acts 1935, c.162, s.142.) As amended by P.L.252-1985, SEC.56.

IC 27-1-11-5

Articles; presentation to secretary of state; duties of secretary of state

Sec. 5. Upon the presentation of the articles of reorganization, the secretary of state, if he finds they conform to law, shall indorse his approval on each of the triplicate copies of the articles, and when all fees have been paid as required by law, shall file one (1) copy of the articles in his office, issue a certificate of reorganization, and return two (2) copies of the articles of reorganization, bearing the

indorsement of his approval, together with the certificate of reorganization to the corporation or its representatives.
(Formerly: Acts 1935, c.162, s.143.)

IC 27-1-11-6
Filing copy of articles; cancellation of certificate of authority; recording articles; exercise of new powers

Sec. 6. (a) The corporation shall then file a certified copy of the articles of reorganization with the department and present to the department its certificate of authority issued or renewed under IC 27-1-6-18 for cancellation. The department shall file the certified copy of articles of reorganization and shall cancel the said certificate of authority and endorse the cancellation thereon, and issue a new certificate of authority to the corporation under the provisions of IC 27-1-6-18.

(b) The corporation shall then file for record with the county recorder of the county in which the principal office of the corporation is located, one (1) of the triplicate copies of the articles of reorganization bearing the endorsement of the approval of the secretary of state as provided for in section 5 of this chapter.

(c) A corporation which is reorganized in accordance with the provisions of this chapter shall not exercise any new power, right, or authority conferred by, or take any action pursuant to, such reorganization until subsections (a) and (b) have been complied with. If a corporation exercises any such new power, right, or authority or takes any such action in violation of this section, the officers and directors who participated therein shall be severally liable for any debts or liabilities of the corporation incurred thereby or arising therefrom.
(Formerly: Acts 1935, c.162, s.144.) As amended by P.L.252-1985, SEC.57.

IC 27-1-11-7
Completion of reorganization; effect

Sec. 7. Upon the issuance of the certificate of reorganization by the secretary of state, the filing for record of the articles with the department and the county recorder as provided in section 6 of this chapter, and the issuance of the new certificate of authority provided for in section 6 of this chapter:

(1) the reorganization shall become effective;

(2) the corporation shall be entitled to all of the rights, privileges, immunities, powers, and franchises and be subject to all of the penalties, liabilities, and restrictions by the provisions of this article granted to or imposed upon corporations organized under this article; and

(3) the articles of incorporation or organization shall be deemed to be amended to the extent, if any, that any provision or provisions of such articles shall be restated in the articles of

reorganization as provided by section 2 of this chapter.
(Formerly: Acts 1935, c.162, s.145.) As amended by P.L.252-1985, SEC.58.

IC 27-1-12

Chapter 12. Life Insurance Company Powers and Policy Requirements

IC 27-1-12-0.1

Application of certain amendments to chapter

Sec. 0.1. The addition of sections 37, 38, 39, 40, 41, and 42 of this chapter by P.L.254-1985 applies to insurance policies delivered in Indiana after December 31, 1985.

As added by P.L.220-2011, SEC.421.

IC 27-1-12-1

Particular rights, privileges, and powers

Sec. 1. In addition to the general rights, privileges, and powers conferred by IC 27-1-5 through IC 27-1-13 and IC 27-11, and subject to the limitations and restrictions contained in this article and in the articles of incorporation, every life insurance company shall possess and may exercise the rights, privileges, and powers enumerated in this chapter and IC 27-1-12.8.

(Formerly: Acts 1935, c.162, s.146.) As amended by P.L.252-1985, SEC.59; P.L.3-1990, SEC.96; P.L.276-2013, SEC.2.

IC 27-1-12-2

Investments; categories, conditions, limitations, and standards

Sec. 2. (a) The following definitions apply to this section:

(1) "Acceptable collateral" means, as to securities lending transactions:

(A) cash;

(B) cash equivalents;

(C) letters of credit; and

(D) direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or any agency of the United States, including the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation.

(2) "Acceptable collateral" means, as to lending foreign securities, sovereign debt that is rated:

(A) A- or higher by Standard & Poor's Corporation;

(B) A3 or higher by Moody's Investors Service, Inc.;

(C) A- or higher by Duff and Phelps, Inc.; or

(D) 1 by the Securities Valuation Office.

(3) "Acceptable collateral" means, as to repurchase transactions:

(A) cash;

(B) cash equivalents; and

(C) direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or any agency of the United States,

including the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation.

(4) "Acceptable collateral" means, as to reverse repurchase transactions:

(A) cash; and

(B) cash equivalents.

(5) "Admitted assets" means assets permitted to be reported as admitted assets on the statutory financial statement of the life insurance company most recently required to be filed with the commissioner.

(6) "Business entity" means:

(A) a sole proprietorship;

(B) a corporation;

(C) a limited liability company;

(D) an association;

(E) a partnership;

(F) a joint stock company;

(G) a joint venture;

(H) a mutual fund;

(I) a trust;

(J) a joint tenancy; or

(K) other, similar form of business organization;

whether organized for-profit or not-for-profit.

(7) "Cash" means any of the following:

(A) United States denominated paper currency and coins.

(B) Negotiable money orders and checks.

(C) Funds held in any time or demand deposit in any depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.

(8) "Cash equivalent" means any of the following:

(A) A certificate of deposit issued by a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.

(B) A banker's acceptance issued by a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.

(C) A government money market mutual fund.

(D) A class one money market mutual fund.

(9) "Class one money market mutual fund" means a money market mutual fund that at all times qualifies for investment pursuant to the "Purposes and Procedures of the Securities Valuation Office" or any successor publication either using the bond class one reserve factor or because it is exempt from asset valuation reserve requirements.

(10) "Dollar roll transaction" means two (2) simultaneous transactions that have settlement dates not more than ninety-six (96) days apart and that meet the following description:

(A) In one (1) transaction, a life insurance company sells to

a business entity one (1) or both of the following:

(i) Asset-backed securities that are issued, assumed, or guaranteed by the Government National Mortgage Association, the Federal National Mortgage Association, or the Federal Home Loan Mortgage Corporation or the successor of an entity referred to in this item.

(ii) Other asset-backed securities referred to in Section 106 of Title I of the Secondary Mortgage Market Enhancement Act of 1984 (15 U.S.C. 77r-1), as amended.

(B) In the other transaction, the life insurance company is obligated to purchase from the same business entity securities that are substantially similar to the securities sold under clause (A).

(11) "Domestic jurisdiction" means:

(A) the United States;

(B) any state, territory, or possession of the United States;

(C) the District of Columbia;

(D) Canada; or

(E) any province of Canada.

(12) "Earnings available for fixed charges" means income, after deducting:

(A) operating and maintenance expenses other than expenses that are fixed charges;

(B) taxes other than federal and state income taxes;

(C) depreciation; and

(D) depletion;

but excluding extraordinary nonrecurring items of income or expense appearing in the regular financial statements of a business entity.

(13) "Fixed charges" includes:

(A) interest on funded and unfunded debt;

(B) amortization of debt discount; and

(C) rentals for leased property.

(14) "Foreign currency" means a currency of a foreign jurisdiction.

(15) "Foreign jurisdiction" means a jurisdiction other than a domestic jurisdiction.

(16) "Government money market mutual fund" means a money market mutual fund that at all times:

(A) invests only in:

(i) obligations that are issued, guaranteed, or insured by the United States; or

(ii) collateralized repurchase agreements composed of obligations that are issued, guaranteed, or insured by the United States; and

(B) qualifies for investment without a reserve pursuant to the "Purposes and Procedures of the Securities Valuation Office" or any successor publication.

(17) "Guaranteed or insured," when used in reference to an obligation acquired under this section, means that the guarantor or insurer has agreed to:

(A) perform or insure the obligation of the obligor or purchase the obligation; or

(B) be unconditionally obligated, until the obligation is repaid, to maintain in the obligor a minimum net worth, fixed charge coverage, stockholders' equity, or sufficient liquidity to enable the obligor to pay the obligation in full.

(18) "Investment company" means:

(A) an investment company as defined in Section 3(a) of the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.), as amended; or

(B) a person described in Section 3(c) of the Investment Company Act of 1940.

(19) "Investment company series" means an investment portfolio of an investment company that is organized as a series company to which assets of the investment company have been specifically allocated.

(20) "Letter of credit" means a clean, irrevocable, and unconditional letter of credit that is:

(A) issued or confirmed by; and

(B) payable and presentable at;

a financial institution on the list of financial institutions meeting the standards for issuing letters of credit under the "Purposes and Procedures of the Securities Valuation Office" or any successor publication. To constitute acceptable collateral for the purposes of paragraph 29 of subsection (b), a letter of credit must have an expiration date beyond the term of the subject transaction.

(21) "Market value" means the following:

(A) As to cash, the amount of the cash.

(B) As to cash equivalents, the amount of the cash equivalents.

(C) As to letters of credit, the amount of the letters of credit.

(D) As to a security as of any date:

(i) the price for the security on that date obtained from a generally recognized source, or the most recent quotation from such a source; or

(ii) if no generally recognized source exists, the price for the security as determined in good faith by the parties to a transaction;

plus accrued but unpaid income on the security to the extent not included in the price as of that date.

(22) "Money market mutual fund" means a mutual fund that meets the conditions of 17 CFR 270.2a-7, under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.).

(23) "Multilateral development bank" means an international

development organization of which the United States is a member.

(24) "Mutual fund" means:

(A) an investment company; or

(B) in the case of an investment company that is organized as a series company, an investment company series;

that is registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.).

(25) "Obligation" means any of the following:

(A) A bond.

(B) A note.

(C) A debenture.

(D) Any other form of evidence of debt.

(26) "Person" means:

(A) an individual;

(B) a business entity;

(C) a multilateral development bank; or

(D) a government or quasi-governmental body, such as a political subdivision or a government sponsored enterprise.

(27) "Repurchase transaction" means a transaction in which a life insurance company purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the life insurance company at a specified price, either within a specified period of time or upon demand.

(28) "Reverse repurchase transaction" means a transaction in which a life insurance company sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period of time or upon demand.

(29) "Securities lending transaction" means a transaction in which securities are loaned by a life insurance company to a business entity that is obligated to return the loaned securities or equivalent securities to the life insurance company, either within a specified period of time or upon demand.

(30) "Securities Valuation Office" refers to:

(A) the Securities Valuation Office of the National Association of Insurance Commissioners; or

(B) any successor of the office referred to in Clause (A) established by the National Association of Insurance Commissioners.

(31) "Series company" means an investment company that is organized as a series company (as defined in Rule 18f-2(a) adopted under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.), as amended).

(32) "Supported", when used in reference to an obligation, by whomever issued or made, means that:

(A) repayment of the obligation by:

(i) a domestic jurisdiction or by an administration, agency, authority, or instrumentality of a domestic jurisdiction; or

(ii) a business entity;

as the case may be, is secured by real or personal property of value at least equal to the principal amount of the obligation by means of mortgage, assignment of vendor's interest in one (1) or more conditional sales contracts, other title retention device, or by means of other security interest in such property for the benefit of the holder of the obligation; and

(B) the:

(i) domestic jurisdiction or administration, agency, authority, or instrumentality of the domestic jurisdiction; or

(ii) business entity;

as the case may be, has entered into a firm agreement to rent or use the property pursuant to which it is obligated to pay money as rental or for the use of such property in amounts and at times which shall be sufficient, after provision for taxes upon and other expenses of use of the property, to repay in full the obligation with interest and when such agreement and the money obligated to be paid thereunder are assigned, pledged, or secured for the benefit of the holder of the obligation. However, where the security for the repayment of the obligation consists of a first mortgage lien or deed of trust on a fee interest in real property, the obligation may provide for the amortization, during the initial, fixed period of the lease or contract, of less than one hundred percent (100%) of the obligation if there is pledged or assigned, as additional security for the obligation, sufficient rentals payable under the lease, or of contract payments, to secure the amortized obligation payments required during the initial, fixed period of the lease or contract, including but not limited to payments of principal, interest, and taxes other than the income taxes of the borrower, and if there is to be left unamortized at the end of such period an amount not greater than the original appraised value of the land only, exclusive of all improvements, as prescribed by law.

(b) Investments of domestic life insurance companies at the time they are made shall conform to the following categories, conditions, limitations, and standards:

1. Obligations of a domestic jurisdiction or of any administration, agency, authority, or instrumentality of a domestic jurisdiction.

2. Obligations guaranteed, supported, or insured as to principal and interest by a domestic jurisdiction or by an administration, agency, authority, or instrumentality of a domestic jurisdiction.

3. Obligations issued under or pursuant to the Farm Credit Act of

1971 (12 U.S.C. 2001 through 2279aa-14) as in effect on December 31, 1990, or the Federal Home Loan Bank Act (12 U.S.C. 1421 through 1449) as in effect on December 31, 1990, interest bearing obligations of the FSLIC Resolution Fund or shares of any institution whose deposits are insured by the Federal Deposit Insurance Corporation to the extent that such shares are insured, obligations issued or guaranteed by a multilateral development bank, and obligations issued or guaranteed by the African Development Bank.

4. Obligations issued, guaranteed, or insured as to principal and interest by a city, county, drainage district, road district, school district, tax district, town, township, village, or other civil administration, agency, authority, instrumentality, or subdivision of a domestic jurisdiction, providing such obligations are authorized by law and are:

(a) direct and general obligations of the issuing, guaranteeing or insuring governmental unit, administration, agency, authority, district, subdivision, or instrumentality;

(b) payable from designated revenues pledged to the payment of the principal and interest thereof; or

(c) improvement bonds or other obligations constituting a first lien, except for tax liens, against all of the real estate within the improvement district or on that part of such real estate not discharged from such lien through payment of the assessment. The area to which such improvement bonds or other obligations relate shall be situated within the limits of a town or city and at least fifty percent (50%) of the properties within such area shall be improved with business buildings or residences.

5. Loans evidenced by obligations secured by first mortgage liens on otherwise unencumbered real estate or otherwise unencumbered leaseholds having at least fifty (50) years of unexpired term, such real estate, or leaseholds to be located in a domestic jurisdiction. Such loans shall not exceed eighty percent (80%) of the fair value of the security determined in a manner satisfactory to the department, except that the percentage stated may be exceeded if and to the extent such excess is guaranteed or insured by:

(a) a domestic jurisdiction or by an administration, agency, authority, or instrumentality of any domestic jurisdiction; or

(b) a private mortgage insurance corporation approved by the department.

If improvements constitute a part of the value of the real estate or leaseholds, such improvements shall be insured against fire for the benefit of the mortgagee in an amount not less than the difference between the value of the land and the unpaid balance of the loan.

For the purpose of this section, real estate or a leasehold shall not be deemed to be encumbered by reason of the existence in relation thereto of:

(1) liens inferior to the lien securing the loan made by the life insurance company;

(2) taxes or assessment liens not delinquent;

(3) instruments creating or reserving mineral, oil, water or timber rights, rights-of-way, common or joint driveways, sewers, walls, or utility connections;

(4) building restrictions or other restrictive covenants; or

(5) an unassigned lease reserving rents or profits to the owner.

A loan that is authorized by this paragraph remains qualified under this paragraph notwithstanding any refinancing, modification, or extension of the loan. Investments authorized by this paragraph shall not in the aggregate exceed forty-five percent (45%) of the life insurance company's admitted assets.

6. Loans evidenced by obligations guaranteed or insured, but only to the extent guaranteed or insured, by a domestic jurisdiction or by any agency, administration, authority, or instrumentality of any domestic jurisdiction, and secured by second or subsequent mortgages or deeds of trust on real estate or leaseholds, provided the terms of the leasehold mortgages or deeds of trust shall not exceed four-fifths (4/5) of the unexpired lease term, including enforceable renewable options remaining at the time of the loan.

7. Real estate contracts involving otherwise unencumbered real estate situated in a domestic jurisdiction, to be secured by the title to such real estate, which shall be transferred to the life insurance company or to a trustee or nominee of its choosing. For statement and deposit purposes, the value of a contract acquired pursuant to this paragraph shall be whichever of the following amounts is the least:

(a) eighty percent (80%) of the contract price of the real estate;

(b) eighty percent (80%) of the fair value of the real estate at the time the contract is purchased, such value to be determined in a manner satisfactory to the department; or

(c) the amount due under the contract.

For the purpose of this paragraph, real estate shall not be deemed encumbered by reason of the existence in relation thereto of: (1) taxes or assessment liens not delinquent; (2) instruments creating or reserving mineral, oil, water or timber rights, rights-of-way, common or joint driveways, sewers, walls or utility connections; (3) building restrictions or other restrictive covenants; or (4) an unassigned lease reserving rents or profits to the owner. Fire insurance upon improvements constituting a part of the real estate described in the contract shall be maintained in an amount at least equal to the unpaid balance due under the contract or the fair value of improvements, whichever is the lesser.

8. Improved or unimproved real property, whether encumbered or unencumbered, or any interest therein, held directly or evidenced by joint venture interests, general or limited partnership interests, trust certificates, or any other instruments, and acquired by the life insurance company as an investment, which real property, if unimproved, is developed within five (5) years. Real property

acquired for investment under this paragraph, whether leased or intended to be developed for commercial or residential purposes or otherwise lawfully held, is subject to the following conditions and limitations:

(a) The real estate shall be located in a domestic jurisdiction.

(b) The admitted assets of the life insurance company must exceed twenty-five million dollars ($25,000,000).

(c) The life insurance company shall have the right to expend from time to time whatever amount or amounts may be necessary to conform the real estate to the needs and purposes of the lessee and the amount so expended shall be added to and become a part of the investment in such real estate.

(d) The value for statement and deposit purposes of an investment under this paragraph shall be reduced annually by amortization of the costs of improvement and development, less land costs, over the expected life of the property, which value and amortization shall for statement and deposit purposes be determined in a manner satisfactory to the commissioner. In determining such value with respect to the calendar years in which an investment begins or ends with respect to a point in time other than the beginning or end of a calendar year, the amortization provided above shall be made on a proportional basis.

(e) Fire insurance shall be maintained in an amount at least equal to the insurable value of the improvements or the difference between the value of the land and the value at which such real estate is carried for statement and deposit purposes, whichever amount is smaller.

(f) Real estate acquired in any of the manners described and sanctioned under section 3 of this chapter, or otherwise lawfully held, except paragraph 5 of that section which specifically relates to the acquisition of real estate under this paragraph, shall not be affected in any respect by this paragraph unless such real estate at or subsequent to its acquisition fulfills the conditions and limitations of this paragraph, and is declared by the life insurance company in a writing filed with the department to be an investment under this paragraph. The value of real estate acquired under section 3 of this chapter, or otherwise lawfully held, and invested under this paragraph shall be initially that at which it was carried for statement and deposit purposes under that section.

(g) Neither the cost of each parcel of improved real property nor the aggregate cost of all unimproved real property acquired under the authority of this paragraph may exceed two percent (2%) of the life insurance company's admitted assets. For purposes of this paragraph, "unimproved real property" means land containing no structures intended for commercial, industrial, or residential occupancy, and "improved real

property" consists of all land containing any such structure. When applying the limitations of subparagraph (d) of this paragraph, unimproved real property becomes improved real property as soon as construction of any commercial, industrial, or residential structure is so completed as to be capable of producing income. In the event the real property is mortgaged with recourse to the life insurance company or the life insurance company commences a plan of construction upon real property at its own expense or guarantees payment of borrowed funds to be used for such construction, the total project cost of the real property will be used in applying the two percent (2%) test. Further, no more than ten percent (10%) of the life insurance company's admitted assets may be invested in all property, measured by the property value for statement and deposit purposes as defined in this paragraph, held under this paragraph at the same time.

9. Deposits of cash in a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation, or certificates of deposit issued by a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.

10. Bank and bankers' acceptances and other bills of exchange of kinds and maturities eligible for purchase or rediscount by federal reserve banks.

11. Obligations that are issued, guaranteed, assumed, or supported by a business entity organized under the laws of a domestic jurisdiction and that are rated:

(a) BBB- or higher by Standard & Poor's Corporation (or A-2 or higher in the case of commercial paper);

(b) Baa 3 or higher by Moody's Investors Service, Inc. (or P-2 or higher in the case of commercial paper);

(c) BBB- or higher by Duff and Phelps, Inc. (or D-2 or higher in the case of commercial paper); or

(d) 1 or 2 by the Securities Valuation Office.

Investments may also be made under this paragraph in obligations that have not received a rating if the earnings available for fixed charges of the business entity for the period of its five (5) fiscal years next preceding the date of purchase shall have averaged per year not less than one and one-half (1 1/2) times its average annual fixed charges applicable to such period and if during either of the last two (2) years of such period such earnings available for fixed charges shall have been not less than one and one-half (1 1/2) times its fixed charges for such year. However, if the business entity is a finance company or other lending institution at least eighty percent (80%) of the assets of which are cash and receivables representing loans or discounts made or purchased by it, the multiple shall be one and one-quarter (1 1/4) instead of one and one-half (1 1/2).

11.(A) Obligations issued, guaranteed, or assumed by a business entity organized under the laws of a domestic jurisdiction, which

obligations have not received a rating or, if rated, have not received a rating that would qualify the obligations for investment under paragraph 11 of this section. Investments authorized by this paragraph may not exceed ten percent (10%) of the life insurance company's admitted assets.

12. Preferred stock of, or common or preferred stock guaranteed as to dividends by, any corporation organized under the laws of a domestic jurisdiction, which over the period of the seven (7) fiscal years immediately preceding the date of purchase earned an average amount per annum at least equal to five percent (5%) of the par value of its common and preferred stock (or, in the case of stocks having no par value, of its issued or stated value) outstanding at date of purchase, or which over such period earned an average amount per annum at least equal to two (2) times the total of its annual interest charges, preferred dividends and dividends guaranteed by it, determined with reference to the date of purchase. No investment shall be made under this paragraph in a stock upon which any dividend is in arrears or has been in arrears for ninety (90) days within the immediately preceding five (5) year period.

13. Common stock of any solvent corporation organized under the laws of a domestic jurisdiction which over the seven (7) fiscal years immediately preceding purchase earned an average amount per annum at least equal to six percent (6%) of the par value of its capital stock (or, in the case of stock having no par value, of the issued or stated value of such stock) outstanding at date of purchase, but the conditions and limitations of this paragraph shall not apply to the special area of investment to which paragraph 23 of this section pertains.

13.(A) Stock or shares of any mutual fund that:

(a) has been in existence for a period of at least five (5) years immediately preceding the date of purchase, has assets of not less than twenty-five million dollars ($25,000,000) at the date of purchase, and invests substantially all of its assets in investments permitted under this section; or

(b) is a class one money market mutual fund or a class one bond mutual fund.

Investments authorized by this paragraph 13(A) in mutual funds having the same or affiliated investment advisers shall not at any one (1) time exceed in the aggregate ten percent (10%) of the life insurance company's admitted assets. The limitations contained in paragraph 22 of this subsection apply to investments in the types of mutual funds described in subparagraph (a). For the purposes of this paragraph, "class one bond mutual fund" means a mutual fund that at all times qualifies for investment using the bond class one reserve factor under the "Purposes and Procedures of the Securities Valuation Office" or any successor publication.

The aggregate amount of investments under this paragraph may be limited by the commissioner if the commissioner finds that

investments under this paragraph may render the operation of the life insurance company hazardous to the company's policyholders or creditors or to the general public.

14. Loans upon the pledge of any of the investments described in this section other than real estate and those qualifying solely under paragraph 20 of this subsection, but the amount of such a loan shall not exceed seventy-five percent (75%) of the value of the investment pledged.

15. Real estate acquired or otherwise lawfully held under the provisions of IC 27-1, except under paragraph 7 or 8 of this subsection, which real estate as an investment shall also include the value of improvements or betterments made thereon subsequent to its acquisition. The value of such real estate for deposit and statement purposes is to be determined in a manner satisfactory to the department.

15.(A) Tangible personal property, equipment trust obligations, or other instruments evidencing an ownership interest or other interest in tangible personal property when the life insurance company purchasing such property has admitted assets in excess of twenty-five million dollars ($25,000,000), and where there is a right to receive determined portions of rental, purchase, or other fixed obligatory payments for the use of such personal property from a corporation whose obligations would be eligible for investment under the provisions of paragraph 11 of this subsection, provided that the aggregate of such payments together with the estimated salvage value of such property at the end of its minimum useful life, to be determined in a manner acceptable to the insurance commissioner, and the estimated tax benefits to the insurer resulting from ownership of such property, is adequate to return the cost of the investment in such property, and provided further, that each net investment in tangible personal property for which any single private corporation is obligated to pay rental, purchase, or other obligatory payments thereon does not exceed one-half of one percent (1/2%) of the life insurance company's admitted assets, and the aggregate net investments made under the provisions of this paragraph do not exceed five percent (5%) of the life insurance company's admitted assets.

16. Loans to policyholders of the life insurance company in amounts not exceeding in any case the reserve value of the policy at the time the loan is made.

17. A life insurance company doing business in a foreign jurisdiction may, if permitted or required by the laws of such jurisdiction, invest funds equal to its obligations in such jurisdiction in investments legal for life insurance companies domiciled in such jurisdiction or doing business therein as alien companies.

17.(A) Investments in (i) obligations issued, guaranteed, assumed, or supported by a foreign jurisdiction or by a business entity organized under the laws of a foreign jurisdiction and (ii) preferred

stock and common stock issued by any such business entity, if the obligations of such foreign jurisdiction or business entity, as appropriate, are rated:

(a) BBB- or higher by Standard & Poor's Corporation (or A-2 or higher in the case of commercial paper);

(b) Baa 3 or higher by Moody's Investors Service, Inc. (or P-2 or higher in the case of commercial paper);

(c) BBB- or higher by Duff and Phelps, Inc. (or D-2 or higher in the case of commercial paper); or

(d) 1 or 2 by the Securities Valuation Office.

If the obligations issued by a business entity organized under the laws of a foreign jurisdiction have not received a rating, investments may nevertheless be made under this paragraph in such obligations and in the preferred and common stock of the business entity if the earnings available for fixed charges of the business entity for a period of five (5) fiscal years preceding the date of purchase have averaged at least three (3) times its average fixed charges applicable to such period, and if during either of the last two (2) years of such period, the earnings available for fixed charges were at least three (3) times its fixed charges for such year. Investments authorized by this paragraph in a single foreign jurisdiction shall not exceed ten percent (10%) of the life insurance company's admitted assets. Subject to section 2.2(g) of this chapter, investments authorized by this paragraph denominated in foreign currencies shall not in the aggregate exceed ten percent (10%) of a life insurance company's admitted assets, and investments in any one (1) foreign currency shall not exceed five percent (5%) of the life insurance company's admitted assets. Investments authorized by this paragraph and paragraph 17(B) shall not in the aggregate exceed twenty percent (20%) of the life insurance company's admitted assets. This paragraph in no way limits or restricts investments which are otherwise specifically eligible for deposit under this section.

17.(B) Investments in:

(a) obligations issued, guaranteed, or assumed by a foreign jurisdiction or by a business entity organized under the laws of a foreign jurisdiction; and

(b) preferred stock and common stock issued by a business entity organized under the laws of a foreign jurisdiction;

which investments are not eligible for investment under paragraph 17.(A).

Investments authorized by this paragraph 17(B) shall not in the aggregate exceed five percent (5%) of the life insurance company's admitted assets. Subject to section 2.2(g) of this chapter, if investments authorized by this paragraph 17(B) are denominated in a foreign currency, the investments shall not, as to such currency, exceed two percent (2%) of the life insurance company's admitted assets. Investments authorized by this paragraph 17(B) in any one (1) foreign jurisdiction shall not exceed two percent (2%) of the life

insurance company's admitted assets.

Investments authorized by paragraph 17(A) of this subsection and this paragraph 17(B) shall not in the aggregate exceed twenty percent (20%) of the life insurance company's admitted assets.

18. To protect itself against loss, a company may in good faith receive in payment of or as security for debts due or to become due, investments or property which do not conform to the categories, conditions, limitations, and standards set out above.

19. A life insurance company may purchase for its own benefit any of its outstanding annuity or insurance contracts or other obligations and the claims of holders thereof.

20. A life insurance company may make investments although not conforming to the categories, conditions, limitations, and standards contained in paragraphs 1 through 11, 12 through 19, and 29 through 31 of this subsection, but limited in aggregate amount to the lesser of:

(a) ten percent (10%) of the company's admitted assets; or

(b) the aggregate of the company's capital, surplus, and contingency reserves reported on the statutory financial statement of the insurer most recently required to be filed with the commissioner.

This paragraph 20 does not apply to investments authorized by paragraph 11.(A) of this subsection.

20.(A) Investments under paragraphs 1 through 20 and paragraphs 29 through 31 of this subsection are subject to the general conditions, limitations, and standards contained in paragraphs 21 through 28 of this subsection.

21. Investments in obligations (other than real estate mortgage indebtedness) and capital stock of, and in real estate and tangible personal property leased to, a single corporation, shall not exceed two percent (2%) of the life insurance company's admitted assets, taking into account the provisions of section 2.2(h) of this chapter. The conditions and limitations of this paragraph shall not apply to investments under paragraph 13(A) of this subsection or the special area of investment to which paragraph 23 of this subsection pertains.

22. Investments in:

(a) preferred stock; and

(b) common stock;

shall not, in the aggregate, exceed twenty percent (20%) of the life insurance company's admitted assets, exclusive of assets held in segregated accounts of the nature defined in class 1(c) of IC 27-1-5-1. These limitations shall not apply to investments for the special purposes described in paragraph 23 of this subsection nor to investments in connection with segregated accounts provided for in class 1(c) of IC 27-1-5-1.

23. Investments in subsidiary companies must be made in accordance with IC 27-1-23-2.6.

24. No investment, other than commercial bank deposits and loans

on life insurance policies, shall be made unless authorized by the life insurance company's board of directors or a committee designated by the board of directors and charged with the duty of supervising loans or investments.

25. No life insurance company shall subscribe to or participate in any syndicate or similar underwriting of the purchase or sale of securities or property or enter into any transaction for such purchase or sale on account of said company, jointly with any other corporation, firm, or person, or enter into any agreement to withhold from sale any of its securities or property, but the disposition of its assets shall at all times be within its control. Nothing contained in this paragraph shall be construed to invalidate or prohibit an agreement by two (2) or more companies to join and share in the purchase of investments for bona fide investment purposes.

26. No life insurance company may invest in the stocks or obligations, except investments under paragraphs 9 and 10 of this subsection, of any corporation in which an officer of such life insurance company is either an officer or director. However, this limitation shall not apply with respect to such investments in:

(a) a corporation which is a subsidiary or affiliate of such life insurance company; or

(b) a trade association, provided such investment meets the requirements of paragraph 5 of this subsection.

27. Except for the purpose of mutualization provided for in section 23 of this chapter, or for the purpose of retirement of outstanding shares of capital stock pursuant to amendment of its articles of incorporation, or in connection with a plan approved by the commissioner for purchase of such shares by the life insurance company's officers, employees, or agents, no life insurance company shall invest in its own stock.

28. In applying the conditions, limitations, and standards prescribed in paragraphs 11, 12, and 13 of this subsection to the stocks or obligations of a corporation which in the seven (7) year period preceding purchase of such stocks or obligations acquired its property or a substantial part thereof through consolidation, merger, or purchase, the earnings of the several predecessors or constituent corporations shall be consolidated.

29. A. Before a life insurance company may engage in securities lending transactions, repurchase transactions, reverse repurchase transactions, or dollar roll transactions, the life insurance company's board of directors must adopt a written plan that includes guidelines and objectives to be followed, including the following:

(1) A description of how cash received will be invested or used for general corporate purposes of the company.

(2) Operational procedures for managing interest rate risk, counterparty default risk, and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction.

(3) A statement of the extent to which the company may engage

in securities lending transactions, repurchase transactions, reverse repurchase transactions, and dollar roll transactions.

B. A life insurance company must enter into a written agreement for all transactions authorized by this paragraph, other than dollar roll transactions. The written agreement:

(1) must require the termination of each transaction not more than one (1) year after its inception or upon the earlier demand of the company; and

(2) must be with the counterparty business entity, except that, for securities lending transactions, the agreement may be with an agent acting on behalf of the life insurance company if:

(A) the agent is:

(i) a business entity, the obligations of which are rated BBB- or higher by Standard & Poor's Corporation (or A-2 or higher in the case of commercial paper), Baa3 or higher by Moody's Investors Service, Inc. (or P-2 or higher in the case of commercial paper), BBB- or higher by Duff and Phelps, Inc. (or D-2 or higher in the case of commercial paper), or 1 or 2 by the Securities Valuation Office;

(ii) a business entity that is a primary dealer in United States government securities, recognized by the Federal Reserve Bank of New York; or

(iii) any other business entity approved by the commissioner; and

(B) the agreement requires the agent to enter into with each counterparty separate agreements that are consistent with the requirements of this paragraph.

C. Cash received in a transaction under this paragraph shall be:

(1) invested:

(A) in accordance with this section 2; and

(B) in a manner that recognizes the liquidity needs of the transaction; or

(2) used by the life insurance company for its general corporate purposes.

D. For as long as a transaction under this paragraph remains outstanding, the life insurance company or its agent or custodian shall maintain, as to acceptable collateral received in the transaction, either physically or through book entry systems of the Federal Reserve, the Depository Trust Company, the Participants Trust Company, or another securities depository approved by the commissioner:

(1) possession of the acceptable collateral;

(2) a perfected security interest in the acceptable collateral; or

(3) in the case of a jurisdiction outside the United States:

(A) title to; or

(B) rights of a secured creditor to;

the acceptable collateral.

E. The limitations set forth in paragraphs 17 and 21 of this

subsection do not apply to transactions under this paragraph 29. For purposes of calculations made to determine compliance with this paragraph, no effect may be given to the future obligation of the life insurance company to:

(1) resell securities, in the case of a repurchase transaction; or

(2) repurchase securities, in the case of a reverse repurchase transaction.

F. A life insurance company shall not enter into a transaction under this paragraph if, as a result of the transaction, and after giving effect to the transaction:

(1) the aggregate amount of securities then loaned, sold to, or purchased from any one (1) business entity under this paragraph would exceed five percent (5%) of the company's admitted assets (but in calculating the amount sold to or purchased from a business entity under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement); or

(2) the aggregate amount of all securities then loaned, sold to, or purchased from all business entities under this paragraph would exceed forty percent (40%) of the admitted assets of the company (provided, however, that this limitation does not apply to a reverse repurchase transaction if the borrowing is used to meet operational liquidity requirements resulting from an officially declared catastrophe and is subject to a plan approved by the commissioner).

G. The following collateral requirements apply to all transactions under this paragraph:

(1) In a securities lending transaction, the life insurance company must receive acceptable collateral having a market value as of the transaction date at least equal to one hundred two percent (102%) of the market value of the securities loaned by the company in the transaction as of that date. If at any time the market value of the acceptable collateral received from a particular business entity is less than the market value of all securities loaned by the company to that business entity, the business entity shall be obligated to deliver additional acceptable collateral to the company, the market value of which, together with the market value of all acceptable collateral then held in connection with all securities lending transactions with that business entity, equals at least one hundred two percent (102%) of the market value of the loaned securities.

(2) In a reverse repurchase transaction, other than a dollar roll transaction, the life insurance company must receive acceptable collateral having a market value as of the transaction date equal to at least ninety-five percent (95%) of the market value of the securities transferred by the company in the transaction as of that date. If at any time the market value of the acceptable

collateral received from a particular business entity is less than ninety-five percent (95%) of the market value of all securities transferred by the company to that business entity, the business entity shall be obligated to deliver additional acceptable collateral to the company, the market value of which, together with the market value of all acceptable collateral then held in connection with all reverse repurchase transactions with that business entity, equals at least ninety-five percent (95%) of the market value of the transferred securities.

(3) In a dollar roll transaction, the life insurance company must receive cash in an amount at least equal to the market value of the securities transferred by the company in the transaction as of the transaction date.

(4) In a repurchase transaction, the life insurance company must receive acceptable collateral having a market value equal to at least one hundred two percent (102%) of the purchase price paid by the company for the securities. If at any time the market value of the acceptable collateral received from a particular business entity is less than one hundred percent (100%) of the purchase price paid by the life insurance company in all repurchase transactions with that business entity, the business entity shall be obligated to provide additional acceptable collateral to the company, the market value of which, together with the market value of all acceptable collateral then held in connection with all repurchase transactions with that business entity, equals at least one hundred two percent (102%) of the purchase price. Securities acquired by a life insurance company in a repurchase transaction shall not be:

(A) sold in a reverse repurchase transaction;

(B) loaned in a securities lending transaction; or

(C) otherwise pledged.

30. A life insurance company may invest in obligations or interests in trusts or partnerships regardless of the issuer, which are secured by:

(a) investments authorized by paragraphs 1, 2, 3, 4, or 11 of this subsection; or

(b) collateral with the characteristics and limitations prescribed for loans under paragraph 5 of this subsection.

For the purposes of this paragraph 30, collateral may be substituted for other collateral if it is in the same amount with the same or greater interest rate and qualifies as collateral under subparagraph (a) or (b) of this paragraph.

31. A life insurance company may invest in obligations or interests in trusts or partnerships, regardless of the issuer, secured by any form of collateral other than that described in subparagraphs (a) and (b) of paragraph 30 of this subsection, which obligations or interests in trusts or partnerships are rated:

(a) A- or higher by Standard & Poor's Corporation or Duff and

Phelps, Inc.;

(b) A 3 or higher by Moody's Investor Service, Inc.; or

(c) 1 by the Securities Valuation Office.

Investments authorized by this paragraph may not exceed ten percent (10%) of the life insurance company's admitted assets.

32. A. A life insurance company may invest in short-term pooling arrangements as provided in this paragraph.

B. The following definitions apply throughout this paragraph:

(1) "Affiliate" means, as to any person, another person that, directly or indirectly through one (1) or more intermediaries, controls, is controlled by, or is under common control with the person.

(2) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract (other than a commercial contract for goods or non-management services), or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote or holds proxies representing ten percent (10%) or more of the voting securities of another person. This presumption may be rebutted by a showing that control does not exist in fact. The commissioner may determine, after furnishing all interested persons notice and an opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(3) "Qualified bank" means a national bank, state bank, or trust company that at all times is not less than adequately capitalized as determined by standards adopted by United States banking regulators and that is either regulated by state banking laws or is a member of the Federal Reserve System.

C. A life insurer may participate in investment pools qualified under this paragraph that invest only in:

(1) obligations that are rated BBB- or higher by Standard & Poor's Corporation (or A-2 or higher in the case of commercial paper), Baa 3 or higher by Moody's Investors Service, Inc. (or P-2 or higher in the case of commercial paper), BBB- or higher by Duff and Phelps, Inc. (or D-2 or higher in the case of commercial paper), or 1 or 2 by the Securities Valuation Office, and have:

(A) a remaining maturity of three hundred ninety-seven (397) days or less or a put that entitles the holder to receive the principal amount of the obligation which put may be exercised through maturity at specified intervals not exceeding three hundred ninety-seven (397) days; or

(B) a remaining maturity of three (3) years or less and a

floating interest rate that resets not less frequently than quarterly on the basis of a current short-term index (for example, federal funds, prime rate, treasury bills, London InterBank Offered Rate (LIBOR) or commercial paper) and is not subject to a maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate changes;

(2) government money market mutual funds or class one money market mutual funds; or

(3) securities lending, repurchase, and reverse repurchase and dollar roll transactions that meet the requirements of paragraph 29 of this subsection and any applicable regulations of the department;

provided that the investment pool shall not acquire investments in any one (1) business entity that exceed ten percent (10%) of the total assets of the investment pool.

D. For an investment pool to be qualified under this paragraph, the investment pool shall not:

(1) acquire securities issued, assumed, guaranteed, or insured by the life insurance company or an affiliate of the company; or

(2) borrow or incur any indebtedness for borrowed money, except for securities lending, reverse repurchase, and dollar roll transactions that meet the requirements of paragraph 29 of this subsection.

E. A life insurance company shall not participate in an investment pool qualified under this paragraph if, as a result of and after giving effect to the participation, the aggregate amount of participation then held by the company in all investment pools under this paragraph and section 2.4 of this chapter would exceed thirty-five percent (35%) of its admitted assets.

F. For an investment pool to be qualified under this paragraph:

(1) the manager of the investment pool must:

(A) be organized under the laws of the United States, a state or territory of the United States, or the District of Columbia, and designated as the pool manager in a pooling agreement; and

(B) be the life insurance company, an affiliated company, a business entity affiliated with the company, or a qualified bank or a business entity registered under the Investment Advisors Act of 1940 (15 U.S.C. 80a-1 et seq.);

(2) the pool manager or an entity designated by the pool manager of the type set forth in subdivision (1) of this subparagraph F shall compile and maintain detailed accounting records setting forth:

(A) the cash receipts and disbursements reflecting each participant's proportionate participation in the investment pool;

(B) a complete description of all underlying assets of the

investment pool (including amount, interest rate, maturity date (if any) and other appropriate designations); and

(C) other records which, on a daily basis, allow third parties to verify each participant's interest in the investment pool; and

(3) the assets of the investment pool shall be held in one (1) or more accounts, in the name of or on behalf of the investment pool, under a custody agreement or trust agreement with a qualified bank, which must:

(A) state and recognize the claims and rights of each participant;

(B) acknowledge that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of its participation in the investment pool; and

(C) contain an agreement that the underlying assets of the investment pool shall not be commingled with the general assets of the qualified bank or any other person.

G. The pooling agreement for an investment pool qualified under this paragraph must be in writing and must include the following provisions:

(1) Insurers, subsidiaries, or affiliates of insurers holding interests in the pool, or any pension or profit sharing plan of such insurers or their subsidiaries or affiliates, shall, at all times, hold one hundred percent (100%) of the interests in the investment pool.

(2) The underlying assets of the investment pool shall not be commingled with the general assets of the pool manager or any other person.

(3) In proportion to the aggregate amount of each pool participant's interest in the investment pool:

(A) each participant owns an undivided interest in the underlying assets of the investment pool; and

(B) the underlying assets of the investment pool are held solely for the benefit of each participant.

(4) A participant or (in the event of the participant's insolvency, bankruptcy, or receivership) its trustee, receiver, or other successor-in-interest may withdraw all or any portion of its participation from the investment pool under the terms of the pooling agreement.

(5) Withdrawals may be made on demand without penalty or other assessment on any business day, but settlement of funds shall occur within a reasonable and customary period thereafter. Payments upon withdrawals under this paragraph shall be calculated in each case net of all then applicable fees and expenses of the investment pool. The pooling agreement shall provide for such payments to be made to the participants in one (1) of the following forms, at the discretion of the pool

manager:

(A) in cash, the then fair market value of the participant's pro rata share of each underlying asset of the investment pool;

(B) in kind, a pro rata share of each underlying asset; or

(C) in a combination of cash and in kind distributions, a pro rata share in each underlying asset.

(6) The records of the investment pool shall be made available for inspection by the commissioner.

(Formerly: Acts 1935, c.162, s.147; Acts 1937, c.288, s.1; Acts 1939, c.63, s.3; Acts 1941, c.115, s.9; Acts 1945, c.175, s.1; Acts 1947, c.43, s.1; Acts 1959, c.21, s.1; Acts 1961, c.138, s.1; Acts 1967, c.60, s.1; Acts 1969, c.184, s.1; Acts 1974, P.L.121, SEC.1; Acts 1975, P.L.44, SEC.2; Acts 1975, P.L.279, SEC.1.) As amended by Acts 1981, P.L.236, SEC.1; P.L.267-1987, SEC.1; P.L.49-1988, SEC.2; P.L.8-1991, SEC.8; P.L.26-1991, SEC.7; P.L.1-1992, SEC.145; P.L.186-1997, SEC.1; P.L.126-2001, SEC.1; P.L.40-2004, SEC.1; P.L.89-2011, SEC.29.

IC 27-1-12-2.1
Repealed

(Repealed by P.L.26-1991, SEC.28.)

IC 27-1-12-2.2
Derivative transactions

Sec. 2.2. (a) The following definitions apply to this section:

(1) "Acceptable collateral" means, as to over-the-counter derivatives transactions and for the purpose of calculating counterparty exposure amounts:

(A) cash;

(B) cash equivalents;

(C) letters of credit; and

(D) direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or any agency of the United States, including the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation.

(2) "Admitted assets" means the life insurance company's assets permitted to be reported as admitted assets on the statutory financial statement of the insurer most recently required to be filed with the commissioner.

(3) "Business entity" means:

(A) a sole proprietorship;

(B) a corporation;

(C) a limited liability company;

(D) an association;

(E) a partnership;

(F) a joint stock company;

(G) a joint venture;

(H) a mutual fund;
(I) a trust;
(J) a joint tenancy; or
(K) another, similar form of business organization;
whether organized for-profit or not-for-profit.
(4) "Cap" means an agreement obligating the seller to make payments to the buyer, with each payment based on the amount by which a reference price or level or the performance or value of one (1) or more underlying interests exceeds a predetermined number, sometimes called the strike rate or strike price.
(5) "Cash" means any of the following:
(A) United States denominated paper currency and coins.
(B) Negotiable money orders and checks.
(C) Funds held in any time or demand deposit in any depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.
(6) "Cash equivalent" means any of the following:
(A) A certificate of deposit issued by a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.
(B) A banker's acceptance issued by a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.
(C) A government money market mutual fund.
(D) A class one money market mutual fund.
(7) "Class one money market mutual fund" means a money market mutual fund that at all times qualifies for investment pursuant to the "Purposes and Procedures of the Securities Valuation Office" or any successor publication either using the bond class one reserve factor or because it is exempt from asset valuation reserve requirements.
(8) "Collar" means two (2) derivatives transactions on the same underlying interest in which the insurer receives payments as the buyer of an option, cap, or floor in one (1) transaction and makes payments as the seller of a different option, cap, or floor in the second transaction.
(9) A. "Counterparty exposure amount" means the net amount of credit risk attributable to a derivative instrument that a life insurance company enters into with another business entity other than through a qualified exchange or a qualified foreign exchange, or cleared through a qualified clearing house ("over the counter derivative instrument"). The amount of credit risk equals:
(1) the market value of the over-the-counter derivative instrument, if the liquidation of the instrument would result in a final cash payment to the insurer; or
(2) zero (0), if the liquidation of the over-the-counter derivative instrument would not result in a final cash

payment to the insurer.

B. If a life insurance company enters into one (1) or more over-the-counter derivative instruments with another business entity under a written master agreement that provides for netting of payments owed by the respective parties, and the domiciliary jurisdiction of the counterparty is either within the United States or a foreign jurisdiction listed in the "Purposes and Procedures of the Securities Valuation Office" or any successor publication as eligible for netting, the net amount of credit risk attributable to the counterparty is the greater of zero (0) or the remainder of:

(1) the market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment to the insurer by the business entity; minus

(2) the market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment by the insurer to the business entity.

C. For open transactions involving over-the-counter derivative instruments, market value:

(1) shall be determined not less frequently than at the end of the most recent quarter of the insurer's fiscal year; and

(2) shall be reduced by the market value of acceptable collateral that is:

(A) held by the insurer; or

(B) placed in escrow by one (1) or both parties.

(10) "Covered" means, in the case of a call option, that:

(A) the life insurance company owns the instrument underlying the call option it has written (a "written call") during the entire period that the written call is outstanding; or

(B) pursuant to the exercise of options, warrants, or conversion rights already owned when the call option is written and held during the period that the written call is outstanding, the life insurance company can immediately acquire the instrument underlying the written call, if:

(1) the price at which the underlying instrument can be acquired is less than or equal to the strike price of the written call; or

(2) the life insurance company has placed in escrow or, pursuant to a custodian agreement, has segregated during the entire period that the written call is outstanding, cash, cash equivalents, or securities with a market value equal to the difference between the price at which the underlying instrument can be acquired and the strike price of the written call.

(11) "Covered" means, in the case of a put option, that the life

insurance company has placed in escrow or, pursuant to a custodian agreement, has segregated during the entire period that the put option it has sold (a "written put") is outstanding, cash, cash equivalents, or securities with a market value equal to the amount of the insurer's obligation under the written put.

(12) "Covered" means, in the case of a cap or floor, that the life insurance company holds in its portfolio, during the entire period that the cap or floor is outstanding, investments that generate sufficient cash flow to make all required payments under the cap or floor.

(13) "Derivative instrument" means an agreement (in the nature of a bilateral contract, option, or otherwise), an instrument, or a series or combination of agreements and instruments:

(A) to make or take delivery of, or assume or relinquish, a specified amount of one (1) or more of the interests underlying the derivative instrument, or to make a cash settlement in lieu thereof; or

(B) that has a price, performance, value, or cash flow based primarily upon the actual or expected price, level, performance, value, or cash flow of one (1) or more of the interests underlying the derivative instrument.

Derivative instruments include options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, swaptions, forwards, futures, and any other agreements (in the nature of bilateral contracts, options, or otherwise) or substantially similar instruments, or any series or combination thereof, and any agreements (in the nature of bilateral contracts, options, or otherwise) or instruments permitted under rules adopted by the department.

(14) "Derivative transaction" means a transaction involving the use of one (1) or more derivative instruments. For purposes of this section, a derivative transaction may involve a requirement that the insurer, a counterparty, or both, are required to post collateral with the other party (or a designated third party) pursuant to an agreement between the insurer and the counterparty.

(15) "Domestic jurisdiction" means the United States, any state, territory, or possession of the United States, the District of Columbia, Canada, or any province of Canada.

(16) "Floor" means an agreement obligating the seller to make payments to the buyer, with each payment based on the amount by which a predetermined number, sometimes called the floor rate or price, exceeds a reference price or level or the performance or value of one or more underlying interests.

(17) "Foreign currency" means a currency other than that of a domestic jurisdiction.

(18) "Foreign jurisdiction" means a jurisdiction other than a

domestic jurisdiction.

(19) "Forward" means an agreement (other than a future) to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance, or value of, one (1) or more underlying interests.

(20) "Future" means an agreement, traded on a qualified exchange or qualified foreign exchange, to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance, or value of, one or more underlying interests.

(21) "Government money market mutual fund" means a money market mutual fund that at all times:

(A) invests only in obligations issued, guaranteed, or insured by the United States or collateralized repurchase agreements composed of these obligations; and

(B) qualifies for investment without a reserve pursuant to the "Purposes and Procedures of the Securities Valuation Office" or any successor publication.

(22) "Guaranteed or insured," when used in connection with an obligation acquired under this section, means that the guarantor or insurer has agreed to:

(A) perform or insure the obligation of the obligor or purchase the obligation; or

(B) be unconditionally obligated until the obligation is repaid to maintain in the obligor a minimum net worth, fixed charge coverage, stockholders' equity, or sufficient liquidity to enable the obligor to pay the obligation in full.

(23) "Hedging transaction" means a derivative transaction that is entered into and maintained to manage:

(A) the risk of a change in the value, yield, price, cash flow, or quantity of assets or liabilities (or a portfolio of assets, liabilities, or assets and liabilities) that the insurer has acquired or incurred or anticipates acquiring or incurring; or

(B) currency exchange rate risk or the degree of exposure to assets or liabilities (or a portfolio of assets, liabilities, or assets and liabilities) that the insurer has acquired or incurred or anticipates acquiring or incurring.

(24) "Income generation transaction" means a derivative transaction involving the writing of covered call options, covered put options, covered caps, or covered floors.

(25) "Investment company" means an investment company as defined in Section 3(a) of the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.), as amended, and a person described in Section 3(c) of the Investment Company Act of 1940.

(26) "Investment company series" means an investment portfolio of an investment company that is organized as a series company and to which assets of the investment company have been specifically allocated.

(27) "Letter of credit" means a clean, irrevocable, and unconditional letter of credit issued or confirmed by, and payable and presentable at, a financial institution on the list of financial institutions meeting the standards for issuing letters of credit under the "Purposes and Procedures of the Securities Valuation Office" or any successor publication.

(28) "Market value" means:

(A) as to cash, cash equivalents, and letters of credit, the amounts thereof;

(B) as to a security (other than a security that is an over-the-counter derivative instrument) as of any date, the price for the security on that date obtained from a generally recognized source or the most recent quotation from such a source or, to the extent no generally recognized source exists, the price for the security as determined in good faith by the parties to a transaction, plus accrued but unpaid income on the security to the extent not included in the price as of that date; and

(C) as to an over-the-counter derivative instrument as of any date, the amount that a life insurance company would have to pay or would receive for entering into an over-the-counter derivative transaction on substantially identical terms with another counterparty.

(29) "Money market mutual fund" means a mutual fund that meets the conditions of 17 CFR 270.2a-7, under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.).

(30) "Mutual fund" means:

(A) an investment company; or

(B) in the case of an investment company that is organized as a series company, an investment company series;

that is registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.).

(31) "Obligation" means any of the following:

(A) A bond.

(B) A note.

(C) A debenture.

(D) Any other form of evidence of debt.

(32) "Option" means an agreement giving the buyer the right to buy or receive (a "call option"), sell or deliver (a "put option"), enter into, extend or terminate, or effect a cash settlement based on the actual or expected price, level, performance, or value of one or more underlying interests.

(33) "Qualified business entity" means a business entity that is:

(A) an issuer of obligations, preferred stock, or derivative instruments that are rated 1 or 2 or are rated the equivalent of 1 or 2 by the Securities Valuation Office or by a nationally recognized statistical rating organization

recognized by the Securities Valuation Office; or

(B) a primary dealer in United States government securities, recognized by the Federal Reserve Bank of New York.

(34) "Qualified clearinghouse" means a clearinghouse:

(A) that is for, and subject to the rules of, a qualified exchange or qualified foreign exchange; and

(B) that provides clearing services, including acting as a counterparty to each of the parties to a transaction so that the parties no longer have credit risk as to each other.

(35) "Qualified exchange" means:

(A) a securities exchange registered as a national securities exchange, or a securities market regulated under the Securities Exchange Act of 1934 (15 U.S.C. 78 et seq.), as amended;

(B) a board of trade or commodities exchange designated as a contract market by the Commodity Futures Trading Commission (CFTC) or any successor of the CFTC;

(C) Private Offerings, Resales, and Trading through Automated Linkages (PORTAL);

(D) a designated offshore securities market as defined in Securities Exchange Commission Regulation S (17 C.F.R. Part 230), as amended; or

(E) a qualified foreign exchange.

(36) "Qualified foreign exchange" means a foreign exchange, board of trade, or contract market located outside the United States or its territories or possessions:

(A) that has received regulatory comparability relief under CFTC Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC's Regulations (17 C.F.R. Part 30));

(B) that is, or whose members are, subject to the jurisdiction of a foreign futures authority that has received regulatory comparability relief under CFTC Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC's Regulations (17 C.F.R. Part 30)) as to futures transactions in the jurisdiction where the exchange, board of trade, or contract market is located; or

(C) upon which are listed foreign stock index futures contracts that are the subject of no-action relief issued by the CFTC's Office of the General Counsel, provided that an exchange, board of trade, or contract market that qualifies as a qualified foreign exchange only under this clause is a qualified foreign exchange only as to foreign stock index futures contracts that are the subject of no-action relief.

(37) "Replication transaction" means a derivative transaction that is intended to replicate the investment in one (1) or more assets that an insurer is authorized to acquire or sell under this section or section 2 of this chapter. A derivative transaction that is entered into as a hedging transaction shall not be considered

a replication transaction.

(38) "Securities Valuation Office" refers to:

(A) the Securities Valuation Office of the National Association of Insurance Commissioners; or

(B) any successor of the office referred to in Clause (A) established by the National Association of Insurance Commissioners.

(39) "Swap" means an agreement to exchange or to net payments at one (1) or more times based on the actual or expected price, level, performance, or value of one (1) or more underlying interests.

(40) "Swaption" means an agreement giving the buyer the right (but not the obligation) to enter into a swap at a specified time in the future.

(41) "Underlying interest" means the assets, liabilities, other interests or a combination thereof underlying a derivative instrument, such as any one (1) or more securities, currencies, rates, indices, commodities, or derivative instruments.

(42) "Warrant" means an instrument that gives the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times outlined in the warrant agreement. Warrants may be issued alone or in connection with the sale of other securities, for example, as part of a merger or recapitalization agreement or to facilitate divestiture of the securities of another business entity.

(b) A life insurance company's board of directors shall do all the following:

(1) Before engaging in derivatives transactions, approve a written plan that specifies guidelines, systems, and objectives to be followed, such as:

(A) investment or, if applicable, underwriting objectives and risk constraints, such as credit risk limits;

(B) permissible transactions and the relationship of those transactions to the insurer's operations;

(C) internal control procedures;

(D) a system for determining whether a derivative instrument used for hedging has been effective;

(E) a credit risk management system for over-the-counter derivatives transactions that measures credit risk exposure using the counterparty exposure amount; and

(F) a mechanism for reviewing and auditing compliance with the guidelines, systems, and objectives specified in the written plan.

(2) Before engaging in derivatives transactions, make a determination that the insurer's investment managers have adequate professional personnel, technical expertise, and systems to implement the insurer's intended investment practices involving derivative instruments.

(3) Review whether derivatives transactions have been made in accordance with the approved guidelines and are consistent with stated objectives.

(4) Take action to correct any deficiencies in internal controls relating to derivatives transactions.

(c) A life insurance company may use derivative instruments under this section to engage in hedging transactions, certain income generation transactions, and certain replication transactions, as these terms may be further defined in rules adopted by the department. For each hedging and replication transaction in which it engages, a life insurance company must be able to demonstrate to the commissioner:

(1) the intended characteristics; and

(2) the ongoing effectiveness;

of the derivative transaction or combination of the derivatives transactions through appropriate analyses.

(d) A life insurance company insurer may enter into a hedging transaction under this section if, as a result of the transaction, and after giving effect to the transaction:

(1) the aggregate statement value of options, caps, floors, and warrants not attached to another financial instrument purchased and used in hedging transactions does not exceed seven and one half percent (7.5%) of the insurer's admitted assets;

(2) the aggregate statement value of options, caps, and floors written in hedging transactions does not exceed three percent (3%) of the insurer's admitted assets; and

(3) the aggregate potential exposure of collars, swaps, forwards, and futures used in hedging transactions does not exceed six and one-half percent (6.5%) of the insurer's admitted assets.

(e) A life insurance company may enter into the following types of income generation transactions:

(1) sales of covered call options on:

(A) non-callable fixed income securities;

(B) callable fixed income securities if the option expires by its terms before the end of the noncallable period; or

(C) derivative instruments based on fixed income securities or yields;

(2) sales of covered call options on equity securities;

(3) sales of covered puts on investments that the insurer is permitted to acquire under section 2 of this chapter; and

(4) sales of covered caps or floors;

only if, as a result of the transactions and after giving effect to the transactions, the aggregate statement value of the fixed income securities that are subject to call or that generate the cash flows for payments under the caps or floors, plus the face value of fixed income securities underlying a derivative instrument subject to call, plus the amount of the purchase obligations under the puts, does not exceed ten percent (10%) of the insurer's admitted assets.

(f) A life insurance company may enter into replication

transactions. For the purposes of this subsection, a replication transaction is subject to the limitations and restrictions set forth in section 2 of this chapter to which the replicated investments are subject.

(g) An investment of a life insurance company that is:

(1) permitted under section 2(b)(17A) or 2(b)(17B) of this chapter; and

(2) denominated in a foreign currency;

shall not be considered denominated in a foreign currency if the acquiring insurer enters into one (1) or more contracts permitted under this section in which the business entity counterparty agrees to exchange, or grants to the insurer the option to exchange, all payments made on the foreign currency denominated investment (or amounts equivalent to the payments that are or will be due to the insurer in accordance with the terms of such investment) for United States or Canadian dollars during the period that the contract or contracts are in effect, or other contracts with like effect, to insulate the insurer against loss caused by diminution of the value of payments owed to the insurer due to future changes in currency exchange rates.

(h) A life insurance company shall include all counterparty exposure amounts in determining compliance with the limitations set forth in section 2(b)(21) of this chapter.

(i) Upon the request of a life insurance company, the commissioner may approve additional transactions involving the use of derivative instruments that:

(1) exceed the limits set forth in subsections (d), (e), and (f); or

(2) are for other risk management purposes.

(j) A life insurance company shall maintain documentation and records relating to each derivative transaction. The documentation and records must record and include matters such as the following:

(1) The purpose or purposes of the transaction.

(2) The assets or liabilities to which the transaction relates.

(3) The specific derivative instrument used in the transaction.

(4) For collateralized derivatives transactions, a description of any collateral posted by the insurer or the counterparty, as well as records documenting any subsequent variations in the amount of the collateral.

(5) For over-the-counter derivative transactions, the name of the counterparty and the counterparty exposure amount.

(6) For exchange traded derivative instruments, the name of the exchange and the name of the firm that handled the trade.

(k) Each derivative instrument shall be:

(1) traded on a qualified exchange;

(2) entered into with, or guaranteed by, a business entity;

(3) issued or written by or entered into with the issuer of the underlying interest on which the derivative instrument is based; or

(4) entered into on a qualified foreign exchange.

As added by P.L.186-1997, SEC.2. Amended by P.L.81-2012, SEC.1.

IC 27-1-12-2.4

Participation in certain investment pools; requirements for pooling agreements

Sec. 2.4. (a) The following definitions apply to this section:

(1) "Admitted assets" means a life insurance company's assets permitted to be reported as admitted assets on the statutory financial statement of the insurer most recently required to be filed with the commissioner.

(2) "Affiliate" means, as to any person, another person that, directly or indirectly, through one (1) or more intermediaries:

(A) controls;

(B) is controlled by; or

(C) is under common control with;

the person.

(3) "Business entity" means:

(A) a sole proprietorship;

(B) a corporation;

(C) a limited liability company;

(D) an association;

(E) a partnership;

(F) a joint stock company;

(G) a joint venture;

(H) a mutual fund;

(I) a trust;

(J) a joint tenancy; or

(K) another, similar form of business organization;

whether organized for-profit or not-for-profit.

(4) "Cash" means any of the following:

(A) United States denominated paper currency and coins.

(B) Negotiable money orders and checks.

(C) Funds held in any time or demand deposit in any depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.

(5) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract (other than a commercial contract for goods or non-management services), or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote or holds proxies representing ten percent (10%) or more of the voting securities of another person. This presumption may be rebutted by a showing that control does not exist in fact. The commissioner may determine, after furnishing

all interested persons notice and an opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(6) "Fixed charges" includes interest on funded and unfunded debt, amortization of debt discount, and rentals for leased property.

(7) "Guaranteed or insured," when used in connection with an obligation acquired under this section, means that the guarantor or insurer has agreed to:

(A) perform or insure the obligation of the obligor or purchase the obligation; or

(B) be unconditionally obligated until the obligation is repaid to maintain in the obligor a minimum net worth, fixed charge coverage, stockholders' equity or sufficient liquidity to enable the obligor to pay the obligation in full.

(8) "Investment company" means an investment company as defined in Section 3(a) of the Investment Company Act of 1940 (15 U.S.C. 80a-1, et seq.), as amended, and a person described in Section 3(c) of the Investment Company Act of 1940.

(9) "Investment company series" means an investment portfolio of an investment company that is organized as a series company and to which assets of the investment company have been specifically allocated.

(10) "Market value" means:

(A) as to cash, cash equivalents, and letters of credit, the amounts thereof; and

(B) as to a security as of any date, the price for the security on that date obtained from a generally recognized source or the most recent quotation from such a source or, to the extent no generally recognized source exists, the price for the security as determined in good faith by the parties to a transaction, plus accrued but unpaid income on the security to the extent not included in the price as of that date.

(11) "Multilateral development bank" means an international development organization of which the United States is a member.

(12) "Mutual fund" means:

(A) an investment company; or

(B) in the case of an investment company that is organized as a series company, an investment company series;

that is registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.).

(13) "Obligation" means any of the following:

(A) A bond.

(B) A note.

(C) A debenture.

(D) Any other form of evidence of debt.

(14) "Person" means an individual, a business entity, a multilateral development bank or a government or quasi-governmental body, such as a political subdivision or a government sponsored enterprise.

(15) "Qualified bank" means a national bank, state bank, or trust company that:

(A) at all times is not less than adequately capitalized, as determined by standards adopted by United States banking regulators; and

(B) is regulated by state banking laws or is a member of the Federal Reserve System.

(16) "Series company" means an investment company that is organized as a series company, as defined in Rule 18f-2(a) adopted under the Investment Company Act of 1940 (15 U.S.C. 80a-1, as amended).

(b) In addition to the authority to participate in investment pools under section 2(b)(31) of this chapter, a life insurance company may participate in investment pools that:

(1) are qualified under this section; and

(2) invest only in investments that an insurer may acquire under section 2 of this chapter;

if the company's proportionate interest in the amount invested in these investments does not exceed the applicable limits of section 2 of this chapter.

(c) For an investment pool to be qualified under this section, the investment pool shall not:

(1) acquire securities issued, assumed, guaranteed, or insured by the insurer or an affiliate of the insurer; or

(2) borrow or incur any indebtedness for borrowed money, except for securities lending, reverse repurchase, and dollar roll transactions that meet the requirements of section 2(b)(29) of this chapter.

(d) A life insurance company shall not participate in an investment pool qualified under this section if, as a result of the participation and after giving effect to the participation, the aggregate amount of participation then held by the insurer in all investment pools under this section and under section 2(b)(31) of this chapter would exceed thirty-five percent (35%) of the admitted assets of the insurer.

(e) For an investment pool to be qualified under this section:

(1) the manager of the investment pool:

(A) must be organized under the laws of the United States, a state or territory of the United States, or the District of Columbia;

(B) must be designated as the pool manager in a pooling agreement; and

(C) must be:

(i) the insurer;
(ii) an affiliated insurer;
(iii) a business entity affiliated with the insurer;
(iv) a qualified bank; or
(v) a business entity registered under the Investment Advisors Act of 1940 (15 U.S.C. 80a-1 et seq.);

(2) the pool manager or an entity of the type referred to in subdivision (1)(C) that is designated by the pool manager must compile and maintain detailed accounting records setting forth:

(A) the cash receipts and disbursements reflecting each participant's proportionate participation in the investment pool;
(B) a complete description of all underlying assets of the investment pool (including the amount, interest rate, maturity date (if any) and other appropriate designations); and
(C) other records that, on a daily basis, allow third parties to verify each participant's interest in the investment pool; and

(3) the assets of the investment pool must be held in one (1) or more accounts, in the name of or on behalf of the investment pool, in a qualified bank under a custody agreement or trust agreement that:

(A) states and recognizes the claims and rights of each participant;
(B) acknowledges that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of the participant's participation in the investment pool; and
(C) contains an agreement that the underlying assets of the investment pool shall not be commingled with the general assets of the qualified bank or the assets of any other person.

(f) The pooling agreement for an investment pool that is qualified under this section must be in writing and must provide the following:

(1) Insurers, subsidiaries, or affiliates of insurers holding interests in the pool, or any pension or profit sharing plan of the insurers or their subsidiaries or affiliates, must at all times hold one hundred percent (100%) of the interests in the investment pool.

(2) The underlying assets of the investment pool must not be commingled with the general assets of the pool manager or any other person.

(3) In proportion to the aggregate amount of each pool participant's interest in the investment pool:

(A) each participant owns an undivided interest in the underlying assets of the investment pool; and
(B) the underlying assets of the investment pool are held solely for the benefit of each participant.

(4) A participant or (in the event of the participant's insolvency,

bankruptcy, or receivership) its trustee, receiver, or other successor-in-interest may withdraw all or any portion of its participation from the investment pool under the terms of the pooling agreement.

(5) Withdrawals may be made on demand without penalty or other assessment on any business day, but settlement of funds shall occur within a reasonable and customary period thereafter. Payments upon withdrawals under this paragraph shall be calculated in each case net of all then applicable fees and expenses of the investment pool. The pooling agreement shall provide for such payments to be made to the participants in one (1) of the following forms, at the discretion of the pool manager:

(A) in cash, the then fair market value of the participant's pro rata share of each underlying asset of the investment pool;

(B) in kind, a pro rata share of each underlying asset; or

(C) in a combination of cash and in kind distributions, a pro rata share in each underlying asset.

(6) The records of the investment pool shall be made available for inspection by the commissioner.

As added by P.L.186-1997, SEC.3.

IC 27-1-12-2.5

Investments; assets of certain segregated investment accounts; limitations and exceptions

Sec. 2.5. (a) A domestic life insurance company, which has a segregated account or accounts in relation to contracts to which class 1(c) of IC 27-1-5-1 applies, is governed as to its investment of assets by the investment limitations of section 2 of this chapter with the following exceptions:

(1) the limitations prescribed in paragraph 22 of section 2(b) of this chapter are not applicable to investments in relation to such segregated account or accounts;

(2) investments under paragraph 20 of section 2(b) of this chapter are solely limited to ten percent (10%) of the assets of such segregated account; and

(3) the limitations in sections 2 and 3 of this chapter do not apply with regard to contributions, premiums, or considerations made by holders of pension contracts issued by a domestic life insurance company, which has net assets of at least twenty-five million dollars ($25,000,000) at the end of the preceding calendar year and which has allocated such contributions, premiums, or considerations to a segregated investment account or accounts.

(b) Nothing in section 2 of this chapter or this section prohibits the investment of all assets of a segregated account or accounts in any open-end diversified management company registered under the federal Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.).

(c) Pension contracts for the purposes of subsection (a)(3) means contracts to which both class 1(c) of IC 27-1-5-1 applies and which are issued in connection with a plan or other arrangement described in section 3(a)(2) of the Securities Act of 1933, (15 U.S.C. 77c(a)(2)). The term also includes agreements reinsuring other insurers' contracts which were issued in connection with plans or other arrangements described in 15 U.S.C. 77c(a)(2).
As added by Acts 1981, P.L.236, SEC.2. Amended by P.L.186-1997, SEC.4.

IC 27-1-12-3
Real estate

Sec. 3. Any domestic life insurance company shall have power to acquire, hold and convey real estate as described below, and no other:

1. The building in which it has its principal office and the land on which it stands;

2. Such as shall be necessary for the convenient transaction of its business;

3. Such as shall have been acquired for the accommodation of its business;

4. Such as shall have been mortgaged to it in good faith by way of security for loans previously contracted or for money due;

5. Such as shall have been conveyed to it in connection with its investments in real estate contracts or its investments in real estate under lease or for the purpose of leasing or developing in accordance with paragraph 8 of section 2 of this chapter or such as shall have been acquired for the purpose of investment under paragraph 20 of section 2(b) of this chapter. Any real estate acquired under paragraph 20 of section 2(b) of this chapter shall be evaluated for statement purposes in a manner satisfactory to the department.

6. Such as shall have been conveyed to it in satisfaction of debts previously contracted in the course of its dealings, or in exchange for real estate so conveyed to it; and

7. Such as it shall have purchased at sales on judgments, decrees or mortgages obtained or made for such debts.

All such real estate specified in paragraphs (3), (4), (5), (6), and (7) of this section, which shall not be necessary for the convenient transaction of its business, and which is not held under paragraphs 7, 8 or 20 of section 2(b) of this chapter, shall be sold by the life insurance company and disposed of within ten (10) years after it shall have acquired the title to same, or within five (5) years after the same shall have ceased to be necessary for the accommodation of its business, unless the company procures the certificate of the commissioner that its interests will suffer materially by a forced sale thereof, in which event the time for the sale may be extended to such time as the commissioner shall direct in such certificate.
(Formerly: Acts 1935, c.162, s.148; Acts 1945, c.175, s.2; Acts 1951,

c.24, s.1.) As amended by Acts 1981, P.L.236, SEC.3; P.L.186-1997, SEC.5.

IC 27-1-12-3.5
Intangible assets attributable to investment in subsidiary; exceptions

Sec. 3.5. Goodwill, trade names, and other like intangible assets attributable to any investment in a subsidiary shall be admitted as assets except:

(1) to the extent that the aggregate amount thereof exceeds ten percent (10%) of the capital and surplus of the insurer as reported in its latest annual report filed with the commissioner;

(2) to the extent that any such asset is not being amortized ratably over a period of ten (10) years or less from the date of acquisition; and

(3) in determining the financial condition or solvency of an insurer under IC 27-9.

As added by P.L.160-1986, SEC.1.

IC 27-1-12-4
Valuation of bonds and securities

Sec. 4. (a) All bonds or other evidences of debt having a fixed term and rate of interest held by an insurer may, if amply secured and not in default as to principal or interest, be valued as follows: If purchased at par, at the par value; if purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield in the meantime the effective rate of interest at which the purchase was made, or, instead of this method, according to an accepted method of valuation approved by the department. The purchase price shall in no case be taken at a higher figure than the actual market value at the time of purchase, plus actual brokerage, transfer, postage, or express charges paid in the acquisition of the securities. The department shall have full discretion in determining the method of calculating values according to the rules set forth in this subsection. However, no such method or valuation under this subsection may be inconsistent with any applicable method or valuation used by insurers in general or any such method then currently formulated or approved by the National Association of Insurance Commissioners or its successor organization.

(b) Securities held by an insurer, other than those referred to in subsection (a), shall be valued, in the discretion of the department, at their market value or at their appraised value or at prices determined by the department as representing the fair market value of the securities. Preferred or guaranteed stocks or shares, while paying full dividends, may be carried at a fixed value in lieu of market value at the discretion of the department and in accordance with the method of valuation that the department approves. No

valuation under this subsection may be inconsistent with any applicable valuation or method then currently formulated or approved by the National Association of Insurance Commissioners or its successor organization.

(Formerly: Acts 1935, c.162, s.150.) As amended by P.L.130-1994, SEC.16; P.L.116-1994, SEC.21.

IC 27-1-12-5

Required provisions of policies between July 1, 1935, and transition date or January 1, 1948

Sec. 5. (a) No policy of life insurance, other than industrial insurance, group life insurance, or reinsurance, bearing a date of issue not earlier than July 1, 1935, nor later than a transition date to be selected by the company pursuant to section 12 of this chapter, such transition date in no event to be later than January 1, 1948, shall be delivered or issued for delivery in this state or issued by a company organized under the laws of this state unless the same shall provide the following:

(1) That all premiums shall be payable in advance, either at the home office of the company, or to an agent of the company, upon delivery of a receipt signed by one (1) or more of the officers who shall be designated in the policy.

(2) For a grace of not less than thirty (30) days for the payment of every premium after the first premium, which may be subject to an interest charge, during which period the insurance shall continue in force; provided, that if the insured shall die within such period of grace the unpaid premium for the current policy year may be deducted in any settlement under the policy.

(3) That the policy, together with the application therefor, a copy of which application shall be attached to the policy and made a part thereof, shall constitute the entire contract between the parties and shall be incontestable after it shall have been in force during the lifetime of the insured for two (2) years from its date, or, at the option of the company after it shall have been in force for two (2) years from its date, except for nonpayment of premiums, and except for violation of the conditions of the policy relating to naval and military service in time of war, and at the option of the company provisions relative to benefits in the event of total and permanent disability and provisions which grant additional insurance specifically against death by accident may also be excepted.

(4) That if the age of the insured and/or the beneficiary, if that age enters into the determination of the premiums charged or benefits promised, has been misstated, the amount payable under the policy shall be such as the premium would have purchased at the correct age of the insured and/or beneficiary.

(5) That all statements made by the insured in the application shall, in the absence of fraud, be deemed representations and

not warranties.

(6) That, in the case of participating policies, the policy shall participate in the surplus of the company as apportioned by the board of directors of the company, and that, beginning not later than the end of the fifth policy year, the company will determine and account for the portion of the divisible surplus so ascertained accruing on the policy, and that the owner of the policy shall have the right to have the current dividends arising from such participation paid in cash, and that at periods of not more than five (5) years, such accounting and payment at the option of the policyholder shall be had. The owner of the policy may elect to take any of the other dividend options in the policy. If the owner of the policy shall not elect any of the other dividend options provided in the policy, the apportioned dividends shall be held to the credit of the policy and be payable in cash at maturity of the policy or be withdrawable in cash at an anniversary of its date; provided, however, if the policy shall contain a provision for an apportionment of the surplus at the end of the first policy year and annually thereafter, then and in that event said policy may provide that each dividend shall be paid subject to the payment of the premium of the next ensuing year.

(7) A table showing in figures the loan values and the cash, paid-up and extended insurance options upon surrender, or available under the policy each year, upon default in premium payment during at least the first twenty (20) years of the policy, beginning at the end of the third policy year, which values shall be equal to the full reserve on the policy, except the reserve for permanent mental or physical disability, or for accidental death, and/or other supplemental benefits, less not to exceed two and one-half percent (2 1/2%) of the sum insured; following this table there shall be a clause specifying the mortality table and rate of interest adopted for computing the reserve and specifying the basis for the values and options after the period covered by the table. The provisions of this subdivision shall not apply to term policies nor to any form of paid-up insurance issued or granted in exchange for lapsed or surrendered policies.

(8) Policies issued by companies doing business in this state may provide for not more than one (1) year preliminary term insurance by incorporating therein the following clause immediately following the table of options and statement of basis therefor, as provided for in subdivision (7): "The first year's insurance under this policy is term insurance, purchased by the whole or part of the premium to be received during the first policy year and the policy shall be valued according to its terms and the laws of the state of Indiana".

(9) That after three (3) full years' premiums shall have been

paid, the company, at any time while the policy is in force, will loan, on the execution of a proper assignment of the policy and on the sole security thereof, at a specified rate of interest, a sum equal to, or at the option of the insured, less than the amount stated in the table of options to be loaned at the end of the current policy year plus the value of the reserve on any dividend additions to the policy, and that the company will deduct from such loan value any existing indebtedness on or secured by the policy and any unpaid balance of the premiums for the current policy year, and may collect interest in advance on the loan to the end of the current policy year, and may further provide that such loan may be deferred for not exceeding six (6) months after the application therefor is made. It shall be further stipulated in the policy that failure to repay any such loan or pay interest thereon shall not void the policy unless such total indebtedness to the company shall equal or exceed such loan value at the time of such failure, nor until thirty (30) days after notice shall have been mailed by the company to the last known address of the insured and to the assignee, if any, if such assignee has notified the company of his address. No condition other than as provided in this subdivision shall be exacted as a prerequisite to any such loan. The provisions of this subdivision shall not be required in term policies nor shall they apply to paid-up insurance issued or granted in exchange for lapsed or surrendered policies.

(10) That in the event of default of premium payment after premiums have been paid for not less than three (3) years, the insured shall be entitled to the extended insurance shown in the table of values and options for the end of the last year for which full annual premiums shall have been paid; provided, that if there be any unpaid note given for a premium or any indebtedness to the company on account of or secured by the policy, the amount of extended insurance shall be reduced in the ratio of such indebtedness to the net value of such extended insurance, or the amount of such indebtedness shall be deducted from the net value of the extended insurance otherwise available and the balance shall be applied as a net single premium to purchase extended insurance for an amount equal either to the face of the policy or to the face of the policy less the amount of such indebtedness; and provided further, that the policy may be surrendered to the company at its home office within one (1) month from the due date of the unpaid premium for a specified cash value at least equal to the sum which would otherwise be available for the purchase of extended insurance as provided in this subdivision; and provided further, that the company may defer payment for not more than six (6) months after the application therefor is made. The provisions of this subdivision shall not be required in term insurance of twenty

(20) years or less.

(11) That, should there have been default in premium payment, and the value of the policy applied to the extension of the insurance, and such insurance be in force and the original policy not surrendered to the company and cancelled, the policy may be reinstated within three (3) years from such default, upon evidence of insurability satisfactory to the company and payment of arrears of premiums with interest.

(12) That when a policy shall become a claim by the death of the insured, settlement shall be made upon receipt of due proof of death and of the interest of the claimant and not later than two (2) months after receipt of such proof.

(13) A title on the face and on the back of the policy describing the same.

(b) Any of the provisions of subsection (a) not applicable to single premium policies shall to that extent not be incorporated therein. The provisions of subsection (a) shall not apply to policies issued on substandard, underaverage, or impaired risks. Any policy may be issued or delivered in this state which in the opinion of the department contains provisions on any one (1) or more of the several requirements of subsection (a) more favorable to the policyholder than those required in subsection (a).

(Formerly: Acts 1935, c.162, s.151; Acts 1943, c.189, s.1.) As amended by P.L.252-1985, SEC.60.

IC 27-1-12-6

Required provisions of policies after transition date or January 1, 1948

Sec. 6. (a) No policy of life insurance, other than industrial insurance, group life insurance or reinsurance, bearing a date of issue which is the same as or later than a transition date to be selected by the company pursuant to section 12 of this chapter, such transition date in no event to be later than January 1, 1948, shall be delivered or issued for delivery in this state or issued by a company organized under the laws of this state unless the same shall provide the following:

(1) That all premiums shall be payable in advance, either at the home office of the company, or to an agent of the company, upon delivery of a receipt signed by one (1) or more of the officers who shall be designated in the policy.

(2) For a grace period of not less than thirty (30) days for the payment of every premium after the first premium, which may be subject to an interest charge, during which period the insurance shall continue in force; provided, that if the insured shall die within such period of grace the unpaid premium for the current policy year may be deducted in any settlement under the policy.

(3) That the policy, together with the application therefor, a

copy of which application shall be attached to the policy and made a part thereof, shall constitute the entire contract between the parties and shall be incontestable after it shall have been in force during the lifetime of the insured for two (2) years from its date, or, at the option of the company after it shall have been in force for two (2) years from its date, except for nonpayment of premiums, and except for violation of the conditions of the policy relating to naval and military service in time of war, and at the option of the company provisions relative to benefits in the event of total and permanent disability and provisions which grant additional insurance specifically against death by accident may also be excepted.

(4) That if the age of the insured and/or beneficiary, if that age enters into the determination of the premiums charged or benefits promised, has been misstated, the amount payable under the policy shall be such as the premium would have purchased at the correct age of the insured and/or beneficiary.

(5) That all statements made by the insured in the application shall, in the absence of fraud, be deemed representations and not warranties.

(6) That, in the case of participating policies, the policy shall participate in the surplus of the company as apportioned by the board of directors of the company, and that, beginning not later than the end of the fifth policy year, the company will determine and account for the portion of the divisible surplus so ascertained accruing on the policy, and that the owner of the policy shall have the right to have the current dividends arising from such participation paid in cash, and that at periods of not more than five (5) years, such accounting and payment at the option of the policyholder shall be had. The owner of the policy may elect to take any of the other dividend options in the policy. If the owner of the policy shall not elect any of the other dividend options provided in the policy, the apportioned dividends shall be held to the credit of the policy and be payable in cash at maturity of the policy or be withdrawable in cash at any anniversary of its date; provided, however, that if the policy shall contain a provision for an apportionment of the surplus at the end of the first policy year and annually thereafter, then and in that event, said policy may provide that each dividend shall be paid subject to the payment of the premium of the next ensuing year.

(7) Nonforfeiture provisions in accordance with the requirements of section 7 of this chapter.

(8) That the company, at any time while the policy is in force, will loan, on the execution of a proper assignment of the policy, and on the sole security thereof, at a specified rate of interest (payable in advance if the company so elects), a sum, which, together with the sum of:

(A) previously existing indebtedness, if any, including interest thereon to the end of the current policy year; and

(B) interest to the end of the current policy year on the amount newly loaned;

is equal to or, at the option of the insured, less than the cash surrender value at the end of the current policy year as provided for by the policy in accordance with the terms of section 7 of this chapter; provided, that the company may, as a condition precedent to the making of such loan, and at its own option, require the payment of the unpaid balance, if any, of the premium or premiums for the current policy year, and may require the payment of interest in advance on the total loan to the end of the current policy year. The policy may provide that, if interest on the loan is not paid when due, it shall be added to the existing loan and become a part thereof and bear interest at the same rate as the loan. It shall further be stipulated in the policy that failure to repay any such loan or pay interest thereon shall not void the policy unless such total indebtedness to the company shall equal or exceed such cash surrender value at the time of such failure, nor until thirty (30) days after notice shall have been mailed by the company to the last known address of the insured and to the assignee, if any, if such assignee has notified the company of his address. No condition other than as provided in this subdivision shall be exacted as prerequisite to any such loan. The company shall reserve the right to defer the granting of any loan, except when made to pay premiums on a policy or policies issued by it, for six (6) months after application therefor is made. The provisions of this subdivision shall not be required in term policies nor shall they apply to paid-up insurance issued or granted in exchange for lapsed or surrendered policies.

(9) That, should there have been default in premium payment and the value of the policy applied to the extension of the insurance, and such insurance be in force and the original policy not surrendered to the company and canceled, the policy may be reinstated within three (3) years from the due date of the premium in default, upon evidence of insurability satisfactory to the company and payment of arrears of premiums with interest.

(10) That when a policy shall become a claim by the death of the insured, settlement shall be made upon receipt of due proof of death and of the interest of the claimant and not later than two (2) months after receipt of such proof.

(11) A title on the face and on the back of the policy describing the same.

(b) Any of the provisions of subsection (a) not applicable to single premium policies shall to that extent not be incorporated therein. The provisions of subsection (a) shall not apply to policies issued on

substandard, underaverage, or impaired risks. Any policy may be issued or delivered in this state which in the opinion of the department contains provisions on any one (1) or more of the several requirements of subsection (a) more favorable to the policyholder than those required in subsection (a).

(Formerly: Acts 1935, c.162, s.151A; Acts 1943, c.189, s.2; Acts 1959, c.146, s.1.) As amended by P.L.252-1985, SEC.61.

IC 27-1-12-7

Required provisions relating to defaulting or surrendering policyholder

Sec. 7. (a) No policy of life insurance, except as stated in subsection (f) of this section, bearing a date of issue which is the same as or later than a transition date to be selected by the company pursuant to section 12 of this chapter, such transition date in no event to be later than January 1, 1948, shall be delivered or issued for delivery in this state, or issued by a company organized under the laws of this state, unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the department are at least as favorable to defaulting or surrendering policyholders as are the minimum requirements specified in this section and are essentially in compliance with subsection (g) of this section:

(1) That, in the event of default in any premium payment after premiums have been paid for at least one (1) full year in the case of ordinary insurance or three (3) full years in the case of industrial insurance, the company will grant, upon proper request made not later than sixty (60) days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of an amount determined as specified in this section. In lieu of such stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than sixty (60) days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits;

(2) That, upon surrender of the policy within sixty (60) days after the due date of any premium in default, after premiums have been paid for at least three (3) full years in the case of ordinary insurance or five (5) full years in the case of industrial insurance, the company will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of a stated amount determined as specified in this section;

(3) That, if a request for a nonforfeiture benefit or surrender of the policy is not made or effected as contemplated in subdivisions (1) and (2) of this subsection, a designated paid-up nonforfeiture benefit shall become operative as specified in the policy;

(4) That, if the policy shall have become paid up by completion of all premium payments or if it continues in the form of a paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the company will pay, upon surrender of the policy within thirty (30) days after any policy anniversary, a cash surrender value of such amount as may be determined in this section;

(5) In the case of policies which cause, on a basis guaranteed in the policy, unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first twenty (20) policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions to the credit of the policy and that there is no indebtedness to the company on account of or secured by the policy;

(6) A brief and general statement of the method to be used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy on the policy anniversaries beyond the last anniversary of those for which such values and benefits are consecutively shown in the table provided for in subdivision (5) of this subsection;

(7) An explanation of the manner in which the cash surrender value and the paid-up nonforfeiture benefit or benefits are affected by the existence of any paid-up additions to the policy or any indebtedness to the company on account of or secured by the policy.

Any of the provisions of this subsection not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

The company shall reserve the right to defer the payment of any cash surrender value for a period of six (6) months after demand therefor and surrender of the policy.

(b) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy (including any existing paid-up additions) if there had been no default, over the sum of (1) the then present value of the adjusted premiums as defined in

subsections (d) and (dd), corresponding to premiums which would have fallen due on and after such anniversary, and (2) the amount of any indebtedness to the company on account of or secured by the policy. However, for any policy issued on or after the operative date of subsection (dd) of this section which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value is an amount not less than the sum of the cash surrender value as defined in this paragraph for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in this paragraph for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

For any family policy issued on or after the operative date of subsection (dd) of this section, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age seventy-one (71), the cash surrender value referred to in the first paragraph of this subsection shall be an amount not less than the sum of the cash surrender value, as defined in that paragraph, for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value, as defined in that paragraph, for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse. Any cash surrender value available within thirty (30) days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by such paid-up policy (including any existing paid-up additions) decreased by any indebtedness to the company on account of or secured by the policy.

(c) Any paid-up nonforfeiture benefit available under a policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be not less than the cash surrender value then provided for by such policy or, if none is provided for, the minimum amount determinable in accordance with subsection (b) in the absence of the condition of subsection (a)(2) that premiums be paid for at least a specified period.

(d) This subsection does not apply to policies issued on or after the operative date of subsection (dd) of this section. Except as provided in the third paragraph of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, that the present value, at the date of issue of the policy, of all such

adjusted premiums shall be equal to the sum of (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) two per cent (2%) of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy; (iii) forty per cent (40%) of the adjusted premium for the first policy year; (iv) twenty-five per cent (25%) of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less; provided that for the sole purpose of computing the amounts of (iii) and (iv) above, no adjusted premiums in excess of four per cent (4%) of the amount of insurance or uniform amount equivalent thereto shall be used.

In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of this subsection shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at date of issue as the benefits under the policy; provided that in the case of a policy for a varying amount of insurance issued on the life of a child under age ten (10), the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten (10) were the amount provided by such policy at age ten (10) or at expiry, if earlier.

The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to (a) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (b) the adjusted premiums for such term insurance, the foregoing items (a) and (b) being calculated separately and as specified in the first two (2) paragraphs of this subsection except that, for the purposes of (ii), (iii) and (iv) of the first such paragraph, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (b) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (a).

Except as otherwise provided in the succeeding paragraphs of this subsection, all adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table, provided, that for any category of ordinary insurance issued

on female risks, adjusted premiums and present values may be calculated according to an age not more than six (6) years younger than the actual age of the insured, and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half percent (3 1/2%) per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits; provided that in calculating the present value of any nonforfeiture benefits consisting of paid-up term insurance with or without pure endowment of a lesser amount, the rates of mortality assumed may be not more than one hundred and thirty per cent (130%) of the rates of the mortality according to such applicable table; and provided that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table or tables of mortality as may be specified by the company and approved by the department.

In the case of ordinary policies bearing a date of issue which is the same as or later than the operative date of this paragraph as defined in the succeeding paragraph, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits; provided, that such rate of interest shall not exceed three and one-half percent (3 1/2%) per annum, except that such rate of interest shall not exceed four percent (4%) per annum for policies bearing a date of issue of or later than September 1, 1973 and prior to September 1, 1979, and the interest rate may not exceed five and one-half percent (5 1/2%) per annum for policies bearing a date of issue after August 31, 1979; provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six (6) years younger than the actual age of the insured; provided that in calculating the present value of any nonforfeiture benefits consisting of paid-up term insurance with or without pure endowment of a lesser amount, the rates of mortality assumed may be not more than those shown in the Commissioners 1958 Extended Term Insurance Table; and provided that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table or tables of mortality as may be specified by the company and approved by the department.

Any company may file with the department a written notice of its election to invoke the provisions of the preceding paragraph after a specified date before January 1, 1966. After the filing of such notice, then upon such specified date (which shall be the operative date of the preceding paragraph for such company), the preceding paragraph shall become operative with respect to the ordinary policies issued

by such company and bearing a date of issue which is the same as or later than such specified date. If a company makes no such election, the operative date of the preceding paragraph for such company shall be January 1, 1966.

In the case of policies of industrial insurance bearing a date of issue which is the same as or later than the operative date of this paragraph as defined in the succeeding paragraph, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits; provided that such rate of interest shall not exceed three and one-half percent (3 1/2%) per annum, except that such rate of interest shall not exceed four percent (4%) per annum for policies bearing a date of issue of or later than September 1, 1973 and before September 1, 1979, and the rate of interest may not exceed five and one-half percent (5 1/2%) per annum for policies bearing a date of issue after August 31, 1979; provided, further, that in calculating the present value of any nonforfeiture benefits consisting of paid-up term insurance with or without pure endowment of a lesser amount, the rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table; and provided that for insurance issued on a substandard basis, the calculations of any such adjusted premiums and present values may be based on such other table or tables of mortality as may be specified by the company and approved by the department.

Any company may file with the department a written notice of its election to invoke the provisions of the preceding paragraph after a specified date before January 1, 1968. After the filing of such notice, then upon such specified date (which shall be the operative date of the preceding paragraph for such company), the preceding paragraph shall become operative with respect to the policies of industrial insurance issued by such company and bearing a date of issue which is the same as or later than such specified date. If a company makes no such election, the operative date of the preceding paragraph for such company shall be January 1, 1968.

(dd)(1) This subsection applies to all policies issued on or after the operative date of this subsection. Except as provided in subdivision (7) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums

shall be equal to the sum of (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) one percent (1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and (iii) one hundred twenty-five percent (125%) of the nonforfeiture net level premium as defined in this subsection. Provided that in applying the percentage specified in (iii) no nonforfeiture net level premium may be considered to exceed four percent (4%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

(2) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one (1) per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

(3) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums, the future adjusted premiums, nonforfeiture net level premiums, and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(4) Except as otherwise provided in subdivision (7) of this subsection, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of: (A) the sum of (i) the then present value of the then future guaranteed benefits provided for by the policy and (ii) the additional expense allowance, if any, over (B) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(5) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of (i) one percent (1%) of the excess, if positive, of the average amount of

insurance at the beginning of each of the first ten (10) policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten (10) policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and (ii) one hundred twenty-five percent (125%) of the increase, if positive, in the nonforfeiture net level premium.

(6) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (A) by (B) where:

(A) equals the sum of:

(i) the nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one (1) per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred; and

(ii) the present value of the increase in future guaranteed benefits provided for by the policy; and

(B) equals the present value of an annuity of one (1) per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(7) Notwithstanding any other provisions of this subsection to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, that policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.

(8) All adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of (i) the Commissioners 1980 Standard Ordinary Mortality Table or (ii) at the election of the company for any one (1) or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; shall for all policies of industrial insurance be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subsection, for policies issued in that calendar year. However:

(A) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year.

(B) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available,

whether or not required by subsection (a) of this section, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.

(C) A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

(D) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance.

(E) For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the tables referred to in this subdivision.

(F) For policies issued:

(i) before the operative date of the valuation manual specified in IC 27-1-12.8-34, any commissioners standard ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table; or

(ii) on or after the operative date of the valuation manual specified in IC 27-1-12.8-34, the valuation manual must provide the commissioners standard ordinary mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. If the commissioner adopts a rule under IC 4-22-2 to approve any commissioners standard ordinary mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(G) For policies issued:

(i) before the operative date of the valuation manual specified in IC 27-1-12.8-34, any commissioners standard industrial mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table; or

(ii) on or after the operative date of the valuation manual specified in IC 27-1-12.8-34, the valuation manual must provide the commissioners standard industrial mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. If the commissioner adopts a rule under IC 4-22-2 to approve any commissioners standard industrial mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(9) The nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be as follows:

(A) For policies issued before the operative date of the valuation manual specified in IC 27-1-12.8-34, equal to one hundred twenty-five percent (125%) of the calendar year statutory valuation interest rate for such policy under IC 27-1-12.8, rounded to the nearer one quarter of one percent (1/4 of 1%).

(B) For policies issued on or after the operative date of the valuation manual specified in IC 27-1-12.8-34, the nonforfeiture interest rate per annum for a policy issued in a particular calendar year must be provided by the valuation manual.

(10) Notwithstanding any other provision in this title to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

(11) After September 1, 1981, any company may file with the commissioner a written notice of its election to comply with the provisions of this subsection after a specified date before January 1, 1989, which shall be the operative date of this subsection for such

company. If a company makes no such election, the operative date of this subsection for such company shall be January 1, 1989.

(e) Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in subsections (b), (c), (d), and (dd) may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide such additions. Notwithstanding the provisions of subsection (b), additional benefits payable (1) in the event of death or dismemberment by accident or accidental means, (2) in the event of total and permanent disability, (3) as reversionary annuity or deferred reversionary annuity benefits, (4) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply, (5) as term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six (26), is uniform in amount after the child's age is one (1), and has not become paid up by reason of the death of a parent of the child, and (6) as other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

(f) This section shall not apply to any reinsurance, group insurance, pure endowment, annuity or reversionary annuity contract, nor to any term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty (20) years or less expiring before age seventy-one (71), for which uniform premiums are payable during the entire term of the policy, nor to any term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in subsections (d) and (dd), is less than the adjusted premium so calculated on a term policy of uniform amount, or renewal of it, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance, and for a term of twenty (20) years or less expiring before age seventy-one (71), for which uniform premiums are payable during the entire term of the policy, nor to any policy which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in subsections (b), (c), (d), and (dd) of

this section, exceeds two and one-half percent (2 1/2%) of the amount of insurance at the beginning of the same policy year, nor to any policy which shall be delivered outside this state through an agent or other representative of the company issuing the policy. For purposes of determining the applicability of this section, the age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

(g) This subsection, in addition to all other applicable subsections of this section, applies to all policies issued on or after January 1, 1985. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be an amount which does not differ by more than two tenths of one percent (.2%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years, from the sum of (a) the greater of zero (0) and the basic cash value specified in this subsection and (b) the present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors, as defined in this subsection, corresponding to premiums which would have fallen due on and after such anniversary. However, the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in subsection (b) or (d) of this section, whichever is applicable, shall be the same as are the effects specified in that subsection on the cash surrender values defined in that subsection.

The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in subsection (d) or (dd), whichever is applicable. Except as is required by the next succeeding sentence of this paragraph, such percentage:

(1) must be the same percentage for each policy year between the second policy anniversary and the later of (i) the fifth policy anniversary and (ii) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two tenths of one percent (.2%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and

(2) must be such that no percentage after the later of the two (2) policy anniversaries specified in the preceding item (a) may apply to fewer than five (5) consecutive policy years. No basic

cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in subsection (d) or (dd) of this section, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

All adjusted premiums and present values referred to in this subsection shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other subsections of this section. The cash surrender values referred to in this subsection shall include any endowment benefits provided for by the policy.

Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in subsections (a), (b), (c), (dd), and (e) of this section. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as subdivisions (1) through (6) in subsection (e) of this section shall conform with the principles of this subsection.

(h) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in subsections (a), (b), (c), (d), or (dd) of this section then:

(1) the commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by subsection (a), (b), (c), (d), or (dd) of this section;

(2) the commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds; and

(3) the cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this section, as determined by regulations promulgated by the department.

(Formerly: Acts 1935, c.162, s.151B; Acts 1943, c.189, s.3; Acts 1949, c.8, s.1; Acts 1959, c.146, s.2; Acts 1963, c.212, s.1; Acts 1973, P.L.273, SEC.1.) As amended by Acts 1979, P.L.250, SEC.1; Acts 1981, P.L.237, SEC.1; P.L.276-2013, SEC.3.

IC 27-1-12-8
Prohibited provisions

Sec. 8. No policy of life insurance shall hereafter be issued or delivered in this state, or be issued by a life insurance company organized under the laws of this state, if it contain any of the following provisions:

(1) Limiting the time within which any action at law or in equity may be commenced, to less than three (3) years after the cause of action shall accrue.

(2) By which the policy shall purport to be issued or to take effect more than six (6) months before the original application for insurance was made.

(3) That in the event of the maturity of any policy after the expiration of the contestable period thereof, for any mode of settlement at maturity of less value according to the company's published rates therefor then in use, than the amount insured under the policy, plus dividend additions, if any, less any indebtedness to the company on account of or secured by the policy and less any premium that may, by the terms of the policy, be deducted.

(4) For the forfeiture of the policy for failure to repay any loan on the policy, or to pay interest on such loan while the total indebtedness on the policy is less than the loan value thereof; or any provision for forfeiture for failure to repay any such loan or to pay interest thereon, unless such provision contain a stipulation that no such forfeiture shall occur until at least thirty (30) days after notice shall have been mailed by the company to the last-known address of the insured and to the assignee, if any, if such assignee has notified the company of his address.

(5) Which contains any clause promising to the holder of such policy any special dividend or benefit to be derived from any other policy; nor shall any company organized under the laws of this state issue in connection with any policy any separate paper or contract promising any such special dividend or benefit; nor shall any company be admitted to do business in this state that issues policies which contain any such clause, or which issues in connection with any policy any separate paper or contract promising any such dividend or benefit.

(Formerly: Acts 1935, c.162, s.152.)

IC 27-1-12-9
Repealed

(Formerly: Acts 1935, c.162, s.153; Acts 1943, c.189, s.4. As amended by P.L.252-1985, SEC.62. Repealed by P.L.276-2013, SEC.4.)

IC 27-1-12-10
Repealed

(Formerly: Acts 1935, c.162, s.153A; Acts 1943, c.189, s.5; Acts 1959, c.146, s.3; Acts 1963, c.212, s.2; Acts 1973, P.L.273, SEC.2. As amended by Acts 1979, P.L.250, SEC.2; Acts 1980, P.L.22,

SEC.16; Acts 1981, P.L.237, SEC.2; P.L.2-1987, SEC.35; P.L.5-1988, SEC.142; P.L.130-1994, SEC.17; P.L.116-1994, SEC.22. Repealed by P.L.276-2013, SEC.5.)

IC 27-1-12-10.1
Repealed

(As added by P.L.130-1994, SEC.18 and P.L.116-1994, SEC.23. Repealed by P.L.276-2013, SEC.6.)

IC 27-1-12-10.5
Rules for minimum standards for establishment of reserves

Sec. 10.5. The department shall adopt rules under IC 4-22-2 to prescribe minimum standards for the establishment of reserves as required by the National Association of Insurance Commissioners or its successor organization for insurers writing Class 1(a), Class 1(b), and Class 1(c) lines of business.
As added by P.L.130-1994, SEC.19 and P.L.116-1994, SEC.24.

IC 27-1-12-11
Deposit of assets to cover reserve valuation and liabilities; additional deposits; foreign deposits; continuation of deposits under repealed or superseded laws

Sec. 11. (a) After the department has ascertained the net reserve value of all policies under IC 27-1-12.8-18 or the reserve liabilities under IC 27-1-12.8 of any life insurance company organized and doing business in this state, the department shall notify said company of the amount or amounts thereof. Within sixty (60) days after the date of such notification, the officers of such company shall deposit with the department, solely for the security and benefit of all its policyholders, assets in an amount, invested in accordance with section 2 of this chapter (except paragraph 20 of section 2(b) of this chapter) which together with the assets already deposited with the department and such additional assets as may be deposited by said company with other states or governments, pursuant to the requirements of the laws of such other states or governments in which said company is doing business, shall be not less than the lesser of the amount of such reserve value or reserve liabilities or the amount provided under subsection (f). No life insurance company organized under this article or any other law of this state shall be required to make such deposit until the amount prescribed by this subsection exceeds the amount deposited by said company under IC 27-1-6-14 or IC 27-1-6-15. Investments in real estate shall be deposited in the form of satisfactory evidences of ownership. The deposit requirement in relation to policy loans and bank deposits shall be considered fulfilled by the inclusion of such item in the company's annual statement, but subject to the right of the company at any time, and the obligation of the company on demand of the department, to file with the department a certificate as to the amount

of such item.

(b) If the department in the course of the year ascertains that the net reserve value of a company's policies under IC 27-1-12.8-18 or its reserve liabilities under IC 27-1-12.8 exceeds such company's deposits as required by subsection (a), it may require such company within sixty (60) days to increase its deposit to the required amount.

(c) Nothing in this article shall prevent the deposit of bonds, mortgages, or other securities which meet the investment requirements of a foreign or alien state or country, to an amount not exceeding the amount of the reserves on policies issued to residents of, and to corporations doing business in, such state or country. If, pursuant to the law of a foreign or alien state or country in which an Indiana life insurance company is doing business, securities belonging to such a company are required to be deposited within the boundaries of such foreign or alien state or country, credit for the amount of such deposit, not exceeding the amount of the reserves on policies issued to residents of, and to corporations doing business in, such foreign or alien state or country, may be taken by the company as an offset against its deposits required under this article.

(d) If, pursuant to the law of a foreign or alien state or country, a life insurance company domiciled therein is not permitted a reserve credit for reserves maintained by a reinsurer foreign to such a state or country, except on the condition that the amount of such reserve be deposited with the insurance supervisory official of such state or country, a deposit credit for the amount of such reserves so deposited shall be allowed a domestic life insurance company accepting reinsurance from companies domiciled in such state or country.

(e) Any deposit of assets with the department pursuant to any law superseded by this chapter shall, prior to the first deposit date contemplated in subsection (a), be continued with the department and otherwise be subject to this section.

(f) The amount of the deposit, except as otherwise provided in subsection (a), shall be one million dollars ($1,000,000) excluding policy loans and bank deposits, or such greater amount as the department deems necessary to protect the interests of the policyholders of a particular company by an order to the company to deposit additional amounts under this section.

(Formerly: Acts 1935, c.162, s.153B; Acts 1943, c.189, s.6; Acts 1945, c.175, s.4.) As amended by Acts 1981, P.L.238, SEC.1; P.L.31-1988, SEC.12; P.L.186-1997, SEC.6; P.L.81-2012, SEC.2; P.L.276-2013, SEC.7; P.L.129-2014, SEC.4.

IC 27-1-12-12

Transition period; selection of date; effect

Sec. 12. The period beginning July 1, 1943, and ending January 1, 1948, both dates inclusive, shall be a transition period between the nonforfeiture provisions set forth respectively in sections 5, 6, and 7 of this chapter and between the valuation provisions set forth

respectively in IC 27-1-12.8-18 and IC 27-1-12.8-19 through IC 27-1-12.8-40. Accordingly, a company may, by means of a writing filed with the department, select a transition date within such period, but should a company fail to make such a selection, the transition date as to such company shall be January 1, 1948. Except as otherwise provided in IC 27-1-12.8, for group annuities and pure endowments, policies issued prior to the transition date shall be governed in all respects and at all times by section 5 of this chapter and IC 27-1-12.8-18, and policies issued on or after such transition date shall be governed in all respects and at all times by sections 6 and 7 of this chapter and IC 27-1-12.8. A company's election of a transition date shall be irrevocable and shall apply to sections 6 and 7 of this chapter and IC 27-1-12.8 without exception, as well as to that portion of section 31 of this chapter which relates to policies bearing a date of issue later than such transition date.
(Formerly: Acts 1935, c.162, s.153C; Acts 1943, c.189, s.7; Acts 1973, P.L.273, SEC.3; Acts 1974, P.L.1, SEC.12.) As amended by P.L.252-1985, SEC.63; P.L.276-2013, SEC.8.

IC 27-1-12-13
Filing form of policy with department; objections; effect on right to issue

Sec. 13. A policy of life insurance shall not be issued or delivered in this state until the form of the same has been filed with the department, nor if the department give written notice within thirty (30) days of such filing, to the company proposing to issue it showing wherein the form of such policy does not comply with the requirements of the laws of this state.
(Formerly: Acts 1935, c.162, s.154.)

IC 27-1-12-14
Designation of beneficiary; change of beneficiary; eligible beneficiaries; exemption of policy proceeds from claims of creditors

Sec. 14. (a) As used in this section, "premium" includes any deposit or contribution.

(b) As used in this section, "proceeds or avails" means death benefits, cash surrender and loan values, premiums waived, and dividends whether used in reduction of the premiums or in whatsoever manner used or applied, excepting only where the debtor has, subsequent to the issuance of the policy, actually elected to receive the dividends in cash.

(c) Any person whose life is insured by any life insurance company may name as his payee or beneficiary any person or persons, natural or artificial, with or without an insurable interest, or his estate. A designation at the option of the policyowner may be made either revocable or irrevocable, and the option elected shall be set out in and shall be made a part of the application for the

certificate or policy of insurance. When the right of revocation has been reserved, the person whose life is insured, subject to any existing assignment of the policy, may at any time designate a new payee or beneficiary, with or without reserving the right of revocation, by filing written notice thereof at the home office of the corporation, accompanied by the policy for suitable indorsement thereon.

(d) Any person may effect an insurance on his life, for any definite period of time, or for the term of his natural life, to inure to the sole benefit of the spouse and children, or of either, or other relative or relatives dependent upon such person or any creditor or creditors as he may cause to be appointed and provided in the policy.

(e) Except as provided in subsection (g), all policies of life insurance upon the life of any person, which name as beneficiary, or are bona fide assigned to, the spouse, children, or any relative dependent upon such person, or any creditor, shall be held, subject to change of beneficiary from time to time, if desired, for the benefit of such spouse, children, other relative or creditor, free and clear from all claims of the creditors of such insured person or of the person's spouse; and the proceeds or avails of all such life insurance shall be exempt from all liabilities from any debt or debts of such insured person or of the person's spouse.

(f) A premium paid for an individual life insurance policy that names as a beneficiary, or is legally assigned to, a spouse, child, or relative who is dependent upon the policy owner is not exempt from the claims of the creditors of the policy owner if the premium is paid:

(1) not more than one (1) year before the date of the filing of a voluntary or involuntary bankruptcy petition by; or

(2) to defraud the creditors of;

the policy owner.

(g) The insurer issuing the policy is discharged from all liability by payment of the proceeds and avails of the policy in accordance with the terms of the policy unless, before payment, the insurer has received at the insurer's home office, written notice by or on behalf of a creditor of the policy owner that specifies the amount claimed against the policy owner.

(Formerly: Acts 1935, c.162, s.155; Acts 1973, P.L.274, SEC.1; Acts 1975, P.L.280, SEC.1.) As amended by Acts 1981, P.L.239, SEC.1; P.L.253-1995, SEC.1; P.L.82-1998, SEC.2.

IC 27-1-12-15

Competency of certain minors to contract for insurance and receive payments

Sec. 15. (a) Any person who is not of the full age of eighteen (18) years but who is of the age, as determined by the nearest birthday, of not less than sixteen (16) years, shall be deemed competent to contract for life, accident and sickness insurance or annuities upon the life of such minor for the benefit of such minor or for the benefit

of the father, mother, husband, wife, brother or sister, child or children, or any grandparent of such minor, and to exercise and enjoy every right, privilege and benefit provided by any such contracts on the life of such minor, subject to the foregoing limitations as to the designation of beneficiary.

(b) No person who shall have attained the age of eighteen (18) years is incompetent because of age to contract for any of the kinds of insurance described in Class 1 of IC 1971, 27-1-5-1, or to exercise and enjoy every right, privilege and benefit provided by any such contract.

(c) No person who shall have attained the age of eighteen (18) years is incompetent because of age to receive and to give full acquittance and discharge for payments made to such person by a life insurance company under the provisions of a contract of insurance of any of the kinds described in Class 1 of IC 1971, 27-1-5-1, or under the provisions of a settlement agreement executed in connection with any such contract of insurance.

(Formerly: Acts 1935, c.162, s.155a; Acts 1961, c.203, s.1; Acts 1971, P.L.383, SEC.1; Acts 1973, P.L.275, SEC.1.)

IC 27-1-12-16

Proceeds of life insurance; definition; payment to trustees

Sec. 16. (A) The terms "proceeds" and "proceeds of life insurance" and similar phrases used in this section mean and include any and all benefits payable by the insurer by reason of the death of the insured under any "life insurance," "policy of life insurance," "insurance policy," "policy," or "annuity contract" providing for benefits on the death of the insured, including individual ordinary life policies, certificates issued under a group policy, annuity contracts, and accident or health policies.

(B) Proceeds of life insurance policies heretofore made payable to a trustee or trustees named as beneficiary or hereafter to be named beneficiary under an inter vivos trust shall be paid directly to the trustee or trustees and held and disposed of by the trustee or trustees as provided in the trust agreement or declaration of trust in writing made and in existence on the date of death of the insured, whether or not such trust or declaration of trust is amendable or revocable or both, or whether it may have been amended, and notwithstanding the reservation of any or all rights of ownership under the insurance policy or annuity contract; subject, however, to a valid assignment of any part of the proceeds. It is not necessary to the validity of such trust agreement or declaration of trust that it be funded or have a corpus other than the right, which need not be irrevocable, of the trustee or trustees named therein to receive such proceeds as beneficiary.

(C) A policy of life insurance or annuity contract may designate as beneficiary a trustee or trustees named or to be named by will if the designation is made in accordance with the provisions of the

policy or contract whether or not the will is in existence at the time of the designation. The company shall, within sixty days after receipt at its home office of proof of probate of the will, pay the proceeds of such insurance or contract to the trustee or trustees designated in the insurance policy or annuity contract, subject to a valid assignment of any part thereof and any other provisions of the policy or contract, unless prior to the actual payment by the company it shall have received at its home office written notice of the filing or pendency of (1) objection to the probate of said will, or (2) a suit to contest the validity of said will or of the testamentary trust or trusts created therein to which such proceeds are payable, or (3) petition for the construction of that part of the testamentary trust designating the trustee or trustees: Provided, however, That if the company makes any payment or payments of proceeds to such trustee or trustees in accordance with the terms of the policy or contract before receipt at the home office of such written notice, said trustee or trustees shall give full acquittance therefor to the company and such payment shall fully discharge the company from all claims and liability to the extent thereof. Provided, further, That if such written notice is received by the company, payment by it of any unpaid proceeds may be delayed during the pendency of said objections, suit, or petition for construction for not to exceed one (1) year from the date of death of insured, and thereafter the company may pay any and all unpaid proceeds due by reason of the death of the insured to the clerk of the court wherein the probate proceeding is pending by depositing them with such clerk who, as such clerk, shall give full acquittance to the company for all proceeds so paid and the company shall be fully discharged from any and all liability and claims by or on behalf of any other person or persons whomsoever to the extent of the amount so paid and deposited. The clerk shall thereafter hold and disburse said proceeds in accordance with the order of said court to the party or parties and in the amount or amounts provided in said order upon receiving proper receipts therefor; all Provided, however, That the procedure provided for herein shall not preclude the company from interpleading or being interpleaded in any appropriate proceeding or filing a bill of interpleader in any court of competent jurisdiction.

(d) If no claim to proceeds is made by any trustee designated as the beneficiary in any policy of insurance or annuity contract within one year after the death of the insured or if satisfactory evidence is furnished the insurance company within the one-year period showing that there is or will be no trustee qualified to receive the proceeds, payment may be made by the insurance company to those thereafter entitled.

(e) The proceeds of insurance collected by the trustee or trustees are not part of the testator's estate and are not subject to the debts of the insured or to transfer, inheritance, or estate taxes to any greater extent than if the proceeds were payable to some named beneficiary or beneficiaries other than to the estate of the insured or executor or

administrator thereof.

(f) This section applies to all trustee designations of a beneficiary or beneficiaries by an insured dying after June 15, 1967, regardless of when made, naming a trustee or trustees of a trust or trusts established by will.

If any provision of this section or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this section which can be given effect without the invalid provision or application.

(Formerly: Acts 1935, c.162, s.155b; Acts 1967, c.127, s.4.)

IC 27-1-12-17

Authority of corporation to insure life of director, officers, agent, or employee; consent to change of beneficiary

Sec. 17. Any corporation organized under the laws of this state may, when authorized by its board of directors, or its executive committee, cause to be insured, for its benefit, the life of any of its directors, officers, agents or employees, and to pay the premiums for such insurance; and may continue to pay such premiums after the insured shall cease to be such a director, officer, agent or employee of such corporation.

Due authority for such corporation to effect, assign, release, convert, surrender, or take any other action with reference to such insurance, shall be sufficiently evidenced to the insurance company by a certificate to that effect by the secretary, or other corresponding officer of such corporation under its corporate seal. Any such certificate shall protect the insurance company for any act done or suffered by it upon the faith thereof, without further inquiry into the validity of the corporate authority or the regularity of the corporate proceedings. The beneficiary in such a policy shall not be changed except with the consent of such corporation, beneficiary, effecting such insurance.

No person shall, by reason of interest in the subject matter, be disqualified from acting as a director, or as a member of the executive committee of such corporation on any corporate act touching such insurance.

(Formerly: Acts 1935, c.162, s.156.)

IC 27-1-12-17.1

Acquisition of insurable interest in and policy on life of employee

Sec. 17.1. (a) As used in this section, "employee" includes a director, an officer, a partner, a manager, a nonmanagement employee, and a retired employee of the employer or the employer's affiliates.

(b) As used in this section, "employer" means an individual, a corporation, a partnership, a limited liability company, and any other legal entity that has at least one (1) employee and is legally doing business in Indiana. The term includes an association of employers

and the employer's affiliates.

(c) An employer that provides life insurance, health insurance, disability insurance, retirement benefits, or similar benefits to an employee of the employer has an insurable interest in the life of the employee. The trustee of a trust established by an employer for the benefit of the employer has the same insurable interest as the employer in the life of an employee. The trustee of a trust established by an employer that provides life insurance, health insurance, disability insurance, retirement benefits, or similar benefits to an employee of the employer and acts in a fiduciary capacity with respect to that employee or the employee's dependents or beneficiaries has an insurable interest in the life of the employee for whom benefits are to be provided.

(d) An employer or the trustee of a trust established by the employer may acquire insurance upon an employee in whom the employer or the trustee of the trust has an insurable interest as determined under subsection (c) if the employee consents to be insured. An employee consents to be insured if the employee is provided written notice of the insurance coverage and does not object to the insurance coverage within thirty (30) days of receipt of the notice.

(e) An insurable interest must exist at the time the contract of life or disability insurance becomes effective, but need not exist at the time the loss occurs.

(f) Proceeds of a policy issued under this section are exempt from the claims of the employee's creditors or dependents.

As added by P.L.254-1995, SEC.1.

IC 27-1-12-18

Contract to extend time for premium payments

Sec. 18. A life insurance company may enter into subsequent agreements in writing with the insured, which need not be attached to the policy, to extend the time for the payment of any premium, or part thereof, upon condition that failure to comply with the terms of such agreement shall lapse the policy as provided in said agreement or in the policy. Subject to such lien as may be created to secure any indebtedness contracted by the insured in consideration of such extension, said agreement shall not impair any right existing under the policy.

(Formerly: Acts 1935, c.162, s.157.)

IC 27-1-12-19

Ascertainment of indebtedness due upon policy or premium loans; interest

Sec. 19. In ascertaining the indebtedness due upon policy or premium loans, the interest, if not paid when due, shall be added to the principal of such loans and shall bear interest at the rate specified in the note or loan agreement.

(Formerly: Acts 1935, c.162, s.158.)

IC 27-1-12-20
Premium deposits; maximum; inclusion in cash surrender value; disposition; withdrawal

Sec. 20. No life insurance company shall receive or accept, by virtue of the provisions set forth in any policy or indorsement thereon, any premium deposit in excess of the regular premium then due whenever the total premium deposit together with the policy reserve shall be sufficient as a gross premium to convert the policy into a fully paid policy. The policy or indorsement shall contain a provision that the amount of any premium deposit fund held by the company will be included as a part of the cash surrender value of the policy, a provision providing for the disposition of such fund if it is not sufficient to pay the next premium, and a provision that such fund is not withdrawable except by surrender of the policy, a loan thereon or through the selection of a nonforfeiture value.
(Formerly: Acts 1935, c.162, s.159.)

IC 27-1-12-21
Power to hold proceeds under trust or other agreement with policyholder

Sec. 21. Any life insurance company organized under the laws of this state shall have power to hold the proceeds of any policy issued by it under a trust or other agreement upon such terms and restrictions as to revocation by the policyholder and control by beneficiaries and with such exemptions from the claims of creditors of beneficiaries other than the policyholder as shall have been agreed to in writing by such company and the policyholder. Such insurance company shall not be required to segregate funds so held but may hold them as a part of its general corporate assets.
(Formerly: Acts 1935, c.162, s.160.)

IC 27-1-12-22
Impairment of assets or capital; notice of time for restoration; suspension of right to issue new policies

Sec. 22. If it appears to the department from an examination made by it or by an examiner appointed by it, that the assets of any domestic life insurance company are insufficient to justify its continuance in business or that its capital is impaired the department shall notify such company, setting a time, within the discretion of the commissioner, by which such impairment of assets or of its capital shall be restored and further notifying such company to issue no new policies until its assets have become equal to its liabilities, or its capital has been restored unimpaired.
(Formerly: Acts 1935, c.162, s.161.)

IC 27-1-12-23

Procedure for converting domestic stock life insurance company into mutual life insurance company

Sec. 23. Any domestic stock life insurance company may become a mutual life insurance company and to that end may carry out a plan for the acquisition of shares of its capital stock by amending its articles of incorporation and complying with the following requirements:

(a) Such plan shall be approved by a two-thirds (2/3) vote of the policyholders, present and voting at a meeting called for that purpose. For the purpose of this section a quorum shall consist of at least ten per cent (10%) of the policyholders of such company. Each policyholder whose insurance shall have been in force for at least one (1) year prior to such meeting shall have one (1) vote, regardless of the number of policies or amount of insurance he may have with such company. Notice of such meeting shall be given by mailing from the principal office of such company at least thirty (30) days prior to the date set for such meeting in a sealed envelope, postage prepaid, addressed to such policyholders at their last known post-office addresses. Voting shall be by ballot, in person or by proxy, or by mail under the direction of inspectors appointed by the commissioner and in accordance with such other regulations as he may prescribe. Such inspectors shall have the power to determine all questions concerning the verification of the ballots, the ascertainment of the validity thereof, the qualifications of the voters, and to canvass the vote. They shall certify to the commissioner and to the company the result of such election. All necessary expenses incurred by the commissioner or by the inspectors appointed by him shall be certified by him to and paid by the company.

(b) Such plan shall be submitted to and approved by the commissioner. The commissioner shall not approve said plan unless in his opinion the rights and interests of all policyholders are preserved. In carrying out said plan a company may acquire any shares of its own stock by gift, bequest or purchase. Any shares thus acquired shall be held in trust for the policyholders of the company as hereinafter provided and shall be assigned and transferred on the books of the company to three (3) trustees who shall hold in trust and shall vote them at all company meetings until all the capital stock of such company is acquired, when the entire capital stock shall be cancelled, and thereupon, the company shall be and become a mutual life insurance company without capital stock. Such trustees shall be appointed and vacancies shall be filled as provided in the plan adopted under the provisions of this section. Such trustees shall file with the company a verified acceptance of their appointments and declarations that they will faithfully discharge their duties as such trustees. All dividends and other sums acquired, after paying the necessary expenses of executing said trust, shall be immediately repaid to said company for the benefit of all who are or may become policyholders of said company and entitled to participate in the

profits thereof, and shall be added to and become a part of the surplus earned by said company and be apportionable accordingly as a part of said surplus among said policyholders.
(Formerly: Acts 1935, c.162, s.162.)

IC 27-1-12-24
Offering stock or certificates as inducement for purchase of insurance or annuity; revocation of authority

Sec. 24. No life insurance company doing business in this state shall issue in this state, nor permit its agents, officers, or employees to issue or deliver in this state, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities, or any special advisory board or other contracts of any kind promising returns and profits as an inducement to insurance or for the purchase of an annuity; and no life insurance company shall be authorized to do business in this state which issues or permits its agents, officers, or employees to issue in this state or in any other state or territory agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities, or any special advisory board or other contracts of any kind promising returns and profits as an inducement to insurance or for the purchase of an annuity; and no corporation or stock company acting as agent of a life insurance company nor any of its agents, officers, or employees shall be permitted to sell, agree to offer or sell, or give or offer to give, directly or indirectly, in any manner whatsoever, any share of stock, securities, bonds, or agreement of any form or nature promising returns and profits as an inducement to insurance or for the purchase of an annuity; or in connection therewith. The department may, upon due proof after notice and hearing that any such company or agent thereof has violated any of the provisions of this section, revoke the authority of the company or agent so offending.
(Formerly: Acts 1935, c.162, s.163.)

IC 27-1-12-25
Misrepresentation of policy terms or benefits; inducing policyholder to lapse, forfeit, or surrender insurance

Sec. 25. No life insurance company doing business in this state, and no officer, director or agent thereof shall make, issue or circulate, or cause to be issued or circulated, any estimate, illustration, circular, or statement of any sort misrepresenting the terms of any policy issued or to be issued by it or the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon, or shall use any name or title of any policy or class of policies misrepresenting the true nature thereof. Nor shall a person make any misrepresentation to any person insured in any company for the purpose of inducing or tending to induce a policyholder in any company to lapse, forfeit, or surrender his

insurance.
(Formerly: Acts 1935, c.162, s.164.) As amended by Acts 1978, P.L.2, SEC.2710.

IC 27-1-12-26
Fraudulent representations; offense

Sec. 26. A person who knowingly makes any false or fraudulent statement or representation in or with reference to any application for life insurance, or for the purpose of obtaining any fee, commission, money, or benefit from or in any company transacting business under this article, commits a Class A misdemeanor.
(Formerly: Acts 1935, c.162, s.165.) As amended by Acts 1978, P.L.2, SEC.2711.

IC 27-1-12-27
Repealed

(Repealed by P.L.254-1985, SEC.7.)

IC 27-1-12-28
Repealed

(Repealed by P.L.254-1985, SEC.7.)

IC 27-1-12-29
Group life insurance; exemption of proceeds from legal process

Sec. 29. (a) As used in this section, "premium" includes any deposit or contribution.

(b) Except as provided in subsection (c), no policy of group insurance nor the proceeds thereof, when paid to any employee or employees, shall be liable to attachment, garnishment, or other process, or to be seized, taken, appropriated, or applied to any legal or equitable process or operation of law, to pay any debt or liability of such employee, or his beneficiary, or any other person who may have a right thereunder, either before or after payment, nor shall the proceeds thereof, where not payable to a named beneficiary, constitute a part of the estate of the employee for the payment of his debts.

(c) A premium paid for an individual life insurance policy that names as a beneficiary, or is legally assigned to, a spouse, child, or relative who is dependent upon the policy owner is not exempt from the claims of the creditors of the policy owner if the premium is paid:

(1) not more than one (1) year before the date of the filing of a voluntary or involuntary bankruptcy petition by; or

(2) to defraud the creditors of;

the policy owner.

(d) The insurer issuing the policy is discharged from all liability by payment of the proceeds and avails of the policy (as defined in section 14(b) of this chapter) in accordance with the terms of the policy unless, before payment, the insurer has received at the

insurer's home office, written notice by or on behalf of a creditor of the policy owner that specifies the amount claimed against the policy owner.
(Formerly: Acts 1935, c.162, s.168.) As amended by P.L.253-1995, SEC.2.

IC 27-1-12-30
Group life insurance; assignment of incidents of ownership

Sec. 30. No provision of this article or of any other law shall be construed as prohibiting an insured under a group insurance policy, pursuant to agreement among the insured, the group policyholder and the insurer, from making an assignment of all or any part of the incidents of ownership held by the insured under such policy, including specifically but not by way of limitation, any right to designate a beneficiary thereunder and any right to have an individual policy issued in accordance with provisions (8) and (9) of section 28 of this chapter. All such assignments, whether made prior to or subsequent to August 18, 1969, shall be valid for the purpose of vesting in the assignee thereof all the incidents of ownership so assigned, and shall entitle the insurer to deal with the assignee as the owner thereof in accordance with the provisions of said policy, but without prejudice to the insurer on account of any payment made or individual policy issued prior to receipt by the insurer of such notice as may be required by the provisions of the policy.
(Formerly: Acts 1935, c.162, s.168.1; Acts 1969, c.327, s.2.) As amended by P.L.252-1985, SEC.64.

IC 27-1-12-31
Authority to issue life or endowment insurance upon group plan; special premium rates; valuation of policies; segregation

Sec. 31. Any life insurance company may issue life or endowment insurance, with or without annuities, upon the group plan as defined in this chapter, with special rates of premiums less than the usual rates of premiums for such policies, and may value such policies on any accepted table of mortality and interest assumption adopted by the company for that purpose, provided, that in no case shall such standard be lower than the American Men Table of Mortality (ultimate) with interest assumption at three and one-half percent (3 1/2%) in the case of policies issued before the transition date selected by the company pursuant to section 12 of this chapter, nor lower than the standard prescribed in IC 27-1-12.8 in the case of policies issued on and after such transition date. All policies of group insurance shall be segregated by the company into a separate class, the mortality experience kept separate, and the number of policies, amount of insurance, reserves, premiums, and payments to policyholders thereunder, together with the mortality table and interest assumption adopted by the company shall be reported separately in the company's annual financial statement.

(Formerly: Acts 1935, c.162, s.169; Acts 1943, c.189, s.8.) As amended by P.L.252-1985, SEC.65; P.L.276-2013, SEC.9.

IC 27-1-12-32
Financial qualifications of companies issuing certain contracts

Sec. 32. A domestic life insurance company shall not issue the type of life insurance or annuity contracts defined and sanctioned under Class 1(c) of IC 27-1-5-1 unless, in addition to fulfilling all other qualifications prescribed by law, it possesses assets of not less than twenty million dollars ($20,000,000), or combined capital and surplus, in the case of a stock company, or surplus, in the case of a mutual company, of not less than two million five hundred thousand dollars ($2,500,000). In applying these qualifications to a subsidiary stock life insurance company that is a subsidiary company (as defined in IC 27-1-23-2.6), the requirements concerning assets, capital, and surplus shall be regarded as fulfilled if the consolidated assets, capital, and surplus of the primary and subsidiary companies equal or exceed the required amounts.

(Formerly: Acts 1935, c.162, s.169.1; Acts 1961, c.138, s.3.) As amended by P.L.252-1985, SEC.66; P.L.1-2002, SEC.103.

IC 27-1-12-33
Variable life insurance policies; contents; regulation

Sec. 33. Variable life insurance policies (contracts providing for immediate or future life insurance benefits as described in Class 1 (c) of IC 1971, 27-1-5-1), to the extent that benefits thereunder are on a variable basis, shall contain a statement to that effect in lieu of stipulating the dollar amount of benefits. Such policies shall also contain such grace period, reinstatement, and nonforfeiture provisions, and shall be subject to the establishment of such reserve liabilities, in accordance with actuarial procedures that recognize the variable nature of benefits provided and any mortality guarantees, as the commissioner shall by regulation prescribe. Upon promulgation of such regulation, variable life insurance policies shall not thereafter be subject to the grace period, nonforfeiture, policy loan, reinstatement, and valuation provisions of the Indiana Insurance Law applicable to or required to be contained in other policies of life insurance. Such regulation shall establish such other requirements with respect to variable life insurance policies, variable life insurance, or any matter incidental thereto, as the commissioner deems to be in the public interest.

(Formerly: Acts 1973, P.L.276, SEC.1.)

IC 27-1-12-34
Repealed

(Repealed, as added by Acts 1977, P.L.284, SEC.1, by Acts 1978, P.L.8, SEC.16.)

(Repealed, as added by Acts 1977, P.L.285, SEC.1, by Acts 1982,

P.L.6, SEC.18.)

IC 27-1-12-34.1
Wholesale, franchise, and employee term life insurance; issuance or delivery; requirements

Sec. 34.1. (a) No policy of wholesale, franchise, or employee life insurance, as defined in this section, shall be issued or delivered in this state unless it conforms to the requirements of this section.

(b) Wholesale, franchise, or employee life insurance is defined as a term life insurance plan under which a number of individual term insurance policies are issued at special rates to a selected group. A special rate is any rate lower than the rate shown in the issuing insurance company's manual for individually issued policies of the same type and to insureds of the same class.

(c) Wholesale, franchise, or employee life insurance may be issued to:

(1) three (3) or more employees of any corporation, copartnership, or individual employer, or any governmental corporation, agency, or department thereof; or

(2) ten (10) or more members, employees, or employees of members of any trade or professional association, or of a labor union, or of any association of members in the same or related occupations, profession, or industry having been in existence for at least two (2) years, where such association or union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance. Evidence of individual insurability satisfactory to the insurer may be required by the insurer as a condition to coverage.

(d) The premiums on such policies may be paid to the insurer periodically by the employer, with or without payroll deductions, or by the insured or association or union for its members, or by some designated person acting on behalf of such employer, association, or union. The term "employees" as used in this chapter refers to officers, managers, employees, and retired employees of the employer and the individual proprietor or partners if the employer is an individual or partnership.

(e) Each policy issued under this section shall provide that, if the insured person ceases to qualify for the policy he may convert the policy, without evidence of insurability, to an individual policy of life insurance, provided application for such conversion is made within thirty-one (31) days of the date the insured person ceases to qualify for coverage under this section. The individual policy shall be issued on any one (1) of the forms, except term insurance, then customarily issued by the insurer at the age and in the amount applied for. The premium on this individual policy is to be at the insurer's then customary rate applicable to the form and amount of such individual policy, the class of risk to which the insured person then belongs, and his age attained on the effective date of such

individual policy.
As added by Acts 1982, P.L.6, SEC.17.

IC 27-1-12-35
Life insurance proceeds; payment; time limit; liability for interest

Sec. 35. (a) Any resident of this state who becomes entitled to receive payment of an obligation in cash under the terms of a policy of individual life insurance issued in this state, including any death benefit riders attached thereto, endowment insurance or an individual annuity contract, shall be entitled to receive payment of interest from the insuring company if any payment is not received by such resident within thirty (30) days after the event giving rise to the obligation, or within thirty (30) days after the scheduled date of payment as the case may be. Interest payable shall be calculated from the date of the event or the scheduled date of payment. However, any interest awarded by a court shall be in lieu of that provided in this section.

(b) The rate of interest payable pursuant to this section shall be not less than that rate, as determined from time to time by the insuring company, applicable to proceeds of life insurance left on deposit with the insuring company and subject to withdrawal on demand.

(c) For the purposes of this section, payment shall be deemed to have been received by a resident when manually delivered by an agent or representative of the insuring company or when deposited by the insuring company in the United States mails, postage prepaid, and directed to the resident at his last known address as evidenced by the business records of the insuring company.
As added by Acts 1978, P.L.8, SEC.15.

IC 27-1-12-36
Repealed

(Repealed by P.L.254-1985, SEC.7.)

IC 27-1-12-37
Group life insurance; eligible policyholders; regulations

Sec. 37. Except as provided in section 38 of this chapter, no policy of group life insurance may be delivered in Indiana unless it conforms to one (1) of the following descriptions:

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

(A) The employees eligible for insurance under the policy must be all of the employees of the employer, or all of any class or classes of employees. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual

proprietors, and partners of one (1) or more affiliated corporations, limited liability companies, proprietorships, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" may include retired employees, former employees, and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" includes elected or appointed officials.

(B) The premium for the policy must be paid either from the employer's funds, from funds contributed by the insured employees, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two (2) or more creditors (which creditor, holding company, affiliate, trustee, trustees, or agent must be deemed the policyholder) to insure debtors of the creditor, or creditors, subject to the following requirements:

(A) The debtors eligible for insurance under the policy must be all of the debtors of the creditor or creditors, or all of any class or classes of debtors. The policy may provide that the term "debtors" includes:

(i) borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(ii) the debtors of one (1) or more subsidiary corporations; and

(iii) the debtors of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control.

(B) The premium for the policy must be paid either from the creditor's funds, from charges collected from the insured debtors, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from the funds contributed by insured debtors

specifically for their insurance must insure all eligible debtors.

(C) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(D) The amount of the insurance on the life of any debtor may at no time exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor.

(E) The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Each payment under this clause must reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment, and any excess of the insurance must be payable to the estate of the insured.

(F) Notwithstanding clauses (A) through (E), insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan, and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(3) A policy issued to a labor union or similar employee organization (which organization must be deemed to be the policyholder) to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(A) The members eligible for insurance under the policy must be all of the members of the union or organization, or all of any class or classes of members.

(B) The premium for the policy must be paid either from funds of the union or organization, from funds contributed by the insured members specifically for their insurance, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) A policy issued to a trust or to one (1) or more trustees of a fund established or adopted by two (2) or more employers, or by one (1) or more labor unions or similar employee organizations, or by one (1) or more employers and one (1) or more labor unions or similar employee organizations (which trust or trustees must be deemed the policyholder) to insure employees of the employers or members of the unions or

organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(A) The persons eligible for insurance must be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes of employees or members. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(B) The premium for the policy must be paid from funds contributed by the employer or employers of the insured persons, by the union or unions or similar employee organizations, or by both, from funds contributed by the insured persons, or from both the insured persons and one (1) or more employers, unions, or similar employee organizations. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured persons, specifically for their insurance must insure all eligible persons, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(5) A policy issued to an association, a trust, or one (1) or more trustees of a fund established, created, or maintained for the benefit of members of one (1) or more associations. The association or associations must have at the outset a minimum of one hundred (100) persons; must have been organized and maintained in good faith for purposes other than that of obtaining insurance; must have been in active existence for at least two (2) years; and must have a constitution and bylaws that provide that the association or associations hold regular meetings not less than annually to further purposes of the members, that, except for credit unions, the association or associations collect dues or solicit contributions from members,

and that the members have voting privileges and representation on the governing board and committees. The policy must be subject to the following requirements:

(A) The policy may insure members or employees of the association or associations, employees of members, one (1) or more of the preceding, or all of any class or classes of members, employees, or employees of members for the benefit of persons other than the employee's employer.

(B) The premium for the policy must be paid from funds contributed by the association or associations, by employer members, or by both, from funds contributed by the covered persons, or from both the covered persons and the association, associations, or employer members.

(C) Except as provided in clause (D), a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons, except those who reject such coverage in writing.

(D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(6) A policy issued to a credit union or to one (1) or more trustees or an agent designated by two (2) or more credit unions (which credit union, trustee, trustees, or agent must be deemed the policyholder) to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee, trustees, or agent, or any of their officials, subject to the following requirements:

(A) The members eligible for insurance must be all of the members of the credit union or credit unions, or all of any class or classes of members.

(B) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in clause (C), must insure all eligible members.

(C) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

As added by P.L.254-1985, SEC.1. Amended by P.L.19-1986, SEC.46; P.L.8-1993, SEC.413.

IC 27-1-12-38

Group life insurance; requirements for issuance of policy to certain groups

Sec. 38. (a) Group life insurance offered to a resident of Indiana under a group life insurance policy issued to a group other than one described in section 37(1)(A), (2)(A), (3)(A), (4)(A), (5)(A), or (6)(A) of this chapter is subject to the requirements set forth in subsections (b) through (e).

(b) A group life insurance policy described in subsection (a) may not be delivered in Indiana unless the commissioner finds that:

(1) the issuance of the policy is not contrary to the best interest of the public;

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

(3) the benefits of the policy are reasonable in relation to the premiums charged.

(c) Group life insurance coverage may not be offered in Indiana by an insurer under a policy that was issued in another state unless Indiana or another state having requirements substantially similar to those contained in subsection (b) has made a determination that the policy meets those requirements.

(d) The premium for a policy described in subsection (a) must be paid either from the policyholder's funds, from funds contributed by the covered persons, or from both sources of funds.

(e) An insurer may exclude or limit the coverage under a policy described in subsection (a) on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

As added by P.L.254-1985, SEC.2. Amended by P.L.268-1987, SEC.1.

IC 27-1-12-39

Direct response solicitations; notice of payment of compensation

Sec. 39. (a) As used in this section, "direct response solicitation" means a solicitation through a sponsoring or endorsing entity through the mails, telephone, or other mass communications media.

(b) As used in this section, "sponsoring or endorsing entity" means an organization that has arranged for the offering of a program of insurance in a manner that communicates that:

(1) eligibility for participation in the program is dependent upon affiliation with the organization; or

(2) the organization encourages participation in the program.

(c) This section applies to any program of insurance that, if issued on a group basis, would not conform to one (1) of the descriptions in section 37 of this chapter.

(d) If compensation of any kind will or may be paid, under a program of insurance described in subsection (c), to:

(1) a policyholder or sponsoring or endorsing entity in the case of a group policy; or

(2) a sponsoring or endorsing entity in the case of individual, blanket, or franchise policies marketed by means of direct response solicitation;

the insurer shall cause to be distributed to prospective insureds under the program a written notice that compensation will or may be paid under the program as indicated in subdivision (1) or (2).

(e) The notice required under subsection (d) shall be given:

(1) whether the compensation that will or may be paid is direct

or indirect; and

(2) whether the compensation is to be paid to or retained by:

(A) the policyholder or sponsoring or endorsing entity; or

(B) a third party, at the direction of the policyholder or sponsoring or endorsing entity, or any entity affiliated with the sponsoring or endorsing entity by way of ownership, contract, or employment.

(f) The notice required under subsection (d) shall be placed on or accompany any application or enrollment form provided prospective insureds.

As added by P.L.254-1985, SEC.3.

IC 27-1-12-40

Group life insurance; premiums; spouse or dependent child coverage

Sec. 40. Except for a policy that conforms to the description in section 37(2) of this chapter, a group life insurance policy may be extended to insure the employees or members, or any class or classes of employees or members, against loss due to the death of their spouses and dependent children, subject to the following:

(1) The premium for the insurance must be paid either from funds contributed by the employer, union, association, or other person to whom the policy has been issued, from funds contributed by the covered persons, or from both sources of funds. Except as provided in subdivision (2), a policy on which no part of the premium for the spouse's and dependent child's coverage is to be derived from funds contributed by the covered persons must insure all eligible employees or members, or any class or classes of eligible employees or members, with respect to their spouses and dependent children.

(2) An insurer may exclude or limit the coverage on any spouse or dependent child as to whom evidence of individual insurability is not satisfactory to the insurer.

As added by P.L.254-1985, SEC.4. Amended by P.L.111-2008, SEC.2.

IC 27-1-12-41

Group life insurance; required provisions

Sec. 41. (a) A policy of group life insurance may not be delivered in Indiana unless it contains in substance:

(1) the provisions described in subsection (b); or

(2) provisions that, in the opinion of the commissioner, are:

(A) more favorable to the persons insured; or

(B) at least as favorable to the persons insured and more favorable to the policyholder;

than the provisions set forth in subsection (b).

(b) The provisions referred to in subsection (a)(1) are as follows:

(1) A provision that the policyholder is entitled to a grace

period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.

(2) A provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two (2) years after its date of issue, and that no statement made by a person insured under the policy relating to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless:

(A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or

(B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon provisions in the policy that relate to eligibility for coverage.

(3) A provision that a copy of the application, if any, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured person or, in the event of death or incapacity of the insured person, to the insured person's beneficiary or personal representative.

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

(5) A provision specifying an equitable adjustment of premiums, benefits, or both to be made in the event the age of a person insured has been misstated. A provision under this subdivision must contain a clear statement of the method of adjustment to be made.

(6) A provision that any sum becoming due by reason of the death of the person insured must be payable to the beneficiary designated by the person insured. However, if a policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms, subject to the provisions of the policy in the event there is no designated beneficiary, as to all or any part of the sum, living at the death

of the person insured, and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of the sum not exceeding two thousand dollars ($2,000) to any person appearing to the insurer to be equitably entitled to that payment by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured.

(7) A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate setting forth a statement that:

(A) explains the insurance protection to which the person insured is entitled;

(B) indicates to whom the insurance benefits are payable;

(C) explains any dependent's coverage included in the certificate; and

(D) sets forth the rights and conditions that apply to the person under subdivisions (8), (9), (10), and (11).

(8) A provision that if the insurance, or any portion of it, on a person covered under the policy, or on the dependent of a person covered, ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy, the person or dependent is entitled, without evidence of insurability, to an individual policy of life insurance issued to the person or dependent by the insurer without disability or other supplementary benefits, provided that an application for the individual policy is made and that the first premium is paid to the insurer within thirty-one (31) days after the termination, and provided further that:

(A) the individual policy must, at the option of the person or dependent, be on any one (1) of the forms then customarily issued by the insurer at the age and for the amount applied for, except that the group policy may exclude the option to elect term insurance;

(B) the individual policy must be in an amount not in excess of the amount of life insurance that ceases because of the termination, less the amount of any life insurance for which the person or dependent becomes eligible under the same policy or any other group policy within thirty-one (31) days after the termination (however, any amount of insurance that has matured on or before the date of the termination as an endowment payable to the person insured, whether in one (1) sum, in installments, or in the form of an annuity, may not, for the purposes of this clause, be included in the amount of insurance that is considered to cease because of the termination); and

(C) the premium on the individual policy must be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which

the person or dependent then belongs, and to the individual age attained by the person or dependent on the effective date of the individual policy.

Subject to the conditions set forth in this subdivision, the conversion privilege created by this subdivision must be available to a surviving dependent of a person covered under a group policy, with respect to the coverage under the group policy that terminates by reason of the death of the person covered, and to the dependent of an employee or member after termination of the coverage of the dependent because the dependent ceases to be a qualified family member under the group policy, while the employee or member remains insured under the group policy.

(9) A provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured under the policy at the date of the termination whose insurance terminates, including the insured dependent of a covered person, and who has been so insured for at least five (5) years before the termination date, is entitled to have issued by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided in subdivision (8), except that the group policy may provide that the amount of the individual policy may not exceed the lesser of:

(A) the amount of the person's life insurance protection that is ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which the person is eligible or becomes eligible under a group policy issued or reinstated by the same insurer or another insurer within thirty-one (31) days after the termination; or

(B) ten thousand dollars ($10,000).

(10) A provision that if a person insured under the group policy, or the insured dependent of a covered person, dies during the period within which the covered person or dependent would have been entitled to have an individual policy issued under subdivision (8) or (9) or before such an individual policy becomes effective, the amount of life insurance that the covered person or dependent would have been entitled to have issued under an individual policy is payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium for the individual policy has been made.

(11) If active employment is a condition of insurance, a provision that an insured may continue coverage during the insured's total disability by timely payment to the policyholder of that portion, if any, of the premium that would have been required for the insured had total disability not occurred. The continuation of coverage under this subdivision on a premium

paying basis must extend for a period of six (6) months from the date on which the total disability started, but not beyond the earlier of:

(A) the date of approval by the insurer of continuation of the coverage under any disability provision that the group insurance policy may contain; or

(B) the date of discontinuance of the group insurance policy.

(12) In the case of a policy insuring the lives of debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the death benefit will first be applied to reduce or extinguish the indebtedness.

(c) Subsections (b)(6) through (b)(11) do not apply to policies insuring the lives of debtors. The standard provisions required under IC 27-1-12 for individual life insurance policies do not apply to group life insurance policies.

(d) If a group life insurance policy is on a plan of insurance other than the group plan, it must contain a nonforfeiture provision that, in the opinion of the commissioner, is equitable to the insured persons and to the policyholder. However, group life insurance policies need not contain the same nonforfeiture provisions as are required for individual life insurance policies under IC 27-1-12.

As added by P.L.254-1985, SEC.5.

IC 27-1-12-42

Group life insurance; conversion rights; notice; time to exercise rights

Sec. 42. (a) If a person who:

(1) is insured under a group life insurance policy delivered in Indiana; and

(2) is entitled under the terms of the group policy to have an individual policy of life insurance issued without evidence of insurability upon the making of application and payment of the first premium within the period specified in the policy;

is not given notice of the existence of the conversion right referred to in subdivision (2) at least fifteen (15) days before the expiration of the period during which the application and payment of the first premium must be made under the terms of the policy, the person has an additional period within which to exercise the conversion right.

(b) The additional period created under subsection (a) for exercise of a right of conversion expires fifteen (15) days after the person is given notice of the conversion right. However, irrespective of the date on which notice is given or of the absence of any notice, the additional period may not extend beyond sixty (60) days after the expiration date of the period within which application and payment of the first premium were to be made under the terms of the policy.

(c) For purposes of this section, notice of the right of conversion

may be given to the person in a writing:

(1) presented to the person;

(2) mailed by the policyholder to the last known address of the person; or

(3) mailed by the insurer to the last known address of the person as furnished by the policyholder.

As added by P.L.254-1985, SEC.6.

IC 27-1-12-43

Life insurance provision allowing for right to return policy

Sec. 43. (a) As used in this section, "life insurance policy" means:

(1) an individual life insurance policy other than a credit life insurance policy; or

(2) an individual policy of variable life insurance;

that is sold after June 30, 1994.

(b) No life insurance policy may be issued in Indiana or issued for delivery in Indiana unless it contains a provision allowing the policyholder to return the policy to:

(1) the insurer;

(2) the insurance producer through whom the policy was purchased; or

(3) any agent of the insurer;

within ten (10) days after the policy is received by the policyholder for a full refund of all money paid by the policyholder.

(c) Each life insurance policy must have prominently printed on its first page a notice setting forth in substance the provisions of subsection (b).

As added by P.L.116-1994, SEC.25. Amended by P.L.178-2003, SEC.16.

IC 27-1-12-44

Stranger originated life insurance allegation; lack of insurable interest

Sec. 44. (a) This section applies to a life insurance policy that is issued after June 30, 2008.

(b) Notwithstanding any other law, an insurer shall not, after a life insurance policy has been in force for two (2) years after the life insurance policy's date of issue, allege that the life insurance policy was issued in connection with stranger originated life insurance (as defined in IC 27-8-19.8-7.8) as a basis to deny payment of the proceeds of the life insurance policy. However, an insurer may seek to void a life insurance policy at any time for lack of insurable interest at the time the life insurance policy was issued.

As added by P.L.112-2008, SEC.1.

IC 27-1-12-45

Execution of POST form does not affect life insurance; prohibition on consideration of POST form in determining life insurance

premiums

Sec. 45. (a) The execution of a POST form under IC 16-36-6 does not affect the sale, issuance, or terms of a policy of life insurance.

(b) A policy of life insurance is not legally impaired or invalidated by the execution of a POST form, including the withholding or withdrawal of life prolonging procedures from an insured under the medical orders included in the POST form.

(c) A POST form may not be considered in the establishment of insurance premiums for an individual.

(d) A person may not require an individual to complete a POST form as a condition for being insured for health care services.

As added by P.L.164-2013, SEC.9.

IC 27-1-12-46

Policy or certificate designated for purchase of funeral services or merchandise; representations by issuer; required disclosures; violations

Sec. 46. (a) This section applies to a life insurance policy or certificate:

(1) that is issued after June 30, 2015;

(2) the proceeds of which may be designated for use in the purchase of funeral services or merchandise upon the death of the insured; and

(3) the ownership of which is not irrevocably assigned to a trustee and used to fund a contract under IC 30-2-13.

(b) An issuer of a life insurance policy or certificate described in subsection (a) may not represent to a policyholder or certificate holder, a prospective policyholder or certificate holder, an insured, a beneficiary, or any other person that the life insurance policy or certificate is:

(1) a contract for prepaid services or merchandise under IC 30-2-13; or

(2) a funeral policy or a policy with any similar designation.

(c) A life insurance policy or certificate described in subsection (a) may not be delivered or issued for delivery in Indiana, or issued by a company organized under the laws of this state, unless the life insurance policy or certificate either contains or includes in an attached disclaimer the following provisions, or corresponding provisions that the department determines are at least as favorable to policyholders or certificate holders:

(1) A statement that the life insurance policy or certificate is not a contract for prepaid services or merchandise under IC 30-2-13.

(2) A statement that the life insurance policy or certificate does not entitle the policyholder, the certificate holder, or any other person to:

(A) prepaid funeral services or merchandise, or any services or merchandise described in IC 30-2-13-8; or

(B) the right to file a complaint with the state board of funeral and cemetery service established by IC 25-15-9-1 for restitution from the preneed consumer protection fund under IC 30-2-13-29;

unless ownership of the policy is irrevocably assigned to a trustee to fund a contract entered into with a seller (as defined under IC 30-2-13-10) under IC 30-2-13.

(3) A statement that:

(A) the life insurance policy or certificate:

(i) is not guaranteed to be exempt as a resource in determining eligibility for Medicaid under IC 12-15-2-17; and

(ii) does not guarantee Medicaid eligibility; and

(B) Medicaid eligibility determinations are made in accordance with applicable Medicaid laws and policies.

(d) A person that willfully violates this section commits an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4 and is subject to the penalties and procedures set forth in IC 27-4-1.

As added by P.L.227-2015, SEC.5.

IC 27-1-12.1

Chapter 12.1. Limited Purpose Subsidiary Life Insurance Companies

IC 27-1-12.1-1

Affiliate

Sec. 1. As used in this chapter, "affiliate" means a domestic life insurance company that is a wholly owned subsidiary of the parent of a limited purpose subsidiary.

As added by P.L.11-2011, SEC.7.

IC 27-1-12.1-2

Limited purpose subsidiary

Sec. 2. As used in this chapter, "limited purpose subsidiary" means a subsidiary life insurance company that is organized under this chapter.

As added by P.L.11-2011, SEC.7.

IC 27-1-12.1-3

Organizing domestic life insurance company

Sec. 3. As used in this chapter, "organizing domestic life insurance company" refers to a life insurance company that organizes a limited purpose subsidiary under this chapter.

As added by P.L.11-2011, SEC.7.

IC 27-1-12.1-4

Parent

Sec. 4. As used in this chapter, "parent" means a person that through at least one (1) intermediary wholly owns a limited purpose subsidiary.

As added by P.L.11-2011, SEC.7. Amended by P.L.115-2011, SEC.1.

IC 27-1-12.1-5

Risk

Sec. 5. As used in this chapter, "risk" means a risk:

(1) that is associated with a life insurance policy that is:

(A) written by a ceding domestic life insurance company; or

(B) assumed by a ceding domestic life insurance company from an affiliate; and

(2) for which a ceding domestic life insurance company holds direct statutory reserves for the policy as required under IC 27-1-12-10.5.

As added by P.L.11-2011, SEC.7.

IC 27-1-12.1-6

Organization of limited purpose subsidiary

Sec. 6. A domestic life insurance company that is authorized to engage in the business of insurance in Indiana may organize a limited

purpose subsidiary under this chapter.
As added by P.L.11-2011, SEC.7.

IC 27-1-12.1-7
Requirements for assumption of risk

Sec. 7. Before assuming risk under a reinsurance contract, a limited purpose subsidiary must do all of the following:

(1) Comply with IC 27-1-6.

(2) File with the commissioner an affidavit, signed by the limited purpose subsidiary's president, vice president, treasurer, or chief financial officer, including all of the following to the best of the individual's knowledge after reasonable inquiry:

(A) That the proposed organization and operation of the limited purpose subsidiary complies with this chapter.

(B) That the limited purpose subsidiary's investment policy reflects and considers the liquidity of assets and the reasonable preservation, administration, and management of the assets with respect to the risks associated with reinsurance contracts issued by the limited purpose subsidiary.

(C) That the reinsurance contract and any arrangement intended to secure the limited purpose subsidiary's obligations under the reinsurance contract (including an agreement to implement the arrangement) comply with this chapter.

(3) File with the commissioner the opinion of a qualified actuary that the methodology and assumptions (including significant stress tests of key assumptions) used to establish reserves held by the limited purpose subsidiary are sufficient to provide for the risk assumed by the limited purpose subsidiary.

(4) File with the commissioner the limited purpose subsidiary's plan of operation, including the following:

(A) A statement that the limited purpose subsidiary will, before an offer and sale of securities of or by the limited purpose subsidiary, file with the commissioner, in a form acceptable to the commissioner, a legal opinion that the offering and sale of securities:

(i) of the limited purpose subsidiary complies with all federal securities laws; and

(ii) by the limited purpose subsidiary complies with all Indiana securities laws.

For purposes of this clause, the issuance of stock by the limited purpose subsidiary to the organizing domestic life insurance company is not the offer and sale of securities requiring a legal opinion.

(B) A complete description of the material terms of all proposed reinsurance transactions, reinsurance security arrangements, securitizations, and any other material

transactions or arrangements of the limited purpose subsidiary.

(C) A description of the source and form of the limited purpose subsidiary's capital and surplus.

(D) The investment policy of the limited purpose subsidiary.

(E) Pro forma balance sheets and income statements that illustrate at least one (1) adverse case scenario, as determined using criteria required by the commissioner, for the performance of the limited purpose subsidiary under all reinsurance contracts.

(F) Policies for payment of dividends and other distributions to the organizing domestic life insurance company.

(G) Copies of all contracts between the limited purpose subsidiary and affiliates.

(H) Other documentation or information required by the commissioner.

(5) Obtain from the commissioner a certificate of authority to engage in the business of reinsurance in Indiana.

As added by P.L.11-2011, SEC.7. Amended by P.L.115-2011, SEC.2.

IC 27-1-12.1-8

Certificate of authority; conditions; production and disclosures to commissioner

Sec. 8. (a) The commissioner may issue a certificate of authority to a limited purpose subsidiary upon a finding by the commissioner of all of the following:

(1) That the proposed plan of operation provides for a viable operation of the limited purpose subsidiary.

(2) That the terms of all proposed reinsurance contracts and related transactions of the limited purpose subsidiary comply with this chapter and any other applicable insurance laws.

(3) That the proposed plan of operation is not hazardous to any ceding insurer.

(b) The commissioner may, in conjunction with the issuance of a certificate of authority to a limited purpose subsidiary, issue an order containing any terms or conditions applying to the limited purpose subsidiary's authority to engage in the business of reinsurance, including terms or conditions concerning the organization, licensing, or operation of the limited purpose subsidiary, consistent with this chapter and determined necessary by the commissioner.

(c) A limited purpose subsidiary shall produce or disclose its plan of operation, amendments, and records, books, documents, reports, and other information that the commissioner requires the limited purpose subsidiary to produce or disclose under:

(1) this chapter;

(2) rules adopted under section 15 of this chapter; or

(3) an order under IC 27-1-3.1.

(d) The commissioner has the powers enumerated in IC 27-1-3.1

with respect to a limited purpose subsidiary.
As added by P.L.11-2011, SEC.7.

IC 27-1-12.1-9
Authority of limited purpose subsidiary

Sec. 9. A limited purpose subsidiary that is granted a certificate of authority by the commissioner under this chapter:

(1) is authorized to engage in the business of reinsurance for purposes of IC 27-6-10 only for the lines of insurance for which the:

(A) organizing domestic life insurance company; and

(B) affiliates of the organizing domestic life insurance company;

are authorized;

(2) may reinsure only risks of:

(A) the organizing domestic life insurance company; and

(B) affiliates of the organizing domestic life insurance company; and

(3) may access alternative forms of financing.

As added by P.L.11-2011, SEC.7. Amended by P.L.115-2011, SEC.3.

IC 27-1-12.1-10
Investment of organizing domestic life insurance company

Sec. 10. An organizing domestic life insurance company may invest funds from the organizing domestic life insurance company's surplus in a limited purpose subsidiary that is organized by the organizing domestic life insurance company.
As added by P.L.11-2011, SEC.7.

IC 27-1-12.1-11
Officers and directors

Sec. 11. The officers and directors of an organizing domestic life insurance company may serve as officers and directors of a limited purpose subsidiary organized by the organizing domestic life insurance company.
As added by P.L.11-2011, SEC.7.

IC 27-1-12.1-12
Purchase of reinsurance

Sec. 12. A limited purpose subsidiary may, upon approval of the commissioner, purchase reinsurance to cede the reinsurance risks assumed by the limited purpose subsidiary.
As added by P.L.11-2011, SEC.7.

IC 27-1-12.1-13
Admitted assets

Sec. 13. (a) If approved by the commissioner, the following are considered to be and must be reported as admitted assets of a limited

purpose subsidiary:

(1) Proceeds from a securitization, premiums, and other amounts payable by an affiliate to the limited purpose subsidiary.

(2) Letters of credit.

(3) Guarantees of the parent.

(4) Other assets.

(b) If the commissioner determines that the value of admitted assets that:

(1) were previously approved by the commissioner under subsection (a); and

(2) are not assets that are addressed by the Accounting Practices and Procedures Manual of the National Association of Insurance Commissioners;

has decreased, the commissioner may require the limited purpose subsidiary to provide additional security or collateral.

(c) The commissioner shall, at least thirty (30) days before taking action under subsection (b):

(1) notify the limited purpose subsidiary of the action; and

(2) provide to the limited purpose subsidiary an opportunity to remedy the issues identified by the commissioner.

As added by P.L.11-2011, SEC.7. Amended by P.L.115-2011, SEC.4.

IC 27-1-12.1-14

Duties of limited purpose subsidiary

Sec. 14. (a) A limited purpose subsidiary shall do the following:

(1) Provide to the commissioner, not later than forty-five (45) days after the closing date of the transactions of an insurance securitization, a copy of a complete set of executed documentation of the insurance securitization.

(2) Notify the commissioner, not later than two (2) business days after any material change in the financial condition or management of the limited purpose subsidiary, written notice of the material change.

(3) Annually file with the commissioner the actuarial opinion of the limited purpose subsidiary's internal actuary concerning reserves held by the limited purpose subsidiary for all risks assumed by the limited purpose subsidiary under the limited purpose subsidiary's reinsurance contracts.

(4) Biennially file with the commissioner the actuarial opinion of a qualified actuary concerning the methodology and assumptions used by the limited purpose subsidiary in establishing the reserves held by the limited purpose subsidiary.

(5) Immediately notify the commissioner concerning any action by a ceding insurer or other person to foreclose on or otherwise take possession of collateral provided by the limited purpose subsidiary to secure an obligation of the limited purpose subsidiary.

(6) Comply with IC 27-1-23 and IC 27-1-36.

(b) Unless otherwise required by the commissioner, a limited purpose subsidiary is not required to file a report, notice, or other document with the National Association of Insurance Commissioners.

As added by P.L.11-2011, SEC.7. Amended by P.L.115-2011, SEC.5.

IC 27-1-12.1-15

Administrative rules; emergency rulemaking

Sec. 15. (a) The commissioner may adopt rules under IC 4-22-2 to implement this chapter.

(b) The rules adopted under subsection (a) may specify the following concerning limited purpose subsidiaries:

(1) Requirements for reserves, including actuarial certification.

(2) Requirements for securities.

(3) Authorized investments.

(4) Requirements with respect to reinsurance ceded or assumed by the limited purpose subsidiary.

(5) Requirements for dividends and distributions.

(6) Requirements for operations.

(7) Conditions of, forms for, and approval of the financing of a limited purpose subsidiary.

(c) The commissioner may adopt emergency rules under IC 4-22-2-37.1 to implement this section if the commissioner determines that:

(1) the need for a rule is so immediate and substantial that rulemaking procedures under IC 4-22-2-23 through IC 4-22-2-36 are inadequate to address the need; and

(2) an emergency rule is likely to address the need.

As added by P.L.11-2011, SEC.7. Amended by P.L.115-2011, SEC.6.

IC 27-1-12.3

Chapter 12.3. Interest Rates on Insurance Policy Loans

IC 27-1-12.3-1

Definitions

Sec. 1. As used in this chapter:

(a) "Published monthly average" means:

(1) Moody's corporate bond yield average-monthly average corporates as published by Moody's Investors Service, Inc. or any successor thereto; or

(2) in the event that the Moody's corporate bond yield average-monthly average corporates is no longer published, a substantially similar average, established by regulation issued by the insurance commissioner.

(b) "Insurer" means an entity issuing a policy.

(c) "Policy loan" means:

(1) a loan secured by a policy of life insurance under IC 27-1-12-6(8) and IC 27-1-12-19;

(2) any premium loan made under a policy to pay one (1) or more premiums that were not paid to the life insurer as they became due; or

(3) a loan secured by any certificate or annuity contract that provides loans on the security of the certificate or annuity contract.

(d) "Policyholder" includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer.

(e) "Policy" means:

(1) a life insurance policy;

(2) a certificate issued by a fraternal benefit society; or

(3) an annuity contract;

that provides for policy loans.

(f) "Rate of interest" or "interest rate" means the rate of interest on policy loans, including the rate of interest charged on reinstatement of policy loans for the period during and after any lapse.

As added by Acts 1981, P.L.240, SEC.1.

IC 27-1-12.3-2

Required provisions in policies

Sec. 2. Policies issued after August 31, 1983, must contain a provision for policy loan interest rates permitting:

(1) a maximum interest rate of not more than eight percent (8%) per year; or

(2) an adjustable interest rate established from time to time as follows:

(A) The maximum rate of interest shall be the greater of the rate determined by the published monthly average for the

calendar month ending two (2) months before the date on which the interest rate is determined or the rate used to compute the cash surrender values under the policy during the applicable loan period as required in IC 27-1-12-7(5), plus one percent (1%) per year.

(B) The maximum interest rate for each policy shall be determined at regular intervals at least once every twelve (12) months, but not more frequently than once every three (3) months. The interval must be specified in the policy.

(C) As of the time of the periodic maximum interest determination, the interest rate on the policy loan will be fixed, not below the minimum rate, as follows:

(i) If the maximum rate is greater than the last previous establishment or change of the interest rate, the interest rate may at the option of the insurer be increased to any rate not in excess of the maximum rate.

(ii) If the maximum rate is less than the last previous establishment or change of the interest rate, the interest rate will be decreased to the new maximum rate.

(iii) Notwithstanding subparts (i) and (ii) of this clause (C), no change in interest rate which is less than one-half percent (1/2%) will be made.

(D) The most recently determined interest rate on a loan made on any policy will apply to the unpaid amount of all policy loans previously made thereon.

As added by Acts 1981, P.L.240, SEC.1. Amended by P.L.260-1983, SEC.6.

IC 27-1-12.3-3
Variable interest rate loans; duties of insurer

Sec. 3. With respect to variable interest rate loans under section 2 of this chapter, the insurer shall:

(1) notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan;

(2) notify the policyholder as soon as is reasonably practical after a premium loan is made of the initial rate of interest on the loan, except that notice need not be given the policyholder when a further premium loan is added other than the notice required by subdivision (3) of this section;

(3) send to the policyholder reasonable advance notice of any increase in the loan interest rate; and

(4) include in the notices required by this section, whether the rate is fixed or variable and, if variable, the permitted frequency of change.

As added by Acts 1981, P.L.240, SEC.1.

IC 27-1-12.3-4
Loan value of policy; determination; termination of policy due to

increase in interest rate

Sec. 4. (a) The loan value of a policy shall be determined in accordance with IC 27-1-12-6(8); however, a policy shall not terminate in a policy year as the sole result of an increase in the interest rate and the failure of the policyholder to pay the amount of interest required by that increase during that policy year. In such event, the insurer shall maintain coverage during that policy year until the time at which the policy would otherwise have terminated if there had been no change during that policy year.

As added by Acts 1981, P.L.240, SEC.1.

IC 27-1-12.3-5

Nonapplicability of other laws

Sec. 5. No statute other than this chapter applies to policy loan interest rates, except to the extent that a statute enacted after the 1981 regular session of the Indiana general assembly specifically provides otherwise.

As added by Acts 1981, P.L.240, SEC.1.

IC 27-1-12.3-6

Inapplicability to contracts issued before September 1, 1981; agreement excepted

Sec. 6. The provisions of this chapter shall not apply to any insurance contract issued before September 1, 1981, unless the policyholder agrees in writing to the applicability of such provisions.

As added by Acts 1981, P.L.240, SEC.1.

IC 27-1-12.4

Chapter 12.4. Charitable Gift Annuities

IC 27-1-12.4-1

"Internal Revenue Code" defined

Sec. 1. As used in this chapter, "Internal Revenue Code" means the Internal Revenue Code of 1986, as amended and in effect on January 1, 1994.

As added by P.L.131-1994, SEC.1.

IC 27-1-12.4-2

Annuities exempt from regulation

Sec. 2. An annuity is not subject to regulation by the department under IC 27 if the annuity:

(1) is established under a transaction that, for federal income tax purposes, is treated:

(A) in part as a charitable contribution under Section 170 of the Internal Revenue Code; and

(B) in part as an investment in an annuity contract under Section 72 of the Internal Revenue Code; and

(2) meets the requirements for exclusion from the definition of "acquisition indebtedness" under Section 514(c)(5) of the Internal Revenue Code.

As added by P.L.131-1994, SEC.1.

IC 27-1-12.5

Chapter 12.5. Nonforfeiture Provisions of Annuity Contracts

IC 27-1-12.5-0.1

Application of certain amendments to chapter

Sec. 0.1. The amendments made to sections 2 and 3 of this chapter by P.L.59-2004 apply to an annuity contract issued after June 30, 2004.

As added by P.L.220-2011, SEC.422.

IC 27-1-12.5-1

"Annuity contract" defined

Sec. 1. The term "annuity contract" as used in this chapter means:

(1) any individual deferred annuity contract; and

(2) any group annuity contract delivered or issued in connection with a plan providing individual retirement accounts or individual annuities under Section 408 of the Internal Revenue Code;

but does not refer to any other group annuity or to any reinsurance, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, and any annuity contract delivered outside this state through an agent or other representative of the company issuing the contract.

As added by Acts 1977, P.L.286, SEC.1. Amended by P.L.2-1987, SEC.36.

IC 27-1-12.5-2

Provisions of contract

Sec. 2. (a) No annuity contract shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions, which in the opinion of the insurance commissioner are at least as favorable to the contract holder, upon cessation of payment of considerations under the contract:

(1) Upon:

(A) cessation of payment of considerations under an annuity contract; or

(B) the written request of the contract holder;

the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in sections 4, 5, 6, 7, and 9 of this chapter.

(2) If an annuity contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in sections 4, 5, 7, and 9 of this chapter. The company may

reserve the right to defer the payment of such cash surrender benefit for a period of not more than six (6) months after demand therefor with surrender of the contract but only after:

(A) submitting to the commissioner a written request that addresses the:

(i) necessity of the deferral; and

(ii) equitability of the deferral for all the company's contract holders; and

(B) receiving the commissioner's written approval to defer.

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits.

(4) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the annuity contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

(b) Notwithstanding the requirements of this chapter, any annuity contract may provide that if no considerations have been received under a contract for a period of two (2) full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to such period would be less than twenty dollars ($20.00) monthly, the company may at its option terminate such contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment shall be relieved of any further obligation under such contract.

As added by Acts 1977, P.L.286, SEC.1. Amended by P.L.59-2004, SEC.1.

IC 27-1-12.5-3

Minimum nonforfeiture amounts

Sec. 3. (a) The minimum values as specified in sections 4, 5, 6, 7, and 9 of this chapter of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

(b) With respect to any annuity contract, the minimum nonforfeiture amounts at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at an annual rate of interest determined under subsections (d)

and (e) of the net considerations as set forth in subsection (c) paid prior to such time, decreased by the sum of the following:

(1) Any prior withdrawals from or partial surrenders of the annuity contract accumulated at an annual rate of interest determined under subsections (d) and (e).

(2) The amount of any indebtedness to the company on the annuity contract, including interest due and accrued.

(3) An annual contract charge of fifty dollars ($50), accumulated at the annual rate of interest determined under subsections (d) and (e).

(c) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent (87.5%) of the gross considerations credited to the annuity contract during that contract year.

(d) Except as provided in subsection (e), the interest rate used in determining minimum nonforfeiture amounts is an annual rate of interest determined under either of the following methods:

(1) The five-year constant maturity treasury rate, rounded to the nearest five-hundredths of one percent (0.05%), as reported by the Federal Reserve as of a date specified in the annuity contract. Reduce this amount by one hundred twenty-five (125) basis points.

(2) An average of the five-year constant maturity treasury rate as reported by the Federal Reserve, rounded to the nearest five-hundredths of one percent (0.05%), over a specified period as set forth in the annuity contract. Reduce this amount by one hundred twenty-five (125) basis points.

The date under subdivision (1) or the average period used under subdivision (2) may not be longer than fifteen (15) months before the annuity contract issue date or the redetermination date as determined under subsection (f).

(e) If the rate of interest determined under subsection (d) is:

(1) less than one percent (1%), the interest rate used in determining minimum nonforfeiture amounts is one percent (1%); or

(2) greater than three percent (3%), the interest rate used in determining minimum nonforfeiture amounts is three percent (3%).

(f) The interest rate determined under subsections (d) and (e) applies for an initial period and may be redetermined for subsequent periods. The redetermination date, basis, and period, if any, must be specified in the annuity contract. The basis is:

(1) the date; or

(2) an average calculated over a specified period;

that produces the value of the five-year constant maturity treasury rate reported by the Federal Reserve to be used at each redetermination date.

(g) During the period or term that an annuity contract provides substantive participation in an equity index benefit, the contract may increase the basis point reduction described in subsection (d) by not more than an additional one hundred (100) basis points to reflect the value of the equity index benefit. The present value at the annuity contract issue date, and at each redetermination date after the annuity contract issue date, of the additional reduction may not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. If the demonstration is not acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.

(h) The commissioner may adopt rules under IC 4-22-2 to provide for further adjustments to the calculation of minimum nonforfeiture amounts for:

(1) annuity contracts that provide participation in an equity index benefit; and

(2) other annuity contracts for which the commissioner determines adjustments are justified.

As added by Acts 1977, P.L.286, SEC.1. Amended by P.L.130-2002, SEC.1; P.L.59-2004, SEC.2.

IC 27-1-12.5-4
Paid-up benefits

Sec. 4. Any paid-up annuity benefit available under any annuity contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

As added by Acts 1977, P.L.286, SEC.1.

IC 27-1-12.5-5
Cash surrender benefits

Sec. 5. If an annuity contract provides cash surrender benefits, the amount of these benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing

additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such an annuity contract shall be at least equal to the cash surrender benefit.
As added by Acts 1977, P.L.286, SEC.1.

IC 27-1-12.5-6
Paid-up annuity benefit available as nonforfeiture option where no cash surrender benefits

Sec. 6. If an annuity contract does not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, and increased by any existing additional amounts credited by the company to the contract. The present values for an annuity contract, not providing any death benefits prior to the commencement of any annuity payments, shall be calculated on the basis of the interest rate and mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.
As added by Acts 1977, P.L.286, SEC.1.

IC 27-1-12.5-7
Maturity date determination

Sec. 7. For the purpose of determining the benefits calculated under sections 5 and 6, in the case of an annuity contract under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.
As added by Acts 1977, P.L.286, SEC.1.

IC 27-1-12.5-8
Statement of benefits not provided

Sec. 8. Any annuity contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

As added by Acts 1977, P.L.286, SEC.1.

IC 27-1-12.5-9
Allowance for lapse of time and payment of scheduled considerations

Sec. 9. Under any annuity contract with fixed scheduled considerations, any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.
As added by Acts 1977, P.L.286, SEC.1.

IC 27-1-12.5-10
Life insurance; additional benefits

Sec. 10. If any annuity contract provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of sections 4, 5, 6, 7, and 9, additional benefits payable (i) in the event of total and permanent disability, (ii) as reversionary annuity or deferred reversionary annuity benefits, or (iii) as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this chapter. The inclusion of such additional benefits shall not be required in any paid-up benefits unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.
As added by Acts 1977, P.L.286, SEC.1.

IC 27-1-12.5-11
Rules

Sec. 11. The commissioner may adopt rules under IC 4-22-2 to implement this chapter.
As added by P.L.59-2004, SEC.3.

IC 27-1-12.6
Chapter 12.6. General Provisions of Annuity Contracts

IC 27-1-12.6-1
Application of law

Sec. 1. Each annuity contract, as defined in IC 27-1-12.5, whether in a separate instrument, or in a separate provision in or as a rider to a life insurance policy, shall be subject to the limitations and disclosures set out in this chapter.

As added by Acts 1977, P.L.286, SEC.2.

IC 27-1-12.6-2
Calculation of paid-up nonforfeiture benefits

Sec. 2. Each annuity contract shall contain a brief and general statement of the method to be used in calculating the paid-up nonforfeiture benefits available under the contract.

As added by Acts 1977, P.L.286, SEC.2.

IC 27-1-12.6-3
Cash surrender value table

Sec. 3. Each annuity contract providing for single or fixed scheduled considerations shall contain a table showing the cash surrender value, if any, available under the contract on each contract anniversary date, during the first twenty (20) contract years or during the term of the contract, whichever is shorter. Such table shall be calculated upon the assumptions that there are no additional amounts credited by the company to the contract, that there is no indebtedness to the company on account of or secured by the contract and that there are no prior withdrawals from or partial surrender of the contract.

As added by Acts 1977, P.L.286, SEC.2.

IC 27-1-12.6-4
Automatic payments

Sec. 4. An annuity contract shall not contain a provision wherein life insurance premium or annuity consideration payments may be automatically made by the company by withdrawing from or placing a loan against annuity nonforfeiture values provided under the contract.

As added by Acts 1977, P.L.286, SEC.2.

IC 27-1-12.6-5
Right to return contracts

Sec. 5. Each annuity contract shall contain a provision giving the purchaser an unrestricted right to return the contract to the company or to the insurance producer through whom it was purchased, on or before the tenth day after it is received by the purchaser, such return entitling the purchaser to a return of the value of a variable annuity

account or the monies paid by the purchaser to a fixed account in connection with the issuance of the contract. This provision shall be conspicuously placed on the face of the contract. This provision does not apply to contracts issued in connection with a pension, annuity, or profit-sharing plan qualified or exempt under Sections 401, 403, 404, or 501 of the Internal Revenue Code, if participation in the plan is a condition of employment.
As added by Acts 1977, P.L.286, SEC.2. Amended by P.L.2-1987, SEC.37; P.L.116-1994, SEC.26; P.L.178-2003, SEC.17.

IC 27-1-12.6-6
Disclosures

Sec. 6. If an annuity contract does not provide a cash surrender benefit or a death benefit prior to the commencement of any annuity payments at least equal to the minimum nonforfeiture amounts provided in IC 27-1-12.5, the company shall, in addition to the disclosures provided in IC 27-1-12.5-8, make such disclosures as the commissioner by regulation shall provide, including, but not limited to, the following:

(1) The execution by the purchaser of a statement in such form as the commissioner may approve, stating specifically the following, as appropriate:
(i) the only nonforfeiture value provided by the contract is a paid-up benefit;
(ii) the contract provides no cash surrender value;
(iii) the contract provides no benefit should the purchaser die before maturity.
(2) The form shall be made a part of the application or may be executed separately from and attached to the application. It shall be executed at or prior to the time of executing the application and shall be filed with the application in the company's office.

As added by Acts 1977, P.L.286, SEC.2.

IC 27-1-12.6-7
Rules and regulations

Sec. 7. The commissioner is authorized to promulgate rules and regulations to provide disclosure of (1) the pertinent facts concerning annuity contracts to purchasers of these contracts in advertising and sales literature, (2) practices connected with their issuance, and (3) their annual nonforfeiture and related values.
As added by Acts 1977, P.L.286, SEC.2.

IC 27-1-12.6-8
Form of contracts

Sec. 8. An annuity contract shall not be issued or delivered in this state until the form has been filed with the department, and not thereafter if the department within thirty (30) days after this filing

gives a written notice to the company setting out the reasons why the form of the contract does not comply with the laws of this state.
As added by Acts 1977, P.L.286, SEC.2.

IC 27-1-12.6-9
Disapproval of benefits

Sec. 9. The commissioner may disapprove any individual annuity contract or contracts issued for delivery in Indiana which do not provide a cash surrender value in accordance with IC 27-1-12.5 upon cessation of the payment of considerations under the contract, if in his opinion the annuity would otherwise be misleading, deceptive or unfair to the purchaser. This provision does not, however, apply (i) to such contract delivered in connection with a pension, profit-sharing or employee benefit plan funded in whole or in part by employer contributions, (ii) to annuities purchased in connection with the termination or winding up of a pension, profit-sharing, or employee benefit plan, or (iii) to an individual annuity contract issued by a company organized and operated without profit to any private shareholder or individual, exclusively for the purpose of aiding nonproprietary education and scientific institutions, and providing a nationwide pension system featuring full funding and full and immediate vesting of benefits.
As added by Acts 1977, P.L.286, SEC.2.

IC 27-1-12.7

Chapter 12.7. Funding Agreements

IC 27-1-12.7-1

"Funding agreement"

Sec. 1. As used in this chapter, "funding agreement" means an agreement that:

(1) is issued by a life insurance company to a holder;

(2) authorizes a life insurance company to accept funds; and

(3) provides for an accumulation of the funds for the purpose of making one (1) or more payments at future dates in amounts that are not based on mortality or morbidity contingencies of the holder of the funding agreement.

As added by P.L.178-2003, SEC.18.

IC 27-1-12.7-2

"Holder"

Sec. 2. As used in this chapter, "holder" means a person described in section 5 of this chapter that is issued a funding agreement by a life insurance company.

As added by P.L.178-2003, SEC.18.

IC 27-1-12.7-3

"Life insurance company"

Sec. 3. As used in this chapter, "life insurance company" means a life insurance company authorized to issue a product described in Class 1(c) of IC 27-1-5-1.

As added by P.L.178-2003, SEC.18.

IC 27-1-12.7-4

"Optional modes of settlement"

Sec. 4. As used in this chapter, "optional modes of settlement" means the manner in which the funding agreement is structured to repay interest and principal to the holder.

As added by P.L.178-2003, SEC.18.

IC 27-1-12.7-5

Issuance or issuance for delivery of funding agreements

Sec. 5. A life insurance company may issue or issue for delivery in Indiana a funding agreement to the following:

(1) A person authorized by a state or foreign country to engage in an insurance business or a subsidiary of an insurance business.

(2) A person who uses the funding agreement for the purpose of funding:

(A) benefits under an employee benefit plan (as defined in the federal Employee Retirement Security Act of 1974, 29 U.S.C. 1001 et seq.);

(B) the activities of a nonprofit organization exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code or a similar nonprofit organization domiciled in a foreign country;

(C) a program of:

(i) the United States government;

(ii) a state government;

(iii) a political subdivision;

(iv) a foreign country; or

(v) an agency or instrumentality of the United States or a state government, a political subdivision, or a foreign country;

(D) an agreement providing for periodic payments in satisfaction of a claim;

(E) a program of an institution with assets exceeding twenty-five million dollars ($25,000,000);

(F) a program in which a business entity, including a trust:

(i) purchases and holds funding agreements; and

(ii) issues securities by using the funding agreement to finance or collateralize the securities; or

(G) any program or activity substantially similar to a program or an activity described in clauses (A) through (F) that is first authorized by the commissioner.

As added by P.L.178-2003, SEC.18.

IC 27-1-12.7-6

Funding agreements interpretation

Sec. 6. The issuance of a funding agreement:

(1) constitutes an activity necessary, convenient, or expedient to the business of a life insurance company under IC 27-1-7-2;

(2) is not insurance under IC 27-1-5-1;

(3) is not a security (as defined in IC 23-19-1-2(28)); and

(4) does not constitute gross premium for taxation purposes under IC 27-1-18-2.

As added by P.L.178-2003, SEC.18. Amended by P.L.27-2007, SEC.25.

IC 27-1-12.7-7

Guaranteed or credited amounts under funding agreements

Sec. 7. An amount may not be guaranteed or credited under a funding agreement except:

(1) upon reasonable assumptions as to investment income and expenses; and

(2) on a basis equitable to all holders of funding agreements of a given class.

As added by P.L.178-2003, SEC.18.

IC 27-1-12.7-8

Segregated asset accounts

Sec. 8. An amount paid to a life insurance company and proceeds applied to amounts paid under optional modes of settlement under a funding agreement may be allocated by the insurer to one (1) or more segregated asset accounts in the manner described in Class 1(c) of IC 27-1-5-1.

As added by P.L.178-2003, SEC.18.

IC 27-1-12.7-9

Commissioner; conditions; rules

Sec. 9. The commissioner may establish reasonable conditions or adopt rules under IC 4-22-2 regarding:

(1) reserve amounts to be maintained by a life insurance company for funding agreements;

(2) accounting and reporting of funds credited under funding agreements; and

(3) other matters regarding funding agreements the commissioner considers necessary, proper, and advisable.

As added by P.L.178-2003, SEC.18.

IC 27-1-12.7-10

Regulation; funding agreement not a covered policy; claim for payments; assets in segregated asset account

Sec. 10. Notwithstanding any other provision of law:

(1) the commissioner has the sole authority to regulate the issuance and sale of funding agreements;

(2) a funding agreement is not considered a covered policy under IC 27-8-8-2.3(d);

(3) a claim for payments under a funding agreement must be treated as a loss claim described in Class 2 of IC 27-9-3-40; and

(4) assets supporting a funding agreement in a segregated asset account under section 8 of this chapter are subject to IC 27-9-3-40.5 and Class 1(c) of IC 27-1-5-1.

As added by P.L.178-2003, SEC.18. Amended by P.L.193-2006, SEC.2; P.L.173-2007, SEC.8; P.L.1-2010, SEC.109.

IC 27-1-12.8

Chapter 12.8. Standard Valuation Law

IC 27-1-12.8-1

"Accident and sickness insurance"

Sec. 1. (a) Before the operative date of the valuation manual specified in section 34 of this chapter, as used in this chapter, "accident and sickness insurance" means insurance described in Class 1(b), Class 1(c)(2), or Class 2(a) of IC 27-1-5-1.

(b) On and after the operative date of the valuation manual specified in section 34 of this chapter, as used in this chapter, "accident and sickness insurance" means insurance described in Class 1(b), Class 1(c)(2), or Class 2(a) of IC 27-1-5-1 and as may be specified in the valuation manual.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-2

"Appointed actuary"

Sec. 2. (a) Before the operative date of the valuation manual specified in section 34 of this chapter, as used in this chapter, "appointed actuary" means a qualified actuary who is appointed to prepare an actuarial opinion required by sections 21 and 22 of this chapter.

(b) On and after the operative date of the valuation manual specified in section 34 of this chapter, as used in this chapter, "appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare an actuarial opinion required by section 23 of this chapter.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-3

"Change in fund basis"

Sec. 3. As used in this chapter, "change in fund basis" refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under an annuity or a guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-4

"Company"

Sec. 4. As used in this chapter, "company" is limited to a company that has:

(1) issued, delivered, or reinsured at least one (1):

(A) policy of insurance described in Class 1(a) or Class 1(c)(1) of IC 27-1-5-1; or

(B) policy of insurance or contract described in Class 1(b), Class 1(c)(2), or Class 2(a) of IC 27-1-5-1;

in Indiana that is in force or subject to at least one (1) outstanding claim; or

(2) issued, delivered, or reinsured a policy or contract described in subdivision (1)(A) or (1)(B) in another state and is required to hold a certificate of authority to issue, deliver, or reinsure a policy or contract described in subdivision (1)(A) or (1)(B) in Indiana.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-5
"Confidential information"

Sec. 5. As used in sections 37 and 38 of this chapter, "confidential information" means the following:

(1) A supporting memorandum submitted under section 21, 22, or 23 of this chapter and any other documents, materials, and other information, including all working papers and copies of working papers that are created, produced, or obtained by or disclosed to the commissioner or another person in connection with the supporting memorandum.

(2) All documents, materials, and other information, including all working papers and copies of working papers that are created, produced, or obtained by or disclosed to the commissioner or another person in the course of an examination made under section 34(f) of this chapter. However, if an examination report or other material prepared in connection with an examination made under IC 27-1-3.1 is not maintained as private and confidential information under IC 27-1-3.1, an examination report or other material prepared in connection with an examination made under section 34(f) of this chapter is not confidential to the same extent as if the examination report or other material had been prepared under IC 27-1-3.1.

(3) A report, document, material, or other information developed by a company in support of or in connection with an annual certification by the company under section 35(c)(2) of this chapter evaluating the effectiveness of the company's internal controls with respect to a principle based valuation and any other document, material, or other information, including all working papers and copies of working papers that are created, produced, or obtained by or disclosed to the commissioner or another person in connection with the report, document, material, or other information.

(4) A principle based valuation report developed under section 35(c)(3) of this chapter and any document, material, or other information, including all working papers and copies of working papers that are created, produced, or obtained by or disclosed to the commissioner or another person in connection with the report.

(5) A document, material, data, or other information submitted

by a company under section 36 of this chapter and any other document, material, data, or other information, including all working papers and copies of working papers that are created or produced in connection with the document, material, data, or other information in each case that:

(A) includes any potentially company identifying or personally identifiable information;

(B) is provided to or obtained by the commissioner with the document, material, data, or other information; and

(C) any other document, material, data, or other information, including all working papers and copies of working papers that are created, produced, or obtained by or disclosed to the commissioner or another person in connection with a document, material, data, or other information described in this subdivision.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-6
"Contract"

Sec. 6. As used in this chapter, "contract" means a contract or a policy.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-7
"Contractholder behavior"

Sec. 7. (a) As used in this chapter, "contractholder behavior" means an action taken by a contract holder, certificate holder, or another person possessing the right to elect options, including:

(1) lapse;
(2) withdrawal;
(3) transfer;
(4) deposit;
(5) premium payment;
(6) loan;
(7) annuitization;
(8) benefit elections; and
(9) other options;

under the contract.

(b) As used in this chapter, "contractholder behavior" does not include events of mortality or morbidity resulting in benefits prescribed according to the terms of the contract.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-8
"Deposit type contract"

Sec. 8. (a) Before the operative date of the valuation manual specified in section 34 of this chapter, as used in this chapter, "deposit type contract" means a contract that does not incorporate

mortality or morbidity risk.

(b) On and after the operative date of the valuation manual specified in section 34 of this chapter, as used in this chapter, "deposit type contract" means a contract that does not incorporate mortality or morbidity risk and as may be specified in the valuation manual.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-9
"Issue year basis"

Sec. 9. As used in this chapter, "issue year basis" refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of an annuity or a guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-10
"Life insurance"

Sec. 10. (a) Before the operative date of the valuation manual specified in section 34 of this chapter, as used in this chapter, "life insurance" means insurance under a contract that incorporates mortality risk, including annuity and pure endowment contracts.

(b) On and after the operative date of the valuation manual specified in section 34 of this chapter, as used in this chapter, "life insurance" means insurance under a contract that incorporates mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-11
"NAIC"

Sec. 11. As used in this chapter, "NAIC" refers to the National Association of Insurance Commissioners.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-12
"Plan type"

Sec. 12. As used in this chapter, "plan type" refers to the following:

(1) "Plan Type A" means a plan type for which a contractholder:

(A) may not withdraw funds; or

(B) at any time may withdraw funds only:

(i) with an adjustment to reflect changes in interest rates or asset values occurring after receipt of the funds by the company;

(ii) without an adjustment, but with installments over at least five (5) years; or
(iii) as an immediate life annuity.
(2) "Plan Type B" means a plan type for which:
(A) before expiration of the interest rate guarantee, a contractholder may not withdraw funds, or may withdraw funds only:
(i) with an adjustment to reflect changes in interest rates or asset values occurring after receipt of the funds by the company; or
(ii) without an adjustment, but in installments over at least five (5) years; and
(B) at the expiration of the interest rate guarantee, funds may be withdrawn without an adjustment in a single sum or installments over less than five (5) years.
(3) "Plan Type C" means a plan type for which a contractholder may withdraw funds before expiration of the interest rate guarantee in a single sum or installments over less than five (5) years:
(A) without adjustment to reflect changes in interest rates or asset values occurring after receipt of the funds by the company; or
(B) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.
As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-13
"Principal based valuation"
Sec. 13. On and after the operative date of the valuation manual specified in section 34 of this chapter, as used in this chapter, "principal based valuation" means a reserve valuation that:
(1) uses at least one (1) method or assumption determined by the insurer; and
(2) is required to comply with section 35 of this chapter as specified in the valuation manual.
As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-14
"Qualified actuary"
Sec. 14. (a) Before the operative date of the valuation manual specified in section 34 of this chapter, as used in this chapter, "qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards.
(b) On and after the operative date of the valuation manual specified in section 34 of this chapter, as used in this chapter, "qualified actuary" means an individual who:
(1) is qualified to sign the applicable statement of actuarial

opinion in accordance with the American Academy of Actuaries qualification standards; and

(2) meets the requirements specified in the valuation manual.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-15

"Reserves"

Sec. 15. As used in this chapter, "reserves" means reserve liabilities.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-16

"Tail risk"

Sec. 16. As used in this chapter, "tail risk" means a risk that occurs where:

(1) the frequency of low probability events is higher than expected under a normal probability distribution; or

(2) there are observed events of very significant size or magnitude.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-17

"Valuation manual"

Sec. 17. As used in this chapter, "valuation manual" refers to the manual of valuation instructions adopted by the NAIC.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-18

Net reserve value of contracts issued before transition date or January 1, 1948; mortality tables

Sec. 18. (a) Contracts of life insurance bearing dates of issue that are earlier than a transition date selected by the company under IC 27-1-12-12, the transition date in no event to be later than January 1, 1948, must be valued in accordance with the following:

(1) As soon as practicable after the filing with the department under IC 27-1-20-21 of the annual statement of a company organized under this article or under another law of this state and doing business in Indiana, the department shall ascertain the net reserve value of each contract in force on the immediately preceding December 31, on the basis of:

(A) the American Experience Table of Mortality and four percent (4%) interest; or

(B) the Actuaries' Combined Experience Table of Mortality and four percent (4%) interest;

as adopted by the company. However, if the company issues a contract based on a higher standard than the standards described in clauses (A) and (B), the contract must be valued according to the higher standard. The department may hire, at the company's

expense, an actuary to make the valuation or the department may accept a valuation made by the company, as determined by the department.

(2) In making a valuation under subdivision (1), the department or a representative of the department shall compute the net reserve value according to the terms of the contract. If a contract provides term insurance, or for a valuation as term insurance for any time covered by the contract, the valuation of the contract must be in accordance with the provision in the contract. However, a contract issued after March 5, 1909:

(A) may provide for not more than one (1) year of preliminary term insurance; and

(B) if the premium charged for term insurance under:

(i) a limited payment life preliminary term contract providing for the payment of less than twenty (20) annual premiums; or

(ii) an endowment preliminary term contract;

exceeds the premium charged for life insurance under twenty (20) payment life preliminary term contracts of the same company, the reserve on the contract at the end of any year, including the first, must not be less than the reserve on a twenty (20) payment life preliminary term contract issued in the same year at the same age, together with an amount that is equivalent to the accumulation of a net level premium sufficient to provide for a pure endowment at the end of the premium payment period equal to the difference between the value at the end of the period of the twenty (20) payment life preliminary term contract and the full reserve at the time of the limited payment life or endowment contract.

(3) All contracts of life insurance, including contracts issued on a reducing premium plan or a return premium plan, must be valued according to this article. However, if the actual premium charged for an insurance contract is less than the net premium for the insurance contract, based on the American Men Ultimate Table of Mortality with three and one-half percent (3 1/2%) interest, the company must also establish an additional reserve equal to the value of an annuity, the amount of which must be equal to the difference between the premium charged and the net premium for insurance based on the American Men Ultimate Table with three and one-half percent (3 1/2%) interest and a term in years that is equal to the number of future annual payments due on the insurance at the date of valuation.

(4) Insurance against permanent mental or physical disability resulting from accident or disease or against accidental death, combined with a contract of life insurance, must be valued on a basis of fifty percent (50%) of the additional annual premium charged for the insurance.

(5) The department may at any time during the year ascertain

the net reserve value of the contracts of a company, as provided in this section, to determine the solvency of the company.

(6) Reserves may be calculated, at the option of the company, according to standards that produce greater aggregate reserves for all contracts than the reserves produced by the standard specified in this section.

(7) A company that has adopted a standard of valuation producing greater aggregate reserves than the aggregate reserves calculated according to the minimum standard provided for in this section may, with the approval of the department, adopt a standard of valuation producing lower aggregate reserves, but not lower in the aggregate than the reserves produced by the standard specified in the company's contracts.

(b) Subsection (a)(1) through (a)(3) applies only to the valuation of life insurance contracts.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-19

Valuation of contracts, annuities, and endowment contracts after transition date or January 1, 1948, and before operative date of valuation manual

Sec. 19. (a) The commissioner shall annually value or cause to be valued the reserves for all outstanding life insurance contracts and annuity and pure endowment contracts:

(1) of each company doing business in Indiana; and

(2) issued on or after the transition date selected by the company under IC 27-1-12-12, the transition date in no event to be later than January 1, 1948, and before the operative date of the valuation manual.

(b) In calculating reserves, the commissioner may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of another state or jurisdiction when the valuation complies with the minimum standard provided in sections 19 through 40 of this chapter.

(c) Sections:

(1) 24 through 33 of this chapter apply to all contracts, as appropriate, issued on or after the transition date selected by a company under IC 27-1-12-12, the transition date in no event to be later than January 1, 1948, and before the operative date of the valuation manual; and

(2) 34 and 35 of this chapter do not apply to contracts described in subdivision (1).

(d) The minimum standard for the valuation of contracts issued before the transition date selected by a company under

IC 27-1-12-12, the transition date in no event to be later than January 1, 1948, is the minimum standard specified in section 18 of this chapter.
As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-20
Annual reserve valuation

Sec. 20. (a) The commissioner shall annually value, or cause to be valued, the reserves for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and sickness insurance contracts, and deposit-type contracts:

(1) of each company; and

(2) issued on or after the operative date of the valuation manual.

In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of another state or jurisdiction if the valuation complies with the minimum standards provided in sections 19 through 40 of this chapter.

(b) Sections 34 and 35 of this chapter apply to all contracts issued on or after the operative date of the valuation manual.
As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-21
Annual submission of qualified actuary opinion; requirements

Sec. 21. (a) This section applies before the operative date of the valuation manual.

(b) A company doing business in Indiana shall annually submit to the department the opinion of a qualified actuary concerning whether the reserves and related actuarial items held by the company in support of the contracts specified by the commissioner in rules adopted under IC 4-22-2:

(1) are computed appropriately;

(2) are based on assumptions that satisfy contractual provisions;

(3) are consistent with previously reported amounts; and

(4) comply with applicable laws of the state.

(c) The commissioner shall adopt rules under IC 4-22-2 to implement this section. The rules adopted by the commissioner:

(1) must specify the information to be included in an actuary's opinion submitted under this section;

(2) may require the inclusion in the opinion of other items of information that the commissioner considers necessary to the scope of the opinion; and

(3) must provide for disciplinary action against a company or a qualified actuary that violates this section.

(d) Unless exempted by a rule adopted by the commissioner under IC 4-22-2, a company doing business in Indiana shall include with the actuary's opinion submitted under subsection (b) an opinion by the same qualified actuary stating whether the reserves and related

actuarial items held by the company in support of the contracts specified by the commissioner in rules adopted under IC 4-22-2 make adequate provision for the obligations of the company under the contracts, including:

(1) the benefits under;

(2) the expenses associated with; and

(3) any other obligations under;

the contracts of the company. In making the determination required under this subsection, the qualified actuary shall consider the assets held by the company with respect to reserves and related actuarial items, including investment earnings on the assets and the considerations anticipated to be received and retained under the contracts.

(e) The commissioner, in rules adopted under IC 4-22-2, may provide for a transition period to establish higher reserves considered necessary by the qualified actuary to render the opinion required by this section.

(f) The following requirements apply to an actuary's opinion required by subsection (d):

(1) A memorandum that meets all requirements established by the commissioner in rules adopted under IC 4-22-2 concerning form and content must be prepared to support each actuarial opinion.

(2) If:

(A) the company fails to provide a supporting memorandum at the request of the commissioner within a period specified by rules adopted by the commissioner under IC 4-22-2; or

(B) the commissioner determines that the supporting memorandum provided by the company does not meet the standards set forth in rules adopted by the commissioner under IC 4-22-2 or is otherwise unacceptable to the commissioner;

the commissioner, at the expense of the company, may engage a qualified actuary to review the opinion and the basis for the opinion and to prepare the supporting memorandum required by the commissioner.

(g) The following apply to an actuarial opinion submitted under this section:

(1) The opinion must:

(A) be submitted with the annual statement of the company; and

(B) reflect the valuation of reserves for each year ending after December 31, 1994.

(2) The opinion must:

(A) apply to all business in force, including individual and group accident and sickness insurance contracts; and

(B) meet all requirements concerning form and content established by the commissioner in rules adopted under

IC 4-22-2.

(3) The opinion must be based on:

(A) standards adopted by the Actuarial Standards Board; and

(B) additional standards prescribed by the commissioner in rules adopted under IC 4-22-2.

(4) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by the foreign or alien company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in Indiana.

(h) Except in cases of fraud or willful misconduct, a qualified actuary who provides an opinion required by this section is not liable for damages to a person other than:

(1) the company for which the opinion is offered; and

(2) the commissioner;

for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-22

Supporting memorandum; confidentiality and privilege

Sec. 22. (a) This section applies before the operative date of the valuation manual.

(b) Except as otherwise provided in this section, a supporting memorandum submitted by a company as required by section 21 of this chapter and material provided to the commissioner by the company in connection with the supporting memorandum:

(1) are confidential;

(2) are not subject to subpoena; and

(3) are not subject to discovery or admissible in evidence in a private civil action.

However, the commissioner may use the materials and information in connection with a regulatory or legal action brought as part of the commissioner's duties.

(c) The commissioner, or a person receiving documents, materials, or other information while acting under the authority of the commissioner, is not permitted or required to testify in a private civil action concerning information that is confidential as described in subsection (b).

(d) The commissioner may disclose documents, materials, and other information, including the information described in subsection (b), to:

(1) other state, federal, and international regulatory agencies;

(2) the NAIC and affiliates and subsidiaries of the NAIC; and

(3) state, federal, and international law enforcement authorities;

if the recipient agrees to maintain the confidential and privileged status of the documents, materials, and other information.

(e) The commissioner:

(1) may receive documents, materials, and other information, including confidential and privileged documents, materials, and information, from:

(A) other state, federal, and international regulatory agencies;

(B) the NAIC and affiliates and subsidiaries of the NAIC; and

(C) other state, federal, and international law enforcement authorities;

(2) shall maintain as confidential or privileged all documents, materials, and other information received with notice or the understanding that the documents, materials, and information are confidential or privileged under the law of the jurisdiction that is the source of the documents, materials, and information; and

(3) may enter into agreements governing sharing and use of information consistent with subsections (b) through (d).

(f) Any applicable privilege or claim of confidentiality in documents, materials, or information described in this section is not waived as a result of the disclosure or receipt of the documents, materials, or information by the commissioner as authorized by this section.

(g) A supporting memorandum described in section 21 of this chapter and other material provided by the company to the commissioner in connection with the supporting memorandum may:

(1) be subject to subpoena to defend an action seeking damages from the actuary who submitted the supporting memorandum under section 21 of this chapter; and

(2) be released by the commissioner:

(A) with the written consent of the company; or

(B) to the American Academy of Actuaries in response to a written request that:

(i) states that the memorandum or other material is required for the purpose of professional disciplinary proceedings; and

(ii) sets forth procedures satisfactory to the commissioner for preserving the confidentiality of the supporting memorandum or other material.

(h) If any part of a supporting memorandum described in section 21 of this chapter is:

(1) cited by the company in the company's marketing;

(2) cited before a governmental agency other than a state insurance department; or

(3) released by the company to the news media;

all parts of the supporting memorandum are no longer confidential.

(i) The commissioner shall adopt rules under IC 4-22-2 containing the minimum standards for the valuation of accident and sickness

insurance contracts.
As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-23
Annual submission of appointed actuary opinion; supporting memorandum; requirements

Sec. 23. (a) This section applies on and after the operative date of the valuation manual.

(b) A company with outstanding life insurance contracts, accident and sickness insurance contracts, or deposit-type contracts in Indiana that is subject to regulation by the commissioner shall:

(1) annually submit the opinion of the appointed actuary concerning whether the reserves and related actuarial items held in support of the contracts:

(A) are computed appropriately;

(B) are based on assumptions that satisfy contractual provisions;

(C) are consistent with previously reported amounts; and

(D) comply with applicable Indiana law;

according to the specific requirements prescribed by the valuation manual; and

(2) except as exempted in the valuation manual, annually submit the opinion of the appointed actuary concerning whether the reserves and related actuarial items held in support of the contracts specified in the valuation manual, when considered with the assets held by the company with respect to the reserves and related actuarial items including the:

(A) investment earnings on the assets; and

(B) considerations anticipated to be received and retained under the contracts;

make adequate provision for the company's obligations, including benefits under, expenses associated with, and any other obligations under the contracts.

(c) The following requirements apply to an opinion required by subsection (b)(2):

(1) A memorandum, in form and substance as specified in the valuation manual and acceptable to the commissioner, must be prepared to support each actuarial opinion.

(2) If:

(A) the company fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual; or

(B) the commissioner determines that the supporting memorandum provided by the company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the commissioner;

the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the

opinion and prepare the supporting memorandum required by the commissioner.

(d) The following requirements apply to an opinion prepared under subsection (b)(1) or (b)(2):

(1) The opinion must be in form and substance as specified in the valuation manual and acceptable to the commissioner.

(2) The opinion must be submitted with the annual statement reflecting the valuation of the reserves for each year ending on or after the operative date of the valuation manual.

(3) The opinion must apply to all contracts subject to subsection (b)(2) plus other actuarial liabilities specified in the valuation manual.

(4) The opinion must be based on:

(A) standards adopted by the Actuarial Standards Board or a successor to the Actuarial Standards Board; and

(B) additional standards prescribed in the valuation manual.

(5) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by the company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in Indiana.

(6) Except in cases of fraud or willful misconduct, the appointed actuary is not liable for damages to a person other than the company and the commissioner for any act, error, omission, decision, or conduct with respect to the appointed actuary's opinion.

(7) Disciplinary action by the commissioner against the company or the appointed actuary must be defined in rules adopted by the commissioner under IC 4-22-2.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-24

Minimum standard for valuation of contracts; mortality tables

Sec. 24. (a) Except as provided in sections 25, 26, and 33 of this chapter, the minimum standard for the valuation of contracts issued before the operative date of the valuation manual specified in section 34 of this chapter and on or after the transition date selected by the company under IC 27-1-12-12, the transition date in no event to be later than January 1, 1948, is:

(1) the commissioners reserve valuation methods described in sections 27, 28, 31, and 33 of this chapter;

(2) three and one-half percent (3 1/2%) interest; or

(3) in the case of life insurance contracts (other than annuity and pure endowment contracts) issued after August 31, 1973:

(A) four percent (4%) interest for contracts issued before September 1, 1979;

(B) five and one-half percent (5 1/2%) interest for single

premium life insurance contracts; and

(C) four and one-half percent (4 1/2%) interest for all other contracts issued after August 31, 1979.

(b) In addition to the minimum standards specified in subsection (a), the following tables apply:

(1) For ordinary contracts of life insurance issued on the standard basis, excluding disability and accidental death benefits in the contracts:

(A) the Commissioners 1941 Standard Ordinary Mortality Table for contracts issued before the operative date of the fifth paragraph of IC 27-1-12-7(d);

(B) for any category of contracts issued:

(i) on male risks; and

(ii) on or after the operative date of the fifth paragraph of IC 27-1-12-7(d) and before the operative date of IC 27-1-12-7(dd);

the Commissioners 1958 Standard Ordinary Mortality Table;

(C) for any category of contracts issued:

(i) on female risks; and

(ii) on or after the operative date of the fifth paragraph of IC 27-1-12-7(d) and before the operative date of IC 27-1-12-7(dd);

the Commissioners 1958 Standard Ordinary Mortality Table with all modified net premiums and present values referred to in sections 19 through 40 of this chapter calculated according to an age not more than six (6) years younger than the actual age of the insured; and

(D) for contracts issued on or after the operative date of IC 27-1-12-7(dd):

(i) the Commissioners 1980 Standard Ordinary Mortality Table;

(ii) at the election of the company for one (1) or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; or

(iii) an ordinary mortality table, adopted after 1980 by the NAIC, which is approved by rule adopted by the department under IC 4-22-2 for use in determining the minimum standard of valuation for the contracts.

(2) For industrial life insurance contracts issued on the standard basis, excluding disability and accidental death benefits in the contracts:

(A) the 1941 Standard Industrial Mortality Table for contracts bearing a date of issue before the operative date of the seventh paragraph of IC 27-1-12-7(d); and

(B) for contracts bearing a date of issue that is the same as or later than the operative date described in clause (A), the Commissioners 1961 Standard Industrial Mortality Table or

an industrial mortality table adopted after 1980 by the NAIC that is approved by rule adopted by the department under IC 4-22-2 for use in determining the minimum standard of valuation for the contracts.

(3) For individual annuity and pure endowment contracts, excluding disability and accidental death benefits in the contracts:

(A) the 1937 Standard Annuity Mortality Table; or

(B) at the option of the company, the Annuity Mortality Table for 1949, Ultimate; or

(C) a modification of a table specified in clause (A) or (B) that is approved by the commissioner.

(4) For group annuity and pure endowment contracts, excluding disability and accidental death benefits in the contracts:

(A) the Group Annuity Mortality Table for 1951;

(B) a modification of the table approved by the commissioner; or

(C) at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

(5) For total and permanent disability benefits in or supplementary to contracts:

(A) for contracts issued after December 31, 1965, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or tables of disablement rates and termination rates adopted after 1980 by the NAIC, that are approved by rule adopted by the department under IC 4-22-2 for use in determining the minimum standard of valuation for those contracts;

(B) for contracts issued after December 31, 1960, and before January 1, 1966:

(i) the tables described in clause (A); or

(ii) at the option of the company, the Class (3) Disability Table (1926); and

(C) for contracts issued before January 1, 1961, the Class (3) Disability Table (1926).

Any table described in this subdivision must, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance contracts.

(6) For accidental death benefits in or supplementary to contracts issued after December 31, 1965:

(A) the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the NAIC that is approved by rule adopted by the commissioner under IC 4-22-2 for use in determining the minimum standard of valuation for the contracts;

(B) for contracts issued after December 31, 1960, and before

January 1, 1966:

(i) the table described in clause (A); or

(ii) at the option of the company, the Inter-Company Double Indemnity Mortality Table; and

(C) for contracts issued before January 1, 1961, the Inter-Company Double Indemnity Mortality Table.

A table described in this subdivision must be combined with a mortality table for calculating the reserves for life insurance contracts.

(7) For group life insurance, life insurance issued on the substandard basis, and other special benefits, tables approved by the commissioner.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-25

Minimum standard for valuation of annuities and pure endowment contracts; mortality tables

Sec. 25. (a) Except as provided in section 26 of this chapter, the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after the operative date of this section, and for annuities and pure endowments purchased on or after the operative date of this section under group annuity and pure endowment contracts, and before the operative date of the valuation manual specified in section 34 of this chapter, is the commissioners reserve valuation methods defined in sections 27 and 28 of this chapter and the following tables and interest rates:

(1) For individual annuity and pure endowment contracts issued before September 1, 1979, excluding disability and accidental death benefits in the contracts, both of the following:

(A) Either of the following:

(i) The 1971 Individual Annuity Mortality Table.

(ii) A modification of the table that is approved by the commissioner.

(B) Either of the following:

(i) Six percent (6%) interest for single premium immediate annuity contracts.

(ii) Four percent (4%) interest for all other individual annuity and pure endowment contracts.

(2) For individual single premium immediate annuity contracts issued after August 31, 1979, excluding disability and accidental death benefits in the contracts, both of the following:

(A) One (1) of the following:

(i) The 1971 Individual Annuity Mortality Table.

(ii) An individual annuity mortality table adopted after 1980 by the NAIC that is approved by rule adopted by the commissioner under IC 4-22-2 for use in determining the minimum standard of valuation for the contracts.

(iii) A modification of a table described in item (i) or (ii)

that is approved by the commissioner.

(B) Seven and one-half percent (7 1/2%) interest.

(3) For individual annuity and pure endowment contracts issued after August 31, 1979, other than single premium immediate annuity contracts, excluding disability and accidental death benefits in the contracts, both of the following:

(A) One (1) of the following:

(i) The 1971 Individual Annuity Mortality Table.

(ii) An individual annuity mortality table adopted after 1980 by the NAIC that is approved by rule adopted by the commissioner under IC 4-22-2 for use in determining the minimum standard of valuation for the contracts.

(iii) A modification of a table described in item (i) or (ii) that is approved by the commissioner.

(B) Either of the following:

(i) Five and one-half percent (5 1/2%) interest for single premium deferred annuity and pure endowment contracts.

(ii) Four and one-half percent (4 1/2%) interest for all other individual annuity and pure endowment contracts.

(4) For annuities and pure endowments purchased before September 1, 1979, under group annuity and pure endowment contracts, excluding disability and accidental death benefits purchased under the contracts, both of the following:

(A) Either of the following:

(i) The 1971 Group Annuity Mortality Table.

(ii) A modification of the table that is approved by the commissioner.

(B) Six percent (6%) interest.

(5) For annuities and pure endowments purchased after August 31, 1979, under group annuity and pure endowment contracts, excluding disability and accidental death benefits purchased under the contracts, both of the following:

(A) One (1) of the following:

(i) The 1971 Group Annuity Mortality Table.

(ii) A group annuity mortality table adopted after 1980 by the NAIC that is approved by rule adopted by the commissioner under IC 4-22-2 for use in determining the minimum standard of valuation for annuities and pure endowments.

(iii) A modification of a table described in item (i) or (ii) that is approved by the commissioner.

(B) Seven and one-half percent (7 1/2%) interest.

(b) After September 1, 1973, a company may file with the commissioner a written notice of the company's election to comply with this section after a specified date before January 1, 1979, which is the operative date of this section for the company. If a company makes no election, the operative date of this section for the company is January 1, 1979.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-26

Interest rates in determining minimum standard for valuation

Sec. 26. (a) The interest rates used in determining the minimum standard for the valuation of the following are the calendar year statutory valuation interest rates described in this section:

(1) Life insurance contracts issued in a particular calendar year, on or after the operative date of IC 27-1-12-7(dd).

(2) Individual annuity and pure endowment contracts issued in a particular calendar year after December 31, 1981.

(3) Annuities and pure endowments purchased in a particular calendar year after December 31, 1981, under group annuity and pure endowment contracts.

(4) A net increase in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts.

(b) Except as provided in subsection (c), the calendar year statutory valuation interest rate, I, is determined as follows, and the results must be rounded to the nearest one-quarter of one percent (1/4 of 1%):

(1) For life insurance,

$I = .03 + W(R1 - .03) + W/2(R2 - .09)$

(2) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options,

$I = .03 + W(R - .03)$

where R1 is the lesser of R and .09,

R2 is the greater of R and .09,

R is the reference interest rate specified in this section, and

W is the weighting factor specified in this section.

(3) For:

(A) other annuities; and

(B) guaranteed interest contracts;

with cash settlement options, valued on an issue year basis, except as provided in subdivision (2), the formula for life insurance specified in subdivision (1) applies to annuities and guaranteed interest contracts with guarantee durations in excess of ten (10) years and the formula for single premium immediate annuities described in subdivision (2) applies to annuities and guaranteed interest contracts with guarantee duration of ten (10) years or less.

(4) For:

(A) other annuities; and

(B) guaranteed interest contracts;

with no cash settlement options, the formula for single premium immediate annuities specified in subdivision (2).

(5) For:

(A) other annuities; and

(B) guaranteed interest contracts;

with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities specified in subdivision (2).

(c) If the calendar year statutory valuation interest rate for a life insurance contract issued in a calendar year determined without reference to this subsection differs from the corresponding actual rate for similar contracts issued in the immediately preceding calendar year by less than one-half of one percent (1/2 of 1%), the calendar year statutory valuation interest rate for the life insurance contract is equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of this subsection, the calendar year statutory valuation interest rate for life insurance contracts issued in a calendar year is determined for 1980 (using the reference interest rate defined in 1979) and must be determined for each subsequent calendar year regardless of when IC 27-1-12-7(dd) becomes operative.

(d) The weighting factors referred to in the formulas specified in subsection (b) are as follows:

(1) Weighting factors for life insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the contract or under options to convert to life insurance contracts with premium rates, nonforfeiture values, or both that are guaranteed in the original contract.

(2) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from:

(A) other annuities; and

(B) guaranteed interest contracts with cash settlement options:

.80

(3) Weighting factors for other annuities and for guaranteed interest contracts are as specified in clauses (A) through (C), according to the requirements of clauses (D) and (E), as follows:

(A) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Type		
	A	B	C

5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

(B) For annuities and guaranteed interest contracts valued on a change in fund basis, the weighting factors specified in clause (A), increased by:

Plan Type		
A	B	C
.15	.25	.05

(C) For annuities and guaranteed interest contracts valued on:

(i) an issue year basis (other than annuities and guaranteed interest contracts with no cash settlement options) that do not guarantee interest on considerations received more than one (1) year after the issue or purchase date; or

(ii) a change in fund basis that do not guarantee interest rates on considerations received more than twelve (12) months after the valuation date;

the weighting factors specified in clause (A) or derived in clause (B), increased by:

Plan Type		
A	B	C
.05	.05	.05

(D) For other annuities and guaranteed interest contracts:

(i) with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance contracts with guarantee duration in excess of twenty (20) years; and

(ii) with no cash settlement options, the guaranteed duration is the number of years from the date of issue or purchase to the date annuity benefits are scheduled to begin.

(E) A company may elect to value:

(i) annuities; and

(ii) guaranteed interest contracts;

with cash settlement options on either an issue year basis or on a change in fund basis. Other annuities and guaranteed interest contracts with no cash settlement options must be valued on an issue year basis.

(e) The reference interest rate referred to in subsection (b) is as follows:

(1) For life insurance, the lesser of:

(A) the average, over a period of thirty-six (36) months; or

(B) the average, over a period of twelve (12) months;

ending on June 30 of the calendar year preceding the year of issue, of the monthly average of the composite yield on seasoned corporate bonds published by Moody's Investors Service, Inc.

(2) For single premium immediate annuities and for annuity benefits involving life contingencies arising from:

(A) other annuities; and

(B) guaranteed interest contracts;

with cash settlement options, the average, over a period of twelve (12) months ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds published by Moody's Investors Service, Inc.

(3) For:

(A) other annuities; and

(B) guaranteed interest contracts;

with cash settlement options valued on a year of issue basis, except as provided in subdivision (2), with guarantee duration in excess of ten (10) years, the lesser of the average over a period of thirty-six (36) months or the average over a period of twelve (12) months ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds published by Moody's Investors Service, Inc.

(4) For:

(A) other annuities; and

(B) guaranteed interest contracts;

with cash settlement options valued on a year of issue basis, except as provided in subdivision (2), with guarantee duration of ten (10) years or less, the average, over a period of twelve (12) months ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds published by Moody's Investors Service, Inc.

(5) For:

(A) other annuities; and

(B) guaranteed interest contracts;

with no cash settlement options, the average, over a period of twelve (12) months ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds published by Moody's Investors Service, Inc.

(6) For:

(A) other annuities; and

(B) guaranteed interest contracts;

with cash settlement options valued on a change in fund basis, except as provided in subdivision (2), the average, over a period of twelve (12) months ending on June 30 of the calendar year

of the change in the fund, of the monthly average of the composite yield on seasoned corporate bonds published by Moody's Investors Service, Inc.

(f) If:

(1) the monthly average of the composite yield on seasoned corporate bonds is no longer published by Moody's Investors Service, Inc.; or

(2) the NAIC determines that the monthly average of the composite yield on seasoned corporate bonds published by Moody's Investors Service, Inc., is no longer appropriate for the determination of the reference interest rate;

an alternative method for determination of the reference interest rate that is adopted by the NAIC and approved under rules adopted by the commissioner under IC 4-22-2 may be substituted.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-27

Reserves according to commissioners reserve valuation method

Sec. 27. (a) Except as provided in sections 28, 31, and 33 of this chapter, reserves according to the commissioners reserve valuation method for the life insurance and endowment benefits of a contract providing for a uniform amount of insurance and requiring the payment of uniform premiums is the excess, if any, of the present value (on the date of valuation) of the future guaranteed benefits provided for by the contract over the then present value of any future modified net premiums for the contract.

(b) The modified net premiums for a contract described in subsection (a) are the uniform percentage of the respective contract premiums for the benefits such that the present value (on the date of issue of the contract) of all modified net premiums is equal to the sum of the then present value of the benefits provided for by the contract plus the excess of subdivision (1) over subdivision (2), as follows:

(1) A net level annual premium equal to the present value (on the date of issue) of the benefits provided for after the first contract year, divided by the present value (at the date of issue) of an annuity of one (1) per annum payable on the first and each subsequent anniversary of the contract on which a premium falls due. However, the net level annual premium must not exceed the net level annual premium on the nineteen (19) year premium whole life plan for insurance of the same amount at an insured age one (1) year greater than the age of the insured on the date of issue of the contract.

(2) A net one (1) year term premium for the benefits provided for in the first contract year.

(c) For a life insurance contract issued on or after January 1, 1985:

(1) for which:

(A) the contract premium in the first contract year exceeds the contract premium in the second contract year; and

(B) no comparable additional benefit is provided in the first contract year for the excess; and

(2) that provides an endowment benefit, a cash surrender value, or a combination, in an amount greater than the excess premium;

the reserve according to the commissioners reserve valuation method on a contract anniversary that occurs on or before the assumed ending date (defined to be the first contract anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than the excess premium) is, except as provided in section 31 of this chapter, the reserve determined under subsection (d).

(d) For purposes of subsection (c), the reserve is the greater of:

(1) the reserve on the contract anniversary calculated under subsections (a) and (b); or

(2) the reserve as of the contract anniversary calculated under subsections (a) and (b) with:

(A) the value described in subsection (b)(1) reduced by fifteen percent (15%) of the amount of the excess first year premium;

(B) all present values of benefits and premiums determined without reference to premiums or benefits provided for by the contract after the assumed ending date;

(C) the contract assumed to mature on the assumed ending date as an endowment; and

(D) the cash surrender value provided on the assumed ending date considered as an endowment benefit.

In making the comparison described in this subsection, the mortality and interest bases specified in sections 24 and 26 of this chapter must be used.

(e) Reserves according to the commissioners reserve valuation method must be calculated by a method consistent with the principles of this section for the following:

(1) A life insurance contract that provides for a varying amount of insurance or requires the payment of varying premiums.

(2) A group annuity or a pure endowment contract that is purchased under a retirement plan or plan of deferred compensation that is established or maintained by:

(A) an employer (including a partnership or sole proprietorship);

(B) an employee organization; or

(C) both;

other than a plan that provides individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code.

(3) Disability and accidental death benefits provided in any

contract.

(4) All other benefits, except life insurance and endowment benefits in a life insurance contract and benefits provided by any other annuity or pure endowment contract.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-28

Reserves according to commissioners annuity reserve method

Sec. 28. (a) This section applies to an annuity or a pure endowment contract other than a group annuity or pure endowment contract that is purchased under a retirement plan or plan of deferred compensation that is established or maintained by:

(1) an employer (including a partnership or sole proprietorship);

(2) an employee organization; or

(3) both;

other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code.

(b) Reserves according to the commissioners annuity reserve method for benefits under an annuity or a pure endowment contract, excluding disability and accidental death benefits in a contract, is the greatest of the respective excesses of:

(1) the present value (on the date of valuation) of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by the contract at the end of each respective contract year; over

(2) the present value (on the date of valuation) of any future valuation considerations derived from future gross considerations required by the terms of the contract, that become payable before the end of the respective contract year.

The future guaranteed benefits must be determined by using any mortality table, if applicable, and the interest rate or rates specified in the contracts for determining guaranteed benefits. The valuation considerations are the portion of the respective gross considerations applied under the terms of a contract to determine the nonforfeiture value.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-29

Aggregate reserves

Sec. 29. (a) A company's aggregate reserves for all contracts, excluding disability and accidental death benefits, issued on or after the transition date selected by the company under IC 27-1-12-12, the transition date in no event to be later than January 1, 1948, must not be less than the aggregate reserves calculated in accordance with sections 27, 28, 31, and 32 of this chapter and the mortality tables and rates of interest used in calculating nonforfeiture benefits for the contracts.

(b) The aggregate reserves for all contracts and benefits must not be less than the aggregate reserves determined by the appointed actuary to be necessary to render an opinion required by section 21 or 23 of this chapter.
As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-30
Reserves; calculation

Sec. 30. (a) Reserves for contracts issued before the transition date selected by a company under IC 27-1-12-12, the transition date in no event to be later than January 1, 1948, may be calculated (at the option of the company) according to any standards that produce greater aggregate reserves for all of the contracts than the minimum reserves required by the laws in effect immediately before the transition date.

(b) Reserves for a category, established by the commissioner, of contracts or benefits issued on or after the transition date selected by a company under IC 27-1-12-12, the transition date in no event to be later than January 1, 1948, may be calculated (at the option of the company) according to any standards that produce greater aggregate reserves for the category than the aggregate reserves calculated according to the minimum standard under this chapter. However, the rates of interest used for contracts other than annuity and pure endowment contracts must not be greater than the corresponding rate of interest used in calculating nonforfeiture benefits provided in the contracts.

(c) A company that adopts a standard of valuation that produces greater aggregate reserves than the aggregate reserves calculated under sections 19 through 40 of this chapter may adopt a lower standard of valuation with the approval of the commissioner. However, the lower standard of valuation must not be lower than the minimum standard provided under this chapter. For purposes of this subsection, the holding of additional reserves previously determined by the appointed actuary to be necessary to render an opinion required by section 21 or 23 of this chapter is not the adoption of a higher standard of valuation.
As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-31
Minimum reserve requirement related to gross premium

Sec. 31. (a) If in any contract year the gross premium charged by a company on a contract is less than the valuation net premium for the contract calculated by the method used in calculating the reserve, but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for the contract is the greater of:

(1) the reserve calculated according to the mortality table, rate of interest, and method actually used for the contract; or

(2) the reserve calculated by the method actually used for the contract, but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium with the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium.

(b) The minimum valuation standards of mortality and rate of interest referred to in this section are the standards specified in sections 24 and 26 of this chapter.

(c) For a life insurance contract issued on or after January 1, 1985:

(1) for which:

(A) the gross premium in the first contract year exceeds the gross premium in the second contract year; and

(B) no comparable additional benefit is provided in the first contract year for the excess; and

(2) that provides an endowment benefit, a cash surrender value, or a combination, in an amount greater than the excess premium;

this section applies as if the method actually used in calculating the reserve for the contract were the method described in section 27(a), 27(b), and 27(d) of this chapter. The minimum reserve on each contract anniversary of a contract described in this subsection is the greater of the minimum reserve calculated in accordance with section 27 of this chapter and the minimum reserve calculated under this section.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-32

Minimum reserve requirement for certain contracts

Sec. 32. In the case of:

(1) a plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the company based on estimates of future experience; or

(2) a contract of life insurance or annuity that is of such a nature that the minimum reserves cannot be determined by the methods described in sections 27, 28, and 31 of this chapter;

the reserves that are held under the contract must be appropriate in relation to the benefits and pattern of premiums for the contract and computed by a method that is consistent with the principles of this chapter, as determined under rules adopted by the commissioner under IC 4-22-2.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-33

Accident and sickness insurance contracts

Sec. 33. The following apply to accident and sickness insurance contracts:

(1) For accident and sickness insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under section 20 of this chapter.

(2) For accident and sickness insurance contracts issued before the operative date of the valuation manual, the minimum standard of valuation is the standard adopted by the commissioner in rules adopted under IC 4-22-2.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-34

Minimum standard of valuation for contracts issued on or after operative date of valuation manual; operative date determination; changes to valuation manual; requirements

Sec. 34. (a) Except as provided in subsections (e) and (g), for contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under section 20 of this chapter.

(b) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(1) The valuation manual has been adopted by the NAIC by an affirmative vote of at least forty-two (42) members, or three-fourths (3/4) of the members voting, whichever is greater.

(2) The "Standard Valuation Law" of the NAIC, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than seventy-five percent (75%) of the direct premiums written as reported in the following annual statements submitted for 2008:

(A) Life, accident, and health annual statements.

(B) Health annual statements.

(C) Fraternal annual statements.

(3) The "Standard Valuation Law" of the NAIC, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two (42) of the following fifty-five (55) jurisdictions:

(A) The fifty (50) states of the United States.

(B) American Samoa.

(C) The American Virgin Islands.

(D) The District of Columbia.

(E) Guam.

(F) Puerto Rico.

(c) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual are effective on the January 1 following the date when the change to the valuation manual has been adopted by the NAIC by an affirmative vote

representing:

(1) at least three-fourths (3/4) of the members of the NAIC voting, but not less than a majority of the total membership; and

(2) members of the NAIC representing jurisdictions totaling greater than seventy-five percent (75%) of the direct premiums written, as reported in the following annual statements most recently available before the vote:

(A) Life, accident, and health annual statements.

(B) Health annual statements.

(C) Fraternal annual statements.

(d) The valuation manual must specify all of the following:

(1) Minimum valuation standards for contracts that are subject to section 20 of this chapter are the following:

(A) The commissioners reserve valuation method for life insurance contracts, other than annuity contracts.

(B) The commissioners annuity reserve valuation method for annuity contracts.

(C) Minimum reserves for all other contracts.

(2) The contracts or types of contracts that are subject to the requirements of a principle based valuation under section 35 of this chapter and the minimum valuation standards consistent with the requirements.

(3) For contracts that are subject to a principle based valuation under section 35 of this chapter, the following:

(A) Requirements for:

(i) the format of the reports to the commissioner under section 35(c)(3) of this chapter; and

(ii) which certifications described in item (i) must include information necessary to determine whether the valuation is appropriate and in compliance with sections 19 through 40 of this chapter.

(B) Assumptions prescribed for risks over which the company does not have significant control or influence.

(C) Procedures for corporate governance and oversight of the actuarial function and a process for appropriate waiver or modification of the procedures.

(4) For contracts that are not subject to a principle-based valuation under section 35 of this chapter, the minimum valuation standard must:

(A) be consistent with the minimum standard of valuation before the operative date of the valuation manual; or

(B) develop reserves that quantify:

(i) the benefits, guarantees, and funding associated with the contracts; and

(ii) the contracts' risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring.

(5) Other requirements, including requirements relating to:

(A) Reserve methods.
(B) Models for measuring risk.
(C) Generation of economic scenarios.
(D) Assumptions.
(E) Margins.
(F) Use of company experience.
(G) Risk measurement.
(H) Disclosure.
(I) Certifications.
(J) Reports.
(K) Actuarial opinions and memorandums.
(L) Transition rules.
(M) Internal controls.

(6) The data and form of the data required under section 36 of this chapter, including:

(A) the person to whom the data must be submitted;
(B) data analyses; and
(C) reporting of analyses.

(e) If:

(1) there is no specific valuation requirement; or
(2) a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with sections 19 through 40 of this chapter;

a company shall, with respect to the specific valuation requirements, comply with minimum valuation standards prescribed by the commissioner in rules adopted under IC 4-22-2.

(f) The commissioner may employ or contract with a qualified actuary, at the expense of a company, to:

(1) perform an actuarial examination of the company and provide an opinion concerning the appropriateness of any reserve assumption or method used by the company; or
(2) review and provide an opinion concerning the company's compliance with a requirement of this chapter. The commissioner may rely upon an opinion of a qualified actuary engaged by the commissioner of another state, district, or territory of the United States concerning sections 19 through 40 of this chapter.

(g) The commissioner may:

(1) require a company to change an assumption or method that in the opinion of the commissioner is necessary to comply with the requirements of the valuation manual or sections 19 through 40 of this chapter; and
(2) take other disciplinary action allowed by law.

A company described in subdivision (1) shall adjust reserves as required by the commissioner.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-35

Principal based valuation for contracts on and after operative date of valuation manual

Sec. 35. (a) This section applies on and after the operative date of the valuation manual specified in section 34 of this chapter.

(b) A company shall, using a principle based valuation, establish reserves that meet the following conditions for contracts, as specified in the valuation manual:

(1) The reserves quantify the benefits, guarantees, and funding associated with the contracts and the contracts' risks at a level of conservatism that:

(A) reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts; and

(B) for polices or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk.

(2) The reserves incorporate assumptions, risk analysis methods, and financial models and management techniques that are consistent with the assumptions, risk analysis methods, and financial models and management techniques used within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and prescribed assumptions or methods.

(3) The reserves incorporate assumptions that are derived in one (1) of the following manners:

(A) The assumption is prescribed in the valuation manual.

(B) For an assumption that is not prescribed in the valuation manual, the assumption must:

(i) be established using the company's available experience to the extent the experience is relevant and statistically credible; or

(ii) to the extent that company data is not available, relevant, or statistically credible, be established using other relevant, statistically credible experience.

(4) The reserves provide margins for uncertainty, including adverse deviation and estimation error, such that the greater the uncertainty, the larger the margin and resulting reserve.

(c) A company using a principle based valuation for at least one (1) contract that is subject to this section, as specified in the valuation manual, shall do the following:

(1) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with the procedures described in the valuation manual.

(2) Provide to the commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle based valuation. The internal controls must be designed to assure that:

(A) all material risks inherent in the liabilities and associated assets that are subject to the valuation are included in the

valuation; and

(B) valuations are made in accordance with the valuation manual.

The certification must be based on the controls in place as of the end of the preceding calendar year.

(3) Develop, and file with the commissioner upon request, a principle based valuation report that complies with standards prescribed in the valuation manual.

(d) A principle based valuation may include a prescribed formulaic reserve component.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-36

Submission of data prescribed by valuation manual

Sec. 36. On and after the operative date of the valuation manual specified in section 34 of this chapter, a company shall submit mortality, morbidity, contractholder behavior, or expense experience and other data as prescribed in the valuation manual.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-37

Confidential information

Sec. 37. (a) Except as provided in this section and section 38 of this chapter, a company's confidential information is:

(1) confidential by law and privileged;

(2) not subject to subpoena; and

(3) not subject to discovery or admissible in evidence in a private civil action.

However, the commissioner may use confidential information in the furtherance of a regulatory or legal action brought against the company as a part of the commissioner's duties.

(b) The commissioner, or a person receiving confidential information while acting under the authority of the commissioner, is not permitted or required to testify in a private civil action concerning confidential information.

(c) The commissioner may disclose confidential information to:

(1) other state, federal, and international regulatory agencies;

(2) the NAIC and affiliates and subsidiaries of the NAIC;

(3) only in the case of confidential information specified in section 5(1) and 5(4) of this chapter, the Actuarial Board for Counseling and Discipline or the successor to the Actuarial Board for Counseling and Discipline upon request stating that the confidential information is required for professional disciplinary proceedings; and

(4) state, federal, and international law enforcement authorities;

if the recipient agrees, and has the legal authority to agree, to maintain the confidential and privileged status of the confidential information in the same manner and to the same extent as required

for the commissioner.

(d) The commissioner:

(1) may receive confidential information, including privileged confidential information, from:

(A) other state, federal, and international regulatory agencies;

(B) the NAIC and affiliates and subsidiaries of the NAIC;

(C) the Actuarial Board for Counseling and Discipline or the successor to the Actuarial Board for Counseling and Discipline; and

(D) other state, federal, and international law enforcement authorities; and

(2) shall maintain as confidential or privileged all confidential information received with notice or the understanding that the confidential information is confidential or privileged under the law of the jurisdiction that is the source of the confidential information.

(e) The commissioner may enter into agreements governing sharing and use of information consistent with this section.

(f) Any applicable privilege or claim of confidentiality in confidential information described in this section is not waived as a result of the disclosure or receipt of the confidential information by the commissioner under this section.

(g) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this section is available and must be enforced in a proceeding in and by any court of this state.

(h) For purposes of this section, "regulatory agency", "law enforcement agency", and "NAIC" include employees, agents, consultants, and contractors of a regulatory agency, law enforcement agency, and NAIC.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-38

Confidential information; release

Sec. 38. The following apply to confidential information specified in section 5(1) and 5(4) of this chapter:

(1) The confidential information may be subject to subpoena to defend an action seeking damages from the appointed actuary submitting the supporting memorandum submitted under sections 21 through 23 of this chapter or principle based valuation report developed under section 35(c)(3) of this chapter due to a requirement of this chapter.

(2) The confidential information may be released by the commissioner with the written consent of the company.

(3) If a part of a supporting memorandum submitted under sections 21 through 23 of this chapter or a principle based valuation report developed under section 35(c)(3) of this

chapter is:

(A) cited by a company in the company's marketing;

(B) publicly volunteered to or before a governmental agency other than a state insurance department; or

(C) released by the company to the news media;

all parts of the supporting memorandum or report are not confidential.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-39

Exemptions of certain products from requirements

Sec. 39. (a) The commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in Indiana from the requirements of section 34 of this chapter if:

(1) the commissioner has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing; and

(2) the company computes reserves using assumptions and methods used before the operative date of the valuation manual in addition to requirements established by the commissioner in rules adopted under IC 4-22-2.

(b) With respect to a company granted an exemption under this section, sections 21 through 33 of this chapter apply. With respect to a company applying the exemption under this section, a reference to section 34 of this chapter in sections 21 through 33 of this chapter does not apply.

As added by P.L.276-2013, SEC.10.

IC 27-1-12.8-40

Conflict of laws; application of chapter

Sec. 40. (a) If a provision of law is inconsistent with this chapter, this chapter prevails.

(b) Except as otherwise provided in this chapter, this chapter applies to valuations performed after June 30, 2013.

(c) Except as otherwise provided in this chapter, IC 27-1-12-9 and IC 27-1-12-10 (before their repeal) apply to valuations performed before July 1, 2013.

As added by P.L.276-2013, SEC.10.

IC 27-1-13

Chapter 13. Casualty, Fire, and Marine Insurance Company Powers and Policy Requirements

IC 27-1-13-0.1

Application of certain amendments to chapter

Sec. 0.1. The amendments made to section 3.5 of this chapter by P.L.88-2000 apply to financial statements filed by an insurer after December 31, 1999.

As added by P.L.220-2011, SEC.423.

IC 27-1-13-1

Particular rights, privileges, and powers of casualty, fire, or marine insurers; exceptions

Sec. 1. In addition to the general rights, privileges, and powers conferred by IC 27-1-5 through IC 27-1-13 and IC 27-11 and subject to the limitations and restrictions contained in this article and in the articles of incorporation, every casualty, fire, or marine insurance company shall possess and may exercise the rights, privileges, and powers enumerated in this chapter, except that such powers shall not be intended or interpreted to mean that a company organized under either class as set out and defined in IC 27-1-5-1 shall make any kind or kinds of insurance as set out and defined in any other class of IC 27-1-5-1 other than as expressly provided in such classification.

(Formerly: Acts 1935, c.162, s.170.) As amended by P.L.252-1985, SEC.67; P.L.3-1990, SEC.97.

IC 27-1-13-2

Repealed

(Repealed by Acts 1981, P.L.241, SEC.4.)

IC 27-1-13-3

Investment of capital and funds above capital; real estate interests

Sec. 3. (a) The following definitions apply throughout this section:

(1) "Acceptable collateral" means the following:

(A) As to securities lending transactions and for the purpose of calculating counterparty exposure:

(i) cash;

(ii) cash equivalents;

(iii) letters of credit; and

(iv) direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or any agency of the United States, including the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation.

(B) As to lending foreign securities, sovereign debt rated 1 by the Securities Valuation Office.

(C) As to repurchase transactions:
(i) cash;
(ii) cash equivalents; and
(iii) direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or any agency of the United States, including the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation.
(D) As to reverse repurchase transactions:
(i) cash; and
(ii) cash equivalents.
(2) "Admitted assets" means assets permitted to be reported as admitted assets on the statutory financial statement of the insurer most recently required to be filed with the commissioner.
(3) "Business entity" means any of the following:
(A) A sole proprietorship.
(B) A corporation.
(C) A limited liability company.
(D) An association.
(E) A general partnership.
(F) A limited partnership.
(G) A limited liability partnership.
(H) A joint stock company.
(I) A joint venture.
(J) A trust.
(K) A joint tenancy.
(L) Any other similar form of business organization, whether for profit or nonprofit.
(4) "Cash" means any of the following:
(A) United States denominated paper currency and coins.
(B) Negotiable money orders and checks.
(C) Funds held in any time or demand deposit in any depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.
(5) "Cash equivalent" means any of the following:
(A) A certificate of deposit issued by a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.
(B) A banker's acceptance issued by a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation.
(C) A government money market mutual fund.
(D) A class one (1) money market mutual fund.
(6) "Class one (1) money market mutual fund" means a money market mutual fund that at all times qualifies for investment using the bond class one (1) reserve factor pursuant to the Purposes and Procedures of the Securities Valuation Office of

the National Association of Insurance Commissioners or any successor publication.

(7) "Derivative transaction" has the meaning set forth in IC 27-1-12-2.2(a)(14).

(8) "Government money market mutual fund" means a money market mutual fund that at all times:

(A) invests only in obligations issued, guaranteed, or insured by the United States or collateralized repurchase agreements composed of these obligations; and

(B) qualifies for investment without a reserve pursuant to the Purposes and Procedures of the Securities Valuation Office of the National Association of Insurance Commissioners or any successor publication.

(9) "Money market mutual fund" means a mutual fund that meets the conditions of 17 CFR 270.2a-7, under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.).

(10) "Mutual fund" means:

(A) an investment company; or

(B) in the case of an investment company that is organized as a series company, an investment company series;

that is registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.).

(11) "Obligation" means any of the following:

(A) A bond.

(B) A note.

(C) A debenture.

(D) Any other form of evidence of debt.

(12) "Qualified business entity" means a business entity that is:

(A) an issuer of obligations or preferred stock that is rated one (1) or two (2) or is rated the equivalent of one (1) or two (2) by the Securities Valuation Office or by a nationally recognized statistical rating organization recognized by the Securities Valuation Office; or

(B) a primary dealer in United States government securities, recognized by the Federal Reserve Bank of New York.

(13) "Securities Valuation Office" refers to the Securities Valuation Office of the National Association of Insurance Commissioners or any successor of the Office established by the National Association of Insurance Commissioners.

(b) Any company, other than one organized as a life insurance company, organized under the provisions of IC 27-1 or any other law of this state and authorized to make any or all kinds of insurance described in class 2 or class 3 of IC 27-1-5-1 shall invest its capital or guaranty fund as follows and not otherwise:

(1) In cash.

(2) In:

(A) direct obligations of the United States; or

(B) obligations secured or guaranteed as to principal and interest by the United States.

(3) In:

(A) direct obligations; or

(B) obligations secured by the full faith and credit;

of any state of the United States or the District of Columbia.

(4) In obligations of any county, township, city, town, village, school district, or other municipal district within the United States which are a direct obligation of the county, township, city, town, village, or district issuing the same.

(5) In obligations secured by mortgages or deeds of trust or unencumbered real estate or perpetual leases thereon in the United States not exceeding eighty percent (80%) of the fair value of the security determined in a manner satisfactory to the department, except that the percentage stated may be exceeded if and to the extent such excess is guaranteed or insured by the United States, any state, territory, or possession of the United States, the District of Columbia, Canada, any province of Canada, or by an administration, agency, authority, or instrumentality of any such governmental units. Where improvements on the land constitute a part of the value on which the loan is made, the improvements shall be insured against fire and tornado for the benefit of the mortgagee. For the purposes of this section, real estate may not be deemed to be encumbered by reason of the existence of taxes or assessments that are not delinquent, instruments creating or reserving mineral, oil, or timber rights, rights-of-way, joint driveways, sewer rights, rights-in-walls, nor by reason of building restrictions, or other restrictive covenants, nor when such real estate is subject to lease in whole or in part whereby rents or profits are reserved to the owner. The restrictions contained in this subdivision do not apply to loans or investments made under section 5 of this chapter.

(c) Any company organized under the provisions of this article or any other law of this state and authorized to make any or all of the kinds of insurance described in class 2 or class 3 of IC 27-1-5-1 shall invest its funds over and above its required capital stock or required guaranty fund as follows, and not otherwise:

(1) In cash or cash equivalents. However, not more than ten percent (10%) of admitted assets may be invested in any single government money market mutual fund or class one (1) money market mutual fund.

(2) In direct obligations of the United States or obligations secured or guaranteed as to principal and interest by the United States.

(3) In obligations issued, guaranteed, or insured as to principal and interest by a city, county, drainage district, road district, school district, tax district, town, township, village or other civil

administration, agency, authority, instrumentality or subdivision of a state, territory, or possession of the United States, the District of Columbia, Canada, or any province of Canada, providing such obligations are authorized by law and are either:

(A) direct and general obligations of the issuing, guaranteeing, or insuring governmental unit, administration, agency, authority, district, subdivision, or instrumentality;

(B) payable from designated revenues pledged to the payment of the principal and interest of the obligations; or

(C) improvement bonds or other obligations constituting a first lien, except for tax liens, against all of the real estate within the improvement district or on that part of such real estate not discharged from such lien through payment of the assessment.

The area to which the improvement bonds or other obligations under clause (C) relate must be situated within the limits of a town or city and at least fifty percent (50%) of the properties within that area must be improved with business buildings or residences.

(4) In:

(A) direct obligations; or

(B) obligations secured by the full faith and credit;

of any state of the United States, the District of Columbia, or Canada or any province thereof.

(5) In obligations guaranteed, supported, or insured as to principal and interest by the United States, any state, territory, or possession of the United States, the District of Columbia, Canada, any province of Canada, or by an administration, agency, authority, or instrumentality of any of the political units listed in this subdivision. An obligation is "supported" for the purposes of this subdivision when repayment of the obligation is secured by real or personal property of value at least equal to the principal amount of the indebtedness by means of mortgage, assignment of vendor's interest in one (1) or more conditional sales contracts, other title retention device, or by means of other security interest in the property for the benefit of the holder of the obligation, and one (1) of the political units listed in this subdivision, or an administration, agency, authority, or instrumentality listed in this subdivision, has entered into a firm agreement to rent or use the property pursuant to which entity is obligated to pay money as rental or for the use of the property in amounts and at times that are sufficient, after provision for taxes upon and for other expenses of the use of the property, to repay in full the indebtedness, both principal and interest, and when the firm agreement and the money obligated to be paid under the agreement are assigned, pledged, or secured for the benefit of the holder of the obligation. However, where the security consists of a first mortgage lien or deed of trust on a fee

interest in real property, the obligation may provide for the amortization, during the initial fixed period of the lease or contract of less than one hundred percent (100%) of the indebtedness if there is pledged or assigned, as additional security for the obligation, sufficient rentals payable under the lease, or of contract payments, to secure the amortized obligation payments required during the initial, fixed period of the lease or contract, including but not limited to payments of principal, interest, and taxes other than the income taxes of the borrower, and if there is to be left unamortized at the end of the period an amount not greater than the original appraised value of the land only, exclusive of all improvements, as prescribed by law.

(6) In obligations secured by mortgages or deeds of trust or unencumbered real estate or perpetual leases thereon, in any state in the United States, the District of Columbia, Canada, or any province of Canada, not exceeding eighty percent (80%) of the fair value of the security determined in a manner satisfactory to the department, except that the percentage stated may be exceeded if and to the extent that the excess is guaranteed or insured by the United States, any state, territory, or possession of the United States, the District of Columbia, Canada, any province of Canada, or by an administration, agency, authority, or instrumentality of any of such governmental units. The value of the real estate must be determined by a method and in a manner satisfactory to the department. The restrictions contained in this subdivision do not apply to loans or investments made under section 5 of this chapter.

(7) In obligations issued under or pursuant to the Farm Credit Act of 1971 (12 U.S.C. 2001 through 2279aa-14) as in effect on December 31, 1990, or the Federal Home Loan Bank Act (12 U.S.C. 1421 through 1449) as in effect on December 31, 1990, interest bearing obligations of the FSLIC Resolution Fund and shares of any institution that is insured by the Federal Deposit Insurance Corporation to the extent that the shares are insured, obligations issued or guaranteed by the International Bank for Reconstruction and Development, obligations issued or guaranteed by the Inter-American Development Bank, and obligations issued or guaranteed by the African Development Bank.

(8) In any mutual fund that:

(A) has been registered with the Securities and Exchange Commission for a period of at least five (5) years immediately preceding the date of purchase;

(B) has net assets of at least twenty-five million dollars ($25,000,000) on the date of purchase; and

(C) invests substantially all of its assets in investments

permitted under this subsection.

The amount invested in any single mutual fund shall not exceed ten percent (10%) of admitted assets. The aggregate amount of investments under this subdivision may be limited by the commissioner if the commissioner finds that investments under this subdivision may render the operation of the company hazardous to the company's policyholders, to the company's creditors, or to the general public. This subdivision in no way limits or restricts investments that are otherwise specifically permitted under this section.

(9) In obligations payable in United States dollars and issued, guaranteed, assumed, insured, or accepted by a foreign government or by a solvent business entity existing under the laws of a foreign government, if the obligations of the foreign government or business entity meet at least one (1) of the following criteria:

(A) The obligations carry a rating of at least A3 conferred by Moody's Investor Services, Inc.

(B) The obligations carry a rating of at least A- conferred by Standard & Poor's Corporation.

(C) The earnings available for fixed charges of the business entity for a period of five (5) fiscal years preceding the date of purchase have averaged at least three (3) times the average fixed charges of the business entity applicable to the period, and if during either of the last two (2) years of the period, the earnings available for fixed charges were at least three (3) times the fixed charges of the business entity for the year. As used in this subdivision, the terms "earnings available for fixed charges" and "fixed charges" have the meanings set forth in IC 27-1-12-2(a).

Foreign investments authorized by this subdivision shall not exceed twenty percent (20%) of the company's admitted assets. This subdivision in no way limits or restricts investments that are otherwise specifically permitted under this section. Canada is not a foreign government for purposes of this subdivision.

(10) In the obligations of any solvent business entity existing under the laws of the United States, any state of the United States, the District of Columbia, Canada, or any province of Canada, provided that interest on the obligations is not in default.

(11) In the preferred or guaranteed shares of any solvent business entity, so long as the business entity is not and has not been for the preceding five (5) years in default in the payment of interest due and payable on its outstanding debt or in arrears in the payment of dividends on any issue of its outstanding preferred or guaranteed stock.

(12) In the shares, other than those specified in subdivision (7), of any solvent business entity existing under the laws of any

state of the United States, the District of Columbia, Canada, or any province of Canada, and in the shares of any institution wherever located which has the insurance protection provided by the Federal Deposit Insurance Corporation. Except for the purpose of mutualization or for the purpose of retirement of outstanding shares of capital stock pursuant to amendment of its articles of incorporation, or in connection with a plan approved by the commissioner for purchase of such shares by the insurance company's officers, employees, or agents, or for the elimination of fractional shares, no company subject to the provisions of this section may invest in its own stock.

(13) In loans upon the pledge of any mortgage, stocks, bonds, or other evidences of indebtedness, acceptable as investments under the terms of this chapter, if the current value of the mortgage, stock, bond, or other evidences of indebtedness is at least twenty-five percent (25%) more than the amount loaned on it.

(14) In real estate, subject to subsections (d) and (e).

(15) In securities lending, repurchase, and reverse repurchase transactions with business entities, subject to the following requirements:

(A) The company's board of directors shall adopt a written plan that specifies guidelines and objectives to be followed, such as:

(i) a description of how cash received will be invested or used for general corporate purposes of the company;

(ii) operational procedures to manage interest rate risk, counterparty default risk, and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction; and

(iii) the extent to which the company may engage in these transactions.

(B) The company shall enter into a written agreement for all transactions authorized in this subdivision. The written agreement shall require the termination of each transaction not more than one (1) year from its inception or upon the earlier demand of the company. The agreement shall be with the counterparty business entity but, for securities lending transactions, the agreement may be with an agent acting on behalf of the company if the agent is a qualified business entity and if the agreement:

(i) requires the agent to enter into separate agreements with each counterparty that are consistent with the requirements of this section; and

(ii) prohibits securities lending transactions under the agreement with the agent or its affiliates.

(C) Cash received in a transaction under this section shall be invested in accordance with this section and in a manner that

recognizes the liquidity needs of the transaction or used by the company for its general corporate purposes. For as long as the transaction remains outstanding, the company or its agent or custodian shall maintain, as to acceptable collateral received in a transaction under this section, either physically or through book entry systems of the Federal Reserve, Depository Trust Company, Participants Trust Company, or other securities depositories approved by the commissioner:

(i) possession of the acceptable collateral;

(ii) a perfected security interest in the acceptable collateral; or

(iii) in the case of a jurisdiction outside the United States, title to, or rights of a secured creditor to, the acceptable collateral.

(D) For purposes of calculations made to determine compliance with this subdivision, no effect may be given to the company's future obligation to resell securities in the case of a repurchase transaction, or to repurchase securities in the case of a reverse repurchase transaction. A company shall not enter into a transaction under this subdivision if, as a result of and after giving effect to the transaction:

(i) the aggregate amount of securities then loaned, sold to, or purchased from any one (1) business entity pursuant to this subdivision would exceed five percent (5%) of its admitted assets (but, in calculating the amount sold to or purchased from a business entity pursuant to repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement); or

(ii) the aggregate amount of all securities then loaned, sold to, or purchased from all business entities under this subdivision would exceed forty percent (40%) of its admitted assets.

(E) In a securities lending transaction, the company shall receive acceptable collateral having a market value as of the transaction date at least equal to one hundred two percent (102%) of the market value of the securities loaned by the company in the transaction as of that date. If at any time the market value of the acceptable collateral is less than the market value of the loaned securities, the business entity shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals one hundred two percent (102%) of the market value of the loaned securities.

(F) In a reverse repurchase transaction, the company shall receive acceptable collateral having a market value as of the transaction date at least equal to ninety-five percent (95%) of the market value of the securities transferred by the

company in the transaction as of that date. If at any time the market value of the acceptable collateral is less than ninety-five percent (95%) of the market value of the securities so transferred, the business entity shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, equals at least ninety-five percent (95%) of the market value of the transferred securities.

(G) In a repurchase transaction, the company shall receive as acceptable collateral transferred securities having a market value equal to at least one hundred two percent (102%) of the purchase price paid by the company for the securities. If at any time the market value of the acceptable collateral is less than one hundred percent (100%) of the purchase price paid by the company, the business entity shall be obligated to provide additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, equals at least one hundred two percent (102%) of the purchase price. Securities acquired by a company in a repurchase transaction shall not be sold in a reverse repurchase transaction, loaned in a securities lending transaction, or otherwise pledged.

(16) In mortgage backed securities, including collateralized mortgage obligations, mortgage pass through securities, mortgage backed bonds, and real estate mortgage investment conduits, adequately secured by a pool of mortgages, which mortgages are fully guaranteed or insured by the government of the United States or any agency of the United States, including the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation.

(17) In mortgage backed securities, including collateralized mortgage obligations, mortgage pass through securities, mortgage backed bonds, and real estate mortgage investment conduits, adequately secured by a pool of mortgages, if the securities carry a rating of at least:

(A) A3 conferred by Moody's Investor Services, Inc.; or

(B) A- conferred by Standard & Poor's Corporation.

The amount invested in any one (1) obligation or pool of obligations described in this subdivision shall not exceed five percent (5%) of admitted assets. The aggregate amount of all investments under this subdivision shall not exceed ten percent (10%) of admitted assets.

(18) Any other investment acquired in good faith as payment on account of existing indebtedness or in connection with the refinancing, restructuring, or workout of existing indebtedness, if taken to protect the interests of the company in that

investment.

(19) In obligations or interests in trusts or partnerships in which a life insurance company may invest as described in paragraph 31 of IC 27-1-12-2(b). Investments authorized by this paragraph may not exceed ten percent (10%) of the company's admitted assets.

(20) In any other investment. The total of all investments under this subdivision, except for investments in subsidiary companies under IC 27-1-23-2.6, may not exceed an aggregate amount of ten percent (10%) of the insurer's admitted assets. Investments are not permitted under this subdivision:

(A) if expressly prohibited by statute; or

(B) in an insolvent organization or an organization in default with respect to the payment of principal or interest on its obligations.

(d) Any company subject to the provisions of this section shall have power to acquire, hold, or convey real estate, or an interest therein, as described below, and no other:

(1) Leaseholds, provided the mortgage term shall not exceed four-fifths (4/5) of the unexpired lease term, including enforceable renewable options, remaining at the time of the loan, such real estate or leaseholds to be located in the United States, any territory or possession of the United States, or Canada, the value of such leasehold for statement purposes shall be determined in a manner and form satisfactory to the department. At the time the leasehold is acquired and approved by the department, a schedule of annual depreciation shall be set up by the department in which the value of said leasehold is to be depreciated, and said depreciation is to be averaged out over not exceeding a period of fifty (50) years.

(2) The building in which it has its principal office and the land on which it stands.

(3) Such as shall be necessary for the convenient transaction of its business.

(4) Such as shall have been acquired for the accommodation of its business.

(5) Such as shall have been mortgaged to it in good faith by way of security for loans previously contracted or for money due.

(6) Such as shall have been conveyed to it in connection with its investments in real estate contracts or its investments in real estate under lease or for the purpose of leasing or such as shall have been acquired for the purpose of investment under any law, order, or regulation authorizing such investment, for statement purposes, the value of such real estate shall be determined in a manner satisfactory to the department.

(7) Such as shall have been conveyed to it in satisfaction of debts previously contracted in the course of its dealings, or in exchange for real estate so conveyed to it.

(8) Such as it shall have purchased at sales on judgments, decrees, or mortgages obtained or made for such debts.

(e) All real estate described in subsection (d)(4) through (d)(8) which is not necessary for the convenient transaction of its business shall be sold by said company and disposed of within ten (10) years after it acquired title to the same, or within five (5) years after the same has ceased to be necessary for the accommodation of its business, unless the company procures the certificate of the commissioner that its interests will suffer materially by a forced sale of the real estate, in which event the time for the sale may be extended to such time as the commissioner directs in the certificate.

(f) The board of directors of a company, other than a company organized as a life insurance company, shall do all the following:

(1) Before engaging in derivatives transactions, approve a written plan that specifies guidelines, systems, and objectives to be followed, such as:

(A) investment of or, if applicable, underwriting objectives and risk constraints, such as credit risk limits;

(B) permissible transactions and the relationship of those transactions to the insurer's operations;

(C) internal control procedures;

(D) a system for determining whether a derivative instrument used for hedging has been effective;

(E) a credit risk management system for over-the-counter derivatives transactions that measures credit risk exposure using the counterparty exposure amount; and

(F) a mechanism for reviewing and auditing compliance with the guidelines, systems, and objectives specified in the written plan.

(2) Before engaging in derivatives transactions, make a determination that the insurer's investment managers have adequate professional personnel, technical expertise, and systems to implement the insurer's intended investment practices involving derivative instruments.

(3) Review whether derivatives transactions have been made in accordance with the approved guidelines and are consistent with stated objectives.

(4) Take action to correct any deficiencies in internal controls relating to derivatives transactions.

(Formerly: Acts 1935, c.162, s.172; Acts 1937, c.288, s.3; Acts 1939, c.63, s.4; Acts 1949, c.206, s.1; Acts 1971, P.L.384, SEC.1; Acts 1973, P.L.277, SEC.1.) As amended by Acts 1981, P.L.241, SEC.1; P.L.159-1986, SEC.3; P.L.161-1986, SEC.1; P.L.121-1990, SEC.2; P.L.8-1991, SEC.9; P.L.184-1996, SEC.2; P.L.186-1997, SEC.7; P.L.1-2002, SEC.104; P.L.40-2004, SEC.2; P.L.89-2011, SEC.30; P.L.81-2012, SEC.3.

IC 27-1-13-3.5

Intangible assets attributable to investment in subsidiary; amount as percentage of capital and surplus

Sec. 3.5. (a) Except as provided by subsection (b), goodwill, trade names, and other like intangible assets attributable to any investment in a subsidiary shall be admitted as assets except:

(1) to the extent that the aggregate amount thereof exceeds ten percent (10%) of the capital and surplus of the insurer as reported in its latest annual report filed with the commissioner;

(2) to the extent that any such asset is not being amortized ratably over a period of ten (10) years or less from the date of acquisition; and

(3) in determining the financial condition or solvency of an insurer under IC 27-9.

(b) The commissioner may increase the ten percent (10%) limitation in subsection (a)(1) to an amount not to exceed twenty percent (20%) of the capital and surplus of the insurer as reported in its latest annual statement filed with the commissioner if:

(1) the assets of the insurer include good will, trade names, and other like intangible assets that are attributable to the acquisition after December 31, 1998, of an insurance company or health maintenance organization authorized to do business under the laws of any state; and

(2) as of the date of the initial request for an increase in the ten percent (10%) limitation in subsection (a)(1) the total adjusted capital of the insurer is at least four hundred percent (400%) of the authorized control level risk based capital of the insurer as reported in the latest annual report filed with the commissioner.

(c) The commissioner may retain experts to assist with a request made under subsection (b). The insurer shall pay all costs for the experts.

As added by P.L.160-1986, SEC.2. Amended by P.L.88-2000, SEC.1.

IC 27-1-13-4

Valuation of bonds and securities

Sec. 4. (a) All bonds or other evidences of debt having a fixed term and rate of interest held by an insurer may, if amply secured and not in default as to principal or interest, be valued as follows: If purchased at par, at the par value; if purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield in the meantime the effective rate of interest at which the purchase was made, or, instead of this method, according to an accepted method of valuation as is approved by the department. The purchase price shall in no case be taken at a higher figure than the actual market value at the time of purchase, plus actual brokerage, transfer, postage, or express charges paid in the acquisition of the securities. The department shall have full discretion in determining the method of calculating values according to the rules set forth in this subsection. However, no such method or

valuation under this subsection may be inconsistent with any applicable method or valuation used by insurers in general or any such method then currently formulated or approved by the National Association of Insurance Commissioners or its successor organization.

(b) Securities held by an insurer, other than those referred to in subsection (a), shall be valued, in the discretion of the department, at their market value or at their appraised value or at prices determined by the department as representing the fair market value of the securities. Preferred or guaranteed stocks or shares, while paying full dividends, may be carried at a fixed value in lieu of market value at the discretion of the department and in accordance with the method of valuation that the department approves. No valuation under this subsection may be inconsistent with any applicable valuation or method then currently formulated or approved by the National Association of Insurance Commissioners or its successor organization.

(Formerly: Acts 1935, c.162, s.172a.) As amended by P.L.130-1994, SEC.20; P.L.116-1994, SEC.27.

IC 27-1-13-5

Insured loans and investments

Sec. 5. (a) Subject to such rules as the department finds to be necessary and proper, any insurance company other than one organized as a life insurance company organized under the provisions of this article or any other law of this state and authorized to make any or all of the kinds of insurance described in Class 2 or Class 3 of IC 27-1-5-1 shall have the following powers:

(1) To make such loans and advances of credit and purchase of obligations representing loans and advances of credit as are eligible for insurance by the federal housing administrator, and to obtain such insurance.

(2) To make such loans secured by mortgages on real property or leasehold, as the federal housing administrator insures or makes a commitment to insure, and to obtain such insurance.

(3) To purchase, invest its capital and other funds in, and dispose of, notes or bonds secured by deed of trusts or mortgage insured by the federal housing administrator or debentures issued by the federal housing administrator, or bonds or other securities issued by national mortgage associations.

(b) No law of this state prescribing the nature, amount, or form of security or requiring security upon which loans or advances of credits may be made, or prescribing or limiting interest rates upon loans or advances of credit, or prescribing or limiting the period for which loans or advances of credit may be made shall be deemed to apply to loans, advances of credit, or purchases made pursuant to subsections (a)(1) and (a)(2).

(c) Any rule made and promulgated under and pursuant to this

section may apply to one (1) or more of the insurance companies to which this section is applicable.
(Formerly: Acts 1935, c.162, s.173; Acts 1937, c.288, s.4.) As amended by P.L.252-1985, SEC.68.

IC 27-1-13-6
Limitation on risks; effect of reinsurance

Sec. 6. (a) No company organized to make any kind or kinds of insurance included in class II and class III of IC 27-1-5-1 may take, on any one (1) risk of whatever nature, a sum exceeding one-tenth (1/10) part of its paid-up capital, surplus, and contingent reserves, if any, if a stock company, or one-tenth (1/10) part of its surplus and contingent reserves, if any, if other than a stock company. No portion of any such risk or hazard which shall have been reinsured in accordance with any regulations that the commissioner may enact pursuant to this section shall be included in determining the limitation of risk prescribed in this section. This section shall not apply to marine insurances, companies organized to make life insurance, or companies organized to issue title insurance.

(b) No stock or mutual insurance company transacting fidelity or surety business in this state shall expose itself to any loss on any one (1) fidelity or surety risk or hazard in an amount exceeding ten percent (10%) of its capital, surplus and contingent reserves, if any, unless it shall be protected in excess of that amount by: (a) Reinsurance in a company authorized to transact the fidelity or surety business in this state, provided that such reinsurance is in such form as to enable the obligee or beneficiary to maintain an action thereon against the company reinsured jointly with such reinsurer and, upon recovering judgment against such reinsured, to have recovery against such reinsurer for payment to the extent in which it may be liable under such reinsurance and in discharge thereof; or (b) the cosuretyship of such a company similarly authorized; or (c) deposit with it in pledge or conveyance to it in trust for its protection of property; or (d) conveyance or mortgage for its protection; or (e) in case a suretyship obligation was made on behalf or on account of a fiduciary holding property in a trust capacity, deposit or other disposition of a portion of the property so held in trust that no future sale, mortgage, pledge or other disposition can be made thereof without the consent of such company; except by decree or order of a court of competent jurisdiction. However (1) such a company may execute what are known as transportation or warehousing bonds for United States internal revenue taxes to an amount equal to fifty percent (50%) of its capital, surplus and contingent reserves, if any; (2) when the penalty of the suretyship obligation exceeds the amount of a judgment described therein as appealed from and thereby secured, or exceeds the amount of the subject-matter in controversy or of the estate in the hands of the fiduciary for the performance of whose duties it is conditioned, the bond may be executed if the actual

amount of the judgment or the subject-matter in controversy or estate not subject to supervision or control of the surety is not in excess of such limitation; and (3) when the penalty of the suretyship obligation executed for the performance of a contract exceeds the contract price, the latter shall be taken as the basis for estimating the limit of risk within the meaning of this section. No such company may, anything to the contrary in this section notwithstanding, execute suretyship obligations guaranteeing the deposits of any single financial institution in an aggregate amount in excess of ten percent (10%) of the capital, surplus and contingent reserves, if any, of such corporate surety, unless it is protected in excess of that amount by credits in accordance with subdivisions (a), (b), (c) or (d) of this subsection.

(Formerly: Acts 1935, c.162, s.175.) As amended by Acts 1982, P.L.162, SEC.1; P.L.260-1983, SEC.4.

IC 27-1-13-7

Policy requirements

Sec. 7. (a) No policy of insurance against:

(1) a:

(A) loss or damage resulting from accident to; or

(B) death or injury suffered by;

an employee or other person or persons and for which the person or persons insured are liable; or

(2) a loss or damage to property resulting from collision with any moving or stationary object and for which loss or damage the person or persons insured are liable;

shall be issued or delivered in this state by any domestic or foreign corporation, insurance underwriters, association, or other insurer authorized to do business in this state, unless the requirements of subsection (b) are met.

(b) A policy described in subsection (a) must contain the following:

(1) A provision that:

(A) the insolvency or bankruptcy of the person or persons insured shall not release the insurance carrier from the payment of damages for injury sustained or loss occasioned during the life of the policy; and

(B) if execution against the insured is returned unsatisfied in an action brought by the injured person or his or her personal representative in case death resulted from the accident because of insolvency or bankruptcy described in clause (A) then an action may be maintained by the injured person, or his or her personal representative, against the domestic or foreign corporation, insurance underwriters, association or other insurer under the terms of the policy for the amount of the judgment in the said action not exceeding the amount of the policy.

(2) A provision that notice given by or on behalf of the insured to any authorized agent of the insurer within this state, with particulars sufficient to identify the insured, shall be deemed to be notice to the insurer.

(3) If the policy is to be issued or delivered in this state to the owner of a motor vehicle, a provision insuring the owner against liability for damages for death or injury to person or property resulting from negligence in the operation of the motor vehicle, in the business of the owner or otherwise, by any person legally using or operating the motor vehicle with the permission, expressed or implied, of the owner.

(c) If a motor vehicle is owned jointly by a husband and wife:

(1) either spouse may, with the written consent of the other spouse, be excluded from coverage under a policy described in subsection (b)(3); and

(2) the husband and wife may choose to have their liability covered under separate policies.

(d) This section does not prohibit an insurer from making available a named driver exclusion in a commercial motor vehicle policy.

(e) A policy issued in violation of this section shall, nevertheless, be held valid but be deemed to include the provisions required by this section, and when any provision in the policy or rider is in conflict with a provision required to be contained by this section, the rights, duties and obligations of the insurer, the policyholder and the injured person or persons shall be governed by the provisions of this section.

(f) No policy of insurance shall be issued or delivered in this state by any foreign or domestic corporation, insurance underwriters, association, or other insurer authorized to do business in this state, unless it contains a provision that authorizes such foreign or domestic corporation, insurance underwriters, association, or other insurer authorized to do business in this state to settle the liability of its insured under IC 34-18 without the consent of its insured when the unanimous opinion of the medical review panel under IC 34-18-10-22(b)(1) is that the evidence supports the conclusion that the defendant failed to comply with the appropriate standard of care as charged in the complaint.

(Formerly: Acts 1935, c.162, s.177.) As amended by Acts 1981, P.L.241, SEC.2; P.L.111-1998, SEC.1; P.L.72-2016, SEC.8.

IC 27-1-13-7.5

Newly acquired motor vehicle; required coverage

Sec. 7.5. (a) As used in this section, "motor vehicle insurance" means any type of insurance described in IC 27-1-5-1, Class 2(f).

(b) As used in this section, "newly acquired motor vehicle" means one (1) of the following types of vehicles of which an individual who is insured under a personal lines motor vehicle insurance policy

becomes the owner during the policy period:

(1) A private passenger motor vehicle.

(2) A pickup truck or van for which no other insurance policy provides coverage.

(c) If the insured notifies the insurer of the newly acquired motor vehicle within the periods specified in subdivisions (1) and (2), an insurer that issues a motor vehicle insurance policy shall provide at least:

(1) fourteen (14) days of liability coverage; and

(2) if the motor vehicle insurance policy provides physical damage coverage, four (4) days of physical damage coverage that is subject to a deductible of not more than five hundred dollars ($500);

for a newly acquired motor vehicle under the motor vehicle insurance policy, effective on the date the insured becomes the owner.

As added by P.L.276-2013, SEC.11.

IC 27-1-13-8

Estimating condition; classification of items as assets or liabilities; reserves

Sec. 8. In estimating the condition of any company which makes insurance comprised within class 2 or class 3 of IC 27-1-5-1, the department shall allow only such investments as assets as are authorized by the laws of this state at the date of the investigation, but unpaid premiums on policies or renewals written within three (3) months shall be admitted as available resources. It shall charge as liabilities in addition to all other outstanding indebtedness of the company the capital stock, if any, and the following:

(a) The premium reserve on policies in force equal to fifty percent (50%) of the gross premiums charged for covering risks, less the reserve computed by the same method, on reinsurance in force. However, the department may, in its discretion, charge a premium reserve equal to the unearned portions of the gross premium charged by computing on each respective risk from the date of the issuance of the policy, less the reserve, computed by the same method, on reinsurance in force.

(b) In the case of policies of marine or inland navigation or transportation insurance it shall charge as a liability fifty percent (50%) of the amount of the premiums written in such policies upon yearly risks and upon risks covering not more than one (1) passage not terminated and the full amount of premiums written in policies upon all other such risks not terminated.

(c) The reserve for outstanding losses at least equal to the aggregate estimated amounts due or to become due on account of all losses or claims of which the company has received notice. However, the loss reserve shall also include the estimated liability on any notices received by the company of the occurrence of any event which may result in a loss and the estimated liability for all losses

which have occurred but on which no notice has been received. For the purpose of such reserves, the company shall keep a complete and itemized record showing all losses and claims on which it has received notice, including all notices received by it of the occurrence of any event which may result in a loss.

(d) Any other reserves as are required by or provided for in the annual statement blanks adopted by the National Association of Insurance Commissioners and furnished to companies under IC 27-1-3-13.

(e) Whenever, in the judgment of the department, the loss reserves calculated in accordance with subsections (a), (b), (c), and (d) are inadequate, it may in its discretion require a company to maintain additional reserves.

(Formerly: Acts 1935, c.162, s.179.) As amended by P.L.260-1983, SEC.7.

IC 27-1-13-8.5

Rules to prescribe minimum standards for establishment of reserves

Sec. 8.5. The department shall adopt rules under IC 4-22-2 to prescribe minimum standards for the establishment of reserves as required by the National Association of Insurance Commissioners or its successor organization for insurers writing Class 2 and Class 3 lines of business.

As added by P.L.130-1994, SEC.21 and P.L.116-1994, SEC.28.

IC 27-1-13-9

Trading or dealing in commodities, goods, wares, and merchandise

Sec. 9. No company shall directly or indirectly deal or trade in buying or selling goods, wares, merchandise or other commodities, except such as may have been insured by it and such as may be sold under judicial process or otherwise, in which, or in the profits of the sale of which, it may be interested by reason of having previously become insurers of the same or of some share or portion thereof.

(Formerly: Acts 1935, c.162, s.180.)

IC 27-1-13-10

Insurance rating bureaus; organizational regulations

Sec. 10. Any insurance rating bureau which files any rating plan, manual, classifications, rules or rates for fire, marine or inland marine and allied risks insurance with the insurance department of the state of Indiana for its members or subscribers shall as a condition precedent to the filing of an application to act as a rating bureau in the state of Indiana, establish in its constitution or by-laws the right of domestic insurers organized and operating under the laws of the state of Indiana, who are members of such rating bureau, to have representation on the board of directors, board of governors or any other governing body whatsoever, controlling said rating bureau,

in an amount of not less than 33 1/3% of all of the voting members of such governing body. The constitution and by-laws of said rating bureau shall also contain the condition that all meetings of the governing body of said rating bureau shall be held either in Chicago, Illinois or in Indianapolis, Indiana; Provided, however, That nothing contained herein shall limit the representation of such domestic insurers on said governing body. Indiana representatives on such governing body shall be nominated by special meeting of the Indiana members of such rating bureau at least 10 days preceding the election of representatives on the governing body of such rating bureau. The insurance commissioner of the state of Indiana shall have no right to approve any such rating bureau as a rating bureau in the state of Indiana until the aforesaid conditions are met by such bureau.
(Formerly: Acts 1935, c.162, s.180a; Acts 1947, c.269, s.1.)

IC 27-1-13-11
Insurance rating bureaus; meetings; appearance by aggrieved persons

Sec. 11. At all such meetings of the governing body held at Indianapolis, Indiana, as set out in section 10 of this chapter, any aggrieved policyholder, insurance producer, company, representative, or any other aggrieved person may appear before such meeting to have complaints heard in full, and it shall be the duty of such rating bureau to rectify such conditions as are justly complained of in such manner as is reasonably possible.
(Formerly: Acts 1935, c.162, s.180b; Acts 1947, c.269, s.2.) As amended by P.L.252-1985, SEC.69; P.L.178-2003, SEC.19.

IC 27-1-13-12
Insurance rating bureau; division of representation

Sec. 12. The representation of Indiana insurors on such governing body of such rating bureau described in section 10 of this chapter shall be equally divided as between domestic stock and mutual insurors, and the number of members on such governing body of such rating bureau shall be fixed so this can be accomplished.
(Formerly: Acts 1935, c.162, s.180c; Acts 1947, c.269, s.3.) As amended by P.L.252-1985, SEC.70.

IC 27-1-13-13
Repealed

(Repealed by P.L.108-1985, SEC.1.)

IC 27-1-13-14
Casualty and liability insurance; qualified public transportation agency; group coverage for functions

Sec. 14. (a) As used in this section:

"Casualty and liability insurance" means insurance included in Class II and Class III of IC 27-1-5-1.

"Qualified public transportation agency" means any of the following:

(1) A public transportation corporation established under IC 36-9-4.

(2) An agency of a city that provides for public transportation.

(3) An agency of a town that provides for public transportation.

(4) An agency of a township that provides for public transportation.

(5) Any person who provides public transportation to a county under an agreement with the county.

(b) A company authorized to issue casualty and liability insurance policies in Indiana may sell group casualty and liability insurance to two (2) or more qualified public transportation agencies only for the purpose of insuring their public transportation functions.

As added by P.L.256-1983, SEC.1.

IC 27-1-13-15

Property and casualty insurance blanket policies for planned unit development owners association or corporation

Sec. 15. (a) As used in this section, "planned unit development" has the meaning set forth in IC 36-7-1-14.5.

(b) As used in this section, "property and casualty insurance" means one (1) or more of the types of insurance described in IC 27-1-5-1, Class 2 and Class 3.

(c) An insurance company may issue a blanket policy of property and casualty insurance to an association or a nonprofit corporation composed of the owners of the property within a planned unit development for the purpose of insuring:

(1) the association or nonprofit corporation;

(2) the owners of the property within the planned unit development;

(3) the executive body of the association or nonprofit corporation;

(4) the managing agent of the association or nonprofit corporation, if any;

(5) all persons who act as agents or employees of:

(A) the association or nonprofit corporation;

(B) the owners of the property;

(C) the executive body; or

(D) the managing agent;

with respect to the planned unit development; and

(6) all other persons entitled to occupy any unit or other portion of the planned unit development, including property owners;

against losses under this subsection, including loss or damage to property within the planned unit development and loss of use or occupancy.

(d) An association or a nonprofit corporation composed of the owners of all of the property within a planned unit development is

authorized to purchase an insurance policy described in subsection (c).

As added by P.L.116-1994, SEC.29. Amended by P.L.1-2010, SEC.110.

IC 27-1-13-16

Notice of residential policy changes

Sec. 16. (a) This section applies to a policy of insurance that:

(1) covers first party loss to property located in Indiana; and

(2) insures against loss or damage to:

(A) real property consisting of not more than four (4) residential units, one (1) of which is the principal place of residence of the named insured; or

(B) personal property in which the named insured has an insurable interest and that is used within a residential dwelling for personal, family, or household purposes.

(b) An insurer that reduces, restricts, or removes, through a rider or an endorsement, coverage provided by a policy of insurance must provide to the named insured written notice, through the United States mail or by electronic means, of the changes to the policy. The written notice required by this subsection must:

(1) be part of a document that is separate from the rider or endorsement;

(2) be printed in at least 12 point type, 1 point leaded;

(3) consist of text that achieves a minimum score of forty (40) on the Flesch reading ease test or an equivalent score on a comparable test approved by the commissioner as provided by IC 27-1-26-6;

(4) identify the forms, provisions, or endorsements that are changed;

(5) indicate that the named insured may contact the servicing insurance producer for the policy, if any, or the insurer for assistance with any questions concerning the policy changes;

(6) indicate whether a premium adjustment will result from the policy changes; and

(7) set forth any options available to the named insured to repurchase the coverage that has been reduced, restricted, or removed.

(c) The insurer bears the burden to prove that notice was sent to the named insured in accordance with this section. If the notice is sent through the United States mail, proof of mailing as described in IC 27-7-6-7 is sufficient proof of the notice.

(d) The commissioner may adopt rules under IC 4-22-2 to implement this section.

As added by P.L.173-2007, SEC.9. Amended by P.L.3-2008, SEC.208; P.L.116-2011, SEC.1; P.L.6-2012, SEC.186; P.L.129-2014, SEC.5.

IC 27-1-13-17
Residential policy restrictions

Sec. 17. (a) This section applies to a policy of insurance that:

(1) covers first party loss to property located in Indiana; and

(2) insures against loss or damage to:

(A) real property consisting of not more than four (4) residential units, one (1) of which is the principal place of residence of the named insured; or

(B) personal property in which the named insured has an insurable interest and that is used within a residential dwelling for personal, family, or household purposes.

(b) A policy of insurance described in subsection (a) may not be issued, renewed, or delivered to any person in Indiana if the policy limits a policyholder's right to bring an action against an insurer to a period of less than two (2) years from the date of loss.

As added by P.L.173-2007, SEC.10.

IC 27-1-14
Repealed
(Repealed by P.L.262-1985, SEC.2.)

IC 27-1-15
Repealed

(Repealed by Acts 1977, P.L.280, SEC.3.)

IC 27-1-15.5
Repealed

(Repealed by P.L.132-2001, SEC.26.)

IC 27-1-15.6

Chapter 15.6. Insurance Producers

IC 27-1-15.6-1

Applicability of chapter

Sec. 1. This chapter governs the qualifications and procedures for the licensing of insurance producers. This chapter does not apply to surplus lines producers licensed under IC 27-1-15.8 except as specifically provided in this chapter or in IC 27-1-15.8.

As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-2

Definitions

Sec. 2. The following definitions apply throughout this chapter, IC 27-1-15.7, and IC 27-1-15.8:

(1) "Bureau" refers to the child support bureau established by IC 31-25-3-1.

(2) "Business entity" means a corporation, an association, a partnership, a limited liability company, a limited liability partnership, or another legal entity.

(3) "Commissioner" means the insurance commissioner appointed under IC 27-1-1-2.

(4) "Consultant" means a person who:

(A) holds himself or herself out to the public as being engaged in the business of offering; or

(B) for a fee, offers;

any advice, counsel, opinion, or service with respect to the benefits, advantages, or disadvantages promised under any policy of insurance that could be issued in Indiana.

(5) "Delinquent" means the condition of being at least:

(A) two thousand dollars ($2,000); or

(B) three (3) months;

past due in the payment of court ordered child support.

(6) "Designated home state license" means a license issued by the commissioner to an insurance producer who:

(A) maintains the insurance producer's principal place of residence or principal place of business in a state that does not license insurance producers for the line of authority for which the insurance producer seeks licensure in Indiana; and

(B) is permitted by the commissioner to designate Indiana as the insurance producer's nonresident home state.

(7) "FINRA" refers to the independent Financial Industry Regulatory Authority.

(8) "Home state" means the District of Columbia or any state or territory of the United States in which an insurance producer:

(A) maintains the insurance producer's principal place of residence or principal place of business; and

(B) is licensed to act as an insurance producer.

(9) "Insurance producer" means a person required to be licensed under the laws of Indiana to sell, solicit, or negotiate insurance.
(10) "License" means a document issued by the commissioner authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent, or inherent, in the holder to represent or commit an insurance carrier.
(11) "Limited line credit insurance" includes the following:
(A) Credit life insurance.
(B) Credit disability insurance.
(C) Credit property insurance.
(D) Credit unemployment insurance.
(E) Involuntary unemployment insurance.
(F) Mortgage life insurance.
(G) Mortgage guaranty insurance.
(H) Mortgage disability insurance.
(I) Guaranteed automobile protection (gap) insurance.
(J) Any other form of insurance:
(i) that is offered in connection with an extension of credit and is limited to partially or wholly extinguishing that credit obligation; and
(ii) that the insurance commissioner determines should be designated a form of limited line credit insurance.
(12) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one (1) or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.
(13) "Limited lines insurance" means any of the following:
(A) The lines of insurance defined in section 18 of this chapter.
(B) Any line of insurance the recognition of which is considered necessary by the commissioner for the purpose of complying with section 8(e) of this chapter.
(C) For purposes of section 8(e) of this chapter, any form of insurance with respect to which authority is granted by a home state that restricts the authority granted by a limited lines producer's license to less than total authority in the associated major lines described in section 7(a)(1) through 7(a)(6) of this chapter.
(14) "Limited lines producer" means a person authorized by the commissioner to sell, solicit, or negotiate limited lines insurance.
(15) "Limited lines travel insurance producer" means a person designated by an insurer to sell, solicit, or negotiate a travel insurance policy. The term includes the following:
(A) A managing general underwriter.
(B) A managing general agent.
(C) A limited lines producer.

(16) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(17) "Person" means an individual or a business entity.

(18) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of a company.

(19) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

(20) "Surplus lines producer" means a person who sells, solicits, negotiates, or procures from an insurance company not licensed to transact business in Indiana an insurance policy that cannot be procured from insurers licensed to do business in Indiana.

(21) "Terminate" means:

(A) the cancellation of the relationship between an insurance producer and the insurer; or

(B) the termination of a producer's authority to transact insurance.

(22) "Travel insurance" means insurance coverage for personal risks incident to planned travel, including the following:

(A) Interruption or cancellation of a trip or an event.

(B) Loss of baggage or personal effects.

(C) Damage to accommodations or rental vehicles.

(D) Sickness, accident, disability, or death that occurs during travel.

The term does not include a major medical plan that provides comprehensive medical insurance for a traveler on a trip that lasts at least six (6) months, including a traveler who is an individual who works overseas as an expatriot or is deployed as a member of the military.

(23) "Travel retailer" means a business entity that offers and delivers travel insurance on behalf of and under the direction of a limited lines travel insurance producer.

(24) "Uniform business entity application" means the current version of the national association of insurance commissioners uniform business entity application for resident and nonresident business entities.

(25) "Uniform application" means the current version of the national association of insurance commissioners uniform application for resident and nonresident producer licensing.

As added by P.L.132-2001, SEC.3. Amended by P.L.182-2001, SEC.1; P.L.145-2006, SEC.163; P.L.11-2011, SEC.8; P.L.276-2013, SEC.12; P.L.146-2015, SEC.21.

IC 27-1-15.6-3

Required licensing

Sec. 3. (a) A person shall not sell, solicit, or negotiate insurance in Indiana for any class or classes of insurance unless the person is licensed for that line of authority under this chapter.

(b) An insurer shall require a person who sells, solicits, or negotiates insurance in Indiana by any means of communication on behalf of the insurer to be licensed under this chapter.

(c) A violation of subsection (b) is deemed an unfair method of competition and an unfair and deceptive act and practice in the business of insurance under IC 27-4-1-4.

As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-4

Insurance producer license; when not required

Sec. 4. (a) As used in this section, "insurer" does not include an officer, director, employee, subsidiary, or affiliate of an insurer.

(b) This chapter does not require an insurer to obtain an insurance producer license.

(c) The following are not required to be licensed as an insurance producer:

(1) An officer, director, or employee of an insurer or of an insurance producer, if the officer, director, or employee does not receive any commission on policies written or sold to insure risks that reside, are located, or are to be performed in Indiana, and if:

(A) the officer, director, or employee's activities are executive, administrative, managerial, clerical, or a combination of these, and are only indirectly related to the sale, solicitation, or negotiation of insurance;

(B) the officer, director, or employee's function relates to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance; or

(C) the officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers and the officer, director, or employee'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:

(A) group life insurance, group property and casualty insurance, group annuities, or group or blanket accident and sickness insurance;

(B) enrolling individuals under plans;

(C) issuing certificates under plans or otherwise assisting in administering plans; or

(D) performing administrative services related to mass

marketed property and casualty insurance;

where no commission is paid to the person for the service.

(3) A person identified in clauses (A) through (C) who is not in any manner compensated, directly or indirectly, by a company issuing a contract, to the extent that the person is engaged in the administration or operation of a program of employee benefits for the employer's or association's employees, or for the employees of a subsidiary or affiliate of the employer or association, that involves the use of insurance issued by an insurer:

(A) An employer or association.

(B) An officer, director, or employee of an employer or association.

(C) The trustees of an employee trust plan.

(4) An:

(A) employee of an insurer; or

(B) organization employed by insurers;

that is engaged in the inspection, rating, or classification of risks, or in the supervision of the training of insurance producers, and that is not individually engaged in the sale, solicitation, or negotiation of insurance.

(5) A person whose activities in Indiana are limited to advertising, without the intent to solicit insurance in Indiana, through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of Indiana, provided that the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in Indiana.

(6) A person who is not a resident of Indiana and 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 (1) state insured under that contract, provided that:

(A) the person is otherwise licensed as an insurance producer to sell, solicit, or negotiate the insurance in the state where the insured maintains its principal place of business; and

(B) the contract of insurance insures risks located in that state.

(7) A salaried full-time employee who counsels or advises the employee's employer about 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) An officer, employee, or representative of a rental company (as defined in IC 24-4-9-7) who negotiates or solicits insurance incidental to and in connection with the rental of a motor vehicle.

(9) An individual who:
(A) furnishes only title insurance rate information at the request of a consumer; and
(B) does not discuss the terms or conditions of a title insurance policy.
(10) An employee or authorized representative of a vendor that is licensed as a limited lines producer under this chapter to sell, solicit, or negotiate portable electronics insurance incidental to and in connection with portable electronics transactions as described in IC 27-1-15.9.
(11) An employee or authorized representative of a self-storage facility that is licensed as a limited lines producer under this chapter to sell, solicit, or negotiate self-storage insurance incidental to and in connection with self-storage rental agreements as described in IC 27-1-16.1.

As added by P.L.132-2001, SEC.3. Amended by P.L.129-2003, SEC.3; P.L.64-2004, SEC.22; P.L.4-2012, SEC.1; P.L.81-2013, SEC.1; P.L.2-2014, SEC.114.

IC 27-1-15.6-5
Licensing examination

Sec. 5. (a) A resident individual applying for:
(1) an insurance producer license;
(2) a consultant's license; or
(3) a surplus lines producer license;

must pass a written examination unless the individual is exempt under section 9 of this chapter.

(b) The examination required under subsection (a) must test the knowledge of the individual concerning the:
(1) lines of authority for which application is made;
(2) duties and responsibilities of a licensee; and
(3) insurance laws and administrative rules of Indiana.

(c) Examinations required under this section must be developed and conducted under rules adopted by the commissioner.

(d) The commissioner may make arrangements, including contracting with an outside testing service, for administering examinations, collecting the nonrefundable examination fee as established by contract with an outside testing service, or collecting the nonrefundable licensure fee set forth in section 32 of this chapter.

(e) An individual who fails to appear for the examination required under subsection (a) as scheduled or who fails to pass the examination must reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

As added by P.L.132-2001, SEC.3. Amended by P.L.1-2002, SEC.105.

IC 27-1-15.6-6
Application for resident insurance producer

Sec. 6. (a) A person applying for a resident insurance producer license shall make application to the commissioner 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.

(b) Before approving an application submitted under subsection (a), the commissioner must find that the individual meets the following requirements:

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

(2) Has not committed any act that is a ground for denial, suspension, or revocation under section 12 of this chapter.

(3) Has completed, if required by the commissioner, a certified prelicensing course of study for the lines of authority for which the individual has applied.

(4) Has paid the nonrefundable fee set forth in section 32 of this chapter.

(5) Has successfully passed the examinations for the lines of authority for which the individual has applied.

(c) An applicant for a resident insurance producer license must file with the commissioner on a form prescribed by the commissioner a certification of completion certifying that the applicant has completed an insurance producer program of study certified by the commissioner under IC 27-1-15.7-5 not more than six (6) months before the application for the license is received by the commissioner. This subsection applies only to licensees seeking qualification in the lines of insurance described in sections 7(a)(1) through 7(a)(6) and 7(a)(8) of this chapter.

(d) A business entity, before acting as an insurance producer, is required to obtain an insurance producer license. The application submitted by a business entity under this subsection must be made using the uniform business entity application. Before approving the application, the commissioner must find that the business entity has:

(1) paid the fees required under section 32 of this chapter; and

(2) designated an individual licensed producer responsible for the business entity's compliance with the insurance laws and administrative rules of Indiana.

(e) The commissioner may require any documents reasonably necessary to verify the information contained in an application submitted under this subsection.

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

As added by P.L.132-2001, SEC.3. Amended by P.L.1-2002, SEC.106; P.L.64-2004, SEC.23.

IC 27-1-15.6-7

Insurance producer licenses; qualifications; expiration; renewal; registry

Sec. 7. (a) Unless denied licensure under section 12 of this chapter, a person who has met the requirements of sections 5 and 6 of this chapter shall be issued an insurance producer license. An insurance producer may receive qualification for a license in one (1) or more of the following lines of authority:

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

(2) Accident and health or sickness — insurance coverage for sickness, bodily injury, or accidental death that may include benefits for disability income.

(3) Property — insurance coverage for the direct or consequential loss of or damage to property of every kind.

(4) Casualty — insurance coverage against legal liability, including liability for death, injury, or disability, or for damage to real or personal property.

(5) Variable life and variable annuity products — insurance coverage provided under variable life insurance contracts and variable annuities.

(6) Personal lines — property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes.

(7) Credit — limited line credit insurance.

(8) Title — insurance coverage against loss or damage on account of encumbrances on or defects in the title to real estate.

(9) Any other line of insurance permitted under Indiana laws or administrative rules.

(b) A person who requests qualification under subsection (a)(5) for variable life and annuity products must:

(1) be licensed as an insurance producer with a life qualification under subsection (a)(1);

(2) be registered with FINRA; and

(3) meet the broker-dealer registration requirements of:

(A) FINRA for a Series 6 limited representative license; or

(B) FINRA for a Series 7 general securities registered representative license.

(c) A resident insurance producer may not request separate qualifications for property insurance and casualty insurance under subsection (a).

(d) An insurance producer license remains in effect unless revoked or suspended, as long as the renewal fee set forth in section 32 of this chapter is paid and the educational requirements for resident individual producers are met by the due date.

(e) An individual insurance producer who:

(1) allows the individual insurance producer's license to lapse;

and

(2) completed all required continuing education before the license expired;

may, not more than twelve (12) months after the expiration date of the license, reinstate the same license without the necessity of passing a written examination. A penalty in the amount of three (3) times the unpaid renewal fee shall be required for any renewal fee received after the expiration date of the license. However, the department of insurance may waive the penalty if the renewal fee is received not more than thirty (30) days after the expiration date of the license.

(f) A licensed insurance producer who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance may request a waiver of the license renewal procedures. The producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with the license renewal procedures.

(g) An insurance producer license shall contain the licensee's name, address, personal identification number, date of issuance, lines of authority, expiration date, and any other information the commissioner considers necessary.

(h) A licensee shall inform the commissioner of a change of address not more than thirty (30) days after the change by any means acceptable to the commissioner. The failure of a licensee to timely inform the commissioner of a change in legal name or address shall result in a penalty under section 12 of this chapter.

(i) To assist in the performance of the commissioner's duties, the commissioner may contract with nongovernmental entities, including the National Association of Insurance Commissioners (NAIC), or any affiliates or subsidiaries that the NAIC oversees, to perform ministerial functions, including the collection of fees related to producer licensing, that the commissioner and the nongovernmental entity consider appropriate.

(j) The commissioner may participate, in whole or in part, with the NAIC or any affiliate or subsidiary of the NAIC in a centralized insurance producer license registry through which insurance producer licenses are centrally or simultaneously effected for states that require an insurance producer license and participate in the centralized insurance producer license registry. If the commissioner determines that participation in the centralized insurance producer license registry is in the public interest, the commissioner may adopt rules under IC 4-22-2 specifying uniform standards and procedures that are necessary for participation in the registry, including standards and procedures for centralized license fee collection.

As added by P.L.132-2001, SEC.3. Amended by P.L.64-2004, SEC.24; P.L.11-2011, SEC.9; P.L.115-2011, SEC.7.

IC 27-1-15.6-7.3

Insurance producer frameable certificates

Sec. 7.3. (a) The commissioner may design or have designed an insurance producer certificate suitable for framing and display.

(b) Upon request of an insurance producer, the commissioner may issue a certificate described in subsection (a).

(c) The commissioner may impose and collect a reasonable fee for a certificate issued under subsection (b). The commissioner shall deposit fees collected under this subsection into the insurance education scholarship fund established by IC 21-12-9-5.

(d) The commissioner shall establish guidelines to implement this section.

As added by P.L.173-2007, SEC.11. Amended by P.L.3-2008, SEC.209.

IC 27-1-15.6-8

Nonresident producer license

Sec. 8. (a) Unless denied licensure under section 12 of this chapter, a nonresident person shall receive a nonresident producer license if:

(1) the person is currently licensed as a resident and in good standing in the person's home state;

(2) the person has submitted the proper request for licensure and has paid the fees required under section 32 of this chapter;

(3) the person has submitted or transmitted to the commissioner:

(A) the application for licensure that the person submitted to the person's home state; or

(B) a completed uniform application; and

(4) the person's home state awards non-resident producer licenses to residents of Indiana on the same basis as non-resident producer licenses are awarded to residents of other states under this chapter.

(b) The commissioner may verify a producer's licensing status through the Producer Database maintained by the National Association of Insurance Commissioners and its affiliates or subsidiaries.

(c) A:

(1) person who holds an Indiana nonresident producer's license and moves from one state to another state; or

(2) resident producer who moves from Indiana to another state;

shall file a change of address with the Indiana department of insurance and provide certification from the new resident state not more than thirty (30) days after the change of legal residence. No fee or license application is required under this subsection.

(d) Notwithstanding any other provision of this chapter, a person licensed as a surplus lines producer in the person's home state shall receive a nonresident surplus lines producer license under subsection

(a). Except as provided in subsection (a), nothing in this section otherwise amends or supercedes IC 27-1-15.8, as added by this act.

(e) Notwithstanding any other provision of this chapter, a person who is not a resident of Indiana and who is licensed as a limited lines credit insurance producer or another type of limited lines producer in the person's home state shall, upon application, receive a nonresident limited lines producer license under subsection (a) granting the same scope of authority as is granted under the license issued by the person's home state.

(f) Notwithstanding any other provision of this chapter, a nonresident producer who receives a nonresident producer license under this section shall maintain licensure in good standing in the nonresident producer's home state.

(g) If a nonresident producer fails to maintain licensure in good standing in the nonresident producer's home state, the commissioner may:

(1) in the commissioner's sole discretion;

(2) without a hearing; and

(3) in addition to any other sanction allowed by law;

suspend any Indiana insurance producer license held by the nonresident producer until the commissioner receives notice from the nonresident producer's home state that the home state license is in effect.

As added by P.L.132-2001, SEC.3. Amended by P.L.72-2016, SEC.9.

IC 27-1-15.6-8.2

Designated home state license

Sec. 8.2. (a) Unless denied licensure under section 12 of this chapter, a person that is not a resident of Indiana shall receive a designated home state license if:

(1) the person has requested licensure in Indiana for a line of authority for which licensure is not required in the person's home state;

(2) the person has submitted the proper request for licensure and has paid the fees required under section 32 of this chapter;

(3) the person has submitted or transmitted to the commissioner a completed uniform application; and

(4) the person has complied with the prelicensing and continuing education requirements that apply to an insurance producer that:

(A) is a resident of Indiana; and

(B) applies for the line of authority described in subdivision (1).

(b) The commissioner may verify an insurance producer's licensing status through the Producer Database maintained by the National Association of Insurance Commissioners and its affiliates or subsidiaries.

(c) A person that holds a designated home state license and moves

from one state to another state shall file a change of address with the department and provide certification from the new resident state not more than thirty (30) days after the change of legal residence. No fee or license application is required under this subsection.

(d) A person that:

(1) holds a designated home state license; and

(2) becomes a resident of a state that requires licensure for the line of authority for which the person holds the designated home state license;

shall become licensed for the line of authority in the new state of residence and notify the commissioner of the new licensure.

(e) Upon receiving notice of new licensure under subsection (d), the commissioner shall transfer the person's designated home state license to a nonresident producer license under section 8 of this chapter.

As added by P.L.146-2015, SEC.22.

IC 27-1-15.6-9

Prelicensing education; exemptions

Sec. 9. (a) An individual who applies for an insurance producer license in Indiana and who was previously licensed for the same lines of authority in another state is not required to complete any prelicensing education or examination. However, the exemption provided by this subsection is available only if:

(1) the individual is currently licensed in the other state; or

(2) the application is received within ninety (90) days after the cancellation of the applicant's previous license and:

(A) the other state issues a certification that, at the time of cancellation, the applicant was in good standing in that state; or

(B) the state's Producer Database records that are maintained by the National Association of Insurance Commissioners, its affiliates, or its subsidiaries, indicate that the producer is or was licensed in good standing for the line of authority requested.

(b) If a person is licensed as an insurance producer in another state and moves to Indiana, the person, to be authorized to act as an insurance producer in Indiana, must make application to become a resident licensee under section 6 of this chapter within ninety (90) days after establishing legal residence in Indiana. However, the person is not required to take prelicensing education or examination to obtain a license for any line of authority for which the person held a license in the other state unless the commissioner determines otherwise by rule.

(c) An individual who:

(1) has attained the designation of chartered life underwriter, certified financial planner, chartered financial consultant, or another nationally recognized designation approved by the

commissioner or the National Association of Insurance Commissioners; and

(2) applies for an insurance producer license in Indiana requesting qualification under sections:

(A) 7(a)(1);

(B) 7(a)(2); or

(C) 7(a)(5);

of this chapter;

is not required to complete prelicensing education and is required to take only the portion of the examination required under section 5(b) of this chapter that pertains to Indiana laws and rules.

(d) An individual who:

(1) has attained the designation of chartered property and casualty underwriter, certified insurance counselor, accredited advisor in insurance, or another nationally recognized designation approved by the commissioner or the National Association of Insurance Commissioners; and

(2) applies for an insurance producer license in Indiana requesting qualification under sections:

(A) 7(a)(3);

(B) 7(a)(4); or

(C) 7(a)(6);

of this chapter;

is not required to complete prelicensing education and is required to take only the portion of the examination required under section 5(b) of this chapter that pertains to Indiana laws and rules.

(e) An individual who:

(1) has attained a bachelor's degree in insurance; and

(2) applies for an insurance producer license in Indiana requesting qualification under section 7(a)(1) through 7(a)(6) of this chapter;

is not required to complete prelicensing education and is required to take only the part of the examination required under section 5 of this chapter that pertains to Indiana laws and rules.

As added by P.L.132-2001, SEC.3. Amended by P.L.11-2011, SEC.10.

IC 27-1-15.6-10

Use of assumed name

Sec. 10. Before an insurance producer may do business in Indiana under any name other than the producer's legal name, the insurance producer shall notify the commissioner of the proposed use of the assumed name.

As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-11

Temporary insurance producer license

Sec. 11. (a) If the commissioner considers the issuance of a

temporary license necessary for the servicing of an insurance business, the commissioner, without requiring an examination, may issue a temporary insurance producer license for a period of not more than one hundred eighty (180) days to any of the following:

(1) To the surviving spouse or court-appointed personal representative of a licensed individual insurance producer who dies or becomes mentally or physically disabled:

(A) to allow adequate time for the sale of the insurance business owned by the producer;

(B) to provide for the servicing of the insurance business until the recovery or return of the producer to the business; or

(C) to provide for the training and licensing of new personnel to operate the producer's business.

(2) To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license.

(3) To the designee of a licensed individual insurance producer entering active service in the armed forces of the United States of America.

(4) To an individual in any other circumstance where the commissioner considers the public interest to be best served by the issuance to the individual of a temporary insurance producer license.

(b) The commissioner may by order limit the authority of a temporary licensee in any way considered necessary to protect insureds and the public. The commissioner may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee and may impose other, similar requirements designed to protect insureds and the public.

(c) The commissioner may by order revoke a temporary insurance producer license if the interest of insureds or the public are endangered. A temporary insurance producer license issued under subsection (a)(1)(A) expires at the time the owner or the personal representative disposes of the business.

As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-12

Penalties

Sec. 12. (a) For purposes of this section, "permanently revoke" means that:

(1) the producer's license shall never be reinstated; and

(2) the former licensee, after the license revocation, is not eligible to submit an application for a license to the department.

(b) The commissioner may reprimand, levy a civil penalty, place an insurance producer on probation, suspend an insurance producer's license, revoke an insurance producer's license for a period of years,

permanently revoke an insurance producer's license, or refuse to issue or renew an insurance producer license, or take any combination of these actions, for any of the following causes:

(1) Providing incorrect, misleading, incomplete, or materially untrue information in a license application.

(2) Violating:

(A) an insurance law;

(B) a regulation;

(C) a subpoena of an insurance commissioner; or

(D) an order of an insurance commissioner;

of Indiana or of another state.

(3) Obtaining or attempting to obtain a license through misrepresentation or fraud.

(4) Improperly withholding, misappropriating, or converting any monies or properties received in the course of doing insurance business.

(5) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance.

(6) Having been convicted of a felony.

(7) Admitting to having committed or being found to have committed any unfair trade practice or fraud in the business of insurance.

(8) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in Indiana or elsewhere.

(9) Having an insurance producer license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory.

(10) Forging another's name to an application for insurance or to any document related to an insurance transaction.

(11) Improperly using notes or any other reference material to complete an examination for an insurance license.

(12) Knowingly accepting insurance business from an individual who is not licensed.

(13) Failing to comply with an administrative or court order imposing a child support obligation.

(14) Failing to pay state income tax or to comply with any administrative or court order directing payment of state income tax.

(15) Failing to satisfy the continuing education requirements established by IC 27-1-15.7.

(16) Violating section 31 of this chapter.

(17) Failing to timely inform the commissioner of a change in legal name or address, in violation of section 7(h) of this chapter.

(c) The commissioner shall refuse to:

(1) issue a license; or

(2) renew a license issued;

under this chapter to any person who is the subject of an order issued by a court under IC 31-16-12-10 (or IC 31-1-11.5-13(m), IC 31-6-6.1-16(m), or IC 31-14-12-7 before their repeal).

(d) If the commissioner refuses to renew a license or denies an application for a license, the commissioner shall notify the applicant or licensee and advise the applicant or licensee, in a writing sent through regular first class mail, of the reason for the denial of the applicant's application or the nonrenewal of the licensee's license. The applicant or licensee may, not more than sixty-three (63) days after notice of denial of the applicant's application or nonrenewal of the licensee's license is mailed, make written demand to the commissioner for a hearing before the commissioner to determine the reasonableness of the commissioner's action. The hearing shall be held not more than thirty (30) days after the applicant or licensee makes the written demand, and shall be conducted under IC 4-21.5.

(e) The license of a business entity may be suspended, revoked, or refused if the commissioner finds, after hearing, that a violation of an individual licensee acting on behalf of the partnership or corporation was known or should have been known by one (1) or more of the partners, officers, or managers of the partnership or corporation and:

(1) the violation was not reported to the commissioner; and

(2) no corrective action was taken.

(f) In addition to or in lieu of any applicable denial, suspension, or revocation of a license under subsection (b), a person may, after a hearing, be subject to the imposition by the commissioner under subsection (b) of a civil penalty of not less than fifty dollars ($50) and not more than ten thousand dollars ($10,000). A penalty imposed under this subsection may be enforced in the same manner as a civil judgement.

(g) A licensed insurance producer or limited lines producer shall, not more than ten (10) days after the producer receives a request in a registered or certified letter from the commissioner, furnish the commissioner with a full and complete report listing each insurer with which the licensee has held an appointment during the year preceding the request.

(h) If a licensee fails to provide the report requested under subsection (g) not more than ten (10) days after the licensee receives the request, the commissioner may, in the commissioner's sole discretion, without a hearing, and in addition to any other sanctions allowed by law, suspend any insurance license held by the licensee pending receipt of the appointment report.

(i) The commissioner shall promptly notify all appointing insurers and the licensee regarding any suspension, revocation, or termination of a license by the commissioner under this section.

(j) The commissioner may not grant, renew, continue, or permit to continue any license if the commissioner finds that the license is

being used or will be used by the applicant or licensee for the purpose of writing controlled business. As used in this subsection, "controlled business" means:

(1) insurance written on the interests of:

(A) the applicant or licensee;

(B) the applicant's or licensee's immediate family; or

(C) the applicant's or licensee's employer; or

(2) insurance covering:

(A) the applicant or licensee;

(B) members of the applicant's or licensee's immediate family; or

(C) either:

(i) a corporation, limited liability company, association, or partnership; or

(ii) the officers, directors, substantial stockholders, partners, members, managers, employees of such a corporation, limited liability company, association, or partnership;

of which the applicant or licensee or a member of the applicant's or licensee's immediate family is an officer, director, substantial stockholder, partner, member, manager, associate, or employee.

However, this section does not apply to insurance written or interests insured in connection with or arising out of credit transactions. A license is considered to have been used or intended to be used for the purpose of writing controlled business if the commissioner finds that during any twelve (12) month period the aggregate commissions earned from the controlled business exceeded twenty-five percent (25%) of the aggregate commission earned on all business written by the applicant or licensee during the same period.

(k) The commissioner has the authority to:

(1) enforce the provisions of; and

(2) impose any penalty or remedy authorized by;

this chapter or any other provision of this title against any person who is under investigation for or charged with a violation of this chapter or any other provision of this title, even if the person's license or registration has been surrendered or has lapsed by operation of law.

(l) For purposes of this section, the violation of any provision of IC 28 concerning the sale of a life insurance policy or an annuity contract shall be considered a violation described in subsection (b)(2).

(m) The commissioner may order a licensee to make restitution if the commissioner finds that the licensee has committed a violation described in:

(1) subsection (b)(4);

(2) subsection (b)(7);

(3) subsection (b)(8); or

(4) subsection (b)(16).

(n) The commissioner shall notify the securities commissioner appointed under IC 23-19-6-1(a) when an administrative action or civil proceeding is filed under this section and when an order is issued under this section denying, suspending, or revoking a license.
As added by P.L.132-2001, SEC.3. Amended by P.L.182-2001, SEC.2; P.L.27-2007, SEC.26; P.L.11-2011, SEC.11; P.L.207-2013, SEC.12.

IC 27-1-15.6-13
No consideration given to unlicensed sellers

Sec. 13. (a) An insurance company or insurance producer shall not pay a commission, service fee, brokerage fee, or other valuable consideration to a person for selling, soliciting, or negotiating insurance in Indiana if the person is required to be licensed under this chapter and is not licensed.

(b) A person shall not accept a commission, service fee, brokerage fee, or other valuable consideration for selling, soliciting, or negotiating insurance in Indiana if the person is required to be licensed under this chapter and is not licensed.

(c) Renewal commissions or other deferred commissions may be paid to a person for selling, soliciting, or negotiating insurance in Indiana if the person was required to be licensed under this chapter and was licensed at the time of the sale, solicitation, or negotiation.

(d) An insurer or insurance producer may pay or assign commissions, service fees, brokerage fees, or other valuable consideration to an insurance agency or to a person who does not sell, solicit, or negotiate insurance in Indiana, unless the payment would violate IC 27-1-20-30.
As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-14
Insurance producer acting as agent of insurer

Sec. 14. An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed producer of the insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.
As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-15
Notification of termination

Sec. 15. (a) An insurer or authorized representative of an insurer that terminates the appointment, employment, contract, or other insurance business relationship with a producer shall notify the commissioner not more than thirty (30) days after the effective date of the termination using a format prescribed by the commissioner, if:

(1) the reason for termination is described in section 12 of this chapter; or

(2) the insurer has knowledge that the producer was found by a court, a government body, or a self-regulatory organization authorized by law to have engaged in any of the activities described in section 12 of this chapter.

Upon the written request of the insurance commissioner, the insurer shall provide additional information, documents, records, and other data pertaining to the termination or activity of the producer.

(b) If an insurer discovers, upon further review or investigation, additional information that would have been reportable to the commissioner under subsection (a) had the insurer known of the existence of the additional information, the insurer or an authorized representative of the insurer shall promptly notify the commissioner of the additional information in a format acceptable to the commissioner.

(c) A copy of the notification of termination of a producer that must be provided to the commissioner under this section shall also be provided to the producer as follows:

(1) Not more than fifteen (15) days after making the notification required under subsection (a) or (b), the insurer shall mail a copy of the notification to the producer at the producer's last known address. If the producer is terminated for cause for any of the reasons described in section 12 of this chapter, the insurer shall provide a copy of the notification to the producer at the producer's last known address by certified mail, return receipt requested, postage prepaid, or by overnight delivery using a nationally recognized carrier.

(2) Not more than thirty (30) days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the commissioner. The producer shall, by the same means used by the producer to file the written comments with the commissioner, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the commissioner's file and accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under subsection (e).

(d) Immunities under this section are as follows:

(1) In the absence of actual malice, an insurer, an authorized representative of an insurer, a producer, the commissioner, and an organization of which the commissioner is a member and that compiles information and makes it available to other insurance commissioners or regulatory or law enforcement agencies are immune from civil liability, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees, as a result of:

(A) a statement or information required by or provided under this section or any information relating to a statement that may be requested in writing by the commissioner from an

insurer or producer; or

(B) a statement by a terminating insurer to a producer or by a producer to a terminating insurer;

limited solely and exclusively to whether a termination for cause referred to in subsection (a) was reported to the commissioner, provided that the propriety of any termination for cause referred to in subsection (a) is certified in writing by an officer or authorized representative of the insurer or producer terminating the relationship.

(2) In any action brought against a person that may have immunity under subdivision (1) for:

(A) making a statement required under this section; or

(B) providing information relating to a statement that may be requested by the commissioner;

the party bringing the action must plead specifically in any allegation that subdivision (1) does not apply because the person making the statement or providing the information did so with actual malice.

(3) Existing statutory or common law privileges or immunities are not abrogated or modified by subdivision (1) or (2).

(e) Confidentiality under this section is as follows:

(1) Documents, materials, and other forms of information in the control or possession of the department that are:

(A) furnished by:

(i) an insurer or producer; or

(ii) an employee or agent of an insurer acting on behalf of the insurer or producer; or

(B) obtained by the commissioner in an investigation under this section;

are confidential by law and privileged, are not subject to public inspection and copying under IC 5-14-3-3, are not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's duties.

(2) Neither the commissioner nor any person who receives confidential documents, materials, or other information described in subdivision (1) while acting under the authority of the commissioner may be permitted or required to testify in any private civil action concerning the confidential documents, materials, or information described in subdivision (1).

(3) To assist in the performance of the commissioner's duties under this chapter, the commissioner may:

(A) share documents, materials, and other information, including the confidential and privileged documents, materials, and information described in subdivision (1), with:

(i) other state, federal, and international regulatory agencies;
(ii) the National Association of Insurance Commissioners, its affiliates or subsidiaries; and
(iii) state, federal, and international law enforcement authorities;
provided that the recipient agrees to maintain the confidentiality and privileged status of the documents, materials, or other information;
(B) receive documents, materials, and information, including otherwise confidential and privileged documents, materials, and information, from:
(i) the National Association of Insurance Commissioners, its affiliates or subsidiaries; and
(ii) regulatory and law enforcement officials of other foreign or domestic jurisdictions;
and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and
(C) enter into agreements governing sharing and use of information consistent with this subsection.
(4) Disclosure of documents, materials, and information:
(A) to the commissioner; or
(B) by the commissioner;
under this section does not result in a waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information.
(5) This chapter does not prohibit the commissioner from releasing final, adjudicated actions, including for cause terminations that are open to public inspection under IC 5-14, to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners or by its affiliates or subsidiaries.

(f) If an insurer, an authorized representative of an insurer, or a producer fails to report as required under this section or is found to have reported falsely with actual malice by a court of competent jurisdiction, the commissioner may, after notice and hearing, suspend or revoke the license or certificate of authority of the insurer, authorized representative, or producer, and may fine the insurer, authorized representative, or producer under IC 27-4-1-6.
As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-16
Nonresident license applicant with license from other state

Sec. 16. (a) The commissioner shall waive any requirements, except the requirements imposed by section 8 of this chapter, for a

nonresident license applicant with a valid license from the applicant's home state if the applicant's home state awards nonresident licenses to residents of Indiana on the same basis.

(b) A nonresident producer's satisfaction of the nonresident producer's home state's continuing education requirements for licensed insurance producers also satisfies Indiana's continuing education requirements if the non-resident producer's home state recognizes the satisfaction of the non-resident producer's home state's continuing education requirements imposed upon producers from Indiana on the same basis.

As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-17

Reports of administrative actions or criminal prosecutions against producers

Sec. 17. (a) A producer shall report to the commissioner any administrative action taken against the producer in another jurisdiction or by another governmental agency in Indiana not more than thirty (30) days after the final disposition of the matter. The report shall include a copy of the order, consent to order, or other relevant legal documents.

(b) Not more than thirty (30) days after an initial pretrial hearing date, a producer shall report to the commissioner any criminal prosecution of the producer initiated in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-18

Issuance of limited lines producer's license without examination

Sec. 18. The commissioner may issue a limited lines producer's license to the following without examination:

(1) A limited lines travel insurance producer.

(2) A limited line credit insurance producer.

(3) A person who will only negotiate or solicit insurance under Class 2(j) of IC 27-1-5-1.

(4) Any person who will negotiate or solicit a kind of insurance that the commissioner finds does not require an examination to demonstrate professional competency.

(5) A person that will sell, solicit, or negotiate only portable electronics insurance as provided in IC 27-1-15.9.

(6) A person that will sell, solicit, or negotiate only self-storage insurance as provided in IC 27-1-16.1.

As added by P.L.132-2001, SEC.3. Amended by P.L.4-2012, SEC.2; P.L.81-2013, SEC.2; P.L.276-2013, SEC.13.

IC 27-1-15.6-19

Prearranged funeral insurance

Sec. 19. (a) As used in this section, "prearranged funeral insurance" means insurance that is used to fund any of the following:

(1) A funeral trust under IC 30-2-10 and IC 30-2-13.

(2) Any other arrangement for advance payment of funeral and burial expenses.

(b) A person shall not sell, solicit, or negotiate prearranged funeral insurance unless the person is licensed as either of the following:

(1) An insurance producer with a life qualification under section 7 of this chapter.

(2) A limited lines producer.

(c) A person may be licensed as a limited lines producer to sell only prearranged funeral insurance if the person is:

(1) licensed under IC 25-15-4-3; and

(2) granted a change in status under subsection (d).

(d) If, after a person is licensed under this chapter as an insurance producer with a life qualification, the person wants to limit the person's insurance business solely to the sale of prearranged funeral insurance, the person must:

(1) request the commissioner to issue the person a limited lines producer's license under this chapter; and

(2) show proof of having completed ten (10) hours of continuing education credit approved by the department.

(e) If the commissioner receives a request and proof under subsection (d), the commissioner shall issue a limited lines producer's license, subject to the provisions of this chapter relating to limited lines producer's licenses.

(f) A person issued a limited lines producer's license under subsection (e) may sell only prearranged funeral insurance.

As added by P.L.132-2001, SEC.3. Amended by P.L.1-2002, SEC.107.

IC 27-1-15.6-19.5

Annuities; insurance producer qualifications and training

Sec. 19.5. (a) As used in this section, "annuity" means an annuity that is:

(1) an insurance product under Indiana law; and

(2) solicited individually, regardless of whether the insurance product is classified as an individual annuity or a group annuity.

(b) A person may not sell, solicit, or negotiate an annuity unless the person meets the following requirements:

(1) The person is licensed as:

(A) an insurance producer with a life qualification under section 7(a)(1) of this chapter; or

(B) in the case of a variable annuity, an insurance producer with a variable annuity qualification under section 7(a)(5) of this chapter.

(2) The person has adequate knowledge of an annuity product

to recommend the annuity product.

(3) The person complies with the insurer's training standards for annuity products.

(4) The person has completed a single four (4) hour annuity training course that is conducted through a structured setting or self-study method and approved by the department in accordance with the requirements for approval that apply to continuing education courses under IC 27-1-15.7.

As added by P.L.11-2011, SEC.12. Amended by P.L.115-2011, SEC.8.

IC 27-1-15.6-19.7

Travel insurance; limited lines travel insurance producer license; requirements

Sec. 19.7. (a) A travel retailer and the travel retailer's employees and authorized representatives may offer and deliver a travel insurance policy if all of the following apply:

(1) The travel insurance policy is offered and delivered under a limited lines travel insurance producer license that is issued to a business entity described in subsection (b).

(2) The travel retailer is registered by the business entity as described in subsection (b).

(b) A business entity that holds a limited lines travel insurance producer license may register as a travel retailer to offer and deliver a travel insurance policy on the business entity's behalf if the business entity complies with all of the following:

(1) The business entity is clearly identified as the limited lines travel insurance producer, including the business entity's name and contact information, on all marketing materials and information delivered to customers by the travel retailer.

(2) The business entity does all of the following:

(A) Maintains a register of each travel retailer that offers travel insurance on the business entity's behalf, including all of the following:

(i) The name and contact information of the travel retailer.

(ii) The name and contact information of an officer or other individual who controls the travel retailer's operations.

(iii) The travel retailer's federal employer identification number.

(B) Certifies that each registered travel retailer complies with 18 U.S.C. 1033.

(C) Submits to the commissioner, not more than thirty (30) days after receiving a request from the commissioner, the register maintained under this subdivision.

(D) Designates an individual employee who is licensed as an insurance producer to be responsible for the business entity's compliance with the insurance laws of the state.

(E) Pays all required insurance producer licensing fees.

(F) Requires each travel retailer employee or authorized representative who offers or delivers travel insurance policies to receive a program of instruction or training that has been reviewed by the commissioner.

(c) A business entity is responsible for the acts of a travel retailer registered by the business entity as described in this section.

As added by P.L.276-2013, SEC.14.

IC 27-1-15.6-20

Crop hail insurance

Sec. 20. (a) As used in this section, "crop hail insurance" means insurance that is used only in the event of hail related disasters to growing farm crops.

(b) As used in this section, "multi-peril crop insurance" means insurance that is:

(1) used in the event of weather related disasters or insect infestations during the growing season; and

(2) guaranteed by the Federal Crop Insurance Corporation.

(c) To sell multi-peril crop insurance or crop hail insurance, a person must be licensed under this chapter.

(d) If, after a person is licensed under this chapter as an insurance producer, the person wants to limit the person's insurance business solely to the sale of:

(1) multi-peril crop insurance;

(2) crop hail insurance; or

(3) multi-peril crop insurance and crop hail insurance;

the person may request the commissioner to issue to the person a limited lines producer's license under this chapter.

(e) If the commissioner:

(1) receives a request from a person under subsection (d); and

(2) the person shows proof of having completed ten (10) hours of continuing education credit approved by the department;

the commissioner shall issue a limited lines producer's license to the person, subject to the provisions of this chapter relating to limited lines producer's licenses.

(f) A person issued a limited lines producer's license under subsection (e) may sell only:

(1) multi-peril crop insurance;

(2) crop hail insurance; or

(3) multi-peril crop insurance and crop hail insurance.

As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-21

Service of process

Sec. 21. (a) Service of process upon any nonresident producer licensee in any action or proceeding in any court of competent jurisdiction of Indiana arising out of the nonresident producer's

insurance business in Indiana may be made by serving the commissioner with appropriate copies thereof and paying to the commissioner a fee of two dollars ($2). The commissioner shall forward a copy of such process by registered or certified mail to the licensee at the licensee's last known address of record or principal place of business, and shall keep a record of all processes so served upon the commissioner.

(b) The service of process under subsection (a) is sufficient if notice of the service and a copy of the process are sent to the licensee at the licensee's last known address of record or principal place of business by registered or certified mail, return receipt requested not more than ten (10) days after the commissioner is served.

As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-22

Compensation; restrictions

Sec. 22. An insurance producer may not receive compensation for the sale, solicitation, negotiation, or renewal of any insurance policy issued to any person or entity for whom the insurance producer, for a fee, acts as a consultant for that policy unless:

(1) the insurance producer provides to the insured a written agreement in accordance with section 23(c) of this chapter; and

(2) the insurance producer discloses to the insured the following information prior to the sale, solicitation, negotiation, or renewal of any policy:

(A) The fact that the insurance producer will receive compensation for the sale of the policy.

(B) The method of compensation.

As added by P.L.132-2001, SEC.3. Amended by P.L.193-2006, SEC.3.

IC 27-1-15.6-23

Insurance consultant license

Sec. 23. (a) An individual or corporation shall not engage in the business of an insurance consultant until a consultant license has been issued to the individual or corporation by the commissioner. However, a consultant license is not required for the following:

(1) An attorney licensed to practice law in Indiana acting in the attorney's professional capacity.

(2) A duly licensed insurance producer or surplus lines producer.

(3) A trust officer of a bank acting in the normal course of the trust officer's employment.

(4) An actuary or a certified public accountant who provides information, recommendations, advice, or services in the actuary's or certified public accountant's professional capacity.

(b) An application for a license to act as an insurance consultant shall be made to the commissioner on forms prescribed by the

commissioner. An applicant may limit the scope of the applicant's consulting services by stating the limitation in the application. The areas of allowable consulting services are:

(1) Class 1, consulting regarding the kinds of insurance specified in IC 27-1-5-1, Class 1; and

(2) Class 2 and Class 3, consulting regarding the kinds of insurance specified in IC 27-1-5-1, Class 2 and Class 3.

Within a reasonable time after receipt of a properly completed application form, the commissioner shall hold a written examination for the applicant that is limited to the type of consulting services designated by the applicant, and may conduct investigations and propound interrogatories concerning the applicant's qualifications, residence, business affiliations, and any other matter that the commissioner considers necessary or advisable in order to determine compliance with this chapter or for the protection of the public.

(c) For purposes of this subsection, "consultant's fee" does not include a late fee charged under section 24 of this chapter or fees otherwise allowed by law. A consultant shall provide consultant services as outlined in a written agreement. The agreement must be signed by the person receiving services, and a copy of the agreement must be provided to the person receiving services before any services are performed. The agreement must outline the nature of the work to be performed by the consultant and the method of compensation of the consultant. The signed agreement must be retained by the consultant for not less than two (2) years after completion of the services. A copy of the agreement shall be made available to the commissioner. In the absence of an agreement on the consultant's fee, the consultant shall not be entitled to recover a fee in any action at law or in equity.

(d) An individual or corporation shall not concurrently hold a consultant license and an insurance producer's license, surplus lines producer's license, or limited lines producer's license at any time.

(e) A licensed consultant shall not:

(1) employ;

(2) be employed by;

(3) be in partnership with; or

(4) receive any remuneration whatsoever;

from a licensed insurance producer, surplus lines producer, or limited lines producer or insurer, except that a consultant may be compensated by an insurer for providing consulting services to the insurer.

(f) A consultant license shall be valid for not longer than twenty-four (24) months and may be renewed and extended in the same manner as an insurance producer's license. The commissioner shall designate on the license the consulting services that the licensee is entitled to perform.

(g) All requirements and standards relating to the denial, revocation, or suspension of an insurance producer's license,

including penalties, apply to the denial, revocation, and suspension of a consultant license as nearly as practicable.

(h) A consultant is obligated under the consultant's license to:

(1) serve with objectivity and complete loyalty solely the insurance interests of the consultant's client; and

(2) render the client such information, counsel, and service as within the knowledge, understanding, and opinion, in good faith of the licensee, best serves the client's insurance needs and interests.

(i) The form of a written agreement required by subsection (c) must be filed with the commissioner not less than thirty (30) days before the form is used. If the commissioner does not expressly approve or disapprove the form within thirty (30) days after filing, the form is considered approved. At any time after notice and for cause shown, the commissioner may withdraw approval of a form effective thirty (30) days after the commissioner issues notice that the approval is withdrawn.

As added by P.L.132-2001, SEC.3. Amended by P.L.193-2006, SEC.4.

IC 27-1-15.6-24

Commercial property and casualty insurance

Sec. 24. (a) This section applies to commercial property and casualty insurance coverage described in Class 2 and Class 3 of IC 27-1-5-1.

(b) A licensed insurance producer may charge a commercial insured a reasonable fee to reimburse the insurance producer for expenses incurred by the insurance producer at the specific request of the commercial insured, subject to the following requirements:

(1) Before incurring any expense described in this subsection, the insurance producer must provide written notice to the commercial insured stating that a fee will be charged and setting forth the:

(A) amount of the fee; or

(B) basis for calculating the fee.

(2) The amount of a fee and the basis for calculating a fee may not vary among commercial insureds.

(3) Any fee that is charged must be identified separately from premium and itemized in any bill provided to the commercial insured.

(c) A licensed insurance producer may charge a commercial insured a reasonable fee for services that are provided at the request of the commercial insured in connection with a policy that provides coverage described in subsection (a) and for which the insurance producer does not receive a commission or other compensation, subject to the following requirements:

(1) Before providing services, the insurance producer must provide to the commercial insured a written description of the

services to be provided and the fee for the services.

(2) Any fee that is charged must be identified separately from premium and itemized in any bill provided to the commercial insured.

(d) A licensed insurance producer who acts as a consultant and provides services described in this section shall comply with the requirements of this section and section 23 of this chapter.

(e) A licensed insurance producer may charge a late fee for agency billed accounts or policies that are more than thirty (30) days delinquent. A late fee may not exceed one and three quarters percent (1.75%) per month of the amount due on the due date.

As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-24.1

Personal property and casualty fees

Sec. 24.1. A licensed insurance producer may charge a reasonable fee for personal lines property and casualty insurance or services related to personal lines property and casualty insurance subject to the following requirements:

(1) The amount of a fee and the basis for calculating a fee may not vary among personal lines insureds.

(2) The amount of a fee is subject to the approval of the commissioner.

As added by P.L.173-2007, SEC.12.

IC 27-1-15.6-25

Representation of a fraternal benefit society

Sec. 25. An individual who performed the functions of a person representing a fraternal benefit society before July 1, 1977, is not required to take an examination, but is entitled to have an insurance producer's license issued to the individual, subject to IC 27-1-15.7 and the requirements of this chapter.

As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-26

Limited lines producer

Sec. 26. A person who performed the functions of a limited lines producer negotiating or soliciting the type of insurance described in IC 27-1-5-1, Class 2(j) before July 1, 1977, is not required to take an examination, but is entitled to have an insurance producer's license issued to the individual, subject to IC 27-1-15.7 and the requirements of this chapter.

As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-27

Solicitor's license

Sec. 27. A person who held a valid solicitor's license on July 1, 1977, is subject to the same rights and responsibilities under a

solicitor's license as the rights and responsibilities that were in effect before enactment of this chapter.
As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-28
Suspension of license

Sec. 28. (a) Upon receiving an order of a court issued under IC 31-16-12-10 (or IC 31-1-11.5-13(m), IC 31-6-6.1-16(m), or IC 31-14-12-7 before their repeal), the commissioner shall:

(1) suspend a license issued under this chapter to the person who is the subject of the order; and

(2) promptly mail a notice to the last known address of the person who is the subject of the order, stating the following:

(A) That the person's license is suspended beginning five (5) business days after the date the notice is mailed, and that the suspension will terminate not earlier than ten (10) business days after the commissioner receives an order allowing reinstatement from the court that issued the suspension order.

(B) That the person has the right to petition for reinstatement of a license issued under this chapter to the court that issued the order for suspension.

(b) The commissioner shall not reinstate a license suspended under subsection (a) until the commissioner receives an order allowing reinstatement from the court that issued the order for suspension.
As added by P.L.132-2001, SEC.3. Amended by P.L.207-2013, SEC.13.

IC 27-1-15.6-29
Probationary status

Sec. 29. (a) Upon receiving an order from the bureau (Title IV-D agency) under IC 31-25-4-32(i), the commissioner shall send to the person who is the subject of the order a notice that does the following:

(1) States that the person is delinquent and is subject to an order placing the person on probationary status.

(2) Explains that unless the person contacts the bureau and:

(A) pays the person's child support arrearage in full;

(B) establishes a payment plan with the bureau to pay the arrearage, which must include an income withholding order under IC 31-16-15-2 or IC 31-16-15-2.5; or

(C) requests a hearing under IC 31-25-4-33;

within twenty (20) days after the date the notice is mailed, the commissioner shall place the person on probationary status with respect to a license issued to the person under this chapter.

(3) Explains that the person may contest the bureau's determination that the person is delinquent and subject to an

order placing the person on probationary status by making written application to the bureau within twenty (20) days after the date the notice is mailed.

(4) Explains that the only basis for contesting the bureau's determination that the person is delinquent and subject to an order placing the person on probationary status is a mistake of fact.

(5) Explains the procedures to:

(A) pay the person's child support arrearage in full;

(B) establish a payment plan with the bureau to pay the arrearage, which must include an income withholding order under IC 31-16-15-2 or IC 31-16-15-2.5; and

(C) request a hearing under IC 31-25-4-33.

(6) Explains that the probation will terminate ten (10) business days after the commissioner receives a notice from the bureau that the person has:

(A) paid the person's child support arrearage in full; or

(B) established a payment plan with the bureau to pay the arrearage, which includes an income withholding order under IC 31-16-15-2 or IC 31-16-15-2.5.

(b) Upon receiving an order from the bureau (Title IV-D agency) under IC 31-25-4-34(d), the commissioner shall send a notice to the person who is the subject of the order stating the following:

(1) That a license issued to the person under this chapter has been placed on probationary status, beginning five (5) business days after the date the notice was mailed, and that the probation will terminate ten (10) business days after the commissioner receives a notice from the bureau that the person has:

(A) paid the person's child support arrearage in full; or

(B) established a payment plan with the bureau to pay the arrearage, which includes an income withholding order under IC 31-16-15-2 or IC 31-16-15-2.5.

(2) That if the commissioner is advised by the bureau that the person whose license has been placed on probationary status has failed to:

(A) pay the person's child support arrearage in full; or

(B) establish a payment plan with the bureau to pay the arrearage, which includes an income withholding order under IC 31-16-15-2 or IC 31-16-15-2.5;

within twenty (20) days after the date the notice is mailed, the commissioner shall suspend the person's license.

(c) If the commissioner receives a notice by the bureau (Title IV-D agency) under IC 31-25-4-32(i) that the person whose license has been placed on probationary status has failed to:

(1) pay the person's child support arrearage in full; or

(2) establish a payment plan with the bureau to pay the arrearage, which includes an income withholding order under IC 31-16-15-2 or IC 31-16-15-2.5;

within twenty (20) days after the notice required under subsection (b) is mailed, the commissioner shall suspend the person's license.

(d) The commissioner may not reinstate any license placed on probation or suspended under this section until the commissioner receives a notice from the bureau that the person has:

(1) paid the person's child support arrearage in full; or

(2) established a payment plan with the bureau to pay the arrearage, which includes an income withholding order under IC 31-16-15-2 or IC 31-16-15-2.5.

As added by P.L.132-2001, SEC.3. Amended by P.L.145-2006, SEC.164; P.L.103-2007, SEC.8.

IC 27-1-15.6-29.5

Determination of suspension or revocation of license

Sec. 29.5. If the commissioner receives a copy of a final order from the securities commissioner under IC 23-19-6-4(h), the commissioner shall:

(1) determine whether the person who is the subject of the final order is licensed by the department under this chapter; and

(2) if the person is licensed under this chapter, institute proceedings to determine whether the person's license should be suspended or revoked.

The determination under subdivision (2) may be based solely on the final order by the securities commissioner.

As added by P.L.48-2006, SEC.10. Amended by P.L.27-2007, SEC.27.

IC 27-1-15.6-30

Authority to enforce compliance

Sec. 30. The commissioner and the director of the department of financial institutions shall consult with each other and assist each other in enforcing compliance with the provisions of IC 28 concerning the sale of life insurance policies and annuity contracts. The commissioner and the director of the department of financial institutions may jointly conduct investigations, prosecute suits, and take other official action that the commissioner and the director consider appropriate under this section if either the commissioner or the director is empowered to take the action. If the director of the department of financial institutions is informed by a financial institution or its affiliate of a violation or suspected violation of any provision of IC 28 concerning the sale of life insurance policies or annuity contracts or of the insurance laws and rules of Indiana, the director of the department of financial institutions shall timely advise the commissioner of the violation. If the commissioner is informed by a financial institution or its affiliate of a violation or suspected violation of any provision of IC 28 concerning the sale of life insurance policies or annuity contracts or of the insurance laws and rules of Indiana, the commissioner shall timely advise the director of

the department of financial institutions of the violation.
As added by P.L.132-2001, SEC.3. Amended by P.L.1-2002, SEC.108.

IC 27-1-15.6-31
Producers not to be named as beneficiaries

Sec. 31. An insurance producer shall not:
(1) be named a beneficiary of;
(2) become an owner of; or
(3) receive a collateral assignment of;
an individual life insurance policy or individual annuity contract unless the insurance producer has an insurable interest in the life of the insured or annuitant. A beneficiary designation, ownership designation, or collateral assignment made in violation of this section is void.
As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-32
Fees for licensure

Sec. 32. (a) The department shall adopt rules under IC 4-22-2 to set fees for licensure under this chapter, IC 27-1-15.7, and IC 27-1-15.8.

(b) Insurance producer and limited lines producer license renewal fees are due every two (2) years. The fee charged by the department every two (2) years for a:
(1) resident license is forty dollars ($40);
(2) nonresident license is ninety dollars ($90); and
(3) designated home state license is ninety dollars ($90).

(c) Consultant renewal fees are due every twenty-four (24) months.

(d) Surplus lines producer renewal fees are due every two (2) years. The fee charged by the department every two (2) years for a:
(1) resident license is eighty dollars ($80); and
(2) nonresident license is one hundred twenty dollars ($120).

(e) The commissioner may issue a duplicate license for any license issued under this chapter. The fee charged by the commissioner for the issuance of a duplicate:
(1) insurance producer license;
(2) surplus lines producer license;
(3) limited lines producer license; or
(4) consultant license;
may not exceed ten dollars ($10).

(f) A fee charged and collected under this section shall be deposited into the department of insurance fund established by IC 27-1-3-28.
As added by P.L.132-2001, SEC.3. Amended by P.L.173-2007, SEC.13; P.L.234-2007, SEC.190; P.L.146-2015, SEC.23.

IC 27-1-15.6-33
Rules

Sec. 33. Except as otherwise provided in section 32 of this chapter, the commissioner may adopt rules under IC 4-22-2 to carry out the purposes of this chapter.

As added by P.L.132-2001, SEC.3.

IC 27-1-15.6-34
Hearings

Sec. 34. All hearings held under this chapter are governed by IC 4-21.5-3. The commissioner may appoint members of the commissioner's staff to act as hearing officers for purposes of hearings held under this chapter.

As added by P.L.132-2001, SEC.3.

IC 27-1-15.7

Chapter 15.7. Insurance Producer License Renewal

IC 27-1-15.7-0.1

Application of certain amendments to chapter

Sec. 0.1. The amendments made to section 2 of this chapter by P.L.60-2005 apply to renewal of an insurance producer license after June 30, 2005.

As added by P.L.220-2011, SEC.424.

IC 27-1-15.7-1

Applicability of definitions

Sec. 1. The definitions in IC 27-1-15.6-2 apply throughout this chapter.

As added by P.L.132-2001, SEC.4.

IC 27-1-15.7-2

License renewal

Sec. 2. (a) Except as provided in subsection (b), to renew a license issued under IC 27-1-15.6, a resident insurance producer must complete at least twenty-four (24) hours of credit in continuing education courses. If the insurance producer has a qualification described in IC 27-1-15.6-7(a)(1), IC 27-1-15.6-7(a)(2), or IC 27-1-15.6-7(a)(5), for a license renewal that occurs after June 30, 2014, at least three (3) of the hours of credit required by this subsection must be related to ethical practices in the marketing and sale of life, health, or annuity insurance products. An attorney in good standing who is admitted to the practice of law in Indiana and holds a license issued under IC 27-1-15.6 may complete all or any number of hours of continuing education required by this subsection by completing an equivalent number of hours in continuing legal education courses that are related to the business of insurance.

(b) Except as provided in subsection (c), to renew a license issued under IC 27-1-15.6, a limited lines producer with a title qualification under IC 27-1-15.6-7(a)(8) must complete at least seven (7) hours of credit in continuing education courses related to the business of title insurance with at least one (1) hour of instruction in a structured setting or comparable self-study in each of the following:

(1) Ethical practices in the marketing and selling of title insurance.

(2) Title insurance underwriting.

(3) Escrow issues.

(4) Principles of the federal Real Estate Settlement Procedures Act (12 U.S.C. 2608).

An attorney in good standing who is admitted to the practice of law in Indiana and holds a license issued under IC 27-1-15.6 with a title qualification under IC 27-1-15.6-7(a)(8) may complete all or any number of hours of continuing education required by this subsection

by completing an equivalent number of hours in continuing legal education courses related to the business of title insurance or any aspect of real property law.

(c) The following insurance producers are not required to complete continuing education courses to renew a license under this chapter:

(1) A limited lines producer who is licensed without examination under IC 27-1-15.6-18(1).

(2) A limited line credit insurance producer.

(3) A nonresident limited lines producer with a title qualification:

(A) whose home state requires continuing education for a title qualification; and

(B) who has met the continuing education requirements described in clause (A).

(d) To satisfy the requirements of subsection (a) or (b), a licensee may use only those credit hours earned in continuing education courses completed by the licensee:

(1) after the effective date of the licensee's last renewal of a license under this chapter; or

(2) if the licensee is renewing a license for the first time, after the date on which the licensee was issued the license under this chapter.

(e) If an insurance producer receives qualification for a license in more than one (1) line of authority under IC 27-1-15.6, the insurance producer may not be required to complete a total of more than twenty-four (24) hours of credit in continuing education courses to renew the license.

(f) Except as provided in subsection (g), a licensee may receive credit only for completing the following continuing education courses:

(1) Continuing education courses that have been approved by the commissioner under section 4 of this chapter.

(2) Continuing education courses that are required for the licensee under IC 27-19-4-14.

(g) A licensee who teaches a course approved by the commissioner under section 4 of this chapter shall receive continuing education credit for teaching the course.

(h) When a licensee renews a license issued under this chapter, the licensee must submit:

(1) a continuing education statement that:

(A) is in a format authorized by the commissioner;

(B) is signed by the licensee under oath; and

(C) lists the continuing education courses completed by the licensee to satisfy the continuing education requirements of this section; and

(2) any other information required by the commissioner.

(i) A continuing education statement submitted under subsection

(h) may be reviewed and audited by the department.

(j) A licensee shall retain a copy of the original certificate of completion received by the licensee for completion of a continuing education course.

(k) A licensee who completes a continuing education course that:

(1) is approved by the commissioner under section 4 of this chapter;

(2) is held in a classroom setting; and

(3) concerns ethics;

shall receive continuing education credit not to exceed four (4) hours in a renewal period.

As added by P.L.132-2001, SEC.4. Amended by P.L.1-2002, SEC.109; P.L.64-2004, SEC.25; P.L.60-2005, SEC.1; P.L.73-2006, SEC.1; P.L.173-2007, SEC.14; P.L.11-2011, SEC.13; P.L.81-2012, SEC.4; P.L.276-2013, SEC.15; P.L.278-2013, SEC.21.

IC 27-1-15.7-2.5

Waiver of licensure and continuing education requirements

Sec. 2.5. The commissioner shall, not later than September 1, 2005, establish a policy to allow a waiver of the:

(1) continuing education requirements of this chapter; and

(2) license renewal requirements of IC 27-1-15.6 and this chapter;

for an insurance producer who is serving on active duty in the armed forces of the United States in an area designated as a combat zone by the President of the United States.

As added by P.L.56-2005, SEC.1 and P.L.60-2005, SEC.2.

IC 27-1-15.7-3

Extension for continuing education requirements

Sec. 3. (a) The commissioner may grant an extension for complying with the continuing education requirement set forth in section 2 of this chapter.

(b) To receive an extension under this section, a licensee must:

(1) file a request with the commissioner on a form provided by the commissioner; and

(2) submit with the request an extension fee of twenty-five dollars ($25) for deposit in the department of insurance fund under IC 27-1-3-28.

(c) After a licensee files a request for an extension, the license of the licensee remains in effect until the commissioner makes a decision on the request.

(d) If the commissioner denies a licensee's request for an extension, the licensee must complete continuing education requirements set forth in section 2 of this chapter within ninety (90) days after the commissioner notifies the licensee of the denial.

As added by P.L.132-2001, SEC.4. Amended by P.L.81-2012, SEC.5.

IC 27-1-15.7-4

Approval of continuing education courses

Sec. 4. (a) The commissioner shall approve and disapprove continuing education courses after considering recommendations made by the insurance producer education and continuing education advisory council created under section 6 of this chapter.

(b) The commissioner may not approve a course under this section if the course:

(1) is designed to prepare an individual to receive an initial license under this chapter;

(2) concerns only routine, basic office skills, including filing, keyboarding, and basic computer skills;

(3) concerns sales promotion and sales techniques;

(4) concerns motivation, psychology, or time management; or

(5) may be completed by a licensee without supervision by an instructor, unless the course involves an examination process that is:

(A) completed and passed by the licensee as determined by the provider of the course; and

(B) approved by the commissioner.

(c) The commissioner shall approve a course under this section that is submitted for approval by an insurance trade association or professional insurance association if:

(1) the objective of the course is to educate a manager or an owner of a business entity that is required to obtain an insurance producer license under IC 27-1-15.6-6(d);

(2) the course teaches insurance producer management and is designed to result in improved efficiency in insurance producer operations, systems use, or key functions;

(3) the course is designed to benefit consumers; and

(4) the course is not described in subsection (b).

(d) Approval of a continuing education course under this section shall be for a period of not more than two (2) years.

(e) A prospective provider of a continuing education course shall pay:

(1) a fee of forty dollars ($40) for each course submitted for approval of the commissioner under this section; or

(2) an annual fee of five hundred dollars ($500) not later than January 1 of a calendar year, which entitles the prospective provider to submit an unlimited number of courses for approval of the commissioner under this section during the calendar year.

The commissioner may waive all or a portion of the fee for a course submitted under a reciprocity agreement with another state for the approval or disapproval of continuing education courses. Fees collected under this subsection shall be deposited in the department of insurance fund established under IC 27-1-3-28.

(f) The commissioner shall adopt rules under IC 4-22-2 to establish procedures for approving continuing education courses.

As added by P.L.132-2001, SEC.4. Amended by P.L.57-2005, SEC.1.

IC 27-1-15.7-5
Certified prelicensing courses of study

Sec. 5. (a) To qualify as a certified prelicensing course of study for purposes of IC 27-1-15.6-6, an insurance producer program of study must meet all of the following criteria:

(1) Be conducted or developed by an:
(A) insurance trade association;
(B) accredited college or university;
(C) educational organization certified by the insurance producer education and continuing education advisory council; or
(D) insurance company licensed to do business in Indiana.

(2) Provide for self-study or instruction provided by an approved instructor in a structured setting, as follows:
(A) For life insurance producers, not less than twenty (20) hours of instruction in a structured setting or comparable self-study on:
(i) ethical practices in the marketing and selling of insurance;
(ii) requirements of the insurance laws and administrative rules of Indiana; and
(iii) principles of life insurance.
(B) For health insurance producers, not less than twenty (20) hours of instruction in a structured setting or comparable self-study on:
(i) ethical practices in the marketing and selling of insurance;
(ii) requirements of the insurance laws and administrative rules of Indiana; and
(iii) principles of health insurance.
(C) For life and health insurance producers, not less than forty (40) hours of instruction in a structured setting or comparable self-study on:
(i) ethical practices in the marketing and selling of insurance;
(ii) requirements of the insurance laws and administrative rules of Indiana;
(iii) principles of life insurance; and
(iv) principles of health insurance.
(D) For property and casualty insurance producers, not less than forty (40) hours of instruction in a structured setting or comparable self-study on:
(i) ethical practices in the marketing and selling of insurance;
(ii) requirements of the insurance laws and administrative rules of Indiana;

(iii) principles of property insurance; and
(iv) principles of liability insurance.

(E) For personal lines producers, a minimum of twenty (20) hours of instruction in a structured setting or comparable self-study on:

(i) ethical practices in the marketing and selling of insurance;
(ii) requirements of the insurance laws and administrative rules of Indiana; and
(iii) principles of property and liability insurance applicable to coverages sold to individuals and families for primarily noncommercial purposes.

(F) For title insurance producers, not less than ten (10) hours of instruction in a structured setting or comparable self-study on:

(i) ethical practices in the marketing and selling of title insurance;
(ii) requirements of the insurance laws and administrative rules of Indiana;
(iii) principles of title insurance, including underwriting and escrow issues; and
(iv) principles of the federal Real Estate Settlement Procedures Act (12 U.S.C. 2608).

(G) For annuity product producers, not less than four (4) hours of instruction in a structured setting or comparable self-study on:

(i) types and classifications of annuities;
(ii) identification of the parties to an annuity;
(iii) the manner in which fixed, variable, and indexed annuity contract provisions affect consumers;
(iv) income taxation of qualified and non-qualified annuities;
(v) primary uses of annuities; and
(vi) appropriate sales practices, replacement, and disclosure requirements.

(3) Instruction provided in a structured setting must be provided only by individuals who meet the qualifications established by the commissioner under subsection (b).

(b) The commissioner, after consulting with the insurance producer education and continuing education advisory council, shall adopt rules under IC 4-22-2 prescribing the criteria that a person must meet to render instruction in a certified prelicensing course of study.

(c) The commissioner shall adopt rules under IC 4-22-2 prescribing the subject matter that an insurance producer program of study must cover to qualify for certification as a certified prelicensing course of study under this section.

(d) The commissioner may make recommendations that the

commissioner considers necessary for improvements in course materials.

(e) The commissioner shall designate a program of study that meets the requirements of this section as a certified prelicensing course of study for purposes of IC 27-1-15.6-6.

(f) For each person that provides one (1) or more certified prelicensing courses of study, the commissioner shall annually determine, of all individuals who received classroom instruction in the certified prelicensing courses of study provided by the person, the percentage who passed the examination required by IC 27-1-15.6-5. The commissioner shall determine only one (1) passing percentage under this subsection for all lines of insurance described in IC 27-1-15.6-7(a) for which the person provides classroom instruction in certified prelicensing courses of study.

(g) The commissioner may, after notice and opportunity for a hearing, do the following:

(1) Withdraw the certification of a course of study that does not maintain reasonable standards, as determined by the commissioner for the protection of the public.

(2) Disqualify a person that is currently qualified under subsection (b) to render instruction in a certified prelicensing course of study from rendering the instruction if the passing percentage calculated under subsection (f) is less than forty-five percent (45%).

(h) Current course materials for a prelicensing course of study that is certified under this section must be submitted to the commissioner upon request, but not less frequently than once every three (3) years.
As added by P.L.132-2001, SEC.4. Amended by P.L.64-2004, SEC.26; P.L.11-2011, SEC.14; P.L.115-2011, SEC.9; P.L.81-2012, SEC.6.

IC 27-1-15.7-6
Insurance producer education and continuing education advisory council

Sec. 6. (a) As used in this section, "council" refers to the insurance producer education and continuing education advisory council created under subsection (b).

(b) The insurance producer education and continuing education advisory council is created within the department. The council consists of the commissioner and fifteen (15) members appointed by the governor as follows:

(1) Two (2) members recommended by the Professional Insurance Agents of Indiana.

(2) Two (2) members recommended by the Independent Insurance Agents of Indiana.

(3) Two (2) members recommended by the Indiana Association of Insurance and Financial Advisors.

(4) Two (2) members recommended by the Indiana State

Association of Health Underwriters.

(5) Two (2) representatives of direct writing or exclusive producer's insurance companies.

(6) One (1) representative of the Association of Life Insurance Companies.

(7) One (1) member recommended by the Insurance Institute of Indiana.

(8) One (1) member recommended by the Indiana Land Title Association.

(9) Two (2) other individuals.

(c) Members of the council serve for a term of three (3) years. Members may not serve more than two (2) consecutive terms.

(d) Before making appointments to the council, the governor must:

(1) solicit; and

(2) select appointees to the council from;

nominations made by organizations and associations that represent individuals and corporations selling insurance in Indiana.

(e) The council shall meet at least semiannually.

(f) A member of the council is entitled to the minimum salary per diem provided under IC 4-10-11-2.1(b). A member is also entitled to reimbursement for traveling expenses and other expenses actually incurred in connection with the member's duties, as provided in the state travel policies and procedures established by the state department of administration and approved by the state budget agency.

(g) The council shall review and make recommendations to the commissioner with respect to course materials, curriculum, and credentials of instructors of each prelicensing course of study for which certification by the commissioner is sought under section 5 of this chapter and shall make recommendations to the commissioner with respect to educational requirements for insurance producers.

(h) A member of the council or designee of the commissioner shall be permitted access to any classroom while instruction is in progress to monitor the classroom instruction.

(i) The council shall make recommendations to the commissioner concerning the following:

(1) Continuing education courses for which the approval of the commissioner is sought under section 4 of this chapter.

(2) Rules proposed for adoption by the commissioner that would affect continuing education.

As added by P.L.132-2001, SEC.4. Amended by P.L.64-2004, SEC.27; P.L.73-2006, SEC.2.

IC 27-1-15.7-7

Rules

Sec. 7. The commissioner may adopt rules under IC 4-22-2 to implement this chapter.

As added by P.L.132-2001, SEC.4.

IC 27-1-15.7-8
Hearings

Sec. 8. All hearings held under this chapter are governed by IC 4-21.5-3. The commissioner may appoint members of the commissioner's staff to act as hearing officers for purposes of hearings held under this chapter.

As added by P.L.132-2001, SEC.4.

IC 27-1-15.8

Chapter 15.8. Surplus Lines Producers

IC 27-1-15.8-1

Applicability of definitions

Sec. 1. The definitions in IC 27-1-15.6-2 apply throughout this chapter.

As added by P.L.132-2001, SEC.5.

IC 27-1-15.8-2

Other provisions applicable to licensure of surplus lines producers

Sec. 2. The following provisions of IC 27-1-15.6 apply to licensure of surplus lines producers under this chapter:

(1) IC 27-1-15.6-5.
(2) IC 27-1-15.6-6.
(3) IC 27-1-15.6-8 through IC 27-1-15.6-13.
(4) IC 27-1-15.6-15 through IC 27-1-15.6-17.
(5) IC 27-1-15.6-21.
(6) IC 27-1-15.6-32 through IC 27-1-15.6-34.

As added by P.L.132-2001, SEC.5.

IC 27-1-15.8-3

Qualifications for license

Sec. 3. (a) A surplus lines producer may receive qualification for a license in one (1) or more of the kinds of insurance defined in Class 2 and Class 3 of IC 27-1-5-1 from insurers that are authorized to do business in one (1) or more states of the United States of America but are not authorized to do business in Indiana whenever, after diligent effort, as determined to the satisfaction of the department, the licensee is unable to procure the amount of insurance desired from insurers authorized and licensed to do business in Indiana.

(b) An applicant for a surplus lines producer's license must be licensed in Indiana as an insurance producer qualified as to the line or lines of insurance to be written.

As added by P.L.132-2001, SEC.5.

IC 27-1-15.8-4

Percent of gross premiums remitted to department; affidavit and financial statement filed with department

Sec. 4. (a) In addition to all other charges, fees, and taxes that may be imposed by law, a surplus lines producer licensed under this chapter shall, on or before February 1 and August 1 of each year, collect from the insured and remit to the department for the use and benefit of the state of Indiana an amount equal to two and one-half percent (2 1/2%) of all gross premiums upon all policies and contracts procured by the surplus lines producer under the provisions of this section during the preceding six (6) month period ending December 31 and June 30, respectively. The declarations page of a

policy referred to in this subsection must itemize the amounts of all charges for taxes, fees, and premiums.

(b) A licensed surplus lines producer shall execute and file with the department of insurance on or before the twentieth day of each month an affidavit that specifies all transactions, policies, and contracts procured during the preceding calendar month, including:

(1) the description and location of the insured property or risk and the name of the insured;

(2) the gross premiums charged in the policy or contract;

(3) the name and home office address of the insurer whose policy or contract is issued, and the kind of insurance effected; and

(4) a statement that:

(A) the licensee, after diligent effort, was unable to procure from any insurer authorized to transact the particular class of insurance business in Indiana the full amount of insurance required to protect the insured; and

(B) the insurance placed under this chapter is not placed for the purpose of procuring it at a premium rate lower than would be accepted by an insurer authorized and licensed to transact insurance business in Indiana.

(c) A licensed surplus lines producer shall file with the department, not later than March 31 of each year, the financial statement, dated as of December 31 of the preceding year, of each unauthorized insurer from whom the surplus lines producer has procured a policy or contract. The insurance commissioner may, in the commissioner's discretion, after reviewing the financial statement of the unauthorized insurer, order the surplus lines producer to cancel an unauthorized insurer's policies and contracts if the commissioner is of the opinion that the financial statement or condition of the unauthorized insurer does not warrant continuance of the risk.

(d) A licensed surplus lines producer shall keep a separate account of all business transacted under this section. The account may be inspected at any time by the commissioner or the commissioner's deputy or examiner.

(e) An insurer that issues a policy or contract to insure a risk under this section is considered to have appointed the commissioner as the insurer's attorney upon whom process may be served in Indiana in any suit, action, or proceeding based upon or arising out of the policy or contract.

(f) The commissioner may revoke or refuse to renew a surplus lines producer's license for failure to comply with this section.

(g) A surplus lines producer licensed under this chapter may accept and place policies or contracts authorized under this section for an insurance producer duly licensed in Indiana, and may compensate the insurance producer even though the insurance producer is not licensed under this chapter.

(h) If a surplus lines producer does not remit an amount due to the

department within the time prescribed in subsection (a), the commissioner shall assess the surplus lines producer a penalty of ten percent (10%) of the amount due. The commissioner shall assess a further penalty of an additional one percent (1%) of the amount due for each month or portion of a month that any amount due remains unpaid after the first month. Penalties assessed under this subsection are payable by the surplus lines producer and are not collectible from an insured.

As added by P.L.132-2001, SEC.5. Amended by P.L.160-2003, SEC.2; P.L.173-2007, SEC.15.

IC 27-1-15.9

Chapter 15.9. Portable Electronics Insurance

IC 27-1-15.9-1

Definitions

Sec. 1. The definitions in IC 27-1-15.6-2 apply throughout this chapter.

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-2

"Customer"

Sec. 2. As used in this chapter, "customer" means a person who purchases portable electronics.

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-3

"Insured customer"

Sec. 3. As used in this chapter, "insured customer" means a customer who purchases insurance under a portable electronics insurance policy that is issued to a vendor.

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-4

"Location"

Sec. 4. As used in this chapter, "location" means:

(1) a geographic site in Indiana; or

(2) an Internet web site, a call center site, or a similar site;

that is intended to be used by Indiana residents to engage in portable electronics transactions.

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-5

"Portable electronics"

Sec. 5. (a) As used in this chapter, "portable electronics" means electronic devices that are portable in nature.

(b) The term includes accessories, wireless services, and other services related to the use of a device described in subsection (a).

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-6

"Portable electronics insurance"

Sec. 6. (a) As used in this chapter, "portable electronics insurance" means insurance that provides coverage for the repair or replacement of portable electronics, including coverage for loss, theft, inoperability due to mechanical failure, malfunction, damage, or other similar causes of loss.

(b) The term does not include the following:

(1) A service contract or extended warranty that provides

coverage for repair, replacement, or maintenance only to address operational or structural failure caused by:

(A) a defect in materials or workmanship;

(B) accidental damage from a power surge; or

(C) normal wear and tear.

(2) A policy of insurance that covers a seller's or manufacturer's obligations under a warranty.

(3) Any of the following:

(A) A homeowner's insurance policy.

(B) A renter's insurance policy.

(C) A private passenger automobile insurance policy.

(D) A commercial multi-peril insurance policy.

(E) An insurance policy that provides coverage similar to the insurance provided by a policy described in clauses (A) through (D).

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-7
"Portable electronics transaction"

Sec. 7. As used in this chapter, "portable electronics transaction" means the sale or lease of portable electronics.

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-8
"Supervising entity"

Sec. 8. As used in this chapter, "supervising entity" means a business entity that:

(1) is an:

(A) insurer; or

(B) insurance producer;

that is licensed under this title; and

(2) issues, or is appointed by the insurer that issues, a portable electronics insurance policy that is sold, solicited, or negotiated by a vendor;

to supervise the activities of the vendor related to the portable electronics insurance policy.

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-9
"Vendor"

Sec. 9. As used in this chapter, "vendor" means a business entity that directly or indirectly engages in portable electronics transactions.

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-10
Limited lines license required; authorization; training requirements; representation as limited lines producer

Sec. 10. (a) A vendor shall not sell, solicit, or negotiate portable electronics insurance unless the vendor holds a limited lines license issued under IC 27-1-15.6 to sell, solicit, or negotiate portable electronics insurance.

(b) A limited lines license required by subsection (a) authorizes each of the following to sell, solicit, or negotiate portable electronics insurance to a customer at each of a vendor's locations:

(1) The vendor.

(2) Each of the vendor's employees or authorized representatives, regardless of whether the employee or authorized representative is individually licensed under IC 27-1-15.6, if the insurer that issues the portable electronics insurance directly supervises or appoints a supervising entity to supervise:

(A) the administration of the portable electronics insurance sold by the vendor; and

(B) a training program for the employees and authorized representatives.

(c) The following apply to a training program described in subsection (b):

(1) The training must be provided to any employee or authorized representative who is directly engaged in the sale, solicitation, or negotiation of portable electronics insurance.

(2) Initial training of an employee or authorized representative:

(A) must be provided before the employee or authorized representative engages in the sale, solicitation, or negotiation of portable electronics insurance; and

(B) may be provided in electronic form.

(3) Continuing training of an employee or authorized representative:

(A) must be provided on a periodic basis; and

(B) may be provided in electronic or another form.

(4) The training must be developed and overseen by employees of the supervising entity who are licensed as insurance producers under IC 27-1-15.6 with the qualifications described in IC 27-1-15.6-7(a)(3) and IC 27-1-15.6-7(a)(4).

(5) The training must provide basic instruction concerning the:

(A) portable electronics insurance offered to customers of the vendor; and

(B) disclosures required by section 12 of this chapter.

(d) An employee or authorized representative of a vendor shall not advertise, represent, or otherwise profess to be an insurance producer other than a limited lines producer licensed under IC 27-1-15.6.

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-11

Supervising entity location registry; examination

Sec. 11. (a) A supervising entity shall:

(1) maintain a registry of locations described in section 10(b) of this chapter; and

(2) make the registry available for examination by the commissioner during the supervising entity's regular business hours.

(b) The commissioner shall, at least ten (10) days before the examination is conducted, provide to a supervising entity written notice of an examination described in subsection (a).

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-12

Written materials; content

Sec. 12. (a) A vendor shall, at each location where portable electronics insurance is sold, solicited, or negotiated, make available to customers written materials concerning the portable electronics insurance.

(b) The written materials available under subsection (a) must do all the following:

(1) Disclose that portable electronics insurance may duplicate coverage already provided under a customer's homeowner's insurance policy, renter's insurance policy, or other coverage.

(2) State that the customer may purchase or lease portable electronics regardless of whether the customer also purchases portable electronics insurance.

(3) Summarize the material terms of each portable electronics insurance policy under which insurance is available from the vendor, including all the following:

(A) The identity of the insurer that issues the portable electronics insurance policy.

(B) The identity of any supervising entity.

(C) The amount of any applicable deductible and the manner by which the deductible is paid.

(D) The benefits of the portable electronics insurance.

(E) The key terms and conditions, including whether portable electronics may be repaired or replaced with:

(i) reconditioned; or

(ii) nonoriginal;

manufacturer equipment of a make or model that is similar to the portable electronics.

(4) Summarize the process for filing a claim, including:

(A) a description of the manner by which to return portable electronics; and

(B) the maximum fee applicable if the customer fails to comply with any applicable equipment return requirement.

(5) State that an insured customer may cancel the portable electronics insurance at any time and the person who pays the premium will receive a refund of unearned premium.

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-13
Coverage availability

Sec. 13. Portable electronics insurance may be sold:

(1) for any period; and

(2) under:

(A) an individual policy; or

(B) a group or master policy issued to a vendor to provide insurance for the vendor's customers.

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-14
Eligibility and underwriting standards

Sec. 14. The:

(1) insurer that issues a portable electronics insurance policy; or

(2) supervising entity that supervises a vendor with respect to a portable electronics insurance policy;

shall establish eligibility and underwriting standards for each portable electronics insurance policy that is sold, solicited, or negotiated by a vendor.

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-15
Charges; funds

Sec. 15. The following apply to charges for portable electronics insurance:

(1) The charges may be billed and collected by the vendor.

(2) If the insurance cost is not included in the cost associated with the purchase or lease of portable electronics, the insurance cost must be separately itemized on the insured customer's bill.

(3) If the insurance cost is included in the cost associated with the purchase or lease of portable electronics, the vendor shall clearly and conspicuously disclose to the insured customer that the portable electronics insurance cost is included with the cost of the portable electronics.

(4) A vendor that bills and collects the charges shall maintain collected funds in a segregated account unless the:

(A) insurer that issues the portable electronics insurance policy authorizes the vendor to hold the funds in an alternative manner; and

(B) vendor remits the funds to the supervising entity less than sixty (60) days after the vendor receives the funds.

(5) All funds received by the vendor from an insured customer for the sale of portable electronics insurance are considered to be funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer.

(6) A vendor may receive from an insurer compensation for billing and collection services.

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-16
Violations

Sec. 16. (a) This section supplements and does not limit the actions that may be taken by the commissioner for a violation under IC 27-1-15.6.

(b) If a vendor or an employee or authorized representative of a vendor violates this chapter, the commissioner may do any of the following:

(1) After notice and hearing, impose on the vendor a civil penalty of not less than fifty dollars ($50) and not more than ten thousand dollars ($10,000).

(2) After notice and hearing, impose other penalties that the commissioner considers necessary and reasonable, including:

(A) suspending the privilege of transacting portable electronics insurance under this chapter at specific locations where violations have occurred; and

(B) suspending or revoking the ability of an individual employee or authorized representative to act under the vendor's limited lines producer license.

(3) Take action that is otherwise authorized under this title against the supervising entity.

As added by P.L.4-2012, SEC.3. Amended by P.L.276-2013, SEC.16.

IC 27-1-15.9-17
Insurer requirements; notices; termination

Sec. 17. (a) To the extent that this section conflicts with any other provision of IC 27 that applies to an insurer, this section is controlling.

(b) The following apply to an insurer that issues a portable electronics insurance policy:

(1) Except as provided in subdivisions (3) and (4), an insurer shall provide written notice to a vendor and an insured customer at least thirty (30) days before terminating or otherwise changing the terms and conditions of a portable electronics insurance policy.

(2) An insurer that changes the terms and conditions as described in subdivision (1) shall provide to the vendor and insured customer:

(A) a revised policy, endorsement, or certificate;

(B) an updated brochure; or

(C) other evidence of the change;

including a summary of material changes.

(3) If an insurer discovers fraud or material misrepresentation by an insured customer in:

(A) obtaining portable electronics insurance; or

(B) presenting a claim under the portable electronics

insurance;

the insurer may, not less than fifteen (15) days after providing written notice to the insured customer, terminate the insured customer's portable electronics insurance.

(4) An insurer may immediately terminate an insured customer's portable electronics insurance for the following reasons:

(A) Nonpayment of premiums.

(B) The insured customer no longer has active service with the vendor.

(C) The:

(i) insured customer has exhausted any aggregate limit of liability under the terms of the portable electronics insurance policy; and

(ii) insurer has sent written notice of the termination to the insured customer.

(5) If portable electronics insurance is terminated by a vendor, the vendor shall, at least thirty (30) days before the effective date of the termination, deliver written notice of the termination, including notice of the effective date of the termination, to each insured customer.

(6) Written notice required by this chapter may be delivered as follows:

(A) By United States mail to:

(i) a vendor at the mailing address specified by the vendor for delivery of written notice; and

(ii) an insured customer at the insured customer's last known mailing address;

that is on file with the insurer.

(B) By electronic mail to:

(i) a vendor at the vendor's electronic mail address specified by the vendor for delivery of written notice; and

(ii) an insured customer at the insured customer's last known electronic mail address provided by the insured customer to the insurer or vendor.

An insured customer's provision of an electronic mail address to an insurer or a vendor is considered to be consent from the insured customer to receive written notices by electronic mail. An insurer and a vendor shall maintain proof that a written notice sent by electronic mail was sent.

(7) A written notice required by this chapter that is delivered by a supervising entity appointed by an insurer on behalf of the insurer or vendor is considered to have been delivered by the insurer or vendor.

As added by P.L.4-2012, SEC.3.

IC 27-1-15.9-18

Application for limited lines producer license

Sec. 18. (a) A vendor shall apply for a limited lines producer

license required by this chapter by filing a sworn application for the license with the commissioner on forms prescribed and furnished by the commissioner.

(b) An application filed under subsection (a) must include the following information:

(1) Except as provided in subdivision (2), the name, residence address, and other information required by the commissioner for an employee or officer of the vendor who is designated by the vendor as the individual who is responsible for the vendor's compliance with this chapter.

(2) If the vendor derives more than fifty percent (50%) of the vendor's revenue from the sale of portable electronics insurance, the name, residence address, and other information required by the commissioner for each officer, director, and shareholder of record that has beneficial ownership of at least ten percent (10%) of any class of securities registered by the vendor under federal securities law.

(3) The physical address of the vendor's home office.

As added by P.L.4-2012, SEC.3.

IC 27-1-16
Repealed

(Repealed by Acts 1977, P.L.280, SEC.3.)

IC 27-1-16.1

Chapter 16.1. Self-Storage Insurance

IC 27-1-16.1-1

Definitions

Sec. 1. The definitions in IC 27-1-15.6-2 apply throughout this chapter.

As added by P.L.81-2013, SEC.3.

IC 27-1-16.1-2

"Customer"

Sec. 2. As used in this chapter, "customer" means a person that obtains the use of storage space from a self-storage facility under the terms of a self-storage rental agreement.

As added by P.L.81-2013, SEC.3.

IC 27-1-16.1-3

"Insured customer"

Sec. 3. As used in this chapter, "insured customer" means a customer that purchases insurance under a self-storage insurance policy that is sold, solicited, or negotiated by a self-storage facility.

As added by P.L.81-2013, SEC.3.

IC 27-1-16.1-4

"Self-storage facility"

Sec. 4. As used in this chapter, "self-storage facility" means a person that is engaged in the business of providing rented storage space to the public.

As added by P.L.81-2013, SEC.3.

IC 27-1-16.1-5

"Self-storage insurance"

Sec. 5. (a) As used in this chapter, "self-storage insurance" means:

(1) insurance that provides insurance coverage for the loss of, or damage to, tangible personal property that is contained in storage space or in transit during a self-storage rental agreement period; or

(2) other coverage that the commissioner approves in connection with the rental of storage space.

(b) The term does not include any of the following:

(1) A homeowner's insurance policy.

(2) A renter's insurance policy.

(3) A private passenger motor vehicle insurance policy.

(4) An insurance policy that provides coverage similar to the insurance provided by a policy described in subdivisions (1) through (3).

As added by P.L.81-2013, SEC.3.

IC 27-1-16.1-6
"Self-storage rental agreement"

Sec. 6. As used in this chapter, "self-storage rental agreement" means a written agreement containing the terms and conditions governing the use of storage space provided by a self-storage facility.
As added by P.L.81-2013, SEC.3.

IC 27-1-16.1-7
"Supervising entity"

Sec. 7. As used in this chapter, "supervising entity" means a business entity that:

(1) supervises the activities of a self-storage facility related to a self-storage insurance policy;

(2) is an:

(A) insurer; or

(B) insurance producer;

that is licensed under this title; and

(3) issues, or is appointed by an insurer that issues, the self-storage insurance policy.

As added by P.L.81-2013, SEC.3.

IC 27-1-16.1-8
Limited lines producer's license required; training and limits on employee and authorized representative conduct

Sec. 8. (a) A self-storage facility shall not sell, solicit, or negotiate self-storage insurance unless the self-storage facility holds a limited lines producer's license issued under IC 27-1-15.6-18 to sell, solicit, or negotiate self-storage insurance.

(b) A limited lines producer's license required by subsection (a) authorizes each of the following to sell, solicit, or negotiate self-storage insurance to a customer at each of a self-storage facility's locations in Indiana:

(1) The self-storage facility.

(2) Each of the self-storage facility's employees or authorized representatives, regardless of whether the employee or authorized representative is individually licensed under IC 27-1-15.6, if the insurer that issues the self-storage insurance directly supervises or appoints a supervising entity to supervise:

(A) the administration of the self-storage insurance sold by the self-storage facility; and

(B) a training program for the employees and authorized representatives.

(c) The following apply to a training program described in subsection (b):

(1) The training must be provided to any employee or authorized representative who is directly engaged in the sale, solicitation, or negotiation of self-storage insurance.

(2) Initial training of an employee or authorized representative:

(A) must be provided before the employee or authorized representative engages in the sale, solicitation, or negotiation of self-storage insurance; and

(B) may be provided in electronic form or another form.

(3) Continuing training of an employee or authorized representative:

(A) must be provided on a periodic basis; and

(B) may be provided in electronic form or another form.

(4) The training must be developed and overseen by employees of the supervising entity who are licensed as insurance producers under IC 27-1-15.6 with the qualifications described in IC 27-1-15.6-7(a)(3) and IC 27-1-15.6-7(a)(4).

(5) The training must provide basic instruction concerning the:

(A) self-storage insurance offered to customers of the self-storage facility; and

(B) disclosures required by section 10 of this chapter.

(d) An employee or authorized representative of a self-storage facility shall not:

(1) sell, solicit, or negotiate self-storage insurance except in connection with and incidental to the rental of storage space by the self-storage facility; or

(2) advertise or represent that the self-storage facility is an insurance producer other than a limited lines producer licensed under IC 27-1-15.6.

As added by P.L.81-2013, SEC.3.

IC 27-1-16.1-9

Supervising entity registry

Sec. 9. (a) A supervising entity shall:

(1) maintain a registry of locations described in section 8(b) of this chapter; and

(2) make the registry available for examination by the commissioner during the supervising entity's regular business hours.

(b) The commissioner shall, at least ten (10) days before the examination is conducted, provide to a supervising entity written notice of an examination described in subsection (a).

As added by P.L.81-2013, SEC.3.

IC 27-1-16.1-10

Written disclosures and information

Sec. 10. (a) A self-storage facility shall, at each location where self-storage insurance is sold, solicited, or negotiated, make available to customers written materials concerning the self-storage insurance.

(b) The written materials available under subsection (a) must do all the following:

(1) Disclose that self-storage insurance may duplicate coverage already provided under a customer's homeowner's insurance

policy, renter's insurance policy, or other coverage.

(2) State that if insurance is required as a condition of a self-storage rental agreement, the requirement may be satisfied by the customer's:

(A) purchase of self-storage insurance that is sold, solicited, or negotiated by the self-storage facility; or

(B) presentation to the self-storage facility of evidence of other applicable insurance coverage.

(3) Summarize the material terms of each self-storage insurance policy under which insurance is available from the self-storage facility, including all the following:

(A) The identity of the insurer that issues the self-storage insurance policy.

(B) The identity of any supervising entity.

(C) All costs related to the self-storage insurance policy.

(D) The amount of any applicable deductible.

(E) The benefits of the self-storage insurance.

(F) The key terms and conditions of coverage.

(4) Summarize the process for filing a claim.

(5) State that an insured customer may cancel the insured customer's coverage under the self-storage insurance policy at any time and the person who pays the premium will receive a refund of unearned premium.

As added by P.L.81-2013, SEC.3.

IC 27-1-16.1-11

Evidence of coverage

Sec. 11. A self-storage facility, supervising entity, or insurer shall provide an evidence of coverage to each insured customer.

As added by P.L.81-2013, SEC.3.

IC 27-1-16.1-12

Manner in which self-storage insurance may be sold

Sec. 12. Self-storage insurance may be sold:

(1) for any period; and

(2) under:

(A) an individual policy; or

(B) a group, commercial, or master policy issued to a self-storage facility to provide insurance for the self-storage facility's customers.

As added by P.L.81-2013, SEC.3.

IC 27-1-16.1-13

Eligibility and underwriting standards

Sec. 13. The:

(1) insurer that issues a self-storage insurance policy; or

(2) supervising entity that supervises a self-storage facility with respect to a self-storage insurance policy;

shall establish eligibility and underwriting standards for each self-storage insurance policy that is sold, solicited, or negotiated by a self-storage facility.
As added by P.L.81-2013, SEC.3.

IC 27-1-16.1-14
Charges for self-storage insurance; handling of funds; compensation

Sec. 14. The following apply to charges for self-storage insurance:

(1) The charges may be billed and collected by the self-storage facility.

(2) If the insurance cost is not included in the cost associated with the self-storage rental agreement, the insurance cost must be separately itemized on the insured customer's bill.

(3) If the insurance cost is included in the cost associated with the self-storage rental agreement, the self-storage facility shall clearly and conspicuously disclose to the insured customer that the self-storage insurance cost is included with the cost of the self-storage rental agreement.

(4) A self-storage facility that bills and collects the charges shall maintain collected funds in a segregated account unless the:

(A) insurer that issues the self-storage insurance policy authorizes the self-storage facility to hold the funds in an alternative manner; and

(B) self-storage facility remits the funds to the supervising entity less than sixty (60) days after the self-storage facility receives the funds.

(5) All funds received by the self-storage facility from an insured customer as payment for the purchase of coverage under a self-storage insurance policy are considered to be funds held in trust by the self-storage facility in a fiduciary capacity for the benefit of the insurer.

(6) A self-storage facility may receive from an insurer or a supervising entity compensation for billing and collection services. Compensation described in this subdivision may be dependent on the sale of self-storage insurance.

As added by P.L.81-2013, SEC.3.

IC 27-1-16.1-15
Violations

Sec. 15. (a) This section supplements and does not limit the actions that may be taken by the commissioner for a violation under IC 27-1-15.6.

(b) If a self-storage facility or an employee or authorized representative of a self-storage facility violates this chapter, the commissioner may do any of the following:

(1) After notice and hearing, impose on the self-storage facility

a civil penalty of at least fifty dollars ($50) and not more than ten thousand dollars ($10,000).

(2) After notice and hearing, impose other penalties that the commissioner considers necessary and reasonable, including:

(A) suspending the privilege of transacting self-storage insurance under this chapter at specific self-storage facility locations where violations have occurred; and

(B) suspending or revoking the ability of an individual employee or authorized representative to act under the self-storage facility's limited lines producer's license.

As added by P.L.81-2013, SEC.3.

IC 27-1-16.1-16

Application for limited lines producer's license

Sec. 16. (a) A self-storage facility shall apply for a limited lines producer's license required by this chapter by filing a sworn application for the license with the commissioner on forms prescribed and furnished by the commissioner.

(b) An application filed under subsection (a) must include the following information:

(1) The name, residence address, and other information required by the commissioner for an employee or officer of the self-storage facility who is designated by the self-storage facility as the individual who is responsible for the self-storage facility's compliance with this chapter.

(2) The physical address of the self-storage facility's home office.

As added by P.L.81-2013, SEC.3.

IC 27-1-17

Chapter 17. Admission of Foreign and Alien Companies to Transact Business in Indiana

IC 27-1-17-1

Necessity of certificate of authority

Sec. 1. Any foreign or alien insurance company organized for the purpose of transacting any insurance business, not qualified as of March 8, 1935, to transact business in this state, before transacting business in this state shall procure a certificate of authority from the department in the manner provided in this chapter and shall otherwise comply with the provisions and be subject to the regulations set forth in this chapter.

(Formerly: Acts 1935, c.162, s.226.) As amended by P.L.252-1985, SEC.71.

IC 27-1-17-2

Equality of treatment between domestic companies and foreign or alien companies; exception

Sec. 2. No foreign or alien company shall be admitted for the purpose of transacting any kind or kinds of insurance business in this state, the transaction of which by a domestic company is not permitted by the laws of this state; provided, however, that where a foreign or alien company whose charter provides for the transaction of the kind or kinds of insurance described in more than one (1) class of IC 27-1-5-1 has been transacting business in this state under a certificate of authority issued by the insurance department or insurance commissioner prior to March 8, 1935, such company may be issued a certificate of authority under the provisions of this article to make the kind or kinds of insurance provided by its charter. A foreign or alien insurance company admitted to do an insurance business in this state shall have the same but no greater rights and privileges than a domestic company.

(Formerly: Acts 1935, c.162, s.227.) As amended by P.L.252-1985, SEC.72.

IC 27-1-17-3

Name

Sec. 3. No foreign or alien insurance company shall be admitted to do business in this state having a name which, at the date of such admission, could not be taken by a domestic corporation under the provisions of IC 27-1-6-3, except that the name of a foreign or alien insurance company need not include the word "company", "corporation", "incorporated", or "mutual", or one (1) of the abbreviations thereof, nor the word "insurance" or the word "assurance" provided the name of such company is authorized by the laws of the state or territory of its organization or domicile and provided such name does not negate the characteristic of such

company as an insurance company. No such foreign or alien insurance company after it has been admitted shall, by amendment to its charter, assume any name which, at the date of the filing of such amendment as provided in this chapter, could not be taken by a domestic corporation under the provisions of IC 27-1-6-3.
(Formerly: Acts 1935, c.162, s.228; Acts 1969, c.164, s.7.) As amended by P.L.252-1985, SEC.73.

IC 27-1-17-4
Documents required for admittance

Sec. 4. Whenever a foreign or an alien insurance company desires to be admitted to do an insurance business in this state, it shall execute in the English language and present the following to the department, at its office, accompanied by the fees prescribed by law:

(1) A copy of its articles of incorporation or association, with all amendments thereto, duly authenticated by the proper officer of the state, country, province, or government wherein it is incorporated or organized, or the state in which it is domiciled in the United States.

(2) An application for admission, executed in the manner provided in this chapter, setting forth:

(A) the name of such company;

(B) the location of its principal office or place of business without this state;

(C) the names of the states in which it has been admitted or qualified to do business;

(D) the character of insurance business under its articles of incorporation or association which it intends to transact in this state, which must conform to the class or classes set forth in the provisions of IC 27-1-5-1;

(E) the total authorized capital stock of the company and the amount thereof issued and outstanding, and the surplus required of such company by the laws of the state, country, province, or government under which it is organized, or the state in which it is domiciled in the United States, if a stock company, which shall equal at least the requirements set forth in section 5(a) of this chapter;

(F) the total amount of assets and the surplus of assets over all its liabilities, if other than a stock company, which shall equal at least the requirements set forth in section 5(b) of this chapter;

(G) if an alien company, the surplus of assets invested according to the laws of the state in the United States where it has its deposit, which shall equal at least the requirements set forth in section 5(c) of this chapter; and

(H) such further and additional information as the department may from time to time require.

The application shall be signed, in the form prescribed by the

department, by the president or a vice president and the secretary or an assistant secretary of the corporation, and verified under oath by the officers signing the same.
(3) A statement of its financial condition and business, in the form prescribed by law for annual statements, signed and sworn to by the president or secretary or other principal officers of the company; provided, however, that an alien company shall also furnish a separate statement comprising only its condition and business in the United States, which shall be signed and sworn to by its United States manager.
(4) A copy of the last report of examination certified to by the insurance commissioner or other proper supervisory official of the state in which such company is domiciled; provided, however, that the commissioner may cause an examination to be made of the condition and affairs of such company before authority to transact business in this state is given.
(5) A certificate from the proper official of the state, country, province, or government wherein it is incorporated or organized, or the state in which it is domiciled in the United States, that it is duly organized or incorporated under those laws and authorized to make the kind or kinds of insurance which it proposes to make in this state.
(6) A copy of its bylaws or regulations, if any, certified to by the secretary or similar officer of the insurance company.
(7) A duly executed power of attorney in a form prescribed by the department which constitutes and appoints an individual or a corporate resident of Indiana, or an authorized Indiana insurer, as the insurance company's agent, its true and lawful attorney upon whom, except as provided in section 4.2 of this chapter, all lawful processes in any action in law or in equity against it shall be served. Such power of attorney shall contain an agreement by the insurance company that any lawful process against it which may be served upon the agent as its attorney shall be of the same force and validity as if served upon the insurance company and that such power of attorney shall continue in force and be irrevocable so long as any liability of the insurance company remains outstanding in this state. Such power of attorney shall be executed by the president and secretary of the insurance company or other duly authorized officers under its seal and shall be accompanied by a certified copy of the resolution of the board of directors of the company making said appointment and authorizing the execution of said power of attorney. Service of any lawful process shall be by delivering to and leaving with the agent two (2) copies of such process, with copy of the pertinent complaint attached. The agent shall forthwith transmit to the defendant company at its last known principal place of business by registered or certified mail, return receipt requested, one (1) of the copies of such

process, with complaint attached, the other copy to be retained in a record which shall show all process served upon and transmitted by the agent. Such service shall be sufficient provided the returned receipt or, if the defendant company shall refuse to accept such mailing, the registered mail together with an affidavit of plaintiff or the plaintiff's attorney stating that service was made upon the agent and forwarded as above set forth but that such mail was returned by the post office department is filed with the court. The agent shall make information and receipts available to plaintiff, defendant or their attorneys. No plaintiff or complainant shall be entitled to a judgment by default based on service authorized by this section until the expiration of at least thirty (30) days from the date on which either the post office receipt or the unclaimed mail together with affidavit is filed with the court. Nothing in this section shall limit or abridge the right to serve any process, notice or demand upon any company in any other manner permitted by law.

(8) Proof which satisfies the department that it has complied with the financial requirements imposed in this chapter upon foreign and alien insurance companies which transact business in this state and that it is entitled to public confidence and that its admission to transact business in this state will not be prejudicial to public interest.

(Formerly: Acts 1935, c.162, s.229; Acts 1967, c.127, s.5.) As amended by P.L.252-1985, SEC.74; P.L.130-1994, SEC.25; P.L.116-1994, SEC.35; P.L.268-1999, SEC.6; P.L.126-2001, SEC.2; P.L.193-2006, SEC.5; P.L.129-2014, SEC.6.

IC 27-1-17-4.2

Service of process in action on surety bonds

Sec. 4.2. (a) A foreign or alien insurance company that provides a surety bond that is required or permitted under the law of the United States shall execute a power of attorney in a form prescribed by the department irrevocably appointing the commissioner as the insurance company's agent for service of process in an action on the surety bond if the:

(1) surety bond was provided in Indiana; and

(2) service of process under this section is in addition to another method of service of process authorized by law or court rule.

(b) Service of process under this section has the same effect as personal service on the insurance company.

(c) Upon receipt of process described in this section, the commissioner shall forward the process to the resident agent designated by the insurance company under section 4(7) of this chapter.

(d) The commissioner may adopt rules under IC 4-22-2 to establish reasonable fees for the acceptance of process described in

this section. Fees collected under rules adopted under this subsection must be deposited in the department of insurance fund established by IC 27-1-3-28.
As added by P.L.193-2006, SEC.6.

IC 27-1-17-5
Capital and surplus or surplus of assets over liabilities; investment of surplus

Sec. 5. (a) Every foreign insurance company authorized to do business in this state shall have, in the case of a stock company, at least the capital and surplus required of a domestic insurance company which makes the same kind or kinds of insurance.

(b) Every foreign insurance company authorized to do business in this state shall have, in the case of other than a stock company, at least the assets with a surplus of assets over all liabilities required of a domestic insurance company which makes the same kind or kinds of insurance, and an additional contingent liability of its policyholders equal to not less than the cash premium expressed in the policies in force, if such contingent liability is required of a like domestic insurance company.

(c) Every alien insurance company authorized to do business in this state shall have the surplus of assets invested according to the laws of the state in the United States, wherein it has its deposit, held in the United States in trust for the benefit and security of all its policyholders and creditors in the United States, over all its liabilities in the United States, of an amount equal to the surplus of assets required of a like domestic insurance company.
(Formerly: Acts 1935, c.162, s.230.)

IC 27-1-17-6
Deposit

Sec. 6. Every alien company shall deposit with the department securities of the amount and value of one hundred thousand dollars ($100,000) invested in the classes of securities in which insurance companies are permitted by the laws of this state to make investments, or, satisfy the department that it has on deposit with the proper official of a state of the United States, authorized by the laws of such state to accept such deposit, securities of the amount and value of one hundred thousand dollars ($100,000), of the classes in which like insurance companies of such state are permitted to make their investments, for the benefit and security of all its policyholders and creditors in the United States, and the company shall file with the department the certificate of such official of any such deposit held by him.
(Formerly: Acts 1935, c.162, s.231.)

IC 27-1-17-7
Trustees of assets of alien insurer

Sec. 7. The directors of an alien company may appoint citizens or corporations of the United States, approved by the commissioner, as its trustees to hold funds and assets in trust for the benefit of the policyholders and creditors of the company in the United States. A certified copy of the record of such appointment and of the deed of trust shall be filed with the commissioner, who may examine such trustees and any officers and agents, books and papers of the company in the same manner as he may examine officer, agents, books, papers and affairs of insurance companies. The funds and assets so held by such trustees shall, with the deposits otherwise made by the company and the funds and assets held by the company in the United States for the benefit of its policyholders and creditors in the United States, constitute the assets of the company for the purpose of making its financial statements required by this law.
(Formerly: Acts 1935, c.162, s.232.)

IC 27-1-17-8
Issuance of certificate of authority

Sec. 8. When any foreign or alien insurance company has complied with the provisions of sections 1 through 7 of this chapter, then the commissioner may issue a certificate of authority, pursuant to IC 27-1-3-20, which shall license such foreign or alien insurance company to transact only the kind or kinds of insurance specified in its application for admission, and which shall expire on midnight of April 30 next, following the date of issuance.
(Formerly: Acts 1935, c.162, s.233.) As amended by P.L.252-1985, SEC.75.

IC 27-1-17-9
Hazardous financial condition

Sec. 9. (a) If, upon satisfactory evidence, it appears to the commissioner that any foreign or alien insurance company doing business in this state is in a hazardous financial condition as evidenced by the existence of any conditions indicated by, but not limited to, the following, he shall take such action as set forth in subsection (b) or (c), compliance herewith not precluding action under other provisions of law:

(1) It cannot meet the current applicable requirements for the conduct of the business of insurance in this state.

(2) It has commenced, or has attempted to commence, any voluntary liquidation or dissolution proceeding, or any proceeding to procure the appointment of a receiver, liquidator, rehabilitator, sequestrator, conservator, or similar officer for itself.

(3) It is the subject of liquidation or dissolution proceedings undertaken by another state, or any other proceeding undertaken by another state to procure the appointment of a receiver, liquidator, rehabilitator, sequestrator, conservator, or similar

officer.

(4) Its further transaction of business would be hazardous to its policyholders, contract holders, or the public as shown by the following conduct or other conduct:

(A) Investment practices not providing availability within a reasonable time of sufficient moneys to promptly meet any demand which might in the ordinary course of business be properly made against it.

(B) Embezzlement, sequestration, or wrongful diversion of any of its assets by any of its officers or directors.

(C) Willful violation of its charter or any law of this state.

(b) Upon finding that a company is in a hazardous financial condition as described in subsection (a), the commissioner shall order the company to take such action as reasonably may be required to correct the situation, such as the following:

(1) Requiring the company to reduce the volume of new business being accepted to an amount and period of time specified by the commissioner in the manner prescribed by his order.

(2) Requiring the submission of such reinsurance contracts for approval and make such requirements relative to the company's reinsurance program as the commissioner deems necessary to protect the interests of Indiana policyholders.

(3) Requiring the company to reinsure all or any part of its Indiana business with a company duly authorized to transact such business in this state.

(4) Requiring a contribution to surplus which will increase the company's surplus for such a period of time, and by such an amount, and in such a manner, as the commissioner may deem necessary and essential.

(5) Requiring the company to maintain a special deposit with the commissioner of insurance of this state in cash or securities of the kinds in which a domestic insurer is permitted to invest its funds, in an amount not less than the lesser of:

(A) the amounts required to be maintained as reserves, for losses and loss adjustment expenses on Indiana business and reserves for unearned premiums on Indiana business. (In determining the amount of deposit required by this subdivision, the reserves for losses, loss adjustment expenses, and unearned premiums shall be reduced only for reinsurance cessions to approved reinsurers which maintain with an independent custodian cash or marketable securities in an amount not less than the sum of the reinsurer's reserves for losses, loss adjustment expenses, and unearned premiums in regard to reinsurance assumed); and

(B) six hundred thousand dollars ($600,000).

Any deposit required by this subsection shall be for the protection and benefit of Indiana policyholders or claimants only and shall not

be withdrawn without the consent of the commissioner. The commissioner shall require such reports as may be necessary to implement supervision of any order issued under this subsection.

(c) If the company fails to comply with the commissioner's order under subsection (b) within sixty (60) days or if the commissioner finds that the company's financial condition is so serious as to make any efforts under subsection (b) meaningless to the company's policyholders, claimants, or the public, the commissioner shall suspend the authority granted to such company to do business in this state. If no demand for a hearing is made by the suspended company within thirty (30) days after suspension, such suspension shall become a revocation of the authority to transact the business of insurance in this state. Any such hearing shall be held in compliance with IC 4-21.5-3. If during such a hearing satisfactory evidence is forced to indicate that the company is in a hazardous financial condition as described in subsection (a), the commissioner shall revoke the authority of the company to transact the business of insurance in this state.

As added by Acts 1977, P.L.281, SEC.4. Amended by P.L.7-1987, SEC.138.

IC 27-1-18

Chapter 18. Additional Provisions Pertaining to Foreign and Alien Companies

IC 27-1-18-1

Policy provisions; foreign insurers; domestic insurers doing business in foreign state

Sec. 1. The policies of a foreign or alien life insurance company, may, when issued in this state, contain any provision which the laws of the state, territory, district, or country under which the company is organized prescribes shall be in such policies and the method of valuation of such policies required by the laws of the state, territory, district, or country where such company is organized, shall be accepted by the department, and the policies of a life insurance company organized under the laws of this state may, when issued or delivered in any other state, territory, district, or country contain any provisions required by the laws of the state, territory, district, or country in which the same are issued or delivered, anything in this article other than in IC 27-1-12-5(5) to the contrary notwithstanding, provided that the provisions of the laws of such state, territory, district, or country are shown to the satisfaction of the department to as carefully safeguard the policyholders as do the laws of this state. *(Formerly: Acts 1935, c.162, s.234.) As amended by P.L.252-1985, SEC.76.*

IC 27-1-18-2

Gross premium privilege tax

Sec. 2. (a) Every insurance company not organized under the laws of this state, and each domestic company electing to be taxed under this section, and doing business within this state shall, on or before March 1 of each year, report to the department, under the oath of the president and secretary, the gross amount of all premiums received by it on policies of insurance covering risks within this state, or in the case of marine or transportation risks, on policies made, written, or renewed within this state during the twelve (12) month period ending on December 31 of the preceding calendar year. From the amount of gross premiums described in this subsection shall be deducted:

(1) considerations received for reinsurance of risks within this state from companies authorized to transact an insurance business in this state;

(2) the amount of dividends paid or credited to resident insureds, or used to reduce current premiums of resident insureds;

(3) the amount of premiums actually returned to residents on account of applications not accepted or on account of policies not delivered; and

(4) the amount of unearned premiums returned on account of

the cancellation of policies covering risks within the state.

(b) A domestic company shall be taxed under this section only in each calendar year with respect to which it files a notice of election. The notice of election shall be filed with the insurance commissioner and the commissioner of the department of state revenue on or before November 30 in each year and shall state that the domestic company elects to submit to the tax imposed by this section with respect to the calendar year commencing January 1 next following the filing of the notice. The exemption from license fees, privilege, or other taxes accorded by this section to insurance companies not organized under the laws of this state and doing business within this state which are taxed under this chapter shall be applicable to each domestic company in each calendar year with respect to which it is taxed under this section. In each calendar year with respect to which a domestic company has not elected to be taxed under this section it shall be taxed without regard to this section.

(c) For the privilege of doing business in this state, every insurance company required to file the report provided in this section shall pay into the treasury of this state an amount equal to the excess, if any, of the gross premiums over the allowable deductions multiplied by one and three-tenths percent (1.3%).

(d) Payments of the tax imposed by this section shall be made on a quarterly estimated basis. The amounts of the quarterly installments shall be computed on the basis of the total estimated tax liability for the current calendar year and the installments shall be due and payable on or before April 15, June 15, September 15, and December 15, of the current calendar year.

(e) Any balance due shall be paid in the next succeeding calendar year at the time designated for the filing of the annual report with the department.

(f) Any overpayment of the estimated tax during the preceding calendar year shall be allowed as a credit against the liability for the first installment of the current calendar year.

(g) In the event a company subject to taxation under this section fails to make any quarterly payment in an amount equal to at least:

(1) twenty-five percent (25%) of the total tax paid during the preceding calendar year; or

(2) twenty per cent (20%) of the actual tax for the current calendar year;

the company shall be liable, in addition to the amount due, for interest in the amount of one percent (1%) of the amount due and unpaid for each month or part of a month that the amount due, together with interest, remains unpaid. This interest penalty shall be exclusive of and in addition to any other fee, assessment, or charge made by the department.

(h) The taxes under this article shall be in lieu of all license fees or privilege or other tax levied or assessed by this state or by any municipality, county, or other political subdivision of this state. No

municipality, county, or other political subdivision of this state shall impose any license fee or privilege or other tax upon any insurance company or any of its agents for the privilege of doing an insurance business therein, except the tax authorized by IC 22-12-6-5. However, the taxes authorized under IC 22-12-6-5 shall be credited against the taxes provided under this chapter. This section shall not be construed to prohibit the levy and collection of state, county, or municipal taxes upon real and tangible personal property of such company, or to prohibit the levy of any retaliatory tax, fine, penalty, or fee provided by law. However, all insurance companies, foreign or domestic, paying taxes in this state predicated in part on their premium income from policies sold and premiums received in Indiana, shall have the same rights and privileges from further taxation and shall be given the same credits wherever applicable, as those set out for those companies paying only a tax on premiums as set out in this section.

(i) Any insurance company failing or refusing, for more than thirty (30) days, to render an accurate account of its premium receipts as provided in this section and pay the tax due thereon shall be subject to a penalty of one hundred dollars ($100) for each additional day such report and payment shall be delayed, not to exceed a maximum penalty of ten thousand dollars ($10,000). The penalty may be ordered by the commissioner after a hearing under IC 4-21.5-3. The commissioner may revoke all authority of such defaulting company to do business within this state, or suspend such authority during the period of such default, in the discretion of the commissioner.

(Formerly: Acts 1935, c.162, s.235; Acts 1963, c.301, s.1; Acts 1971, P.L.386, SEC.1.) As amended by P.L.252-1985, SEC.77; P.L.245-1987, SEC.15; P.L.268-1999, SEC.7; P.L.144-2000, SEC.2; P.L.81-2012, SEC.7.

IC 27-1-18-3
Amendment of articles; filing copies; effect

Sec. 3. Each foreign or alien corporation admitted to do business in this state shall keep on file in the office of the department a duly authenticated copy of each instrument amending its articles of incorporation or association, but the filing of any such instrument shall not of itself enlarge or alter the character of business which the foreign corporation is authorized to transact in this state as set forth in the certificate of admission, unless such foreign corporation apply for and receive an amended certificate of admission as provided for in section 4 of this chapter.

(Formerly: Acts 1935, c.162, s.236.) As amended by P.L.252-1985, SEC.78.

IC 27-1-18-4
Amended certificate of authority

Sec. 4. (a) Any foreign or alien corporation admitted to do business in this state may alter or enlarge the character of the business which it is authorized to transact in this state under its articles of incorporation or association, and any amendments thereof filed with the department as provided in section 3 of this chapter, by procuring an amended certificate of authority from the department in the manner provided in subsection (b).

(b) Whenever a foreign or alien corporation desires to procure such amended certificate, it shall present to the department at its office, accompanied by the fees prescribed by law, an application for an amended certificate of authority, setting forth the change desired in the kind or kinds of insurance business under its articles of incorporation or association which it intends to thereafter carry on in this state; the application shall be filed in the form prescribed by the department by the president or a vice president and the secretary or an assistant secretary of the corporation, and verified by the oaths of the officers signing the same.

(c) Upon the presentation of such application, accompanied by the corporation's certificate of authority, the department, if it finds that it conforms to law and that the foreign or alien company has fulfilled the requirements set forth in subsection (b) and in section 3 of this chapter, may endorse its approval upon the application, and, in case of the approval of such application and when all fees required by law shall have been paid, shall file one (1) copy of the application in its office, cancel the certificate of authority presented with the application, and issue to the corporation a new certificate of authority, which certificate shall set forth the kind or kinds of business that the corporation is authorized thereafter to transact in this state, which shall be accompanied by one (1) copy of the application bearing the endorsement of the approval of the department.

(d) Upon the issuance of the new certificate of authority by the department, the corporation therein named shall have authority thereafter to transact in this state the kind or kinds of insurance business set forth in such certificate, subject to the terms and conditions prescribed in this article.

(Formerly: Acts 1935, c.162, s.237.) As amended by P.L.252-1985, SEC.79; P.L.11-2011, SEC.15.

IC 27-1-18-5

Condensed statement of assets and liabilities; examination; correction of statement; publication; expense

Sec. 5. At the time of filing its annual statement, an alien or foreign company shall submit, on a form prescribed by the department, a condensed statement of its assets and liabilities as of December 31 of the preceding year. If the department, on examination of such statement, determines from information available to it that it is true and correct, it shall cause such statement

to be published in a newspaper in this state selected by the department. In the event the department determines that the statement submitted by a company is inaccurate or incorrect, it shall, after giving the company notice of the proposed changes and an opportunity to be heard, certify the corrected statement and proceed with its publication as above provided. The company shall bear the expenses of the publication, but in no event shall an amount exceeding forty dollars ($40) be charged for such publication. Any cost of publication that exceeds forty dollars ($40) must be borne by the newspaper publishing the statement.
(Formerly: Acts 1935, c.162, s.238; Acts 1971, P.L.385, SEC.4.) As amended by P.L.267-1987, SEC.2; P.L.160-2003, SEC.3.

IC 27-1-18-6
Procedure for withdrawal

Sec. 6. (a) Any foreign or alien corporation admitted to do business in this state may withdraw from this state by surrendering its certificate of authority and by filing with the department, accompanied by the fees prescribed by law, a statement of withdrawal setting forth:

(1) the name of the corporation and the state, country, province, or government wherein it is incorporated or organized, or the state in which it is domiciled in the United States;
(2) the date of the issuance of the original certificate of authority;
(3) that it surrenders its authority to transact business in this state and returns for cancellation its certificate of authority; and
(4) a post office address to which the commissioner may mail a copy of any process against the withdrawing company that may be served upon him.

(b) Such statement shall be signed, in the form prescribed by the department, by the president or a vice president and the secretary or an assistant secretary of the corporation, and shall be verified by the oaths of the officers signing the same.

(c) The statement as provided for in this section shall be filed with the department, accompanied by a report of taxable premiums as provided for in section 2 of this chapter, the amount of tax shown to be due and payable by such report, its certificate of authority, and after the payment of the fees prescribed by law, the department shall cancel the certificate of authority and endorse the same thereon, and return such cancelled certificate to the company, and the authority of the company to transact an insurance business in this state shall cease, but the withdrawal and cessation of business shall not affect any action by or against such corporation pending at the time thereof, or any right of action existing at or before the filing of such statement, in favor of or against such company.
(Formerly: Acts 1935, c.162, s.239.) As amended by P.L.252-1985, SEC.80.

IC 27-1-19

Chapter 19. Reorganization of Foreign Companies Into Domestic Companies

IC 27-1-19-1

Authority to reorganize as domestic company

Sec. 1. Any foreign life insurance company authorized to do business in this state, and empowered by the laws of the state, territory or insular possession of the United States, or the District of Columbia under which it was incorporated to reincorporate, is hereby authorized to reorganize under the laws of this state by compliance with the provisions of this chapter and thereafter be a new corporation of this state under this article.

(Formerly: Acts 1935, c.162, s.240.) As amended by P.L.252-1985, SEC.81.

IC 27-1-19-2

Articles of reorganization; adoption by directors; contents

Sec. 2. (a) The board of directors of any such company desiring to reorganize under this article shall, after full compliance with the laws of state, territory, or insular possession of the United States, or the District of Columbia, under which the company was incorporated or organized, by a resolution adopted by a majority vote of the members of such board, approve and adopt articles of reorganization setting forth:

(1) the name of the company;

(2) the location of its principal office and the location of its proposed principal office in this state;

(3) the date of its incorporation or organization;

(4) a designation of the statute under which it was organized;

(5) a declaration that it accepts all of the terms and provisions of this article; and

(6) a restatement of such provisions of its articles of incorporation or association as may be deemed advisable so long as the provisions restated would have been authorized by this article as provisions of original articles of incorporation for a company organized under this article.

(b) Upon the approval and adoption thereof by the board of directors, the articles of reorganization shall be executed and signed in triplicate originals by the president and the secretary of the company, and acknowledged and sworn to before an officer authorized to take the acknowledgments of deeds by the officers signing the same.

(Formerly: Acts 1935, c.162, s.241.) As amended by P.L.252-1985, SEC.82.

IC 27-1-19-3

Articles of reorganization; presentation and approval

Sec. 3. The articles of reorganization shall be presented to the department, accompanied by a certified copy of the resolution of the board of directors adopting and approving the same, signed by the president and secretary of the company. The department may approve or disapprove the articles of reorganization, in the same manner as provided in IC 27-1-6-8. In the event the department approves the articles of reorganization as provided, it shall then submit them to the attorney general for the state of Indiana, who shall examine such articles and endorse his approval thereon and return them to the department in the same manner as provided in IC 27-1-6-9. When the articles of reorganization have been approved by the attorney general and returned to the department, the department shall present them to the secretary of state for the state of Indiana, who shall endorse his approval thereon in the same manner as provided in IC 27-1-6-10 and file one (1) copy in his office and return the other two (2) copies to the company or its representatives.
(Formerly: Acts 1935, c.162, s.242.) As amended by P.L.252-1985, SEC.83.

IC 27-1-19-4
Certificate of authority

Sec. 4. When the provisions of sections 1, 2, and 3 of this chapter have been complied with and the applicant has fulfilled all the requirements imposed by this article upon a similar domestic company doing a like business, then the commissioner may, in his discretion, issue a certificate of authority as provided in IC 27-1-6-18.
(Formerly: Acts 1935, c.162, s.243.) As amended by P.L.252-1985, SEC.84.

IC 27-1-19-5
Continuation of existing obligations

Sec. 5. Any such corporation so organizing under the provisions of this article is hereby required to faithfully carry out any and all rights, duties, obligations, contracts, and any and all other liabilities of every kind and description existing in its favor or against it at the time of its reorganization under the provisions of this article, and it shall have the rights, privileges, powers, duties, and responsibilities, unchanged and unaffected, which it had at the time of such reorganization under the provisions of this article; nothing contained in this chapter or authorized by this chapter shall impair or operate to impair the obligations of any contract existing at the time of the creation of the new corporation, but such new corporation shall be subject to and shall assume, carry out, fulfill, and pay all liabilities, obligations, responsibilities, and contracts connected with and arising out of its business prior to such reincorporation.
(Formerly: Acts 1935, c.162, s.244.) As amended by P.L.252-1985, SEC.85.

IC 27-1-19-6
Vesting of assets in new corporation; name; treatment of real estate

Sec. 6. Upon compliance with the provisions of this article, the entire assets of any such corporation shall thereby become vested in the new corporation. The name of the new corporation may be the same as the former corporation, or, upon resolution of the board of trustees or directors or other governing body, such name may be changed. If such corporation shall be the owner of any real estate situate in said state of Indiana or of any other state, such real estate shall become vested, upon compliance with this statute, in the new corporation, and a copy of such resolution, duly certified by the secretary of state and filed in the recorder's office of the proper county in which such real estate may be situated, shall constitute a conveyance of said real estate to said new corporation.
(Formerly: Acts 1935, c.162, s.245.) As amended by P.L.252-1985, SEC.86.

IC 27-1-19-7
Reports; regulation and supervision; location of principal office

Sec. 7. Such new corporation shall hereafter make its reports in accordance with the laws of the state of Indiana, and shall be subject to the exclusive regulation and supervision of the department of insurance of the state of Indiana, and thereafter shall make its applications for the purpose of doing business in other states, and countries, as a corporation of the state of Indiana, and shall be subject to regulation and supervision by the insurance departments of other states and countries as a foreign insurance company. In its resolution for reincorporation under this law, it shall state the location of its principal office, which shall be in this state.
(Formerly: Acts 1935, c.162, s.246.)

IC 27-1-19-8
Directors

Sec. 8. The board of directors, or other governing body, of such corporation, shall remain for the new corporation, the same as for the old, until changed by the board of directors of the new corporation. Their election and terms of office shall remain the same as they were prior to the new incorporation.
(Formerly: Acts 1935, c.162, s.247.)

IC 27-1-20

Chapter 20. Additional Provisions Pertaining to All Insurance Companies

IC 27-1-20-1

Insurance of deposited securities

Sec. 1. The department, in the name of the State of Indiana, and for the benefit of the owners of all securities subject to negotiation by delivery, and deposited with the department or under its supervision, shall purchase and maintain insurance, in an aggregate amount not to exceed one million dollars, against loss from any cause that the department may deem appropriate.

(Formerly: Acts 1935, c.162, s.248; Acts 1971, P.L.385, SEC.5.)

IC 27-1-20-2

Repealed

(Repealed by Acts 1971, P.L.1, SEC.8.)

IC 27-1-20-3

Eligibility of investments for deposit; existing investments

Sec. 3. Eligible investments made or deposited prior to March 8, 1935, shall continue to be eligible for deposit, subject, however, to section 4 of this chapter.

(Formerly: Acts 1935, c.162, s.250.) As amended by P.L.252-1985, SEC.87.

IC 27-1-20-4

Revaluation of investments omitting interest or dividends

Sec. 4. If any investment when made or purchased conforms to the requirements of this law, or of any law of this state at the date of such deposit, it shall continue to be eligible for deposit for the full amount thereof so long as: (a) in the case of an interest-bearing investment, the interest is not in default for more than two (2) years; and (b) in the case of a dividend-paying investment, the dividends are not unpaid for more than two (2) years: Provided, however, That when there shall be a default in the payment of interest, or a failure to pay dividends, for a period of more than two (2) years, the commissioner may, if he deems it advisable, require the company to furnish reasonable proof of the then fair value of the investment and the same shall thereafter continue to be a proper investment and available for deposit for the fair value thus determined, not exceeding the amount due on any given promise to pay or the amount paid for a given share of stock.

(Formerly: Acts 1935, c.162, s.251.)

IC 27-1-20-5

Deposit of securities acquired from foreign life insurer under reinsurance agreement

Sec. 5. Nothing in this law shall prevent the deposit of securities and other evidences of ownership of property, acquired from a life insurance company domiciled in a foreign state or alien country by a domestic life insurance company under a reinsurance agreement approved by the department, provided such securities and property comply with the investment requirements of the state of incorporation of such reinsured company.
(Formerly: Acts 1935, c.162, s.252.)

IC 27-1-20-6
Transfer of defaulted deposited securities to other depository under financial reorganization agreement; filing receipt; effect on deposit credit

Sec. 6. If a life insurance company, in order to protect itself against loss on account of defaulted securities issued by a public or private corporation and deposited with the department in accordance with this article, enters into an agreement incidental to the financial reorganization of such corporation, and requiring a deposit of such securities with a committee or a depository designated in such agreement, such securities may be withdrawn from the deposit with the department and transferred to the committee or depository designated in such agreement without reducing the deposit credit of such company, provided that a proper receipt executed by the committee or depository be filed with the department within fifteen (15) days following the date such securities are withdrawn, or within such further period of time as the commissioner may in his discretion allow.
(Formerly: Acts 1935, c.162, s.253.) As amended by P.L.252-1985, SEC.88.

IC 27-1-20-7
Withdrawal from deposit to pledge for loan; effect; redeposit

Sec. 7. Nothing in this article shall prevent a life insurance company, with the commissioner's consent, from withdrawing investments from deposit for the purpose of pledging them for a loan or loans, in which case the difference between the deposit value of such investments and the amount of the obligation or obligations thereby secured shall, unless and until such pledge is foreclosed, continue as a deposit credit, and when such investments are offered for deposit they shall be reinstated in all respects to their former status as a deposit.
(Formerly: Acts 1935, c.162, s.254.) As amended by P.L.252-1985, SEC.89.

IC 27-1-20-8
Deposits as a condition of doing business; definitions; securities; bank deposits with restricted withdrawal privileges

Sec. 8. (a) The definitions set forth in this subsection apply

throughout this section:

(1) "Broker dealer" means an entity that:

(A) is registered with and subject to the jurisdiction of the Securities and Exchange Commission;

(B) maintains membership in the Securities Investor Protection Corporation; and

(C) has a tangible net worth of at least two hundred fifty million dollars ($250,000,000).

(2) "Clearing corporation" means a corporation as defined in IC 26-1-8.1-102 except that with respect to securities issued by institutions organized or existing under the laws of any foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein. "Clearing corporation" may include a corporation organized or existing under the laws of any foreign country and which is legally qualified under such laws to effect transactions in securities by computerized book entry.

(3) "Direct participant" means a bank, trust company, or safety deposit company approved by the commissioner which maintains an account in its name in a clearing corporation and through which an insurance company participates in a clearing corporation.

(4) "Federal Reserve book-entry system" means the computerized systems sponsored by the United States Department of the Treasury and certain agencies and instrumentalities of the United States for holding and transferring securities of the United States government and such agencies and instrumentalities, respectively, in Federal Reserve Banks through banks which are members of the Federal Reserve System, or which otherwise have access to such computerized systems.

(5) "Member bank" means a national bank, state bank, or trust company which is a member of the Federal Reserve System and through which an insurance company participates in the Federal Reserve book-entry system.

(6) "Securities" means instruments meeting the definition set forth in IC 26-1-8.1-102.

(b) Notwithstanding any other provision of law, a domestic insurance company may deposit or arrange for the safekeeping of securities held in or purchased for its general account and its separate accounts in a clearing corporation or the Federal Reserve book-entry system. When securities are deposited with a clearing corporation, certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of the nominee of such clearing corporation with any other securities deposited with such clearing corporation by any person, regardless of the ownership of such securities, and certificates representing securities of small denominations may be merged into one (1) or more certificates of

larger denominations. The records of any member bank or broker dealer through which an insurance company holds securities in the Federal Reserve book-entry system, and the records of any custodian through which an insurance company holds securities in a clearing corporation, shall at all times show that such securities are held for such insurance company and for which accounts thereof. Ownership of, and other interests in, such securities may be transferred by bookkeeping entry on the books of such clearing corporation or in the Federal Reserve book-entry system without, in either case, physical delivery of certificates representing such securities.

(c) Any Indiana law requiring an insurance company operating under the laws of Indiana to deposit assets with the department shall be deemed complied with if such deposit is made pursuant to a written agreement between the insurance company and any bank, trust company or a safety deposit company and approved by the commissioner which limits withdrawals to those sanctioned and approved by the department. Deposits so made shall be credited by the department as deposits in its possession on the basis of the insurance company's affidavit describing such deposits as to amount and nature.

(d) Notwithstanding any other provisions of law, securities eligible for deposit under the insurance law of this state relating to deposit of securities by an insurance company as a condition of commencing or continuing to do an insurance business in this state may be deposited with a clearing corporation or held in the Federal Reserve book-entry system. Securities deposited with a clearing corporation or held in the Federal Reserve book-entry system and used to meet the deposit requirements under the insurance laws of this state shall be under the control of the commissioner and shall not be withdrawn by the insurance company without the approval of the commissioner. Any insurance company holding such securities in such manner shall provide to the commissioner evidence issued by its custodian or a member bank through which such insurance company has deposited securities with a clearing corporation or held in the Federal Reserve book-entry system, respectively, in order to establish that the securities are actually recorded in an account in the name of the custodian or other direct participant or member bank and evidence that the records of the custodian, other participant, or member bank reflect that such securities are held subject to the order of the commissioner.

(e) The commissioner of insurance is authorized to promulgate rules and regulations governing the deposit by insurance companies of securities with clearing corporations and in the Federal Reserve book-entry system.

(Formerly: Acts 1935, c.162, s.255; Acts 1945, c.175, s.5; Acts 1957, c.22, s.1.) As amended by Acts 1981, P.L.238, SEC.2; Acts 1982, P.L.164, SEC.1; P.L.255-1995, SEC.4; P.L.247-1995, SEC.24; P.L.11-2011, SEC.16.

IC 27-1-20-9

Substitution of securities on deposit; withdrawal of securities in excess of requirements

Sec. 9. Companies shall have the right at any time to change their securities on deposit, by substituting for those withdrawn a like amount in other securities of the character provided for in this article, and whenever the net cash value of policies outstanding and in force against any company is less than the amount of securities then on deposit with the department, said company shall have the right to withdraw such excess, but at least twenty-five thousand dollars ($25,000) shall remain on deposit.

(Formerly: Acts 1935, c.162, s.256.) As amended by P.L.252-1985, SEC.90.

IC 27-1-20-10

Disposition of interest earned by securities on deposit

Sec. 10. The department shall permit companies having on deposit with it stocks or bonds as security, to collect the interest accruing on such deposits, delivering to their authorized agents, respectively, the coupons or other evidences of interest as the same become due; but upon default by any company to deposit additional security as called for by the department or pending any proceedings for rehabilitation, liquidation or conservation of such company, the department shall collect the interest as it becomes due and add the same to the securities in its possession, or under its control, belonging to such company.

(Formerly: Acts 1935, c.162, s.257.)

IC 27-1-20-11

Discontinuance of business; procedure for return of deposited securities

Sec. 11. When any company determines to discontinue its business and ceases to do business in this state and desires to withdraw its deposit made in this state pursuant to this article, the department shall upon the application of the company and at the expense of the company give notice of such intention in a newspaper of general circulation in the state once a week for a period of four (4) weeks. After such publication it shall deliver to such company or its assigns the securities so deposited when it is satisfied upon examination and investigation made by it or under its authority and upon the oaths of the president or a vice president and the secretary or an assistant secretary of the company that all debts and liabilities of every kind due and to become due which the deposit was made to secure are paid and extinguished.

(Formerly: Acts 1935, c.162, s.258.) As amended by P.L.252-1985, SEC.91.

IC 27-1-20-12

Retaliatory provisions

Sec. 12. (a) When, by the laws of any other state, any taxes, fines, penalties, licenses, fees, deposits of money or securities, or other obligations or prohibitions are imposed upon insurance companies of this or other states, or their agents, greater than are required by laws of this state, then the same obligations and prohibitions, of whatever kind, shall, in like manner for like purposes, be imposed upon all insurance companies of such states and their agents. All insurance companies of other nations, under this section, shall be held as of the state where they have elected to make their deposit and establish their principal agency in the United States.

(b) Whenever it shall be made to appear to the insurance commissioner that permission to transact business within any state of the United States, other than the state of Indiana, or within any foreign country, is refused to an insurance company organized under the laws of this state, after a certificate of the solvency and good management of such company has been issued to it by the insurance commissioner and after such company has complied with any reasonable laws of such other state or foreign country requiring deposits of money or securities with the government of such other state or foreign country, then and in every such case, the commissioner may forthwith cancel the authority of every insurance company organized under the laws of such other state or foreign country and licensed to do business in this state, and may refuse a certificate of authority to every such company thereafter applying to him for authority to do business in this state, until his certificate shall have been duly recognized by the government of such other state or foreign country.

(Formerly: Acts 1935, c.162, s.259; Acts 1937, c.288, s.5.)

IC 27-1-20-13

Fees of secretary of state

Sec. 13. The fees payable to the secretary of the state by insurance companies which are organized or reorganized under the laws of this state or the laws of any other state, territory or insular possession of the United States or the District of Columbia shall be the same as the fees prescribed in chapter 219 of the Acts of the General Assembly of 1929.

(Formerly: Acts 1935, c.162, s.262.)

IC 27-1-20-14

Pension plan for officers and employees

Sec. 14. Any insurance company organized under the laws of this state, in addition to the rights and powers conferred upon it by the law under which it was organized and/or under which it operates, shall have the power to establish a pension plan or system for the benefit of its officers and employees. Before such a plan or system is adopted by a company, it shall be submitted to and approved by

the commissioner of insurance.
(Formerly: Acts 1935, c.162, s.262a.)

IC 27-1-20-15
Automatic revocation of authority for failure to timely complete organization

Sec. 15. If any company, whether organized under the provisions of this article or of any statute enacted prior to March 8, 1935, for the purpose of making any kind or kinds of insurance, does not complete its organization and proceed with the transaction of business, pursuant to the provisions of the statute under which it is organized, within a period of one (1) year after its articles of incorporation or its organization shall have been approved and filed in the office of the secretary of state, the approval so given shall be deemed to be revoked and such articles of incorporation or such organization shall be null and void.
(Formerly: Acts 1935, c.162, s.264.) As amended by P.L.252-1985, SEC.92.

IC 27-1-20-16
Repealed

(Repealed by P.L.1-1989, SEC.75.)

IC 27-1-20-17
Repealed

(Repealed by Acts 1978, P.L.2, SEC.2728.)

IC 27-1-20-18
Repealed

(Repealed by Acts 1976, P.L.122, SEC.1.)

IC 27-1-20-19
Misrepresentation of funds available to pay losses or policy claims

Sec. 19. No company doing business in this state or agent thereof shall state or represent by advertisement in any newspaper, periodical or magazine or by any sign, circular, card, policy of insurance or certificate of renewal thereof or otherwise that any funds or assets are in possession of such company which are not actually owned by it and available for the payment of losses and claims and held for the protection of its policyholders and creditors. Funds deposited by any company, under depository laws of this or other states, shall be considered as in the company's possession for the payment of losses or policy claims.
(Formerly: Acts 1935, c.162, s.267.)

IC 27-1-20-20
Financial statement; requirements; violations; penalties

Sec. 20. Except as otherwise provided in this section, every

advertisement or public announcement and every sign, circular or card issued or displayed by any domestic, foreign or alien company doing business in this state, purporting to make known its financial condition, shall state the amount of its paid-up capital, the assets owned, its liabilities, including therein the premium and loss reserves required by law, and the amount of net surplus of admitted assets over all its liabilities actually available for the payment of its losses and claims and held for the protection of its policyholders and shall correspond to the next preceding verified statement made to the department by such company. The foregoing shall not apply to a statement showing only the capital stock paid up and the surplus separately and combined, but such items shall not be in excess of the corresponding items shown on the verified statements made by such company to the department next preceding the making or issuing of the same. Every advertisement or public announcement and every sign, circular or card issued or displayed by an alien company doing business in this state, purporting to make known its financial condition, shall segregate and state separately the capital and assets held by its United States branch, the liabilities, including therein the premium and loss reserves required by law, and the amount of net surplus of assets over all its liabilities actually available for the payment of its losses and claims and held for the protection of its policyholders in the United States and shall correspond to the next preceding verified annual statement made by such company to the commissioner.

Despite any other provision of the laws of this state an insurer may, subject to requirements set forth by regulation promulgated by the Commissioner, publish financial statements or information based on financial statements prepared on a basis which is in accordance with requirements of a competent authority and which differs from the basis of the statements which have been filed with the Insurance Commissioner. Such differing financial statements or information based on financial statements shall not be made the basis for the application of provisions of any laws of this state not relating solely to the publication of financial information unless such provisions specifically so require.

For every willful violation of this section and section 19 of this chapter by any such company or by an agent thereof the company shall forfeit for the first offense to the state of Indiana the sum of five hundred dollars ($500) and for every subsequent offense the sum of one thousand dollars ($1,000), which, when recovered, shall be paid to the state treasurer.

(Formerly: Acts 1935, c.162, s.268; Acts 1974, P.L.123, SEC.1.)

IC 27-1-20-21

Annual financial statement; microfilm copies

Sec. 21. Every company doing business in this state shall file with the department on or before March 1 in each year a financial

statement for the year ending December 31 immediately preceding in a format in accordance with IC 27-1-3-13. For good and sufficient cause shown, the commissioner may grant to any individual company a reasonable extension of time not to exceed ninety (90) days within which such statement may be filed. Such statement shall be verified by the oaths of the president or a vice president and the secretary or an assistant secretary of the company. The statement of an alien company shall segregate and state separately its condition and transaction in the United States and such segregated and separated statement shall be verified by the oath of its resident manager or principal representative in the United States. The commissioner of insurance may, with the approval of the Indiana archives and records administration, authorize the destruction of such annual statements which have been on file for two (2) years or more and microfilm copies of which have been made and filed.

(Formerly: Acts 1935, c.162, s.269; Acts 1957, c.124, s.1.) As amended by P.L.252-1985, SEC.94; P.L.159-1986, SEC.4; P.L.271-1987, SEC.3; P.L.3-1989, SEC.151; P.L.246-1989, SEC.1; P.L.130-1994, SEC.26; P.L.116-1994, SEC.36; P.L.1-1998, SEC.140; P.L.268-1999, SEC.8; P.L.171-2015, SEC.45.

IC 27-1-20-21.1
Repealed

(Repealed by P.L.1-1990, SEC.257.)

IC 27-1-20-21.2
Civil penalty; failure to comply with IC 27-1-20-21

Sec. 21.2. The commissioner may impose a civil penalty of five hundred dollars ($500) under IC 4-21.5-3 on an insurance company that fails to comply with section 21 of this chapter.

As added by P.L.1-1990, SEC.258.

IC 27-1-20-21.3
Actuarial opinions

Sec. 21.3. (a) Every domestic casualty insurance company, domestic fire and marine insurance company, and domestic life and health insurance company shall include an actuarial opinion as an additional part of the financial statement required under section 21 of this chapter. The commissioner shall adopt rules under IC 4-22-2 that:

(1) prescribe the form and content of the actuarial opinion required by this section; and

(2) establish minimum qualifications that an actuary must meet in order to provide the actuarial opinion required under this section.

(b) The actuarial opinion required by subsection (a) shall be included with every annual statement beginning with the statement for calendar year 1994.

As added by P.L.1-1990, SEC.259. Amended by P.L.130-1994, SEC.27; P.L.116-1994, SEC.37; P.L.14-2000, SEC.57.

IC 27-1-20-22
Verification of accounts and reports

Sec. 22. Whenever any provision of this article requires that there shall be filed any verified account, report, or other paper by any person, firm, or corporation, such account, report, or other paper shall be executed by the person or persons filing such account, report, or other paper or by the president or such other officer as may be designated by the board of directors of any corporation filing such account, report, or other paper, and the truth of the matters therein stated shall be sworn to under oath by such person or by such president or other officer, before a notary public or other officer duly qualified to administer oaths.

(Formerly: Acts 1935, c.162, s.270.) As amended by P.L.252-1985, SEC.95.

IC 27-1-20-23
Remedies of receivership exclusive with department; exception in favor of judgment creditor

Sec. 23. No order, judgment, or decree providing for an accounting or enjoining, restraining, or interfering with the operation of the business of any insurance company, association, or society, to which any provision of this article is applicable, or for the appointment of a temporary or permanent receiver thereof, shall be made or granted otherwise than upon the application of the department, except in an action by a judgment creditor or in proceedings supplemental to execution.

(Formerly: Acts 1935, c.162, s.270a.) As amended by P.L.252-1985, SEC.96.

IC 27-1-20-24
Repealed

(Repealed by Acts 1978, P.L.2, SEC.2728.)

IC 27-1-20-25
Organization of new companies on Lloyds or assessment plan prohibited; surplus requirement for reciprocal plan

Sec. 25. (a) A domestic company that organized after March 7, 1935, may not operate:

(1) an insurance business on the assessment plan; or

(2) an insurance business as Lloyds.

(b) A domestic company may not operate an insurance business on the reciprocal plan as an interinsurer or individual underwriter unless it has a surplus over all policy liabilities of not less than two hundred fifty thousand dollars ($250,000).

(Formerly: Acts 1935, c.162, s.272.) As amended by Acts 1977,

P.L.282, SEC.4.

IC 27-1-20-26
Exemption from article of a farm mutual insurance company

Sec. 26. Except as provided in IC 27-5.1-2-8, the provisions of this article shall not apply to a farm mutual insurance company or any similar company organized and operating under IC 27-5 (before its repeal) or IC 27-5.1, nor shall any provision of this article be construed as repealing any provision of the statutes applicable to the companies and associations referred to in this section.
(Formerly: Acts 1935, c.162, s.272a.) As amended by P.L.252-1985, SEC.97; P.L.129-2003, SEC.4.

IC 27-1-20-27
Exemption of domestic mutual fire insurance companies

Sec. 27. The provisions of IC 27-1-5 through IC 27-1-19 and this chapter shall not apply to any domestic mutual fire insurance company or association licensed as of March 8, 1935, originally organized and operated by farmers to insure farm property.
(Formerly: Acts 1935, c.162, s.272b.) As amended by P.L.252-1985, SEC.98.

IC 27-1-20-28
Exemption of interinsurance associations or reciprocal or interinsurance exchanges dealing with worker's compensation insurance

Sec. 28. The provisions of this article shall not apply to any interinsurance association or reciprocal or interinsurance exchange organized under and by virtue of Acts 1915, c.106, as amended and supplemented, and formed and operating on or before January 1, 1991, for the sole purpose of writing worker's compensation insurance.
(Formerly: Acts 1935, c.162, s.272c.) As amended by P.L.252-1985, SEC.99; P.L.28-1988, SEC.78; P.L.170-1991, SEC.26.

IC 27-1-20-29
Exemption of abstract and title insurance companies

Sec. 29. Nothing contained in this article shall be construed to affect or apply to any corporation organized before March 8, 1935, under any law of this state which is authorized to engage in the making of abstracts of title to real estate and the issuing of certificates insuring or guaranteeing the titles to real estate.
(Formerly: Acts 1935, c.162, s.272d.) As amended by P.L.252-1985, SEC.100.

IC 27-1-20-30
Rebate of premium or commission; unfair competition

Sec. 30. (a) No company acting through its officers or members,

attorney-in-fact, or by any other party, no officer of a company acting on the officer's own behalf and no insurance producer, broker, or solicitor, personally or by any other party, shall offer, promise, allow, give, set off or pay, directly or indirectly, any rebate of or part of the premium payable on a policy, or any insurance producer's commission thereon, or earnings, profits, dividends or other benefits founded, arising, accruing, or to accrue thereon or therefrom, or any special advantage in date of policy or age of issue, or any paid employment or contract for services of any kind, or any other valuable consideration or inducement, to or for insurance on any risk in this state, now or hereafter to be written, or for or upon any renewal of any such insurance, which is not specified in the policy contract of insurance, or offer, promise, give, option, sell or purchase any stocks, bonds, securities, or property, or any dividends or profits accruing or to accrue thereon, or other thing of value whatsoever as inducement to insurance or in connection therewith, or any renewal thereof, which is not specified in the policy. Nothing in this section shall prevent a company which transacts industrial life insurance on a weekly payment plan from returning to policyholders who have made a premium payment for a period of at least one (1) year directly to the company at its home or district office a percentage of premium which the company would otherwise have paid for the weekly collection of such premium, nor shall this section be construed to prevent the taking of a bona fide obligation, with legal interest, in payment of any premium.

(b) No insured person or party or applicant for insurance shall directly or indirectly, receive or accept, or agree to receive or accept, any rebate of premium or of any part thereof, or all or any part of any insurance producer's or broker's commission thereon, or any favor or advantage, or share in any benefit to accrue under any policy of insurance, or any valuable consideration or inducement, other than such as are specified in the policy.

(Formerly: Acts 1935, c.162, s.273.) As amended by Acts 1978, P.L.2, SEC.2713; P.L.178-2003, SEC.20.

IC 27-1-20-31

Restrictions on interlocking directorates

Sec. 31. Insurance corporations may have interlocking directorates, provided no person at the same time shall be a director in two (2) or more insurance corporations where the effect may be to substantially lessen competition generally or tend to create a monopoly. Whenever the commissioner of insurance has reason to believe that there is a violation of this section, he shall have the authority to proceed to an adjudication of the violation under IC 4-21.5-3.

(Formerly: Acts 1935, c.162, s.273a; Acts 1949, c.90, s.1.) As amended by P.L.252-1985, SEC.101; P.L.7-1987, SEC.139.

IC 27-1-20-32
Effect of captions

Sec. 32. No caption of any section or set of sections of Acts 1935, c.162 shall in any way affect the interpretation of this article or any provision of this article.

(Formerly: Acts 1935, c.162, s.275.) As amended by P.L.252-1985, SEC.102.

IC 27-1-20-33
Annual statement convention blank, additional filings, and quarterly statements; filings with NAIC

Sec. 33. (a) As used in this section, "insurer" refers to each:

(1) domestic company;
(2) foreign company; and
(3) alien company;

that is authorized to transact business in Indiana.

(b) As used in this section, "NAIC" means the National Association of Insurance Commissioners.

(c) On or before March 1 of each year, an insurer shall file with the National Association of Insurance Commissioners and with the department a copy of the insurer's annual statement convention blank and additional filings prescribed by the commissioner for the preceding year. An insurer shall also file quarterly statements with the NAIC and with the department on or before May 15, August 15, and November 15 of each year in a form prescribed by the commissioner. The information filed with the NAIC under this subsection:

(1) must be:
(A) in the same format; and
(B) of the same scope;

as is required by the commissioner under section 21 of this chapter;

(2) to the extent required by the NAIC, must include the signed jurat page and the actuarial certification; and
(3) must be filed electronically in accordance with NAIC electronic filing specifications.

The commissioner may grant an exemption from the requirement of subdivision (3) to domestic companies that operate only in Indiana. If an insurer files any amendment or addendum to an insurer's annual statement convention blank or quarterly statement with the commissioner, the insurer shall also file a copy of the amendment or addendum with the NAIC. Annual and quarterly financial statements are deemed filed with the NAIC when delivered to the address designated by the NAIC for the filings regardless of whether the filing is accompanied by any applicable fee.

(d) The commissioner may, for good cause, grant an insurer an extension of time for the filing required by subsection (c).

(e) A foreign company that:

(1) is domiciled in a state that has a law substantially similar to subsection (c); and

(2) complies with that law;

shall be considered to be in compliance with this section.

(f) In the absence of actual malice:

(1) members of the NAIC;

(2) duly authorized committees, subcommittees, and task forces of members of the NAIC;

(3) delegates of members of the NAIC;

(4) employees of the NAIC; and

(5) other persons responsible for collecting, reviewing, analyzing, and disseminating information developed from the filing of annual statement convention blanks under this section;

shall be considered to be acting as agents of the commissioner under the authority of this section and are not subject to civil liability for libel, slander, or any other cause of action by virtue of the collection, review, analysis, or dissemination of the data and information collected from the filings required by this section.

(g) The commissioner may suspend, revoke, or refuse to renew the certificate of authority of an insurer that fails to file the insurer's annual statement convention blank or quarterly statements with the NAIC or with the department within the time allowed by subsection (c) or (d).

As added by P.L.121-1992, SEC.3. Amended by P.L.251-1995, SEC.16; P.L.91-1998, SEC.7; P.L.268-1999, SEC.9.

IC 27-1-20-34

Repealed

(As added by P.L.268-1999, SEC.10. Repealed by P.L.193-2006, SEC.33.)

IC 27-1-20-35

Insurer response to department request

Sec. 35. (a) Except as otherwise provided in this title, a company shall respond to a written inquiry or request that:

(1) is made by the department; and

(2) meets the requirements of subsection (b);

not more than twenty (20) business days after the date the written inquiry or request is received by the company.

(b) A written inquiry or request described in subsection (a) must do all of the following:

(1) Be addressed to the individual who holds the position that the company has designated as the position reasonably capable of processing such an inquiry or request.

(2) Specify that the inquiry or request is made under this section.

(3) Specify the penalty described in subsection (d) to which the company is subject for noncompliance with the inquiry or

request.

(4) Numerically list the questions to which a response is requested.

(c) The commissioner may, upon request of a company for extenuating circumstances, grant a company an extension of the period specified in subsection (a) or waive all or any part of a civil penalty described in subsection (d).

(d) The commissioner may assess against a company that does not comply with subsection (a) a civil penalty of one hundred dollars ($100) per day of noncompliance. A civil penalty assessed under this subsection may not exceed three thousand dollars ($3,000).

(e) The commissioner shall deposit a civil penalty collected under this section in the department of insurance fund established by IC 27-1-3-28.

As added by P.L.81-2012, SEC.8.

IC 27-1-20-36

Health insurer withdrawal from individual market

Sec. 36. (a) As used in this section, "health insurance" means the kind of coverage provided under a health insurance plan.

(b) As used in this section, "health insurance plan" means any of the following:

(1) An individual policy of accident and sickness insurance (as defined in IC 27-8-5-1). However, the term does not include the coverages described in IC 27-8-5-2.5(a).

(2) An individual contract (as defined in IC 27-13-1-21).

(c) As used in this section, "insurer" is limited to a person that enters into, issues, or delivers a health insurance plan on an individual basis in Indiana.

(d) An insurer shall, at least one hundred eighty (180) days before withdrawing from the individual health insurance market in Indiana, provide to the department written notice of the insurer's intent to withdraw.

As added by P.L.81-2012, SEC.9.

IC 27-1-21

Chapter 21. Additional Provisions Pertaining to Insurance Company Investments

IC 27-1-21-1

Treatment of prior investments

Sec. 1. IC 27-1-12-2, IC 27-1-12-3, IC 27-1-12-11, and IC 27-1-20-8 in their operation shall be subject to the following limitations and reservations:

(a) The validity for deposit and investment purposes of investments made before March 6, 1945, pursuant to the deposit investment requirements of s.147, s.148, s.149, or s.155 of Acts 1935, c.162 or which qualified for deposit under any of those sections prior to March 6, 1945, shall not be affected by the amendments made by Acts 1945, c.175.

(b) Investments made before March 6, 1945, not pursuant to the deposit investment requirements of s.147, s.148, s.149, or s.155 of Acts 1935, c.162 which did not qualify for deposit under any of these sections prior to March 6, 1945, shall be considered within the embrace of investments made under paragraph 20 of IC 27-1-12-2(b) and shall be subject to all the provisions applicable thereto.

(c) Investments described in subdivision (b) and those made pursuant to paragraph 20 of IC 27-1-12-2(b) may, provided the life insurance company so elects in a writing filed with the department, be transferred to any other appropriate paragraph of IC 27-1-12-2(b) under which they would have qualified if purchased at the date of such transfer.

(Formerly: Acts 1945, c.175, s.6.) As amended by P.L.252-1985, SEC.103; P.L.186-1997, SEC.8.

IC 27-1-22

Chapter 22. Regulation of Insurance Rates

IC 27-1-22-1

Purpose

Sec. 1. The purpose of this chapter is to promote the public welfare by empowering the commissioner of insurance to regulate insurance rates to the end that they shall not be excessive, inadequate, or unfairly discriminatory, and to encourage reasonable competition among insurance companies (referred to in this chapter as insurers) and to permit and regulate, but not require, cooperative action among insurers as to rates, rating systems, rating plans and practices, and other matters within the scope of this chapter. This chapter shall be liberally interpreted to carry into effect the provisions of this section.

(Formerly: Acts 1967, c.133, s.1.) As amended by P.L.252-1985, SEC.104.

IC 27-1-22-2

Application of act; exceptions; "inland marine insurance"

Sec. 2. (a) This chapter applies to all forms of casualty insurance including fidelity, surety, and guaranty bonds, to all forms of motor vehicle insurance, to all forms of fire, marine, and inland marine insurance, to all forms of title insurance, and to any and all combinations of the foregoing or parts thereof, on risks or operations in this state, except:

(1) reinsurance, other than joint reinsurance to the extent stated in section 14 of this chapter;

(2) accident and health insurance;

(3) 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;

(4) insurance against loss or damage to aircraft or against liability arising out of the ownership, maintenance, or use of aircraft; and

(5) worker's compensation insurance.

(b) Inland marine insurance includes insurance defined by statute, or by interpretation of statute, or if not so defined or interpreted, by ruling of the commissioner of insurance (referred to as the commissioner), or as established by general custom of the business, as inland marine insurance.

(Formerly: Acts 1967, c.133, s.2.) As amended by P.L.252-1985, SEC.105; P.L.28-1988, SEC.79; P.L.129-2003, SEC.5; P.L.80-2013, SEC.1.

IC 27-1-22-2.5

"Commercial policyholder" defined

Sec. 2.5. As used in this chapter, "commercial policyholder" means a business, nonprofit, or governmental entity that purchases a policy of commercial insurance through an insurance producer licensed under IC 27-1-15.6 or IC 27-1-15.8.
As added by P.L.268-1999, SEC.11. Amended by P.L.132-2001, SEC.6; P.L.178-2003, SEC.21; P.L.193-2006, SEC.7.

IC 27-1-22-3
Guidelines for establishing rates; uniformity; fleet or fleet policy

Sec. 3. (a) Rates shall be made in accordance with the following provisions:

(1) Due consideration shall be given to the past and prospective loss experience within and outside this state, to conflagration and catastrophe hazards, if any, to a reasonable margin for underwriting profit and contingencies, to dividends or savings allowed or returned by insurers to their policyholders or members, to past and prospective expenses both countrywide and those specifically applicable to this state, to all other relevant factors, including trend factors, within and outside this state, and in the case of fire insurance rates, to the underwriting experience of the fire insurance business during a period of not less than the most recent five (5) year period for which such experience is available and relevant.

(2) Risks may be grouped by classifications, by rating schedules, or by any other reasonable methods, for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that can be demonstrated to have a probable effect upon losses or expenses.

(3) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

(4) Rates shall not be excessive, inadequate, or unfairly discriminatory.

No rate shall be held to be excessive unless such rate is unreasonably high for the insurance coverage provided and a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable. No rate shall be held to be inadequate unless such rate is unreasonably low for the insurance coverage provided and is insufficient to sustain projected losses and expenses, or unless such rate is unreasonably low for the

insurance coverage provided and the use of such rate has, or if continued, will have, the effect of destroying competition or creating a monopoly. A rating difference that results from application of a rating plan that is intended to control rate changes applicable to a current policyholder upon renewal of the policy or the transfer of a policy in force among insurers is not unfairly discriminatory, is not an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4, and is not a violation of IC 27-1-20-30.

(b) Except to the extent necessary to meet the provisions of subsection (a)(4), uniformity among insurers in any matters within the scope of this section is neither required nor prohibited.

(c) For the purpose of making rates upon automobiles and other motor vehicles under the provisions of this chapter, the terms "fleet" or "fleet policy" shall mean an insurance risk of five (5) or more automobiles and other vehicles of any kind, all owned by one (1) insured and all under one (1) direct operating management; provided, that automobiles and other motor vehicles owned by employees may not be included or insured under a fleet policy of an employer under any circumstances.

(Formerly: Acts 1967, c.133, s.3.) As amended by P.L.252-1985, SEC.106; P.L.55-2011, SEC.1.

IC 27-1-22-3.1

Senior citizens participating in motor vehicle accident prevention courses; reduced premiums

Sec. 3.1. (a) As used in this section, "motor vehicle insurance" means any type of insurance described in IC 27-1-5-1, Class 2(f).

(b) A motor vehicle insurance rate filed under section 4 of this chapter may provide for an appropriate reduction in premium charges for a policy if the principal operator of the motor vehicle covered under the policy:

(1) is at least fifty-five (55) years of age; and

(2) has, within three (3) years before the issuance or renewal of the policy, successfully completed a motor vehicle accident prevention course approved by the bureau of motor vehicles.

(c) A reduction in premium charges need not be provided under this section if the principal operator of the motor vehicle covered under the policy participated in the motor vehicle accident prevention course under the order of a court.

(d) This section does not prevent an insurer from withholding or rescinding the reduction in premium charges for a motor vehicle insurance policy if the principal operator of the motor vehicle covered under the policy is involved in a motor vehicle accident for which the principal operator is at fault.

As added by P.L.121-1989, SEC.11.

IC 27-1-22-4

Rate filings; exemptions; procedure and requirements; rules;

confidentiality; inspection; notice of changes

Sec. 4. (a) Every insurer shall file with the commissioner every manual of classifications, rules, and rates, every rating schedule, every rating plan, and every modification of any of the foregoing which it proposes to use.

(b) The following types of insurance are exempt from the requirements of subsections (a) and (k):

(1) Inland marine risks, which by general custom of the business are not written according to manual rates or rating plans.

(2) Insurance that is:

(A) written by an insurer that:

(i) complies with subsection (n) and maintains at least a B rating by A.M. Best or an equivalent rating by another independent insurance rating organization; or

(ii) is approved for an exemption by the commissioner; and

(B) issued to commercial policyholders.

(c) Every such filing shall indicate the character and extent of the coverage contemplated and shall be accompanied by the information upon which the filer supports such filing.

(d) The information furnished in support of a filing may include:

(1) the experience and judgment of the insurer or rating organization making the filing;

(2) its interpretation of any statistical data it relies upon;

(3) the experience of other insurers or rating organizations; or

(4) any other relevant factors.

The commissioner shall have the right to request any additional relevant information.

(e) The following apply to a filing and any supporting information filed under this section:

(1) If the filer marks the filing or supporting information "confidential", "trade secret", or "proprietary", the filer shall, upon the request of the commissioner, provide a sufficient basis on which the commissioner may determine that the filing or supporting information is confidential.

(2) If the commissioner does not, less than thirty (30) days after receiving the filing or information, notify the filer that the commissioner disapproves the confidentiality of the filing or supporting information, the filing and supporting information is considered to have been determined to be confidential.

(3) The commissioner shall do the following:

(A) Upon the request of the filer before the filing or supporting information is open to public inspection:

(i) return the filing or supporting information to the filer; and

(ii) make a notation in the policy filing retained by the commissioner that the filing or supporting information was

returned to the filer.

(B) If the commissioner determines that a filing or supporting information is not confidential under this subsection, upon the request of the filer before the filing or supporting information is open to public inspection, return the entire filing to the filer.

(C) Adopt rules under IC 4-22-2 to establish a process for a determination under this subsection that a filing or supporting information is confidential.

(4) Except for information determined by the commissioner to be confidential under this subsection, the filing and supporting information that has not been returned to the filer under subdivision (3) shall be open to public inspection as soon as stamped "filed" within a reasonable time after receipt by the commissioner, and copies may be obtained by any person on request and upon payment of a reasonable charge therefor.

The work product of the commissioner in making a determination under this subsection is confidential. The department, the commissioner, and employees of the department are immune from civil and criminal liability for the good faith performance of their duties under this subsection.

(f) Filings shall become effective upon the date of filing by delivery or upon date of mailing by registered mail to the commissioner, or on a later date specified in the filing.

(g) Specific inland marine rates on risks specially rated, made by a rating organization, shall be filed with the commissioner.

(h) Any insurer may satisfy its obligation to make any such filings by becoming a member of, or a subscriber to, a licensed rating organization which makes such filings and by authorizing the commissioner to accept such filings on its behalf, provided that nothing contained in this chapter shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization or as requiring any member or subscriber to authorize the commissioner to accept such filings on its behalf.

(i) Every insurer which is a member of or a subscriber to a rating organization shall be deemed to have authorized the commissioner to accept on its behalf all filings made by the rating organization which are within the scope of its membership or subscribership, provided:

(1) that any subscriber may withdraw or terminate such authorization, either generally or for individual filings, by written notice to the commissioner and to the rating organization and may then make its own independent filings for any kinds of insurance, or subdivisions, or classes of risks, or parts or combinations of any of the foregoing, with respect to which it has withdrawn or terminated such authorization, or may request the rating organization, within its discretion, to make any such filing on an agency basis solely on behalf of the

requesting subscriber; and

(2) that any member may proceed in the same manner as a subscriber unless the rating organization shall have adopted a rule, with the approval of the commissioner:

(A) requiring a member, before making an independent filing, first to request the rating organization to make such filing on its behalf and requiring the rating organization, within thirty (30) days after receipt of such request, either:

(i) to make such filing as a rating organization filing;

(ii) to make such filing on an agency basis solely on behalf of the requesting member; or

(iii) to decline the request of such member; and

(B) excluding from membership any insurer which elects to make any filing wholly independently of the rating organization.

(j) Under such rules as the commissioner shall adopt, the commissioner may, by written order, suspend or modify the requirement of filing as to any kinds of insurance, or subdivision, or classes of risk, or parts or combinations of any of the foregoing, the rates for which can not practicably be filed before they are used. Such orders and rules shall be made known to insurers and rating organizations affected thereby. The commissioner may make such examination as the commissioner may deem advisable to ascertain whether any rates affected by such order are excessive, inadequate, or unfairly discriminatory.

(k) Upon the written application of the insured, stating the insured's reasons therefor, filed with the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

(l) An insurer shall not make or issue a policy or contract except in accordance with filings which are in effect for that insurer or in accordance with the provisions of this chapter. Subject to the provisions of section 6 of this chapter, any rates, rating plans, rules, classifications, or systems in effect on May 31, 1967, shall be continued in effect until withdrawn by the insurer or rating organization which filed them.

(m) The commissioner shall have the right to make an investigation and to examine the pertinent files and records of any insurer, insurance producer, or insured in order to ascertain compliance with any filing for rate or coverage which is in effect. The commissioner shall have the right to set up procedures necessary to eliminate noncompliance, whether on an individual policy, or because of a system of applying charges or discounts which results in failure to comply with such filing.

(n) This subsection applies to an insurer that issues a commercial property or commercial casualty insurance policy to a commercial policyholder. Not more than thirty (30) days after the insurer begins using a commercial property or commercial casualty insurance:

(1) rate;
(2) rating plan;
(3) manual of classifications;
(4) form; or
(5) modification of an item specified in subdivision (1), (2), (3), or (4);

the insurer shall file with the department, for informational purposes only, the item specified in subdivision (1), (2), (3), (4), or (5). Use of an item specified in subdivision (1), (2), (3), (4), or (5) is not conditioned on review or approval by the department. This subsection does not require filing of an individual policy rate if the original manuals, rates, and rules for the insurance plan or program to which the individual policy conforms has been filed with the department.

(o) An insurer that issues a commercial property or commercial casualty insurance policy form, endorsement, or rider that is prepared to provide or exclude coverage for an unusual or extraordinary risk of a particular commercial policyholder must maintain the policy form, endorsement, or rider in the insurer's Indiana office and provide the policy form, endorsement, or rider to the commissioner at the commissioner's request.

(p) If coverage under a commercial property or commercial casualty insurance policy is changed, upon renewal of the policy, the insurer shall provide to the policyholder and insurance producer through which the policyholder obtains the coverage a written notice that the policy has been changed.

(Formerly: Acts 1967, c.133, s.4.) As amended by P.L.252-1985, SEC.107; P.L.268-1999, SEC.12; P.L.178-2003, SEC.22; P.L.193-2006, SEC.8; P.L.173-2007, SEC.16; P.L.81-2012, SEC.10.

IC 27-1-22-5

Hearing on question of compliance with filing requirements; finding and order

Sec. 5. (a) Upon the commissioner's motion, or upon written request by any insured affected thereby or by any licensed insurance producer or broker, if such request is made in good faith and states reasonable grounds, the commissioner, if the commissioner shall have reason to believe that any filing is not in compliance with the applicable provisions of section 3 of this chapter, or in the case of an alleged violation of section 6 of the chapter if the commissioner finds on the basis of the information on file with the department that there has been a prima facie showing of a violation of that section, shall hold a hearing upon not less than ten (10) days written notice to the rating organization or insurer which made the filing in issue, specifying the items and matters to be considered and stating in what manner and to what extent noncompliance is alleged to exist. No other matter or subject shall be considered at such hearing. Only the rating organization or insurer which made such filing and the

commissioner may be parties to any hearing or to any judicial appeal resulting therefrom. Within a reasonable time, the commissioner shall notify every person making request as to the decision as to the validity of the request and subsequently shall notify every such person of any action which may thereafter be taken with reference to such request.

(b) If, after such hearing, the commissioner finds, based upon a preponderance of the evidence adduced at such hearing and made a part of the record thereof, that such filing is not in compliance with the provisions of section 3 of this chapter, the commissioner shall immediately issue a written order to the parties specifying in detail in what respects and upon what evidence such noncompliance exists and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. Said order shall not affect any contract policy made or issued prior to the expiration of the period set forth in said order.

(c) If after such hearing the commissioner finds that such filing does not violate the provisions of section 3 of this chapter, the commissioner shall immediately issue a written order to the parties dismissing the proceedings.

(d) The finding and order of the commissioner shall be made within ninety (90) days after the close of such hearing or within such reasonable time extensions as may be fixed by the commissioner.

(e) No manual of classifications, rule, rate, rating schedule, rating plan, or any modification of any of the foregoing which establishes standards for measuring variations in hazards or expense provisions, or both, which has been filed pursuant to section 4 of this chapter shall be disapproved if the rates produced thereby meet the requirements of section 3 of this chapter.

(f) All actions of the commissioner under this chapter and all appeals from the commissioner's action shall be governed by IC 4-21.5, except where a different specific provision is made in this chapter.

(Formerly: Acts 1967, c.133, s.5; Acts 1971, P.L.1, SEC.9.) As amended by P.L.252-1985, SEC.108; P.L.7-1987, SEC.140; P.L.178-2003, SEC.23.

IC 27-1-22-6

Bad faith filing; burden of proof; order to rewrite policies at approved rate

Sec. 6. (a) A "bad-faith filing", as used in this chapter, means a rate filing made by any filer who, in bad faith, files a rate which it knows, or should know, is grossly inadequate for the insurance coverage provided, and which is filed and used for the purpose of unfairly obtaining a particular risk or limited group of risks, and which is available only to such risk or limited group of risks.

(b) At any hearing conducted under this section, the burden shall be on the filer to prove that such filing is not in violation of this

section. If, after such hearing, the commissioner finds that the filer has failed to prove that such filing is not in violation of this section, based on the evidence adduced at the hearing and made a part of the record, he may order all policies written under such bad-faith filing to be rewritten at an approved rate from the date of the inception of such policies of insurance, or all such policies shall be cancelled pro rata in accordance with the policy provisions.

(c) Nothing in this section shall be deemed to supersede the provisions set forth in section 24 of this chapter.

(Formerly: Acts 1967, c.133, s.6.) As amended by P.L.252-1985, SEC.109.

IC 27-1-22-7

Rate adjustment filing or deviation; effectiveness unless disapproved; hearing; approval or disapproval

Sec. 7. (a) When a filing or deviation involving a rate adjustment depends upon a change in the relationship between the proposed rates and the anticipated production expense portion thereof from the relationship anticipated under any rates previously filed and currently in effect for the company or rating organization involved, such filing or deviation shall be subject to the provisions of subsection (b).

(b) Each filing or deviation subject to this section shall be on file for a waiting period of twenty (20) days before it becomes effective. If within such waiting period or after hearing as provided in this section, the commissioner finds that the filing or deviation does not meet the requirements of this chapter, the commissioner shall send to the insurer or rating organization which made the filing or to the insurer which filed the deviation written notice of disapproval specifying therein in what respects the filing or deviation fails to meet the requirements of this chapter and stating that the same shall not become effective. Such filing or deviation shall be deemed to meet the requirements of this act unless disapproved:

(1) within such waiting period; or

(2) if a hearing has been called and written notice thereof given by the commissioner during such waiting period, then within ten (10) days after the date of commencement of such hearing.

Upon the commissioner's own motion, or upon timely written request by any insurance producer or broker of the company or companies to which such filing or deviation is applicable, if such request is in good faith and states reasonable grounds, the commissioner may at any time within the waiting period call a hearing upon not less than ten (10) nor more than fifteen (15) days written notice to the company or rating organization making the filing or to the company filing the deviation. Within ten (10) days after the commencement of such hearing, the commissioner shall in writing either approve such filing or deviation or shall disapprove the same as provided in this section.

(Formerly: Acts 1967, c.133, s.7.) As amended by P.L.252-1985, SEC.110; P.L.178-2003, SEC.24.

IC 27-1-22-8

Rating organizations; definitions; license; services to subscribers; rules; cooperation

Sec. 8. (a) A rating organization is an individual, partnership, corporation, limited liability company, or unincorporated association other than an insurer located within or without this state, who or which has as its primary object and purpose the making and filing of rates, rating plans, rating systems, or rules relating thereto, and who or which may also examine policies, daily reports, binders, renewal certificates, endorsements, and other evidences of insurance or the cancellation thereof for any member or subscriber requesting such auditing service.

(b) Such a rating organization shall make application to the commissioner for license as a rating organization for such kinds of insurance, or subdivisions, or classes of risk, or parts or combination of any of the foregoing as are specified in its application and shall file therewith:

(1) a copy of its constitution, its articles of agreement or association or its certificate of incorporation, and of its bylaws, rules, and regulations governing the conduct of its business;

(2) a list of its members and subscribers;

(3) the name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting such rating organization may be served; and

(4) a statement of its qualifications as a rating organization.

(c) If the commissioner finds that the applicant is competent, trustworthy, and otherwise qualified to act as a rating organization, and that its constitution, its articles of agreement or association, or its certificate of incorporation, and its bylaws, rules, and regulations governing the conduct of its business conform to the requirements of law, he shall issue a license specifying the kinds of insurance, or subdivisions, or classes of risk, or parts or combinations of any of the foregoing for which the applicant is authorized to act as a rating organization. Every such application shall be granted or denied in whole or in part by the commissioner within sixty (60) days of the date of its filing with him. Licenses issued pursuant to this section shall remain in effect for three (3) years unless sooner suspended or revoked by the commissioner. The fee for the license is seventy-five dollars ($75). Licenses issued pursuant to this section may be suspended or revoked by the commissioner, after hearing upon notice, in the event the rating organization ceases to meet the requirements of this subsection. Every rating organization shall notify the commissioner promptly of every change in:

(1) its constitution, its articles of agreement or association, or its certificate of incorporation, and its bylaws, rules, and regulations governing the conduct of its business;

(2) its list of members and subscribers; and

(3) the name and address of the resident of this state designated

by it upon whom notices or orders of the commissioner or process affecting such rating organization may be served.

(d) Subject to rules and regulations which have been approved by the commissioner as reasonable, each rating organization shall permit any insurer, not a member, to be a subscriber to its services for any one (1) or more of the kinds of insurance, subdivisions, or classes of risk or parts or combinations of any of the foregoing for which it is authorized to act as an organization. Notice of proposed changes in such rules and regulations shall be given to subscribers. Each rating organization shall furnish its services without discrimination to its members and subscribers. The reasonableness of any rule or regulation in its application to subscribers, or the refusal of any rating organization to admit an insurer as a subscriber, shall, at the request of any subscriber or any such insurer, be reviewed by the commissioner at a hearing held upon at least ten (10) days written notice to such rating organization and to such subscriber or insurer. If the commissioner finds that such rule or regulation is unreasonable in its application to subscribers, he shall order that such rule or regulation shall not be applicable to subscribers. If the rating organization fails to grant or reject an insurer's application for subscribership within thirty (30) days after it was made, the insurer may request a review by the commissioner as if the application had been rejected. If the commissioner finds that the insurer has been refused admittance to the rating organization as a subscriber without justification, he shall order the rating organization to admit the insurer as a subscriber. If he finds that the action of the rating organization was justified, he shall make an order affirming its action.

(e) No rating organization shall adopt any rule the effect of which would be to prohibit or regulate the payment of dividends or savings allowed or returned by insurers to their policyholders or members.

(f) Cooperation among rating organizations or among rating organizations and insurers in ratemaking or in other matters within the scope of this chapter is hereby authorized, provided the filings resulting from such cooperation are subject to all the provisions of this chapter which are applicable to filing generally. The commissioner may review such cooperative activities and practices and if, after a hearing, he finds that any such activity or practice is unfair or unreasonable, or otherwise inconsistent with the provisions of this chapter, he may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter and requiring the discontinuance of such activity or practice.

(g) Any rating organization may subscribe for or purchase actuarial, technical, or other services, and such services shall be available to all members and subscribers without discrimination.

(h) A member of a rating organization means an insurer entitled to participate in its management and electing to exercise its right to

so participate.
(Formerly: Acts 1967, c.133, s.8.) As amended by P.L.252-1985, SEC.111; P.L.31-1988, SEC.14; P.L.8-1993, SEC.415.

IC 27-1-22-9
Deviation from rates; filing; effective date; termination; public inspection

Sec. 9. (a) In addition to any rights conferred pursuant to section 4 of this chapter any member or subscriber to a rating organization may file with commissioner a deviation from the rates, rating schedules, rating plans, rating systems, or rules respecting any kind of insurance, division, subdivision, classification, or any part or combination of any of the foregoing.

(b) Such a filing shall specify the nature and extent of the deviation and shall be accompanied by the relevant information upon which the filer supports the deviation. The commissioner shall have the right to request any additional relevant information.

(c) Such deviation shall become effective upon the date of filing by delivery or upon date of mailing by registered mail to the commissioner or on a later date specified in the filing. It shall be in effect until terminated by the filer giving notice to the commissioner of the termination of the deviation. A change in the rates, rating schedules, rating plans, rating systems, or rules to which the deviation applies shall not terminate the deviation without the consent of the insurer to which the deviation applies. Any such deviation may be terminated by the commissioner pursuant to the provisions of section 5 of this chapter and after notice and hearings as provided in section 5 of this chapter.

(d) A deviation filing and supporting information shall be open to public inspection as soon as stamped "filed" within a reasonable time after receipt by the commissioner and copies may be had by any person on request and upon the payment of a reasonable charge therefor.
(Formerly: Acts 1967, c.133, s.9.) As amended by P.L.252-1985, SEC.112.

IC 27-1-22-10
Insurers acting in concert

Sec. 10. Subject to and in compliance with all other provisions of this chapter, two (2) or more insurers may act in concert with each other and with others with respect to any matters within the purview of this chapter and are authorized to act in concert between or among themselves to the same extent as if they constituted a single insurer.
(Formerly: Acts 1967, c.133, s.10.) As amended by P.L.252-1985, SEC.113.

IC 27-1-22-11
Appeal to commissioner from act or decision of rating

organization; decision and order

Sec. 11. (a) Any subscriber which has authorized a rating organization to making filings on its behalf and any member thereof which does not wish to act under sections 4(h) and 4(i) of this chapter may appeal to the commissioner from the action or decision of such rating organization in approving or rejecting any proposed change in or addition to the filings of such rating organization and the commissioner shall, after a hearing held upon not less than ten (10) days written notice to the appellant and to such rating organization, issue an order approving the action or decision of such rating organization or directing it to give further consideration to such proposal, or, if such appeal is from the action or decision of the rating organization in rejecting a proposed addition to its filings, the commissioner may, in the event the commissioner finds that such action or decision was unreasonable, issue an order directing the rating organization to make an addition to its filings in a manner consistent with the commissioner's findings within a reasonable time after the issuance of such order.

(b) If such appeal is based upon the failure of the rating organization to make a filing on behalf of such member or subscriber which is based on a system of expense provisions which differs, in accordance with the right granted in section 3(a)(3) of this chapter from the system of expense provisions included in a filing made by the rating organization, the commissioner shall, if the commissioner grants the appeal, order the rating organization to make the requested filing for use by the appellant. In deciding such appeal the commissioner shall apply the standards set forth in section 3 of this chapter.

(Formerly: Acts 1967, c.133, s.11.) As amended by P.L.252-1985, SEC.114; P.L.268-1999, SEC.13; P.L.81-2012, SEC.11.

IC 27-1-22-12

Procedure on complaint by insured

Sec. 12. Any insured may, in writing, request his insurer or its rating organization to review the manner in which its filing or the filing made by a rating organization on its behalf has been applied with respect to insurance afforded him. Any such insured aggrieved by the failure or refusal of an insurer or rating organization to make such review and to grant appropriate relief within thirty (30) days after such request is received may file a written complaint and request for a hearing with the commissioner, specifying the grounds relied upon. If the complaint charges a violation of this chapter and the commissioner finds that the complaint was made in good faith and that the complainant would be aggrieved if the violation is proven, he shall hold a hearing upon not less than ten (10) days written notice to the complainant, the insurer, and the related rating organization, if any, stating the grounds of complaint. If after such hearing he finds the complaint justified, he shall order the matter

complained of to be corrected within a reasonable time, but not less than twenty (20) days after a copy of his written order has been mailed to or served upon the insurer complained against.
(Formerly: Acts 1967, c.133, s.12.) As amended by P.L.252-1985, SEC.115.

IC 27-1-22-13
Advisory organization; filing and regulation; orders of commissioner

Sec. 13. (a) Every group, association, or other organization of insurers, whether located within or outside this state, which assists insurers which make their own filings or rating organizations in ratemaking, by the collection and furnishing of loss or expense statistics, or by the submission of recommendations, but which does not make filings under this chapter, shall be known as an advisory organization.

(b) Every advisory organization shall file with the commissioner:

(1) a copy of its constitution, its articles of agreement or association, or its certificate of incorporation and of its bylaws, rules, and regulations governing its activities;

(2) a list of its members;

(3) the name and address of a resident of this state upon whom notices or orders of the commissioner or process issued at his direction may be served; and

(4) an agreement that the commissioner may examine such advisory organization in accordance with the provisions of section 15 of this chapter.

(c) If, after a hearing, the commissioner finds that the furnishing of such information or assistance involves any act or practice which is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, he may issue a written order specifying in what respect such act or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, and requiring the discontinuance of such act or practice.

(d) No insurer which makes its own filings nor any rating organization shall support its findings by statistics or adopt ratemaking recommendations furnished to it by an advisory organization which has not complied with this section or with an order of the commissioner involving such statistics or recommendations issued under subsection (c). If the commissioner finds such insurer or rating organization to be in violation of this subsection, he may issue an order requiring the discontinuance of the violation.
(Formerly: Acts 1967, c.133, s.13.) As amended by P.L.252-1985, SEC.116.

IC 27-1-22-14
Regulation of organization of insurers engaging in joint

underwriting or joint reinsurance; unfair or unreasonable practices

Sec. 14. (a) Every group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance shall be subject to regulation with respect thereto as provided in this chapter, subject, however, with respect to joint underwriting, to all other provisions of this chapter and with respect to joint reinsurance, to section 15 of this chapter.

(b) If, after a hearing, the commissioner finds that any activity or practice of any such group, association, or other organization is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, he may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter and requiring the discontinuance of such activity or practice.

(Formerly: Acts 1967, c.133, s.14.) As amended by P.L.252-1985, SEC.117.

IC 27-1-22-15

Examination of licensed rating organization; report of examination in another state; cost of examination

Sec. 15. (a) The commissioner shall, at least once every three (3) years, make or cause to be made an examination of each licensed rating organization, and may, as often as he may deem it expedient, make or cause to be made an examination of each advisory organization and of each group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance pursuant to section 13 of this chapter to ascertain whether such rating or advisory organization or group, association or other organization complies with the applicable provisions of this chapter. In lieu of any such examination the commissioner may accept the report of an examination made by the insurance supervisory official of another state.

(b) The officers, managers, agents, and employees of any such organization, group or association may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation, together with all data, statistics and information of every kind and character collected or considered by such organization, group or association in the conduct of the operations to which such examination relates.

(c) The reasonable cost of any examination authorized by this chapter shall be paid by the organization, group, or association examined, upon presentation to it of a detailed account of such cost.

(d) No report of examination shall be made public until the organization examined has an opportunity to review the proposed report and to have a hearing with reference thereto, after which hearing the report shall be filed for public inspection and become admissible in evidence as a public record.

(Formerly: Acts 1967, c.133, s.15.) As amended by P.L.252-1985, SEC.118.

IC 27-1-22-16
Approval of rules and statistical plans; exchange of information and experience data

Sec. 16. a. The commissioner shall approve reasonable rules and statistical plans, reasonably adapted to each of the rating systems on file with him, which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss and countrywide expense experience, in order that the experience of all insurers may be made available at least annually. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible of determination by a prorating of countrywide expense experience. In approving such rules and plans, the commissioner shall give due consideration to the rating systems on file with him and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it. The commissioner may designate rating organizations or other agencies, or both, to assist him in gathering such experience and making compilations thereof, and such compilations shall be made available, subject to reasonable rules approved by the commissioner to insurers and advisory and rating organizations.

b. In order to further uniform administration of the regulatory laws, the commissioner and every insurer, rating organization, advisory organization or statistical agency may exchange information and experience data with insurance supervisory officials, insurers, rating organizations, advisory organizations or statistical agencies in this and other states and may consult with them with respect to rate making and the application of rating systems.

c. The commissioner may make reasonable rules and regulations necessary to effect the purposes of this section.

(Formerly: Acts 1967, c.133, s.16.)

IC 27-1-22-17
Withholding information; giving false or misleading information

Sec. 17. No person may knowingly withhold information from, or knowingly give false or misleading information to, the commissioner or the department, to any statistical agency designated by the department, to any rating organization, or to any insurer, which will affect the rates or premiums chargeable under this article.

(Formerly: Acts 1967, c.133, s.17.) As amended by Acts 1978, P.L.2, SEC.2714.

IC 27-1-22-18

Deviation from authorized premium charge; discounts and rebates as inducement to insure; commissions for insurance producers

Sec. 18. No insurer, broker, or insurance producer shall knowingly charge, demand, or receive a premium for any policy of insurance except in accordance with the provisions of this chapter. No insurer or employee thereof, and no broker or insurance producer shall pay, allow, or give, directly or indirectly, as an inducement to insurance, or after insurance has been effected, any rebate, discount, abatement, credit, or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducement whatever, not specified in the policy of insurance, except to the extent provided for in applicable filings. No insured named in any policy of insurance shall knowingly receive or accept, directly or indirectly, any such rebate, discount, abatement, credit or reduction of premium, or any such special favor or advantage or valuable consideration or inducement. Nothing in this section shall be construed as prohibiting the payment of, nor permitting the regulation of the payment of, commissions or other compensation to duly licensed insurance producers and brokers, nor as prohibiting, or permitting the regulation of, any insurer from allowing or returning to its participating policyholders or members, dividends or savings.
(Formerly: Acts 1967, c.133, s.18.) As amended by P.L.252-1985, SEC.119; P.L.178-2003, SEC.25.

IC 27-1-22-19

Freedom of contract with reference to commissions

Sec. 19. Nothing in this chapter abridges or restricts the freedom of contract of insurers, insurance producers, or brokers with reference to the amount of commission to be paid to insurance producers or brokers by insurers, and such payments are expressly authorized.
(Formerly: Acts 1967, c.133, s.19.) As amended by P.L.252-1985, SEC.120; P.L.178-2003, SEC.26.

IC 27-1-22-20

High risk auto insurance; apportionment agreements; rate modifications

Sec. 20. Agreements may be made among insurers with respect to the equitable apportionment among them of automobile, bodily injury liability, and property damage insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods, and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements and rate modifications to be subject to the terms of this chapter.
(Formerly: Acts 1967, c.133, s.20.) As amended by P.L.252-1985,

SEC.121.

IC 27-1-22-21
Repealed

(Repealed by P.L.4-1988, SEC.17.)

IC 27-1-22-22
Appointment and removal of additional personnel; powers of deputy conducting hearings; exemption from personal liability

Sec. 22. (a) For the purpose of maintaining the affirmative, active, and definite administration of the provisions of this chapter, the commissioner, with the approval of the governor, may appoint such additional actuaries, deputies, examiners, assistants, and other employees in the department as may be found necessary to carry out the provisions of this chapter. Except as otherwise provided in this chapter, such additional deputies, examiners, assistants, and employees so appointed shall be chosen for their fitness, either professional or practical, as the nature of the position may require, irrespective of their political beliefs or affiliations. The technical or professional qualifications of any applicant shall be determined by examination, professional rating or otherwise, as the commissioner with the approval of the governor may determine. Subject to the approval of the governor and the state budget director, the salaries of such additional actuaries, deputies, examiners, assistants, and other employees shall be fixed by the commissioner. Any actuary, deputy, examiner, assistant, or employee so employed may be removed at any time by the commissioner.

(b) In the absence of the commissioner, he may, by written order, designate a deputy to conduct any hearing, and, in such case, such deputy commissioner shall possess and may exercise any and all powers of the commissioner with respect to the matter in hearing.

(c) Neither the commissioner nor any actuary, deputy, examiner, assistant, or employee in the department shall be liable in their individual capacity, except to the state of Indiana, for any act done or omitted in connection with the performance of their respective duties under the provisions of this chapter.

(Formerly: Acts 1967, c.133, s.22.) As amended by P.L.252-1985, SEC.123.

IC 27-1-22-23
Exemption of rates and classifications from law governing rules and regulations

Sec. 23. No provision of IC 4-22-2 shall be construed to apply to rates or classifications made pursuant to the provisions of this chapter and approved by the commissioner or department.

(Formerly: Acts 1967, c.133, s.23.) As amended by P.L.252-1985, SEC.124.

IC 27-1-22-24
Suspension or revocation of licenses

Sec. 24. (a) The commissioner may suspend the license of any rating organization or insurer which fails to comply with an order of the commissioner or department within the time limited by such order, or any extension thereof which the commissioner may grant. The commissioner shall not suspend the license of any rating organization or insurer for failure to comply with an order until the time prescribed for an appeal therefrom has expired or if an appeal has been taken, until such order has been affirmed. The commissioner may determine when a suspension of license shall become effective and it shall remain in effect for the period fixed by him, unless he modifies or rescinds such suspension, or until the order upon which such suspension is based is modified, rescinded or reversed. No license shall be suspended or revoked except upon a written order of the commissioner, stating his findings, made after a hearing is held upon not less than fifteen (15) days' written notice to the person specifying the alleged violation.

(b) A person who violates this chapter commits a Class A misdemeanor.

(Formerly: Acts 1967, c.133, s.24.) As amended by Acts 1978, P.L.2, SEC.2715.

IC 27-1-22-25
Motor vehicle insurance; rating plan establishing higher rates for bankruptcy petitioners; violations

Sec. 25. (a) This section only applies to a policyholder or an applicant who is an individual.

(b) As used in this section, "motor vehicle insurance" means any type of insurance described in IC 27-1-5-1, Class 2(f).

(c) A motor vehicle insurance rating plan filed under section 4 of this chapter may not establish a higher rate for a policyholder based on the fact that the policyholder has filed a voluntary petition under the federal bankruptcy law (11 U.S.C. 101 et seq.).

(d) The premium rate for an individual policy of motor vehicle insurance may not be set higher than the applicable rate set forth in the rating plan in effect under this chapter based on the fact that the policyholder or applicant has filed a voluntary petition under the federal bankruptcy law.

(e) The violation of this section is an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4.

As added by P.L.122-1992, SEC.1.

IC 27-1-22-26
Motor vehicle insurance; rating plan establishing higher rates for persons in armed forces; violations

Sec. 26. (a) As used in this section, "armed forces" means the following:

(1) The Army.
(2) The Navy.
(3) The Air Force.
(4) The Marine Corps.
(5) The Coast Guard.

(b) This section applies only to an individual:
(1) who is applying for motor vehicle insurance; and
(2) who:
(A) is serving in one (1) of the armed forces; or
(B) has served in one (1) of the armed forces within six (6) months before applying for motor vehicle insurance.

(c) As used in this section, "motor vehicle insurance" means any type of insurance described in IC 27-1-5-1, Class 2(f).

(d) As used in this chapter, "rating plan" means the rating schedule or rating plan of an insurer concerning premium rates for motor vehicle insurance that has been filed with the commissioner and is in effect under section 4 of this chapter.

(e) An insurer may not set the premium rate for a policy of motor vehicle insurance for an individual described in subsection (b) at an amount higher than the applicable rate set forth in the rating plan due to the fact that the individual has not been covered by motor vehicle insurance for a period of time.

(f) The violation of this section is an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4.

As added by P.L.223-1993, SEC.5.

IC 27-1-22-26.1

Motor vehicle insurance; rating plan for active and reserve members of armed forces; violation

Sec. 26.1. (a) As used in this section, "armed forces" means the active and reserve components of the following:
(1) The United States Army.
(2) The United States Navy.
(3) The United States Air Force.
(4) The United States Marine Corps.
(5) The United States Coast Guard.
(6) The Indiana National Guard.

(b) As used in this section, "motor vehicle insurance" means any type of insurance described in IC 27-1-5-1, Class 2(f).

(c) As used in this chapter, "rating plan" means the rating schedule or rating plan of an insurer:
(1) concerning premium rates for motor vehicle insurance;
(2) that has been filed with the commissioner; and
(3) that is in effect under section 4 of this chapter.

(d) An insurer that issues or renews a policy of motor vehicle insurance may not set the premium rate for a policy of motor vehicle insurance that covers an individual who is serving in one (1) of the armed forces at an amount higher than the applicable rate set forth in

the rating plan for a policy of motor vehicle insurance that covers an individual who is not serving in one (1) of the armed forces.

(e) A violation of this section is an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4.

As added by P.L.39-2005, SEC.1.

IC 27-1-22-27

Motor vehicle insurance; rates for innocent prior-uninsured motorists

Sec. 27. (a) The purpose of this section is to preclude insurers from charging higher rates for innocent prior-uninsured motorists who have not operated a motor vehicle in violation of any financial responsibility or compulsory insurance requirement within the prior twelve months.

(b) As used in this section, "motor vehicle insurance" means any type of insurance described in IC 27-1-5-1, Class 2(f).

(c) A motor vehicle insurer may not discriminate in establishing a rate for a policyholder or applicant, based solely on the absence of insurance by the applicant or policyholder.

(d) This section does not apply to applicants who first received their driver's license within the past thirty-six (36) month period.

(e) A violation of this section is an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4.

As added by P.L.169-1999, SEC.1.

IC 27-1-22-28

Title insurance filings; title insurance rate comparison tool

Sec. 28. (a) This section applies to a title policy issued after June 30, 2014. To the extent of any conflicts with any other provision of this chapter, this section is controlling.

(b) The definitions in IC 27-7-3 apply throughout this section.

(c) For purposes of this section, "form", when used in reference to a title policy:

(1) includes:

(A) a commitment for title insurance and a title policy or guaranty; and

(B) the terms and conditions of the title insurance or title policy or guaranty; and

(2) excludes:

(A) a reinsurance contract or agreement;

(B) an exception:

(i) that is included in a commitment or title policy; and

(ii) for specific defects in a title that may be ascertained from an examination of a specific risk;

(C) an affirmative assurance of a company, through endorsement or otherwise, with respect to a defect described in clause (B); and

(D) any other exception from coverage due to:

(i) a limitation on the examination of the risk imposed by a particular applicant for title insurance; or

(ii) failure of a particular applicant for title insurance to provide the data necessary for determination of insurability.

(d) A company doing business in Indiana shall, at least thirty (30) days before the proposed effective date of the filing, file with the commissioner all of the following that the company proposes to use, including the proposed effective date and an indication of the character and extent of the coverage contemplated:

(1) The form of a title policy, endorsement, manual, rating schedule or rating plan, and other rating rule.

(2) A modification of any filing described in subdivision (1).

If the commissioner does not, within a thirty (30) day waiting period beginning on the date of filing, disapprove a filing made under this subsection, the filing is considered approved.

(e) If a company is a member of or a subscriber to a rating organization that is licensed under section 8 of this chapter, the filing requirement of subsection (d) may be satisfied by a filing made:

(1) by the rating organization; and

(2) on behalf of all of the rating organization's members and subscribers;

in accordance with subsection (f).

(f) A rating organization that makes a filing described in subsection (e) shall, at least thirty (30) days before the proposed effective date of the filing, file with the commissioner for review and approval or disapproval all of the following that the company proposes to use, including the proposed effective date and an indication of the character and extent of the coverage contemplated:

(1) The form of a title policy, endorsement, manual, rating schedule or rating plan, and other rating rule.

(2) A modification of any filing described in subdivision (1).

(g) The commissioner shall, within a thirty (30) day waiting period beginning on the date of filing, approve or disapprove a filing made under subsection (f). However, the commissioner may do the following:

(1) Upon written notice to the rating organization making the filing within the initial thirty (30) day period, extend the waiting period for not more than an additional thirty (30) days to enable the commissioner to complete the review of the filing.

(2) With the consent of the rating organization making the filing, extend the waiting period for additional thirty (30) day periods.

(3) Upon receiving a written request by the rating organization making the filing, approve the filing or a part of the filing that the commissioner has reviewed to become effective before the expiration of a waiting period described in subdivision (1) or (2).

(h) If the commissioner, during a waiting period described in subsection (g), determines that a filing made by a rating organization under this section:

(1) meets the requirements of this chapter, the commissioner shall approve the filing and send to the rating organization written notice of the approval; or

(2) does not meet the requirements of this chapter, the commissioner shall disapprove the filing and send to the rating organization written notice of the disapproval, including the following:

(A) The notice must specify the manner in which the filing does not meet the requirements of this chapter.

(B) The notice must specify that the filing will not become effective.

(i) If the commissioner, at any time after approval under subsection (d), (g), or (h), determines that the filing does not comply with this chapter, the commissioner shall, after a hearing held on ten (10) days written notice:

(1) sent to the person making the filing; and

(2) specifying the matters to be considered at the hearing;

issue an order specifying the manner in which the filing does not comply with this chapter and the date on which the filing will no longer be effective.

(j) The commissioner shall send a copy of an order issued under subsection (i) to the person making the filing. The order does not affect a title policy made or issued before the date specified in the order on which the filing is no longer effective.

(k) The commissioner may not disapprove a filing described in subsection (d) or (f) if the rates produced by the filing comply with this chapter.

(l) A rating organization that receives notice of a hearing or a copy of an order under subsection (i) shall promptly notify all of the rating organization's members or subscribers that would be affected by the hearing or order. For purposes of subsection (i), notice to a rating organization is considered to be notice to the rating organization's members or subscribers.

(m) If:

(1) a filing is not accompanied by the information on which the filing is based; and

(2) the commissioner does not have sufficient information to determine whether the filing complies with this chapter;

the commissioner shall require the person making the filing to furnish to the commissioner the information on which the filing is based, and the waiting period described in subsection (d) or (g) begins on the date on which all required information is received by the commissioner.

(n) Information furnished under subsection (m) may include the following:

(1) The experience or judgment of the company or the rating organization making the filing.

(2) The company's or rating organization's interpretation of any statistical data relied on by the company or rating organization.

(3) The experience of other title insurance companies or rating organizations.

(4) Any other factor that the commissioner considers relevant.

(o) The department shall create a title insurance consumer comparison tool, subject to the following:

(1) The filed rates of every insurer that issues title insurance policies in Indiana will be included on the consumer comparison tool.

(2) The information on the consumer comparison tool shall be designed to allow an average consumer of ordinary intelligence to compare and differentiate between all substantially similar title insurance rates offered by all title insurers approved in Indiana. At a minimum, the consumer comparison tool must include the following:

(A) Organizational data, including the company name, address, and telephone number, and the name of the head of local operations.

(B) Whether the applicant, or a related entity, has previously offered title insurance in Indiana and, if so, the year or years in which the title insurance was offered, along with the rate or rates charged by the applicant prior to the most recent filing.

(C) A listing of the rates the title insurer will charge for:

(i) a commitment; and

(ii) a closing protection letter;

and a sample of rates the title insurer will charge for title insurance policies of varying amounts of insured value.

(D) Any other substantive information that the commissioner considers relevant and appropriate.

(3) The consumer comparison tool must be made available to the public free of charge on the department's Internet web site not later than September 1, 2014. After September 1, 2014, the department shall make any:

(A) new approved filings; or

(B) changes to existing filings;

available on the consumer comparison tool not later than ten (10) business days after the application is stamped "filed" by the department.

As added by P.L.80-2013, SEC.2. Amended by P.L.133-2014, SEC.1.

IC 27-1-23

Chapter 23. Regulation of Insurance Holding Company Systems

IC 27-1-23-1

Definitions

Sec. 1. As used in this chapter, the following terms shall have the respective meanings set forth in this section, unless the context shall otherwise require:

(a) An "acquiring party" is the specific person by whom an acquisition of control of a domestic insurer or of any corporation controlling a domestic insurer is to be effected, and each person who directly, or indirectly through one (1) or more intermediaries, controls the person specified.

(b) An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(c) A "beneficial owner" of a voting security includes any person who, directly or indirectly, through any contract, arrangement, understanding, relationship, revocable or irrevocable proxy, or otherwise has or shares:

(1) voting power including the power to vote, or to direct the voting of, the security; or

(2) investment power which includes the power to dispose, or to direct the disposition, of the security.

(d) "Commissioner" means the insurance commissioner of this state.

(e) "Control" (including the terms "controlling", "controlled by", and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the beneficial ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position or corporate office. Control shall be presumed to exist if any person beneficially owns ten percent (10%) or more of the voting securities of any other person. The commissioner may determine this presumption has been rebutted only by a showing made in the manner provided by section 3(k) of this chapter that control does not exist in fact, after giving all interested persons notice and an opportunity to be heard. Control shall be presumed again to exist upon the acquisition of beneficial ownership of each additional five percent (5%) or more of the voting securities of the other person. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(f) "Department" means the department of insurance created by

IC 27-1-1-1.

(g) A "domestic insurer" is an insurer organized under the laws of this state.

(h) "Earned surplus" means an amount equal to the unassigned funds of an insurer as set forth in the most recent annual statement of an insurer that is submitted to the commissioner, excluding surplus arising from unrealized capital gains or revaluation of assets.

(i) "Enterprise risk" means an activity, circumstance, event, or series of events that involves at least one (1) affiliate of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or the insurer's insurance holding company system as a whole, including an activity, circumstance, event, or series of events that would cause the:

(1) insurer's risk based capital to fall into company action level under IC 27-1-36; or

(2) insurer to be in hazardous financial condition subject to IC 27-1-3-7 and rules adopted under IC 27-1-3-7.

(j) "Group wide supervisor" means the regulatory official who is:

(1) authorized by the commissioner to conduct and coordinate group wide supervision of an internationally active insurance group; and

(2) determined by the commissioner to have sufficient significant contact with the internationally active insurance group to enable group wide supervision.

(k) An "insurance holding company system" consists of two (2) or more affiliated persons, one (1) or more of which is an insurer.

(l) "Insurer" has the same meaning as set forth in IC 27-1-2-3, except that it does not include:

(1) agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state; or

(2) nonprofit medical and hospital service associations.

The term includes a health maintenance organization (as defined in IC 27-13-1-19) and a limited service health maintenance organization (as defined in IC 27-13-1-27).

(m) "Internationally active insurance group" means an insurance holding company system that:

(1) includes an insurer that is registered under section 3 of this chapter; and

(2) meets the following requirements:

(A) The insurance holding company system has premiums written in at least three (3) countries.

(B) The percentage of the insurance holding company system's gross premiums written outside the United States is at least ten percent (10%) of the insurance holding company system's total gross written premiums.

(C) Based on a three (3) year rolling average, the:

(i) total assets of the insurance holding company system are at least fifty billion dollars ($50,000,000,000); or

(ii) total gross written premiums of the insurance holding company system are at least ten billion dollars ($10,000,000,000).

(n) "NAIC" refers to the National Association of Insurance Commissioners.

(o) "Supervisory college" means a temporary or permanent forum:

(1) comprised of regulators, including other state, federal, and international regulators, responsible for the supervision of:

(A) a domestic insurer that is part of an insurance holding company system that has international operations;

(B) an insurance holding company system described in clause (A); or

(C) an affiliate of:

(i) a domestic insurer described in clause (A); or

(ii) an insurance holding company system described in clause (B); and

(2) established to facilitate communication and cooperation between the regulators described in subdivision (1).

(p) A "person" is an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert. The term does not include the following:

(1) A securities broker performing no more than the usual and customary broker's function.

(2) A joint venture partnership that is exclusively engaged in owning, managing, leasing, or developing real or tangible personal property.

(q) A "policyholder" of a domestic insurer includes any person who owns an insurance policy or annuity contract issued by the domestic insurer, any person reinsured by the domestic insurer under a reinsurance contract or treaty between the person and the domestic insurer, and any health maintenance organization with which the domestic insurer has contracted to provide services or protection against the cost of care.

(r) "Securityholder" means a person that owns a security of a specified person, including common stock, preferred stock, debt obligations, and any other security that:

(1) is convertible to; or

(2) evidences the right to acquire;

a common stock, preferred stock, or debt obligation.

(s) A "subsidiary" of a specified person is an affiliate controlled by that person directly or indirectly through one or more intermediaries.

(t) "Surplus" means the total of gross paid in and contributed

surplus, special surplus funds, and unassigned surplus, less treasury stock at cost.

(u) "Voting security" includes any security convertible into or evidencing a right to acquire a voting security.

(Formerly: Acts 1971, P.L.387, SEC.1.) As amended by Acts 1981, P.L.244, SEC.1; P.L.26-1991, SEC.8; P.L.8-1993, SEC.416; P.L.130-1994, SEC.28; P.L.116-1994, SEC.38; P.L.26-1994, SEC.9; P.L.2-1995, SEC.100; P.L.203-2001, SEC.5; P.L.81-2012, SEC.12; P.L.72-2016, SEC.10.

IC 27-1-23-1.5

Dividend payments; notice; content

Sec. 1.5. (a) A domestic insurer that is a member of an insurance holding company system may not pay a dividend unless the insurer notifies the department of the dividend and the department receives the notice from the insurer:

(1) not more than five (5) business days after the declaration of the dividend or distribution; and

(2) at least ten (10) days before the payment of the dividend or distribution.

(b) A notice provided by an insurer under subsection (a) must contain information indicating that the surplus of the insurer as regards policyholders will be:

(1) reasonable in relation to the outstanding liabilities of the insurer; and

(2) adequate to the financial needs of the insurer;

following the payment of the dividend.

(c) After receiving a notice from an insurer under this section, the department shall promptly consider the information set forth in the notice under subsection (b). In the department's consideration of the information, the department shall apply the factors set forth in section 4(f) of this chapter.

As added by P.L.130-1994, SEC.29 and P.L.116-1994, SEC.39.

IC 27-1-23-2

Acquisition of domestic insurance company; statement to commissioner; hearings; notice; approval; exceptions; process

Sec. 2. (a) No person other than the issuer shall commence a tender offer for or a request or invitation for tenders of, or enter into any agreement to purchase or exchange securities for, or otherwise seek to acquire, or acquire, in the open market or otherwise, or solicit proxies relating to, any voting security of a domestic insurer or of any corporation controlling a domestic insurer if, after the consummation thereof, such person would, directly or indirectly (or by conversion or by exercise of any right to acquire), be in control of such insurer, and no person shall enter into an agreement to acquire control of a domestic insurer or of any corporation controlling a domestic insurer unless, at the time any such offer, request, or

invitation is commenced or any such agreement is entered into, or any such solicitation is begun, or prior to the acquisition of such securities if no offer or agreement is involved:

(1) each acquiring party has filed with the commissioner and has sent to such insurer and any such controlling corporation a statement containing the information required by this section;

(2) the offer, request, invitation, agreement, solicitation, or acquisition has been approved by the commissioner; and

(3) two (2) business days have elapsed following the commissioner's determination approving the offer, request, invitation, agreement, solicitation, or acquisition;

all in the manner prescribed in this section.

(b) Unless a statement described in subsection (a) is otherwise filed, the following apply to an acquisition or a divestiture of a person's controlling interest in a domestic insurer:

(1) If a controlling person of a domestic insurer seeks to divest the person's controlling interest, the person shall:

(A) file with the commissioner a confidential notice of the person's proposed divestiture at least thirty (30) days before the person ceases control; and

(B) send a copy of the filing required by clause (A) to the insurer.

(2) The commissioner shall determine whether a person:

(A) described in subdivision (1); or

(B) that seeks to acquire a controlling interest in a domestic insurer;

is required to obtain from the commissioner approval of the divestiture or acquisition.

(3) Information obtained by the commissioner under this subsection is confidential until the conclusion of the divestiture or acquisition unless the commissioner determines that maintaining confidentiality of the information interferes with enforcement of this section.

(c) A statement to be filed with the commissioner under this section shall be made under oath or affirmation and shall contain the following information:

(1) The name and address of the acquiring party.

(2) If the acquiring party is an individual, the individual's principal occupation and all offices and positions held during the past five (5) years, and any conviction of crimes other than minor traffic violations during the past ten (10) years.

(3) If the acquiring party is not an individual, a report of the nature of its business operations during the past five (5) years or for such lesser period as the acquiring party and any predecessors thereof shall have been in existence, including, but not limited to:

(A) information relating to the acquisition or disposition of control by the acquiring party of any other person and any

subsequent material change in the financial condition, management, organization, or operations of such other person;

(B) an informative description of the business intended to be done by the acquiring party and its affiliates;

(C) any plans or proposals for the conduct of the business or employment of the assets and surplus of the domestic insurer and any corporation controlling such insurer;

(D) an informative description of any transaction in which the acquiring party received, employed, or used any affiliate's assets;

(E) an informative description of any transaction or presently proposed transaction between the acquiring party and any of its affiliates in which either such acquiring party or such affiliate has a direct or indirect material interest; however, no information need be given as to any such transaction where the amount involved in the transaction or series of similar transactions, including all periodic payments or installments in the case of any lease or agreement providing for periodic payments or installments, does not or would not exceed one hundred thousand dollars ($100,000); and

(F) a list of all individuals who are or who have been selected to become directors or officers of the acquiring party, or who perform or will perform functions appropriate to such positions, such list to include for each such individual the information required by subdivision (2).

(4) The source, nature, and amount of the consideration to be used in effecting the acquisition of control, a description of any transaction wherein funds were or are to be obtained for any such purpose (including any pledge of the insurer's stock, or the stock of any of the insurer's subsidiaries or controlling affiliates), all documents evidencing, supporting, referring to, or relating to any such transaction and the identity of persons who are furnishing or who will furnish such consideration.

(5) Fully audited financial information as to the earnings and financial condition of the acquiring party for its preceding five (5) fiscal years (or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence), and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement.

(6) Any plans or proposals which the acquiring party may have to liquidate such domestic insurer or such controlling corporation, to sell its assets or merge or consolidate it with any person, or to make any other material change in its investment policy, business, corporate structure, or management.

(7) The number of shares of any security referred to in subsection (a) which the acquiring party proposes to acquire,

the terms of the proposed offer, request, invitation, agreement, or acquisition referred to in subsection (a), and a statement as to the method by which the terms of the proposal were arrived at.

(8) The amount of each class of any security referred to in subsection (a) which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the acquiring party.

(9) A full description of any contracts, arrangements, or understandings with respect to any security referred to in subsection (a) in which the acquiring party proposes to be or is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements, or understandings have been or will be entered into.

(10) A description of the purchase of any security referred to in subsection (a) during the twelve (12) calendar months preceding the filing of the statement by the acquiring party, including the dates of purchase, names of the purchasers, and consideration paid or agreed to be paid therefor.

(11) A description of any recommendations to purchase any security referred to in subsection (a) made during the twelve (12) calendar months preceding the filing of the statement by the acquiring party, or by anyone, based upon interviews or at the suggestion of such acquiring party.

(12) Copies of the proposed forms of all tender offers for, requests or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in subsection (a), and of the proposed form of additional soliciting material relating thereto.

(13) The terms of any agreement, contract, or understanding made or proposed to be made with any broker-dealer as to solicitation of securities referred to in subsection (a) for tender, and the amount of any fees, commissions, or other compensation paid or to be paid to broker-dealers with regard thereto.

(14) A full description of any existing or proposed contracts, arrangements, or understandings between the acquiring party and any present or former director, officer, or employee of the domestic insurer or of any corporation controlling such insurer. Such description shall identify the persons with whom such contracts, arrangements, or understandings have been or will be entered into.

(15) Copies of all studies, analyses, and reports which were prepared by or for the acquiring party or any affiliate of the

acquiring party for the purpose of evaluating or analyzing the proposed acquisition of control with respect to market shares, competition, competitors, markets, and potential for growth or expansion into product or geographic markets.

(16) If the acquiring party or any affiliate of the acquiring party is an insurer:

(A) the amount of any premiums, deposits, or annuity considerations received by the insurer during each of the last five (5) fiscal years (calculated on an accrual basis) for each line of insurance business conducted in any section of this state, and copies of annual statements for each of the last five (5) fiscal years filed by any such insurer with the insurance regulatory authority of its domiciliary jurisdiction;

(B) a full and complete description of any direct or indirect reinsurance relationship between the acquiring party or any affiliate of the acquiring party and the domestic insurer or any affiliate of the domestic insurer, together with copies of any treaties or contracts relating to that relationship; and

(C) such additional information as the commissioner may by rule or order prescribe as necessary or appropriate to enable the commissioner to make the determination required by subsection (f)(2).

(17) An agreement that a person required to obtain the commissioner's approval of a statement described in subsection (a) will file an annual enterprise risk report described in section 3(l) of this chapter as long as the person continues to hold a controlling interest in the domestic insurer.

(18) An acknowledgment that:

(A) a person described in subdivision (17); and

(B) any subsidiary in the insurance holding company system that is within the person's control;

will, upon the commissioner's request, provide to the commissioner information that the commissioner considers necessary to evaluate enterprise risk to the domestic insurer.

(19) Such additional information as the commissioner may by rule or order prescribe as necessary or appropriate for the protection of policyholders or in the public interest.

If any material change occurs in the facts set forth in a statement filed with the commissioner and sent to the insurer and any controlling corporation under this section, an amendment made under oath or affirmation setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the commissioner and sent to the insurer and any controlling corporation within two (2) business days after any acquiring party learns of this change.

(d) If any acquiring party is a partnership, limited partnership, syndicate, or other group, the commissioner may require that the information called for by subsection (c)(1) through (c)(19) shall be

given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group, and each person who controls such partner or member. If any such partner, member, person, or acquiring party is a corporation, the commissioner may require that the information called for by subsection (c)(1) through (c)(19) shall be given with respect to all individuals who are or have been selected to become directors or officers of any such corporation or who perform or will perform functions appropriate to these positions.

(e) If the proposed acquisition of control referred to in subsection (a) requires the filing of a registration statement under the federal Securities Act of 1933 (15 U.S.C. 77a-15 U.S.C. 77aa) or requires the disclosure of similar information under the federal Securities Exchange Act of 1934 (15 U.S.C. 78a-15 U.S.C. 78kk) or under a state law requiring similar registration or disclosure, an acquiring party may utilize such documents in furnishing the information called for by the statement.

(f) The commissioner shall hold a public hearing on the proposed acquisition of control referred to in subsection (a) and shall thereafter approve such acquisition of control only if the commissioner finds, by a preponderance of the evidence, that:

(1) the acquisition of control would not tend to affect adversely the contractual obligations of the domestic insurer or its ability and tendency to render service in the future to its policyholders and the public;

(2) the effect of the acquisition of control would not be substantially to lessen competition in any line of insurance business in any section of this state or tend to create a monopoly therein;

(3) the financial condition of any acquiring party is not such as might jeopardize the financial stability of the domestic insurer or of any corporation controlling such insurer, or prejudice the interest of its policyholders;

(4) the plans or proposals which any acquiring party has to liquidate the domestic insurer or any such controlling corporation, sell its assets or consolidate or merge it with any person, or to make any other material change in its investment policy, business, corporate structure, or management are fair and reasonable to policyholders of the domestic insurer and in the public interest; and

(5) the competence, experience, and integrity of those persons who would control the operation of the domestic insurer are such that the acquisition of control would not tend to affect adversely the general capacity or intention of the domestic insurer to transact the business of insurance in a safe and prudent manner.

(g) For the purposes of the commissioner's application of the competitive standard set forth in subsection (f)(2) to a proposed

acquisition:

(1) the acquiring person must file a pre-acquisition notification that meets the requirements set forth in section 2.5(e) of this chapter;

(2) the commissioner shall apply the provisions of section 2.5(h) of this chapter; and

(3) the commissioner may not disapprove the acquisition based upon the application of subsection (f)(2) if the commissioner finds that either of the conditions set forth in section 2.5(i) of this chapter applies to the proposed acquisition.

(h) The public hearing referred to in subsection (f) shall be held within sixty (60) days after all statements required by subsection (a) are filed, or within such longer period after the statements are filed as the commissioner determines upon a showing of good cause therefor, in the city of Indianapolis at such place, date, and time as the commissioner shall specify. At least thirty (30) days written notice of the hearing shall be given by the commissioner to each acquiring party, the domestic insurer, any corporation controlling such insurer, and to other persons as the commissioner may designate. In the event that an amendment to any such statement is filed, the hearing shall be postponed for a further period not to exceed sixty (60) days after the filing of such amendment, or for such longer period after the amendment is filed as the commissioner determines upon a showing of good cause therefor. If the proposed acquisition of control requires the approval of the commissioners of more than one (1) state, the public hearing may be held on a consolidated basis upon the request of the person that files the statement described in subsection (a). The person shall file the statement with the NAIC not more than five (5) days after the person makes the request for a public hearing. The commissioner of a state may opt out of a consolidated hearing by notifying the person not more than ten (10) days after receiving the statement described in subsection (a). A hearing conducted on a consolidated basis must be public and held in the United States before the commissioners of the domiciliary states of the insurers. The commissioners shall hear and receive evidence and may attend in person or by telecommunication.

(i) The commissioner shall give notice of the hearing by publication in a newspaper of general circulation in the city of Indianapolis, and in the city wherein is located the principal office of the domestic insurer, and in such other city or cities as the commissioner may deem appropriate. Any policyholder of the domestic insurer who makes a written request to the commissioner is entitled to a copy of all statements, amendments, or other material filed with the commissioner by any acquiring party.

(j) The commissioner may retain at the acquiring party's expense any attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed acquisition of

control. All hearing expenses, including transcript costs, expenses of publication and of preparing and mailing material to policyholders, shall be borne equally by each acquiring party. As security for the payment of such expenses, each acquiring party shall file with the commissioner an acceptable bond or other deposit in an amount to be determined by the commissioner.

(k) At such hearing, each acquiring party, the domestic insurer, any corporation controlling such insurer, policyholders of the domestic insurer, and any other person whose interests may be affected by the proposed acquisition of control shall have the right to appear and become party to the proceeding. Each such person shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as provided in the Indiana Rules of Trial Procedure. The commissioner may employ any sanction or power granted courts in the Indiana Rules of Trial Procedure, excluding the power of contempt, to enforce the commissioner's discovery rulings or orders. The commissioner shall make a determination within thirty (30) days after the conclusion of such hearing and shall immediately upon making that determination notify all persons who appeared and became parties to the proceeding of that determination. To permit an aggrieved party to perfect an appeal under IC 27-1-23-12, no offer, request, invitation, agreement, or acquisition referred to in subsection (a) may be commenced, entered into, or consummated until two (2) business days have elapsed following the commissioner's determination approving an acquisition of control.

(l) If the commissioner determines that a person acquiring control of a domestic insurer is required to maintain or restore the capital of the insurer to the level required by Indiana law, the person shall, not later than sixty (60) days after the closing date of the acquisition, file with the commissioner evidence that the capital has been maintained or restored to that level.

(m) Except as otherwise provided in this section, the hearing and the determination made therein shall be subject to IC 4-21.5-3.

(n) The provisions of this section shall not apply to the following:

(1) Any transaction to be undertaken under a statutory procedure for the purchase of dissenting shareholder's stock.

(2) Any transaction to be undertaken under a judicially approved reorganization.

(3) Any offer, request, invitation, agreement, solicitation, or acquisition respecting any security of a domestic insurer or of any corporation controlling such insurer if any acquiring party, immediately prior to such offer, request, invitation, agreement, solicitation, or acquisition being commenced, entered into, begun, or consummated, beneficially owns more than fifty percent (50%) of all the outstanding voting securities of such domestic insurer or corporation controlling such insurer.

(4) Any solicitation of proxies respecting any security of a domestic insurer or of any corporation controlling a domestic insurer that is undertaken by the management or the board of directors of the issuer of the security for purposes other than effecting, directly or indirectly, a transaction that would otherwise be subject to the requirements of this section.

(5) Any offer, request, invitation, agreement, solicitation, or acquisition respecting a security of a non-insurance corporation controlling one (1) or more domestic insurers if all of the following conditions are met:

(A) the offer, request, invitation, agreement, solicitation, or acquisition has been approved by the insurance regulatory authority of any state or territory of the United States of America other than Indiana, and the insurance regulatory authority of the state or territory has been accredited by the National Association of Insurance Commissioners;

(B) the domestic insurer or insurers meet all of the following conditions, determined in accordance with generally accepted accounting principles:

(i) the investments in and advances to the domestic insurer or insurers by the controlling non-insurance corporation and its other subsidiaries equal less than ten percent (10%) of the total assets of the controlling non-insurance corporation and all of its subsidiaries consolidated as of the end of the most recently completed fiscal year;

(ii) the proportionate share of the controlling non-insurance corporation and its other subsidiaries in the total assets (after intercompany eliminations) of the domestic insurer or insurers equals less than ten percent (10%) of the total assets of the controlling non-insurance corporation and all of its subsidiaries consolidated as of the end of the most recently completed fiscal year; and

(iii) the equity of the controlling non-insurance corporation and its other subsidiaries in the income from continuing operations before income taxes, extraordinary items, and the cumulative effect of a change in accounting principle of the domestic insurer or insurers is less than ten percent (10%) of the income of that corporation and all of its subsidiaries consolidated for the end of the most recently completed fiscal year; and

(C) the commissioner has not determined that the application of this section to the offer, request, invitation, agreement, solicitation, or acquisition is necessary or appropriate for the protection of policyholders of the domestic insurer or insurers.

(6) Any acquisition of stock of a former mutual by a parent company, as those terms are defined in IC 27-15-1, that occurs in connection with the conversion of a mutual insurance

company to a stock insurance company under IC 27-15, provided that no person acquires control of the parent company.

(o) The courts of this state are hereby vested with jurisdiction over every acquiring party not resident, domiciled, or authorized to do business in this state, and over all actions involving each such acquiring party arising out of violations of this section, and each such acquiring party shall be deemed to have performed acts equivalent to and constituting an appointment by the acquiring party of the commissioner to be the acquiring party's true and lawful attorney upon whom may be served all lawful process in any action, suit, or proceeding arising out of violations of this section. Copies of all such lawful process shall be served on the commissioner and transmitted by registered or certified mail by the commissioner to such acquiring party at the acquiring party's last known address.

(Formerly: Acts 1971, P.L.387, SEC.1.) As amended by Acts 1979, P.L.252, SEC.1; Acts 1981, P.L.244, SEC.2; P.L.2-1987, SEC.38; P.L.26-1991, SEC.9; P.L.130-1994, SEC.30; P.L.116-1994, SEC.40; P.L.94-1999, SEC.2; P.L.81-2012, SEC.13.

IC 27-1-23-2.5

Acquisitions in which there is a change in control of an insurer; preacquisition notification; waiting period; competitive standards; violations; order; penalties

Sec. 2.5. (a) The following definitions apply throughout this section:

(1) "Acquisition" means any agreement, arrangement, or activity the consummation of which results in a person acquiring directly or indirectly the control of another person. The term includes the acquisition of voting securities, and the acquisition of assets, assumption reinsurance, and mergers.

(2) "Involved insurer" includes an insurer that:

(A) acquires;

(B) is acquired;

(C) is affiliated with an acquirer;

(D) is affiliated with an acquired; or

(E) is the result of a merger.

(b) Except as provided in subsection (c), this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in Indiana.

(c) This section does not apply to the following:

(1) An acquisition subject to approval or disapproval by the commissioner under section 2 of this chapter.

(2) A purchase of securities solely for investment purposes, so long as those securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control under section 1(e) of this chapter, it is not solely for investment purposes

unless the commissioner of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and this disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the commissioner of Indiana.

(3) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if a pre-acquisition notification is filed with the commissioner in accordance with subsection (d) at least thirty (30) days before the proposed effective date of the acquisition. However, a pre-acquisition notification is not required for an exclusion from this section if the acquisition would otherwise be excluded from this section by any other subdivision of this subsection.

(4) The acquisition of persons already affiliated with the acquirer.

(5) An acquisition if, as an immediate result of the acquisition:

(A) in no market would the combined market share of the involved insurers exceed five percent (5%) of the total market;

(B) there would be no increase in any market share; or

(C) in no market would the combined market share of the involved insurers:

(i) exceed twelve percent (12%) of the total market; or

(ii) increase by more than two percent (2%) of the total market.

(6) An acquisition for which a pre-acquisition notification would be required under this section due solely to the resulting effect on the ocean marine insurance line of business.

(7) An acquisition of an insurer, if:

(A) the domiciliary commissioner of the insurer affirmatively finds that:

(i) the insurer is in failing condition;

(ii) there is a lack of feasible alternatives to improving that condition; and

(iii) the public benefits of improving the insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and

(B) those findings are communicated by the domiciliary commissioner to the commissioner of Indiana.

For the purposes of this subsection, a "market" means the total direct written insurance premium of all insurers providing insurance in Indiana for a particular line of business, as reported in the annual statements required to be filed by insurers licensed to do business in Indiana.

(d) An order pursuant to subsection (j) may be entered with respect to an acquisition to which this section applies unless the

acquiring person files a pre-acquisition notification with respect to the acquisition and the waiting period referred to in subsection (f) has expired. An acquired person may also file a pre-acquisition notification with respect to an acquisition. Information in pre-acquisition notifications filed under this section is confidential and protected from disclosure under section 6 of this chapter.

(e) A pre-acquisition notification filed under this section must be in the form and must contain the information prescribed by the National Association of Insurance Commissioners with respect to markets that meet the description set forth in subsection (c)(5), causing an acquisition not to be exempted from the provisions of this section. The commissioner may require additional material and information that the commissioner considers necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard set forth in subsection (g). The required information may include an opinion of an economist as to the competitive impact of the acquisition in Indiana, accompanied by a summary of the education and experience of the economist, indicating the economist's ability to render an informed opinion.

(f) The waiting period required with respect to a proposed acquisition begins on the day when the commissioner receives a pre-acquisition notification and ends:

(1) on the thirtieth day after the day the commissioner receives the notification; or

(2) upon the commissioner's termination of the waiting period, if earlier.

Before the end of the waiting period, the commissioner, on a one-time basis, may require the submission of additional needed information relevant to the proposed acquisition. If the commissioner requests additional information under this subsection, the waiting period ends on the earlier of the thirtieth day after receipt of the additional information by the commissioner or the termination of the waiting period by the commissioner.

(g) The commissioner may enter an order under subsection (j) with respect to an acquisition if:

(1) there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in Indiana or to tend to create a monopoly in any line of insurance in Indiana; or

(2) the insurer fails to file adequate information in compliance with subsections (d) and (e).

(h) In determining whether a proposed acquisition to which this section applies would violate the competitive standard set forth in subsection (g), the commissioner shall consider the following:

(1) An acquisition to which this section applies that involves two (2) or more insurers competing in the same market is prima facie evidence of a violation of the competitive standard:

(A) If the market is highly concentrated and the involved

insurers possess the following shares of the market:

(i) Insurer A a share of four percent (4%) and insurer B a share of 4% or more.

(ii) Insurer A a share of ten percent (10%) and insurer B a share of two percent (2%) or more.

(iii) Insurer A a share of fifteen percent (15%) and insurer B a share of one percent (1%) or more.

(B) If the market is not highly concentrated and the involved insurers possess the following shares of the market:

(i) Insurer A a share of five percent (5%) and insurer B a share of five percent (5%) or more.

(ii) Insurer A a share of ten percent (10%) and insurer B a share of four percent (4%) or more.

(iii) Insurer A a share of fifteen percent (15%) and insurer B a share of three percent (3%) or more.

(iv) Insurer A a share of nineteen percent (19%) and insurer B a share of one percent (1%) or more.

For the purposes of this subdivision, a highly concentrated market is a market in which the share of the four (4) largest insurers is seventy-five percent (75%) or more of the market. Percentages not referred to in this subdivision must be interpolated proportionately to the percentages that are referred to in this subdivision. If more than two (2) insurers are involved in a proposed acquisition, exceeding the total of the two (2) figures set forth for insurer A and insurer B in an item set forth in this subdivision is prima facie evidence of violation of the competitive standard set forth in subsection (g). For the purpose of this subdivision, the insurer with the largest share of the market shall be considered to be insurer A.

(2) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two (2) largest to the eight (8) largest, has increased by seven percent (7%) or more of the market over a period of time extending from any base year five (5) to ten (10) years before the acquisition up to the time of the acquisition. Any acquisition or merger to which this section applies involving two (2) or more insurers competing in the same market is prima facie evidence of violation of the competitive standard set forth in subsection (g) if:

(A) there is a significant trend toward increased concentration in the market;

(B) one (1) of the insurers involved is one (1) of the insurers in a grouping of those large insurers showing the requisite increase in the market share; and

(C) the market share of another involved insurer is two percent (2%) or more.

(3) For the purposes of this subsection:

(A) The term "insurer" includes any company or group of

companies under common management, ownership, or control.

(B) The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets with respect to an acquisition, the commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the National Association of Insurance Commissioners, and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business that is used in the annual statement required to be filed by insurers doing business in Indiana, and the relevant geographical market is assumed to be Indiana.

(C) The burden of showing prima facie evidence of a violation of the competitive standard rests upon the commissioner.

(4) Even though an acquisition is not prima facie violative of the competitive standard under subdivisions (1) and (2), the commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under subdivisions (1) and (2), a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this subdivision include, but are not limited to, the following:

(A) Market shares.

(B) Volatility of ranking of market leaders.

(C) Number of competitors.

(D) Concentration and trend of concentration in the industry.

(E) Ease of entry into and exit from the market.

(i) An order may not be entered under subsection (j) if:

(1) the acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits that would arise from those economies exceed the public benefits that would arise from not lessening competition; or

(2) the acquisition will substantially increase the availability of insurance, and the public benefits of that increase exceed the public benefits that would arise from not lessening competition.

(j) If an acquisition violates the standards set forth in this section, the commissioner may enter an order:

(1) requiring an involved insurer to cease and desist from doing business in Indiana with respect to the line or lines of insurance involved in the violation; or

(2) denying the application of an acquired or acquiring insurer

for a license to do business in Indiana.

(k) An order may not be entered under subsection (j) unless:

(1) there is a hearing;

(2) notice of the hearing is issued before the end of the waiting period and not less than fifteen (15) days before the hearing; and

(3) the hearing is concluded and the order is issued not more than sixty (60) days after the end of the waiting period.

Every order shall be accompanied by a written decision of the commissioner setting forth the commissioner's findings of fact and conclusions of law.

(l) An order entered under subsection (j) shall not become final less than thirty (30) days after it is issued, during which time the involved insurer may submit a plan to remedy the anticompetitive impact of the acquisition within a reasonable time. Based upon that plan or other information, the commissioner shall specify the conditions, if any, under which the aspects of the acquisition causing a violation of the standards of this section would be remedied and the order vacated or modified, and the time period within which those aspects would have to remedied.

(m) An order entered under subsection (j) does not apply if the acquisition to which the order applies is not consummated.

(n) A person who violates a cease and desist order issued by the commissioner under subsection (j) while that order is in effect may, after notice and hearing under IC 4-21.5 and upon order of the commissioner, be subject at the discretion of the commissioner to any one (1) or more of the following:

(1) A civil penalty of not more than ten thousand dollars ($10,000) for each day of violation.

(2) The suspension or revocation of the person's license.

(3) Both a monetary penalty under subdivision (1) and the suspension or revocation or the person's license under subdivision (2).

(o) An insurer or other person who fails to make any filing required by this section and also fails to demonstrate a good faith effort to comply with that filing requirement is subject to a civil penalty of not more than fifty thousand dollars ($50,000).

(p) Sections 8(b), 8(c), and 10 of this chapter do not apply to an acquisition to which this section applies.

As added by P.L.26-1991, SEC.10.

IC 27-1-23-2.6

Primary and subsidiary companies

Sec. 2.6. (a) As used in this section, "entity" means:

(1) a sole proprietorship;

(2) a corporation;

(3) a limited liability company;

(4) a partnership;

(5) an association;
(6) a joint stock company;
(7) a mutual fund;
(8) a joint venture;
(9) a trust;
(10) a joint tenancy;
(11) an unincorporated organization; or
(12) a similar entity.

(b) As used in this section, "primary company" means a domestic insurance company that beneficially owns more than fifty percent (50%) of one (1) or more subsidiary companies.

(c) As used in this section, "subsidiary company" means an entity of which more than fifty percent (50%) is beneficially owned by an insurance company.

(d) As used in this section, "total investment of the primary company" means the total of:

(1) a direct investment by a primary company in an asset; plus
(2) the primary company's proportionate share of an investment made by a subsidiary company of the primary company.

The primary company's proportionate share must be determined by multiplying the amount of the subsidiary company's investment by the percentage of the primary company's ownership interest in the subsidiary company.

(e) A primary company may, independently or in cooperation with another person, organize or acquire one (1) or more subsidiary companies.

(f) A subsidiary company of a primary company may conduct business of any kind, and the authority to conduct the business is not limited because of the status of the subsidiary company as a subsidiary company of the primary company.

(g) In addition to investments in common stock, preferred stock, debt obligations, and other securities as permitted under IC 27-1-12-2 or IC 27-1-13-3, a primary company to which this section applies may, directly or through one (1) or more subsidiary companies, also do the following:

(1) Invest in common stock, preferred stock, debt obligations, and other securities of one (1) or more subsidiary companies, amounts that in total do not exceed the lesser of ten percent (10%) of the primary company's admitted assets or fifty percent (50%) of the primary company's surplus as regards policyholders, if, after the investments, the primary company's surplus as regards policyholders is reasonable in relation to the primary company's outstanding liabilities and adequate to the primary company's financial needs. In calculating the amount of investments permitted under this subdivision:

(A) investments, whether made directly or through one (1) or more subsidiary companies, in domestic or foreign insurance subsidiary companies and health maintenance

organizations must be excluded; and

(B) to the extent that expenditures relate to an investment other than an investment described in clause (A), the following must be included:

(i) Total net money or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary company, including all organizational expenses and contributions to capital and surplus of the subsidiary company, whether or not represented by the purchase of capital stock or issuance of other securities.

(ii) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities and all contributions to the capital or surplus of a subsidiary company subsequent to the subsidiary company's acquisition or formation.

(2) Notwithstanding subdivision (1), invest an amount in common stock, preferred stock, debt obligations, and other securities of one (1) or more subsidiary companies engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the primary company, if the subsidiary company agrees to limit the subsidiary company's investment in an asset so that, when combined with the investments of the primary company, the total investment of the primary company will not exceed the investment limitations described in subdivision (1) or in any applicable provision of IC 27-1-12-2 or IC 27-1-13-3.

(3) Notwithstanding subdivision (1), with the prior approval of the commissioner, invest a greater amount in common stock, preferred stock, debt obligations, or other securities of one (1) or more subsidiary companies, if, after the investment, the primary company's surplus as regards policyholders is reasonable in relation to the primary company's outstanding liabilities and adequate to the primary company's financial needs.

(h) Investments that are made under this section in common stock, preferred stock, debt obligations, or other securities of a subsidiary company are not subject to restrictions or prohibitions under IC 27-1-12-2 or IC 27-1-13-3 that otherwise apply to investments of primary companies.

(i) Before a primary company to which this section applies makes an investment described in subsection (g), a primary company shall make a determination regarding whether the proposed investment meets the applicable requirements by determining the applicable investment limitations as though the investment has been made, considering:

(1) the currently outstanding principal balance on previous investments in debt obligations; and

(2) the value of previous investments in equity securities as of

the day that the investments in equity securities were made; net of any return of capital invested.

(j) If a primary company ceases to control a subsidiary company, the primary company shall dispose of any investment in the subsidiary company made under this section not more than:

(1) three (3) years from the time of the cessation of control; or

(2) the period determined appropriate by the commissioner;

unless the investment meets the requirements for investment under any applicable provision of IC 27-1-12-2 or IC 27-1-13-3 and the primary company has notified the commissioner that the investment meets the requirements.

(k) A primary company, at the time of establishing a subsidiary company, must possess:

(1) assets of not less than twenty-five million dollars ($25,000,000); or

(2) not less than three million five hundred thousand dollars ($3,500,000) of:

(A) combined capital and surplus in the case of a stock company; and

(B) surplus in the case of a mutual company.

(l) The department has the power to:

(1) conduct periodic examinations of a subsidiary company;

(2) require reports that reflect the effect of the condition and operation of a subsidiary company on the financial condition of a primary company; and

(3) make additional examinations or require other reports with respect to a subsidiary company that are necessary to carry out the purposes of this section.

A noninsurance subsidiary company shall annually furnish the department financial statements that are prepared under generally accepted accounting principles and certified by an independent certified public accountant and the department may rely on the statements. If a subsidiary company conducts the business of the subsidiary company in a manner that clearly tends to impair the capital or surplus fund of the primary company, or otherwise makes the operation of the primary company financially unsafe, the department may act under IC 27-1-3-19 with respect to the primary company.

(m) A primary company and a subsidiary company shall, in all respects, stand before the law as separate and distinct companies and neither company is liable to the creditors, policyholders, or stockholders of the other company, acts or omissions of an officer, director, stockholder, or member of either company notwithstanding.

(n) The board of directors and officers of a primary company and a subsidiary company may be identical. However, the affairs of each company shall be carried on separate and distinct from the other company.

(o) A foreign subsidiary company shall be treated in the same

manner as other foreign companies, except that the treatment may be withheld or suspended with respect to a subsidiary company that is domiciled in a state that does not treat a:

(1) primary company; or

(2) subsidiary company;

that is domiciled in Indiana in a manner equal to a foreign or domestic company doing business in the other state.

(p) Interests in a subsidiary company that are owned by a primary company must be registered in the name of the primary company except for shares that are required under Indiana law to be registered in the name of another person.

As added by P.L.126-2001, SEC.3.

IC 27-1-23-3

Registration statement; amendments; termination; disclaimer of affiliation; enterprise risk reports; civil penalty

Sec. 3. (a) Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in:

(1) this section;

(2) section 4(a) and 4(c) of this chapter; and

(3) section 4(b) of this chapter or a provision such as the following:

> Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen (15) days after the end of the month in which it learns of each such change or addition.

Any insurer which is subject to registration under this section shall register within fifteen (15) days after it becomes subject to registration, and annually thereafter by July 1 of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for registration, and then within such extended time. The commissioner may require any authorized insurer which is a member of an insurance holding company system but not subject to registration under this section to furnish a copy of the registration statement or other information filed by such insurer with the insurance regulatory authority of its domiciliary jurisdiction.

(b) Every insurer subject to registration shall file a registration statement on a form prescribed by the commissioner, which shall contain current information about all of the following:

(1) The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer.

(2) The identity of every member of the insurance holding

company system.

(3) The following agreements in force, relationships subsisting, and transactions that are currently outstanding or that have occurred during the last calendar year between such insurer and its affiliates:

(A) loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(B) purchases, sales, or exchanges of assets;

(C) transactions not in the ordinary course of business;

(D) guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(E) all management and service contracts and all cost-sharing arrangements;

(F) reinsurance agreements;

(G) dividends and other distributions to shareholders; and

(H) consolidated tax allocation agreements.

(4) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

(5) If requested by the commissioner, financial statements of the insurance holding company system, the parent corporation of the insurer, or all affiliates, including annual audited financial statements filed with the federal Securities and Exchange Commission under the Securities Act of 1933 or the federal Securities Exchange Act of 1934, both as amended.

(6) Statements reflecting that the insurer's:

(A) board of directors oversees corporate governance and internal controls; and

(B) officers or senior management have approved and implemented and maintain and monitor corporate governance and internal control procedures.

(7) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms prescribed by the commissioner.

(8) Other information that the commissioner requires under rules adopted under IC 4-22-2.

(c) Every registration statement must contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

(d) No information need be disclosed on the registration statement filed pursuant to subsection (b) if such information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, or investments, involving one-half of one per cent (0.5%) or less of an insurer's admitted assets as of the 31st day

of December next preceding shall not be deemed material for purposes of this section.

(e) Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms prescribed by the commissioner within fifteen (15) days after the end of the month in which it learns of each such change or addition.

(f) A person within an insurance holding company system subject to registration under this chapter shall provide complete and accurate information to an insurer when that information is reasonably necessary to enable the insurer to comply with this chapter.

(g) The commissioner shall terminate the registration of any insurer which demonstrates that it no longer is subject to the provisions of this section.

(h) The commissioner may require or allow two (2) or more affiliated insurers subject to registration under this section to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

(i) The commissioner may allow an insurer which is authorized to do business in this state and which is a member of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (a) and to file all information and material required to be filed under this section.

(j) The provisions of this section shall not apply to any insurer, information, or transaction if and to the extent that the commissioner by rule or order shall exempt the same from the provisions of this section.

(k) Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or such a disclaimer may be filed by such insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report under this section which may arise out of the insurer's relationship with such person unless and until the commissioner disallows such disclaimer. A disclaimer of affiliation is considered to have been granted unless the commissioner, less than thirty (30) days after receiving a disclaimer, notifies the person filing the disclaimer that the disclaimer is disallowed. The commissioner shall disallow such disclaimer only after furnishing all parties in interest with notice and opportunity to be heard.

(l) The person that ultimately controls an insurer that is subject to registration shall file with the lead state commissioner of the insurance holding company system (as determined by the procedures in the Financial Analysis Handbook adopted by the NAIC) an annual enterprise risk report that identifies, to the best of the person's

knowledge, the material risks within the insurance holding company system that could pose enterprise risk to the insurer.

(m) The commissioner may impose on a person a civil penalty of one hundred dollars ($100) per day that the person fails to file, within the period specified, a:

(1) registration statement; or

(2) summary of a registration statement or enterprise risk filing;

required by this section. The commissioner shall deposit a civil penalty collected under this subsection in the department of insurance fund established by IC 27-1-3-28.

(Formerly: Acts 1971, P.L.387, SEC.1.) As amended by Acts 1981, P.L.244, SEC.3; P.L.26-1991, SEC.11; P.L.81-2012, SEC.14; P.L.129-2014, SEC.7; P.L.72-2016, SEC.11.

IC 27-1-23-4

Material transactions; standards; prohibitions; review; notice; financial status; payment of extraordinary dividends; shareholder distributions; civil penalty

Sec. 4. (a) Material transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(1) The terms shall be fair and reasonable.

(2) Agreements concerning cost sharing services and management must include provisions required by the commissioner in rules adopted under IC 4-22-2.

(3) The charges or fees for services performed shall be reasonable.

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

(5) The books, accounts, and records of each party as to all transactions described in this subsection shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including accounting information necessary to support the reasonableness of the charges or fees to the respective parties.

(6) The insurer's surplus as regards policyholders following any transactions with affiliates or shareholder dividend shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(b) The following transactions involving a domestic insurer and any person in its insurance holding company system (including amendments or modifications to affiliate agreements previously filed under this chapter) that are subject to any materiality standards described in subdivisions (1) through (7) may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into such transaction at least thirty (30) days prior thereto, or such shorter period as the commissioner may permit, and

the commissioner has not disapproved it within that period:

(1) Sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments, provided those transactions are equal to or exceed:

(A) with respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders; and

(B) with respect to life insurers, three percent (3%) of the insurer's admitted assets;

each as of December 31 next preceding.

(2) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes those loans or extensions of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, provided those transactions are equal to or exceed:

(A) with respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders; and

(B) with respect to life insurers, three percent (3%) of the insurer's admitted assets;

each as of December 31 next preceding.

(3) Reinsurance agreements or modifications thereto, including:

(A) reinsurance pooling agreements; and

(B) agreements under which:

(i) a reinsurance premium;

(ii) a change in the insurer's liabilities; or

(iii) the projected reinsurance premium;

in any of the immediately succeeding three (3) years equals or exceeds five percent (5%) of the insurer's surplus as regards policyholders, as of December 31 next preceding, including those agreements that may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one (1) or more affiliates of the insurer.

(4) Management agreements, service contracts, cost-sharing arrangements, lease agreements, guarantees, and tax allocation agreements.

(5) Guarantees made by the insurer, only as follows:

(A) A guarantee, the amount of which is not quantifiable.

(B) A guarantee, the amount of which is quantifiable, if the amount of the guarantee exceeds the lesser of:

(i) one-half of one percent (0.5%) of the insurer's admitted assets; or

(ii) ten percent (10%) of surplus as regards policyholders;

on December 31 of the immediately preceding calendar year.

(6) Direct or indirect acquisitions or investments, as follows:

(A) In:

(i) a person that controls the insurer; or

(ii) an affiliate of the insurer in an amount that, together with the insurer's present holdings in the investments, exceeds two and one-half percent (2.5%) of the insurer's surplus to policyholders.

(B) This subdivision does not apply to direct or indirect acquisitions or investments in:

(i) subsidiaries acquired under section 2.6 of this chapter; or

(ii) nonsubsidiary insurance affiliates that are subject to this chapter.

(7) Material transactions, specified by rule, that the commissioner determines may adversely affect the interests of the insurer's policyholders.

This subsection does not authorize or permit any transactions that, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law. Notice concerning amendments or modifications of a transaction must include the reasons for the change and the financial impact on the domestic insurer. Not more than thirty (30) days after an agreement that was previously filed under this section is terminated, the domestic insurer shall send written notice of the termination to the commissioner. The commissioner shall determine whether a filing concerning the termination is required and shall notify the domestic insurer of the commissioner's determination.

(c) A domestic insurer may not enter into transactions that are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise.

(d) The commissioner, in reviewing transactions pursuant to subsection (b), shall consider whether the transactions comply with the standards set forth in subsection (a) and whether the transactions may adversely affect the interests of policyholders.

(e) The commissioner shall be notified within thirty (30) days of any investment of the domestic insurer in any one (1) corporation if the total investment in that corporation by the insurance holding company system exceeds ten percent (10%) of the corporation's voting securities.

(f) For purposes of this chapter, in determining whether an insurer's surplus is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and

other appropriate criteria.

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

(3) The number and size of risks insured in each line of business.

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

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

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

(7) The recent past and projected future trend in the size of the insurer's surplus as regards policyholders.

(8) The surplus as regards policyholders maintained by other comparable insurers in respect of the factors described in subdivisions (1) through (7).

(9) The adequacy of the insurer's reserves.

(10) The quality and liquidity of investments in subsidiaries, except that the commissioner may discount or treat any such investment in subsidiaries as a disallowed asset for purposes of determining the adequacy of surplus whenever in the commissioner's judgment such investment so warrants.

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

(g) No domestic insurer subject to registration under section 3 of this chapter shall pay an extraordinary dividend or make any other extraordinary distribution to its security holders until:

(1) thirty (30) days after the commissioner has received notice of the declaration thereof and has not within such period disapproved such payment; or

(2) the commissioner shall have approved such payment within such thirty (30) day period.

(h) For purposes of subsection (g), the following apply with respect to an extraordinary dividend or distribution:

(1) An extraordinary dividend or distribution is any dividend or distribution of cash or other property whose fair market value, together with that of other dividends or distributions made within the twelve (12) consecutive months ending on the date on which the proposed dividend or distribution is scheduled to be made, exceeds the lesser of:

(A) ten percent (10%) of such insurer's surplus as regards policyholders as of the most recently preceding December 31; or

(B) the:

(i) net gain from operations of such insurer, if such insurer is a life insurer; or

(ii) net income, if such insurer is not a life insurer;

not including realized capital gains, for the twelve (12)

month period ending on the most recently preceding December 31.

(2) An extraordinary dividend or distribution does not include pro rata distribution of any class of an insurer's own securities.

(3) For purposes of determining whether a dividend or distribution is extraordinary, an insurer that is not a life insurer may carry forward net income that:

(A) was received during the two (2) immediately preceding calendar years; and

(B) has not been paid out as dividends;

computed by subtracting the amount of dividends paid in the first and second immediately preceding calendar years from the amount of net income, not including realized capital gains, received in the second and third immediately preceding calendar years.

(i) Notwithstanding any other provision of law, a domestic insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval thereof, but such a declaration shall confer no rights upon shareholders until:

(1) the commissioner has approved the payment of such dividend or distribution; or

(2) the commissioner has not disapproved the payment within the thirty (30) day period referred to in subsection (g).

(j) The commissioner may impose a civil penalty of five thousand dollars ($5,000) on a person who fails to file a transaction as required by this section. The commissioner shall deposit a civil penalty collected under this subsection in the department of insurance fund established by IC 27-1-3-28.

(Formerly: Acts 1971, P.L.387, SEC.1.) As amended by Acts 1981, P.L.244, SEC.4; P.L.26-1991, SEC.12; P.L.130-1994, SEC.31; P.L.116-1994, SEC.41; P.L.11-2011, SEC.17; P.L.81-2012, SEC.15; P.L.146-2015, SEC.24; P.L.72-2016, SEC.12.

IC 27-1-23-5

Examination of registered insurer records; liability for expenses; noncompliance

Sec. 5. (a) Subject to the limitations contained in this section and in addition to the powers which the commissioner has under the insurance laws of this state relating to the examination of insurers, the commissioner shall have the power to do the following:

(1) Examine an insurer registered under section 3 of this chapter, and affiliates of the insurer, to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by:

(A) the person who ultimately controls the insurer;

(B) one (1) or more other persons within the insurance holding company system; or

(C) the insurance holding company system;

on a consolidated basis.

(2) Order any insurer registered under section 3 of this chapter to produce such records, books, or other information papers in the possession of the insurer or its affiliates as are reasonably necessary to ascertain the financial condition or legality of conduct of such insurer. In the event such insurer fails to comply with such order, the commissioner shall have the power to examine such insurer or affiliates to obtain such information.

(b) The commissioner shall exercise the commissioner's power under subsection (a) only if the examination of the insurer under the insurance laws of this state is deemed inadequate for the purposes of this chapter or if the interests of the policyholders of such insurer may be adversely affected.

(c) The commissioner may order an insurer registered under section 3 of this chapter to produce information that is not in the possession of the insurer if the insurer is able to obtain the information under contractual relationships, statutory obligations, or another method. If the insurer is unable to obtain the information, the insurer shall provide to the commissioner a detailed explanation of the reason for the insurer's inability and the identity of the person that holds the information. If the commissioner determines that the detailed explanation is without merit, the commissioner may:

(1) after notice and hearing, impose on the insurer a civil penalty of not more than one thousand dollars ($1,000) for each day that the insurer does not produce the information; or

(2) suspend or revoke the insurer's certificate of authority.

The commissioner shall deposit a civil penalty collected under this subsection in the department of insurance fund established by IC 27-1-3-28.

(d) The commissioner may retain at the registered insurer's expense such attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as shall be reasonably necessary to assist in the conduct of the examination under subsection (a). Any persons so retained shall be under the direction and control of the commissioner and shall act in a purely advisory capacity.

(e) Each registered insurer producing for examination records, books, and papers pursuant to subsection (a) shall be liable for and shall pay the expense of such examination.

(f) If an insurer fails to comply with an order under this section, the commissioner may:

(1) examine affiliates of the insurer to obtain information;

(2) issue subpoenas;

(3) administer oaths; and

(4) examine under oath any person;

to determine compliance with this section. The commissioner may petition a court with jurisdiction for an order to compel a person that refuses to comply with a subpoena to testify or produce evidence. A

witness who testifies under this section is entitled to the same compensation as the compensation to which a witness is entitled under IC 34, which must be paid by the insurer that is under examination.

(Formerly: Acts 1971, P.L.387, SEC.1.) As amended by Acts 1981, P.L.244, SEC.5; P.L.26-1991, SEC.13; P.L.81-2012, SEC.16.

IC 27-1-23-5.1

Supervisory college

Sec. 5.1. (a) The commissioner may participate in a supervisory college for a domestic insurer that is part of an insurance holding company system that has international operations, and any affiliate of the insurer, to do the following:

(1) Determine whether the insurer or affiliate is in compliance with this chapter.

(2) Assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management, and governance processes that apply to the insurer or affiliate.

(3) Examine the insurer or affiliate.

(b) The powers of the commissioner under subsection (a) include the following:

(1) Initiation of the establishment of the supervisory college.

(2) Clarification of the membership and participation of other supervisors in the supervisory college.

(3) Clarification of the functions of the supervisory college and the role of other regulators, including the establishment of a group wide supervisor.

(4) Coordination of the activities of the supervisory college, including planning meetings, supervisory activities, and information sharing procedures.

(5) Establishment of a crisis management plan.

(c) An insurer that is described in subsection (a) shall pay the commissioner's reasonable expenses of participation in a supervisory college, including travel expenses. The commissioner may establish a regular assessment to the insurer for payment of the expenses.

(d) The commissioner may enter into agreements in accordance with the requirements that apply to an agreement entered into with the NAIC under section 6 of this chapter to specify the activities of the commissioner and other regulators participating in the supervisory college.

(e) This section does not delegate to a supervisory college a commissioner's authority to regulate or supervise the insurer described in subsection (a) or the insurer's affiliates within the commissioner's jurisdiction.

As added by P.L.81-2012, SEC.17. Amended by P.L.72-2016, SEC.13.

IC 27-1-23-5.3

Internationally active insurance group; group wide supervisor

Sec. 5.3. (a) The commissioner shall, in cooperation with other state, federal, and international regulatory agencies, do either of the following to identify a single group wide supervisor for an internationally active insurance group:

(1) Act as the group wide supervisor if the commissioner determines that the internationally active insurance group conducts substantial insurance operations in Indiana.

(2) Acknowledge another regulatory official as the group wide supervisor if the commissioner determines that the internationally active insurance group:

(A) does not have substantial insurance operations in the United States;

(B) has substantial insurance operations in the United States, but not in Indiana; or

(C) has substantial insurance operations in the United States and Indiana, but the commissioner has determined according to subsections (c), (d), and (j) that the other regulatory official is the appropriate group wide supervisor.

(b) The commissioner may, upon request of an insurance holding company system that does not qualify as an internationally active insurance group, make a determination and act as, or acknowledge another regulatory official as, a group wide supervisor for the insurance holding company system under subsection (a) as if the insurance holding company system was an internationally active insurance group.

(c) In making a determination under subsection (a), the commissioner shall consider all of the following:

(1) The place of domicile of the internationally active insurance group insurers that hold the largest share of the internationally active insurance group's written premiums, assets, or liabilities.

(2) The place of domicile of the top tiered insurers in the internationally active insurance group's insurance company holding system.

(3) The location of the internationally active insurance group's executive offices or largest operational offices.

(4) Whether another regulatory official is acting or seeks to act as the group wide supervisor under a regulatory system that the commissioner determines to be:

(A) substantially similar to the regulatory system under the law of this state; or

(B) sufficient to provide for group wide supervision, enterprise risk analysis, and cooperation with other regulatory officials.

(5) Whether a regulatory official described in subdivision 4 provides the commissioner with reasonably reciprocal recognition and cooperation.

(d) If a regulatory official who is identified as the group wide

supervisor under this section considers another regulatory official to be more appropriate to serve as the group wide supervisor, the commissioner shall cooperatively do the following with the other regulatory officials involved with supervision of members of the internationally active insurance group, and in consultation with the internationally active insurance group:

(1) Consider the factors described in subsection (c) with respect to the other regulatory official considered more appropriate to serve as the group wide supervisor.

(2) If the commissioner considers the other regulatory official to be appropriate to serve as the group wide supervisor, acknowledge the other regulatory official, subject to the acknowledgment of the other regulatory officials.

(e) Notwithstanding any other law, if another regulatory official is acting as the group wide supervisor of an internationally active insurance group, the commissioner shall acknowledge the other regulatory official as the group wide supervisor. However, if there is a material change in the internationally active insurance group that results in:

(1) the internationally active insurance group's Indiana domiciled insurers holding the largest share of the internationally active insurance group's premiums, assets, or liabilities; or

(2) Indiana being the domicile of the internationally active insurance group's insurance holding company system's top tiered insurers;

the commissioner shall make a determination concerning the appropriate group wide supervisor for the internationally active insurance group as described in subsections (c) and (d).

(f) The commissioner may, under section 5 of this chapter, obtain from an insurer that is registered under section 3 of this chapter all information necessary to make a determination under this section.

(g) Before making a final determination that the commissioner will act as the group wide supervisor of an internationally active insurance group:

(1) the commissioner shall notify the:

(A) insurer that is registered under section 3 of this chapter; and

(B) ultimate controlling person;

in the internationally active insurance group; and

(2) the internationally active insurance group has at least thirty (30) days to provide the commissioner with additional information relevant to the commissioner's final determination.

(h) Upon making a final determination that the commissioner will act as the group wide supervisor of an internationally active insurance group, the commissioner shall publish that information, including the identity of the internationally active insurance group, in the Indiana Register and on the department's Internet web site.

(i) The commissioner may do any of the following with respect to an internationally active insurance group subject to group wide supervision by the commissioner:

(1) Assess enterprise risk in the internationally active insurance group to ensure that:

(A) the material financial condition and liquidity risks to members of the internationally active insurance group that are engaged in the business of insurance are identified by management; and

(B) reasonable and effective mitigation measures are in place to address the risks described in clause (A).

(2) Request from any member of the internationally active insurance group information necessary and appropriate to assess enterprise risk, including the following information concerning the members of the internationally active insurance group:

(A) Governance, risk assessment, and management.

(B) Capital adequacy.

(C) Material intercompany transactions.

(3) Coordinate and, through the regulatory authority of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures to ensure that the internationally active insurance group is able to, in a timely manner, recognize and mitigate enterprise risks to members of the internationally active insurance group that are engaged in the business of insurance.

(4) Communicate with other state, federal, and international regulatory officials for members in the internationally active insurance group and share relevant information subject to the confidentiality provisions of section 6 of this chapter, through supervisory colleges under section 5.1 of this chapter or otherwise.

(5) Enter into agreements with or obtain documentation from any:

(A) insurer registered under section 3 of this chapter;

(B) member of the internationally active insurance group; and

(C) other state, federal, and international regulatory official for members of the internationally active insurance group;

to establish the basis for or otherwise clarify the commissioner's role as group wide supervisor, including provisions to resolve disputes with other regulatory officials. An agreement or documentation described in this subdivision may not serve as evidence in any proceeding that an insurer or a person in an insurance holding company system that is not domiciled or incorporated in Indiana is doing business in Indiana or is otherwise subject to the jurisdiction of this state.

(6) Other group wide supervision activities consistent with this

section, as the commissioner determines necessary.

(j) If the commissioner acknowledges another regulatory official from a jurisdiction that is not accredited by the NAIC as the group wide supervisor of an internationally active insurance group, the commissioner may reasonably cooperate, through supervisory colleges or otherwise, with the regulatory official's group wide supervision if:

(1) the commissioner's cooperation is in compliance with the law of this state; and

(2) the regulatory official recognizes and cooperates with the commissioner's activities as a group wide supervisor for other internationally active insurance groups, as applicable.

If a regulatory official is not described in subdivision (2), the commissioner may refuse to recognize and cooperate with the regulatory official as the group wide supervisor.

(k) The commissioner may enter into agreements with or obtain documentation from:

(1) an insurer registered under section 3 of this chapter;

(2) an affiliate of an insurer described in subdivision (1); and

(3) other state, federal, and international regulatory agencies for members;

of an internationally active insurance group that provide a basis for or clarify a regulatory official's role as group wide supervisor of the internationally active insurance group.

(l) An insurer that is registered under section 3 of this chapter and subject to this section is liable for and shall pay the reasonable expenses of the commissioner's participation in the implementation of this section, including costs of attorneys, actuaries, other professionals, and reasonable travel expense.

As added by P.L.72-2016, SEC.14.

IC 27-1-23-6

Confidential and privileged information; sharing of information; requirements

Sec. 6. (a) Documents, materials, and other information in the possession or control of the department that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to section 5 of this chapter and all information reported pursuant to sections 2(c)(17), 2(c)(18), 3, and 4 of this chapter are confidential and privileged and shall not be subject to subpoena, discoverable, or admissible in evidence in a private civil action. However, the commissioner may use the documents, materials, and other information in the performance of the commissioner's duties as described in subsections (c) and (d). The commissioner shall not make the materials, documents, or other information public without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer and its affiliates who would be affected

thereby notice and opportunity to be heard, determines that the interests of policyholders or the public will be served by the publication thereof, in which event the commissioner may publish all or any part thereof in such manner as the commissioner considers appropriate.

(b) The commissioner and any other person:

(1) who receives documents, materials, or other information while acting under the authority of the commissioner; or

(2) with whom the documents, materials, or other information are shared;

under this chapter is not permitted or required to testify in a private civil action concerning any documents, materials, or other information that is confidential under subsection (a).

(c) The commissioner may do the following:

(1) Except as provided in subdivision (2), share documents, materials, and other information described in this section with the following if the recipient agrees in writing, and provides written verification that the recipient has the legal authority, to maintain the confidential and privileged status of the documents, materials, and other information:

(A) Other state, federal, and international regulatory agencies.

(B) The NAIC and affiliates and subsidiaries of the NAIC.

(C) State, federal, and international law enforcement authorities.

(D) Members of a supervisory college described in section 5.1 of this chapter.

(2) With respect to confidential and privileged documents, materials, and other information reported under section 3(l) of this chapter, share the documents, materials, and other information with commissioners who:

(A) regulate insurance in states with a law that is substantially similar to subsection (a); and

(B) have agreed in writing not to disclose the documents, materials, or other information.

(3) Receive documents, materials, or other information from:

(A) the NAIC and affiliates and subsidiaries of the NAIC;

(B) regulatory and law enforcement officials of domestic or foreign jurisdictions;

if the commissioner maintains the confidential or privileged status of the documents, materials, and other information that are received with notice or the understanding that the documents, materials, and other information are confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials, and other information.

(d) The commissioner shall enter into written agreements with the NAIC governing sharing and use of information provided under this chapter, including the following:

(1) Procedures and protocols concerning the confidentiality and security of information shared:

(A) with the NAIC and affiliates and subsidiaries of the NAIC under this chapter; and

(B) by the NAIC with other state, federal, and international regulators.

(2) A statement that, with respect to information shared with and used by the NAIC and affiliates and subsidiaries of the NAIC under this chapter:

(A) the commissioner maintains ownership of the information; and

(B) the use of the information is subject to the direction of the commissioner.

(3) A requirement that, if confidential information of an insurer that is in the possession of the NAIC under this chapter is subject to a request or subpoena to the NAIC for production or disclosure, the NAIC will provide prompt notice to the insurer.

(4) A requirement that the NAIC and affiliates and subsidiaries of the NAIC will allow intervention by an insurer in a judicial or administrative action under which the NAIC or affiliates or subsidiaries of the NAIC may be required to disclose confidential information concerning the insurer that has been shared with the NAIC or affiliates or subsidiaries of the NAIC under this chapter.

(e) The sharing of information by the commissioner under this chapter is not considered to be a delegation of regulatory authority. The commissioner is solely responsible for the administration, implementation, and enforcement of this chapter.

(f) Disclosure to or sharing by the commissioner of documents, materials, or other information under this chapter is not a waiver of any applicable privilege or claim of confidentiality in the documents, materials, or other information.

(g) Documents, materials, and other information in the possession or control of the NAIC under this section are:

(1) confidential;

(2) privileged;

(3) not subject to subpoena; and

(4) not discoverable or admissible in evidence in a private civil action.

(Formerly: Acts 1971, P.L.387, SEC.1.) As amended by Acts 1981, P.L.244, SEC.6; P.L.26-1991, SEC.14; P.L.81-2012, SEC.18.

IC 27-1-23-7

Rules and orders

Sec. 7. The commissioner may adopt, under IC 4-22-2, such rules and orders as are necessary to carry out this chapter, including emergency rules under IC 4-22-2-37.1.

(Formerly: Acts 1971, P.L.387, SEC.1.) As amended by Acts 1981,

P.L.244, SEC.7; P.L.26-1991, SEC.15.

IC 27-1-23-8
Enjoining violations; seizure or sequestration of securities

Sec. 8. (a) Whenever it appears to the commissioner that any person has committed or is about to commit a violation of this chapter or of any rule or order issued by the commissioner hereunder, the commissioner may apply to the circuit court, superior court, or probate court for the county in which such person resides or, in the case of a corporation or other entity, has its principal office, or if such person has no such residence or office in this state then to the circuit court or superior court of Marion County, for an order enjoining such person from violating or continuing to violate this chapter or any such rule or order, and for such other equitable relief as the nature of the case and the interests of policyholders or the public may require.

(b) No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of the provisions of this chapter or of any rule or order issued by the commissioner hereunder may be voted at any shareholders' meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though such securities were not issued and outstanding; but no action taken at any such meeting shall be invalidated by the voting of such securities, unless the action would materially affect control of a domestic insurer or any corporation controlling such insurer or unless the courts of this state have so ordered. If a domestic insurer, any corporation controlling such insurer or the commissioner has reason to believe that any security of the domestic insurer or any corporation controlling such insurer has been or is about to be acquired in contravention of the provisions of this chapter or of any rule or order issued by the commissioner hereunder, the domestic insurer, any corporation controlling such insurer or the commissioner may apply to the circuit court or superior court of Marion County or to the circuit court, superior court, or probate court of the county in which the domestic insurer or corporation controlling such insurer has its principal place of business to enjoin any offer, request, invitation, agreement or acquisition commenced, entered into, or consummated in contravention of this chapter or any rule or order issued by the commissioner under this chapter, to enjoin the voting of any security so acquired, to void any vote of such security already cast at any meeting of shareholders, and for such other equitable relief as the nature of the case and the interests of the domestic insurer's policyholders or the public may require.

(c) In any case where a person has acquired or is proposing to acquire securities in violation of this chapter or any rule or order issued by the commissioner hereunder, the circuit court or superior

court of Marion County or the circuit court, superior court, or probate court of the county in which the domestic insurer or any corporation controlling such insurer has its principal place of business may, on such notice as the court deems appropriate, upon the application of the domestic insurer, any corporation controlling such insurer or the commissioner, seize or sequester any such securities owned directly or indirectly by such person, and issue such orders with respect thereto as may be appropriate to effectuate the provisions of this chapter. Notwithstanding any other provision of law, for the purposes of this chapter the situs of the ownership of the securities of domestic insurers and corporations controlling such insurers shall be deemed to be in this state.

(d) Violation of this chapter or any rule or order issued by the commissioner under this chapter shall be deemed to be irreparable harm for the purpose of obtaining any form of equitable relief.

(Formerly: Acts 1971, P.L.387, SEC.1.) As amended by Acts 1981, P.L.244, SEC.8; P.L.84-2016, SEC.117.

IC 27-1-23-8.1

Violations; penalties

Sec. 8.1. (a) If it appears to the commissioner that an insurer or a director, an officer, an employee, or an agent of an insurer has knowingly or intentionally violated this chapter, the commissioner may report the violation to the prosecutor of the county in which the conduct giving rise to the report occurred.

(b) Except as provided in subsection (c), an officer, a director, an employee, or an agent of an insurer or of an insurance holding company system who knowingly or intentionally violates the following commits a Level 6 felony (IC 35-50-2-7):

(1) Section 1.5(a) or 1.5(b) of this chapter.

(2) Section 2(a) or 2(b) of this chapter.

(3) Section 2.5(n) or 2.5(o) of this chapter.

(4) Section 2.6(g), 2.6(i), 2.6(j), 2.6(k), 2.6(l), 2.6(m), 2.6(n), or 2.6(p) of this chapter.

(5) Section 3(a), 3(b), 3(e), or 3(f) of this chapter.

(6) Section 4(a), 4(b), 4(c), 4(e), 4(g), or 4(i) of this chapter.

(7) Section 5(c) or 5(e) of this chapter.

(8) Section 8(b) of this chapter.

(c) An officer, a director, or an employee of an insurance holding company system who knowingly or intentionally subscribes to or makes or causes to be made a false statement, false report, or false filing with the intent to deceive the commissioner in the performance of the commissioner's duties under this chapter:

(1) commits a Level 4 felony (IC 35-50-2-5.5); and

(2) except as provided in subsection (d), is in the officer's, director's, or employee's individual capacity subject to a civil penalty imposed by the commissioner of not more than one million dollars ($1,000,000).

(d) A director or an officer of an insurance holding company system who:

(1) knowingly or intentionally violates this chapter; or

(2) knowingly or intentionally participates in, assents to, or permits an insurer's, officer's, employee's, or agent's engagement in transactions or the purchase of investments that:

(A) have not been properly reported or submitted under section 3(a), 4(b), or 4(g) of this chapter; or

(B) violate this chapter;

is, in the director's or officer's individual capacity and after notice and hearing under IC 4-21.5, subject to a civil penalty of not more than ten thousand dollars ($10,000) per violation.

(e) The commissioner may impose a civil penalty of not more than one million dollars ($1,000,000) on an insurer that knowingly or intentionally violates this chapter.

(f) In determining the amount of the civil penalty under this section, the commissioner shall consider the appropriateness of the amount of the civil penalty with respect to the gravity of the violation, any history of previous violations, and other matters considered appropriate by the commissioner.

(g) If it appears to the commissioner that an insurer subject to this chapter, or a director, an officer, an employee, or an agent of an insurer, has engaged in a transaction or entered into a contract:

(1) that is subject to section 4 of this chapter;

(2) for which the commissioner's approval was not requested; and

(3) that would not have been approved by the commissioner if the commissioner's approval had been requested;

the commissioner may order the insurer to immediately cease and desist from activity under the transaction or contract. The commissioner may, after notice and hearing under IC 4-21.5, order the insurer to void any contract and restore the status quo if the commissioner determines that the action is in the best interest of the insurer's policyholders or creditors or the public.

(h) If it appears to the commissioner that:

(1) a person has committed a violation of section 2 of this chapter; and

(2) the violation prevents the full understanding of the enterprise risk to the insurer by affiliates or the insurance holding company system;

the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with IC 27-9.

As added by P.L.72-2016, SEC.15.

IC 27-1-23-9
Repealed

(Repealed by Acts 1981, P.L.244, SEC.12.)

IC 27-1-23-10
Seizure of property of domestic insurer

Sec. 10. Whenever it appears to the commissioner that any person has committed a violation of this chapter which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders or the public, the commissioner may proceed as provided in the insurance laws of this state to take possession of the property of such domestic insurer and to conduct the business thereof. A determination made under this section must be accompanied by specific findings of fact and conclusions of law.
(Formerly: Acts 1971, P.L.387, SEC.1.) As amended by Acts 1981, P.L.244, SEC.9; P.L.26-1991, SEC.16.

IC 27-1-23-10.5
Receiver's right to recover upon liquidation or rehabilitation

Sec. 10.5. (a) If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under the order has a right to recover on behalf of the insurer:

(1) from any parent corporation or holding company or person or affiliate that otherwise controlled the insurer, the amount of distributions other than distributions of shares of the same class of stock paid by the insurer on the insurer's capital stock; or

(2) any payment in the form of a bonus, a termination settlement, or an extraordinary lump sum salary adjustment made by the insurer or the insurer's subsidiaries to a director, an officer, or an employee;

if the distribution or payment described in subdivision (1) or (2) is made at any time during the one (1) year preceding the petition for liquidation, conservation, or rehabilitation, as the case may be, subject to the limitations of subsections (b), (c), and (d).

(b) A distribution is not recoverable if the parent or affiliate shows that, when paid, the distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill the insurer's contractual obligations.

(c) Any person that was a parent corporation or holding company or a person that otherwise controlled the insurer or affiliate at the time distributions described in subsection (a) were paid shall be liable up to the amount of distributions or payments under subsection (a) that the person received. Any person that otherwise controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions the person would have received if the distributions had been paid immediately. If at least two (2) persons are liable with respect to the same distributions, they are jointly and severally liable.

(d) The maximum amount recoverable under this section shall be

the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

(e) To the extent that any person liable under subsection (c) is insolvent or otherwise fails to pay claims due from the person, the person's parent corporation or holding company or the person that otherwise controlled the person at the time the distribution was paid is jointly and severally liable for any resulting deficiency in the amount recovered from the parent corporation or holding company or person that otherwise controlled the person.

As added by P.L.130-1994, SEC.32 and P.L.116-1994, SEC.42.

IC 27-1-23-11

Denial, suspension, or revocation of license or authority to do business

Sec. 11. Whenever it appears to the commissioner that any person has committed a violation of this chapter which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the commissioner may, after giving notice and an opportunity to be heard, determine to suspend, revoke or refuse to renew such insurer's license or authority to do business in this state for such period as he finds is required for the protection of policyholders or the public.

(Formerly: Acts 1971, P.L.387, SEC.1.)

IC 27-1-23-12

Review of actions of commissioner; stay; mandamus

Sec. 12. (a) Any person aggrieved by any agency action of the commissioner pursuant to this chapter may petition for judicial review thereof in accordance, so far as practical, with IC 4-21.5-5.

(b) Notwithstanding IC 4-21.5-5, the filing of a petition for review of the commissioner's determination approving an acquisition of control under section 2 of this chapter shall stay the application of any such determination or other action of the commissioner unless the court to which the petition is directed, after giving the petitioner notice and an opportunity to be heard, determines that such a stay would be detrimental to the interests of policyholders or the public.

(c) Any person aggrieved by any failure of the commissioner to act or make a determination required by this chapter may bring an action for mandate in the circuit court of Marion County to compel the commissioner to act or make such determination forthwith.

(Formerly: Acts 1971, P.L.387, SEC.1.) As amended by Acts 1981, P.L.244, SEC.10; P.L.7-1987, SEC.141.

IC 27-1-23-13

Application of chapter

Sec. 13. This chapter, while independent in its enactment of any other law, shall be supplemental to the Indiana Insurance Law (IC

27-1-2 through IC 27-1-20). All provisions of IC 27-1-2 through IC 27-1-20 shall be fully and completely applicable to this chapter in the same manner as if the provisions of this chapter had been an original part of IC 27-1-2 through IC 27-1-20. This chapter shall be controlling in the event there exists any conflict between this chapter and IC 27-1-2 through IC 27-1-20.

(Formerly: Acts 1971, P.L.387, SEC.1.) As amended by Acts 1981, P.L.244, SEC.11.

IC 27-1-23.5

Chapter 23.5. Risk Management and Own Risk and Solvency Assessment

IC 27-1-23.5-1

Application of chapter

Sec. 1. This chapter applies beginning January 1, 2015.

As added by P.L.129-2014, SEC.8.

IC 27-1-23.5-2

Definitions

Sec. 2. Except as otherwise provided in this chapter, the definitions in IC 27-1-23 apply throughout this chapter.

As added by P.L.129-2014, SEC.8.

IC 27-1-23.5-3

"Insurance group"

Sec. 3. As used in this chapter, "insurance group", for purposes of conducting an ORSA, means insurers and affiliates of an insurance holding company system (as defined in IC 27-1-23-1).

As added by P.L.129-2014, SEC.8.

IC 27-1-23.5-4

"Insurer"

Sec. 4. As used in this chapter, "insurer" has the same meaning as set forth in IC 27-1-2-3, except that the term:

(1) refers only to domestic insurers (as defined in IC 27-1-36-8); and

(2) does not include agencies, authorities, or instrumentalities of the United States, possessions and territories of the United States, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

As added by P.L.129-2014, SEC.8.

IC 27-1-23.5-5

"ORSA"

Sec. 5. As used in this chapter, "ORSA" or "own risk and solvency assessment" means a confidential internal assessment:

(1) that is:

(A) appropriate to the nature, scale, and complexity of; and

(B) conducted by;

an insurer or insurance group; and

(2) of the:

(A) material and relevant risks associated with the insurer or insurance group's current business plan; and

(B) sufficiency of capital resources to support the risks described in clause (A).

As added by P.L.129-2014, SEC.8.

IC 27-1-23.5-6
"ORSA guidance manual"

Sec. 6. (a) As used in this chapter, "ORSA guidance manual" refers to the current version of the Own Risk and Solvency Assessment Guidance Manual of the NAIC.

(b) As used in subsection (a), "current version" means the version containing:

(1) all changes that were made before; and

(2) no changes that were made on or after;

January 1 of the current calendar year.

As added by P.L.129-2014, SEC.8.

IC 27-1-23.5-7
"ORSA summary report"

Sec. 7. As used in this chapter, "ORSA summary report" means a confidential, high level summary of an insurer or insurance group's ORSA.

As added by P.L.129-2014, SEC.8.

IC 27-1-23.5-8
Risk management framework

Sec. 8. (a) An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing, and reporting concerning the insurer's material and relevant risks.

(b) If an insurance group of which an insurer is a member maintains a risk management framework described in subsection (a) that applies to the operations of the insurer, the insurer is considered to be in compliance with subsection (a).

As added by P.L.129-2014, SEC.8.

IC 27-1-23.5-9
Conducting an ORSA

Sec. 9. Subject to section 11 of this chapter, an:

(1) insurer; or

(2) insurance group of which an insurer is a member;

shall, at any time when significant changes occur to the risk profile of the insurer or insurance group and at least one (1) time per year, conduct an ORSA in a manner consistent with the ORSA guidance manual.

As added by P.L.129-2014, SEC.8.

IC 27-1-23.5-10
ORSA reports; requirements

Sec. 10. (a) Upon the request of the commissioner, and not more than one (1) time per year, an insurer shall submit to the commissioner:

(1) an ORSA summary report; or

(2) a combination of reports that together contain the information described in the ORSA guidance manual;

applicable to the insurer or insurance group of which the insurer is a member.

(b) Regardless of a request from the commissioner, if the commissioner is the lead state commissioner of an insurance group of which an insurer is a member (as determined by the procedures in the NAIC Financial Analysis Handbook), the insurer shall submit a report described in subsection (a) at least one (1) time per year.

(c) A report required by this section must include a signature of the insurer's or insurance group's chief risk officer, or another executive who has responsibility for the oversight of the insurer's enterprise risk management process, attesting that:

(1) to the best of the officer's or executive's belief and knowledge the insurer applies the enterprise risk management process described in the ORSA summary report; and

(2) a copy of the report has been provided to the insurer's board of directors or the appropriate committee of the insurer's board of directors.

(d) If an insurer or another member of an insurance group of which the insurer is a member submits to the commissioner the most recent report that:

(1) was provided to the:

(A) commissioner of another state; or

(B) regulatory authority of an alien jurisdiction;

(2) is substantially similar to an ORSA summary report; and

(3) contains information that is comparable to the information described in the ORSA guidance manual;

the insurer is considered to have satisfied the requirements of this section.

(e) If a report described in subsection (d) is completed in a language other than English, a translation of the report into the English language must be submitted with the report.

As added by P.L.129-2014, SEC.8.

IC 27-1-23.5-11

Exemptions

Sec. 11. (a) Except as otherwise provided in this section, an insurer is exempt from the requirements of this chapter if:

(1) the insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than five hundred million dollars ($500,000,000); and

(2) the insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance

Corporation and Federal Flood Program, of less than one billion dollars ($1,000,000,000).

(b) If:

(1) an insurer qualifies under subsection (a)(1) for exemption from the requirements of this chapter; and

(2) the insurance group of which the insurer is a member does not qualify for exemption under subsection (a)(2);

an ORSA summary report required by section 10 of this chapter must include every insurer that is a member of the insurance group.

(c) If:

(1) an insurance group described in subsection (b) submits more than one (1) ORSA summary report for a combination of insurers; and

(2) the combination of ORSA summary reports submitted as described in subdivision (1) includes every insurer that is a member of the insurance group;

the insurance group is considered to be in compliance with subsection (b).

(d) If:

(1) an insurer does not qualify under subsection (a)(1) for exemption from the requirements of this chapter; and

(2) the insurance group of which the insurer is a member qualifies for exemption under subsection (a)(2);

the only ORSA summary report that is required under section 10 of this chapter is the report that applies to the insurer.

(e) An insurer that does not qualify under subsection (a) for exemption from the requirements of this chapter may apply to the commissioner for a waiver from the requirements of this chapter based on unique circumstances. In deciding whether to grant an insurer's request for a waiver, the commissioner:

(1) may consider the type and volume of business written, ownership and organizational structure, and any other factor the commissioner considers relevant to the insurer or insurance group of which the insurer is a member; and

(2) shall, if the insurer is part of an insurance group with insurers domiciled in more than one (1) state, coordinate with the:

(A) lead state commissioner of the insurance group (as determined by the procedures in the NAIC Financial Analysis Handbook); and

(B) other domiciliary commissioners;

in considering whether to grant the insurer's request for a waiver.

(f) The commissioner may, regardless of an insurer's qualification under this section for exemption from the requirements of this chapter, require that an insurer maintain a risk management framework, conduct an ORSA, and file an ORSA summary report if one (1) of the following applies:

(1) If unique circumstances exist, as determined by the commissioner, including the following:
(A) The type and volume of business written by the insurer.
(B) The insurer's ownership and organizational structure.
(C) The request of a federal agency.
(D) The request of an international supervisor.
(2) If the insurer:
(A) has authorized control level RBC for a company action level event under IC 27-1-36;
(B) meets at least one (1) of the standards of an insurer considered to be in hazardous financial condition according to rules adopted by the department under IC 27-1-3-7; or
(C) exhibits other qualities of a troubled insurer, as determined by the commissioner.

(g) If an insurer ceases to qualify for an exemption under this section due to changes in premium, as reflected in:
(1) the insurer's most recent annual statement; or
(2) the most recent annual statements of the insurers that are members of the insurance group of which the insurer is a member;

the insurer must meet the requirements of this chapter not later than one (1) year after the date on which the premium change occurs.
As added by P.L.129-2014, SEC.8.

IC 27-1-23.5-12
ORSA summary report preparation, review

Sec. 12. (a) Except as provided in subsection (b), an ORSA summary report must be prepared in a manner consistent with the ORSA guidance manual. Documentation and supporting information must be maintained and made available upon examination or request of the commissioner.

(b) The commissioner's review of an ORSA summary report, and any requests for additional information, must be made in a manner similar to the procedures used by the commissioner in the analysis and examination of multistate or global insurers and insurance groups.
As added by P.L.129-2014, SEC.8.

IC 27-1-23.5-13
Documents, materials, other information

Sec. 13. (a) Documents, materials, and other information related to an ORSA, including an ORSA summary report, in the possession of or control of the department that are obtained by, created by, or disclosed to the commissioner or another person under this chapter, are:
(1) considered to be proprietary and contain trade secrets;
(2) confidential and privileged;
(3) not subject to subpoena; and

(4) not subject to discovery or admissible in evidence in a private civil action.

(b) The commissioner may:

(1) use the documents, materials, and other information described in subsection (a) in relation to a regulatory or legal action brought as part of the commissioner's duties; and

(2) otherwise make the documents, materials, and other information public only with the prior written consent of the insurer or insurance group.

(c) The commissioner, and any other person:

(1) who receives documents, materials, or other information related to an ORSA while acting under the authority of the commissioner; or

(2) with whom the documents, materials, or other information are shared;

under this chapter is not permitted or required to testify in a private civil action concerning any documents, materials, or other information described in subsection (a).

(d) The commissioner may do the following:

(1) Upon request, share all documents, materials, and other information described in subsection (a) with the following if the recipient agrees in writing, and provides written verification that the recipient has the legal authority, to maintain the confidential and privileged status of the documents, materials, and other information:

(A) Other state, federal, and international financial regulatory agencies.

(B) The NAIC.

(C) Members of a supervisory college.

(D) A third party consultant designated by the commissioner.

(2) Receive documents, materials, and other information described in subsection (a) from:

(A) regulatory officials of domestic or foreign jurisdictions;

(B) members of a supervisory college; and

(C) the NAIC;

if the commissioner maintains the confidential or privileged status of the documents, materials, and other information that are received with notice or the understanding that the documents, materials, and other information are confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials, and other information.

(e) The commissioner shall enter into a written agreement with the NAIC or a third party consultant governing sharing and use of information provided under this chapter, including the following:

(1) Procedures and protocols concerning the confidentiality and security of information shared:

(A) with the NAIC or a third party consultant under this chapter; and

(B) by the NAIC with regulators of other states in which insurers that are members of an insurance group are domiciled.

(2) A statement that the recipient agrees in writing, and provides written verification that the recipient has the legal authority, to maintain the confidential and privileged status of the documents, materials, and other information.

(3) A statement that, with respect to information shared with the NAIC or a third party consultant under this chapter:

(A) the commissioner maintains ownership of the information; and

(B) the use of the information is subject to the direction of the commissioner.

(4) A statement that the NAIC or a third party consultant may not store information shared under this chapter in a permanent data base after the underlying analysis is completed.

(5) A requirement that, if confidential information of an insurer that is in the possession of the NAIC or a third party consultant under this chapter is subject to a request or subpoena to the NAIC or third party consultant for production or disclosure, the NAIC or a third party consultant will provide prompt notice to the insurer.

(6) A requirement that the NAIC or a third party consultant will allow intervention by an insurer in a judicial or administrative action under which the NAIC or third party consultant may be required to disclose confidential information concerning the insurer that has been shared with the NAIC or third party consultant under this chapter.

(7) If the written agreement is with a third party consultant, a statement that the insurer's written consent is required for the sharing of the information with the third party consultant.

(f) The sharing of information by the commissioner under this chapter is not a delegation of regulatory authority. The commissioner is solely responsible for the administration, implementation, and enforcement of this chapter.

(g) Disclosure to or sharing by the commissioner of documents, materials, or other information under this chapter is not a waiver of any applicable privilege or claim of confidentiality in the documents, materials, or other information.

(h) Documents, materials, and other information in the possession or control of the NAIC or a third party consultant under this chapter are:

(1) confidential and privileged;

(2) not subject to subpoena; and

(3) not discoverable or admissible in evidence in a private civil action.

As added by P.L.129-2014, SEC.8.

IC 27-1-23.5-14
Civil penalties

Sec. 14. (a) An insurer that fails, without just cause (as determined by the commissioner), to timely file an ORSA summary report as required by this chapter shall, after notice and hearing under IC 4-21.5, pay a civil penalty of one hundred dollars ($100) for each day of noncompliance, not to exceed ten thousand dollars ($10,000).

(b) The commissioner may reduce a penalty imposed under subsection (a) if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

(c) A civil penalty collected under this section shall be deposited in the department of insurance fund established by IC 27-1-3-28.

As added by P.L.129-2014, SEC.8.

IC 27-1-24
Repealed
(Repealed by P.L.257-1983, SEC.3.)

IC 27-1-25

Chapter 25. Insurance Administrators

IC 27-1-25-1

Definitions

Sec. 1. As used in this chapter:

(a) "Administrator" means a person who directly or indirectly and on behalf of an insurer underwrites, collects charges or premiums from, or adjusts or settles claims on residents of Indiana in connection with life, annuity, or health coverage offered or provided by an insurer. The term "administrator" does not include the following persons:

(1) An employer or a wholly owned direct or indirect subsidiary of an employer acting on behalf of the employees of:

(A) the employer;

(B) the subsidiary; or

(C) an affiliated corporation of the employer.

(2) A union acting for its members.

(3) An insurer.

(4) An insurance producer:

(A) that is licensed under IC 27-1-15.6;

(B) that has:

(i) a life; or

(ii) an accident and health or sickness;

qualification under IC 27-1-15.6-7; and

(C) whose activities are limited exclusively to the sale of insurance.

(5) A creditor acting for its debtors regarding insurance covering a debt between them.

(6) A trust established under 29 U.S.C. 186 and the trustees, agents, and employees acting pursuant to that trust.

(7) A trust that is exempt from taxation under Section 501(a) of the Internal Revenue Code and:

(A) the trustees and employees acting pursuant to that trust; or

(B) a custodian and the agents and employees of the custodian acting pursuant to a custodian account that meets the requirements of Section 401(f) of the Internal Revenue Code.

(8) A financial institution that is subject to supervision or examination by federal or state banking authorities to the extent that the financial institution collects and remits premiums to an insurance producer or an authorized insurer in connection with a loan payment.

(9) A credit card issuing company that:

(A) advances for; and

(B) collects from, when a credit card holder authorizes the collection;

credit card holders of the credit card issuing company, insurance premiums or charges.

(10) A person that adjusts or settles claims in the normal course of the person's practice or employment as an attorney at law and that does not collect charges or premiums in connection with life, annuity, or health coverage.

(11) A health maintenance organization that has a certificate of authority issued under IC 27-13.

(12) A limited service health maintenance organization that has a certificate of authority issued under IC 27-13.

(13) A mortgage lender to the extent that the mortgage lender collects and remits premiums to an insurance producer or an authorized insurer in connection with a loan payment.

(14) A person that:

(A) is licensed as a managing general agent as required under IC 27-1-33; and

(B) acts exclusively within the scope of activities provided for under the license referred to in clause (A).

(15) A person that:

(A) directly or indirectly underwrites, collects charges or premiums from, or adjusts or settles claims on residents of Indiana in connection with life, annuity, or health coverage provided by an insurer;

(B) is affiliated with the insurer; and

(C) performs the duties specified in clause (A) only according to a contract between the person and the insurer for the direct and assumed life, annuity, or health coverage provided by the insurer.

(b) "Affiliate" means an entity or a person that:

(1) directly or indirectly through an intermediary controls or is controlled by; or

(2) is under common control with;

a specified entity or person.

(c) "Church plan" has the meaning set forth in IC 27-8-10-1.

(d) "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

(e) "Control" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, whether:

(1) through ownership of voting securities;

(2) by contract other than a commercial contract for goods or nonmanagement services; or

(3) otherwise;

unless the power is the result of an official position with the person or a corporate office held by the person. Control is presumed to exist if a person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing not less than ten percent (10%) of the voting securities of another person.

(f) "Covered individual" means an individual who is covered under a benefit program provided by an insurer.

(g) "Financial institution" means a bank, savings association, credit union, or any other institution regulated under IC 28 or federal law.

(h) "GAAP" refers to consistently applied United States generally accepted accounting principles.

(i) "Governmental plan" has the meaning set forth in IC 27-8-10-1.

(j) "Home state" means the District of Columbia or any state or territory of the United States in which an administrator is incorporated or maintains the administrator's principal place of business. If the place in which the administrator is incorporated or maintains the administrator's principal place of business is not governed by a law that is substantially similar to this chapter, the administrator's home state is another state:

(1) in which the administrator conducts the business of the administrator; and

(2) that the administrator declares is the administrator's home state.

(k) "Insurance producer" has the meaning set forth in IC 27-1-15.6-2.

(l) "Insurer" means:

(1) a person who obtains a certificate of authority under:

(A) IC 27-1-3-20;

(B) IC 27-13-3; or

(C) IC 27-13-34; or

(2) an employer that provides life, health, or annuity coverage in Indiana under a governmental plan or a church plan.

(m) "NAIC" refers to the National Association of Insurance Commissioners.

(n) "Negotiate" has the meaning set forth in IC 27-1-15.6-2.

(o) "Nonresident administrator" means a person that applies for or holds a license under section 12.2 of this chapter.

(p) "Person" has the meaning set forth in IC 27-1-15.6-2.

(q) "Sell" has the meaning set forth in IC 27-1-15.6-2.

(r) "Solicit" has the meaning set forth in IC 27-1-15.6-2.

(s) "Underwrite" refers to the:

(1) acceptance of a group application or an individual application for coverage of an individual in accordance with the written rules of the insurer; or

(2) planning and coordination of a benefit program provided by an insurer.

(t) "Uniform application" means the current version of the NAIC uniform application for third party administrators.

As added by Acts 1980, P.L.168, SEC.2. Amended by Acts 1982, P.L.165, SEC.1; P.L.26-1991, SEC.18; P.L.26-1994, SEC.10; P.L.2-1995, SEC.101; P.L.185-1996, SEC.9; P.L.79-1998, SEC.31;

P.L.207-1999, SEC.1 and P.L.255-1999, SEC.1; P.L.132-2001, SEC.7; P.L.160-2003, SEC.4; P.L.178-2003, SEC.27; P.L.97-2004, SEC.96; P.L.11-2011, SEC.18.

IC 27-1-25-2
Written agreements

Sec. 2. (a) An administrator may act only if there is a written agreement between the administrator and an insurer. This agreement must conform to the requirements of this chapter, which apply to the functions performed by the administrator.

(b) An agreement between an administrator and an insurer must be retained by both parties as part of their official records for a period of not less than five (5) years after the termination of the agreement.

(c) When a policy is issued to a trustee, a copy of the trust agreement and all amendments to it must be:

(1) furnished by the administrator to the insurer with which the administrator has a written agreement; and

(2) retained as part of the official records of the administrator for a period of not less than five (5) years after the termination of the trust.

(d) The written agreement required under subsection (a) must:

(1) include a statement of functions that the administrator will perform on behalf of the insurer;

(2) specify the lines, classes, or types of coverage that the administrator is authorized to administer on behalf of the insurer; and

(3) contain provisions concerning the standard of underwriting required by the insurer.

(e) The commissioner may require any written agreement executed by an administrator and an insurer to be filed with the department at the time the administrator applies for a license under this chapter. The commissioner may require any written agreement executed subsequent to the original issue of the license to the administrator to be filed with the department at the time the administrator is applying for renewal of the license.

(f) An administrator or insurer may, with written notice, terminate a written agreement for cause as provided in the written agreement. The insurer may suspend the underwriting authority of the administrator during the pendency of a dispute regarding the cause for termination of the written agreement. The insurer shall fulfill lawful obligations with respect to coverage affected by the written agreement, regardless of a dispute described in this subsection.

As added by Acts 1980, P.L.168, SEC.2. Amended by Acts 1982, P.L.165, SEC.2; P.L.160-2003, SEC.5.

IC 27-1-25-3
Presumptions as to payment of premiums and claims

Sec. 3. (a) If an insurer utilizes the services of an administrator:

(1) premiums or charges for coverage paid by or on behalf of the covered individual are considered to have been received by the insurer when paid to the administrator; and

(2) claims or return premiums paid by the insurer to the administrator are not considered to have been paid to the covered individual or claimant until the payment is received by the covered individual or claimant.

(b) This section does not limit the rights of an insurer against an administrator resulting from the failure of the administrator to make payments to the insurer, covered individuals, or claimants.

As added by Acts 1980, P.L.168, SEC.2. Amended by P.L.26-1991, SEC.19; P.L.160-2003, SEC.6.

IC 27-1-25-4

Books and records; maintenance; inspection; transfer; ownership; notice of material change; maintenance of bond

Sec. 4. (a) An administrator:

(1) shall maintain at its principal administrative office books and records of all transactions between the administrator and insurers for at least five (5) years after the creation of the books and records; or

(2) may transfer the books and records of transactions between the administrator and an insurer with which the administrator has entered into a written agreement under section 2 of this chapter to a new administrator if:

(A) the agreement between the administrator and the insurer is canceled; and

(B) a written agreement for a transfer of the books and records is made between the administrator and the insurer.

If the books and records are transferred to a new administrator under subdivision (2), the new administrator shall acknowledge in writing that the new administrator is responsible for retaining the books and records of the prior administrator as required under subdivision (1). The books and records must be maintained in accordance with generally accepted standards of insurance record keeping.

(b) The commissioner is entitled to inspect all books and records of the administrator for the purpose of examinations and audits. Trade secrets contained within those books and records, including the identity and addresses of policyholders and certificate holders, financial information concerning the administrator, and the business plan of the administrator, are to remain confidential. However, the commissioner may use that confidential information in proceedings instituted against the administrator.

(c) An insurer is the owner of records that:

(1) are generated by an administrator with which the insurer has entered into a written agreement under section 2 of this chapter; and

(2) pertain to the insurer.

However, the administrator retains the right to continuing access to books and records necessary to fulfill the administrator's contractual obligations to covered individuals, claimants, and the insurer.

(d) An administrator that is licensed under section 11.1 of this chapter shall make available for inspection by the commissioner copies of written agreements with insurers.

(e) An administrator that is licensed under section 11.1 of this chapter shall:

(1) produce the administrator's accounts, records, and files for examination; and

(2) make the administrator's officers available to provide information concerning the affairs of the administrator;

whenever reasonably required by the commissioner.

(f) An administrator that is licensed under section 11.1 of this chapter shall immediately notify the commissioner of a material change in:

(1) the ownership or control of the administrator; or

(2) another fact or circumstance that affects the administrator's qualification for a license.

The commissioner, upon receiving notice under this subsection, shall report the change to an electronic data base maintained by the NAIC or an affiliate or a subsidiary of the NAIC.

(g) An administrator that is licensed under section 11.1 of this chapter and that administers a governmental plan or a church plan shall maintain a bond:

(1) for the use and benefit of:

(A) the commissioner; and

(B) the insurance regulator of any state in which the administrator is authorized to conduct business; and

(2) that covers an individual and a person that has remitted premiums, insurance, charges, or other money to the administrator in the course of the administrator's business;

in an amount equal to the greater of one hundred thousand dollars ($100,000) or ten percent (10%) of the total of funds administered in connection with governmental plans or church plans in Indiana and all other states in which the administrator is authorized to conduct business.

As added by Acts 1980, P.L.168, SEC.2. Amended by Acts 1982, P.L.165, SEC.3; P.L.2-1995, SEC.102; P.L.160-2003, SEC.7.

IC 27-1-25-5

Advertising

Sec. 5. An administrator may use advertising relating to the business underwritten by an insurer only to the extent that the advertising has been approved in writing by that insurer before the advertising is used.

As added by Acts 1980, P.L.168, SEC.2. Amended by P.L.160-2003,

SEC.8.

IC 27-1-25-5.5
Insurer responsibilities

Sec. 5.5. (a) If an insurer uses the services of an administrator, the insurer is responsible for:

(1) determining the:

(A) benefits;

(B) premium rates;

(C) underwriting criteria; and

(D) claims payment procedures;

that apply to the coverage; and

(2) securing reinsurance.

(b) An insurer shall provide to an administrator, with the written agreement required under section 2 of this chapter:

(1) the rules that the administrator must follow in administering the coverage, as determined under subsection (a); and

(2) the responsibilities of the administrator as to administering the coverage.

(c) An insurer that uses the services of an administrator has sole responsibility for the competent administration of benefit programs provided by the insurer.

(d) If an administrator administers benefits for more than one hundred (100) covered individuals on behalf of an insurer, the insurer shall, not less than semiannually, review the operations of the administrator. At least one (1) of the semiannual reviews must be an onsite audit of the operations of the administrator.

As added by P.L.160-2003, SEC.9.

IC 27-1-25-6
Fiduciary status of administrator; fiduciary accounts

Sec. 6. (a) An administrator is a fiduciary in collecting or returning premiums or charges for the insurer with whom it has a written agreement for administrative services.

(b) Funds collected by the administrator shall be immediately remitted to the person entitled to the funds or deposited in a fiduciary account, which shall be established and maintained by the administrator in a federally insured or state insured financial institution.

(c) The administrator shall maintain records clearly showing the deposits and withdrawals from the fiduciary account for each insurer with whom it has a written agreement for administrative services. The administrator shall furnish to the insurer:

(1) upon the insurer's request, copies of the required records; and

(2) at intervals specified in the written agreement, a periodic accounting of transactions performed by the administrator pertaining to the business underwritten by the insurer.

(d) Subject to the written agreement required by section 2 of this chapter, withdrawals from the fiduciary account shall only be made for the following:

(1) Remittance to an insurer entitled to the funds.

(2) Deposit in an account maintained in the name of the insurer with whom the administrator has a written agreement.

(3) Transfer to and deposit in a claims paying account, with claims to be paid as required under section 7 of this chapter.

(4) Payment to a group policyholder for remittance to the insurer entitled to the funds.

(5) Payment to the administrator for its commission, fees, or charges.

(6) Remittance of return premiums to the person entitled to the funds.

(e) An administrator may not pay any claim with money withdrawn from a fiduciary account established under subsection (b) in which premiums or charges are deposited.

As added by Acts 1980, P.L.168, SEC.2. Amended by Acts 1982, P.L.165, SEC.4; P.L.26-1991, SEC.20; P.L.160-2003, SEC.10.

IC 27-1-25-7

Payment of claims

Sec. 7. All claims paid by an administrator from funds collected on behalf of an insurer shall only be paid on drafts or checks authorized by the insurer.

As added by Acts 1980, P.L.168, SEC.2. Amended by Acts 1982, P.L.165, SEC.5; P.L.160-2003, SEC.11.

IC 27-1-25-7.5

Repealed

(As added by P.L.207-1999, SEC.2 and P.L.255-1999, SEC.2. Repealed by P.L.11-2011, SEC.46.)

IC 27-1-25-8

Administrator compensation

Sec. 8. (a) An administrator may not enter into an agreement or understanding with an insurer if the effect of the agreement or understanding is to make the amount of a:

(1) commission;

(2) fee; or

(3) charge;

that is payable to the administrator contingent on savings effected in the adjustment, settlement, and payment of losses covered by the insurer's obligations.

(b) This section does not prevent an administrator from receiving performance based compensation for providing hospital auditing services or other auditing services.

As added by Acts 1980, P.L.168, SEC.2. Amended by P.L.26-1991,

SEC.21; P.L.160-2003, SEC.12.

IC 27-1-25-9
Delivery of written communications

Sec. 9. Policies, certificates, booklets, termination notices, or other written communications delivered by an insurer to an administrator for delivery to its covered individuals shall be delivered by the administrator promptly after receipt of instructions from the insurer to do so.

As added by Acts 1980, P.L.168, SEC.2. Amended by P.L.160-2003, SEC.13.

IC 27-1-25-10
Notice of relationship; statement of premiums or charges

Sec. 10. (a) An administrator having a written agreement with an insurer shall provide written notice, which must first be approved by the insurer, to covered persons advising them of the relationship among the administrator, the covered person, and the insurer.

(b) When the administrator collects premiums or charges, the administrator shall state separately the amount of any premium or charge for coverage specified by the insurer to the person paying the premium or charge. Additional charges may not be made for a service to the extent that the charge for the service has been paid by the insurer.

(c) The administrator shall disclose to the insurer:

(1) charges;
(2) fees; and
(3) commissions;

received by the administrator in connection with the provision of administrative services for the insurer, including fees or commissions paid by insurers that provide reinsurance.

As added by Acts 1980, P.L.168, SEC.2. Amended by Acts 1982, P.L.165, SEC.6; P.L.160-2003, SEC.14.

IC 27-1-25-11
Repealed

(As added by Acts 1980, P.L.168, SEC.2. Amended by P.L.267-1987, SEC.4; P.L.192-1991, SEC.1; P.L.26-1991, SEC.22; P.L.1-1992, SEC.146. Repealed by P.L.160-2003, SEC.28.)

IC 27-1-25-11.1
Resident administrator license; commissioner refusal to issue; fees; notice of material change; maintenance of bond

Sec. 11.1. (a) If the home state of a person is Indiana, the person shall:

(1) apply to act as an administrator in Indiana upon the uniform application;
(2) pay an application fee in an amount determined by the

commissioner; and

(3) receive a license from the commissioner;

before performing the function of an administrator in Indiana. The commissioner shall deposit a fee paid under subdivision (2) into the department of insurance fund established by IC 27-1-3-28.

(b) The uniform application must include or be accompanied by the following:

(1) Basic organizational documents of the applicant, including:

(A) articles of incorporation;

(B) articles of association;

(C) partnership agreement;

(D) trade name certificate;

(E) trust agreement;

(F) shareholder agreement;

(G) other applicable documents; and

(H) amendments to the documents specified in clauses (A) through (G).

(2) Bylaws, rules, regulations, or other documents that regulate the internal affairs of the applicant.

(3) The NAIC biographical affidavits for individuals who are responsible for the conduct of affairs of the applicant, including:

(A) members of the applicant's:

(i) board of directors;

(ii) board of trustees;

(iii) executive committee; or

(iv) other governing board or committee;

(B) principal officers, if the applicant is a corporation;

(C) partners or members, if the applicant is:

(i) a partnership;

(ii) an association; or

(iii) a limited liability company;

(D) shareholders or members that hold, directly or indirectly, at least ten percent (10%) of the:

(i) voting stock;

(ii) voting securities; or

(iii) voting interest;

of the applicant; and

(E) any other person who exercises control or influence over the affairs of the applicant.

(4) Financial information reflecting a positive net worth, including:

(A) audited annual financial statements prepared by an independent certified public accountant for the two (2) most recent fiscal years; or

(B) if the applicant has been in business for less than two (2) fiscal years, financial statements or reports that are:

(i) prepared in accordance with GAAP; and

(ii) certified by an officer of the applicant;

for any completed fiscal years and for any month during the current fiscal year for which financial statements or reports have been completed.

If an audited financial statement or report required under clause (A) or (B) is prepared on a consolidated basis, the statement or report must include a columnar consolidating or combining worksheet that includes the amounts shown on the consolidated audited financial statement or report, separately reported on the worksheet for each entity included on the statement or report, and an explanation of consolidating and eliminating entries.

(5) Information determined by the commissioner to be necessary for a review of the current financial condition of the applicant.

(6) A description of the business plan of the applicant, including:

(A) information on staffing levels and activities proposed in Indiana and nationwide; and

(B) details concerning the applicant's ability to provide a sufficient number of experienced and qualified personnel for:

(i) claims processing;

(ii) record keeping; and

(iii) underwriting.

(7) Any other information required by the commissioner.

(c) An administrator that applies for licensure under this section shall make copies of written agreements with insurers available for inspection by the commissioner.

(d) An administrator that applies for licensure under this section shall:

(1) produce the administrator's accounts, records, and files for examination; and

(2) make the administrator's officers available to provide information concerning the affairs of the administrator;

whenever reasonably required by the commissioner.

(e) The commissioner may refuse to issue a license under this section if the commissioner determines that:

(1) the administrator or an individual who is responsible for the conduct of the affairs of the administrator:

(A) is not:

(i) competent;

(ii) trustworthy;

(iii) financially responsible; or

(iv) of good personal and business reputation; or

(B) has had an:

(i) insurance certificate of authority or insurance license; or

(ii) administrator certificate of authority or administrator

license;
denied or revoked for cause by any jurisdiction;
(2) the financial information provided under subsection (b)(4) does not reflect that the applicant has a positive net worth; or
(3) any of the grounds set forth in section 12.4 of this chapter exists with respect to the administrator.

(f) An administrator that applies for a license under this section shall immediately notify the commissioner of a material change in:
(1) the ownership or control of the administrator; or
(2) another fact or circumstance that affects the administrator's qualification for a license.

The commissioner, upon receiving notice under this subsection, shall report the change to an electronic data base maintained by the NAIC or an affiliate or a subsidiary of the NAIC.

(g) An administrator that applies for a license under this section and will administer a governmental plan or a church plan shall obtain a bond as required under section 4(g) of this chapter.

(h) A license that is issued under this section is valid:
(1) for one (1) year after the date of issuance, unless subdivision (2) applies; or
(2) until:
(A) the license is:
(i) surrendered; or
(ii) suspended or revoked by the commissioner; or
(B) the administrator:
(i) ceases to do business in Indiana; or
(ii) is not in compliance with this chapter.

As added by P.L.160-2003, SEC.15. Amended by P.L.11-2011, SEC.19.

IC 27-1-25-12
Repealed

(As added by Acts 1980, P.L.168, SEC.2. Amended by P.L.26-1991, SEC.23. Repealed by P.L.160-2003, SEC.28.)

IC 27-1-25-12.2
Nonresident administrator license; commissioner refusal to issue license or delay of issuance; fees

Sec. 12.2. (a) An administrator that:
(1) performs the duties of an administrator in Indiana; and
(2) does not hold a license issued under section 11.1 of this chapter;

shall obtain a nonresident administrator license under this section by filing a uniform application, accompanied by an application fee in an amount determined by the commissioner, with the commissioner. The commissioner shall deposit a fee paid under this subsection into the department of insurance fund established by IC 27-1-3-28.

(b) Unless the commissioner verifies the nonresident

administrator's home state license status through an electronic data base maintained by the NAIC or by an affiliate or a subsidiary of the NAIC, a uniform application filed under subsection (a) must be accompanied by a letter of certification from the nonresident administrator's home state, verifying that the nonresident administrator holds a resident administrator license in the home state.

(c) A nonresident administrator is not eligible for a nonresident administrator license under this section unless the nonresident administrator is licensed as a resident administrator in a home state that has a law or regulation that is substantially similar to this chapter.

(d) Except as provided in subsections (b) and (h), the commissioner shall issue a nonresident administrator license to a nonresident administrator that makes a filing under subsections (a) and (b) upon receipt of the filing.

(e) Unless a nonresident administrator is notified by the commissioner that the commissioner is able to verify the nonresident administrator's home state licensure through an electronic data base described in subsection (b), the nonresident administrator shall:

(1) on September 15 of each year, file a renewal application and a statement with the commissioner affirming that the nonresident administrator maintains a current license in the nonresident administrator's home state; and

(2) pay to the commissioner a filing fee in an amount determined by the commissioner.

The commissioner shall deposit a filing fee paid under subdivision (2) into the department of insurance fund established by IC 27-1-3-28.

(f) A nonresident administrator that applies for licensure under this section shall:

(1) produce the accounts of the nonresident administrator;

(2) produce the records and files of the nonresident administrator for examination; and

(3) make the officers of the nonresident administrator available to provide information with respect to the affairs of the nonresident administrator;

when reasonably required by the commissioner.

(g) A nonresident administrator is not required to hold a nonresident administrator license in Indiana if the nonresident administrator's function in Indiana is limited to the administration of life, health, or annuity coverage for a total of not more than one hundred (100) Indiana residents.

(h) The commissioner may refuse to issue or may delay the issuance of a nonresident administrator license if the commissioner determines that:

(1) due to events occurring; or

(2) based on information obtained;

after the nonresident administrator's home state's licensure of the

nonresident administrator, the nonresident administrator is unable to comply with this chapter or grounds exist for the home state's revocation or suspension of the nonresident administrator's home state license.

(i) If the commissioner makes a determination described in subsection (h), the commissioner:

(1) shall provide written notice of the determination to the insurance regulator of the nonresident administrator's home state; and

(2) may delay the issuance of a nonresident administrator license to the nonresident administrator until the commissioner determines that the nonresident administrator is able to comply with this chapter and that grounds do not exist for the home state's revocation or suspension of the nonresident administrator's home state license.

As added by P.L.160-2003, SEC.16. Amended by P.L.173-2007, SEC.17; P.L.234-2007, SEC.191; P.L.11-2011, SEC.20.

IC 27-1-25-12.3

Resident administrator annual filings

Sec. 12.3. (a) An administrator that is licensed under section 11.1 of this chapter shall, not later than July 1 of each year unless the commissioner grants an extension of time for good cause, file a report for the previous calendar year that complies with the following:

(1) The report must contain financial information reflecting a positive net worth prepared in accordance with section 11.1(b)(4) of this chapter.

(2) The report must be in the form and contain matters prescribed by the commissioner.

(3) The report must be verified by at least two (2) officers of the administrator.

(4) The report must include the complete names and addresses of insurers with which the administrator had a written agreement during the preceding fiscal year.

(5) The report must be accompanied by a filing fee in an amount determined by the commissioner.

The commissioner shall collect a filing fee paid under subdivision (5) and deposit the fee into the department of insurance fund established by IC 27-1-3-28.

(b) The commissioner shall review a report filed under subsection (a) not later than September 1 of the year in which the report is filed. Upon completion of the review, the commissioner shall:

(1) issue a certification to the administrator:

(A) indicating that:

(i) the financial statement reflects a positive net worth; and

(ii) the administrator is currently licensed and in good standing; or

(B) noting deficiencies found in the report; or

(2) update an electronic data base that is maintained by the NAIC or by an affiliate or a subsidiary of the NAIC:

(A) indicating that the administrator is solvent and in compliance with this chapter; or

(B) noting deficiencies found in the report.

As added by P.L.160-2003, SEC.17. Amended by P.L.173-2007, SEC.18; P.L.234-2007, SEC.192; P.L.11-2011, SEC.21.

IC 27-1-25-12.4

Denial, suspension, or revocation of administrator license

Sec. 12.4. (a) The commissioner shall deny, suspend, or revoke a license issued under this chapter if the commissioner determines that the administrator:

(1) is in unsound financial condition;

(2) engages in methods or practices in the conduct of the administrator's business so as to render the administrator's continued transaction of business in Indiana hazardous or injurious to covered persons or the public; or

(3) fails to pay a judgment rendered against the administrator in Indiana not more than sixty (60) days after the judgment is final and all appeals have been exhausted.

(b) The commissioner may deny, suspend, or revoke a license issued under this chapter if the commissioner determines that:

(1) the administrator has violated a lawful rule or order of the commissioner or a provision of the insurance laws of Indiana;

(2) the administrator refuses to be examined or to produce the administrator's accounts, records, and files for examination;

(3) an individual who is responsible for the conduct of the affairs of the administrator, including:

(A) a member of the administrator's:

(i) board of directors;

(ii) board of trustees;

(iii) executive committee; or

(iv) other governing board or committee;

(B) a principal officer, if the administrator is a corporation;

(C) a partner or member, if the administrator is:

(i) a partnership;

(ii) an association; or

(iii) a limited liability company;

(D) a shareholder or member that holds, directly or indirectly, ten percent (10%) or more of the:

(i) voting stock;

(ii) voting securities; or

(iii) voting interest;

of the administrator; or

(E) any other person who exercises control or influence over the affairs of the administrator;

refuses to provide information with respect to the administrator's business or to perform another legal obligation with respect to an examination when required by the commissioner;

(4) the administrator, without just cause:

(A) refuses to pay proper claims or to perform services arising under a written agreement;

(B) causes a covered individual to accept less than the amount due to the covered individual; or

(C) causes a covered individual to employ an attorney or bring suit against the administrator to secure full payment or settlement of a proper claim;

(5) the administrator fails to meet a qualification for which issuance of the administrator's license could have been refused if the failure had existed and been known by the commissioner at the time of license issuance;

(6) an individual who is responsible for the conduct of the affairs of the administrator, including:

(A) a member of the administrator's:

(i) board of directors;

(ii) board of trustees;

(iii) executive committee; or

(iv) other governing board or committee;

(B) a principal officer, if the administrator is a corporation;

(C) a partner or member, if the administrator is:

(i) a partnership;

(ii) an association; or

(iii) a limited liability company;

(D) a shareholder or member that holds, directly or indirectly, ten percent (10%) or more of the:

(i) voting stock;

(ii) voting securities; or

(iii) voting interest;

of the administrator; or

(E) any other person who exercises control or influence over the affairs of the administrator;

is convicted of or enters a plea of guilty or nolo contendere to a felony, without regard to whether adjudication is withheld;

(7) the administrator's license has been suspended or revoked in another state; or

(8) the administrator fails to timely file the:

(A) report required under section 12.3 of this chapter; or

(B) statement and pay the filing fee required under section 12.2(e) of this chapter.

(c) The commissioner may, in the commissioner's discretion and without advance notice or hearing, immediately suspend the license of an administrator if the commissioner finds one (1) or more of the following:

(1) The administrator is insolvent or financially impaired.

(2) A proceeding for receivership, conservatorship, rehabilitation, or other delinquency proceeding regarding the administrator has been commenced in any state.

(3) The financial condition or business practices of the administrator pose an imminent threat to the public health, safety, or welfare of residents of Indiana.

(d) If the commissioner determines that cause exists for the suspension or revocation of a license issued under this chapter, the commissioner may, instead of suspension or revocation, impose a civil penalty not to exceed twenty-five thousand dollars ($25,000) per act or violation upon the administrator. A civil penalty imposed under this subsection may be enforced in the same manner as a civil judgment. Civil penalties collected under this subsection shall be deposited in the state general fund.

As added by P.L.160-2003, SEC.18.

IC 27-1-25-13

Public documents; confidentiality; financial information

Sec. 13. (a) Except as provided by section 4(b) of this chapter, and except that all provisions of the written agreement between the administrator and an insurer shall be treated by the commissioner as confidential and shall not be open to any member of the public for inspection or copying, all documents submitted to the commissioner under this chapter are public documents:

(1) when filed by the commissioner; or

(2) thirty (30) days after their receipt by the department.

(b) Any financial information concerning an administrator submitted by an administrator to the commissioner must remain confidential and is not open to any member of the public for inspection or copying. However, the commissioner may use the financial information in a proceeding under section 12.4 of this chapter.

As added by Acts 1980, P.L.168, SEC.2. Amended by Acts 1982, P.L.165, SEC.7; P.L.192-1991, SEC.2; P.L.160-2003, SEC.19.

IC 27-1-25-14

Regulations

Sec. 14. The commissioner may, under IC 4-22-2, adopt regulations necessary to implement this chapter.

As added by Acts 1980, P.L.168, SEC.2.

IC 27-1-25-15

Violations; offense; notice

Sec. 15. (a) An administrator acting without a license issued under this chapter commits a Class C infraction.

(b) The commissioner shall notify the prosecuting attorney or the attorney general of Indiana of violations under subsection (a).

As added by Acts 1980, P.L.168, SEC.2. Amended by P.L.160-2003, SEC.20.

IC 27-1-25-16
Presumption of control

Sec. 16. (a) A presumption of control arising under section 1(e) of this chapter may be rebutted by a showing made in the manner provided under IC 27-1-23-3(k) that control does not exist in fact.

(b) In the absence of a presumption that control exists in fact, the commissioner may determine that control exists in fact after:

(1) providing notice and an opportunity to be heard under IC 4-21.5 to all interested parties; and

(2) making specific findings of fact to support the determination.

As added by P.L.160-2003, SEC.21.

IC 27-1-25.1

Chapter 25.1. Certain Insurer Responsibilities

IC 27-1-25.1-1

"Affiliate"

Sec. 1. As used in this chapter, "affiliate" has the meaning set forth in IC 27-1-25-1(b).

As added by P.L.160-2003, SEC.22.

IC 27-1-25.1-2

"Insurer"

Sec. 2. As used in this chapter, "insurer" has the meaning set forth in IC 27-1-25-1(l).

As added by P.L.160-2003, SEC.22.

IC 27-1-25.1-3

"Person"

Sec. 3. As used in this chapter, "person" refers to a person described in IC 27-1-25-1(a)(15).

As added by P.L.160-2003, SEC.22.

IC 27-1-25.1-4

Insurer responsibility for actions of affiliate

Sec. 4. The insurer with which a person is affiliated is responsible for:

(1) the acts of the person; and

(2) providing the person's books and records to the commissioner.

As added by P.L.160-2003, SEC.22.

IC 27-1-26

Chapter 26. Policy Language Simplification

IC 27-1-26-1

Definitions

Sec. 1. As used in this chapter:

(a) "Commissioner" refers to the insurance commissioner.

(b) "Company" or "insurer" means a life or health insurance company, fraternal benefit society, prepaid health plan, dental care plan, vision care plan, pharmaceutical plan, health maintenance organization, and all similar type organizations.

(c) "Department" refers to the insurance department.

(d) "Policy" or "policy form" means:

(1) Any policy, contract, plan, or agreement of life or health insurance, including credit life insurance and credit health insurance, to be issued in Indiana by a company subject to this chapter.

(2) Any certificate, contract, or policy issued by a fraternal benefit society.

(3) Any certificate issued under a group insurance policy to be issued for delivery in Indiana.

(e) "Text" means all printed matter except the following:

(1) The name and address of the insurer.

(2) The name, number, or title of the policy.

(3) The table of contents or index.

(4) Captions and subcaptions.

(5) Specification pages.

(6) Schedules or tables.

(7) Language that is drafted to conform to the requirements of federal law, regulation, or federal agency interpretation.

(8) Language required by a collectively bargained agreement.

(9) Medical terminology.

(10) Words that are defined in the policy.

As added by Acts 1981, P.L.245, SEC.1.

IC 27-1-26-2

Policies and forms not subject to chapter

Sec. 2. (a) This chapter does not apply to:

(1) A policy that is security subject to federal jurisdiction.

(2) A group policy, other than a group credit life insurance policy or a group credit health insurance policy.

(3) A group annuity contract that serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans.

(4) A form used in connection with a policy issued for delivery on a form approved or permitted to be issued for delivery in Indiana.

As added by Acts 1981, P.L.245, SEC.1.

IC 27-1-26-3
Minimum requirements

Sec. 3. Except as otherwise provided in this chapter, a policy issued for delivery in Indiana must meet the following minimum requirements:

(1) The text achieves a minimum score of forty (40) on the Flesch reading ease test or an equivalent score on a comparable test approved by the commissioner as provided by section 6 of this chapter.

(2) It is printed, except for specification pages, schedules, and tables, in not less than ten (10) point type, one (1) point leaded.

(3) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders.

(4) It must contain a table of contents or an index of the principal sections of the policy if:

(A) the policy has three thousand (3,000) or more words; or

(B) the policy has three (3) or more pages.

As added by Acts 1981, P.L.245, SEC.1.

IC 27-1-26-4
Non-English language policies

Sec. 4. A non-English language policy that is issued for delivery in Indiana is in compliance with this chapter if the insurer issuing the policy certifies that the policy if translated into English would comply with section 3 of this chapter.

As added by Acts 1981, P.L.245, SEC.1.

IC 27-1-26-5
Flesch reading ease score; procedure to determine; rules of construction

Sec. 5. (a) The following procedure shall be used in determining the Flesch reading ease score:

(1) First, a sample of the text of the policy shall be chosen for analysis:

(A) For policy forms containing ten thousand (10,000) or less words of text, the entire policy form shall be analyzed.

(B) For policy forms containing ten thousand and one (10,001) or more words of text, two (2) samples of two hundred (200) words from each page, with each sample separated by at least twenty (20) lines, may be analyzed instead of the entire form.

(2) Second, the number of words and sentences in the text shall be counted and the total number of words shall be divided by the total number of sentences. The figure obtained shall be multiplied by a factor of one and fifteen thousandths (1.015).

(3) Third, the total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of eighty-four and six tenths (84.6).

(4) Fourth, the sum of the figures computed under subdivisions (2) and (3) when subtracted from two hundred six and eight hundred thirty-five thousandths (206.835) equals the Flesch reading ease score for the policy form.

(b) For the purposes of subsections (a)(2) through (4), the following rules of construction shall be used:

(1) A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be treated as one (1) word.

(2) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence.

(3) The term "syllable" means a unit of spoken language consisting of one (1) or more letters of a word as divided by a dictionary approved by the commissioner.

(4) When a dictionary approved by the commissioner shows two (2) or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

As added by Acts 1981, P.L.245, SEC.1.

IC 27-1-26-6

Reading ease; alternative tests

Sec. 6. The commissioner may approve the use of any other reading ease test as an alternative to the Flesch reading ease test if it is comparable in result to the Flesch reading ease test.

As added by Acts 1981, P.L.245, SEC.1.

IC 27-1-26-7

Certificate of insurer to accompany policy filed with department; contents; additional information

Sec. 7. (a) A policy filed with the department must be accompanied by a certificate signed by an officer of the insurer stating that:

(1) the policy meets the minimum reading ease score on the test used; or

(2) the score for the policy is lower than the minimum required but should be approved in accordance with section 9 of this chapter.

(b) To confirm the accuracy of a certification under subsection (a), the commissioner may require the submission of additional information to verify the certification.

As added by Acts 1981, P.L.245, SEC.1.

IC 27-1-26-8

Separate test scores permitted for riders, endorsements, applications, and other forms

Sec. 8. At the option of an insurer, riders, endorsements, applications, and other forms made a part of the policy may be scored separately.

As added by Acts 1981, P.L.245, SEC.1.

IC 27-1-26-9
Policies with failing scores; issuance for delivery authorized upon certain findings

Sec. 9. The commissioner may authorize a policy to be issued for delivery in Indiana with a score lower than the score required by section 3 of this chapter if he finds that the lower score:

(1) will provide a more accurate reflection of the readability of a policy form;

(2) is necessary because of the nature of a particular policy form or type or class of policy forms; or

(3) is caused by policy language that is drafted to conform to the requirements of Indiana law, regulation, or agency interpretation.

As added by Acts 1981, P.L.245, SEC.1.

IC 27-1-26-10
Compliance with other laws

Sec. 10. A policy form meeting the requirements of this chapter shall be approved notwithstanding the requirements of any other law that specifies the contents of policies, only if the policy form provides the policyholders and claimants with protection as favorable as they are entitled to under that law.

As added by Acts 1981, P.L.245, SEC.1.

IC 27-1-26-11
Regulations

Sec. 11. The commissioner may adopt regulations under IC 4-22-2 necessary to administer this chapter.

As added by Acts 1981, P.L.245, SEC.1.

IC 27-1-26-12
Application of chapter

Sec. 12. This chapter applies to all policy forms filed after June 30, 1982. A policy may not be issued for delivery in Indiana after June 30, 1985, unless approved by the commissioner or permitted to be issued under this chapter. A policy that has been approved or permitted to be issued under this chapter before July 1, 1985, and that meets the standards of this chapter does not need to be refiled for approval on July 1, 1985, but may continue being issued in Indiana upon filing with the commissioner a list of those forms, identified by form number, and accompanied by a certificate for each form as provided by section 7 of this chapter.

As added by Acts 1981, P.L.245, SEC.1.

IC 27-1-27

Chapter 27. Public Adjusters

IC 27-1-27-1

"Public adjuster" defined

Sec. 1. (a) The term "public adjuster" shall include every individual or corporation who, or which, for compensation or reward, renders advice or assistance to the insured in the adjustment of a claim or claims for loss or damages under any policy of insurance covering real or personal property and any person or corporation who, or which, advertises, solicits business, or holds itself out to the public as an adjuster of such claims. However, no public adjuster shall:

(1) act in any manner in relation to claims for personal injury or automobile property damage; or

(2) bind the insured in the settlement of claims.

(b) This chapter does not apply to, and the following are not included in the term "public adjuster":

(1) An attorney at law admitted to practice in the state of Indiana who adjusts insurance losses in the course of the practice of the attorney's profession.

(2) An officer, regular salaried employee, or other representative of an insurer or of an attorney in fact of any reciprocal insurer of Lloyd's underwriter licensed to do business in Indiana who adjusts losses arising under an employer's or principal's own policies.

(3) An adjustment bureau or association owned and maintained by insurers to adjust or investigate losses of such insurers, or any regular salaried employee who devotes substantially all the employee's time to the business of such bureau or association.

(4) Any licensed insurance producer or an authorized insurer or officer or employee of the same who adjusts losses for such insurer, and any insurance producer or representative of a farm mutual insurance company operating under the farm mutual insurance laws of this state on behalf of an insurer.

(5) Any independent adjuster representing an insurer.

As added by P.L.257-1983, SEC.1. Amended by P.L.129-2003, SEC.6; P.L.178-2003, SEC.28.

IC 27-1-27-2

Certification requirement

Sec. 2. (a) No individual or corporation shall act within Indiana as a public adjuster, or receive, directly or indirectly, compensation or reward for services rendered in the adjustment of any claim or claims under the types of insurance policies set forth in section 1(a) of this chapter, unless he, or it, is the holder of a certificate of authority to act as such public adjuster issued by the commissioner of insurance of the state of Indiana pursuant to this chapter.

(b) Any individual or corporation who, or which, shall have received from the commissioner of insurance a public adjuster's certificate of authority shall be styled and be known as a "Certified Public Adjuster".
As added by P.L.257-1983, SEC.1.

IC 27-1-27-3
Certificates of authority; issuance; prerequisites

Sec. 3. (a) The commissioner of insurance shall issue resident and nonresident public adjusters' certificates of authority to each person who:

(1) has complied with the requirements of this chapter, including the payment of fees, the completion of the examination, and, in the case of a nonresident applicant, the service of process designation;
(2) is at least eighteen (18) years of age; and
(3) has not been convicted of:
(A) an act which would constitute a ground for disciplinary sanction under section 7.1 of this chapter; or
(B) a felony that has a direct bearing on his ability to practice competently.

A certificate of authority may be issued to a corporation that has one (1) or more officers, directors, or employees who have been issued public adjusters' certificates of authority. However, a corporation may practice public adjusting only through its officers, directors, or employees who have been issued certificates under this chapter.

(b) The commissioner of insurance may issue a resident certificate of authority only to an applicant who is a bona fide resident of Indiana.

(c) The commissioner may issue a nonresident certificate of authority only to a nonresident of Indiana who holds an equivalent resident certificate of authority or a license issued under the laws of any other state, any territorial possession of the United States, or any foreign country.
As added by P.L.257-1983, SEC.1. Amended by P.L.146-2015, SEC.25.

IC 27-1-27-4
Certificates of authority; application; renewal; surety bond

Sec. 4. (a) Each applicant for a certificate of authority as a public adjuster shall file with the commissioner of insurance an application therefor on forms furnished by the commissioner of insurance, which application shall set forth:

(1) the name and address of the applicant, and if the applicant be a corporation, the name and address of each of its officers and directors;
(2) whether the person is applying as a resident or nonresident;
(3) whether any license or certificate of authority as insurance

producer, broker, public adjuster, or independent adjuster has been issued previously by the commissioner of insurance of the state of Indiana or by the insurance department of any other state, any territorial possession of the United States, or any foreign country to the applicant; and

(4) the business or employment in which the applicant has been engaged for the five (5) years next preceding the date of the application, and the name and address of such business and the name or names and addresses of the applicant's employer or employers.

(b) An application for any certificate of authority must be signed and verified under oath by the applicant.

(c) An annual fee of fifty dollars ($50) is to be paid to the commissioner of insurance by the applicant for such public adjuster's certificate of authority before the application or annual renewal thereof is granted. However, the commissioner may, by rule adopted under IC 4-22-2, change the amount of the fee to an amount necessary to pay all of the direct and indirect costs of administering this chapter. Fees collected shall be used by the department to administer this chapter.

(d) Every public adjuster's certificate of authority shall expire on December 31 of the calendar year in which the same shall have been issued, but if an application for the renewal of such certificate shall have been filed with the commissioner of insurance before January 1 of any year, the certificate of authority sought to be renewed shall continue in full force and effect until the issuance by the commissioner of insurance of the new certificate applied for or until five (5) days after the commissioner of insurance shall have refused to issue such new certificate and shall have served notice of such refusal on the applicant therefor. Service of such notice shall be made by registered mail directed to the applicant at the place of business specified in the application.

(e) The applicant shall file with the commissioner of insurance a surety bond in a sum equal to ten thousand dollars ($10,000) payable to the state of Indiana and conditioned on the principal's faithful performance and discharge of the principal's duties under this title and under any rule of the department of insurance. The bond must be renewed annually.

As added by P.L.257-1983, SEC.1. Amended by P.L.178-2003, SEC.29.

IC 27-1-27-5

Nonresident applicants; service of process designation

Sec. 5. (a) The commissioner may not issue a certificate of authority to a nonresident applicant until that nonresident files with the commissioner, in a form prescribed by the commissioner, a designation of an individual resident of Indiana, a corporate resident of Indiana, or an authorized Indiana insurer as the nonresident

applicant's legal representative upon whom may be served all lawful process in any action, suit, or proceeding:

(1) instituted by or on behalf of an interested person; and

(2) arising out of the nonresident applicant's public adjuster's insurance business.

(b) The designation required by subsection (a) constitutes an agreement that service of process upon the nonresident applicant's legal representative is of the same legal force and validity as personal service of process upon an Indiana resident.

(c) Service upon a nonresident may be made by serving the nonresident applicant's legal representative with an appropriate number of copies of the process.

(d) The nonresident applicant's legal representative shall forward a copy of the process by registered mail to the nonresident at his last known address of record or principal place of business, keeping a record of such process and service.

(e) Service of process is sufficient as long as notice of the service and a copy of the process are sent not more than ten (10) days after the nonresident applicant's legal representative received the service of process on behalf of the nonresident.

(f) Service of process upon a nonresident in any action instituted by the commissioner under this chapter shall be made by the commissioner by mailing the process to the nonresident applicant's legal representative or the nonresident by registered mail at his last known address of record or principal place of business.

As added by P.L.257-1983, SEC.1. Amended by P.L.31-1988, SEC.15; P.L.130-1994, SEC.33; P.L.116-1994, SEC.43; P.L.268-1999, SEC.14.

IC 27-1-27-6

Examination requirement; exception

Sec. 6. (a) The commissioner of insurance shall, in order to determine the competency of an applicant for a certificate of authority to act as a public adjuster, require such applicant to submit to a written examination, except such applicants who shall be entitled to such certificate without the examination as provided in this chapter. Such examinations shall be held in such place in the state of Indiana and at such time as the commissioner of insurance may designate. The examination as described in this section shall include such questions which, at the discretion of the commissioner, will properly test the applicant's knowledge and competency to engage in the adjustment of claims of an insured to include, but not be limited to the following areas:

(1) The Indiana insurance law, IC 27.

(2) Inventory and appraisal procedures.

(3) Building construction.

(4) Standard fire policy.

(5) Insurance contracts related to claims on real or personal

property.

(6) Insurance coverage questions regarding business interruption, improvements and betterments, replacement cost coverage, concurrent and noncurrent apportionment, coinsurance, and contribution.

(b) The commissioner of insurance may issue a public adjuster's certificate of authority without examination to any individual or corporation who, or which, has transacted the business of adjusting, as a public adjuster, losses covered by policies of insurance within Indiana as his or its principal occupation or business for a period of at least one (1) year immediately preceding the date of application for such certificate of authority, and who, or which, the commissioner determines to be competent to act as a public adjuster. Examination shall not be required for an applicant for renewal of a certificate of authority in effect at the date the application for renewal thereof is filed.

As added by P.L.257-1983, SEC.1.

IC 27-1-27-7

Repealed

(As added by P.L.257-1983, SEC.1. Amended by P.L.7-1987, SEC.142. Repealed by P.L.146-2015, SEC.26.)

IC 27-1-27-7.1

Violations; penalties; notice and hearing

Sec. 7.1. (a) The commissioner may suspend, revoke, or refuse to issue or renew a public adjuster's certificate of authority to act as a public adjuster in Indiana, or place a public adjuster on probation, for a cause set forth in subsection (b).

(b) A public adjuster is subject to the penalties set forth in subsection (a) for any of the following:

(1) Providing incorrect, misleading, incomplete, or materially untrue information in an application for a certificate of authority.

(2) Violating an insurance law, a subpoena, or an order of the commissioner or another state's insurance commissioner.

(3) Obtaining or attempting to obtain a certificate of authority through misrepresentation or fraud.

(4) Improperly withholding, misappropriating, or converting money or property received in the course of doing insurance business.

(5) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance.

(6) Having been convicted of a felony.

(7) Having admitted or been found to have committed any unfair trade practice or fraud in the business of insurance.

(8) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness, or financial

irresponsibility, in the conduct of insurance business.

(9) Having an insurance license, or the equivalent of an insurance license, probated, suspended, revoked, or refused in another state, province, district, or territory.

(10) Forging another person's name to a document related to an insurance transaction.

(11) Cheating, including improperly using notes or any other reference material, to complete an examination for an insurance license.

(12) Failing to comply with an administrative or court order imposing a child support obligation.

(13) Failing to pay state income tax or failing to comply with an administrative or court order directing payment of state income tax.

(c) If the commissioner refuses an application for a certificate of authority to act as a public adjuster or for the renewal of an existing certificate of authority under this chapter, the commissioner shall notify the applicant or certificate holder in writing, advising of the reason for the refusal. The applicant or certificate holder may, not more than thirty (30) days after receiving the commissioner's notice of refusal, make written demand upon the commissioner for a hearing to determine the reasonableness of the refusal. The hearing must be held under IC 4-21.5 not more than twenty (20) days after the commissioner receives the applicant's or certificate holder's written demand.

As added by P.L.146-2015, SEC.27.

IC 27-1-27-7.2

Nonresident public adjuster certificate of authority

Sec. 7.2. (a) Notwithstanding any other provision of this chapter, a nonresident public adjuster who receives a certificate of authority under this chapter shall maintain licensure as a public adjuster in good standing in the nonresident public adjuster's home state.

(b) If a nonresident public adjuster fails to maintain licensure in good standing in the nonresident public adjuster's home state, the commissioner may:

(1) in the commissioner's sole discretion;

(2) without a hearing; and

(3) in addition to any other sanction allowed by law;

suspend any Indiana insurance producer license or certificate of authority held by the nonresident public adjuster until the commissioner receives notice from the nonresident public adjuster's home state that the home state license is in effect.

As added by P.L.72-2016, SEC.16.

IC 27-1-27-8

Professional standards; adoption

Sec. 8. The commissioner of insurance shall, in the manner

prescribed by IC 4-22-2, adopt standards for the competent practice of public adjusting appropriate to establish and maintain a high standard of integrity and dignity in the profession of public adjusting.
As added by P.L.257-1983, SEC.1.

IC 27-1-27-9
Practice of law prohibited

Sec. 9. A public adjuster may not:

(1) engage in the practice of law;

(2) deal directly with any claimant represented by an attorney at law without the consent of the attorney;

(3) advise a claimant to refrain from seeking legal advice or retaining counsel; or

(4) in the case where legal counsel is desired by claimants, advise the retention of specific attorneys or law firms.

As added by P.L.257-1983, SEC.1.

IC 27-1-27-10
Validity of resident certificates of authority

Sec. 10. A resident certificate of authority issued to a person claiming residency is void if that person:

(1) holds a resident certificate of authority issued by another state;

(2) makes application for a resident certificate of authority from another state; or

(3) ceases to be a resident of Indiana.

As added by P.L.257-1983, SEC.1.

IC 27-1-27-11
Violations

Sec. 11. (a) A person who adjusts an insurance loss without having obtained the required certificate of authority or who adjusts an insurance loss after his certificate of authority has been cancelled, suspended, or revoked by the commissioner of insurance commits a Class B infraction.

(b) A person who makes any false statement pertaining to any matter or thing required by this chapter to be made commits a Class B infraction.

(c) A contract or agreement for compensation or services made between any insured and a public adjuster for any loss suffered by the insured which occurred in Indiana is void unless the public adjuster, at the time of the making of the contract or agreement, has a certificate of authority issued by the commissioner of insurance under this chapter.

(d) This section does not limit the authority of the commissioner of insurance to suspend, revoke, place on probation, or refuse to issue a certificate of authority.

As added by P.L.257-1983, SEC.1.

IC 27-1-28

Chapter 28. Independent Adjuster Licensing

IC 27-1-28-1

Governance

Sec. 1. This chapter governs the qualifications and procedure for the licensing of independent adjusters.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-2

Administrative rules

Sec. 2. The commissioner may adopt rules under IC 4-22-2 to implement this chapter.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-3

Automated claims adjudication system

Sec. 3. As used in this chapter, "automated claims adjudication system" means a preprogrammed computer system that:

(1) is designed for the collection, data entry, calculation, and system generated final resolution of property insurance claims;

(2) is used only by a licensee or a person described in section 6(b)(2) or 6(b)(3) of this chapter;

(3) complies with all claim payment requirements under Indiana insurance law; and

(4) is certified as compliant with the claims adjudication requirements of this chapter by an individual who is an:

(A) independent adjuster who is licensed under this chapter; and

(B) officer of a business entity that is licensed under this chapter.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-4

Catastrophe

Sec. 4. As used in this chapter, "catastrophe" means an event that is the subject of a declaration by the commissioner and that:

(1) results in a large number of deaths or injuries;

(2) causes extensive damage or destruction of facilities used to provide and sustain human needs;

(3) produces an overwhelming demand on state and local response resources and mechanisms;

(4) causes a severe long term effect on general economic activity; or

(5) severely affects state, local, and private sector capabilities to begin and sustain response activities.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-5
Home state

Sec. 5. As used in this chapter, "home state" means:

(1) a state, district, or territory of the United States in which an independent adjuster:

(A) maintains the independent adjuster's principal place of residence or business; and

(B) is licensed to act as a resident independent adjuster; or

(2) if the principal place of residence described in subdivision (1) does not license independent adjusters for the line of authority in which the independent adjuster seeks licensing under this chapter, the state, district, or territory of the United States:

(A) that is designated by the independent adjuster as the independent adjuster's home state; and

(B) in which the independent adjuster is licensed and in good standing.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-6
Independent adjuster

Sec. 6. (a) As used in this chapter, "independent adjuster" means a person, or an independent contractor or employee of a person, that:

(1) contracts for compensation with insurers or self-insurers to investigate, negotiate, or settle property, casualty, or worker's compensation claims; and

(2) for tax purposes is treated by the insurers or self-insurers in a manner consistent with treatment of an independent contractor rather than an employee under Title 26, Subtitle C of the Internal Revenue Code.

(b) The term does not include the following:

(1) An attorney who:

(A) is admitted to practice in Indiana; and

(B) acts in a professional capacity as an attorney.

(2) A person employed solely to do any of the following:

(A) Obtain facts surrounding a claim.

(B) Furnish technical assistance to a licensed independent adjuster.

(3) An individual:

(A) who is an employee of:

(i) an independent adjuster who is licensed under this chapter; or

(ii) an affiliate of an independent adjuster who is licensed under this chapter;

(B) who is supervised by:

(i) an independent adjuster licensed under this chapter; or

(ii) an insurance producer licensed under IC 27-1-15.6;

who supervises not more than twenty-five (25) persons

described in this subdivision; and
(C) who is employed solely to:
(i) collect claim information from insureds or claimants;
(ii) furnish claim information to insureds or claimants; or
(iii) perform data entry into an automated claims adjudication system.
(4) An individual who is employed to investigate suspected fraudulent insurance claims, but who does not adjust losses or determine claim payments.
(5) A person that:
(A) performs only executive, administrative, managerial, or clerical duties; and
(B) does not investigate, negotiate, or settle claims with policyholders, claimants, or legal representatives of policyholders or claimants.
(6) A person that settles only reinsurance or subrogation claims.
(7) An officer, director, manager, or employee of an authorized insurer, a managing general agent, a surplus lines insurer, a risk retention group, or an attorney in fact of a reciprocal insurer.
(8) A manager of the United States branch of an alien insurer.
(9) A person that investigates, negotiates, or settles life, accident and health, annuity, or disability insurance claims.
(10) Under a self-insured arrangement, an individual who adjusts claims on behalf of the individual's employer.
(11) A licensed insurance producer, an attorney in fact of a reciprocal insurer, or a managing general agent of an insurer to whom claim authority has been granted by the insurer.
(12) A person that is authorized to adjust worker's compensation or disability claims under the authority of a third party administrator.
(13) A person that investigates, negotiates, or settles crop insurance claims.
(14) An individual who:
(A) does not adjust losses or determine claim payments; and
(B) is employed to use a specialized skill possessed by the individual to make a determination:
(i) concerning an element of a claim; and
(ii) that is used by an independent adjuster, or an adjuster who is directly employed by an insurer, in adjusting a loss or determining a claim payment.
As added by P.L.11-2011, SEC.22.

IC 27-1-28-7
NAIC
Sec. 7. As used in this chapter, "NAIC" refers to the National Association of Insurance Commissioners.
As added by P.L.11-2011, SEC.22.

IC 27-1-28-8
Uniform individual application

Sec. 8. As used in this chapter, "uniform individual application" means the NAIC uniform individual application for resident and nonresident individuals.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-9
Uniform business entity application

Sec. 9. As used in this chapter, "uniform business entity application" means the NAIC uniform business entity application for resident and nonresident business entities.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-10
Independent adjuster licensure and exemption

Sec. 10. A person shall not:

(1) act as an independent adjuster in Indiana; or

(2) hold the person's self out as an independent adjuster in Indiana;

unless the person is licensed or exempt from licensure under this chapter.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-11
Temporary emergency independent adjuster licensure

Sec. 11. (a) If a catastrophe is declared, an insurer may contract with an individual who:

(1) is not licensed under this chapter; but

(2) is otherwise qualified to adjust claims;

to act as a temporary emergency independent adjuster on behalf of the insurer if the insurer obtains for the individual a temporary emergency independent adjuster license under this section.

(b) An insurer described in subsection (a) must, not more than five (5) days after the individual begins to adjust claims arising from the declared catastrophe, submit to the commissioner an application for temporary emergency licensure of the individual under this section.

(c) An application submitted under subsection (b) must include the following information in a format prescribed by the commissioner:

(1) The name of the individual.

(2) The Social Security number of the individual.

(3) The name of the insurer.

(4) The effective date of the contract between the insurer and the individual.

(5) The catastrophe or loss number.

(6) The catastrophe event name.

(7) Other information the commissioner considers necessary.

(d) The commissioner shall establish standards and procedures for temporary emergency independent adjuster licensure under this section.

(e) A temporary emergency independent adjuster license issued under this section is effective for not more than ninety (90) days, unless extended by the commissioner. In the event of multiple catastrophes, an individual who holds a temporary emergency independent adjuster license issued under this section with respect to one (1) declared catastrophe may adjust claims arising from any other catastrophe that occurs within the ninety (90) day period during which the license is effective under this subsection without the insurer applying for an additional temporary emergency independent adjuster license.

(f) The rules adopted by the commissioner under section 2 of this chapter may establish a fee for an application submitted under this section.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-12

Resident individual independent adjuster licensure

Sec. 12. (a) An individual may apply for a resident independent adjuster license by submitting:

(1) a uniform individual application to the commissioner with a declaration, under penalty of suspension, revocation, or refusal of licensure, that the statements made in the application are true and complete to the best of the individual's knowledge; and

(2) an application fee of forty dollars ($40).

(b) The commissioner shall approve an application submitted under subsection (a) upon finding all of the following:

(1) The individual is at least eighteen (18) years of age.

(2) The individual is eligible to designate Indiana as the individual's home state.

(3) The individual is determined by the commissioner to be trustworthy, reliable, and of good reputation.

(4) The individual has not committed an act that is grounds for probation, suspension, revocation, or refusal of licensure under section 18 of this chapter.

(5) The individual has completed a prelicensing course of study for the line of authority in which the individual has applied for licensing under this section.

(6) The individual has successfully passed the written examination administered under section 15 of this chapter for the line of authority in which the individual has applied for licensing under this section.

(c) The commissioner may require any documents reasonably necessary to verify the information contained in the application.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-13
Resident business entity independent adjuster licensure

Sec. 13. (a) A business entity may apply for a resident independent adjuster license by submitting:

(1) a uniform business entity application to the commissioner with a declaration, under penalty of suspension, revocation, or refusal of licensure, that the statements made in the application are true and complete to the best knowledge of the individual submitting the application on behalf of the business entity;

(2) an application fee of forty dollars ($40); and

(3) the name, address, Social Security number, and criminal and administrative history of each of the following:

(A) An owner that has at least ten percent (10%) interest or voting interest in the business entity.

(B) A partner of the business entity.

(C) An executive officer of the business entity.

(D) A director of the business entity.

(b) The commissioner shall approve an application submitted by a business entity under subsection (a) upon finding all of the following:

(1) The business entity is eligible to designate Indiana as the business entity's home state.

(2) The business entity has designated an individual independent adjuster licensed under this chapter to be responsible for the business entity's compliance with Indiana insurance law.

(3) The business entity has not committed any act that is grounds for probation, suspension, revocation, or refusal of an independent adjuster license under section 18 of this chapter.

(c) The commissioner may require a business entity applying under this section to produce any documents reasonably necessary to verify the information contained in the application.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-14
Qualifications; renewal; fees; expiration; content of license; change of information; contract for administration

Sec. 14. (a) An independent adjuster may qualify for an independent adjuster license under this chapter in one (1) or more of the following lines of authority:

(1) Property and casualty insurance.

(2) Worker's compensation insurance.

(b) An independent adjuster licensed under this chapter is not required to hold another independent adjuster, insurance producer, or insurance administrator license in Indiana.

(c) An independent adjuster license:

(1) is effective for two (2) years after the date of issuance unless probated, suspended, revoked, or refused; and

(2) may be renewed if all requirements for renewal, including submission to the commissioner of a renewal fee of forty dollars ($40), are met on or before the renewal date.

(d) If an independent adjuster license expires, the independent adjuster may, within twelve (12) months after the date of expiration, be reissued an independent adjuster license upon receipt by the commissioner of:

(1) a request for reissuance, as prescribed by the commissioner; and

(2) a reissuance fee of eighty dollars ($80).

(e) An independent adjuster who is unable to comply with the license renewal requirements of this section due to:

(1) military service;

(2) long term medical disability; or

(3) another extenuating circumstance determined by the commissioner;

may request a waiver of the renewal requirements or applicable sanction.

(f) A license issued under this chapter must contain the following:

(1) The licensee's name, address, and personal identification number.

(2) The date of issuance.

(3) The date of expiration.

(4) Other information considered necessary by the commissioner.

(g) An independent adjuster is subject to IC 27-4-1-4.5.

(h) An independent adjuster shall, not more than thirty (30) days after the occurrence of a change of the independent adjuster's:

(1) legal name; or

(2) home state address;

provide written notice to the commissioner of the change.

(i) The commissioner may contract with a nongovernmental entity to perform ministerial functions required by this section, including the collection of data and fees related to licensing.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-15

Written examination

Sec. 15. (a) Except as provided in section 16 of this chapter, an individual who applies for an independent adjuster license under this chapter must pass a written examination that is:

(1) developed and conducted according to rules adopted by the commissioner under IC 4-22-2; and

(2) intended to test the knowledge of the individual concerning:

(A) the lines of authority in which the individual has applied for licensing under this chapter;

(B) the duties and responsibilities of an independent adjuster; and

(C) Indiana insurance law.

(b) The commissioner may contract with a nongovernmental entity to administer the written examination required by this section.

(c) An individual described in subsection (a) shall remit, with the application to take the written examination required by this section, a nonrefundable examination fee in an amount set by the commissioner or the organization administering the examination.

(d) If an individual:

(1) fails to appear for or to pass an examination; and

(2) desires to reschedule the examination;

the individual shall reapply for the written examination and remit all fees and forms before scheduling an examination date.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-16

Nonresident licensure

Sec. 16. (a) An individual who applies for an independent adjuster license under this chapter and who:

(1) possesses an independent adjuster license for the same line of authority in which the individual has applied for licensing under this chapter in a state in which a prelicensing independent adjuster licensure examination is required;

(2) possessed an independent adjuster license that:

(A) was for the same line of authority in which the individual has applied for licensing under this chapter in a state in which a prelicensing independent adjuster licensure examination is required; and

(B) expired less than ninety (90) days before the date the commissioner receives the application; or

(3) provides proof from contracting insurers that the individual has participated in claims adjudication in the same line of authority during the five (5) years immediately preceding the date of application;

is not required to complete a prelicensing course as described in section 12(b)(5) of this chapter or pass a written examination under section 15 of this chapter before being licensed under this chapter.

(b) An applicant who meets the criteria set forth in subsection (a)(1) or (a)(2) must provide certification from the other state that the applicant's independent adjuster license:

(1) is currently in good standing; or

(2) was in good standing at the time of expiration.

(c) A person that:

(1) is licensed as an independent adjuster in another state where a prelicensing independent adjuster licensure examination is required;

(2) establishes legal residency in Indiana; and

(3) applies for a resident independent adjuster license under this chapter less than ninety (90) days after the person establishes legal residency in Indiana;

is not required to complete a prelicensing course as described in section 12(b)(5) of this chapter or pass a written examination under section 15 of this chapter before being licensed under this chapter.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-17

Issuance of nonresident license

Sec. 17. (a) Except as provided in section 18 of this chapter, the commissioner shall issue a nonresident independent adjuster license to a person if:

(1) the person is currently licensed in good standing as an independent adjuster in the person's home state;

(2) the person has submitted:

(A) the proper application for licensure;

(B) a nonresident application fee of ninety dollars ($90); and

(C) in the case of a business entity, the information described in section 13(a)(3) of this chapter; and

(3) the person's designated home state awards nonresident independent adjuster licenses to residents of Indiana on the same basis as nonresident independent adjuster licenses are awarded under this chapter to residents of other states.

(b) Except as provided in section 18 of this chapter, if a person that:

(1) is not a resident of Indiana; and

(2) is not licensed as an independent adjuster in another state;

desires to obtain an independent adjuster license under this chapter, the person must comply with the requirements of section 12 or 13 of this chapter, and sections 14 and 15 of this chapter, and must remit the nonresident application fee of ninety dollars ($90).

(c) The commissioner may:

(1) verify an independent adjuster's licensure status in another state through an appropriate data base, including the insurance producer data base maintained by the NAIC or an affiliate or a subsidiary of the NAIC; or

(2) request certification of good standing as described in section 16(b) of this chapter.

(d) To maintain a valid nonresident independent adjuster license issued under this chapter:

(1) the independent adjuster must maintain a valid resident independent adjuster license in the independent adjuster's home state; and

(2) the independent adjuster's home state must award nonresident independent adjuster licenses to residents of Indiana on the same basis as nonresident independent adjuster licenses are awarded under this chapter to residents of other

states.

(e) For a nonresident independent adjuster license issued under this chapter to be renewed:

(1) the independent adjuster must:

(A) maintain a valid resident independent adjuster license in the independent adjuster's home state; and

(B) remit to the commissioner a nonresident independent adjuster license renewal fee of ninety dollars ($90); and

(2) the independent adjuster's home state must award nonresident independent adjuster licenses to residents of Indiana on the same basis as nonresident independent adjuster licenses are awarded under this chapter to residents of other states.

(f) If a nonresident independent adjuster's home state license terminates for any reason other than issuance of a new resident independent adjuster license in a new home state:

(1) the person's nonresident independent adjuster license issued under this chapter also terminates immediately; and

(2) the person shall immediately surrender the nonresident independent adjuster license to the commissioner.

(g) If a nonresident independent adjuster's home state license terminates due to the issuance of a new resident independent adjuster license in a new home state, the independent adjuster shall, not more than thirty (30) days after the nonresident independent adjuster's home state license termination date, provide notice of the termination to the commissioner and the insurance commissioner of any state that has issued a nonresident independent adjuster license to the independent adjuster. The notice must specify the independent adjuster's previous home state address and new home state address.

(h) If a resident independent adjuster's license issued under this chapter terminates for any reason, the resident independent adjuster shall, not more than thirty (30) days after the resident adjuster license termination date, provide notice of the termination to the insurance commissioner of any state that has issued a nonresident independent adjuster license to the resident independent adjuster. If the termination results from a change of the resident independent adjuster's home state, the notice must specify the independent adjuster's previous home state address and new home state address.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-18

Penalties; refusal of license renewal

Sec. 18. (a) The commissioner may suspend, revoke, or refuse to issue or renew an independent adjuster license, or place an independent adjuster on probation, for a cause set forth in subsection (b).

(b) An independent adjuster is subject to the penalties set forth in subsection (a) for any of the following:

(1) Providing incorrect, misleading, incomplete, or materially untrue information in a license application.
(2) Violating an insurance law, a subpoena, or an order of the commissioner or another state's insurance commissioner.
(3) Obtaining or attempting to obtain a license through misrepresentation or fraud.
(4) Improperly withholding, misappropriating, or converting money or property received in the course of doing insurance business.
(5) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance.
(6) Having been convicted of a felony.
(7) Having admitted or been found to have committed any unfair trade practice or fraud in the business of insurance.
(8) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness, or financial irresponsibility, in the conduct of insurance business.
(9) Having an insurance license, or its equivalent, probated, suspended, revoked, or refused in another state, province, district, or territory.
(10) Forging another person's name to a document related to an insurance transaction.
(11) Cheating, including improperly using notes or any other reference material, to complete an examination for an insurance license.
(12) Failing to comply with an administrative or court order imposing a child support obligation.
(13) Failing to pay state income tax or failing to comply with an administrative or court order directing payment of state income tax.

(c) If the commissioner refuses an application for licensure or for the renewal of an existing license under this chapter, the commissioner shall notify the applicant or licensee in writing, advising of the reason for the refusal. The applicant or licensee may, not more than thirty (30) days after receiving the commissioner's notice of refusal, make written demand upon the commissioner for a hearing to determine the reasonableness of the refusal. The hearing must be held under IC 4-21.5 not more than twenty (20) days after the commissioner receives the applicant's or licensee's written demand.

(d) The commissioner may suspend, revoke, or refuse a business entity's independent adjuster license under this chapter or place a business entity licensed under this chapter on probation if, after a hearing under IC 4-21.5, the commissioner finds that:

(1) the individual licensed independent adjuster designated by the business entity under section 13(b)(2) of this chapter as being responsible for the business entity's compliance with Indiana insurance law committed a violation described in

subsection (b) while acting on behalf of or representing the business entity;

(2) the violation was known or should have been known by at least one (1) of the business entity's partners, officers, or managers;

(3) the violation was not reported to the commissioner; and

(4) the business entity did not take corrective action.

(e) In addition to or instead of a penalty imposed under subsection (a), the commissioner may, after a hearing under IC 4-21.5, impose a civil penalty of at least fifty dollars ($50) and not more than ten thousand dollars ($10,000), regardless of whether the person on whom the penalty is imposed holds an independent adjuster license issued under this chapter that is in effect. A penalty imposed under this subsection may be enforced in the same manner as a civil judgment.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-19

Continuing education

Sec. 19. (a) Except as provided in subsection (b), an individual who holds a license under this chapter shall, every two (2) years, satisfactorily complete a minimum of twenty-four (24) hours of continuing education courses and report the completion of the courses to the commissioner.

(b) This section does not apply to the following:

(1) An individual who is licensed for less than twelve (12) months before the end of the applicable continuing education biennium.

(2) A licensed nonresident independent adjuster who has met the continuing education requirements of the licensed nonresident independent adjuster's designated home state.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-20

Contracts

Sec. 20. An independent adjuster shall:

(1) maintain a copy of each contract between the independent adjuster and an insurer or a self-insurer; and

(2) comply with the record retention policy agreed to in the contract described in subdivision (1).

As added by P.L.11-2011, SEC.22.

IC 27-1-28-21

Duties

Sec. 21. An independent adjuster shall do all of the following:

(1) Be honest and fair in all communications with an insured, an insurer, a self-insurer, and the public.

(2) Give policyholders and claimants prompt and

knowledgeable service and courteous, fair, and objective treatment.

(3) Refrain from:

(A) giving legal advice; or

(B) dealing directly with a policyholder or claimant who is represented by legal counsel unless the legal counsel consents to the direct contact.

(4) Comply with all local, state, and federal privacy and information security laws.

(5) Identify:

(A) the independent adjuster's self as an independent adjuster; and

(B) if applicable, the independent adjuster's employer;

when dealing with a policyholder or claimant.

(6) Refrain from:

(A) having any financial interest in an adjustment; or

(B) acquiring, for the independent adjuster or any person, an interest or a title in salvage without first receiving written authority from the principal.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-22

Reports to commissioner of administrative and criminal actions

Sec. 22. (a) An independent adjuster shall report to the commissioner an administrative action taken against the independent adjuster:

(1) in another jurisdiction; or

(2) by another governmental agency in Indiana;

not more than thirty (30) days after the final disposition of the matter. The report must include a copy of the order or consent order, and any other relevant documentation.

(b) An independent adjuster shall report to the commissioner any criminal action taken against the independent adjuster:

(1) in another jurisdiction; or

(2) by another governmental agency in Indiana;

not more than thirty (30) days after the final disposition of the criminal matter. The report must include a copy of the initial complaint filed, the final order issued by the court, and any other relevant documentation.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-23

Certification of automated claims adjudication system

Sec. 23. If an independent adjuster uses an automated claims adjudication system, the independent adjuster shall maintain proof of the certification described in section 3(4) of this chapter and provide the proof of certification to the commissioner upon request.

As added by P.L.11-2011, SEC.22.

IC 27-1-28-24
Deposit of fees

Sec. 24. The commissioner shall deposit a fee received under this chapter into the department of insurance fund established by IC 27-1-3-28.

As added by P.L.11-2011, SEC.22.

IC 27-1-29

Chapter 29. Indiana Political Subdivision Risk Management Commission

IC 27-1-29-1

"Commission" defined

Sec. 1. As used in this chapter, "commission" refers to the Indiana political subdivision risk management commission established by this chapter.

As added by P.L.162-1986, SEC.1.

IC 27-1-29-2

"Fund" defined

Sec. 2. As used in this chapter, "fund" refers to the political subdivision risk management fund established by this chapter.

As added by P.L.162-1986, SEC.1.

IC 27-1-29-3

"Liability" defined

Sec. 3. As used in this chapter, "liability" means an obligation arising from a claim for the payment of money in an amount established under IC 34-13-3 (or IC 34-4-16.5 before its repeal) or any other claim for which coverage is provided for members of the fund under rules adopted by the commission.

As added by P.L.162-1986, SEC.1. Amended by P.L.1-1998, SEC.141.

IC 27-1-29-4

"Political subdivision" defined

Sec. 4. As used in this chapter, "political subdivision" has the meaning set forth in IC 34-6-2-110.

As added by P.L.162-1986, SEC.1. Amended by P.L.5-1988, SEC.143; P.L.1-1998, SEC.142.

IC 27-1-29-5

Creation; purpose; membership; appointment; term; qualifications; vacancies; per diem and expenses; tax exempt property of commission

Sec. 5. (a) The Indiana political subdivision risk management commission is created as a separate body corporate and politic, constituting an instrumentality of the state for the public purposes set out in this chapter, but not a state agency. The commission is separate from the state in its corporate and sovereign capacity. The purpose of the commission is aiding political subdivisions in protecting themselves against liabilities. The commission is not subject to IC 27-6-8, and the Indiana guaranty association created by IC 27-6-8-5 has no obligation to insureds or claimants of the commission.

(b) The commission consists of the insurance commissioner, who shall serve as chairman, and nine (9) other commission members. However, the reduction in membership of the commission from ten (10) appointed members to nine (9) appointed members shall be accomplished as the terms of members end and new members are appointed. Until the expiration of the term of a member who is serving on the commission on January 1, 2014, and resides in the same congressional district as another member, the commission consists of ten (10) appointed members. Except for the commissioner, the members of the commission shall be appointed by the governor for a term of four (4) years. No more than five (5) commission members appointed by the governor under this section may be members of the same political party. The commission members appointed by the governor under this section must include one (1) resident of each congressional district in Indiana. The commission shall elect one (1) of the appointed commission members as secretary of the commission.

(c) A commission member may be reappointed to the commission.

(d) In appointing commission members under this section, the governor shall consider the qualifications, expertise, and background that would provide the proper talent to administer this chapter. To the degree possible, the members must have backgrounds in educational administration, risk management, and governance of a political subdivision and must include persons with knowledge of insurance matters.

(e) A vacancy occurring on the commission shall be filled through the appointment of a resident of the same congressional district as the vacating commission member for the unexpired term of the commission member leaving the commission.

(f) Each member of the commission who is not a state employee is entitled to the minimum salary per diem provided by IC 4-10-11-2.1(b). Such a commission member is also entitled to reimbursement for traveling expenses and other expenses actually incurred in connection with the member's duties, as provided in the state travel policies and procedures established by the department of administration and approved by the state budget agency.

(g) Each member of the commission who is a state employee is entitled to reimbursement for traveling expenses and other expenses actually incurred in connection with the commission member's duties, as provided in the state travel policies and procedures established by the department of administration and approved by the state budget agency.

(h) All property of the commission is public property devoted to an essential public and governmental function and purpose and is exempt from all taxes and special assessments of the state or a political subdivision of the state.

As added by P.L.162-1986, SEC.1. Amended by P.L.272-1987, SEC.1; P.L.53-2014, SEC.141.

IC 27-1-29-6
Meetings; actions

Sec. 6. The commission shall meet upon the call of the commissioner, who shall convene meetings as often as necessary to accomplish the purposes of this chapter. The commission may act:

(1) through the vote of a majority of members at a meeting at which at least six (6) members are present; or

(2) through the commissioner, pursuant to powers granted to the commission under this chapter and delegated to the commissioner by the vote of a majority of members at a meeting at which at least six (6) members are present.

As added by P.L.162-1986, SEC.1.

IC 27-1-29-7
Powers of commission; limit on surcharge levied against members of fund; reports

Sec. 7. (a) The commission is granted all powers necessary, convenient, or appropriate to carry out and effectuate its public and corporate purposes under this chapter and IC 27-1-29.1 including, but not limited to, and except as otherwise restricted in this chapter or IC 27-1-29.1:

(1) The power to have perpetual existence as a body corporate and politic, and an independent instrumentality, but not a state agency, exercising essential public functions.

(2) The power to sue and be sued.

(3) The power to adopt and alter an official seal.

(4) The power to make and enforce bylaws and rules for the conduct of its business, which bylaws and rules may be adopted by the commission without complying with IC 4-22-2.

(5) The power to make contracts and incur liabilities, borrow money, issue its negotiable bonds or notes in accordance with this chapter, subject to provisions for registration of negotiable bonds and notes, and provide for and secure their payment and provide for the rights of their holders, and purchase and hold and dispose of any of its bonds or notes.

(6) The power to acquire, hold, use, and dispose of its income, revenues, funds, and money.

(7) The power to acquire, rent, lease, hold, use, and dispose of property for its purposes.

(8) The power to fix and revise from time to time and charge and collect fees and charges for the use of its services or facilities.

(9) The power to accept gifts or grants of property, funds, money, materials, labor, supplies, or services from the United States, any governmental unit, or any person, carry out the terms or provisions or make agreements with respect to the gifts or grants, and do all things necessary, useful, desirable, or convenient in connection with procuring, accepting, or

disposing of the gifts or grants.

(10) The power to do anything authorized by this article, through its officers, agents, or employees or by contracts with a person.

(11) The power to procure insurance against any losses in connection with its property, operations, or assets in amounts and from insurers as it considers desirable.

(12) The power to cooperate with and exchange services, personnel, and information with any federal, state, or local government agency.

(b) The commission may:

(1) implement a statewide program of loss control and risk management to minimize the liabilities of members of the fund;

(2) contract with any persons or entities to obtain or provide the services of risk managers, actuaries, loss control specialists, attorneys, and other professionals in carrying out its powers and duties under this chapter and to pay for those services from the fund;

(3) exercise control over the defense of members of the fund against tort claims, including the selection and retention of legal counsel, the direction of counsel in the conduct of cases, and the negotiation and acceptance or rejection of any settlement;

(4) establish procedures by which political subdivisions can gain or regain membership and relinquish membership in the fund;

(5) establish procedures and criteria for the imposition of assessments to be paid by members of the fund, and the payment of members' liabilities;

(6) establish programs for the payment of money from the fund to compensate members for damage to or loss of real or personal property;

(7) establish programs for the payment of:

(A) liabilities covered under IC 34-13-3 (or IC 34-4-16.5 before its repeal); and

(B) liabilities that are not covered under IC 34-13-3 (or IC 34-4-16.5 before its repeal), including, but not limited to, liability due to alleged violations of the Constitution of the United States or federal civil rights statutes by law enforcement officers;

(8) establish programs by which members can protect their elected officers and employees against liability arising from their alleged errors or omissions;

(9) establish procedures by which a member of the fund can settle small claims that are within the deductible provision of coverage under the fund;

(10) capitalize the fund by levying against each member of the fund an annual surcharge over and above the assessment imposed against the member under section 12 of this chapter;

and

(11) establish any other programs or procedures the commission considers necessary for the implementation of this chapter.

The amount of the surcharge levied against a member of the fund for a particular year under subdivision (10) may not exceed twenty-five percent (25%) of the member's assessment for the same year.

(c) The commission shall file a report in an electronic format under IC 5-14-6 with the general assembly each year concerning the operations of the commission and the condition of the fund.

As added by P.L.162-1986, SEC.1. Amended by P.L.272-1987, SEC.2; P.L.1-1998, SEC.143; P.L.28-2004, SEC.166.

IC 27-1-29-8

Expenses incurred; payment

Sec. 8. (a) All expenses incurred by the commission in administering the fund under this chapter shall be paid from the fund.

(b) All expenses incurred by the commission in administering the political subdivision catastrophic liability fund established by IC 27-1-29.1 shall be paid from the political subdivision catastrophic liability fund.

(c) All expenses incurred by the commission that are not incurred directly in connection with the administration of the political subdivision risk management fund or the political subdivision catastrophic liability fund shall be paid equally from each fund.

As added by P.L.162-1986, SEC.1. Amended by P.L.272-1987, SEC.3.

IC 27-1-29-9

Liability insurance or indemnification; state responsibility for commission obligations

Sec. 9. (a) The commission shall purchase liability insurance for, or otherwise indemnify, its members against personal liability for acts and omissions arising out of their performance, in good faith, of their duties as members of the commission.

(b) The state is not responsible for the payment of any obligation of the commission.

As added by P.L.162-1986, SEC.1.

IC 27-1-29-10

Political subdivision risk management fund; purpose; administration; expenses; depositories; investment; reserve account

Sec. 10. (a) The political subdivision risk management fund is established for the purpose of:

(1) paying the liabilities of political subdivisions to the extent specified in this chapter;

(2) receiving assessments paid by political subdivisions to replenish the fund and to pay the principal of and interest on

bonds or notes issued by the commission under section 17(b)(2) of this chapter; and

(3) receiving money from any other source.

(b) The fund shall be administered by the commission.

(c) The expenses of administering the fund shall be paid from money in the fund.

(d) All money received by the commission under this chapter, whether as assessments, proceeds from the sale of bonds, or revenues, are trust funds, to be held and applied solely as provided in this chapter. Current operating funds shall be kept in depositories selected by the commission. The commission shall deposit with the treasurer of state the money in the fund not currently needed to meet the obligations of the fund, and the treasurer of state shall invest such money for the commission in accordance with the provisions of any resolution or trust agreement that the commission adopts or enters into under this chapter. Interest that accrues from these investments shall be credited to the commission and to the fund.

(e) Money in the fund at the end of a particular fiscal year does not revert to the state general fund.

(f) The commission shall create a reserve account in the fund and shall capitalize the reserve account through the surcharges levied under section 7(b)(10) of this chapter.

As added by P.L.162-1986, SEC.1. Amended by P.L.272-1987, SEC.4.

IC 27-1-29-11

Fund members; eligibility; assessments; surcharge levies; payment of liabilities

Sec. 11. All political subdivisions are eligible for membership in the fund. Each member of the fund:

(1) shall contribute to the fund in the amount of the assessment charged the member under this chapter;

(2) shall pay the annual surcharge levied against the member under this chapter; and

(3) is entitled to payment of its liabilities from the fund under this chapter.

As added by P.L.162-1986, SEC.1.

IC 27-1-29-12

Assessments on members of fund

Sec. 12. (a) The commission shall impose an assessment to be paid by each member of the fund. The assessments to be paid by members of the fund shall be set in fairness to all members, based upon the uniform application of actuarial principles and underwriters' rating principles. A member shall pay its assessment in accordance with rules of the commission.

(b) The assessment for the first twelve (12) months of a political subdivision's membership in the fund shall be no greater than the

payment made by the political subdivision to a commercial insurer for like coverage for the twelve (12) month period immediately preceding the political subdivision's application to become a member. In the case of an applicant not insured by a commercial insurer, the commission shall set the amount of the assessment for the first twelve (12) months of membership in accordance with subsection (a).
As added by P.L.162-1986, SEC.1.

IC 27-1-29-13
Payment of liabilities of members of fund; primary coverage

Sec. 13. (a) The commission shall pay liabilities of members of the fund in accordance with rules established by the commission.

(b) Payment from the fund for any liability covered under IC 34-13-3 (or IC 34-4-16.5 before its repeal) or for any other liability designated under rules adopted by the commission is primary coverage in relation to the following:

(1) Any insurance policy issued to a member of the fund that, by its terms, provides coverage secondary to coverage provided through membership in the fund.

(2) A fund member's own program of self insurance.

Payment of a liability identified in this subsection must be made within the limits set forth in section 14(b) of this chapter and irrespective of the existence of an insurance policy described in subdivision (1) or of a self insurance program described in subdivision (2).
As added by P.L.162-1986, SEC.1. Amended by P.L.1-1998, SEC.144.

IC 27-1-29-14
Eligibility and guidelines for payment from fund

Sec. 14. (a) In order to be eligible for payment under this chapter, a liability of a political subdivision must arise out of a claim based upon an act or omission that takes place while the political subdivision is a member of the fund.

(b) The maximum amount payable from the fund for any liability, whether or not it is covered under IC 34-13-3 (or IC 34-4-16.5 before its repeal), is:

(1) for injury, death, or damage suffered by any one (1) person as a result of the act or omission from which the liability arises:

(A) three hundred thousand dollars ($300,000) for a cause of action that accrues before January 1, 2006;

(B) five hundred thousand dollars ($500,000) for a cause of action that accrues on or after January 1, 2006, and before January 1, 2008; or

(C) seven hundred thousand dollars ($700,000) for a cause of action that accrues on or after January 1, 2008; and

(2) one million dollars ($1,000,000) for all injury, death, or

damage suffered by all persons as a result of the act or omission from which the liability arises.

(c) No amount may be paid from the fund in respect of punitive damages paid by or assessed against a member of the fund.

(d) No amount may be paid from the fund in the case of a liability based upon bodily injury or property damage arising out of the discharge, dispersal, release, or escape of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids, gases, waste materials, or other irritants, contaminants, or pollutants into or upon land, the atmosphere, or any watercourse or body of water unless the discharge, dispersal, release, or escape:

(1) is caused by an act or omission of a political subdivision that is a member of the fund; and

(2) occurs as a result of:

(A) a household hazardous waste; or

(B) a conditionally exempt small quantity generator (as described in 40 CFR 261.5(a));

collection, disposal, or recycling project conducted by or controlled by the political subdivision.

(e) The commissioner may pay a liability of a member of the fund in a series of annual payments. The amount of any annual payment under this subsection must be one hundred thousand dollars ($100,000) or more, except for the final payment in a series of payments.

(f) The commission may negotiate a structured settlement of any claim.

(g) As used in this section, "household hazardous waste" means solid waste generated by households that consists of or contains a material that is:

(1) ignitable, as described in 40 CFR 261.21;

(2) corrosive, as described in 40 CFR 261.22;

(3) reactive, as described in 40 CFR 261.23; or

(4) toxic, as described in 40 CFR 261.24.

As added by P.L.162-1986, SEC.1. Amended by P.L.273-1987, SEC.1; P.L.256-1995, SEC.1; P.L.1-1998, SEC.145; P.L.108-2003, SEC.1.

IC 27-1-29-15

Filing notice of intent to become member of fund; relinquishing membership in fund

Sec. 15. (a) A political subdivision may become a member of the fund by filing a written notice of its intent to become a member with the commission by the date exactly six (6) months before the expiration date of the liability insurance policy covering the political subdivision on December 31, 1986.

(b) Each political subdivision that files a notice of intent to become a member of the fund by the date set forth in subsection (a) shall be granted membership in the fund. A political subdivision that

files a notice of intent to become a member after the date set forth in subsection (a) may be admitted to or rejected for membership in the fund at the discretion of the commission.

(c) A rule adopted by the commission to establish the procedures described in section 7(b)(4) of this chapter may not provide that a political subdivision continues to be a member of the fund more than twelve (12) months after the political subdivision gives notice to the commissioner of its intention to relinquish its membership.

(d) After relinquishing its membership in the fund, a political subdivision remains liable for its pro rata share of assessments to pay for liabilities of fund members that arose out of claims based upon acts or omissions that took place while the political subdivision was a member of the fund. If a political subdivision fails to pay an assessment to which it is subject under this chapter, the commission may give notice to any department or agency of the state (including the treasurer of state or the auditor of state) that is the custodian of money payable to the delinquent political subdivision after the date of the notice, that the political subdivision is in default on the payment of an assessment under this chapter. After receiving this notice, the department or agency shall withhold the delinquent amount from money payable to the political subdivision and pay over the money to the commission to be applied against the delinquent assessment.

As added by P.L.162-1986, SEC.1. Amended by P.L.273-1987, SEC.2; P.L.272-1987, SEC.5.

IC 27-1-29-16

Appointment of members; rules

Sec. 16. (a) The governor shall appoint the initial members of the commission by May 1, 1986.

(b) The commission shall adopt rules under IC 4-22-2 for the implementation of this chapter by October 1, 1986, and shall adopt other rules as required after that date.

As added by P.L.162-1986, SEC.1.

IC 27-1-29-17

Bonds or notes issued by commission; purposes; status; procedures

Sec. 17. (a) As used in this section:

(1) "basic fund" refers to the political subdivision risk management fund established by this chapter; and

(2) "catastrophic fund" refers to the political subdivision catastrophic liability fund established by IC 27-1-29.1.

(b) Before July 1, 2005, the commission may issue its bonds or notes in amounts that it considers necessary to provide funds to:

(1) establish or maintain the reserve account in the catastrophic fund provided for in IC 27-1-29.1-8;

(2) provide for the payment of liabilities payable out of the basic fund to the extent such liabilities exceed the money in the

basic fund; and

(3) pay, fund, or refund, regardless of when due, the principal of or interest or redemption premiums on bonds or notes issued under subdivision (1) or (2).

Bonds or notes issued under subdivision (2) must mature within three (3) years after their date of issuance.

(c) The bonds or notes of the commission may be issued and sold by the commission to the Indiana bond bank under IC 5-1.5.

(d) Every issue of bonds or notes is an obligation of the commission. An issue of bonds or notes under subsection (b)(1) is payable solely from assessments imposed by the commission under IC 27-1-29.1 on political subdivisions that are members of the catastrophic fund, and the commission may secure such bonds or notes by a pledge of assessments imposed under IC 27-1-29.1. An issue of bonds or notes under subsection (b)(2) is payable solely from assessments imposed by the commission under section 12 of this chapter on political subdivisions that are members of the basic fund, and the commission may secure such bonds or notes by a pledge of assessments imposed under section 12 of this chapter.

(e) A bond or note of the commission:

(1) is not a debt, liability, loan of credit, or pledge of the faith and credit of the state; and

(2) must contain on its face a statement that the commission is obligated to pay principal and interest, and the redemption premium, if any, and that the faith, credit, and taxing power of the state are not pledged to the payment of the bond or note.

(f) The state pledges to and agrees with the holders of the bonds or notes issued under this chapter that the state will not:

(1) limit or restrict the rights vested in the commission to fulfill the terms of any agreement made with the holders of its bonds or notes; or

(2) in any way impair the rights or remedies of the holders of the bonds or notes;

until the bonds or notes, together with the interest on the bonds or notes, and interest on unpaid installments of interest, and all costs and expenses in connection with an action or proceeding by or on behalf of the holders, are fully met, paid, and discharged.

(g) The bonds or notes of the commission are negotiable instruments for all purposes of IC 26-1, subject only to the provisions of the bonds and notes for registration.

(h) Bonds or notes of the commission must be authorized by resolution of the commission, may be issued in one (1) or more series, and must:

(1) bear the date;

(2) mature at the time or times;

(3) be in the denomination;

(4) be in the form;

(5) carry the conversion or registration privileges;

(6) have the rank or priority;
(7) be executed in the manner;
(8) be payable from the sources in the medium of payment at the place inside or outside the state; and
(9) be subject to the terms of redemption;

as the resolution of the commission or the trust agreement securing the bonds or notes provides.

(i) Bonds or notes may be issued under this chapter without obtaining the consent of any agency of the state and without any other proceeding or condition other than the proceedings or conditions specified in this chapter.

(j) The rate or rates of interest on the bonds or notes may be fixed or variable. Variable rates shall be determined in the manner and in accordance with the procedures set forth in the resolution authorizing the issuance of the bonds or notes. Bonds or notes bearing a variable rate of interest may be converted to bonds or notes bearing a fixed rate or rates of interest, and bonds or notes bearing a fixed rate or rates of interest may be converted to bonds or notes bearing a variable rate of interest, to the extent and in the manner set forth in the resolution pursuant to which the bonds or notes are issued. The interest on bonds or notes may be payable semiannually or annually or at any other interval or intervals as may be provided in the resolution, or the interest may be compounded and paid at maturity or at any other times as may be specified in the resolution.

(k) The bonds or notes may be made subject, at the option of the holders, to mandatory redemption by the commission at the times and under the circumstances set forth in the authorizing resolution.

(l) Bonds or notes of the commission may be sold at public or private sale at such price, either above or below the principal amount, as the commission fixes. If bonds or notes of the commission are to be sold at public sale, the commission shall comply with IC 5-1-11 and shall publish notice of the sale in accordance with IC 5-3-1-2 in two (2) newspapers published and of general circulation in Indianapolis.

(m) The commission may periodically issue its notes under this chapter and pay and retire the principal of the notes, pay the interest due on the notes, or fund or refund the notes from proceeds of bonds or of other notes or from other funds or money of the commission available for that purpose in accordance with a contract between the commission and the holders of the notes.

(n) The commission may secure any bonds or notes issued under this chapter by a trust agreement by and between the commission and a corporate trustee, which may be any trust company or bank having the powers of a trust company within or outside Indiana.

(o) The trust agreement or the resolution providing for the issuance of the bonds or notes may contain provisions for protecting and enforcing the rights and remedies of the holders of any such bonds or notes as are reasonable and proper and not in violation of

law.

(p) The trust agreement or resolution may set forth the rights and remedies of the holders of any bonds or notes and of the trustee and may restrict the individual right of action by the holders.

(q) In addition to the provisions of subsections (n) through (p), any trust agreement or resolution may contain other provisions the commission considers reasonable and proper for the security of the holders of any bonds or notes.

(r) All expenses incurred in carrying out the provisions of the trust agreement or resolution may be paid from assessments, revenues, or assets pledged or assigned to the payment of the principal of and the interest on bonds and notes or from any other funds available to the commission.

(s) Notwithstanding the restrictions of any other law, all financial institutions, investment companies, insurance companies, insurance associations, executors, administrators, guardians, trustees, and other fiduciaries may legally invest sinking funds, money, or other funds belonging to them or within their control in bonds or notes issued under this chapter.

(t) All bonds or notes issued under this chapter are issued by a body corporate and politic of this state, but not a state agency, and for an essential public and government purpose and the bonds and notes, the interest thereon, the proceeds received by a holder from the sale of the bonds or notes to the extent of the holder's cost of acquisition, proceeds received upon redemption before maturity, and proceeds received at maturity, and the receipt of the interest and proceeds are exempt from taxation in Indiana for all purposes except the financial institutions tax imposed under IC 6-5.5 or a state inheritance tax imposed under IC 6-4.1.

As added by P.L.272-1987, SEC.6. Amended by P.L.21-1990, SEC.52; P.L.254-1997(ss), SEC.25; P.L.235-2005, SEC.203.

IC 27-1-29-27.1
Repealed

(As added by P.L.5-1996, SEC.19. Repealed by P.L.177-2011, SEC.5.)

IC 27-1-29-28
Actions affecting fund warranted by declining membership or financial conditions

Sec. 28. (a) As used in this section, "fund" means the political subdivision risk management fund established by section 10 of this chapter.

(b) Notwithstanding any other provision of this chapter, the commission:

(1) with the approval of the insurance commissioner; and

(2) upon a determination by the commission that:

(A) membership in the fund is declining; and

(B) financial conditions warrant the action;

is authorized to take action under subsection (c).

(c) Under the circumstances set forth in subsection (b), the commission may do the following with respect to the fund:

(1) Prevent any political subdivision that is not already a member of the fund from becoming a member.

(2) Decline to renew the membership of the political subdivisions that are members of the fund.

(3) When the membership of the last member has expired, cease the operation of the fund, except for:

(A) the payment of liabilities of former members of the fund; and

(B) the collection of assessments from former members of the fund, if any are due;

in accordance with this chapter and rules adopted by the commission.

(4) Allow or cause a partial reduction or complete depletion of the balance of the fund through:

(A) the payment of liabilities of former members of the fund; and

(B) at the discretion of the commission, and with the approval of the commissioner, the pro rata return to former members of assessments paid by former members of the fund;

in accordance with this chapter and rules adopted by the commission.

(d) After any or all of the actions authorized by subsection (c), the commission, with the approval of the insurance commissioner, may resume using the fund to pay the liabilities of members of the fund under this chapter.

As added by P.L.103-1998, SEC.1.

IC 27-1-29.1

Chapter 29.1. Political Subdivision Catastrophic Liability Fund

IC 27-1-29.1-1

"Commission" defined

Sec. 1. As used in this chapter, "commission" refers to the Indiana political subdivision risk management commission established by IC 27-1-29-5.

As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-2

"Fund" defined

Sec. 2. As used in this chapter "fund" refers to the political subdivision catastrophic liability fund established by this chapter.

As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-3

"Liability" defined

Sec. 3. As used in this chapter, "liability" means an obligation arising from:

(1) multiple claims for the payment of money that are within the limits set forth in IC 34-13-3-4 (or IC 34-4-16.5-4 before its repeal) and that arise from a single catastrophic occurrence; or

(2) any other claim for which coverage is provided for members of the fund under rules adopted by the commission.

As added by P.L.272-1987, SEC.7. Amended by P.L.1-1998, SEC.146.

IC 27-1-29.1-4

"Member" defined

Sec. 4. As used in this chapter "member" refers to any political subdivision that has a membership in the fund, as provided in section 9 of this chapter.

As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-5

"Political subdivision" defined

Sec. 5. As used in this chapter, "political subdivision" has the meaning set forth in IC 34-6-2-110.

As added by P.L.272-1987, SEC.7. Amended by P.L.3-1989, SEC.152; P.L.1-1998, SEC.147.

IC 27-1-29.1-6

"Underlying coverage" defined

Sec. 6. As used in this chapter, "underlying coverage" refers to any liability insurance policy that names a member of the fund or its officials or employees as a named insured, an additional named

insured, an insured, or an additional insured.
As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-7
Establishment of fund; purpose; administration; expenses; depositories; investment

Sec. 7. (a) The political subdivision catastrophic liability fund is established for the purpose of:

(1) paying a part of certain liabilities of members of the fund under this chapter;

(2) receiving assessments paid by fund members to replenish the fund and to pay the principal of the interest on bonds or notes issued by the commission under IC 27-1-29-17(b)(1); and

(3) receiving money from any other source.

(b) The fund shall be administered by the commission, using the powers granted in IC 27-1-29-7, as modified by this chapter.

(c) The expenses of administering the fund shall be paid from money in the fund.

(d) All money received by the commission under this chapter, whether as assessments, proceeds from the sale of bonds, or revenues, are trust funds, to be held and applied solely as provided in this chapter. Current operating funds shall be kept in depositories selected by the commission. The commission shall deposit with the treasurer of state the money in the fund not currently needed to meet the obligations of the fund, and the treasurer of state shall invest such money for the commission in accordance with the provisions of any resolution or trust agreement that the commission may adopt or enter into under this chapter or IC 27-1-29. Interest that accrues from these investments shall be credited to the commission and to the fund.

(e) Money in the fund at the end of a fiscal year does not revert to the state general fund.
As added by P.L.272-1987, SEC.7. Amended by P.L.159-1988, SEC.1.

IC 27-1-29.1-8
Reserve account; issuance of bonds to establish account; use of funds

Sec. 8. (a) The commission shall establish a reserve account in the fund. A balance of at least five million dollars ($5,000,000) must remain in the reserve account. To provide money to establish the reserve account, the commission may issue bonds under IC 27-1-29-17(b)(1). The bonds issued to provide money for the establishment of the reserve account may not exceed a total amount of forty million dollars ($40,000,000).

(b) Money in the reserve account shall be held and applied solely to pay claims against the fund that cannot be paid from other money in the fund.
As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-9
Membership eligibility; rights and duties

Sec. 9. All political subdivisions that satisfy the criteria for membership under the rules of the commission are eligible for membership in the fund. A political subdivision is not required to be a member of the political subdivision risk management fund under IC 27-1-29 to be eligible for membership in the fund established by this chapter. Each member of the fund:

(1) shall contribute to the fund in the amount of the assessment charged the member under this chapter; and

(2) is entitled to the partial payment of certain liabilities from the fund under this chapter.

As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-10
Liabilities qualifying for partial payment from fund; notice of claim

Sec. 10. (a) The commissioner, using money from the fund, shall pay a part of every liability that qualifies for partial payment under this chapter and under the terms of the coverage provided by the commission according to rules adopted under this chapter.

(b) A liability of a member of the fund that has no underlying coverage or that has occurrence basis underlying coverage qualifies for partial payment under this chapter if it:

(1) is a liability covered under the coverage document issued by the commission to the member;

(2) arises out of an act or omission that takes place while the political subdivision bearing the liability is a member of the fund; and

(3) satisfies the minimum total amount requirement set forth in section 12 of this chapter.

(c) A liability of a member of the fund that has claims made basis underlying coverage qualifies for partial payment under this chapter if it:

(1) is a liability covered under the coverage document issued by the commission to the member;

(2) arises out of an act or omission with respect to which a claim is made while the political subdivision bearing the liability is a member of the fund;

(3) is covered by the underlying coverage; and

(4) satisfies the minimum total amount requirement set forth in section 12 of this chapter.

(d) For the purposes of subsection (c)(2) and section 11 of this chapter, the question of when and how a claim is made shall be determined by the provisions of the insurance policy providing the underlying coverage. However, if the underlying coverage is not applicable to a liability, a claim is considered to have been made for purposes of subsection (c)(2) when notice of a claim giving rise to

the liability is received by the fund member from the claimant or the claimant's representative.
As added by P.L.272-1987, SEC.7. Amended by P.L.159-1988, SEC.2.

IC 27-1-29.1-11
Preexisting liabilities qualifying for partial payment

Sec. 11. A liability that arises out of an act or omission that takes place before the political subdivision bearing the liability becomes a member of the fund does not qualify for partial payment under this chapter unless the liability:

(1) is expressly covered by the provisions of a coverage document that:

(A) is issued to the fund member; and

(B) is in effect when the claim is made; and

(2) is also covered by the underlying coverage that is claims made basis coverage.

As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-12
Liabilities of members that are or are not also members of political subdivision risk management fund; conditional payment

Sec. 12. (a) A liability of a member of the fund that is not a member of the political subdivision risk management fund under IC 27-1-29 does not qualify for partial payment under this chapter unless the total amount of the liability exceeds:

(1) one million dollars ($1,000,000); or

(2) another sum that is:

(A) greater than one million dollars ($1,000,000); and

(B) approved by the commission as a provision of the fund member's coverage because the fund member has underlying coverage with limits of liability that exceed one million dollars ($1,000,000).

(b) A liability of a member of the fund that is also a member of the political subdivision risk management fund under IC 27-1-29 does not qualify for partial payment under this chapter unless the amount of the liability exceeds the amount of liability payable by the commission under IC 27-1-29 under the terms of the coverage document that is issued to the fund member and applicable to the liability.
As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-13
Liability partial payment determination; formula

Sec. 13. The amount that is to be paid by the commission toward the satisfaction of a liability qualifying for partial payment under this chapter is determined in STEP FOUR of the following formula:

STEP ONE: If the total amount of the liability exceeds five

million dollars ($5,000,000), subtract five million dollars ($5,000,000) from the total amount of the liability.

STEP TWO: Add the remainder under STEP ONE to the minimum total amount figure that applies to the liability under section 12 of this chapter.

STEP THREE: Add to the sum determined under STEP TWO the total amount expended by the commission under section 16 of this chapter in defending the member of the fund against claims giving rise to the liability.

STEP FOUR: Subtract the sum determined under STEP THREE from the total amount of the liability.

As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-14
Excess coverage provided

Sec. 14. The coverage of a liability under this chapter is excess of any and all other valid and collectible insurance and coverage under liability risk management, risk sharing, and risk financing pools or funds.

As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-15
Single or installment payments; limits

Sec. 15. An amount payable under section 13 of this chapter that is no more than ten thousand dollars ($10,000) may be paid in a single, immediate payment. An amount payable under section 13 of this chapter that is greater than ten thousand dollars ($10,000) shall be paid:

(1) in installments under section 18(c) of this chapter; or

(2) under a structured settlement negotiated under section 18(d) of this chapter.

As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-16
Defense of claims; expenses

Sec. 16. The commission may associate with a member of the fund in the defense of a claim and, if no defense is provided by the insurer providing the fund member's underlying coverage, the commission may defend the member and control that defense. Amounts expended by the commission from the fund under this section must be deducted under section 13 of this chapter from the amount to be paid by the commission toward the satisfaction of a liability.

As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-17
Biannual recognition of liabilities; payment; proration in event of insufficient funds

Sec. 17. On June 30 and December 31 of every year, the commission shall recognize every liability that has qualified for partial payment under this section during the six (6) month period that ended on that day. The commission shall pay the part of each liability that is payable under section 13 of this chapter within fifteen (15) days after the liability is recognized as qualifying for partial payment. However, if the balance in the fund is insufficient to pay the full payable amount of every liability that has qualified for partial payment during a six (6) month period, the commission shall pay a prorated portion of each liability that qualified for partial payment during the period. Any part of the payable amount of a liability left unpaid due to the prorating of payments under this subsection must be paid before the payment of liabilities that qualify for partial payment during any of the following six (6) month periods.
As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-18
Punitive damages; bodily injury or property damage; installment payments; structured settlements

Sec. 18. (a) No amount may be paid from the fund in respect of punitive damages paid by or assessed against a member of the fund.

(b) No amount may be paid from the fund in the case of a liability based upon bodily injury or property damage arising out of the discharge, dispersal, release, or escape of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids, gases, waste materials, or other irritants, contaminants, or pollutants into or upon land, the atmosphere, or any watercourse or body of water unless the discharge, dispersal, release, or escape:

(1) is caused by an act or omission of a political subdivision that is a member of the fund; and

(2) occurs as a result of:

(A) a household hazardous waste; or

(B) a conditionally exempt small quantity generator (as described in 40 CFR 261.5(a);

collection, disposal, or recycling project conducted by or controlled by the political subdivision.

(c) The commissioner may pay a liability of a member of the fund in a series of annual payments. The amount of any annual payment under this subsection based upon the injury to or death of one (1) person in any one (1) occurrence must be one hundred thousand dollars ($100,000) or more, except for the final payment in a series of payments.

(d) The commission may negotiate a structured settlement of any claim.

(e) As used in this section, "household hazardous waste" means solid waste generated by households that consists of or contains a material that is:

(1) ignitable, as described in 40 CFR 261.21;

(2) corrosive, as described in 40 CFR 261.22;
(3) reactive, as described in 40 CFR 261.23; or
(4) toxic, as described in 40 CFR 261.24.

As added by P.L.272-1987, SEC.7. Amended by P.L.256-1995, SEC.2.

IC 27-1-29.1-19
Notice of intent to become member of fund

Sec. 19. (a) A political subdivision may become a member of the fund by filing a written notice of its intent to become a member with the commission by the latter of the following dates:

(1) December 31, 1987.
(2) The date exactly six (6) months before the expiration date of the liability insurance policy covering the political subdivision on December 31, 1987.

(b) Each political subdivision that files a notice of intent to become a member by the latter of the two (2) dates set forth in subsection (a) shall be granted membership in the fund. A political subdivision that files a notice of intent to become a member after the latter of the two (2) dates set forth in subsection (a) may be admitted to or rejected for membership in the fund at the discretion of the commission.

As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-20
Implementing rules; coverage limitations; commission powers; rules governing relinquishment of membership in fund

Sec. 20. (a) The commission shall adopt rules under IC 4-22-2 to implement this chapter.

(b) The commission, in accordance with the rules adopted under subsection (a), may, in whole or in part, conform or limit the coverage provided to a member of the fund under this chapter (as described in the coverage document issued to the member by the commission) with the provisions of insurance policies providing underlying coverage to the fund member.

(c) In accordance with the rules adopted under subsection (a), the commission may provide, to a member of the fund that is not a member of the political subdivision risk management fund under IC 27-1-29, coverage of a liability that exceeds the amount of one million dollars ($1,000,000) but that is subject to reduction by exhaustion of the aggregate limits of liability in the fund member's underlying coverage.

(d) In accordance with the rules adopted under subsection (a), the commission may provide, to a member of the fund that is also a member of the political subdivision risk management fund under IC 27-1-29, coverage of liabilities for which no coverage is provided under IC 27-1-29.

(e) Except as otherwise specifically provided in this chapter, the

commission has the same powers in the administration of the fund as it has in the administration of the political subdivision risk management fund under IC 27-1-29-7(b). A rule adopted by the commission to establish the procedure by which a political subdivision can withdraw from membership in the fund may not provide that a political subdivision continues to be a member of the fund more than twelve (12) months after the political subdivision gives notice to the commissioner of its intention to relinquish its membership.
As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-21
Relinquishment of membership in fund; prerelinquishment liabilities; assessments

Sec. 21. After relinquishing its membership in the fund, a political subdivision remains liable for its pro rata share of assessments to pay for liabilities of fund members that arose out of claims based upon acts or omissions that took place while the political subdivision was a member of the fund. If a political subdivision fails to pay an assessment to which it is subject under this chapter, the commission may give notice to any department or agency of the state (including the treasurer of state or the auditor of state) that is the custodian of money payable to the delinquent political subdivision after the date of the notice, that the political subdivision is in default on the payment of an assessment under this chapter. After receiving this notice, the department or agency shall withhold the delinquent amount from the money payable to the political subdivision and pay over the money to the commission to be applied against the delinquent assessment.
As added by P.L.272-1987, SEC.7.

IC 27-1-29.1-22
Assessments on members of fund

Sec. 22. (a) The commission shall impose an assessment to be paid by each member of the fund. The assessments to be paid by members of the fund shall be determined by the commission and must be fair to all members, in consideration of the uniform application of actuarial principles and underwriters' rating principles and in consideration of the need to pay the principal of and interest on bonds or notes issued under IC 27-1-29-17(b)(1). A member shall pay its assessment in accordance with rules of the commission.

(b) The assessment for the first twelve (12) months of a political subdivision's membership in the fund shall be no greater than the payment made by the political subdivision to a commercial insurer for like coverage for the twelve (12) month period immediately preceding the political subdivision's application to become a member. In the case of an applicant not insured by a commercial insurer, the department shall set the amount of the assessment for the

first twelve (12) months of membership in accordance with subsection (a).

As added by P.L.272-1987, SEC.7.

IC 27-1-30

Chapter 30. Group Casualty and Liability Insurance for Foster Parents

IC 27-1-30-1

Repealed

(Repealed by P.L.2-1992, SEC.897.)

IC 27-1-30-2

"Casualty and liability insurance" defined

Sec. 2. As used in this chapter, "casualty and liability insurance" means the types of insurance described in IC 27-1-5-1, Class 2(h) and 2(l).

As added by P.L.270-1987, SEC.2.

IC 27-1-30-3

"Casualty insurance company" defined

Sec. 3. As used in this chapter, "casualty insurance company" has the meaning set forth in IC 27-1-2-3(t).

As added by P.L.270-1987, SEC.2.

IC 27-1-30-4

"Foster parent" defined

Sec. 4. As used in this chapter, "foster parent" means a person who holds a license to operate a foster family home under IC 31-27.

As added by P.L.270-1987, SEC.2. Amended by P.L.99-1988, SEC.24; P.L.2-1992, SEC.782; P.L.81-1992, SEC.35; P.L.1-1993, SEC.200; P.L.61-1993, SEC.64; P.L.145-2006, SEC.165.

IC 27-1-30-5

Issuance of group policies

Sec. 5. An insurer authorized under IC 27-1-3-20 to transact business as a casualty insurance company may provide casualty and liability insurance to foster parents on a group basis. A policy may not be issued or renewed to provide group coverage under this chapter to a group that includes fewer than ten (10) members.

As added by P.L.270-1987, SEC.2.

IC 27-1-30-6

Administrative regulations

Sec. 6. The insurance commissioner may promulgate regulations under IC 4-22-2 that he considers necessary for the proper administration of this chapter.

As added by P.L.270-1987, SEC.2.

IC 27-1-31

Chapter 31. Cancellation and Nonrenewal of Commercial Property and Casualty Insurance

IC 27-1-31-1

Application of chapter

Sec. 1. (a) Except as provided in subsection (b), this chapter applies to all lines of commercial property and casualty insurance.

(b) This chapter:

(1) does not apply to the cancellation or nonrenewal of automobile insurance policies, as restricted under IC 27-7-6; and

(2) does not affect requirements applying to:

(A) the cancellation of medical malpractice insurance policies under IC 34-18-13-4 (or IC 27-12-13-4 before its repeal); or

(B) the cancellation of property or liability insurance by a creditor under IC 24-4.5-4-304.

As added by P.L.271-1987, SEC.4. Amended by P.L.2-1993, SEC.149; P.L.224-1993, SEC.1; P.L.1-1998, SEC.148.

IC 27-1-31-2

Grounds for cancellation; notice of cancellation

Sec. 2. (a) An insurer may not cancel a policy of insurance that the insurer has written that has been in effect more than ninety (90) days unless:

(1) the insured under the policy has failed to pay the premium;

(2) there is a substantial change in the scale of risk covered by the policy;

(3) the insured has perpetrated a fraud or material misrepresentation upon the insurer;

(4) the insured has failed to comply with reasonable safety recommendations; or

(5) reinsurance of the risk associated with the policy has been cancelled.

(b) An insurer shall provide a written notice of cancellation to a person insured under a policy issued by the insurer at least:

(1) forty-five (45) days before cancelling the policy for any reason set forth in subsection (a)(2), (a)(4), or (a)(5);

(2) twenty (20) days before cancelling the policy for the reason set forth in subsection (a)(3); or

(3) ten (10) days before cancelling the policy for the reason set forth in subsection (a)(1).

As added by P.L.271-1987, SEC.4. Amended by P.L.162-1988, SEC.3.

IC 27-1-31-2.5

Notice of cancellation

Sec. 2.5. An insurer may cancel a policy of insurance that the insurer has written that has been in effect ninety (90) days or less by providing a written notice of cancellation to a person insured under the policy at least:

(1) ten (10) days before cancelling if an insured has failed to pay a premium;

(2) twenty (20) days before cancelling if the insured has perpetrated a fraud or material misrepresentation upon the insurer; or

(3) thirty (30) days before cancelling for any other reason.

As added by P.L.162-1988, SEC.4.

IC 27-1-31-3

Notice of nonrenewal

Sec. 3. (a) If an insurer refuses to renew a policy of insurance written by the insurer, the insurer shall provide written notice of nonrenewal to the insured:

(1) at least forty-five (45) days before the expiration date of the policy, if the coverage provided is for one (1) year, or less; or

(2) at least forty-five (45) days before the anniversary date of the policy, if the coverage provided is for more than one (1) year.

(b) A notice of nonrenewal is not required if:

(1) the insured is transferred from an insurer to an affiliate of the insurer for future coverage as a result of a merger, an acquisition, or a company restructuring;

(2) the transfer results in the same or broader coverage; and

(3) the insured approves the transfer.

As added by P.L.271-1987, SEC.4. Amended by P.L.160-2003, SEC.23.

IC 27-1-32
Repealed
(Repealed by P.L.1-1992, SEC.147.)

IC 27-1-33

Chapter 33. Managing General Agents

IC 27-1-33-1

Actuary

Sec. 1. As used in this chapter, "actuary" means a person who is a member in good standing of the American Academy of Actuaries.
As added by P.L.1-1992, SEC.148.

IC 27-1-33-2

Commissioner

Sec. 2. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.
As added by P.L.1-1992, SEC.148.

IC 27-1-33-3

Insurer

Sec. 3. As used in this chapter, "insurer" means any person, firm, association, or corporation duly authorized to act in Indiana as an insurance company pursuant to IC 27-1.
As added by P.L.1-1992, SEC.148.

IC 27-1-33-4

Managing general agent

Sec. 4. (a) As used in this chapter, "managing general agent" or "MGA" means any person, firm, association, or corporation:

(1) that manages all or part of the insurance business of an insurer (including the management of a separate division, department, or underwriting office);

(2) that acts as an agent for the insurer, whether known as a managing general agent, manager, or other similar term;

(3) that, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium at least five percent (5%) of the policyholder surplus as reported in the last annual statement of the insurer in any one (1) quarter or year; and

(4) that does at least one (1) of the following activities related to the business produced:

(A) Adjusts or pays claims in excess of an amount determined by the commissioner.

(B) Negotiates reinsurance on behalf of the insurer.

(b) Notwithstanding subsection (a), the following persons are not MGAs for the purposes of this chapter:

(1) An employee of the insurer.

(2) A United States manager of the United States branch of an alien insurer.

(3) An underwriting manager that, pursuant to contract:

(A) manages all or part of the insurance operations of the insurer;

(B) is under common control with the insurer, subject to IC 27-1-23; and

(C) is not compensated based on the volume of premiums written.

(4) An attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer as authorized in IC 27-6-6-1 or an interinsurance exchange as authorized in IC 27-1-2-2 under powers of attorney.

As added by P.L.1-1992, SEC.148. Amended by P.L.130-1994, SEC.34; P.L.116-1994, SEC.44.

IC 27-1-33-5

Underwrite

Sec. 5. As used in this chapter, "underwrite" means the authority to accept or reject risk on behalf of the insurer.

As added by P.L.1-1992, SEC.148.

IC 27-1-33-6

Acting in capacity of MGA with respect to risks; prohibitions; bond; errors and omissions policy

Sec. 6. (a) A person, a firm, an association, or a corporation may not act in the capacity of an MGA with respect to risks located in Indiana for an insurer licensed in Indiana unless that person is a licensed producer in Indiana.

(b) A person, a firm, an association, or a corporation may not act in the capacity of an MGA representing an insurer domiciled in Indiana with respect to risks located outside Indiana unless that person is licensed as a producer in Indiana pursuant to the provisions of this chapter. For the purposes of this subsection, a person is licensed as a producer in Indiana if that person holds a nonresident license.

(c) The commissioner may require a bond in an amount determined by the commissioner for the protection of the insurer.

(d) The commissioner may require an MGA to maintain an errors and omissions policy.

As added by P.L.1-1992, SEC.148.

IC 27-1-33-7

Placement of business with an insurer; contract; contents

Sec. 7. A person, a firm, an association, or a corporation acting in the capacity of an MGA may not place business with an insurer unless there is in force a written contract between the parties. A contract required by this section must set forth the responsibilities of each party and, where both parties share responsibility for a particular function, specify the division of those responsibilities. The contract must, at a minimum, contain provisions that state the

following:

(1) The insurer may terminate the contract for cause upon written notice to the MGA and may suspend the underwriting authority of the MGA during the pendency of any dispute regarding the cause for termination.

(2) The MGA will:

(A) render accounts to the reinsurer detailing all transactions; and

(B) remit all funds due under the contract to the insurer on not less than a monthly basis.

(3) All funds collected for the account of an insurer will be held by the MGA in a fiduciary capacity in a bank that is a member of the Federal Reserve System. This account shall be used for all payments on behalf of the insurer. The MGA may retain not more than three (3) months estimated claims payments and allocated loss adjustment expenses.

(4) Separate records of business written by the MGA shall be maintained. The insurer shall have access and right to copy all accounts and records related to its business in a form usable by the insurer, and the commissioner shall have access to all books, bank accounts, and records of the MGA in a form usable to the commissioner.

(5) The contract may not be assigned in whole or part by the MGA.

(6) Appropriate underwriting guidelines, including the following:

(A) The maximum annual premium volume.

(B) The basis of the rates to be charged.

(C) The types of risks which may be written.

(D) Maximum limits of liability.

(E) Applicable exclusions.

(F) Territorial limitations.

(G) Policy cancellation provisions.

(H) The maximum policy period.

(7) The insurer has the right to cancel or nonrenew any policy of insurance subject to the applicable laws and regulations concerning the cancellation and nonrenewal of insurance policies.

(8) If the contract permits the MGA to settle claims on behalf of the insurer, the following apply:

(A) All claims must be reported to the company in a timely manner.

(B) A copy of the claim file will be sent to the insurer at its request or as soon as it becomes known that the claim:

(i) has the potential to exceed an amount determined by the commissioner or exceeds the limit set by the company, whichever is less;

(ii) involves a coverage dispute;

(iii) may exceed the MGA's claims settlement authority;
(iv) is open for more than six (6) months; or
(v) is closed by payment of an amount set by the commissioner or an amount set by the company, whichever is less.

(C) All claim files will be the joint property of the insurer and MGA. However, upon an order of liquidation of the insurer, those files shall become the sole property of the insurer or its estate. The MGA shall have reasonable access to and the right to copy the files on a timely basis.

(D) Any settlement authority granted to the MGA may be terminated for cause upon the insurer's written notice to the MGA or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

(9) Where electronic claims files are in existence, the contract must address the timely transmission of the data in those files.

(10) If the contract provides for a sharing of interim profits by the MGA, and the MGA has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits will not be paid to the MGA:

(A) until one (1) year after the profits are earned, for property insurance business, and five (5) years after the profits are earned on casualty business; and

(B) until the profits have been verified pursuant to section 8 of this chapter.

(11) An MGA may not do any of the following:

(A) Bind reinsurance or retrocessions on behalf of the insurer, except that the MGA may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines, including, for both reinsurance assumed and ceded, a list of reinsurers with which the automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(B) Commit the insurer to participate in insurance or reinsurance syndicates.

(C) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of insurance for which the producer is appointed.

(D) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which may not exceed one percent (1%) of the insurer's policyholder's surplus as of December 31 of the last completed calendar year before the payment or commitment.

(E) Collect any payment from a reinsurer or commit the

insurer to any claim settlement with a reinsurer without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer.

(F) Permit its subproducer to serve on the insurer's board of directors.

(G) Jointly employ an individual who is employed with the insurer, unless the MGA and the insurer are affiliated in an insurance holding company system.

(H) Appoint a sub-MGA.

As added by P.L.1-1992, SEC.148. Amended by P.L.186-1997, SEC.9.

IC 27-1-33-8

Independent financial examination; loss reserves; on-site review of underwriting and claims; reinsurance; termination of contracts; review of books and records; board of directors

Sec. 8. (a) An insurer shall have on file an independent financial examination, in a form acceptable to the commissioner, of each MGA with which it has done business.

(b) If an MGA establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA. This requirement is in addition to any other required loss reserve certification.

(c) The insurer shall periodically (at least semiannually) conduct an on-site review of the underwriting and claims processing operations of the MGA.

(d) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who may not be affiliated with the MGA.

(e) Within thirty (30) days after entering into or terminating a contract with an MGA, the insurer shall provide written notification of the appointment or termination to the commissioner. Notices of appointment of an MGA must include a statement of duties that the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other information the commissioner may request.

(f) An insurer shall review its books and records each quarter to determine if any producer (as defined by section 4 of this chapter) has become, by operation of section 4 of this chapter, an MGA. If the insurer determines that a producer has become an MGA pursuant to section 4 of this chapter, the insurer shall promptly notify the producer and the commissioner of that determination, and the insurer and producer shall fully comply with the provisions of this chapter within thirty (30) days.

(g) An insurer shall not appoint to its board of directors an officer, a director, an employee, a subproducer, or a controlling shareholder of its MGAs. This subsection does not apply to relationships

governed by IC 27-1-23.

(h) An insurance holding company system regulated under IC 27-1-23 may perform the obligations imposed by this section for insurers affiliated in the system by submitting, in a form acceptable to the commissioner, consolidated information concerning the MGAs with whom the insurers have done business.

As added by P.L.1-1992, SEC.148. Amended by P.L.116-1994, SEC.45.

IC 27-1-33-9

Actions of MGA; examinations

Sec. 9. The acts of the MGA are considered to be the acts of the insurer on whose behalf the MGA is acting. An MGA may be examined as if it were the insurer.

As added by P.L.1-1992, SEC.148.

IC 27-1-33-10

Violations; penalties; civil actions

Sec. 10. (a) If the commissioner determines that the MGA or any other person has not materially complied with this chapter or any rule or order adopted under this chapter, after notice and opportunity to be heard:

(1) the commissioner may order:

(A) for each separate violation, a civil penalty in an amount not exceeding five thousand dollars ($5,000); and

(B) the revocation or suspension of the producer's license; and

(2) if it is found that because of such material noncompliance the insurer has suffered any loss or damage, the commissioner may maintain a civil action brought by or on behalf of the insurer and its policyholders and creditors for recovery of compensatory damages for the benefit of the insurer and its policyholders and creditors or other appropriate relief.

(b) If an order of rehabilitation or liquidation of the insurer has been entered under IC 27-9 and the receiver appointed under that order determines that the MGA or any other person has not materially complied with this chapter or any rule or order adopted under this chapter and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

(c) Nothing contained in this section affects the right of the commissioner to impose any other penalties provided for by law.

(d) Nothing contained in this chapter is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, and auditors.

As added by P.L.1-1992, SEC.148. Amended by P.L.130-1994, SEC.35; P.L.116-1994, SEC.46.

IC 27-1-33-11

Rules for implementation and administration of chapter

Sec. 11. The commissioner may adopt reasonable rules under IC 4-22-2 for the implementation and administration of this chapter.

As added by P.L.1-1992, SEC.148.

IC 27-1-34

Chapter 34. Multiple Employer Welfare Arrangements

IC 27-1-34-1

"Multiple employer welfare arrangement" defined

Sec. 1. (a) As used in this chapter, "arrangement" refers to a multiple employer welfare arrangement.

(b) As used in this chapter, "multiple employer welfare arrangement" means an entity other than a duly admitted insurer that establishes an employee benefit plan for the purpose of offering or providing accident and sickness or death benefits to the employees of at least two (2) employers, including self-employed individuals and their dependents. For purposes of this subsection, two (2) employers, one (1) of which holds an ownership interest of at least fifty-one percent (51%) in the other, are considered to be one (1) employer.

As added by P.L.1-1992, SEC.149. Amended by P.L.173-2007, SEC.19.

IC 27-1-34-2

Certificate of registration

Sec. 2. (a) An arrangement must annually obtain a certificate of registration from the department under rules adopted by the commissioner.

(b) An arrangement that does not obtain a certificate of registration described in subsection (a) or violates the requirements of this chapter is subject to IC 27-4.

As added by P.L.1-1992, SEC.149.

IC 27-1-34-3

Benefits under an employee benefit plan

Sec. 3. An arrangement may provide benefits under an employee benefit plan in Indiana only through an employee benefit plan that has been filed and approved by the department of insurance.

As added by P.L.1-1992, SEC.149.

IC 27-1-34-4

Annual statement

Sec. 4. An arrangement shall file an annual statement on a form prescribed by the commissioner.

As added by P.L.1-1992, SEC.149.

IC 27-1-34-5

Application of insurance law

Sec. 5. Except as provided by this chapter and by IC 27-9, Indiana insurance law does not apply to the operation of multiple employer welfare arrangements.

As added by P.L.1-1992, SEC.149.

IC 27-1-34-6

Examination of arrangements; revocation or suspension of certificate of registration

Sec. 6. (a) It shall be the duty of the department to examine every domestic multiple employer welfare arrangement at least every five (5) years or as often as the department in its discretion may deem necessary. The expense of the examination and or investigations of such arrangements shall be paid by the arrangement so examined.

(b) The commissioner shall revoke or suspend:

(1) the certificate of registration to do business in Indiana of any multiple employer welfare arrangement which refuses to permit such examination described in subsection (a); and

(2) any certificate of registration when any condition prescribed by law or regulation for the issuance or continuance of the certificate no longer exists.

As added by P.L.1-1992, SEC.149.

IC 27-1-34-7

Insolvency; notification of department

Sec. 7. If any domestic multiple employer welfare arrangement is insolvent or in imminent danger of insolvency, or fails or suspends operation between periods of examination authorized, it is a class A misdemeanor for the highest officer then actively in charge of such multiple employer welfare arrangement to knowingly fail to notify the department immediately of such condition, failure, or suspension.

As added by P.L.1-1992, SEC.149.

IC 27-1-34-8

Reinsurers and insurance producers; multiple employer welfare arrangement

Sec. 8. (a) A reinsurer may not issue a policy of insurance to a multiple employer welfare arrangement that does not have a certificate of registration from the department.

(b) An insurance producer licensed by the department may not solicit, offer, or provide coverage through a multiple employer welfare arrangement that does not have a certificate of registration from the department.

(c) A reinsurer or insurance producer who knows or reasonably should have known that the arrangement does not have a current certificate of registration is liable for any claims for benefits that are due and unpaid.

As added by P.L.1-1992, SEC.149. Amended by P.L.178-2003, SEC.30.

IC 27-1-34-9

Rules

Sec. 9. The department of insurance shall adopt rules under IC 4-22-2 necessary to implement this chapter, including but not

limited to:

(1) certificate of registration requirements;
(2) reinsurance requirements;
(3) reserve levels;
(4) deposits;
(5) financial reporting;
(6) fidelity bonds; and
(7) the operations;

of multiple employer welfare arrangements.
As added by P.L.1-1992, SEC.149.

IC 27-1-34-10
Exemptions

Sec. 10. This chapter does not apply to a multiple employer welfare arrangement which offers or provides benefits which are fully insured by an authorized insurer or to an arrangement which is exempt under the federal Employee Retirement Income Security Act (29 U.S.C. 1001 et seq.).
As added by P.L.1-1992, SEC.149.

IC 27-1-35

Chapter 35. Business Transacted With Producer Controlled Property and Casualty Insurers

IC 27-1-35-1

Applicability of law

Sec. 1. This chapter applies to licensed insurers either domiciled in Indiana or domiciled in a state that is not an accredited state having in effect a substantially similar law. All provisions of the Insurance Holding Company System Regulation Act, to the extent the provisions are not superseded by this chapter, continue to apply to all parties within holding company systems subject to this chapter.

As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-2

"Accredited state" defined

Sec. 2. As used in this chapter, "accredited state" means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established periodically by the National Association of Insurance Commissioners (NAIC).

As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-3

"Captive insurer" defined

Sec. 3. As used in this chapter, "captive insurer" means an insurance company owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies, or in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks of any of the following:

(1) Member organizations.

(2) Group members and their affiliates.

(3) Member organizations and group members and their affiliates.

As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-4

"Control" or "controlled" defined

Sec. 4. As used in this chapter, "control" or "controlled" has the meaning set forth in IC 27-1-23-1.

As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-5

"Controlled insurer" defined

Sec. 5. As used in this chapter, "controlled insurer" means a licensed insurer that is controlled, directly or indirectly, by a producer.

As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-6
"Controlling producer" defined

Sec. 6. As used in this chapter, "controlling producer" means a producer that, directly or indirectly, controls an insurer.
As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-7
"Licensed insurer" or "insurer" defined

Sec. 7. As used in this chapter, "licensed insurer" or "insurer" means any person, firm, association, or corporation licensed to transact a property/casualty insurance business in Indiana. The following are not licensed insurers for the purposes of this chapter:

(1) All risk retention groups (as defined in the Superfund Amendments Reauthorization Act of 1986, Pub. L. No. 99-499, 100 Stat. 1613 (1986), the Risk Retention Act, 15 U.S.C. Section 3901 et seq. (1982 & Supp. 1986), and IC 27-7-10-11).
(2) All residual market pools and joint underwriting authorities or associations.
(3) All captive insurers.

As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-8
"Producer" defined

Sec. 8. As used in this chapter, "producer" means an insurance broker or brokers or any other person, firm, association, or corporation, when, for any compensation, commission, or other thing of value, the person, firm, association, or corporation acts or aids in any manner in soliciting, negotiating, or procuring the making of any insurance contract on behalf of an insured other than the person, firm, association, or corporation.
As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-9
Threshold limit of premiums

Sec. 9. The provisions of sections 11 through 14 of this chapter apply if, in any calendar year, the aggregate amount of gross written premiums on business placed with a controlled insurer by a controlling producer is equal to or greater than five percent (5%) of the admitted assets of the controlled insurer, as reported in the controlled insurer's quarterly statement filed as of September 30 of the prior year.
As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-10
Exempt transactions

Sec. 10. Notwithstanding section 9 of this chapter, the provisions

of sections 11 through 14 of this chapter do not apply if:

(1) the controlling producer:

(A) places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate, or subsidiary and receives no compensation based upon the amount of premiums written in connection with such insurance; and

(B) accepts insurance placements only from nonaffiliated subproducers, and not directly from insureds; and

(2) the controlled insurer, except for insurance business written through a residual market facility accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer.

As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-11

Written contract requirement

Sec. 11. A controlled insurer shall not accept business from a controlling producer and a controlling producer shall not place business with a controlled insurer unless there is a written contract between the controlling producer and the controlled insurer specifying the responsibilities of each party, which contract has been approved by the board of directors of the controlled insurer and contains the following minimum provisions:

(1) The controlled insurer may terminate the contract for cause, upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination.

(2) The controlling producer shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the controlling producer.

(3) The controlling producer shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that premiums or installments of premiums collected shall be remitted not later than ninety (90) days after the effective date of any policy placed with the controlled insurer under this contract.

(4) All funds collected for the controlled insurer's account shall be held by the controlling producer in a fiduciary capacity, in one (1) or more appropriately identified bank accounts in banks that are members of the Federal Reserve System, in accordance with the provisions of the insurance law as applicable. However, funds of a controlling producer not required to be licensed in Indiana shall be maintained in compliance with the

requirements of the controlling producer's domiciliary jurisdiction.

(5) The controlling producer shall maintain separately identifiable records of business written for the controlled insurer.

(6) The contract shall not be assigned in whole or in part by the controlling producer.

(7) The controlled insurer shall provide the controlling producer with the controlled insurer's underwriting standards, rules, and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates, and conditions. The standards, rules, procedures, rates, and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer.

(8) The rates and terms of the controlling producer's commissions, charges, or other fees, and the purposes for those charges or fees. The rates of the commissions, charges, and other fees shall be no greater than those applicable to comparable business placed with the controlled insurer by producers other than controlling producers. For purposes of this subdivision and subdivision (7), examples of "comparable business" include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business.

(9) If the contract provides that the controlling producer, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then such compensation shall not be determined and paid until at least five (5) years after the premiums on liability insurance are earned and at least one (1) year after the premiums are earned on any other insurance. The commissions may not be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified under section 13 of this chapter.

(10) A limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings. The insurer may establish a different limit for each line or sub-line of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and shall not accept business from the controlling producer if the limit is reached. The controlling producer shall not place business with the controlled insurer if the controlling producer has been notified by the controlled insurer that the limit has been reached.

(11) The controlling producer may negotiate but shall not bind reinsurance on behalf of the controlled insurer on business the

controlling producer places with the controlled insurer, except that the controlling producer may bind facultative reinsurance contracts under obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines, including for both reinsurance assumed and ceded a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules.

As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-12
Audit committees

Sec. 12. Each controlled insurer shall have an audit committee of the board of directors composed of independent directors. The audit committee shall annually meet with management, the insurer's independent certified public accountants, and an independent casualty actuary or other independent loss reserve specialist acceptable to the commissioner to review the adequacy of the insurer's loss reserves.

As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-13
Opinions of independent casualty actuaries or independent loss reserve specialists

Sec. 13. In addition to any other required loss reserve certification, the controlled insurer shall annually, on April 1 of each year, file with the commissioner an opinion of an independent casualty actuary or such other independent loss reserve specialist acceptable to the commissioner reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year end (including incurred but not reported) on business placed by the producer.

As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-14
Annual reports

Sec. 14. The controlled insurer shall annually report to the commissioner the amount of commissions paid to the producer, the percentage this amount represents of the net premiums written, and comparable amounts and percentage paid to noncontrolling producers for placements of the same kind of insurance.

As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-15
Notice of relationship

Sec. 15. A producer, before the effective date of the policy, shall deliver written notice to the prospective insured disclosing the

relationship between the producer and the controlled insurer, except that, if the business is placed through a subproducer who is not a controlling producer, the controlling producer shall retain in the controlling producer's records a signed commitment from the subproducer that the subproducer is aware of the relationship between the insurer and the producer and that the subproducer has or will notify the insured.
As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-16
Orders to cease placing business

Sec. 16. If the commissioner believes that the controlling producer or any other person has not materially complied with this chapter or any rule or order adopted under this chapter, after notice and opportunity to be heard, the commissioner may order the controlling producer to cease placing business with the controlled insurer.
As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-17
Civil actions by commissioner

Sec. 17. If the commissioner finds that because of a material noncompliance under section 16 of this chapter the controlled insurer or any policyholder of the controlled insurer has suffered any loss or damage, the commissioner may maintain a civil action or intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages for the benefit of the insurer or policyholder or other appropriate relief.
As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-18
Civil actions by receivers

Sec. 18. If an order for liquidation or rehabilitation of the controlled insurer has been entered under IC 27-9, and the receiver appointed under that order believes that the controlling producer or any other person has not materially complied with this chapter or any rule or order adopted under this chapter, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.
As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-35-19
Other rights not affected

Sec. 19. Sections 16 through 18 of this chapter do not:

(1) affect the right of the commissioner to impose any other penalties provided by Indiana law; or

(2) in any manner alter or affect the rights of policyholders, claimants, creditors, or other third parties.

As added by P.L.130-1994, SEC.36 and P.L.116-1994, SEC.47.

IC 27-1-36

Chapter 36. Risk Based Capital Requirements

IC 27-1-36-1

Exemption from applicability of chapter

Sec. 1. The commissioner may exempt from the application of this chapter:

(1) A domestic property and casualty insurer that:

(A) writes direct business only in Indiana;

(B) receives annual premiums from direct business written of not more than two million dollars ($2,000,000); and

(C) assumes no reinsurance in excess of five percent (5%) of direct business written.

(2) A health maintenance organization that:

(A) operates only in Indiana; and

(B) receives annual subscriber premiums (as defined in IC 27-13-1-33) of not more than two million dollars ($2,000,000).

(3) A limited service health maintenance organization that:

(A) operates only in Indiana;

(B) receives annual subscriber premiums (as defined in IC 27-13-1-33) of not more than two million dollars ($2,000,000); and

(C) covers not more than two thousand (2,000) enrollees.

As added by P.L.186-1996, SEC.1. Amended by P.L.51-2002, SEC.1.

IC 27-1-36-2

"Adjusted RBC report"

Sec. 2. As used in this chapter, "adjusted RBC report" means an RBC report that has been adjusted by the commissioner under section 28 of this chapter.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-3

"Authorized control level event"

Sec. 3. As used in this chapter, "authorized control level event" has the meaning set forth in section 39 of this chapter.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-4

"Authorized control level RBC"

Sec. 4. As used in this chapter, the "authorized control level RBC" means, with respect to an insurer, the number determined under the risk-based capital formula in accordance with the RBC instructions.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-5

"Company action level event"

Sec. 5. As used in this chapter, "company action level event" has the meaning set forth in section 29 of this chapter.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-6
"Company action level RBC"

Sec. 6. As used in this chapter, "company action level RBC" means, with respect to an insurer, the product of two (2) multiplied by the insurer's authorized control level RBC.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-7
"Corrective order"

Sec. 7. As used in this chapter, "corrective order" means an order issued by the commissioner that specifies the corrective actions that the commissioner determines are required.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-8
"Domestic insurer"

Sec. 8. As used in this chapter, "domestic insurer" means any:
(1) insurance company;
(2) health maintenance organization;
(3) limited service health maintenance organization; or
(4) fraternal benefit society;
that is domiciled in Indiana.
As added by P.L.186-1996, SEC.1. Amended by P.L.51-2002, SEC.2; P.L.276-2013, SEC.17.

IC 27-1-36-9
"Foreign insurer"

Sec. 9. As used in this chapter, "foreign insurer" means the following:
(1) An insurer that is:
(A) licensed to do business in Indiana under IC 27-1-17; but
(B) not a domestic insurer.
(2) A health maintenance organization that:
(A) is organized under the laws of a state other than Indiana, a territory or another insular possession of the United States, or the District of Columbia; and
(B) has obtained a certificate of authority under IC 27-13-2.
(3) A limited service health maintenance organization that:
(A) is organized under the laws of a state other than Indiana, a territory or another insular possession of the United States, or the District of Columbia; and
(B) has obtained a certificate of authority under IC 27-13-34.
(4) A fraternal benefit society that:
(A) is organized under the laws of a state other than Indiana,

a territory or another insular possession of the United States, or the District of Columbia; and

(B) has obtained a certificate of authority under IC 27-11-8-5.

As added by P.L.186-1996, SEC.1. Amended by P.L.51-2002, SEC.3; P.L.276-2013, SEC.18.

IC 27-1-36-9.2
"Fraternal benefit society"

Sec. 9.2. As used in this chapter, "fraternal benefit society" refers to a society (as defined in IC 27-11-1-11) that holds a certificate of authority issued under IC 27-11-4 or IC 27-11-8-5.

As added by P.L.276-2013, SEC.19.

IC 27-1-36-9.3
"Health insurer"

Sec. 9.3. As used in this chapter, "health insurer" means the following:

(1) A health maintenance organization.

(2) A limited service health maintenance organization.

(3) An insurer that makes one (1) or more of the types of insurance described in Class 1(b) or Class 2(a) of IC 27-1-5-1.

(4) An insurer that files a health blank in accordance with the NAIC Annual Statement Instructions.

As added by P.L.276-2013, SEC.20.

IC 27-1-36-9.4
"Health maintenance organization"

Sec. 9.4. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

As added by P.L.51-2002, SEC.4.

IC 27-1-36-9.6
"Insurer"

Sec. 9.6. As used in this chapter, "insurer" includes:

(1) a health maintenance organization;

(2) a limited service health maintenance organization; and

(3) a fraternal benefit society.

As added by P.L.51-2002, SEC.5. Amended by P.L.276-2013, SEC.21.

IC 27-1-36-9.8
"Limited service health maintenance organization"

Sec. 9.8. As used in this chapter, "limited service health maintenance organization" has the meaning set forth in IC 27-13-34-4.

As added by P.L.51-2002, SEC.6.

IC 27-1-36-10
"Life insurer"

Sec. 10. As used in this chapter, "life insurer" means an insurer that makes one (1) or more of the types of insurance described in Class 1 of IC 27-1-5-1.

As added by P.L.186-1996, SEC.1. Amended by P.L.276-2013, SEC.22.

IC 27-1-36-11
"Mandatory control level event"

Sec. 11. As used in this chapter, "mandatory control level event" has the meaning set forth in section 41 of this chapter.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-12
"Mandatory control level RBC"

Sec. 12. As used in this chapter, "mandatory control level RBC" means, with respect to an insurer, the product of seven-tenths (.7) multiplied by the insurer's authorized control level RBC.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-13
"NAIC"

Sec. 13. As used in this chapter, "NAIC" refers to the National Association of Insurance Commissioners.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-14
"Negative trend"

Sec. 14. As used in this chapter, "negative trend" means, with respect to an insurer, a negative trend over a period of time, as determined in accordance with the trend test calculation included in the RBC instructions.

As added by P.L.186-1996, SEC.1. Amended by P.L.276-2013, SEC.23.

IC 27-1-36-15
"Property and casualty insurer"

Sec. 15. As used in this chapter, "property and casualty insurer" means an insurer that is authorized to make one (1) or more of the types of insurance described in Class 2 and Class 3 of IC 27-1-5-1. The term does not include the following:

(1) A monoline mortgage guaranty insurer.
(2) A financial guaranty insurer.
(3) A title insurer.
(4) A health maintenance organization.
(5) A limited service health maintenance organization.

As added by P.L.186-1996, SEC.1. Amended by P.L.51-2002, SEC.7.

IC 27-1-36-16
"RBC"
Sec. 16. As used in this chapter, "RBC" refers to risk based capital.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-17
"RBC instructions"
Sec. 17. As used in this chapter, "RBC instructions" means the RBC report including risk based capital instructions adopted by the NAIC, as amended by the NAIC.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-18
"RBC level"
Sec. 18. As used in this chapter, "RBC level" means an insurer's:
(1) company action level RBC;
(2) regulatory action level RBC;
(3) authorized control level RBC; or
(4) mandatory control level RBC.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-19
"RBC plan"
Sec. 19. As used in this chapter, "RBC plan" means a comprehensive financial plan containing the elements specified in section 30 of this chapter.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-20
"RBC report"
Sec. 20. As used in this chapter, "RBC report" means the report required by section 25 of this chapter.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-21
"Regulatory action level event"
Sec. 21. As used in this chapter, "regulatory action level event" has the meaning set forth in section 35 of this chapter.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-22
"Regulatory action level RBC"
Sec. 22. As used in this chapter, "regulatory action level RBC" means, with respect to an insurer, the product of one and five-tenths (1.5) multiplied by the insurer's authorized control level RBC.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-23
"Revised RBC plan"

Sec. 23. As used in this chapter, "revised RBC plan" means the revised RBC plan that an insurer must prepare, with or without the commissioner's recommendation, if the commissioner rejects the insurer's previous RBC plan.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-24
"Total adjusted capital"

Sec. 24. As used in this chapter, "total adjusted capital" means the sum of:

(1) an insurer's statutory capital and surplus determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under IC 27-1-3.5; and

(2) other items, if any, that the RBC instructions may provide.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-25
RBC report; requirements; filing

Sec. 25. (a) A domestic insurer shall prepare a report of the RBC levels of the insurer as of the last day of the calendar year most recently ended. The report must:

(1) be in the form; and

(2) contain the information;

required by the RBC instructions.

(b) On or before March 1 of each year, a domestic insurer shall file the RBC report described in subsection (a) with:

(1) the commissioner;

(2) the NAIC, in accordance with the RBC instructions; and

(3) the insurance commissioner in any state other than Indiana in which the insurer is authorized to do business, if the insurance commissioner has notified the insurer in writing of the commissioner's request for the insurer's RBC report.

An insurer is not required to pay a fee when filing an RBC report under this subsection.

(c) If an insurer is required under subsection (b)(3) to file its RBC report with the insurance commissioner of a state other than Indiana, the insurer shall file the RBC report with the insurance commissioner of that state not later than:

(1) fifteen (15) days after the insurer receives the notice; or

(2) March 1 of the calendar year in which the insurer receives the notice;

whichever occurs later.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-26

Life insurer's and fraternal benefit society's RBC; formula

Sec. 26. (a) This section applies to the following:

(1) A life insurer.

(2) A fraternal benefit society.

(b) An insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take into account (and may adjust for the covariance between):

(1) the risk with respect to the insurer's assets;

(2) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(3) the interest rate risk with respect to the insurer's business; and

(4) all other business risks and such other relevant risks as are set forth in the RBC instructions;

determined by applying the factors in the manner set forth in the RBC instructions.

As added by P.L.186-1996, SEC.1. Amended by P.L.276-2013, SEC.24.

IC 27-1-36-26.1

Health insurer's RBC; formula

Sec. 26.1. A health insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions for a health insurer. The formula must take into account (and may adjust for the covariance between):

(1) affiliation investment risk;

(2) asset risk;

(3) credit risk;

(4) underwriting risk; and

(5) all other business risks and such other relevant risks as are set forth in the RBC instructions;

determined by applying the factors in the manner set forth in the RBC instructions.

As added by P.L.51-2002, SEC.8. Amended by P.L.276-2013, SEC.25.

IC 27-1-36-27

Property and casualty insurer's RBC; formula

Sec. 27. A property and casualty insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take into account (and may adjust for the covariance between):

(1) asset risk;

(2) credit risk;

(3) underwriting risk; and

(4) all other business risks and such other relevant risks as are set forth in the RBC instructions;

determined by applying the factors in the manner set forth in the

RBC instructions.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-28
Inaccuracy of RBC report filed by domestic insurer

Sec. 28. (a) If the commissioner determines an RBC report filed by a domestic insurer is inaccurate, the commissioner shall:

(1) adjust the RBC report to correct the inaccuracy; and
(2) notify the insurer of the adjustment.

(b) A notice provided by the commissioner under subsection (a) must contain a statement of the reason for the adjustment.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-29
"Company action level event"

Sec. 29. As used in this chapter, "company action level event" means any of the following events:

(1) The filing of an RBC report by an insurer that indicates that:
(A) the insurer's total adjusted capital is:
(i) greater than or equal to its regulatory action level RBC; but
(ii) less than its company action level RBC;
(B) if a life insurer or a fraternal benefit society, the insurer:
(i) has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of three (3) multiplied by its authorized control level RBC; and
(ii) has a negative trend;
(C) if a property and casualty insurer, the insurer:
(i) has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of three (3) multiplied by its authorized control level RBC; and
(ii) has a negative trend; or
(D) if a health insurer, the insurer:
(i) has a total adjusted capital that is greater than or equal to its company action level RBC but less than the product of three (3) multiplied by its authorized control level RBC; and
(ii) has a negative trend.
(2) The notification by the commissioner to the insurer of an adjusted RBC report that indicates that:
(A) the insurer's total adjusted capital is:
(i) greater than or equal to its regulatory action level RBC; but
(ii) less than its company action level RBC;
(B) if a life insurer or a fraternal benefit society, the insurer:
(i) has total adjusted capital that is greater than or equal to

its company action level RBC but less than the product of three (3) multiplied by its authorized control level RBC; and

(ii) has a negative trend;

(C) if a property and casualty insurer, the insurer:

(i) has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of three (3) multiplied by its authorized control level RBC; and

(ii) has a negative trend; or

(D) if a health insurer, the insurer:

(i) has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of three (3) multiplied by its authorized control level RBC; and

(ii) has a negative trend;

unless the insurer challenges the adjusted RBC report under section 44 of this chapter.

(3) The notification by the commissioner to the insurer that the commissioner has, after a hearing under section 44 of this chapter, rejected the insurer's challenge to an adjusted RBC report described in subdivision (2).

As added by P.L.186-1996, SEC.1. Amended by P.L.11-2011, SEC.23; P.L.81-2012, SEC.19; P.L.276-2013, SEC.26.

IC 27-1-36-30

Preparation and submission of RBC plan after company action level event

Sec. 30. If a company action level event occurs, the insurer shall prepare and submit to the commissioner an RBC plan that does all the following:

(1) Addresses the following:

(A) The conditions that contribute to the insurer's RBC level.

(B) The key assumptions affecting the insurer's projections and the sensitivity of the projections to the assumptions.

(C) The quality of, and problems associated with, the insurer's business, including the following:

(i) Assets.

(ii) Anticipated business growth and associated surplus strain.

(iii) Extraordinary exposure to risk.

(iv) Mix of business and use of reinsurance, if any, in each case.

(2) Contains proposals for corrective actions that the insurer intends to take and that would be expected to result in the elimination of the RBC level.

(3) Provides projections of the insurer's financial results in the current year and at least the four (4) consecutive succeeding

years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of the following:

(A) Statutory operating income.

(B) Net income.

(C) Capital.

(D) Surplus. (The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.)

As added by P.L.186-1996, SEC.1.

IC 27-1-36-31

Timing for submission of RBC plan after company action level event

Sec. 31. An insurer must submit to the commissioner an RBC plan required under section 30 of this chapter:

(1) not more than forty-five (45) days after the company action level event; or

(2) not more than forty-five (45) days after notification to the insurer that the commissioner has, after a hearing under section 44 of this chapter, rejected the insurer's challenge.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-32

RBC plan; notice by commissioner; revised RBC plan

Sec. 32. (a) Not more than sixty (60) days after an insurer submits an RBC plan under section 31 of this chapter, the commissioner shall notify the insurer of whether the RBC plan:

(1) must be implemented; or

(2) is unsatisfactory.

(b) If the commissioner determines that an RBC plan is unsatisfactory, the notification to the insurer:

(1) must state the reasons for the determination; and

(2) may include revisions proposed by the commissioner that will render the RBC plan satisfactory.

(c) Upon receiving a notification from the commissioner under subsection (b), the insurer shall prepare a revised RBC plan. The revised RBC plan may incorporate by reference any revisions proposed by the commissioner. The insurer shall submit the revised RBC plan to the commissioner:

(1) not more than forty-five (45) days after the insurer receives the notification under subsection (a)(2); or

(2) not more than forty-five (45) days after the insurer receives the notification from the commissioner that the commissioner has, after a hearing under section 44 of this chapter, rejected the insurer's challenge.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-33
Notification by commissioner as regulatory action level event

Sec. 33. If the commissioner notifies an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner may, subject to the insurer's right to a hearing under section 44 of this chapter, specify in the notification that the notification constitutes a regulatory action level event.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-34
Filing RBC plan with commissioner of state other than Indiana

Sec. 34. (a) A domestic insurer that files an RBC plan or a revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in each state other than Indiana in which the insurer is authorized to do business, if:

(1) the state has an RBC provision substantially similar to section 45 of this chapter; and

(2) the insurance commissioner of that state has notified the insurer in writing of its request for the filing.

(b) If an insurer is required under subsection (a) to file its RBC plan or revised RBC plan with the insurance commissioner of a state other than Indiana, the insurer shall file the RBC plan or revised RBC plan not later than:

(1) fifteen (15) days after the insurer receives notice under subsection (a)(2); or

(2) the date on which the RBC plan or revised RBC plan is filed under sections 31 and 32 of this chapter;

whichever occurs later.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-35
"Regulatory action level event"

Sec. 35. As used in this chapter, "regulatory action level event" means any of the following events:

(1) The filing of an RBC report by the insurer that indicates that the insurer's total adjusted capital is:

(A) greater than or equal to its authorized control level RBC; but

(B) less than its regulatory action level RBC.

(2) The notification by the commissioner to an insurer of an adjusted RBC report that indicates that the insurer's total adjusted capital is:

(A) greater than or equal to its authorized control level RBC; but

(B) less than its regulatory action level RBC;

unless the insurer challenges the adjusted RBC report under section 44 of this chapter.

(3) The notification by the commissioner to the insurer that the commissioner has, after a hearing under section 44 of this chapter, rejected the insurer's challenge to an adjusted RBC report.

(4) The failure of the insurer to file an RBC report by the filing date, unless the insurer:

(A) has provided an explanation for the failure that is satisfactory to the commissioner; and

(B) has cured the failure not more than ten (10) days after the March 1 filing date.

(5) The failure of the insurer to submit an RBC plan to the commissioner within the period prescribed in section 31 of this chapter.

(6) Notification by the commissioner to the insurer under section 33 of this chapter, unless the insurer challenges the notification under section 44 of this chapter.

(7) The notification by the commissioner to the insurer that the commissioner has, after a hearing under section 44 of this chapter, rejected the challenge to a determination by the commissioner under section 33 of this chapter.

(8) Notification by the commissioner to the insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan, but only if:

(A) the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its RBC plan or revised RBC plan; and

(B) the commissioner has so stated in the notification;

unless the insurer challenges the determination under section 44 of this chapter.

(9) The notification by the commissioner to the insurer that the commissioner has, after a hearing under section 44 of this chapter, rejected the insurer's challenge to the determination made under subdivision (8).

As added by P.L.186-1996, SEC.1.

IC 27-1-36-36

Action by commissioner after regulatory action level event

Sec. 36. If a regulatory action level event occurs, the commissioner shall:

(1) require the insurer to prepare an RBC plan or, if applicable, a revised RBC plan;

(2) perform such examination or analysis as the commissioner considers necessary of the assets, liabilities, and operations of the insurer, including a review of the insurer's RBC plan or revised RBC plan; and

(3) after the examination or analysis, issue a corrective order specifying the corrective actions that the commissioner determines are required, taking into account relevant factors

with respect to the insurer, based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the insurer, including the results of any sensitivity tests undertaken under the RBC instructions.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-37

Timing for submission of RBC plan or revised RBC plan after regulatory action level event

Sec. 37. The RBC plan or revised RBC plan must be submitted:

(1) not more than forty-five (45) days after the regulatory action level event;

(2) not later than forty-five (45) days after the notification to the insurer that the commissioner has, after a hearing under section 44 of this chapter, rejected the insurer's challenge to an adjusted RBC report; or

(3) not more than forty-five (45) days after the notification to the insurer that the commissioner has, after a hearing under section 44 of this chapter, rejected the insurer's challenge to an adjusted RBC plan.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-38

Consultants to commissioner

Sec. 38. (a) The commissioner may retain actuaries, investment experts, and other consultants that the commissioner determines to be necessary to:

(1) review the insurer's RBC plan or revised RBC plan;

(2) examine or analyze the assets, liabilities, and operations of the insurer; and

(3) formulate the corrective order with respect to the insurer.

(b) The reasonable costs and expenses relating to consultants shall be paid by the affected insurer or another party, as directed by the commissioner.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-39

"Authorized control level event"

Sec. 39. As used in this chapter, "authorized control level event" means any of the following events:

(1) The filing of an RBC report by an insurer that indicates that the insurer's total adjusted capital is:

(A) greater than or equal to its mandatory control level RBC; but

(B) less than its authorized control level RBC.

(2) The notification by the commissioner to the insurer of an adjusted RBC report that indicates that the insurer's total adjusted capital is:

(A) greater than or equal to its mandatory control level RBC; but

(B) less than its authorized control level RBC;

unless the insurer challenges the adjusted RBC report under section 44 of this chapter.

(3) Notification by the commissioner to the insurer that the commissioner has, after a hearing under section 44 of this chapter, rejected the insurer's challenge to an adjusted RBC report.

(4) The failure of the insurer to respond, in a manner satisfactory to the commissioner, to a corrective order, unless the insurer has challenged the corrective order under section 44 of this chapter.

(5) The failure of the insurer to respond, in a manner satisfactory to the commissioner, to a corrective order if, after a challenge and a hearing under section 44 of this chapter, the commissioner has:

(A) rejected the challenge; or

(B) modified the corrective order.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-40

Action by commissioner after authorized control level event

Sec. 40. (a) If an authorized control level event occurs with respect to an insurer, the commissioner shall:

(1) take the actions required under section 36 of this chapter regarding an insurer; or

(2) if the commissioner considers it to be in the best interests of:

(A) the policyholders and creditors of the insurer; and

(B) the public;

take any action necessary to cause the insurer to be placed under regulatory control under IC 27-9.

(b) An authorized control level event is sufficient grounds for the commissioner to:

(1) determine, under IC 27-9-2-1, that an insurer has committed or engaged in, or is about to commit or engage in, an act, a practice, or a transaction that would subject the insurer to a delinquency proceeding under IC 27-9-3-1 or IC 27-9-3-6; and

(2) serve upon the insurer, under IC 27-9-2-1, orders reasonably necessary to correct, eliminate, or remedy the conduct, condition, or ground.

The commissioner has the rights, powers, and duties with respect to the insurer that are set forth in IC 27-9.

(c) If the commissioner takes action under subsection (a)(2), the insurer is entitled to the protections of IC 27-9-2 pertaining to summary proceedings.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-41
"Mandatory control level event"

Sec. 41. As used in this chapter, "mandatory control level event" means any of the following events:

(1) The filing of an RBC report that indicates that the insurer's total adjusted capital is less than its mandatory control level RBC.

(2) Notification by the commissioner to the insurer of an adjusted RBC report that indicates that the insurer's total adjusted capital is less than its mandatory control level RBC unless the insurer challenges the adjusted RBC report under section 44 of this chapter.

(3) Notification by the commissioner to the insurer that the commissioner has, after a hearing under section 44 of this chapter, rejected the insurer's challenge to an adjusted RBC report.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-42
Action by commissioner after mandatory control level event with respect to life and health insurer

Sec. 42. (a) If a mandatory control level event occurs with respect to a life insurer, a health insurer, or a fraternal benefit society, the commissioner shall take the actions necessary to place the insurer under regulatory control under IC 27-9.

(b) A mandatory control level event is sufficient grounds for the commissioner to take action against a life insurer, a health insurer, or a fraternal benefit society under IC 27-9, and the commissioner has the rights, powers, and duties with respect to the insurer that are set forth in IC 27-9.

(c) If the commissioner takes action against a life insurer, a health insurer, or a fraternal benefit society under an adjusted RBC report, the insurer is entitled to the protections of IC 27-9-2 pertaining to summary proceedings.

(d) The commissioner may forego action under subsections (a) through (c) for not more than ninety (90) days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety (90) day period.

As added by P.L.186-1996, SEC.1. Amended by P.L.276-2013, SEC.27.

IC 27-1-36-42.1
Action by commissioner after mandatory control level event with respect to health maintenance organization or limited service health maintenance organization

Sec. 42.1. (a) If a mandatory control level event occurs with respect to a health maintenance organization or a limited service

health maintenance organization, the commissioner shall take the action necessary to place the health maintenance organization or limited service health maintenance organization under regulatory control under IC 27-13.

(b) A mandatory control level event is sufficient grounds for the commissioner to take action against a health maintenance organization or a limited service health maintenance organization under IC 27-13 and the commissioner has the rights, powers, and duties with respect to the health maintenance organization or limited service health maintenance organization that are set forth in IC 27-13.

(c) If the commissioner takes action against a health maintenance organization or a limited service health maintenance organization under an adjusted RBC report, the health maintenance organization or limited service health maintenance organization is entitled to the protections under IC 27-9-2 pertaining to summary proceedings.

(d) The commissioner may forego action under subsections (a) through (c) for not more than ninety (90) days after the mandatory control level event if the commissioner finds that there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety (90) day period.

As added by P.L.51-2002, SEC.9.

IC 27-1-36-43

Action by commissioner after mandatory control level event with respect to property and casualty insurer

Sec. 43. (a) If a mandatory control level event occurs with respect to a property and casualty insurer, the commissioner:

(1) shall take the actions necessary to place the insurer under regulatory control under IC 27-9; or

(2) in the case of an insurer that is not writing business and that is running off its existing business, may allow the insurer to continue its run-off under the supervision of the commissioner.

(b) A mandatory control level event is sufficient grounds for the commissioner to take action against a property and casualty insurer under IC 27-9, and the commissioner has the rights, powers, and duties with respect to the insurer that are set forth in IC 27-9.

(c) If the commissioner takes action against a property and casualty insurer under an adjusted RBC report, the insurer is entitled to the protections of IC 27-9-2 pertaining to summary proceedings.

(d) The commissioner may forego action for not more than ninety (90) days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety (90) day period.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-44

Confidential department hearing

Sec. 44. (a) The insurer has the right to a confidential departmental hearing, on the record, upon the occurrence of any of the following:

(1) Notification to an insurer by the commissioner of an adjusted RBC report.

(2) Notification to an insurer by the commissioner under section 32(b) of this chapter.

(3) Notification to an insurer by the commissioner that:

(A) the insurer has failed to adhere to its RBC plan or revised RBC plan; and

(B) the insurer's failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its RBC plan or revised RBC plan.

(4) Notification to an insurer by the commissioner of a corrective order with respect to the insurer.

(b) At a confidential hearing under this section, the insurer may challenge any determination or action by the commissioner.

(c) An insurer must notify the commissioner of the insurer's request for a hearing under this section not more than five (5) days after the notification by the commissioner under subsection (a). Upon receiving the insurer's request for a hearing, the commissioner shall set a date for the hearing. The date set by the commissioner must be:

(1) at least ten (10); and

(2) not more than thirty (30);

days after the date of the insurer's request.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-45

Confidential information

Sec. 45. (a) Because they contain information that might be damaging to an insurer if made available to the insurer's competitors, the following are declared confidential for purposes of IC 5-14-3-4 and are not subject to inspection and copying by the public under IC 5-14-3-3:

(1) An RBC report filed with the commissioner under this chapter, to the extent that the information in the report is not required to be provided in a publicly available annual statement schedule.

(2) An RBC plan filed with the commissioner under this chapter, including:

(A) the results or report of any examination or analysis of an insurer performed under the plan; and

(B) any corrective order issued by the commissioner under the examination or analysis.

(b) The information described in subsection (a):

(1) must be kept confidential by the commissioner;

(2) shall not be made public; and

(3) is not:
(A) subject to subpoena;
(B) subject to discovery in a private civil action; or
(C) admissible in evidence in a private civil action;
other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner under this chapter or another provision of this title.

(c) The commissioner, or a person receiving documents, materials, or other information while acting under the authority of the commissioner, is not permitted or required to testify in a private civil action concerning confidential information described in subsection (a).

(d) The commissioner may disclose documents, materials, and other information, including the information described in subsection (a), to:
(1) other state, federal, and international regulatory agencies;
(2) the NAIC and affiliates and subsidiaries of the NAIC; and
(3) state, federal, and international law enforcement authorities;
if the recipient agrees to maintain the confidential and privileged status of the documents, materials, and other information.

(e) The commissioner:
(1) may receive documents, materials, and other information, including confidential and privileged documents, materials, and information, from:
(A) other state, federal, and international regulatory agencies;
(B) the NAIC and affiliates and subsidiaries of the NAIC; and
(C) other state, federal, and international law enforcement authorities; and
(2) shall maintain as confidential or privileged all documents, materials, and other information received with notice or the understanding that the documents, materials, and information are confidential or privileged under the law of the jurisdiction that is the source of the documents, materials, and information.

(f) Any applicable privilege or claim of confidentiality in documents, materials, or information described in this section is not waived as a result of the disclosure or receipt of the documents, materials, or information by the commissioner under this section.

As added by P.L.186-1996, SEC.1. Amended by P.L.276-2013, SEC.28.

IC 27-1-36-46
Comparison of insurer's total adjusted capital to RBC levels

Sec. 46. (a) The comparison of an insurer's total adjusted capital to any of its RBC levels is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer and it is not intended as a means to rank insurers generally. Except as

provided in subsection (b), the action of an insurer, an insurance producer, a broker, or other person engaged in any manner in the insurance business, in:

(1) making, publishing, disseminating, circulating, or placing before the public; or

(2) 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, an announcement, or a statement containing an assertion, a representation, or a statement regarding the RBC level of an insurer or any component derived in the calculation of the RBC level of an insurer is misleading and is prohibited.

(b) If:

(1) a materially false statement with respect to the comparison regarding an insurer's total adjusted capital to an RBC level of the insurer or an inappropriate comparison of any other amount to the insurer's RBC levels is published in any written publication; and

(2) the insurer is able to demonstrate to the commissioner with substantial proof the:

(A) falsity; or

(B) inappropriateness;

of the statement;

the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

As added by P.L.186-1996, SEC.1. Amended by P.L.178-2003, SEC.31.

IC 27-1-36-47

Use of documents referred to in chapter

Sec. 47. (a) The:

(1) RBC instructions;

(2) RBC reports;

(3) adjusted RBC reports;

(4) RBC plans; and

(5) revised RBC plans;

referred to in this chapter are intended solely for use by the commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers.

(b) The instructions, reports, and plans referred to in subsection (a) shall not be:

(1) used by the commissioner for ratemaking;

(2) considered or introduced as evidence in a rate proceeding; or

(3) used by the commissioner to calculate or derive any

elements of an appropriate premium level or rate of return for any line of insurance that an insurer or an affiliate is authorized to write.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-48

Chapter supplements other Indiana law

Sec. 48. This chapter is supplemental to other provisions of Indiana law and does not preclude or limit any other powers or duties of the commissioner under other provisions of Indiana law, including IC 27-9.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-49

Submission of RBC report by foreign insurer

Sec. 49. (a) Upon the written request of the commissioner, a foreign insurer shall submit to the commissioner an RBC report as of the last day of the calendar year most recently ended. The foreign insurer shall submit the report on or before:

(1) the date on which a domestic insurer would be required to file an RBC report under this chapter; or

(2) fifteen (15) days after the foreign insurer receives the request;

whichever occurs later.

(b) Upon the written request of the commissioner, a foreign insurer shall promptly submit to the commissioner a copy of any RBC plan that the foreign insurer has filed with the insurance commissioner of any other state.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-50

Filing of RBC plan by foreign insurer

Sec. 50. (a) If:

(1) an event that is:

(A) a company action level event;

(B) a regulatory action level event; or

(C) an authorized control level event;

occurs with respect to a foreign insurer as determined under the RBC statute applicable in the state of domicile of the insurer (or, if no RBC statute is in force in that state, under this chapter); and

(2) the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file an RBC plan in the manner specified under that state's RBC statute (or, if no RBC statute is in force in that state, under sections 31 through 35 of this chapter);

the commissioner may require the foreign insurer to file an RBC plan with the commissioner.

(b) In a situation described in subsection (a), the failure of the foreign insurer to file an RBC plan with the commissioner is grounds for the commissioner to order the insurer to cease and desist from writing new insurance business in Indiana.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-51
Liquidation of property of foreign insurer

Sec. 51. If:

(1) a mandatory control level event occurs with respect to a foreign insurer; and

(2) no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer;

the commissioner may apply to the Marion County circuit court with respect to the liquidation of property of the foreign insurer that is found in Indiana. The occurrence of the mandatory control level event is adequate grounds for the application.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-52
Effective notice

Sec. 52. (a) A notice by the commissioner to an insurer that may result in regulatory action under this chapter, if transmitted by registered or certified mail, is effective when the notice is put in the mail.

(b) A transmission by the commissioner to an insurer under this chapter other than a notice described in subsection (a) is effective upon the insurer's receipt of the transmission.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-53
Immunity from liability

Sec. 53. There is no liability on the part of, and no cause of action shall arise against:

(1) the commissioner;

(2) the department; or

(3) any employee or agent of the department;

for any action taken in the exercise of their powers and the performance of duties under this chapter.
As added by P.L.186-1996, SEC.1.

IC 27-1-36-54
Severability of chapter provisions

Sec. 54. The provisions of this chapter are severable in the manner provided in IC 1-1-1-8. If:

(1) any provision of this chapter; or

(2) the application of this chapter to any person or

circumstance;

is held invalid, that determination shall not affect the provisions or applications of this chapter that can be given effect without the invalid provision or application.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-55

Rules

Sec. 55. The commissioner, under IC 4-22-2, may adopt reasonable rules necessary for the implementation of this chapter.

As added by P.L.186-1996, SEC.1.

IC 27-1-36-56

Excess capital

Sec. 56. (a) An excess of capital over the amount produced by the:

(1) risk based capital requirements contained in this chapter; and

(2) formulas, schedules, and instructions referred to in this chapter;

is desirable in the business of insurance. Therefore, insurers should seek to maintain capital above the RBC levels required by this chapter.

(b) Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks that are:

(1) inherent in or affecting the business of insurance; and

(2) not accounted for or only partially measured by the risk based capital requirements contained in this chapter.

As added by P.L.186-1996, SEC.1.

IC 27-1-37

Chapter 37. Health Provider Contracts

IC 27-1-37-1

"Emergency" defined

Sec. 1. As used in this chapter, "emergency" means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

(1) place an individual's health in serious jeopardy;

(2) result in serious impairment to the individual's bodily functions; or

(3) result in serious dysfunction of a bodily organ or part of the individual.

As added by P.L.197-2001, SEC.1.

IC 27-1-37-2

"Health maintenance organization" defined

Sec. 2. As used in this chapter, "health maintenance organization" means a person that undertakes to provide or arrange for the delivery of health care services to individuals on a prepaid basis, except for the individual's responsibility for copayments or deductibles. The term includes a limited service health maintenance organization. The term does not include a staff-model health maintenance organization that employs a group of providers and that requires the providers to provide health care services solely to individuals who are entitled to coverage under a contract with the staff-model health maintenance organization or an affiliate of the staff-model health maintenance organization.

As added by P.L.197-2001, SEC.1.

IC 27-1-37-3

"Health provider contract" defined

Sec. 3. As used in this chapter, "health provider contract" means an agreement with a provider relating to terms and conditions of reimbursement for health care services provided to an individual under:

(1) an employee welfare benefit plan (as defined in 29 U.S.C. 1002 et seq.);

(2) a policy of accident and sickness insurance (as defined in IC 27-8-5-1);

(3) a contract with a health maintenance organization;

(4) a self-insurance program established under IC 5-10-8-7(b); or

(5) a prepaid health care delivery plan entered into under IC 5-10-8-7(c).

As added by P.L.197-2001, SEC.1.

IC 27-1-37-4
"Person" defined

Sec. 4. (a) As used in this chapter, "person" means an individual, an agency, a political subdivision, a partnership, a corporation, an association, or any other entity.

(b) The term does not include a health care provider described in IC 16-18-2-163(a)(1), IC 16-18-2-163(a)(2), IC 16-18-2-163(a)(3), or IC 16-18-2-163(a)(4).

As added by P.L.197-2001, SEC.1.

IC 27-1-37-5
"Provider" defined

Sec. 5. As used in this chapter, "provider" means an individual or entity licensed or legally authorized to provide health care services.

As added by P.L.197-2001, SEC.1.

IC 27-1-37-6
Requiring provider to provide health care services

Sec. 6. (a) Except as provided in subsection (b), a person may not require a provider, as a condition of entering into a health provider contract for the provision of health care services other than health care services to enrollees of a health maintenance organization, to provide health care services to enrollees of a health maintenance organization.

(b) A person may require a provider, as a condition of entering into a health provider contract for the provision of health care services other than health care services to enrollees of a health maintenance organization, to provide health care services to enrollees of a health maintenance organization:

(1) in an emergency; or

(2) upon referral.

(c) If a person requires a provider to provide health care services to enrollees of a health maintenance organization under subsection (b), the person:

(1) shall reimburse the provider at rates established under the health provider contract; and

(2) may not require the provider to comply with the terms and conditions of the health maintenance organization.

As added by P.L.197-2001, SEC.1.

IC 27-1-37.1

Chapter 37.1. Termination of Health Provider Contracts

IC 27-1-37.1-1

"Health maintenance organization" defined

Sec. 1. As used in this chapter, "health maintenance organization" means a person that undertakes to provide or arrange for the delivery of health care services to individuals on a prepaid basis, except for the individual's responsibility for copayments or deductibles. The term includes a limited service health maintenance organization. The term does not include a staff-model health maintenance organization that employs a group of providers and that requires the providers to provide health care services solely to individuals who are entitled to coverage under a contract with the staff-model health maintenance organization or an affiliate of the staff-model health maintenance organization.

As added by P.L.196-2001, SEC.1.

IC 27-1-37.1-2

"Health provider contract" defined

Sec. 2. As used in this chapter, "health provider contract" means an agreement with a provider relating to terms and conditions of reimbursement for health care services provided to an individual under:

(1) an employee welfare benefit plan (as defined in 29 U.S.C. 1002 et seq.);

(2) a policy of accident and sickness insurance (as defined in IC 27-8-5-1);

(3) a contract with a health maintenance organization;

(4) a self-insurance program established under IC 5-10-8-7(b); or

(5) a prepaid health care delivery plan entered into under IC 5-10-8-7(c).

As added by P.L.196-2001, SEC.1.

IC 27-1-37.1-3

"Person" defined

Sec. 3. (a) As used in this chapter, "person" means an individual, an agency, a political subdivision, a partnership, a corporation, an association, or any other entity that enters into a health provider contract with a provider.

(b) The term does not include a health care provider described in IC 16-18-2-163(a)(1), IC 16-18-2-163(a)(2), IC 16-18-2-163(a)(3), or IC 16-18-2-163(a)(4).

As added by P.L.196-2001, SEC.1.

IC 27-1-37.1-4

"Provider" defined

Sec. 4. As used in this chapter, "provider" means:

(1) a physician licensed under IC 25-22.5;
(2) a dentist licensed under IC 25-14;
(3) an advanced practice nurse licensed under IC 25-23;
(4) a chiropractor licensed under IC 25-10;
(5) a podiatrist licensed under IC 25-29;
(6) an optometrist licensed under IC 25-24; or
(7) a clinical psychologist licensed under IC 25-33.

As added by P.L.196-2001, SEC.1.

IC 27-1-37.1-5
Notice of amendment of contract

Sec. 5. A person who enters into a health provider contract with a provider shall provide written notice to the provider of any amendment to the health provider contract not less than forty-five (45) days before the proposed effective date of the amendment.

As added by P.L.196-2001, SEC.1.

IC 27-1-37.1-6
Termination of contract without penalty

Sec. 6. (a) Subject to subsection (b), a provider who receives notice under section 5 of this chapter may terminate the health provider contract without penalty by informing the person with whom the health care provider contracts that the provider chooses not to approve the amendment.

(b) Notice under subsection (a) must be:

(1) given not later than fifteen (15) days after the provider receives notice under section 5 of this chapter; and
(2) in writing.

As added by P.L.196-2001, SEC.1.

IC 27-1-37.1-7
Effective date of termination

Sec. 7. The termination of a contract under section 6 of this chapter is effective:

(1) ninety (90) days after the person with whom the provider contracts receives written notice from the provider that the provider does not approve the amendment; or
(2) on a date earlier than the date described in subdivision (1), if agreed to by the person with whom the provider contracts and the provider.

As added by P.L.196-2001, SEC.1.

IC 27-1-37.1-8
Compliance with proposed amendment not required

Sec. 8. If a person with whom a provider contracts receives notice from a provider under section 6 of this chapter, the person with whom a provider contracts may not require the provider to comply

with the proposed amendment.
As added by P.L.196-2001, SEC.1.

IC 27-1-37.1-9
Notification to patient that provider's contract terminated

Sec. 9. Except in an emergency, a provider who elects to terminate a health provider contract under this section shall, before providing services to a patient who is covered by the contract, notify the patient that the provider's contract has been or will be terminated.
As added by P.L.196-2001, SEC.1.

IC 27-1-37.1-10
Contrary contract provisions void

Sec. 10. Except as provided in section 7(2) of this chapter, a health provider contract provision that is contrary to this chapter is void.
As added by P.L.196-2001, SEC.1.

IC 27-1-37.1-11
Chapter inapplicable to compliance with state or federal laws

Sec. 11. This chapter does not apply to an amendment to a health provider contract that is required to comply with a state or federal law.
As added by P.L.196-2001, SEC.1.

IC 27-1-37.2

Chapter 37.2. Health Insurance Educator

IC 27-1-37.2-1

"Health benefit plan" defined

Sec. 1. As used in this chapter, "health benefit plan" means coverage for health care services provided under:

(1) a policy of accident and sickness insurance (as defined in IC 27-8-5-1);

(2) a contract with a health maintenance organization under IC 27-13; or

(3) any other benefit program that provides payment, reimbursement, or indemnification for the costs of health care except:

(A) worker's compensation or similar insurance; or

(B) benefits provided under a certificate of exemption issued by the worker's compensation board under IC 22-3-2-5.

As added by P.L.258-2001, SEC.1.

IC 27-1-37.2-2

"Health benefit plan provider" defined

Sec. 2. As used in this chapter, "health benefit plan provider" means a person that provides coverage under a health benefit plan.

As added by P.L.258-2001, SEC.1.

IC 27-1-37.2-3

"Health insurance educator" defined

Sec. 3. As used in this chapter, "health insurance educator" refers to the health insurance educator appointed under section 6 of this chapter.

As added by P.L.258-2001, SEC.1.

IC 27-1-37.2-4

"Position" defined

Sec. 4. As used in this chapter, "position" means the position of health insurance educator established under section 5 of this chapter.

As added by P.L.258-2001, SEC.1.

IC 27-1-37.2-5

Establishment of position

Sec. 5. The department shall establish the position of health insurance educator within the department.

As added by P.L.258-2001, SEC.1.

IC 27-1-37.2-6

Qualifications

Sec. 6. The commissioner shall appoint a health insurance educator who must possess expertise in the areas of health benefit

plans, education, and advocacy.
As added by P.L.258-2001, SEC.1.

IC 27-1-37.2-7
Contracts with nonprofit organizations

Sec. 7. The department may contract with a nonprofit organization to provide the services required under this chapter.
As added by P.L.258-2001, SEC.1.

IC 27-1-37.2-8
Duties; prohibitions

Sec. 8. (a) The health insurance educator shall do the following:

(1) Assist health benefit plan consumers in making informed choices regarding health benefit plans by providing information about the following:

(A) The purchase, or enrollment in, a health benefit plan.

(B) The manner in which to resolve a dispute with a health benefit plan.

(C) The method of filing a claim under a health benefit plan.

(D) The availability of resources useful to a health benefit plan consumer.

(E) Consumer rights and responsibilities under a health benefit plan.

(F) Comparative information about health benefit plans to consumers and purchasers of health benefit plans.

(G) Other matters that may further a health benefit plan consumer's knowledge of health insurance benefit plans.

(2) Apply to obtain funds through federal grants and any other source. Any funds obtained shall be used to fulfill the purposes described in subdivision (1).

(b) Notwithstanding subsection (a)(1), the health insurance educator shall not:

(1) recommend a particular company, insurance producer, or product; or

(2) interpret or advise an individual regarding a particular contract or disputed claim that is subject to the federal Employee Retirement Income Security Act (29 U.S.C. 1001 et seq.).

As added by P.L.258-2001, SEC.1.

IC 27-1-37.3

Chapter 37.3. Third Party Rights and Responsibilities Under Health Care Contracts

IC 27-1-37.3-0.1

Application of chapter

Sec. 0.1. The addition of this chapter by P.L.55-2008 applies to a health care contract that is entered into, amended, or renewed after June 30, 2008.

As added by P.L.220-2011, SEC.425.

IC 27-1-37.3-1

Application of definitions

Sec. 1. Unless otherwise specified in this chapter, the definitions in IC 27-8-11-1 apply throughout this chapter.

As added by P.L.55-2008, SEC.1.

IC 27-1-37.3-2

"Affiliate"

Sec. 2. As used in this chapter, "affiliate" has the meaning set forth in IC 27-1-25-1.

As added by P.L.55-2008, SEC.1.

IC 27-1-37.3-3

"Contractor"

Sec. 3. As used in this chapter, "contractor" refers to a person with a primary business purpose of entering into health care contracts with providers.

As added by P.L.55-2008, SEC.1.

IC 27-1-37.3-4

"Covered individual"

Sec. 4. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a health plan.

As added by P.L.55-2008, SEC.1.

IC 27-1-37.3-5

"Health plan"

Sec. 5. (a) As used in this chapter, "health plan" means a plan through which coverage is provided for health care services through insurance, prepayment, reimbursement, or otherwise. The term includes the following:

(1) An employee welfare benefit plan (as defined in 29 U.S.C. 1002 et seq.).

(2) A policy of accident and sickness insurance (as defined in IC 27-8-5-1).

(3) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16).

(b) The term does not include the following:
(1) Accident-only, credit, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy issued as an individual policy.
(6) A short term insurance plan that:
(A) may not be renewed; and
(B) has a duration of not more than six (6) months.
(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.
As added by P.L.55-2008, SEC.1.

IC 27-1-37.3-6
"Health care contract"
Sec. 6. As used in this chapter, "health care contract" means a contract between a person and a provider specifying the rights and responsibilities of the:
(1) person; and
(2) provider;
in relation to payment for and delivery of health care services to a covered individual.
As added by P.L.55-2008, SEC.1.

IC 27-1-37.3-7
Granting access to contracted health care services; requirements
Sec. 7. A contractor may not lease, rent, or otherwise grant access to a provider's health care services under a health care contract unless the contractor complies with one (1) of the following:
(1) The third party to which the access is granted is:
(A) an employer or another entity providing coverage for health care services to the employer's or entity's employees or members and the entity has a contract with the contractor or the contractor's affiliate for the administration or processing of claims for payment or service provided under the health care contract; or
(B) an affiliate or a subsidiary of the contractor or providing administrative services to or receiving administrative services from the contractor or the contractor's affiliate or subsidiary.
(2) The:
(A) health care contract specifically states that the contractor may lease, rent, or otherwise grant access to the provider's health care services under the health care contract;
(B) third party accessing the health care contract is:
(i) a payer or third party administrator or another entity

that administers claims on behalf of the payer;
(ii) a preferred provider organization or preferred provider network, including a physician-hospital organization; or
(iii) an entity engaged in the electronic claims transport between the contractor and the payer; and
(C) third party that is granted access to the provider's health care services under the health care contract is obligated to comply with all the applicable terms of the health care contract.
As added by P.L.55-2008, SEC.1.

IC 27-1-37.3-8
List of third parties with access to contracted health care services
Sec. 8. (a) A contractor that leases, rents, or otherwise grants access to a provider's health care services as described in section 7(2) of this chapter shall maintain an Internet web page or a toll free telephone number through which the provider may obtain a listing, updated at least semiannually, of the third parties to which access to the provider's health care services has been granted.
(b) A contractor shall, at the time a health care contract is entered into with a provider, identify and provide any preferred provider organization, preferred provider network, physician hospital organization, or other entity identified in section 7(2)(B)(ii) of this chapter that is known at the time of contracting, to which the contractor will grant access to the provider's health care services under section 7 of this chapter.
As added by P.L.55-2008, SEC.1.

IC 27-1-37.3-9
Identification of contractual source of discounts
Sec. 9. A contractor that leases, rents, or otherwise grants access to a provider's health care services under section 7 of this chapter shall ensure that an explanation of benefits or remittance advice furnished to the provider that delivers health care services under the health care contract identifies the contractual source of any discount that applies.
As added by P.L.55-2008, SEC.1.

IC 27-1-37.3-10
Termination of third party rights
Sec. 10. Subject to applicable continuity of care requirements, a third party's right to exercise a contractor's rights and responsibilities under a health care contract terminates on the date that the health care contract is terminated.
As added by P.L.55-2008, SEC.1.

IC 27-1-37.3-11
Arbitration of disputes

Sec. 11. A health care contract may provide for arbitration of disputes arising under this chapter.
As added by P.L.55-2008, SEC.1.

IC 27-1-38

Chapter 38. Regulation of Depository Institutions

IC 27-1-38-1

"Affiliate" defined

Sec. 1. As used in this chapter, "affiliate" means a company that controls, is controlled by, or is under common control with another company.

As added by P.L.130-2002, SEC.2.

IC 27-1-38-2

"Customer" defined

Sec. 2. As used in this section, "customer" means an individual who purchases, applies to purchase, or is solicited to purchase insurance primarily for personal, family, or household purposes.

As added by P.L.130-2002, SEC.2.

IC 27-1-38-3

"Depository institution" defined

Sec. 3. As used in this chapter, "depository institution" means a depository financial institution (as defined in IC 28-9-2-6).

As added by P.L.130-2002, SEC.2.

IC 27-1-38-4

"Insurance producer" defined

Sec. 4. As used in this section, "insurance producer" has the meaning set forth in IC 27-1-15.6-2.

As added by P.L.130-2002, SEC.2.

IC 27-1-38-5

"Person that sells, solicits, advertises, or offers insurance on behalf of a depository institution" defined

Sec. 5. As used in this chapter, "person that sells, solicits, advertises, or offers insurance on behalf of a depository institution" means a person to which one (1) of the following applies:

(1) The person represents to a customer that the sale, solicitation, advertisement, or offer of insurance is by or on behalf of the depository institution.

(2) The depository institution:

(A) refers a customer to the person; and

(B) has a contractual arrangement with the person to receive commissions or fees on sales of insurance that result from referrals to the person.

(3) Documents that provide evidence of the sale, solicitation, advertisement, or offer of insurance identify or refer to the depository institution.

As added by P.L.130-2002, SEC.2.

IC 27-1-38-6
Application of chapter

Sec. 6. This chapter does not apply to credit insurance.

As added by P.L.130-2002, SEC.2.

IC 27-1-38-7
Prohibited activities of a depository institution of an affiliate of a depository institution

Sec. 7. A depository institution or an affiliate of a depository institution may not do the following:

(1) As a condition precedent to a loan of money, an extension of credit, or the renewal of a loan of money or an extension of credit, require a customer to:

(A) purchase; or

(B) renew;

insurance through a particular insurer, insurance producer, broker, or group of insurers or insurance producers.

(2) When insurance is required in connection with a loan of money or an extension of credit, reject an insurance policy solely because the insurance policy was issued by an insurer that is not associated with the depository institution or an affiliate of the depository institution.

(3) As a condition precedent to an extension of credit or an offer of a product or service that is equivalent to an extension of credit, require a customer to obtain insurance from a particular depository institution, affiliate of a depository institution, insurance producer, or insurer. This subdivision does not prohibit a depository institution or an affiliate of a depository institution from informing a customer or prospective customer that:

(A) insurance is required for a loan of money or an extension of credit;

(B) approval for a loan of money or an extension of credit is contingent upon the purchase of insurance; or

(C) insurance is available through the depository institution or affiliate.

(4) Unreasonably reject an insurance policy that is furnished by a customer for the protection of property that secures a loan of money or an extension of credit to the customer. For purposes of this subdivision, a rejection is not unreasonable if the rejection is based on uniformly applied reasonable standards that:

(A) relate to the extent of insurance required;

(B) relate to the financial soundness and services of the insurer issuing the insurance policy;

(C) do not discriminate against a particular kind of insurer; and

(D) do not require rejection of an insurance policy because

the insurance policy provides coverage in addition to the coverage required for the loan of money or extension of credit.

(5) Require a person to pay a separate charge:

(A) in connection with the issuance of insurance that is required as surety for a loan of money for real estate; or

(B) to substitute insurance issued by one (1) insurer for an insurance policy issued by another insurer.

For purposes of this subdivision, a separate charge does not include interest charged on loans of money or advancements for premiums under the terms of a loan agreement or credit agreement. This subdivision does not apply to charges that apply when the insurance producer that provides the insurance is the depository institution or the affiliate of a depository institution.

(6) Require of an:

(A) insurance producer; or

(B) insurer;

a condition that is not customarily required of an insurance producer or insurer that is connected with the depository institution or the affiliate of a depository institution.

(7) Use advertising or insurance promotional material that would cause a reasonable person to incorrectly believe that the federal or state government:

(A) is responsible for the insurance sales activity; or

(B) guarantees the credit;

of the depository institution or the affiliate of a depository institution.

(8) Use advertising or insurance promotional material that would cause a reasonable person to incorrectly believe that the federal or state government:

(A) guarantees a return on an insurance product sold by; or

(B) is a source of payment on an insurance obligation of;

the depository institution or the affiliate of a depository institution.

(9) Act as an insurance producer, unless the depository institution or the affiliate of a depository institution is licensed under IC 27-1-15.6.

(10) Solicit or sell insurance, other than credit insurance or flood insurance, unless the solicitation or sale is completed through documents separate from a loan of money or an extension of credit.

(11) Include the expense of an insurance premium, other than a credit insurance premium or a flood insurance premium, in a primary loan of money or extension of credit without the express written consent of the customer.

(12) Solicit or sell insurance, unless the area in which insurance sales activities of the depository institution or affiliate occur is,

to the extent practicable, physically separate from the area where retail deposits are routinely accepted by the depository institution or affiliate.

(13) Solicit or sell insurance, unless the depository institution or the affiliate of a depository institution maintains separate books and records that relate to insurance transactions, including files related to consumer complaints.

As added by P.L.130-2002, SEC.2.

IC 27-1-38-8

Required disclosure concerning insurance related to a loan or a credit extension

Sec. 8. (a) A depository institution or the affiliate of a depository institution that:

(1) lends money or extends credit; and

(2) solicits insurance primarily for personal, family, or household purposes;

shall disclose in writing to a customer that the insurance related to the loan or credit extension may be purchased from an insurer or insurance producer chosen by the customer, subject only to the ability of the depository institution or affiliate to reasonably reject an insurer or insurance producer as described in section 7(4) of this chapter.

(b) A disclosure under subsection (a) must inform the customer that the customer's choice of insurer or insurance producer does not affect:

(1) the decision of the depository institution or the affiliate of a depository institution regarding the loan or credit extension; or

(2) the terms of the loan or credit extension;

except that the depository institution or the affiliate of a depository institution may impose reasonable requirements concerning the creditworthiness of the insurer and the scope of insurance coverage chosen, as described in section 7(4) of this chapter.

As added by P.L.130-2002, SEC.2.

IC 27-1-38-9

Required disclosures before sale of insurance

Sec. 9. (a) This section applies as follows:

(1) To an affiliate of a depository institution only to the extent that the affiliate sells, solicits, advertises, or offers insurance at the office of a depository institution or on behalf of a depository institution.

(2) To the:

(A) sale of;

(B) solicitation for; or

(C) application for;

insurance by an individual primarily for personal, family, or

household purposes and only to the extent that a disclosure is accurate.

(b) A depository institution or an affiliate of a depository institution that solicits, sells, advertises, or offers insurance, and a person that sells, solicits, advertises, or offers insurance on behalf of a depository institution, shall disclose to a customer, in writing where practicable, in a clear and conspicuous manner, and before a sale of insurance, that the insurance:

(1) is not a deposit;

(2) is not insured by the Federal Deposit Insurance Corporation or another federal government agency;

(3) is not guaranteed by the depository institution, the affiliate of a depository institution, or the person that sells, solicits, advertises, or offers insurance on behalf of a depository institution; and

(4) involves investment risk including possible loss of value, if appropriate.

As added by P.L.130-2002, SEC.2.

IC 27-1-38-10

Acknowledgment of receipt of required disclosure

Sec. 10. (a) A depository institution that solicits, sells, advertises, or offers insurance, a depository institution's affiliate that solicits, sells, advertises, or offers insurance, or a person that sells, solicits, advertises, or offers insurance on behalf of a depository institution shall obtain from a customer to whom a disclosure is made under section 9 of this chapter a written acknowledgment of receipt of the disclosure:

(1) when the customer receives the disclosure; or

(2) at the time of the initial purchase of the insurance.

(b) If a solicitation for insurance is conducted by telephone, the depository institution, the affiliate of a depository institution, or the person that sells, solicits, advertises, or offers insurance on behalf of a depository institution shall:

(1) obtain an oral acknowledgment of receipt of the disclosure;

(2) maintain documentation to show that the acknowledgment was given by the customer; and

(3) make reasonable efforts to obtain a written acknowledgment from the customer.

As added by P.L.130-2002, SEC.2.

IC 27-1-38-11

Requirements for electronic disclosure

Sec. 11. If:

(1) a customer consents to receive the disclosure required under section 8 of this chapter electronically; and

(2) the disclosure is provided to the customer in a format that the customer may retain or obtain at a later time;

the depository institution, the affiliate of a depository institution, or the person that sells, solicits, advertises, or offers insurance on behalf of a depository institution may provide the disclosure electronically and may obtain from the customer acknowledgment of receipt of the disclosure electronically.
As added by P.L.130-2002, SEC.2.

IC 27-1-38-12
Commissioner examination and investigation

Sec. 12. (a) The commissioner may examine and investigate the insurance activities of a person that the commissioner believes to be in violation of this chapter. A person examined or investigated under this section shall, upon reasonable notice from the commissioner, make the insurance related books and records of the person available to the commissioner.

(b) In the case of an examination or investigation of a depository institution under subsection (a), the commissioner shall, before performing the examination or investigation:

(1) notify the federal or state banking agency that regulates the depository institution that the commissioner intends to examine or investigate the depository institution; and

(2) advise the federal or state banking agency of the depository institution's suspected violation of this section.

As added by P.L.130-2002, SEC.2.

IC 27-1-38-13
Allowed activities

Sec. 13. This chapter does not prevent a depository institution or an affiliate of a depository institution that lends money or extends credit from placing insurance on real or personal property if a customer fails to provide insurance that is required under terms of a loan agreement or credit agreement.
As added by P.L.130-2002, SEC.2.

IC 27-1-38-14
Violation of chapter

Sec. 14. A person that violates this chapter commits an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4.
As added by P.L.130-2002, SEC.2.

IC 27-1-39

Chapter 39. Independent Educational Institution Self-Insurance Consortium

IC 27-1-39-1

"Commissioner" defined

Sec. 1. As used in this chapter, "commissioner" means the insurance commissioner appointed under IC 27-1-1-2.

As added by P.L.38-2006, SEC.1.

IC 27-1-39-2

"Consortium" defined

Sec. 2. As used in this chapter, "consortium" refers to a self-insurance consortium established under section 7 of this chapter.

As added by P.L.38-2006, SEC.1.

IC 27-1-39-3

"Department" defined

Sec. 3. As used in this chapter, "department" refers to the department of insurance created by IC 27-1-1-1.

As added by P.L.38-2006, SEC.1.

IC 27-1-39-4

"Independent postsecondary educational institution" defined

Sec. 4. As used in this chapter, "independent postsecondary educational institution" refers to an independent, degree granting college or university that is:

(1) accredited by the Higher Learning Commission of the North Central Association of Colleges and Schools;

(2) chartered in Indiana; and

(3) operated as a nonprofit entity under Section 501(c)(3) of the Internal Revenue Code.

As added by P.L.38-2006, SEC.1. Amended by P.L.2-2007, SEC.352.

IC 27-1-39-5

"Member" defined

Sec. 5. As used in this chapter, "member" means an independent postsecondary educational institution that enters into an agreement under section 7 of this chapter to form a consortium.

As added by P.L.38-2006, SEC.1. Amended by P.L.2-2007, SEC.353.

IC 27-1-39-6

"Self-insurance fund" defined

Sec. 6. As used in this chapter, "self-insurance fund" means a fund established by a consortium to provide money sufficient to:

(1) cover self-insured risk retained by the consortium;

(2) pay premiums for stop-loss insurance coverage; and

(3) pay the administrative and other costs of the consortium.

As added by P.L.38-2006, SEC.1.

IC 27-1-39-7
Establishing self-insurance consortium and trust

Sec. 7. (a) Notwithstanding any other law, two (2) or more independent postsecondary educational institutions may establish a trust under Indiana law to establish and maintain a self-insurance consortium through which the independent educational institutions jointly maintain a self-insurance fund to cover certain retained risks and jointly purchase stop-loss insurance coverage. The coverage for retained risks or stop-loss insurance coverage provided for through the trust may include any of the following types of coverage:

(1) Property and casualty coverage.
(2) Worker's compensation coverage.
(3) Employee health coverage.
(4) Employee vision coverage.
(5) Employee dental coverage.
(6) Other coverage.

(b) If the coverage described in subsection (a)(3), (a)(4), or (a)(5) is provided through the self-insurance fund, the coverage must be provided through a multiple employer welfare arrangement regulated under IC 27-1-34.

As added by P.L.38-2006, SEC.1. Amended by P.L.2-2007, SEC.354.

IC 27-1-39-8
Consortium governance

Sec. 8. A consortium shall be governed by a governing authority comprised entirely of representatives of the consortium's members.

As added by P.L.38-2006, SEC.1.

IC 27-1-39-9
Regulation of trust

Sec. 9. A trust created under section 7 of this chapter is subject to regulation by the department as follows:

(1) The trust must be registered with the department.
(2) The trust shall:
  (A) retain a total risk for the self-insurance fund of not more than one hundred twenty-five percent (125%) of the amount of expected claims for the following year; and
  (B) obtain stop-loss insurance issued by an insurer authorized to do business in Indiana to cover losses in excess of the amount retained under clause (A).
(3) Contributions by the members must be set to fund one hundred percent (100%) of the total risk retained under subdivision (2)(A) plus all other costs of the trust.
(4) The trust shall maintain a fidelity bond in an amount approved by the department, covering each person responsible for the trust, to protect against acts of fraud or dishonesty in

servicing the trust.

(5) The trust is subject to IC 27-4-1-4.5 regarding claims settlement practices.

(6) The trust shall, before March 1 of each year, file an annual financial statement in the form required by IC 27-1-3-13.

(7) The trust is not a member of the Indiana insurance guaranty association under IC 27-6-8. The liability of each member is joint and several.

(8) The trust is subject to examination by the department. The trust shall pay all costs associated with an examination.

(9) The department may deny, suspend, or revoke the registration of the trust if the commissioner finds that the trust:

(A) is in a hazardous financial condition;

(B) refuses to be examined or produce records for examination; or

(C) has failed to pay a final judgment rendered against the trust by a court within thirty (30) days.

As added by P.L.38-2006, SEC.1. Amended by P.L.1-2007, SEC.184.

IC 27-1-39-10

Rulemaking authority

Sec. 10. The department may adopt rules under IC 4-22-2 to implement this chapter.

As added by P.L.38-2006, SEC.1.

IC 27-1-40

Chapter 40. Entry of Unauthorized Alien Companies

IC 27-1-40-1

"Trusteed surplus"

Sec. 1. As used in this chapter, "trusteed surplus" means the aggregate value of a United States branch's:

(1) surplus and reserve funds required under IC 27-1-6; and

(2) trust assets described in section 4 of this chapter;

plus investment income accrued on the items described in subdivisions (1) and (2) if the investment income is collected by the state for the trustees, less the aggregate net amount of all of the United States branch's reserves and other liabilities in the United States, as determined under section 6 of this chapter.

As added by P.L.173-2007, SEC.20. Amended by P.L.3-2008, SEC.210.

IC 27-1-40-2

"United States branch"

Sec. 2. As used in this chapter, "United States branch" means:

(1) an entity that is considered, for purposes of this chapter, to be a domestic company through which insurance business is transacted in the United States by an alien company; and

(2) the alien company's assets and liabilities that are attributable to the insurance business transacted in the United States.

As added by P.L.173-2007, SEC.20.

IC 27-1-40-3

Indiana as state of entry for alien company

Sec. 3. Indiana may serve as a state of entry to enable an alien company to transact insurance business in the United States through a United States branch if the United States branch:

(1) qualifies under this title for a certificate of authority as if the United States branch were a domestic company organized under this title; and

(2) establishes a trust account that meets the following conditions:

(A) The trust account is established under a trust agreement approved by the commissioner with a United States bank.

(B) The amount in the trust account is at least equal to:

(i) the minimum capital and surplus requirements; or

(ii) the authorized control level risk based capital requirements;

whichever is greater, that apply to a domestic company that possesses a certificate of authority to transact the same kind of insurance business in Indiana as the United States branch will transact.

As added by P.L.173-2007, SEC.20.

IC 27-1-40-4

Trust account; requirements; trust agreement

Sec. 4. (a) A trust account established under section 3(2) of this chapter must contain, at all times, an amount equal to the United States branch's reserves and other liabilities, plus the:

(1) minimum capital and surplus requirement; or

(2) authorized control level risk based capital requirement;

whichever is greater, that applies to a domestic company granted a certificate of authority under this title to transact the same kind of insurance business as the United States branch transacts.

(b) One (1) or more trustees must be appointed to administer the trust.

(c) A trust agreement for a trust account established under section 3(2) of this chapter, and amendments to the trust agreement:

(1) must be authenticated in a manner prescribed by the commissioner; and

(2) are effective only when approved by the commissioner after the commissioner finds all of the following:

(A) The trust agreement and amendments are sufficient in form and in conformity with law.

(B) All trustees appointed under subsection (b) are eligible to serve as trustees.

(C) The trust agreement is adequate to protect the interests of the beneficiaries of the trust.

(d) The commissioner may withdraw an approval granted under subsection (c)(2) if, after notice and hearing, the commissioner determines that one (1) or more of the conditions required under subsection (c)(2) for approval no longer exist.

(e) The commissioner may approve modifications of, or variations in, a trust agreement under subsection (c) if the modifications or variations are not prejudicial to the interests of Indiana residents, United States policyholders, and creditors of the United States branch.

(f) A trust agreement for a trust account established under section 3(2) of this chapter must contain provisions that:

(1) vest legal title to trust assets in the trustees and lawfully appointed successors of the trustees;

(2) require that all assets deposited in the trust account be continuously kept in the United States;

(3) provide for appointment of a new trustee in case of a vacancy, subject to the approval of the commissioner;

(4) require that the trustees continuously maintain a record sufficient to identify the assets of the trust account;

(5) require that the trust assets consist of:

(A) cash;

(B) investments of the same kind as the investments in which funds of a domestic company may be invested; and

(C) interest accrued on the cash and investments specified in

clauses (A) and (B), if collectible by the trustees;

(6) establish that the trust:

(A) is for the exclusive benefit, security, and protection of:

(i) United States policyholders of the United States branch; and

(ii) United States creditors of the United States branch after all obligations to policyholders are paid; and

(B) shall be maintained as long as any liability of the United States branch arising out of the United States branch's insurance transactions in the United States is outstanding; and

(7) establish that trust assets, other than income as specified in subsection (g), may not be withdrawn or permitted by the trustees to be withdrawn without the approval of the commissioner, except for any of the following purposes:

(A) To make deposits required by the law of any state for the security or benefit of all policyholders of the United States branch in the United States.

(B) To substitute other assets permitted by law and at least equal in value and quality to the assets withdrawn, upon the specific written direction of the United States manager of the United States branch when the United States manager is empowered and acting under general or specific written authority previously granted or delegated by the alien company's board of directors.

(C) To transfer the assets to an official liquidator or rehabilitator under a court order.

(g) A trust agreement for a trust account established under section 3(2) of this chapter may provide that income, earnings, dividends, or interest accumulations of the trust assets may be paid over to the United States manager of the United States branch upon request of the United States manager if the total amount of trust assets following the payment to the United States manager is not less than the amount required under subsection (a).

(h) A trust agreement for a trust account established under section 3(2) of this chapter may provide that written approval of the insurance supervising official of another state in which:

(1) trust assets are deposited; and

(2) the United States branch is authorized to transact insurance business;

is sufficient, and approval of the commissioner is not required, for withdrawal of the trust assets in the other state if the amount of total trust assets after the withdrawal will not be less than the amount required under subsection (a). However, the United States branch shall provide written notice to the commissioner of the nature and extent of the withdrawal.

(i) The commissioner may at any time:

(1) make examinations of the trust assets of a United States

branch that holds a certificate of authority under this chapter, at the expense of the United States branch; and

(2) require the trustees to file a statement, on a form prescribed by the commissioner, certifying the assets of the trust account and the amounts of the assets.

(j) Refusal or neglect of a trustee to comply with this section is grounds for:

(1) the revocation of the United States branch's certificate of authority; or

(2) the liquidation of the United States branch.

As added by P.L.173-2007, SEC.20.

IC 27-1-40-5

Certificate of authority for United States branch; requirements

Sec. 5. (a) The commissioner shall require a United States branch to do the following before granting the United States branch a certificate of authority to transact insurance business as described in section 3(1) of this chapter:

(1) Comply with this chapter and any other requirement of this title.

(2) Submit the following:

(A) A copy of the current charter and bylaws of the alien company that intends to transact business through the United States branch and any other documents determined by the commissioner to be necessary to provide evidence of the kinds of insurance business that the alien company is authorized to transact. Documents submitted under this clause must be attested to as accurate by the insurance supervisory official in the alien company's domiciliary jurisdiction.

(B) A full statement, subscribed and affirmed as true under penalty of perjury by two (2) officers or equivalent responsible representatives of the alien company in a manner prescribed by the commissioner, of the alien company's financial condition as of the close of the alien company's latest fiscal year, showing the alien company's:

(i) assets;

(ii) liabilities;

(iii) income disbursements;

(iv) business transacted; and

(v) other facts required to be shown in the alien company's annual statement reported to the insurance supervisory official in the alien company's domiciliary jurisdiction.

(C) An English translation, if necessary, of any document submitted under this subdivision.

(3) Submit to an examination of the affairs of the alien company that intends to transact business through the United States branch at the alien company's principal office in the United

States. However, the commissioner may accept a report of the insurance supervisory official in the alien company's domiciliary jurisdiction in lieu of the examination required under this subdivision.

(b) The commissioner may at any time hire, at a United States branch's expense, any independent experts that the commissioner considers necessary to implement this chapter with respect to the United States branch.

As added by P.L.173-2007, SEC.20.

IC 27-1-40-6

United States branch filing requirements

Sec. 6. (a) A United States branch shall file with the commissioner, not later than March 1, May 15, August 15, and November 15 of each year, all of the following:

(1) Statements of the insurance business transacted in the United States, the assets held by or for the United States branch in the United States for the protection of policyholders and creditors in the United States, and the liabilities incurred against the assets. All of the following apply to the statements filed under this subdivision:

(A) The statements must contain information concerning only the United States branch's assets and insurance business in the United States.

(B) The statements must be in the same form as statements required of a domestic company that possesses a certificate of authority to transact the same kinds of insurance business as the United States branch transacts.

(C) The statements must be filed as follows:

(i) Quarterly statements filed not later than May 15, August 15, and November 15 of each year for the first three (3) quarters of the calendar year.

(ii) An annual statement, filed not later than March 1 of each year.

(2) A trusteed surplus statement, in a form prescribed by the commissioner, at the end of the period covered by each statement described in subdivision (1)(C). In determining the net amount of the United States branch's liabilities in the United States to be reported in the statement of trusteed surplus, the United States branch shall make adjustments to total liabilities reported on the accompanying annual or quarterly statement as follows:

(A) Add back liabilities used to offset admitted assets reported in the accompanying quarterly or annual statement.

(B) Deduct:

(i) unearned premiums on insurance producer balances or uncollected premiums that are not more than ninety (90) days past due;

(ii) losses reinsured by reinsurers authorized to do business in Indiana, less unpaid reinsurance premiums to be paid to the authorized reinsurers;
(iii) reinsurance recoverables on paid losses from reinsurers not authorized to do business in Indiana that are included as an asset in the annual statement, but only to the extent that a liability for the unauthorized recoverables is included in the liabilities report in the trusteed surplus statement;
(iv) special state deposits held for the exclusive benefit of policyholders of a particular state that do not exceed net liabilities reports for the particular state;
(v) secured accrued retrospective premiums;
(vi) if the alien company transacting business through the United States branch is a life insurer, the amount of the alien company's policy loans to policyholders in the United States, not exceeding the amount of legal reserve required on each policy, and the net amount of uncollected and deferred premiums; and
(vii) any other nontrust asset that the commissioner determines secures liabilities in a manner substantially similar to the manner in which liabilities are secured by the unearned premiums, losses reinsured, reinsurance recoverables, special state deposits, secured accrued retrospective premiums, and policy loans referred to in items (i) through (vi).

(3) Any additional information that relates to the business or assets of the alien company and is required by the commissioner.

(b) The annual statement and trusteed surplus statement described in subsection (a) must be signed and verified by the United States manager, the attorney in fact, or an empowered assistant United States manager, of the United States branch. Items of securities and other property held under a trust agreement must be certified in the trusteed surplus statement by the United States trustees.

(c) Each report concerning an examination of a United States branch conducted under section 4(i) of this chapter must include a trusteed surplus statement as of the date of examination and a general statement of the financial condition of the United States branch.
As added by P.L.173-2007, SEC.20.

IC 27-1-40-7
Issuance and renewal of certificate of authority

Sec. 7. (a) Before issuing a new or renewal certificate of authority to a United States branch, the commissioner may require satisfactory proof:

(1) in the charter of the alien company transacting business through the United States branch;

(2) by an agreement evidenced by a certified resolution of the alien company's board of directors; or

(3) otherwise as required by the commissioner;

that the United States branch will not engage in any insurance business not authorized by this chapter and by the alien company's charter.

(b) The commissioner shall issue a renewal certificate of authority to a United States branch if the commissioner is satisfied that the United States branch is not delinquent in any requirement of this title and that the United States branch's continued insurance business in Indiana is not contrary to the best interest of the citizens of Indiana.

(c) A United States branch may not be:

(1) granted a certificate of authority to transact any kind of insurance business in Indiana that is not permitted to be transacted in Indiana by a domestic company granted a certificate of authority under this title; or

(2) authorized to transact an insurance business in Indiana if the United States branch transacts, anywhere in the United States, any kind of business other than an insurance business (and business incidental to the kind of insurance business) that the United States branch is authorized to transact in Indiana.

(d) A United States branch entering the United States through Indiana or another state may not be authorized to transact an insurance business in Indiana if the United States branch fails to substantially comply with any requirement of this title that:

(1) applies to a similar domestic company that is organized after July 1, 2007; and

(2) the commissioner determines is necessary to protect the interest of the policyholders.

(e) Unless the commissioner determines that the kind of insurance is not contrary to the best interest of the citizens of Indiana, a United States branch may not transact any kind of insurance business that is not permitted to be transacted in Indiana by a similar domestic company that is organized after July 1, 2007.

(f) A United States branch may not be authorized to transact an insurance business in Indiana unless the United States branch maintains correct and complete records of the United States branch's transactions that are:

(1) open to inspection by any person who has the right to inspect the records; and

(2) maintained at the United States branch's principal office in Indiana.

As added by P.L.173-2007, SEC.20.

IC 27-1-40-8

Insolvency proceedings

Sec. 8. If the commissioner determines from a quarterly or annual statement, a trusteed surplus statement, or another report that a

United States branch's trusteed surplus is less than:

(1) the minimum capital and surplus requirements; or

(2) the authorized control level risk based capital requirements;

whichever is greater, that apply to a domestic insurer granted a certificate of authority to transact the same kind of insurance business in Indiana, the commissioner may proceed under IC 27-9 against the United States branch as if the United States branch were an insurer in such condition that further transaction by the insurer of insurance business in the United States would be hazardous to the insurer's policyholders, creditors, or residents of the United States.

As added by P.L.173-2007, SEC.20.

IC 27-1-41

Chapter 41. Group Personal Excess or Umbrella Liability Insurance

IC 27-1-41-1

"Certificate"

Sec. 1. As used in this chapter, "certificate" means a document issued to an individual group member as evidence of the group member's coverage under a master group insurance policy.

As added by P.L.32-2012, SEC.2.

IC 27-1-41-2

"Group"

Sec. 2. As used in this chapter, "group" means the following:

(1) The membership of any of the following:

(A) A trade association.

(B) A professional association.

(C) A labor union.

(D) An employee association.

(E) A club.

(F) A league.

(G) A fraternity.

(H) A guild.

(I) Another organization.

(2) The employees of any of the following:

(A) An employer.

(B) Two (2) or more employers.

As added by P.L.32-2012, SEC.2.

IC 27-1-41-3

"Group administrator"

Sec. 3. As used in this chapter, "group administrator" means the officers or directors of a group or any other person legally vested with the responsibility to manage the affairs of a group. In the case of a group that consists of employees of a single employer, the employer is considered to be the group administrator.

As added by P.L.32-2012, SEC.2.

IC 27-1-41-4

"Group insurance policy"

Sec. 4. As used in this chapter, "group insurance policy" means a policy of insurance that provides personal excess liability insurance or personal umbrella liability insurance to participating group members under one (1) master policy:

(1) that is issued to the group administrator; and

(2) under which individual certificates are issued to each participating group member.

As added by P.L.32-2012, SEC.2.

IC 27-1-41-5
Authorization to issue group insurance policy

Sec. 5. An insurer that is:

(1) authorized under IC 27-1-3-20 to engage in the business of insurance in Indiana; or

(2) doing business with an insurance producer that is licensed under IC 27-1-15.8;

may issue a group insurance policy in Indiana.

As added by P.L.32-2012, SEC.2.

IC 27-1-41-6
Group eligibility requirements

Sec. 6. (a) A group described in section 2(1) of this chapter must meet the following requirements to be eligible to purchase coverage under a group insurance policy:

(1) The group consists of at least ten (10) individuals who are members.

(2) The group has been in existence for at least two (2) years.

(3) The group was formed for a purpose other than the purchase of insurance.

(b) A group described in section 2(2) of this chapter may include each of the following as a group member:

(1) An employee of a subsidiary or an affiliate of the employer.

(2) A retired employee of the employer.

(3) An individual business owner or proprietor who is the employer.

(4) A partner of a partnership that is the employer.

(5) A director or retired director of the employer.

(6) A former employee, owner, proprietor, partner, or director who purchased coverage under a group insurance policy before leaving the position.

(7) A spouse, child, or household resident of any individual described in subdivisions (1) through (6).

(c) A group is not eligible to purchase, and an insurer shall not provide to the group, coverage under a group insurance policy if:

(1) the purchase of insurance is a condition of membership in the group; or

(2) a group member is penalized by the group as a result of the group member refusing coverage under a group insurance policy.

As added by P.L.32-2012, SEC.2.

IC 27-1-41-7
Rates

Sec. 7. An insurer may apply to a group insurance policy a lower rate than the rate shown in the insurer's manual for insurance policies that are:

(1) of the same type as the group insurance policy; and

(2) individually issued to insureds of the same class as the group members insured under the group insurance policy.

As added by P.L.32-2012, SEC.2.

IC 27-1-41-8

Premium payment

Sec. 8. (a) A group administrator may, if authorized by the insurer, aggregate the group members' premiums and remit the premiums to the insurer or insurance producer.

(b) If an insurer authorizes payment of premiums as described in subsection (a), payment of a premium by a group member to the group administrator is considered to be payment to the insurer.

(c) An employer or group administrator of a group described in section 2(2) of this chapter may remit premiums to an insurer through an employee benefit plan.

As added by P.L.32-2012, SEC.2.

IC 27-1-41-9

Certificate of coverage; notice

Sec. 9. (a) A certificate that is issued under a group insurance policy to an individual participating group member must include the following information:

(1) The full name and address of the insurer.

(2) The policy number of the master policy.

(3) The full name, address, and telephone number of the group administrator that holds the master policy.

(4) A description of the coverage provided under the certificate, including the amount and term of the coverage.

(5) The amount of premium charged to the individual participating group member for the coverage.

(6) Coverage limits that specifically apply under the individual participating group member's certificate.

(7) Unless:

(A) the master policy is incorporated by reference in the certificate; and

(B) a copy of the master policy accompanies the certificate;

all material terms and conditions of coverage under the certificate.

(b) An insurer shall provide to each individual participating group member separate notice that provides instructions on claim submission procedures.

(c) An insurer or group administrator shall deliver to each individual participating group member a certificate, an amended certificate, or an endorsement to a certificate if any of the following occurs:

(1) A change in coverage limits.

(2) A change in the type of coverage provided.

(3) An addition to, reduction in, or elimination of coverage

provided.

(4) An addition of an exclusion of coverage.

As added by P.L.32-2012, SEC.2.

IC 27-1-41-10

Cancellation; refusal to renew

Sec. 10. (a) An insurer may cancel or refuse to renew an individual certificate while maintaining in force the master policy and other individual certificates issued under the master policy.

(b) An insurer that cancels or refuses to renew a master policy shall, within a period determined by the commissioner, provide:

(1) to the group administrator; and

(2) to each individual participating group member;

written notice of the cancellation or refusal to renew.

As added by P.L.32-2012, SEC.2.

IC 27-1-41-11

Administrative rules

Sec. 11. The department may adopt rules under IC 4-22-2 to implement this chapter.

As added by P.L.32-2012, SEC.2.

IC 27-1-42

Chapter 42. Certificates of Insurance

IC 27-1-42-1

Application of chapter

Sec. 1. This chapter applies to a certificate of insurance that is issued in connection with a contract related to property, operations, or risks located in Indiana, regardless of the location of the policyholder, insurer, insurance producer, or person that requests or requires the issuance of the certificate of insurance.

As added by P.L.70-2013, SEC.1.

IC 27-1-42-2

"Certificate of insurance"

Sec. 2. (a) As used in this chapter, "certificate of insurance" means a document prepared by an insurer or insurance producer as evidence of property or casualty insurance coverage.

(b) The term does not include a policy of insurance, an insurance binder, a policy endorsement, or a motor vehicle insurance identification or information card.

As added by P.L.70-2013, SEC.1.

IC 27-1-42-3

"Commissioner"

Sec. 3. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

As added by P.L.70-2013, SEC.1.

IC 27-1-42-4

"Department"

Sec. 4. As used in this chapter, "department" refers to the department of insurance created by IC 27-1-1-1.

As added by P.L.70-2013, SEC.1.

IC 27-1-42-5

"Insurance producer"

Sec. 5. As used in this chapter, "insurance producer" has the meaning set forth in IC 27-1-15.6-2.

As added by P.L.70-2013, SEC.1.

IC 27-1-42-6

"Insurer"

Sec. 6. As used in this chapter, "insurer" refers to an insurer (as defined in IC 27-1-2-3) that issues a policy of property or casualty insurance.

As added by P.L.70-2013, SEC.1.

IC 27-1-42-7

"Person"

Sec. 7. As used in this chapter, "person" has the meaning set forth in IC 27-1-2-3.

As added by P.L.70-2013, SEC.1.

IC 27-1-42-8

"Property or casualty insurance"

Sec. 8. As used in this chapter, "property or casualty insurance" means one (1) or more of the kinds of insurance described in Class 2 and Class 3 of IC 27-1-5-1.

As added by P.L.70-2013, SEC.1.

IC 27-1-42-9

Unfair or deceptive acts

Sec. 9. (a) The use of a certificate of insurance form that:

(1) is unfair, misleading, or deceptive; or

(2) violates any law;

is an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4.

(b) If:

(1) the commissioner has reason to believe that a certificate of insurance form is described in subsection (a)(1) or (a)(2); and

(2) the certificate of insurance form was provided by a financial institution;

the commissioner may refer the matter to the department of financial institutions for review under IC 28.

As added by P.L.70-2013, SEC.1.

IC 27-1-42-10

Limits of certificate of insurance

Sec. 10. A certificate of insurance does not:

(1) amend, extend, or alter the coverage provided under; or

(2) confer to a person any rights in addition to the rights expressly provided in;

the policy of property or casualty insurance to which the certificate of insurance refers.

As added by P.L.70-2013, SEC.1.

IC 27-1-42-11

Preparation of certificate of insurance

Sec. 11. A person may not prepare or issue, or request or require the issuance of, a certificate of insurance that:

(1) contains false or misleading information concerning; or

(2) alters, amends, or extends the coverage provided by;

the policy of property or casualty insurance to which the certificate of insurance refers.

As added by P.L.70-2013, SEC.1.

IC 27-1-42-12
Not a warranty

Sec. 12. (a) A certificate of insurance must not contain a warranty that the policy of property or casualty insurance to which the certificate of insurance refers complies with the insurance or indemnification requirements of a contract.

(b) The inclusion of a contract number or contract description in a certificate of insurance does not warrant that the policy of property or casualty insurance to which the certificate of insurance refers complies with the insurance or indemnification requirements of the contract.

As added by P.L.70-2013, SEC.1.

IC 27-1-42-13
Notice rights are under policy

Sec. 13. (a) A person is not entitled to notice of:

(1) cancellation of;
(2) nonrenewal of; or
(3) a material change in;

a policy of property or casualty insurance unless the person has notice rights under the terms of the policy of property or casualty insurance or an endorsement to the policy.

(b) The terms and conditions of notice described in subsection (a) are governed by the policy of property or casualty insurance or an endorsement to the policy and are not altered by a certificate of insurance.

As added by P.L.70-2013, SEC.1.

IC 27-1-42-14
Violations of chapter

Sec. 14. A certificate of insurance or any other document that is prepared, issued, requested, or required in violation of this chapter is void.

As added by P.L.70-2013, SEC.1.

IC 27-1-42-15
Examinations and penalties

Sec. 15. (a) The commissioner may examine and investigate the activities of a person that the commissioner reasonably believes has violated this chapter.

(b) The commissioner may issue a cease and desist order or impose a civil penalty of not more than one thousand dollars ($1,000) for each violation of this chapter.

As added by P.L.70-2013, SEC.1.

IC 27-1-42-16
Rulemaking

Sec. 16. The department may adopt rules under IC 4-22-2 to

implement this chapter.
As added by P.L.70-2013, SEC.1.

IC 27-1-43

Chapter 43. Electronic Delivery of Notices and Documents

IC 27-1-43-1

"Electronic delivery"

Sec. 1. As used in this chapter, "electronic delivery" or "electronically delivered" includes the following:

(1) Delivery to an electronic mail address at which a party has consented to receive notices or documents.

(2) Posting on an electronic network or web site accessible via the Internet, a mobile application, a computer, a mobile device, a tablet, or another electronic device, with separate notice delivered to the electronic mail address at which a party has consented to receive notice of the posting.

As added by P.L.119-2014, SEC.1.

IC 27-1-43-2

"Party"

Sec. 2. (a) As used in this chapter, "party" means a recipient of a notice or document required as part of an insurance transaction.

(b) The term includes an applicant, an insured, a policyholder, and an annuity contract holder.

As added by P.L.119-2014, SEC.1.

IC 27-1-43-3

Electronic delivery of notice or document; requirements

Sec. 3. (a) Except as provided in subsection (c), a notice to a party, or another document, that:

(1) is legally required in an insurance transaction; or

(2) serves as evidence of insurance coverage;

may be electronically delivered, stored, and presented in compliance with IC 26-2-8.

(b) Electronic delivery of a notice or document under this section is considered to be equivalent to any legally required delivery method, including delivery by:

(1) first class mail;

(2) first class mail, postage prepaid;

(3) certified mail;

(4) certificate of mail; or

(5) certificate of mailing.

(c) Electronic delivery of a notice or document by an insurer to a party is permitted under this chapter if all the following apply:

(1) The party has affirmatively consented to electronic delivery and has not withdrawn the consent.

(2) The party, before giving consent, is provided with a clear and conspicuous statement informing the party of all the following:

(A) Any right or option of the party to have the notice or

document provided or made available in paper or another nonelectronic form.

(B) The right of the party to withdraw consent to electronic delivery of a notice or document and any fees, conditions, or consequences that will be imposed on the party if the party withdraws consent.

(C) Whether the party's consent applies:

(i) only to the particular transaction as to which the notice or document must be given; or

(ii) to identified categories of notices or documents subject to electronic delivery during the course of the party's relationship with the insurer.

(D) The:

(i) means, after consent is given, by which the party may obtain a paper copy of an electronically delivered notice or document; and

(ii) applicable fee for the paper copy.

(E) The procedure the party must follow to:

(i) withdraw consent to electronic delivery of a notice or document; and

(ii) update information needed to contact the party electronically.

(3) The party:

(A) before giving consent, is provided with a statement of the hardware and software requirements for access to and retention of an electronically delivered notice or document; and

(B) electronically:

(i) consents; or

(ii) confirms consent;

in a manner that reasonably demonstrates that the party is able to access information in the electronic form that will be used for electronic delivery of notices or documents to which the party has given consent.

(4) If, after the party has consented to electronic delivery of notices or documents, a change in the hardware or software requirements needed for the party to access or retain an electronically delivered notice or document creates a material risk that the party will not be able to access or retain a subsequent notice or document to which the consent applies, the insurer:

(A) provides the party with a statement of the:

(i) revised hardware and software requirements for access to and retention of an electronically delivered notice or document; and

(ii) right of the party to withdraw consent without the imposition of a fee, condition, or consequence that was not disclosed under subdivision (2)(B); and

(B) complies with subdivision (2).
As added by P.L.119-2014, SEC.1.

IC 27-1-43-4
Application of other legal requirements; legal effect

Sec. 4. (a) This chapter does not affect any applicable legal requirement related to content or timing of a notice or document.

(b) If another law requiring a notice or document to be provided to a party expressly requires verification or acknowledgment of receipt of the notice or document, electronic delivery of the notice or document is permitted only if the method of electronic delivery provides for verification or acknowledgment of receipt.

(c) The legal effectiveness, validity, or enforceability of a contract or policy of insurance executed by a party may not be denied solely because of the failure of the insurer to obtain electronic consent or confirmation of consent of the party in accordance with section 3(c)(3)(B) of this chapter.
As added by P.L.119-2014, SEC.1.

IC 27-1-43-5
Withdrawal of consent to electronic delivery

Sec. 5. (a) A withdrawal of consent by a party does not affect the legal effectiveness, validity, or enforceability of a notice or document that is electronically delivered to the party before the withdrawal of consent is effective.

(b) A withdrawal of consent by a party is effective thirty (30) days after the insurer receives notice of the withdrawal.

(c) An insurer's failure to comply with section 3(c)(4) of this chapter is, at the election of the party, considered to be a withdrawal of the party's consent under this chapter.
As added by P.L.119-2014, SEC.1.

IC 27-1-43-6
Application of chapter

Sec. 6. (a) This chapter does not apply to a notice or document that is electronically delivered:

(1) by an insurer before July 1, 2014; and

(2) to a party who, before July 1, 2014, consented to receive electronically delivered notices or documents as otherwise allowed by law.

(b) If:

(1) the consent of a party to receive certain electronically delivered notices or documents is on file with an insurer before July 1, 2014; and

(2) the insurer intends to electronically deliver additional notices or documents to the party under this chapter;

the insurer shall, before electronically delivering the additional notices or documents, notify the party that notices or documents that

were not previously electronically delivered may now be electronically delivered under this chapter and that the party has a right to withdraw consent to electronic delivery of notices or documents.
As added by P.L.119-2014, SEC.1.

IC 27-1-43-7
Electronic oral communications

Sec. 7. (a) Except as otherwise provided by law, if an oral communication or a recording of an oral communication from a party can be reliably stored and reproduced by an insurer, the oral communication or recording may qualify as an electronically delivered notice or document under this chapter.

(b) If a provision of this title or other applicable law requires a signature, notice, or document to be notarized, acknowledged, verified, or made under oath, the requirement is satisfied if:

(1) the electronic signature of the person authorized to notarize, acknowledge, verify, or give an oath; and

(2) all other information required to be included by the provision;

are attached to or logically associated with the signature, notice, or document.
As added by P.L.119-2014, SEC.1. Amended by P.L.5-2015, SEC.60.

IC 27-1-43-8
Federal law; exemption from applicability

Sec. 8. (a) This chapter does not modify, limit, or supersede the federal Electronic Signatures in Global and National Commerce Act (15 U.S.C. 7001 et seq.).

(b) This chapter does not apply to a document to which IC 27-1-44 applies.

(c) This chapter does not apply to a notice or document related to title insurance (as defined in IC 27-7-3-2).
As added by P.L.119-2014, SEC.1. Amended by P.L.146-2015, SEC.28.

IC 27-1-43-9
Insurance producer immunity

Sec. 9. An insurance producer is not liable for harm or injury that occurs in relation to electronic delivery or nondelivery of a notice or document covered under this chapter.
As added by P.L.129-2014, SEC.9.

IC 27-1-43.2

Chapter 43.2. Service Contracts

IC 27-1-43.2-1

"Ancillary protection product"

Sec. 1. (a) As used in this chapter, "ancillary protection product" means a protective chemical, substance, device, or system that is:

(1) installed on or applied to a motor vehicle;

(2) formulated or designed to:

(A) prevent; or

(B) minimize the likelihood of;

a specified loss or damage to a motor vehicle from a specific cause; and

(3) sold with a service contract under which the provider agrees to pay specified incidental costs incurred by the holder as a result of the failure of the chemical, substance, device, or system to prevent or minimize the loss or damage described in subdivision (2).

(b) As used in this chapter, "ancillary protection product" includes the following:

(1) Protective chemicals.

(2) Alarm systems.

(3) Body part marking products.

(4) Steering locks.

(5) Window etching products.

(6) Pedal and ignition locks.

(7) Fuel and ignition kill switches.

(8) Electronic, radio, and satellite tracking devices.

(c) As used in this chapter, "ancillary protection product" does not include the following:

(1) Fuel additives.

(2) Oil additives.

(3) Other chemical products applied to the engine, transmission, or fuel system of a motor vehicle.

As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-2

"Holder"

Sec. 2. As used in this chapter, "holder" means a person who is entitled to services or indemnification under a service contract.

As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-3

"Incidental cost"

Sec. 3. (a) As used in this chapter, "incidental cost" means an expense that is:

(1) specified in a service contract that applies to a motor vehicle;

(2) incurred by the holder due to the failure of an ancillary protection product to perform as provided in the service contract sold with the ancillary protection product; and
(3) reimbursed to the holder:
(A) as a fixed amount specified in the service contract; or
(B) by use of a formula that itemizes specific incurred expenses.
(b) "Incidental cost" includes the following:
(1) Insurance policy deductibles.
(2) Rental vehicle charges.
(3) The difference between the actual value of a stolen motor vehicle at the time of theft and the cost of a replacement motor vehicle.
(4) Sales tax.
(5) Registration fees.
(6) Transaction fees.
(7) Mechanical inspection fees.
(8) Expense incurred due to a defective part or mechanical or electrical breakdown.
(9) Expense incurred for labor.
(10) Expense incurred for other remedial measures, including a repair, a replacement, or repetition of a service.
As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-4
"Motor vehicle"
Sec. 4. As used in this chapter, "motor vehicle" has the meaning set forth in IC 9-13-2-105(a).
As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-5
"Provider"
Sec. 5. As used in this chapter, "provider" means a person who is contractually obligated to a holder under a service contract.
As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-6
"Road hazard"
Sec. 6. (a) As used in this chapter, "road hazard" means a hazard encountered by a motor vehicle in normal driving conditions.
(b) "Road hazard" includes the following:
(1) A pothole.
(2) A rock.
(3) Wood debris.
(4) Metal parts.
(5) Glass.
(6) Plastic.
(7) A curb.

(8) A composite scrap.
As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-7
"Service contract"

Sec. 7. (a) As used in this chapter, "service contract" means an agreement:

(1) that is effective for a specified period; and
(2) under which a provider:
(A) receives consideration that is separate from the lease or purchase price of a motor vehicle; and
(B) agrees to provide the performance, or indemnification for the cost of performance, of the repair, replacement, or maintenance of a motor vehicle related to the operational or structural failure of the motor vehicle due to a defect in materials or workmanship, accidental damage, normal wear and tear, or damage resulting from a power surge or interruption.

A service contract may also provide for the incidental payment of indemnity under limited circumstances, including indemnity for towing, temporary replacement motor vehicle rental, and emergency road service.

(b) The repair, replacement, or maintenance described in subsection (a)(2)(B) includes the following:

(1) Repair or replacement of tires or wheels on a motor vehicle damaged as a result of road hazards.
(2) Removal of dents, dings, or creases on a motor vehicle that can be repaired using the process of paintless dent removal without affecting the existing paint finish and without replacing vehicle body panels, sanding, bonding, or painting.
(3) Repair of chips or cracks in, or replacement of, motor vehicle windshields as a result of damage caused by road hazards.
(4) Replacement of an inoperable, lost, or stolen motor vehicle key or keyfob.
(5) Payment of specified incidental costs resulting from failure of an ancillary protection product to perform as specified.
(6) Payment related to other products and services approved by the commissioner and consistent with this chapter.

(c) A service contract may not include coverage:

(1) for the:
(A) repair of damage to;
(B) replacement of; or
(C) repair of damage to and replacement of;
the interior surfaces of a vehicle; or
(2) for the:
(A) repair of damage to;
(B) replacement of; or

(C) repair of damage to and replacement of;
the exterior paint or finish of a vehicle.

However, coverage described in subdivision (1) or (2) may be offered in connection with the sale of an ancillary protection product as defined in section 1 of this chapter.

(d) "Service contract" does not include an insurance policy that:

(1) is issued by an insurer authorized to engage in the insurance business in Indiana; and

(2) provides coverage for repair, replacement, or maintenance described in subsection (a)(2)(B).

As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-8
"Service contract reimbursement policy"

Sec. 8. As used in this chapter, "service contract reimbursement policy" means a policy of insurance that provides coverage for one (1) of the following:

(1) All obligations and liabilities incurred by a provider under a service contract issued by the provider in Indiana.

(2) In the event of the provider's nonperformance under a service contract issued by the provider in Indiana, performance of all obligations:

(A) of the provider under the service contract; and

(B) that the provider did not perform.

As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-9
"Warranty"

Sec. 9. As used in this chapter, "warranty" means a guarantee that:

(1) is made:

(A) solely by the manufacturer, importer, or seller of property or services; and

(B) without consideration;

(2) is not negotiated or separated from the sale of the property or services;

(3) is incidental to the sale of the property or services; and

(4) the person making the guarantee will indemnify the warranty holder for:

(A) defective parts;

(B) mechanical or electrical failure;

(C) labor; or

(D) other remedial measures, including repair or replacement of the property or repetition of services.

As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-10
Service contract characterization and regulation

Sec. 10. (a) A service contract:

(1) is not insurance; and
(2) except as provided in this chapter, is not regulated under IC 27.

(b) The authority of the commissioner under this chapter is in addition to all other authority of the commissioner under this title.
As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-11
Service contract requirements

Sec. 11. (a) Except as provided in section 14 of this chapter, a service contract may not be offered, sold, or issued in Indiana unless the provider complies with one (1) of the following subdivisions:

(1) All of the following conditions are met:
(A) The provider is insured under a service contract reimbursement policy issued by an insurer authorized to do business in Indiana.
(B) True and correct copies of the service contract reimbursement policy have been filed with the commissioner.
(C) The service contract conspicuously:
(i) states that the obligations of the provider to the holder are covered under the service contract reimbursement policy; and
(ii) sets forth the name and address of the insurer that issued the service contract reimbursement policy.

(2) The provider maintains a funded reserve account for its obligations under each service contract issued by the provider in Indiana and outstanding, subject to the following:
(A) The reserves are calculated at not less than forty percent (40%) of the gross consideration received, then minus the amount of claims paid under the service contracts.
(B) The service contract conspicuously states that the obligations of the provider under the service contract are backed by the full faith and credit of the provider.

A reserve account maintained under subdivision (2) is subject to examination and review by the commissioner under section 15 of this chapter.

(b) A filing described in subsection (a)(1)(B) is for informational purposes only and is not subject to approval by the commissioner.
As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-12
Service contract form

Sec. 12. A service contract must meet the following requirements:

(1) Be legibly typed or printed in understandable language.
(2) Include the following disclosures:
(A) The name and address of:
(i) the provider;

(ii) any administrator of the service contract, if different from the provider;

(iii) the person selling the service contract; and

(iv) if the information has been furnished by the holder, the holder.

This information may be added to the service contract at the time of sale and is not required to be preprinted on the service contract.

(B) The total purchase price and the terms under which the service contract is sold. This information may be negotiated with the holder and added to the service contract at the time of sale and is not required to be preprinted on the service contract.

(C) The existence and amount of any applicable deductible.

(D) The products and services to be provided under the service contract, including any conditions, limitations, exceptions, and exclusions.

(E) Whether the use of nonoriginal manufacturer parts is allowed.

(F) Any applicable restrictions governing the transferability of the service contract.

(G) The terms, restrictions, or conditions governing cancellation, by the provider or the holder, of the service contract before the termination or expiration date of the service contract.

(H) All obligations and duties of the holder, including any applicable:

(i) duty to protect the motor vehicle from additional damage; and

(ii) motor vehicle service requirements, as provided in the motor vehicle owner's manual, supplement, or guide.

(I) Whether the service contract provides for or excludes consequential damages or preexisting conditions.

(3) Conspicuously set forth the following statement or a substantially similar statement:

"This service contract is not insurance and is not subject to Indiana insurance law.".

(4) If the service provider is insured under a service contract reimbursement policy under section 11(a)(1)(A) of this chapter, conspicuously state that if the provider fails to perform or make payment due under the service contract within sixty (60) days after the holder requests the performance or payment, the holder may request the performance or payment directly from the insurer that issued the provider's service contract reimbursement policy, including any applicable requirement under the service contract that the provider refund any part of the cost of the service contract upon cancellation of the service contract.

As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-13
Service contract reimbursement policy form

Sec. 13. Except as provided in section 14 of this chapter, a service contract reimbursement policy may not be offered, sold, or issued in Indiana unless the service contract reimbursement policy conspicuously states that the insurer will do either of the following:

(1) Pay all sums that the provider is obligated to pay under service contracts issued by the provider and outstanding in Indiana.

(2) In the event of the provider's nonperformance under a service contract issued by the provider and outstanding in Indiana, perform or pay for the performance of services that the provider:

(A) is obligated to perform under the service contract; and

(B) failed to perform.

As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-14
Application of chapter provisions

Sec. 14. Sections 11, 12(4), and 13 of this chapter do not apply to a warranty, service contract, or other agreement:

(1) that is offered or sold by a motor vehicle dealer in connection with a motor vehicle sold by the motor vehicle dealer; and

(2) under which the motor vehicle dealer, motor vehicle manufacturer, or affiliate of the dealer or manufacturer is obligated to perform.

As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-15
Commissioner authority; violations

Sec. 15. The commissioner may do the following:

(1) Conduct an investigation or examination of a provider, an administrator, an insurer, or another person to enforce this chapter.

(2) Take action that is necessary or appropriate to enforce this chapter.

(3) If a provider violates this chapter, issue an order to do the following:

(A) Require a provider to cease and desist.

(B) Prohibit a provider from offering, issuing, or selling a service contract in Indiana.

(C) Impose a civil penalty not to exceed ten thousand dollars ($10,000) per violation.

As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-16
Administrative hearing

Sec. 16. (a) If a person is aggrieved by an order issued under section 15(3) of this chapter, the person may, not more than twenty (20) days after the effective date of the order, request a hearing under IC 4-21.5.

(b) If a person requests a hearing under subsection (a) the commissioner shall suspend the effective date of the order pending the outcome of the hearing.

(c) In a hearing requested under subsection (a), the burden is on the commissioner to show cause why the order is justified.

As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-17

Court action

Sec. 17. The commissioner may commence an action in the circuit or superior court of Marion County to do the following:

(1) Enjoin an actual or threatened violation of this chapter.

(2) Seek restitution on behalf of a person aggrieved by a violation of this chapter.

As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-18

Nonapplicability of chapter

Sec. 18. This chapter does not apply to the following:

(1) A warranty provided under the Magnuson-Moss Warranty Act, 15 U.S.C. 2301 et seq.

(2) A contract that is effective for a specified period and under which a person agrees to:

(A) provide; or

(B) indemnify the contract holder for;

regular maintenance.

(3) A motor club approved under IC 9-30-2-8.

As added by P.L.129-2014, SEC.10.

IC 27-1-43.2-19

Rules

Sec. 19. The commissioner may adopt rules under IC 4-22-2 to implement this chapter.

As added by P.L.129-2014, SEC.10.

IC 27-1-44

Chapter 44. Electronic Posting of Documents

IC 27-1-44-1

"Property and casualty insurance"

Sec. 1. As used in this chapter, "property and casualty insurance" means one (1) or more of the types of insurance described in IC 27-1-5-1, Class 2 and Class 3. The term does not include title insurance (as defined in IC 27-7-3-2).

As added by P.L.119-2014, SEC.2. Amended by P.L.146-2015, SEC.29.

IC 27-1-44-2

Electronic posting of policy or endorsement

Sec. 2. A standard property and casualty insurance policy or endorsement that does not contain personally identifiable information may be:

(1) mailed or electronically delivered (as provided in IC 27-1-43) to the insured; or

(2) posted on the insurer's Internet web site.

As added by P.L.119-2014, SEC.2.

IC 27-1-44-3

Requirements for electronic posting of policy or endorsement

Sec. 3. An insurer that elects to post a property and casualty insurance policy or endorsement on the insurer's Internet web site under section 2 of this chapter shall comply with all the following:

(1) The policy or endorsement must remain accessible as long as the policy is in force.

(2) After the expiration of the policy or endorsement, the insurer shall:

(A) archive the expired policy or endorsement for at least five (5) years; and

(B) make the expired policy or endorsement available upon request.

(3) The policy or endorsement must be posted in a manner that enables the insured to print and save the policy or endorsement using programs or applications that are widely available on the Internet and free of charge.

(4) The insurer provides to the insured the following information in, or in addition to, each declaration page provided at issuance and each renewal of the policy or endorsement:

(A) A description of the specific policy or endorsement forms purchased by the insured.

(B) A method by which the insured may obtain, upon request and without charge, a paper copy of the policy or endorsement.

(C) The Internet web site address at which the policy or

endorsement is posted.

(5) The insurer provides written or electronic notice, in the format preferred by the insured, of the following:

(A) Any change to the policy or endorsement form.

(B) The insured's right to obtain, upon request and without charge:

(i) a paper copy of the change to the policy or endorsement form; and

(ii) the Internet web site address at which the policy or endorsement is posted.

As added by P.L.119-2014, SEC.2.

IC 27-2

ARTICLE 2. POWERS AND DUTIES OF INSURERS

IC 27-2-1

Chapter 1. Actuaries' Authority to Administer Oaths

IC 27-2-1-1

Administration of oaths

Sec. 1. Actuaries of mutual fire insurance companies or associations organized by virtue of the laws of this state for the purpose of mutual insurance of the property of its members against loss by fire or damage by lightning, which property to be insured shall embrace dwelling-houses, barns, accompanying outbuildings and their contents, farm implements, hay, grain, wool and other farm products, live stock, wagons, carriages, harness, household goods, wearing apparel, provisions, musical instruments and libraries, such property being upon farms as farm property, shall have the authority to administer oaths to the insured and all persons necessary to be examined as witnesses in the adjustment of losses to the property of persons insured in said companies or associations where such loss was caused by fire or lightning.

(Formerly: Acts 1891, c.158, s.1.)

IC 27-2-2

Chapter 2. Annual Statement by Special Charter Companies

IC 27-2-2-1

Time of filing; contents; duties of insurance commissioner

Sec. 1. (a) Every company created by special act of the general assembly of the state of Indiana for the purpose of transacting the business of insurance shall, on or before the third Monday of January of each year, furnish the insurance commissioner with a statement, verified by the oaths of the president and secretary of said company and signed by a majority of the directors of such company, which statement shall show the following:

(1) First, the name and locality of the company.

(2) Second, the amount of its capital stock.

(3) Third, the amount of its capital stock paid-in.

(4) Fourth, the assets of the company, including the following:

(A) The amount of cash on hand and in the hands of agents or other persons.

(B) The value of its real estate.

(C) The bonds owned by the company and how they are secured, with the rate of interest.

(D) Debts to the company secured by mortgage.

(E) Debts otherwise secured.

(F) Debts for premiums.

(G) All other securities.

(5) Fifth, the amount of liabilities due or not due to banks or other creditors of the company.

(6) Sixth, losses adjusted and due.

(7) Seventh, losses adjusted and not due.

(8) Eighth, losses unadjusted.

(9) Ninth, losses in suspense waiting for further proof.

(10) Tenth, all other claims against the company.

(11) Eleventh, the greatest amount insured in any one (1) risk.

(12) Twelfth, the greatest amount allowed by the rules of the company to be insured in any one (1) city or town.

(13) Thirteenth, the greatest amount allowed to be insured in any one (1) block.

(b) The insurance commissioner shall cause a copy of such annual statement to be published in the two (2) leading daily newspapers of the state having the largest general circulation and also in some newspaper of general circulation, printed and published in the city or town in which the principal office of such company is located, provided that not more than one dollar ($1) per square shall be paid for each one (1) of such publications, the expense to be paid by the company; and provided further, that it shall be the duty of the commissioner to furnish such company with a certified copy of such statement or report whenever so requested to do by any officer of such company.

(Formerly: Acts 1899, c.134, s.1.) As amended by P.L.252-1985, SEC.125; P.L.11-1987, SEC.29.

IC 27-2-2-2
Fees of insurance commissioner

Sec. 2. The insurance commissioner shall charge and collect for the state of Indiana the sum of five dollars ($5) in each and every case for the examination of the charter and five dollars ($5) in each and every case for the examination of the statement and investigation of evidence of the investment of the assets of such company in accordance with the provisions of their respective charters, and two dollars ($2) for each certified copy of such statement, and shall pay the same over to the treasurer of state to go into the general fund of the state; provided, however, the provisions of this chapter shall not apply to farmers' mutual fire insurance associations organized under special act since the year 1852, and doing business strictly under the assessment plan.

(Formerly: Acts 1899, c.134, s.2.) As amended by P.L.252-1985, SEC.126.

IC 27-2-3

Chapter 3. Disbursements by Vouchers

IC 27-2-3-1

Contents of vouchers; affidavit

Sec. 1. No domestic life insurance corporation shall make any disbursements unless the same be evidenced by a voucher signed by or on behalf of the person, firm, limited liability company, or corporation receiving the money and correctly describing the consideration for the payment, and, if the same be for services and disbursements, setting forth the services rendered and an itemized statement of the disbursements made, and if it be in connection with any matter pending before any legislative or public body or before any department or officer of any government, correctly describing, in addition, the nature of the matter and of the interest of such corporation therein, or, if such a voucher can not be obtained, by an affidavit stating the reasons therefor and setting forth the particulars above mentioned.

(Formerly: Acts 1907, c.168, s.1.) As amended by P.L.1-1994, SEC.133.

IC 27-2-4

Chapter 4. Receivers

IC 27-2-4-1

Powers of attorney general

Sec. 1. No suit or action seeking the appointment of a receiver for any domestic insurance company, whether stock or mutual, organized and doing business under the laws of Indiana and subject to supervision and examination of the insurance commissioner or other department of state, shall be instituted or maintained, or a receiver appointed by any court, except and only in an action instituted by the attorney general, on the request of the insurance commissioner or other department of state having supervision of such corporation; provided, nothing in this section shall affect any litigation pending on May 15, 1919, in any court of record.

(Formerly: Acts 1919, c.101, s.1.) As amended by P.L.252-1985, SEC.127.

IC 27-2-5

Chapter 5. Provisions Concerning Alienation of Benefits

IC 27-2-5-1

Spendthrift laws; exemption from judicial process

Sec. 1. (a) As used in this section, "premium" includes any deposit or contribution.

(b) No person entitled to receive benefits under a life insurance or life annuity contract, or under a written agreement supplemental thereto, issued by domestic life insurance company, shall be permitted to commute, anticipate, encumber, alienate, or assign such benefits, if the right to do so is expressly prohibited or withheld by a provision contained in such contract or supplemental agreement. And if such contract, policy, or supplemental agreement so provides, such benefits, except when payable to the person who provided the consideration for such contract, shall not be subject to such persons' debts, contracts, or engagements, nor to any judicial process to levy upon or attach the same for payment thereof.

(c) A premium paid for an individual life insurance policy that names as a beneficiary, or is legally assigned to, a spouse, child, or relative who is dependent upon the policy owner is not exempt from the claims of the creditors of the policy owner if the premium is paid:

(1) not more than one (1) year before the date of the filing of a voluntary or involuntary petition by; or

(2) to defraud the creditors of;

the policy owner.

(d) The insurer issuing the policy is discharged from all liability by payment of the proceeds and avails of the policy (as defined in IC 27-1-12-14(b)) in accordance with the terms of the policy unless, before payment, the insurer has received at the insurer's home office, written notice by or on behalf of a creditor of the policy owner that specifies the amount claimed against the policy owner.

(Formerly: Acts 1931, c.20, s.1.) As amended by P.L.253-1995, SEC.3.

IC 27-2-6

Chapter 6. Investment in Certain Bonds

IC 27-2-6-1

Authorized investments

Sec. 1. Any life insurance, fire insurance, livestock insurance, casualty or accident insurance, or bonding or surety company, or trust company or savings bank now or hereafter organized under the laws of the state of Indiana, in addition to the investments now authorized by law, be and it hereby is authorized and empowered to invest its funds in obligations issued by or for federal land banks, federal intermediate credit banks and banks for cooperatives under the Farm Credit Act of 1971 (12 U.S.C. 2001 et seq.) as amended and such obligations are hereby declared eligible for any deposit required of any such company under the laws of this state.

(Formerly: Acts 1931, c.55, s.1; Acts 1975, P.L.44, SEC.3.)

IC 27-2-7

Chapter 7. Compliance With Other States' Regulations

IC 27-2-7-1

Power of compliance; payment of fees and taxes

Sec. 1. Every domestic insurer shall have power to comply with any statute, ordinance or other law of any state, territory or political subdivision thereof (including the District of Columbia) imposing any license, excise, privilege, premium, occupation or other fee or tax and to pay such fee or tax unless prior to such payment such statute, ordinance or other law shall have been expressly held invalid by the state court having final appellate jurisdiction in the premises, or by the Supreme Court of the United States.

(Formerly: Acts 1945, c.123, s.1.)

IC 27-2-7-2

Exemption from personal liability

Sec. 2. No officer, director or trustee of any insurer shall be subject to any personal liability by reason of any payment, or determination not to contest payment, deemed by the board of directors or trustees to be in the corporate interests of such insurer, of any license, excise, privilege, premium, occupation or other fee or tax to any state, territory or political subdivision thereof (including the District of Columbia), unless prior to such payment the statute, ordinance or other law imposing such fee or tax shall have been expressly held invalid by the state court having final appellate jurisdiction in the premises, or by the Supreme Court of the United States.

(Formerly: Acts 1945, c.123, s.2.)

IC 27-2-7-3

Application of act

Sec. 3. This chapter shall be applicable to acts done and payments made on and after March 3, 1945; provided, however, that nothing contained in this chapter shall be construed as directly or indirectly limiting, minimizing, or interpreting the rights and powers and duties of insurers and their officers, directors, and trustees, existing before March 3, 1945, except as specifically exempted by this chapter.

(Formerly: Acts 1945, c.123, s.3.) As amended by P.L.252-1985, SEC.128.

IC 27-2-8

Chapter 8. Commissioner's List of Motor Vehicle Insurers

IC 27-2-8-1

List of motor vehicle insurers agreeable to meeting state standards

Sec. 1. The insurance commissioner shall annually forward to all departments and divisions of the state requiring the posting of security because of motor vehicle accidents and resultant damage and loss a list of those insurers which are, or which are agreeable to be, examined by the insurance department in the same manner as set out in IC 27-1-3-7 and IC 27-1-3.1, and set up and maintain liabilities and reserves in the same manner as set out in IC 27-1-13-8, and submit a written statement of their financial condition and their operations on the forms as prescribed by the National Association of Insurance Commissioners, and in the same manner as set out in IC 27-1-3-7 and IC 27-1-20-21. No certificates or policies shall be accepted by such departments or divisions as such security unless the insurer so filing the certificate or policy shall have met or is agreeable to meeting the requirements as set out above.

(Formerly: Acts 1949, c.240, s.1.) As amended by P.L.252-1985, SEC.129; P.L.26-1991, SEC.24.

IC 27-2-9
Repealed

(Repealed by P.L.126-2001, SEC.4.)

IC 27-2-10
Chapter 10. Equity Securities of Insurance Companies

IC 27-2-10-1
Statement of equity ownership and changes in holdings

Sec. 1. Every person who is directly or indirectly the beneficial owner of more than ten per cent (10%) of any class of any equity security of a domestic stock insurance company, or who is a director or an officer of such company, shall file in the office of the insurance commissioner of Indiana on or before December 31, 1965, or within ten (10) days after he becomes such beneficial owner, director, or officer, a statement, in such form as the insurance commissioner may prescribe, of the amount of all equity securities of such company of which he is the beneficial owner, and within ten (10) days after the close of each calendar month thereafter, if there has been a change in such ownership during such month, shall file in the office of the insurance commissioner a statement, in such form as the commissioner may prescribe, indicating his ownership at the close of the calendar month and such changes in his ownership as have occurred during such calendar month.
(Formerly: Acts 1965, c.5, s.1.)

IC 27-2-10-2
Accounting for profits from short term equity trading; persons entitled to bring action; limitation of actions

Sec. 2. For the purpose of preventing the unfair use of information which may have been obtained by such beneficial owner, director, or officer by reason of his relationship to such domestic stock insurance company, any profit realized by him from any purchase and sale, or any sale and purchase, of any equity security of such company within any period of less than six (6) months, unless such security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the company, irrespective of any intention on the part of such beneficial owner, director, or officer in entering into such transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six (6) months. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the company, or by the owner of any security of the company in the name and in behalf of the company if the company shall fail or refuse to bring such suit within sixty (60) days after request or shall fail diligently to prosecute the same thereafter; but no such suit shall be brought more than two (2) years after the date such profit was realized. This section shall not be construed to cover any transaction where such beneficial owner was not such both at the time of the purchase and sale, or the sale and purchase, of the security involved, or any transaction or transactions which the insurance commissioner by rules and regulations may exempt as not comprehended within the

purpose of this section.
(Formerly: Acts 1965, c.5, s.2.)

IC 27-2-10-3
Short sales; time for delivery of securities sold

Sec. 3. It shall be unlawful for any such beneficial owner, director, or officer, directly or indirectly, to sell any equity security of such domestic insurance company if the person selling the security or his principal (i) does not own the security sold, or (ii) if owning the security, does not deliver it against such sale within twenty (20) days thereafter, or does not within five (5) days after such sale deposit it in the mails or other usual channels of transportation; but no person shall be deemed to have violated this section if he proves that notwithstanding the exercise of good faith he was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.
(Formerly: Acts 1965, c.5, s.3.)

IC 27-2-10-4
Exemption of dealers

Sec. 4. The provisions of section 2 of this chapter shall not apply to any purchase and sale, or sale and purchase, and the provisions of section 3 of this chapter shall not apply to any sale, of an equity security of a domestic stock insurance company not then or theretofore held by him in an investment account, by a dealer in the ordinary course of his business and incident to the establishment or maintenance by him of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934, 15 U.S.C. 78a et seq.) for such security. The insurance commissioner may, by such rules as he deems necessary or appropriate and in the public interest, define and prescribe terms and conditions with respect to equity securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.
(Formerly: Acts 1965, c.5, s.4.) As amended by P.L.252-1985, SEC.132.

IC 27-2-10-5
Exemption of arbitrage transactions

Sec. 5. The provisions of sections 1, 2, and 3 of this chapter shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules as the insurance commissioner may adopt in order to carry out the purposes of this chapter.
(Formerly: Acts 1965, c.5, s.5.) As amended by P.L.252-1985, SEC.133.

IC 27-2-10-6

"Equity security" defined

Sec. 6. The term "equity security", when used in this chapter, means any stock or similar security, or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security, or any such warrant or right, or any other security which the insurance commissioner shall deem to be of similar nature and consider necessary or appropriate, by such rules as he may prescribe in the public interest or for the protection of investors, to treat as an equity security.

(Formerly: Acts 1965, c.5, s.6.) As amended by P.L.252-1985, SEC.134.

IC 27-2-10-7

Exemption of sale of registered securities or securities in closely held corporation

Sec. 7. The provisions of sections 1, 2, and 3 of this chapter shall not apply to transactions in equity securities of a domestic stock insurance company if:

(a) such securities shall be registered, or shall be required to be registered, pursuant to section 12 of the Securities Exchange Act of 1934 (15 U.S.C. 781), as amended; or

(b) such domestic stock insurance company shall not have any class of its equity securities held of record by one hundred (100) or more persons on the last business day of the year next preceding the year in which equity securities of the company would be subject to the provisions of sections 1, 2, and 3 of this chapter except for the provisions of this subdivision.

(Formerly: Acts 1965, c.5, s.7.) As amended by P.L.252-1985, SEC.135; P.L.3-1989, SEC.153.

IC 27-2-10-8

Powers of commissioner

Sec. 8. The insurance commissioner shall have the power to make such rules as may be necessary for the execution of the functions vested in him by sections 1 through 7 of this chapter and may for such purpose classify domestic stock insurance companies, securities, and other persons or matters within his jurisdiction. No provision of sections 1, 2, and 3 of this chapter imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule of the insurance commissioner, notwithstanding that such rule may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

(Formerly: Acts 1965, c.5, s.8.) As amended by P.L.252-1985, SEC.136.

IC 27-2-10-9

Construction of act

Sec. 9. This chapter shall be construed as supplemental to IC 27-1. *(Formerly: Acts 1965, c.5, s.9.) As amended by P.L.252-1985, SEC.137; P.L.11-1987, SEC.30.*

IC 27-2-11
Repealed

(Repealed by Acts 1971, P.L.387, SEC.2.)

IC 27-2-11.1

Chapter 11.1. Minors

IC 27-2-11.1-1

Competence to contract for insurance

Sec. 1. No person eighteen (18) years of age or over is incompetent because of age to contract for any insurance or exercise every right, privilege and benefit provided by any insurance contract.
(Formerly: Acts 1973, P.L.275, SEC.5.)

IC 27-2-11.1-2

Competence to receive insurance payments

Sec. 2. No person eighteen (18) years of age or over is incompetent because of age to receive and give full acquittance and discharge for payments or execute assignments under the provisions of an insurance contract or under the provisions of a settlement agreement executed in connection with any such contract of insurance.
(Formerly: Acts 1973, P.L.275, SEC.5.)

IC 27-2-13

Chapter 13. Arson Reporting

IC 27-2-13-0.1

Application of certain amendments to chapter

Sec. 0.1. The addition of section 5 of this chapter by P.L.247-1989 applies only to insurance policies issued or renewed after June 30, 1989.

As added by P.L.220-2011, SEC.426.

IC 27-2-13-1

Definitions

Sec. 1. As used in this chapter:

(a) "Authorized agency" means:

(1) the state fire marshal or a fire department acting under IC 36-8-17;

(2) the superintendent of the state police;

(3) the prosecuting attorney responsible for prosecutions in the county where the fire occurred;

(4) the attorney general; and

(5) an arson investigator.

(b) "Relevant" refers to information having any tendency to make the existence of any fact that is of consequence to the investigation or determination of a fire loss more probable or less probable than it would have been without the evidence.

(c) "Insurer" has the same meaning as in IC 27-1-2-3(x) and includes the Indiana FAIR plan.

(d) "Arson investigator" means an officer of a unit of local government whose duties include the investigation of arson.

As added by Acts 1979, P.L.253, SEC.1. Amended by P.L.139-1984, SEC.1; P.L.245-1987, SEC.16; P.L.1-2006, SEC.485.

IC 27-2-13-2

Release of information by insurer to investigating authorized agency

Sec. 2. (a) An authorized agency charged with the responsibility of investigating a fire loss may, in writing, request that an insurer investigating that loss release to the requesting agency any or all relevant information or evidence considered important to the authorized agency, including:

(1) pertinent insurance policy information relevant to a fire loss under investigation and any application for that policy;

(2) policy premium payment records;

(3) history of previous claims made by the insured; and

(4) material relating to the investigation of the loss, including:

(A) statements of any person;

(B) proof of loss; and

(C) other evidence relevant to the investigation.

(b) An insurer shall furnish information requested under this section to the requesting authorized agency.
As added by Acts 1979, P.L.253, SEC.1. Amended by P.L.139-1984, SEC.2.

IC 27-2-13-3
Notice to authorized agency by insurer of suspected nonaccidental fire loss

Sec. 3. (a) When an insurer has reason to believe that a fire loss in which it has an interest was caused by a means that was not accidental, then, for the purpose of notification and for having that fire loss investigated, the company shall, in writing, notify an authorized agency and provide that agency with all material developed from the insurer's inquiry into the fire loss.

(b) When an insurer provides an authorized agency with notice of a fire loss, it shall be considered sufficient notice for the purpose of this chapter. However, the insurer shall provide the state fire marshal a copy of the information provided under subsection (a), if the notice was provided to an authorized agency other than the state fire marshal.
As added by Acts 1979, P.L.253, SEC.1. Amended by P.L.139-1984, SEC.3; P.L.245-1987, SEC.17; P.L.1-2006, SEC.486.

IC 27-2-13-4
Supplying information to other authorized agency or insurer; immunity from civil or criminal liability

Sec. 4. (a) An authorized agency provided with information under this chapter may release or provide that information to any other authorized agency to further its investigation.

(b) An insurer providing information to an authorized agency under section 3 of this chapter has the right to request and to receive from that agency relevant information. The agency shall provide the requested information within a reasonable time, not to exceed thirty (30) days from the date of the request.

(c) An insurer (or a person acting on its behalf) or an authorized agency who releases or provides evidence or information under this chapter is immune from any civil or criminal liability for providing the evidence or information.
As added by Acts 1979, P.L.253, SEC.1. Amended by P.L.139-1984, SEC.4.

IC 27-2-13-5
Withholding of insurance proceeds; exceptions

Sec. 5. An authorized agency that is investigating a fire believed to have been caused by arson may, in writing, order an insurer to withhold payment of the proceeds of an insurance policy on the damaged or destroyed property for up to thirty (30) days from the date of the order. The insurer may not make a payment during that

time, except for payments:

(1) for emergency living expenses;

(2) for emergency action necessary to secure the premises;

(3) necessary to prevent further damage to the premises; or

(4) to a mortgagee who is not the target of investigation by the authorized agency.

As added by P.L.247-1989, SEC.1.

IC 27-2-14

Chapter 14. Vehicle Theft Reporting

IC 27-2-14-1

Definitions

Sec. 1. As used in this chapter:

"Authorized agency" means the state police, the prosecuting attorney responsible for prosecutions in the county where the theft occurred, or any law enforcement agency.

"Insurer" means an insurance company.

"Relevant" means information having any tendency to make the existence of any fact that is of consequence to the investigation or determination of an allegedly fraudulent vehicle theft claim more probable or less probable than it would have been without the evidence.

As added by Acts 1981, P.L.246, SEC.1.

IC 27-2-14-2

Fraudulent claims; notification by insurer

Sec. 2. If an insurer has reason to believe that a vehicle theft claim made by an insured is fraudulent, the insurer shall:

(1) notify, in writing, an authorized agency of the suspected fraudulent claim; and

(2) provide the agency with all material developed from the insurer's inquiry into the claim.

As added by Acts 1981, P.L.246, SEC.1.

IC 27-2-14-3

Investigative agencies; disclosure of information or evidence by insurer

Sec. 3. An authorized agency charged with the responsibility of investigating a vehicle theft may, in writing, require an insurer investigating that loss to release to the requesting agency any or all relevant information or evidence considered important to the authorized agency including:

(1) pertinent insurance policy information relevant to the theft under investigation and any application for that policy;

(2) policy premium payment records;

(3) history of previous claims made by the insured; and

(4) material relating to the investigation, including:

(A) statements of any person;

(B) proof of loss; and

(C) other evidence relevant to the investigation.

As added by Acts 1981, P.L.246, SEC.1.

IC 27-2-14-4

Release of information to other agencies; reciprocal disclosure to insurer; immunity from civil or criminal liability

Sec. 4. (a) An authorized agency provided with information under this chapter may release or provide that information to any other authorized agency to further its investigation.

(b) An insurer providing information to an authorized agency under section 2 or section 3 of this chapter has the right to request and to receive from that agency relevant information. The agency shall provide the requested information within a reasonable time, not to exceed thirty (30) days from the date of the request.

(c) An insurer (or a person acting on its behalf) or an authorized agency that releases or provides evidence or information under this chapter is immune from any civil or criminal liability for providing such evidence or information.

As added by Acts 1981, P.L.246, SEC.1.

IC 27-2-15

Chapter 15. Available Insurance Proceeds Set Aside

IC 27-2-15-1

"Available insurance proceeds" defined

Sec. 1. As used in this chapter, "available insurance proceeds" means the proceeds payable under an insurance policy based upon a claim for damage to or loss of a building or other structure caused by fire or explosion, minus proceeds paid to:

(1) the insured for emergency living expenses;

(2) take emergency action necessary to secure the premises;

(3) prevent further damage to the premises; or

(4) a lienholder or mortgagee who is not the target of an investigation by an authorized agency (as defined in IC 27-2-13-1).

As added by P.L.247-1989, SEC.2.

IC 27-2-15-2

Repealed

(As added by P.L.247-1989, SEC.2. Repealed by P.L.238-2013, SEC.1.)

IC 27-2-15-2.5

"Department"

Sec. 2.5. As used in this chapter, "department" refers to the department of insurance created by IC 27-1-1-1.

As added by P.L.238-2013, SEC.2.

IC 27-2-15-3

"Enforcement authority" defined

Sec. 3. As used in this chapter, "enforcement authority" has the meaning set forth in IC 36-7-9-2.

As added by P.L.247-1989, SEC.2.

IC 27-2-15-3.2

"Final settlement"

Sec. 3.2. (a) As used in this chapter, "final settlement" means a determination:

(1) of the amount owed to an insured:

(A) under the building coverage part of an insurance policy issued by an insurer; and

(B) for damage to or loss of a building or other structure caused by fire or explosion; and

(2) made by any of the following means:

(A) Acceptance of a proof of loss by the insurer.

(B) Execution of a release by the named insured.

(C) Acceptance of an arbitration award by the named insured and the insurer.

(D) Judgment of a court of competent jurisdiction.

(b) The term "final settlement" does not apply to damage or loss related to contents, personal property, or another loss that is not covered under the building coverage part of an insurance policy.

As added by P.L.238-2013, SEC.3.

IC 27-2-15-4

"Insurer" defined

Sec. 4. As used in this chapter, "insurer" means a fire and marine insurance company, as defined in IC 27-1-2-3(u).

As added by P.L.247-1989, SEC.2.

IC 27-2-15-4.2

"Municipality"

Sec. 4.2. As used in this chapter, "municipality" has the meaning set forth in IC 36-1-2-11.

As added by P.L.238-2013, SEC.4.

IC 27-2-15-4.3

Application of chapter

Sec. 4.3. (a) This chapter applies to damage to or loss of a building or structure caused by fire or explosion only if all of the following are true:

(1) The municipality in which the building or structure is located is included on the list maintained by the department under section 4.4(b) of this chapter.

(2) The fire or explosion occurs on or after the effective date specified by the department for the municipality under section 4.4(b) of this chapter.

(3) The amount of the final settlement concerning the damage or loss exceeds seventy-five percent (75%) of available insurance proceeds.

(4) If the insurer, in good faith, withheld payment under an insurance policy due to:

(A) suspected arson;

(B) suspected fraud; or

(C) another question concerning coverage;

the reason for withholding payment has been resolved and final settlement concerning the damage or loss has occurred.

As added by P.L.238-2013, SEC.5.

IC 27-2-15-4.4

Municipality election regarding governance by chapter

Sec. 4.4. (a) A municipality may elect to be governed by this chapter by submitting to the department a written request. The request must:

(1) be approved by adoption of an ordinance by the municipality's legislative body; and

(2) contain contact information for the specific individual who will act on behalf of the enforcement authority with respect to this chapter.

(b) The department shall:

(1) maintain a list of all municipalities that submit a request under subsection (a), including the contact information required by subsection (a)(2);

(2) specify the effective date of each addition of a municipality to the list; and

(3) publish the list on an Internet web site.

(c) A municipality that made an election under subsection (a) may elect to cease being governed by this chapter and may be removed from the list maintained under subsection (b) as follows:

(1) The municipality shall submit to the department a written request, approved by adoption of an ordinance by the municipality's legislative body, to cease being governed by this chapter and to be removed from the list.

(2) The department shall:

(A) amend the list by removing the municipality;

(B) specify on the amended list the effective date of the municipality's removal from the list; and

(C) publish the amended list on the Internet web site described in subsection (b)(3).

(d) A municipality that is governed by this chapter shall remit to the department a one (1) time fee of one hundred dollars ($100).

As added by P.L.238-2013, SEC.6.

IC 27-2-15-4.5

Notice to enforcement authority of existence of policy

Sec. 4.5. (a) An insurer that:

(1) issued an insurance policy that:

(A) covers a building or other structure that is:

(i) located in a municipality governed by this chapter; and

(ii) damaged by a fire or explosion; and

(B) is in effect at the time that the fire or explosion occurs; and

(2) receives notice of a claim for the damage by the named insured;

shall, not more than fifteen (15) days after a final settlement is reached, notify the enforcement authority of the municipality about the existence of the policy.

(b) The notice to an enforcement authority required by subsection (a) must:

(1) be in writing;

(2) identify the insurer and state the insurer's address; and

(3) identify the building or structure and state the location of the building or structure.

(c) The commissioner may take action under IC 27-1-3-10 and

IC 27-1-3-19 against an insurer that violates this section.
As added by P.L.123-1992, SEC.1. Amended by P.L.119-2012, SEC.159; P.L.238-2013, SEC.7.

IC 27-2-15-5
Evidence of repair contract; set aside of insurance proceeds; amount in escrow

Sec. 5. (a) This section does not apply to damage or loss to a building or structure described in section 4.5 of this chapter if:

(1) not more than fifteen (15) days after final settlement has occurred concerning the building or structure, the named insured files with the insurer evidence of a contract to repair the building or structure; and

(2) upon receipt of the evidence of a contract to repair, the insurer notifies the municipality that this section does not apply due to the existence of the evidence.

(b) If:

(1) the requirements of subsection (a) are not met; and

(2) the enforcement authority of a municipality that receives notice from an insurer under section 4.5(a) of this chapter certifies to the insurer the amount of demolition or rehabilitation expenses that the municipality anticipates incurring or has incurred under IC 36-7-9 in connection with the building or structure;

the insurer shall remit to the municipality or the enforcement authority the amount determined under subsection (d).

(c) To require the remittance of money under this section, an enforcement authority must:

(1) provide the certification under subsection (b) within fifteen (15) days after the enforcement authority receives notice under section 4.5(a) of this chapter; and

(2) comply with subsection (d).

(d) The amount that must be remitted to the municipality or the enforcement authority under subsection (b) is the lesser of:

(1) ten percent (10%) of the available insurance proceeds, if any;

(2) an amount equal to the amount certified; or

(3) the following:

(A) Seven thousand dollars ($7,000) for a residential building or structure.

(B) Fifteen thousand dollars ($15,000) for a nonresidential building or structure.

For purposes of this subsection, "a residential building or structure" means real property consisting of not more than four (4) residential units, one (1) of which is the principal place of residence of the named insured.

(e) The amount remitted under this section shall be placed by the enforcement authority in an interest bearing escrow account to be

administered by the enforcement authority and the municipality. The insured shall be notified by the enforcement authority of the actions taken under this section.
As added by P.L.247-1989, SEC.2. Amended by P.L.123-1992, SEC.2; P.L.238-2013, SEC.8.

IC 27-2-15-6
Claims against set aside; use of funds

Sec. 6. (a) Upon a judgment being rendered under IC 36-7-9-13(c) or IC 36-7-9-13(d), the municipality is entitled to the available insurance proceeds set aside only:

(1) to the extent of the costs set forth in IC 36-7-9-12; and
(2) for demolition and rehabilitation expenses certified under section 5(b) of this chapter.

Available insurance proceeds set aside under section 5 of this chapter may not be used to pay the costs of fire service, police service, or any other service provided in the normal course of the municipality's business.

(b) All claims by the municipality against the available insurance proceeds must be made within one (1) year after the date of the fire or explosion or within one (1) year after the final outcome of a case or appeal initiated under IC 36-7-9, whichever is later. Proceeds in the escrow account that are not claimed in this manner shall be paid to the insured.
As added by P.L.247-1989, SEC.2. Amended by P.L.238-2013, SEC.9.

IC 27-2-15-7
Immunity of insurers

Sec. 7. An insurer complying with this chapter or attempting in good faith to comply with this chapter is immune from civil and criminal liability in connection with actions taken under this chapter, and those actions, including withholding payment of any insurance proceeds under this chapter or releasing or disclosing any information under this chapter, may not be considered to violate IC 27-4-1.
As added by P.L.247-1989, SEC.2.

IC 27-2-15-8
Satisfaction of contractual liability

Sec. 8. Insurance proceeds set aside in an escrow account under section 5 of this chapter shall be considered as having been paid to the insured in satisfaction of any contractual liability under the policy.
As added by P.L.247-1989, SEC.2.

IC 27-2-15-9
Immunity

Sec. 9. The department, the commissioner and employees of the department, the state fire marshal, a deputy fire marshal, an enforcement authority, or an officer of a municipality complying with this chapter or attempting in good faith to comply with this chapter is immune from civil and criminal liability in connection with actions taken under this chapter.
As added by P.L.247-1989, SEC.2. Amended by P.L.238-2013, SEC.10.

IC 27-2-15-10
Rules
Sec. 10. The insurance commissioner may adopt rules under IC 4-22-2 necessary to implement this chapter. These rules must include a procedure for the administration of escrow accounts established under section 5 of this chapter, including the disposition of any funds in the escrow account not claimed under section 6 of this chapter.
As added by P.L.247-1989, SEC.2.

IC 27-2-15-11
Expired
(As added by P.L.238-2013, SEC.11. Expired 7-1-2015 by P.L.238-2013, SEC.11.)

IC 27-2-16

Chapter 16. Insurance Claim Form Notice

IC 27-2-16-0.1

Application of chapter

Sec. 0.1. The addition of this chapter by P.L.193-1991 applies to policies first issued or renewed after June 30, 1991.

As added by P.L.220-2011, SEC.427.

IC 27-2-16-1

Supplemental construction of chapter

Sec. 1. This chapter is supplemental to IC 27-1.

As added by P.L.193-1991, SEC.1.

IC 27-2-16-2

"Insurer" defined

Sec. 2. As used in this chapter, "insurer" has the meaning set forth in IC 27-1-2-3(x).

As added by P.L.193-1991, SEC.1.

IC 27-2-16-3

Claim forms; statement of false claim constituting fraud; effect of absence of statement

Sec. 3. (a) All preprinted claim forms provided by an insurer to a claimant that are required as a condition of payment of a claim must contain a statement that clearly states in substance the following:

> "A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.".

(b) The lack of a statement required under subsection (a) does not constitute a defense against a prosecution under IC 35-43-5-4.5.

As added by P.L.193-1991, SEC.1. Amended by P.L.181-2005, SEC.1.

IC 27-2-16-4

Identification cards and benefit booklets; utilization review determination clause

Sec. 4. An insurer shall include on each identification card and on all benefit booklets that are delivered to an enrollee (as defined in IC 27-8-17-3) whose policy requires a utilization review determination (as defined in IC 27-8-17-8) a printed statement in boldface 8 point type in the benefit booklets and in 6 point type on the identification cards that reads substantially as follows:

> "NOTICE: Precertification or preauthorization does NOT guarantee coverage for or the payment of the service or procedure reviewed.".

As added by P.L.132-1994, SEC.1.

IC 27-2-17

Chapter 17. Discrimination in Insurance

IC 27-2-17-1

"Commissioner" defined

Sec. 1. As used in this chapter, "commissioner" means the insurance commissioner of Indiana.

As added by P.L.130-1994, SEC.37 and P.L.116-1994, SEC.48.

IC 27-2-17-2

"Department" defined

Sec. 2. As used in this chapter, "department" means the department of insurance of Indiana.

As added by P.L.130-1994, SEC.37 and P.L.116-1994, SEC.48.

IC 27-2-17-3

"Independent insurance producer" defined

Sec. 3. As used in this chapter, "independent insurance producer" means an insurance producer who:

(1) represents an insurer in the sale of insurance as an independent contractor rather than as an employee; and

(2) is not limited to representing:

(A) one (1) insurer; or

(B) several insurers that are under common management.

As added by P.L.130-1994, SEC.37 and P.L.116-1994, SEC.48. Amended by P.L.178-2003, SEC.32.

IC 27-2-17-4

"Property or casualty insurance" defined

Sec. 4. As used in this chapter, "property or casualty insurance" means a type of insurance described in Class 2 and Class 3 of IC 27-1-5-1. However, the term does not mean insurance described in Class 2(a) of IC 27-1-5-1.

As added by P.L.130-1994, SEC.37 and P.L.116-1994, SEC.48.

IC 27-2-17-5

Discrimination based on geographical location prohibited

Sec. 5. (a) This chapter applies to an insurer that obtains a certificate of authority under IC 27-1-3-20 as:

(1) a domestic insurer formed under IC 27-1-6;

(2) a foreign insurer that has become a domestic insurer under IC 27-1-6.5; or

(3) a foreign or an alien insurer under IC 27-1-17.

(b) An insurer that:

(1) obtains a certificate of authority authorizing the insurer to provide property or casualty insurance in Indiana; and

(2) provides property or casualty insurance covering risks in any location in Indiana;

may not cancel or refuse to issue or renew a policy of property or casualty insurance based solely on the geographical location of the risk within Indiana. This subsection does not preclude an insurer from refusing to issue or renew or from canceling a policy based on sound underwriting or actuarial principles reasonably related to actual or anticipated loss experience or any other sound business purpose.

(c) If an insurer is found by the commissioner to have violated subsection (b), the commissioner may, after a hearing, suspend or revoke the certificate of authority of the insurer.

(d) Any determination made by the commissioner under this section is subject to IC 4-21.5.

(e) Except as provided in subsection (f), the department has exclusive jurisdiction to investigate any alleged violation of this section.

(f) Subsection (e) is not intended to restrict the jurisdiction, if any, the civil rights commission may have under IC 22-9-1-4.

As added by P.L.130-1994, SEC.37 and P.L.116-1994, SEC.48.

IC 27-2-17-6

Appointment of independent insurance producers; jurisdiction; hearing; violation; administrative orders and procedures; evidence

Sec. 6. (a) An insurance company that issues property or casualty insurance shall not discriminate in the appointment of an independent insurance producer on the basis of race, color, national origin, or gender.

(b) Except as provided in subsection (c), the department has exclusive jurisdiction to investigate any complaints of discrimination in the appointment of independent insurance producers in violation of subsection (a).

(c) If the commissioner of the department determines after a hearing that an insurance company has violated subsection (a), the commissioner may order one (1) of the following remedies:

(1) Payment of a civil penalty of not more than two thousand dollars ($2,000) for each violation.

(2) Suspension or revocation of the insurance company's certificate of authority if the commissioner determines that the violation was willful or wanton and that similar violations have been committed by that company with a frequency that constitutes a general business practice.

(3) Any other remedy agreed to by the department and the insurance company.

(d) Any determination made by the commissioner under this section is subject to IC 4-21.5.

(e) Findings of the department under this section may not be considered as evidence in any civil action other than an appeal as provided under IC 4-21.5.

As added by P.L.116-1994, SEC.48 and P.L.130-1994, SEC.37.

Amended by P.L.2-1995, SEC.103; P.L.178-2003, SEC.33.

IC 27-2-18

Chapter 18. Disclosure of Material Transactions

IC 27-2-18-1

"Asset acquisition" defined

Sec. 1. (a) As used in this chapter, "asset acquisition" includes every purchase, lease, exchange, merger, consolidation, succession, or other acquisition.

(b) The term does not include the construction on or development of real property by or for the reporting insurer or the acquisition of materials for construction or development.

As added by P.L.251-1995, SEC.17.

IC 27-2-18-2

"Asset disposition" defined

Sec. 2. As used in this chapter, "asset disposition" includes every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment (whether for the benefit of creditors or otherwise), abandonment, destruction, or other disposition.

As added by P.L.251-1995, SEC.17.

IC 27-2-18-3

"Domicile" defined

Sec. 3. As used in this chapter, "domicile" means the following:

(1) For a corporation, the state in which the purchasing group is incorporated.

(2) For an unincorporated entity, the state of its principal place of business.

As added by P.L.251-1995, SEC.17.

IC 27-2-18-4

"Material acquisition" defined

Sec. 4. As used in this chapter, "material acquisition" means an asset acquisition or a series of related asset acquisitions during any thirty (30) day period that:

(1) is nonrecurring;

(2) is not in the normal course of business; and

(3) involves more than five percent (5%) of the reporting insurer's total admitted assets as reported in the insurer's most recent statutory statement filed with the department.

As added by P.L.251-1995, SEC.17.

IC 27-2-18-5

"Material disposition" defined

Sec. 5. As used in this chapter, "material disposition" means an asset disposition or a series of related asset dispositions during any thirty (30) day period that:

(1) is nonrecurring;

(2) is not in the normal course of business; and

(3) involves more than five percent (5%) of the reporting insurer's total admitted assets as reported in the insurer's most recent statutory statement filed with the department.

As added by P.L.251-1995, SEC.17.

IC 27-2-18-6

"Material nonrenewal, cancellation, or revision of a ceded reinsurance agreement" defined; reportable material revisions

Sec. 6. (a) As used in this chapter, "material nonrenewal, cancellation, or revision of a ceded reinsurance agreement" has the following meanings:

(1) When used in connection with property and casualty business, including accident and sickness insurance business written by a property and casualty insurer, the term means a nonrenewal, cancellation, or revision that affects:

(A) more than fifty percent (50%) of the insurer's total ceded written premium; or

(B) more than fifty percent (50%) of the insurer's total ceded indemnity and loss adjustment reserves.

(2) When used in connection with life insurance or accident and sickness insurance business, the term means a nonrenewal, cancellation, or revision that affects more than fifty percent (50%) of the total reserve credit taken for business ceded on an annualized basis, as indicated in the insurer's most recent annual statement.

(b) The following events constitute a material revision of a ceded reinsurance agreement for property and casualty insurance, life insurance, or accident and sickness insurance business meeting the requirements of subsection (a) and must be reported:

(1) An authorized reinsurer representing more than ten percent (10%) of a total cession is replaced by one (1) or more unauthorized reinsurers.

(2) Previously established collateral requirements have been reduced or waived as respects one (1) or more unauthorized reinsurers representing collectively more than ten percent (10%) of a total cession.

(c) A nonrenewal, cancellation, or revision of a ceded reinsurance agreement is not material and a filing is not required under subsection (a) or (b) for the following:

(1) In connection with property and casualty business, including accident and sickness insurance business written by a property and casualty insurer, the insurer's total ceded written premium represents, on an annualized basis, less than ten percent (10%) of the insurer's total written premiums for direct and assumed business.

(2) In connection with life insurance or accident and sickness insurance business, the total reserve credit taken for business

ceded represents, on an annualized basis, less than ten percent (10%) of the statutory reserve requirement before any cession.

As added by P.L.251-1995, SEC.17.

IC 27-2-18-7

Reports

Sec. 7. (a) Except as provided in subsection (b), an insurer domiciled in Indiana shall file a report with the commissioner disclosing:

(1) a material acquisition;

(2) a material disposition; and

(3) a material nonrenewal, cancellation, or revision of a ceded reinsurance agreement.

(b) A report of a transaction described in subsection (a) does not have to be filed with the commissioner under this section if the transaction was previously submitted to the commissioner for review, approval, or information purposes under other provisions of IC 27, rules adopted by the department, or other requirements.

As added by P.L.251-1995, SEC.17.

IC 27-2-18-8

Time of filing

Sec. 8. The report required in section 7 of this chapter must be filed not later than fifteen (15) days after the end of the calendar month in which the transaction that requires the filing occurred.

As added by P.L.251-1995, SEC.17.

IC 27-2-18-9

Filing copies

Sec. 9. One (1) complete copy of the report, including any exhibits or other attachments filed with the report, shall be filed with the department.

As added by P.L.251-1995, SEC.17. Amended by P.L.81-2012, SEC.20.

IC 27-2-18-10

Reports as confidential information; exceptions

Sec. 10. (a) Except as provided in subsections (b) and (c), any report obtained by or disclosed to the commissioner under this chapter:

(1) shall be confidential information; and

(2) shall not, without the prior written consent of the insurer to which it pertains, be:

(A) subject to subpoena; or

(B) made public by the commissioner, the National Association of Insurance Commissioners, or any other person.

(b) A report obtained under this chapter may be made available to

other departments of insurance in other states subject to IC 27-1-3-10.5.

(c) The commissioner may, after giving notice and an opportunity to be heard to the insurer that would be affected by the release of information under this chapter:

(1) determine that the interests of policyholders, shareholders, or the public will be served by the publication of information in the report under section 7 of this chapter; and

(2) publish all or any part of the information in such manner as the commissioner considers appropriate.

(d) The commissioner may not:

(1) disclose; or

(2) subject to subpoena;

financial information regarding material transactions disclosed by an insurer under this chapter.

As added by P.L.251-1995, SEC.17.

IC 27-2-18-11

Contents of reports of material acquisitions and dispositions

Sec. 11. The following information must be disclosed in any report of a material asset acquisition or asset disposition:

(1) The date of the transaction.

(2) The manner of the asset acquisition or asset disposition.

(3) A description of the assets involved.

(4) The nature and amount of the consideration given or received in connection with the asset acquisition or the asset disposition.

(5) The purpose of or reason for the transaction.

(6) The manner by which the amount of consideration was determined.

(7) The gain or loss recognized or realized as a result of the transaction.

(8) The name of each person from whom the assets were acquired or to whom the assets were disposed.

As added by P.L.251-1995, SEC.17.

IC 27-2-18-12

Reports of material acquisitions and dispositions on nonconsolidated basis; exceptions

Sec. 12. (a) Insurers must report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that uses a pooling arrangement or one hundred percent (100%) reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool.

(b) An insurer is considered to have ceded substantially all of its direct and assumed business to a pool under subsection (a) if the insurer has less than one million dollars ($1,000,000) total direct plus

assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent (5%) of the insurer's capital and surplus.
As added by P.L.251-1995, SEC.17.

IC 27-2-18-13
Contents of reports of material nonrenewals, cancellations, or revisions

Sec. 13. The following information must be disclosed on a nonconsolidated basis in any report of a material nonrenewal, cancellation, or revision of a ceded reinsurance agreement:

(1) The effective date of the nonrenewal, cancellation, or revision.

(2) The description of the transaction with an identification of the initiator of the transaction.

(3) The purpose of or reason for the transaction.

(4) If applicable, the identity of the replacement reinsurers.

As added by P.L.251-1995, SEC.17.

IC 27-2-18-14
Reports of material nonrenewals, cancellations, or revisions on nonconsolidated basis; exceptions

Sec. 14. (a) An insurer must report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless:

(1) the insurer is part of a consolidated group of insurers that uses a:

(A) pooling arrangement; or

(B) one hundred percent (100%) reinsurance agreement;

that affects the solvency and integrity of the insurer's reserves; and

(2) the insurer ceded substantially all of its direct and assumed business to the pool.

(b) An insurer is considered to have ceded substantially all of its direct and assumed business to a pool under subsection (a) if the insurer has less than one million dollars ($1,000,000) total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent (5%) of the insurer's capital and surplus.
As added by P.L.251-1995, SEC.17.

IC 27-2-19

Chapter 19. Fraud Investigation Information Exchange

IC 27-2-19-0.1

Application of chapter

Sec. 0.1. The addition of this chapter by P.L.187-1996 applies only to claims made or a cause of action that arises after June 30, 1996.

As added by P.L.220-2011, SEC.428.

IC 27-2-19-1

"Governmental agency" defined

Sec. 1. As used in this chapter, "governmental agency" means any:

(1) department;
(2) division;
(3) public agency;
(4) political subdivision; or
(5) other public instrumentality;

of a political subdivision, the state of Indiana, or the federal government.

As added by P.L.187-1996, SEC.1.

IC 27-2-19-2

"Insurer" defined

Sec. 2. As used in this chapter, "insurer" means a person who transacts a property and casualty insurance business.

As added by P.L.187-1996, SEC.1.

IC 27-2-19-3

"Law enforcement agency" defined

Sec. 3. As used in this chapter, "law enforcement agency" means an agency or a department of any level of government whose principal function is the apprehension of criminal offenders. The term includes the office of the inspector general.

As added by P.L.187-1996, SEC.1. Amended by P.L.222-2005, SEC.36.

IC 27-2-19-4

"Person" defined

Sec. 4. As used in this chapter, "person" includes individuals, corporations, associations, limited liability companies, and partnerships.

As added by P.L.187-1996, SEC.1.

IC 27-2-19-5

"Political subdivision" defined

Sec. 5. As used in this chapter, "political subdivision" has the

meaning set forth in IC 36-1-2-13.
As added by P.L.187-1996, SEC.1.

IC 27-2-19-6
Authorization or release from claimant; when required; exceptions

Sec. 6. (a) Except as provided in subsections (b) and (c), a law enforcement agency, an insurer, or a governmental agency that has reason to believe that an application for insurance or a claim for insurance proceeds is being, or is likely to be, presented:

(1) based upon misrepresentation; and
(2) with intent to defraud;

is not required to obtain any authorization or release in order to receive or provide any information other than medical records and medical reports and medical related information contained in medical records and medical reports regarding or in any way potentially relating to that claim or application from or to any other law enforcement agency, insurer, or governmental agency.

(b) In claims for bodily injury, only information:

(1) regarding the type of injury claimed;
(2) regarding the date of the alleged injury;
(3) regarding the name and address of each medical provider submitted to support the claimed injuries; and
(4) referred to in subsection (a);

may be released without first obtaining authorization or a release from the injured claimant.

(c) Medical records and medical reports and medical related information contained in medical records and medical reports may not be released under this chapter without first obtaining authorization or a release from the injured claimant unless:

(1) the claim is a bodily injury claim; and
(2) the parties requesting the release have complied with section 8 of this chapter.

As added by P.L.187-1996, SEC.1.

IC 27-2-19-7
Immunity from liability

Sec. 7. (a) As used in this section, "representative" includes:

(1) a representative investigative agency; and
(2) an attorney;

of a law enforcement agency, insurer, or governmental agency.

(b) Any:

(1) law enforcement agency, insurer, or governmental agency; or
(2) agent, employee, or representative of a law enforcement agency, insurer, or governmental agency;

that receives or provides information referred to in this chapter in good faith is immune from liability arising from the act of receiving or the act of providing the information.

As added by P.L.187-1996, SEC.1.

IC 27-2-19-8
Obtaining medical records and reports in claims for bodily injury

Sec. 8. (a) A law enforcement agency, insurer, or governmental agency who has obtained the names and addresses of a claimant's medical providers under section 6(b) of this chapter may obtain the claimant's medical records and medical reports from any other law enforcement agency, insurer, or governmental agency:

(1) with the prior authorization or release of the injured claimant; or

(2) without the prior authorization or release of the injured claimant if:

(A) there is a reasonable belief that the mere request for authorization or a release will hinder a fraud investigation; and

(B) a verified application is presented to the circuit court, superior court, or probate court in the county where the application or claim is presented that sets forth:

(i) probable cause for the need to obtain the medical records and medical reports and medical related information contained in the medical records and medical reports without obtaining the proper release or authorization; and

(ii) the specific medical records and medical reports and medical related information contained in the medical records and medical reports requested.

(b) The court, upon review of the information presented in subsection (a), may issue an order authorizing the law enforcement agency, insurer, or governmental agency to release the medical records and medical reports and the medical related information contained in the medical records and reports requested.

As added by P.L.187-1996, SEC.1. Amended by P.L.84-2016, SEC.118.

IC 27-2-19-9
Conflict of laws

Sec. 9. For the purpose of insurance fraud investigation, if another provision in Indiana law regarding the release or receipt of information conflicts with this chapter, this chapter governs and controls.

As added by P.L.187-1996, SEC.1.

IC 27-2-20

Chapter 20. Disclosure of Nonpublic Personal Financial Information

IC 27-2-20-1

"Person" defined

Sec. 1. As used in this chapter, "person" has the meaning set forth in IC 27-1-2-3.

As added by P.L.203-2001, SEC.6.

IC 27-2-20-2

Disclosure prohibited

Sec. 2. A person may not disclose any nonpublic personal information to a non-affiliated third party in violation of Title V of the Gramm-Leach-Blilely Act of 1999, 15 U.S.C. 6801 et seq.

As added by P.L.203-2001, SEC.6.

IC 27-2-20-3

Adoption of rules

Sec. 3. The commissioner may adopt rules under IC 4-22-2 to implement this chapter. These rules:

(1) must be consistent with; and

(2) may not be more restrictive than;

the standards contained in 15 U.S.C. 6801 et seq.

As added by P.L.203-2001, SEC.6.

IC 27-2-20-4

Private right of action not created

Sec. 4. This chapter does not create a private right of action against any person.

As added by P.L.203-2001, SEC.6.

IC 27-2-21

Chapter 21. Use of Credit Information

IC 27-2-21-0.1

Application of chapter

Sec. 0.1. The addition of this chapter by P.L.201-2003 applies to a personal insurance policy:

(1) application that is submitted; or

(2) that is issued, delivered, amended, or renewed;

after December 31, 2003.

As added by P.L.220-2011, SEC.429.

IC 27-2-21-1

"Adverse action"

Sec. 1. As used in this chapter, "adverse action" means:

(1) a denial or cancellation of;

(2) an increase in a charge for; or

(3) a reduction or other adverse or unfavorable change in the terms of coverage or amount of;

insurance in connection with the underwriting of a personal insurance policy.

As added by P.L.201-2003, SEC.1.

IC 27-2-21-2

"Affiliate"

Sec. 2. As used in this chapter, "affiliate" means a company that controls, is controlled by, or is under common control with another company.

As added by P.L.201-2003, SEC.1.

IC 27-2-21-3

"Applicant"

Sec. 3. As used in this chapter, "applicant" means an individual who has applied with an insurer for coverage under a personal insurance policy.

As added by P.L.201-2003, SEC.1.

IC 27-2-21-4

"Commissioner"

Sec. 4. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

As added by P.L.201-2003, SEC.1.

IC 27-2-21-5

"Consumer"

Sec. 5. As used in this chapter, "consumer" means an:

(1) insured whose:

(A) credit information is used; or

(B) insurance score is calculated;
in the underwriting or rating of a personal insurance policy; or
(2) applicant for a personal insurance policy.
As added by P.L.201-2003, SEC.1.

IC 27-2-21-6
"Consumer reporting agency"
Sec. 6. As used in this chapter, "consumer reporting agency" means a person that, for a monetary fee or dues or on a cooperative nonprofit basis, regularly engages in the practice of assembling or evaluating consumer credit information or other information concerning consumers for the purpose of furnishing consumer reports to third parties.
As added by P.L.201-2003, SEC.1.

IC 27-2-21-7
"Credit information"
Sec. 7. As used in this chapter, "credit information" means credit related information:
(1) derived from a credit report;
(2) found on a credit report; or
(3) provided on an application for a personal insurance policy.
The term does not include information that is not credit related, regardless of whether the information is contained in a credit report or in an application or is used to calculate an insurance score.
As added by P.L.201-2003, SEC.1.

IC 27-2-21-8
"Credit report"
Sec. 8. As used in this chapter, "credit report" means a written, an oral, or another communication of information by a consumer reporting agency concerning a consumer's creditworthiness, credit standing, or credit capacity that is used or expected to be used or collected as a factor to determine personal insurance policy premiums, eligibility for coverage, or tier placement.
As added by P.L.201-2003, SEC.1.

IC 27-2-21-9
"Department"
Sec. 9. As used in this chapter, "department" refers to the department of insurance created by IC 27-1-1-1.
As added by P.L.201-2003, SEC.1.

IC 27-2-21-10
"Insurance producer"
Sec. 10. As used in this chapter, "insurance producer" has the meaning set forth in IC 27-1-15.6-2.
As added by P.L.201-2003, SEC.1. Amended by P.L.11-2011,

SEC.24.

IC 27-2-21-11
"Insurance score"

Sec. 11. As used in this chapter, "insurance score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based on credit information for the purpose of predicting the future insurance loss exposure of an individual consumer.
As added by P.L.201-2003, SEC.1.

IC 27-2-21-12
"Insured"

Sec. 12. As used in this chapter, "insured" means an individual entitled to coverage under a personal insurance policy.
As added by P.L.201-2003, SEC.1.

IC 27-2-21-13
"Insurer"

Sec. 13. As used in this chapter, "insurer" refers to an insurer (as defined in IC 27-1-2-3) that issues a personal insurance policy.
As added by P.L.201-2003, SEC.1.

IC 27-2-21-14
"Personal insurance policy"

Sec. 14. As used in this chapter, "personal insurance policy" means a policy that:

(1) provides one (1) or more of the kinds of insurance described in Class 2 or Class 3 of IC 27-1-5-1; and

(2) is underwritten on an individual basis for personal, family, or household use.

As added by P.L.201-2003, SEC.1.

IC 27-2-21-15
Applicability

Sec. 15. This chapter does not apply to commercial insurance.
As added by P.L.201-2003, SEC.1.

IC 27-2-21-16
Requirements for insurer use of credit information

Sec. 16. (a) An insurer that uses credit information to underwrite or rate risks shall not do the following:

(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 decline to renew a personal insurance policy solely on the basis of credit information.

(3) Base an insured's renewal rate for a personal insurance

policy solely on credit information.

(4) Take an adverse action against a consumer solely because the consumer does not have a credit card account.

(5) Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating a personal insurance policy, unless the insurer does one (1) of the following:

(A) Presents to the commissioner information that the absence or inability relates to the risk for the insurer and treats the consumer as approved by the commissioner.

(B) Treats the consumer as if the consumer had neutral credit information, as defined by the insurer.

(6) Take an adverse action against a consumer based on credit information unless the insurer obtains and uses:

(A) a credit report issued; or

(B) an insurance score calculated;

not more than ninety (90) days before the date the personal insurance policy is first written or the renewal is issued.

(7) Use the following as a negative factor in an insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a personal insurance policy:

(A) A credit inquiry:

(i) not initiated by the consumer; or

(ii) requested by the consumer for the consumer's own credit information.

(B) A credit inquiry relating to insurance coverage.

(C) A late payment or a collection account with a medical industry code on the consumer's credit report.

(D) Multiple lender inquiries:

(i) coded by the consumer reporting agency on the consumer's credit report as being from the home mortgage industry; and

(ii) made within thirty (30) days of one another.

(E) Multiple lender inquiries:

(i) coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry; and

(ii) made within thirty (30) days of one another.

(b) An insurer that uses credit information to underwrite or rate risks shall, at annual renewal upon the request of an insured or an insured's agent, re-underwrite and re-rate the insured's personal insurance policy based on a current credit report or insurance score unless one (1) of the following applies:

(1) The insurer's treatment of the consumer is otherwise approved by the commissioner.

(2) The insured is in the most favorably priced tier of the insurer, within a group of affiliated insurers.

(3) Credit information was not used for underwriting or rating

the insured when the personal insurance policy was initially written.

(4) The insurer reevaluates the insured at least every thirty-six (36) months after a personal insurance policy is issued based on underwriting or rating factors other than credit information.

(5) The insurer has re-underwritten and re-rated the insured's personal insurance policy based on a credit report obtained or an insurance score recalculated less than twelve (12) months before the date of the request by the insured or the insured's agent.

(c) An insurer that uses credit information to underwrite or rate risks may obtain current credit information upon the renewal of a personal insurance policy when renewal occurs more frequently than every thirty-six (36) months if consistent with the insurer's underwriting guidelines.

As added by P.L.201-2003, SEC.1. Amended by P.L.84-2009, SEC.1.

IC 27-2-21-17

Incorrect or incomplete credit information; notice; remedy

Sec. 17. (a) If:

(1) a determination is made through the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 U.S.C. 1681i(a)(5), that the credit information of a current insured was incorrect or incomplete; and

(2) the insurer receives notice of the determination from the consumer reporting agency or the insured;

the insurer shall re-underwrite and re-rate the insured not more than thirty (30) days after receiving the notice.

(b) After an insurer re-underwrites or re-rates an insured as described in subsection (a), the insurer shall:

(1) make necessary adjustments, consistent with the insurer's underwriting and rating guidelines; and

(2) if the insurer determines that the insured has overpaid a premium, refund to the insured the amount of overpayment calculated back to the shorter of the:

(A) immediately preceding twelve (12) month period of coverage; or

(B) actual policy period.

As added by P.L.201-2003, SEC.1.

IC 27-2-21-18

Disclosure of use of credit information

Sec. 18. (a) If an insurer uses credit information in underwriting or rating a consumer, the insurer or the insurer's agent shall disclose, either on the insurance application or at the time the insurance application is taken, that the insurer may obtain credit information in connection with the application. The disclosure must be:

(1) written; or

(2) provided to the consumer in the same medium as the application for insurance.

The insurer is not required to provide the disclosure statement required under this section to an insured on a renewal policy if the insured has previously been provided a disclosure statement.

(b) Use of the following sample disclosure statement constitutes compliance with this section: "In connection with this application for insurance, we may review your credit report or obtain or use a credit based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score.".

As added by P.L.201-2003, SEC.1.

IC 27-2-21-19

Adverse action based on credit information; notice

Sec. 19. (a) If an insurer takes an adverse action based on credit information, the insurer shall:

(1) provide notice to the consumer that an adverse action has been taken, in accordance with the requirements of the federal Fair Credit Reporting Act, 15 U.S.C. 1681m(a); and

(2) provide notice to the consumer explaining the reason for the adverse action.

(b) The reason provided under subsection (a)(2) must be provided in sufficiently clear and specific language so that an individual can identify the basis for the insurer's decision to take an adverse action. The notice must include a description of all factors up to four (4) primary factors that were the primary influences of the adverse action. The use of generalized terms such as "poor credit history", "poor credit rating", or "poor insurance score" does not meet requirements of this subsection. A standardized credit explanation provided by a consumer reporting agency or other third party vendor meets the requirements of this section.

As added by P.L.201-2003, SEC.1.

IC 27-2-21-20

Filings

Sec. 20. (a) An insurer that uses an insurance score to underwrite and rate risks shall file the insurer's scoring models or other scoring processes with the department.

(b) A third party may file a scoring model or scoring process on behalf of an insurer.

(c) A filing that includes insurance scoring may include loss experience justifying the use of credit information.

(d) A filing related to credit information is confidential.

As added by P.L.201-2003, SEC.1.

IC 27-2-21-21

Insurance producer indemnification, defense, and hold harmless

Sec. 21. (a) An insurer shall indemnify and defend an insurance producer and hold an insurance producer harmless from and against liability, fees, and costs arising out of or related to the actions, errors, or omissions of the insurance producer relating to a use of credit information if the insurance producer:

(1) obtains or uses credit information or insurance scores for the insurer;

(2) follows the instructions of or procedures established by the insurer; and

(3) complies with applicable laws and regulations.

(b) This section does not provide a consumer with a cause of action that does not exist in the absence of this section.

As added by P.L.201-2003, SEC.1.

IC 27-2-21-22

Consumer reporting agency prohibitions

Sec. 22. (a) A consumer reporting agency may not provide or sell data or lists that include information submitted in conjunction with:

(1) an insurance inquiry about a consumer's credit information; or

(2) a request for a credit report or insurance score;

including the expiration dates of an insurance policy or other information that may identify periods during which a consumer's insurance expires and the terms and conditions of the consumer's insurance coverage.

(b) The restrictions under subsection (a) do not apply to data or lists a consumer reporting agency supplies to an:

(1) insurance producer from whom the information was received;

(2) insurer on behalf of which the insurance producer described in subdivision (1) acted; or

(3) affiliate or holding company of the insurer described in subdivision (2).

(c) This section does not prohibit an insurer from obtaining a claim history report or a motor vehicle report.

As added by P.L.201-2003, SEC.1.

IC 27-2-21-23

Violations

Sec. 23. A violation of this chapter by an insurer is an unfair and deceptive act and practice in the business of insurance under IC 27-4-1-4.

As added by P.L.201-2003, SEC.1.

IC 27-2-22

Chapter 22. Retained Asset Accounts

IC 27-2-22-1

Application of chapter

Sec. 1. This chapter applies to a claim that is filed under a policy after June 30, 2011.

As added by P.L.67-2011, SEC.1.

IC 27-2-22-2

"Commissioner"

Sec. 2. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

As added by P.L.67-2011, SEC.1.

IC 27-2-22-3

"Insured"

Sec. 3. As used in this chapter, "insured" means the individual whose life is the subject of insurance under a policy.

As added by P.L.67-2011, SEC.1.

IC 27-2-22-4

"Insurer"

Sec. 4. As used in this chapter, "insurer" means an insurance company that issues a policy.

As added by P.L.67-2011, SEC.1.

IC 27-2-22-5

"Policy"

Sec. 5. As used in this chapter, "policy" means a policy or certificate that provides the kind of insurance described in Class 1 of IC 27-1-5-1.

As added by P.L.67-2011, SEC.1.

IC 27-2-22-6

"Retained asset account"

Sec. 6. As used in this chapter, "retained asset account" means a mechanism through which the settlement of proceeds payable under a policy occurs by the insurer's deposit of the proceeds into a checking or draft account:

(1) in which the proceeds are retained by the insurer; and

(2) under a contract that is supplemental to the policy and does not involve annuity benefits.

As added by P.L.67-2011, SEC.1.

IC 27-2-22-7

Requirements for use of retained asset account

Sec. 7. An insurer may not use a retained asset account unless,

before the policy proceeds are transferred to the retained asset account, the insurer:

(1) informs:

(A) the beneficiary;

(B) the legal representative of the beneficiary; or

(C) in the case of a group policy, the policy owner;

of the beneficiary's right to a lump sum payment of the full amount of the policy proceeds; and

(2) makes the disclosure described in section 8(c) of this chapter to the beneficiary.

As added by P.L.67-2011, SEC.1.

IC 27-2-22-8

Required disclosures by insurer to the beneficiary

Sec. 8. (a) An insurer that pays a policy death benefit in any manner other than a lump sum payment of the full amount of the policy proceeds shall provide, in written or electronic form, a disclosure containing a complete list and clear explanation of all payment options available to the beneficiary.

(b) An insurer described in subsection (a) shall not use a retained asset account as the default manner of payment of the policy death benefit unless the insurer conspicuously discloses to the beneficiary that, in the event that the beneficiary does not choose another payment option, a retained asset account will be used as the default manner of payment.

(c) The disclosure required by section 7 of this chapter must include the following information:

(1) A recommendation for the beneficiary to consult a tax, investment, or other financial adviser regarding tax liability and investment options.

(2) The:

(A) method by which interest rates are determined;

(B) timing and method of interest rate changes; and

(C) dividends or other gains that may be paid to the beneficiary;

applicable to the funds in the retained asset account.

(3) The identity of the custodian of the funds in the retained asset account.

(4) Whether the retained asset account is insured by the Federal Deposit Insurance Corporation and, if so, the amount of the coverage.

(5) Any limitations on the number and amount of withdrawals of funds from the retained asset account, including minimum or maximum benefit payment amounts.

(6) Services related to the retained asset account that are provided for a fee, including a list of the fees or method of calculation of the fees.

(7) The nature and frequency of statements of account for the

retained asset account.

(8) That the payment of some or all of the proceeds may be by the delivery of checks, drafts, or other instruments to access the available funds.

(9) That the entire proceeds are available to the beneficiary by the use of one (1) check, draft, or other instrument.

(10) That the insurer or a related party may derive income, in addition to fees charged on the retained asset account, from the total gains received on the investment of the balance of funds in the retained asset account.

(11) The telephone number, address, and other contact information, including Internet web site address, from which the beneficiary may obtain additional information regarding the retained asset account.

(12) The following statement:

"FOR FURTHER INFORMATION, PLEASE CONTACT YOUR STATE DEPARTMENT OF INSURANCE.".

(d) The disclosures described in this section must be written in:

(1) layman's terms; and

(2) bold or at least 12 point type.

As added by P.L.67-2011, SEC.1. Amended by P.L.6-2012, SEC.187.

IC 27-2-22-9

Violation of chapter

Sec. 9. A violation of this chapter is an unfair and deceptive act in the business of insurance under IC 27-4-1-4.

As added by P.L.67-2011, SEC.1.

IC 27-2-23

Chapter 23. Unclaimed Life Insurance Benefits

IC 27-2-23-1

Application of chapter

Sec. 1. This chapter applies after June 30, 2015.

As added by P.L.90-2014, SEC.1.

IC 27-2-23-2

Definitions

Sec. 2. Except as provided in this chapter, the definitions in IC 27-2-22 apply throughout this chapter.

As added by P.L.90-2014, SEC.1.

IC 27-2-23-3

"Account owner"

Sec. 3. As used in this chapter, "account owner" means an Indiana resident who is the owner of a retained asset account.

As added by P.L.90-2014, SEC.1.

IC 27-2-23-4

"Annuity"

Sec. 4. (a) As used in this chapter, "annuity" refers to an annuity contract issued in Indiana after June 30, 2015.

(b) The term does not include an annuity contract used to fund an employment based retirement plan, the sponsor or administrator of which directs the insurer that issues the annuity contract.

As added by P.L.90-2014, SEC.1. Amended by P.L.166-2015, SEC.2.

IC 27-2-23-5

"Death master file"

Sec. 5. As used in this chapter, "death master file" refers to:

(1) the federal Social Security Administration's Death Master File; or

(2) another data source that, for the purpose of determining that a person is reported to have died, is at least as comprehensive as the federal Social Security Administration's Death Master File.

As added by P.L.90-2014, SEC.1.

IC 27-2-23-6

"Death master file match"

Sec. 6. As used in this chapter, "death master file match" means the result of a search of a death master file that indicates a match of a person's name with the person's:

(1) Social Security number; or

(2) date of birth.

As added by P.L.90-2014, SEC.1.

IC 27-2-23-7
"Knowledge of death"

Sec. 7. As used in this chapter, "knowledge of death" means one (1) of the following:

(1) Receipt of a certified original or copy of a death certificate of a person.

(2) A death master file match that an insurer has validated with a secondary source.

As added by P.L.90-2014, SEC.1.

IC 27-2-23-8
"Person"

Sec. 8. As used in this chapter, "person" refers to an insured, annuity owner, annuitant, or a retained asset account owner.

As added by P.L.90-2014, SEC.1.

IC 27-2-23-9
"Policy"

Sec. 9. (a) As used in this chapter, "policy" means a policy or certificate issued in Indiana after June 30, 2015, that provides the kind of insurance described in Class 1 of IC 27-1-5-1.

(b) The term does not include the following:

(1) A policy or certificate that provides a death benefit under:

(A) an employee benefit plan that is subject to the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.); or

(B) a federal employee benefit program.

(2) A policy or certificate that is used to fund a preneed funeral contract or prearrangement.

(3) A policy or certificate of credit life or accidental death insurance.

(4) A policy issued to a group policy owner for which the insurer does not provide record keeping services.

As added by P.L.90-2014, SEC.1. Amended by P.L.166-2015, SEC.3.

IC 27-2-23-10
"Record keeping services"

Sec. 10. As used in this chapter, "record keeping services" means an insurer's responsibility, under an agreement with a group policy owner, to obtain, maintain, and administer in the insurer's system information concerning each individual insured under a group policy (or a line of coverage under a group policy), including at least the following:

(1) The individual's Social Security number and date of birth or name and date of birth.

(2) The individual's beneficiary designation information.

(3) The individual's eligibility for coverage.

(4) The individual's benefit amount.

(5) The individual's premium payment status.
As added by P.L.90-2014, SEC.1.

IC 27-2-23-10.2
"Retained asset account"

Sec. 10.2. As used in this chapter, "retained asset account" refers to a retained asset account that is issued in Indiana after June 30, 2015.
As added by P.L.166-2015, SEC.4.

IC 27-2-23-11
Performance of death master file comparison; frequency; death certificate

Sec. 11. (a) An insurer shall, at least every six (6) months, perform a comparison of in-force policies, annuities, and retained asset accounts issued by the insurer in Indiana against a death master file to identify potential death master file matches.

(b) An insurer that performs a comparison under subsection (a) using:

(1) a complete death master file one (1) time per year; and

(2) only the update files of the death master file used under subdivision (1) for additional comparisons during the twelve (12) months after the comparison under subdivision (1);

is considered to be compliant with subsection (a).

(c) This section does not prevent an insurer from requesting a certified original or copy of a death certificate as a part of a claim validation process.
As added by P.L.90-2014, SEC.1.

IC 27-2-23-12
Insurer duty related to possible death

Sec. 12. An insurer shall, not later than ninety (90) days after learning of the possible death of a person through a comparison performed under section 11 of this chapter, do the following:

(1) Complete and document a good faith effort to confirm the death of the person against other available records and information.

(2) Review the insurer's records to determine whether the person had purchased any other products from the insurer.

(3) Determine whether benefits may be due under a policy, annuity, or retained asset account.

(4) If the beneficiary or authorized representative under a policy, annuity, or retained asset account has not communicated with the insurer before the expiration of the ninety (90) day period, complete and document a good faith effort to locate and contact the beneficiary or authorized representative, including sending to the beneficiary or authorized representative information concerning the:

(A) insurer's claim process; and
(B) need to provide a certified original or copy of the death certificate, if applicable under the policy, annuity, or retained asset account.

As added by P.L.90-2014, SEC.1.

IC 27-2-23-13
Repealed

(As added by P.L.90-2014, SEC.1. Repealed by P.L.166-2015, SEC.5.)

IC 27-2-23-14
Disclosure of personal information

Sec. 14. An insurer may, to the extent permitted by law, disclose the minimum necessary personal information about a person or a beneficiary to an individual or entity reasonably believed by the insurer to possess the ability to assist the insurer in locating the beneficiary or another individual or entity that is entitled to payment of the claim proceeds.

As added by P.L.90-2014, SEC.1.

IC 27-2-23-15
Charges related to search

Sec. 15. An insurer, and an entity providing services to an insurer, shall not charge a beneficiary or authorized representative a fee or cost associated with:
(1) a death master file search; or
(2) verification of a death master file match;
conducted under this chapter.

As added by P.L.90-2014, SEC.1.

IC 27-2-23-16
Order of payment; unclaimed property

Sec. 16. (a) The benefit of a policy, annuity, or retained asset account, plus accrued interest applicable under the policy, annuity, or retained asset account, is first payable to designated beneficiaries or policy owners, annuity owners, or account owners.

(b) If beneficiaries or policy owners, annuity owners, or account owners cannot be found, the benefit of the policy, annuity, or retained asset account (not including applicable accrued interest) escheats to the state as unclaimed property under IC 32-34-1.

As added by P.L.90-2014, SEC.1.

IC 27-2-23-17
Commissioner accommodations for insurer compliance

Sec. 17. The commissioner may do the following:
(1) Either:
(A) limit an insurer's death master file comparisons required

by section 11 of this chapter to the insurer's electronic searchable files; or

(B) approve a plan and time period for conversion of an insurer's files to electronic searchable files.

(2) Either:

(A) exempt an insurer from the death master file comparisons required by section 11 of this chapter; or

(B) upon demonstration of hardship by the insurer, permit an insurer to perform the death master file comparisons less frequently than required by section 11 of this chapter.

(3) Allow an insurer to begin compliance with this chapter according to a plan and time period approved by the commissioner.

As added by P.L.90-2014, SEC.1.

IC 27-2-23-18

Insurer actions with respect to proceeds; unclaimed property; liability

Sec. 18. (a) With respect to a policy, an annuity, or a retained asset account for which an insurer has knowledge of death:

(1) if:

(A) within one (1) year after the insurer has obtained the knowledge of death, the insurer:

(i) conducts reasonable search efforts; and

(ii) is unable to locate in Indiana a beneficiary under the policy, annuity, or retained asset account; or

(B) no beneficiary was named and the person, for purposes of IC 32-34-1, had a last known address in Indiana; and

(2) the insurer has, without success, attempted to make the contacts required by and in accordance with IC 32-34-1;

the insurer may, without further notice to or consent by the state, report and remit the proceeds of the policy, annuity, or retained asset account to the state on an early reporting basis in accordance with IC 32-34-1.

(b) After a report and remittance of proceeds described in subsection (a), the insurer is relieved and indemnified from any additional liability in relation to the proceeds, in accordance with IC 32-34-1.

As added by P.L.90-2014, SEC.1.

IC 27-2-23-19

Violation

Sec. 19. An insurer's failure to comply with this chapter is an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

As added by P.L.90-2014, SEC.1.

IC 27-2-23-20

Rulemaking

Sec. 20. The department may adopt rules under IC 4-22-2 to implement this chapter.

As added by P.L.90-2014, SEC.1.

IC 27-2-23-21

Attorney general examinations

Sec. 21. This chapter does not prevent the attorney general from conducting an examination of the records of an insurance company under IC 32-34-1-42.

As added by P.L.166-2015, SEC.6.

IC 27-3

ARTICLE 3. CONSOLIDATIONS AND REORGANIZATION

IC 27-3-1

Chapter 1. Exchange of Securities

IC 27-3-1-1

Construction and application

Sec. 1. This chapter shall be supplemental to IC 27-1. All provisions of IC 27-1 shall be fully and completely applicable to this chapter in the same manner as if the provisions of this chapter had been an original part of IC 27-1; provided, that the provisions of this chapter shall be controlling in the event there exists any conflict between the provisions of this chapter and the provisions of IC 27-1. *(Formerly: Acts 1967, c.61, s.1.) As amended by P.L.252-1985, SEC.138.*

IC 27-3-1-2

Authority to adopt plan of exchange

Sec. 2. Any domestic stock insurance company (referred to in this chapter as the "domestic company") may adopt a plan of exchange providing for the exchange by its shareholders of their stock in the domestic company for:

(i) shares of stock issued by any other stock insurance corporation organized or reorganized under the provisions of IC 27-1 or any statute enacted prior to March 8, 1935, or any stock corporation organized under the provisions of IC 23-1 or any foreign stock corporation (such other corporation is referred to in this chapter as the "acquiring corporation");

(ii) other securities issued by the acquiring corporation;

(iii) cash;

(iv) other consideration; or

(v) any combination of such stock, such other securities, cash, or other consideration.

(Formerly: Acts 1967, c.61, s.2.) As amended by P.L.252-1985, SEC.139.

IC 27-3-1-3

Manner of adoption of plan of exchange; approvals; compensation of dissenting shareholders

Sec. 3. (a) Subject to section 2 of this chapter, any domestic company may adopt a plan of exchange with any acquiring corporation providing for the exchange of the outstanding stock of the domestic company for shares of stock or other securities issued by the acquiring corporation or cash or other consideration, or any combination, in the following manner. The boards of directors of the domestic company and of the acquiring corporation by resolutions

approved by a majority of the whole of each board shall adopt a plan of exchange that sets forth the terms and conditions of the exchange and the mode of carrying the terms and conditions into effect and other provisions with respect to the exchange as may be deemed necessary or desirable.

(b) The domestic company and the acquiring corporation shall submit to the insurance commissioner three (3) copies of the plan of exchange certified by an officer of each as having been adopted in accordance with subsection (a). The copies of the plan of exchange shall be accompanied by financial statements of the domestic company for its last preceding fiscal year prepared pursuant to IC 27-1-20-21, pro forma financial statements of each corporation based on the assumption that the plan of exchange was effective as proposed at the end of the last preceding fiscal year of the domestic company, an estimate of expenses already incurred and of expenses expected to be incurred in connection with the proposed plan of exchange, and a written statement that sets forth for each corporation the proposed changes, if any, in management policies and in the identity of officers and directors of the domestic company and of the acquiring corporation that are initially contemplated if the plan of exchange is effected as proposed. The insurance commissioner shall hold a hearing upon the fairness of the terms, conditions, and provisions of the plan of exchange and the proposed exchange of stock or other securities of the acquiring corporation or cash or other consideration or any combination thereof for the stock of the domestic company at which the policyholders and the shareholders of both the domestic company and the acquiring corporation and any other interested party may appear and to become party to the proceeding. The commissioner shall require the domestic company and the acquiring corporation to produce evidence as the commissioner considers necessary to establish the foregoing, including evidence concerning the valuation of the respective companies and the method utilized by the management of each corporation to accomplish the valuation, inclusive of the value established with respect to the stock of the domestic company that is proposed to be exchanged as well as the value of the stock, securities, and consideration other than cash to be offered by the acquiring corporation in the exchange. The hearing shall be commenced not less than twenty (20) days after the date on which the plan of exchange is presented to the commissioner. The hearing shall be held in Indianapolis, Indiana, at a place, date, and time specified by the insurance commissioner. Notice of the hearing shall be published in a newspaper of general circulation in the city where the principal office of the domestic company and of the acquiring corporation are located and Indianapolis once a week for two (2) successive weeks. Written notice of the hearing shall be mailed at least ten (10) days before the hearing by the domestic company and by the acquiring corporation to all of their respective shareholders.

All expenses of publication shall be borne by the domestic company or the acquiring corporation, or both, as specified in the plan of exchange. Except as otherwise provided in this section, the hearing and the determination are subject to IC 4-21.5-3. The commissioner shall issue an order approving the plan of exchange as delivered to the commissioner by the domestic company and the acquiring corporation and the modifications approved by a majority of the whole board of directors of each corporation if the commissioner finds:

(1) that the plan, including all modifications, if effected, will not tend adversely to affect the financial stability or management of the domestic company or the general capacity or intention to continue the safe and prudent transaction of the insurance business of the domestic company, or of the acquiring corporation, if it is a domestic insurance company;

(2) that the interests of the policyholders and shareholders of the domestic company, and, if the acquiring corporation is a domestic insurance company, the policyholders of the acquiring corporation are protected;

(3) that the fulfillment of the plan will not affect either the contractual obligations of the domestic company and of the acquiring corporation, if it is a domestic insurance company, to its policyholders or the ability and tendency of either to render service to its policyholders in the future; and

(4) that the terms and conditions of the plan of exchange and the proposed issuance and exchange are fair and reasonable.

The order of the commissioner approving or disapproving the plan of exchange shall be filed in the department within sixty (60) days after the date the plan of exchange is presented to the commissioner. The department shall give notice of the order in the manner prescribed in IC 4-21.5-3 to all parties to the proceeding, and the department shall endorse the commissioner's approval or disapproval on the plan of exchange in the manner provided in IC 27-1-6-8 and shall deliver copies to the domestic company and to the acquiring corporation. Any party to the proceeding aggrieved by the order are entitled to a judicial review of the order in accordance with IC 4-21.5-5.

(c) The plan of exchange as approved by the insurance commissioner shall then be submitted to a vote of the shareholders of the domestic company at an annual or special meeting of the shareholders. Notice of the submission of the plan to the shareholders shall be included in the notice of the annual or special meeting. The shareholders entitled to vote in respect of the plan may vote in person or by proxy, and each shareholder has one (1) vote for each share of voting stock held by the shareholder. Jointly owned shares may only be voted jointly. The plan shall be approved by the shareholders of the domestic company upon receiving the affirmative votes representing two thirds (2/3) of the outstanding capital stock of

the domestic company or a larger proportion as may be specified in the plan of exchange. Notwithstanding shareholder adoption of the plan of exchange and at any time before the filing of the certificate setting forth the plan of exchange by the department, pursuant to section 4 of this chapter, the plan of exchange may be abandoned pursuant to a provision for abandonment, if any, contained in the plan of exchange.

(d) Within ten (10) days after the plan of exchange is adopted by the shareholders of the domestic company, a written notice of the adoption of the plan of exchange shall be mailed or delivered personally to each shareholder of record of the company who was entitled to vote on the plan. The domestic company shall file with the department an affidavit of the secretary or an assistant secretary of the company or of an officer of the transfer agent of the company that the notice was given.

(e) Any shareholder of the domestic company owning shares not voted in favor of the plan at the meeting at which the plan was approved by the shareholders of the domestic company may object in writing to the plan and demand payment, should the plan become effective, of the fair value of any shares as of the day on which the plan of exchange was approved by the shareholders of the domestic company pursuant to subsection (c). The objection and demand must be received, together with the certificate or certificates representing the shares with respect to which objection and demand have been made for notation that the objection and demand have been made, by the domestic company or its transfer agent within thirty (30) days after the date of the meeting of shareholders. The objection and demand may not pertain to any shares that were voted in favor of the plan. Objection and demand can only be made jointly by the holders of any share jointly held. The objection and demand may not be withdrawn unless the domestic company, by an authorized officer, consents in writing. Upon the plan of exchange becoming effective, the holder of any shares, with respect to which the objection and demand have been made and certificates for which have been delivered to the domestic company or its transfer agent for notation, or any transferee, ceases to be a shareholder of the domestic company with respect to the shares and does not have rights with respect to the shares except the right to receive payment for the shares under this subsection. Every shareholder failing to make objection and demand accompanied by certificates representing the shares with respect to which the objection and demand have been made or withdrawing the objection and demand as provided in this subsection are conclusively presumed to have assented to, and to have agreed to be bound by, the plan of exchange in accordance with its terms. Within forty-five (45) days after the date of the meeting of shareholders of the domestic company at which the plan of exchange was approved by the shareholders, the domestic company, or, if the plan of exchange specifies, the acquiring corporation, shall mail a

written offer to each holder of record of shares with respect to which an objection and demand have been made, as provided in this subsection, to pay for the shares a price per share considered by the corporation to be the fair value of the shares as of the date of the meeting. The form of written offer to be used, including the price per share, shall first be submitted to and approved by the insurance commissioner. If the offer is accepted in writing by the holder, the corporation shall pay the holder, within forty-five (45) days after the date of the plan of exchange becoming effective, the price upon the surrender of the certificate or certificates representing the shares. If, within thirty (30) days after the date of the mailing of the written offer, the domestic company or the acquiring corporation, as the case may be, and a shareholder do not agree, the corporation or the shareholder may, within ninety (90) days after the date of the mailing of the written offer, petition the circuit or the superior court of the county in which the principal office of the domestic company is located to appraise the fair value of the shares as of the date of the meeting of shareholders of the domestic company at which the plan of exchange was approved by the shareholders and payment of the appraised value of the shares shall be made by the domestic company or, if the plan of exchange so specifies, the acquiring corporation within sixty (60) days after the entry of the judgment or order finding the appraised value upon the surrender of the certificate or certificates representing the shares. The practice, procedure, and judgment in the circuit or superior court upon the petition is the same, so far as practical, as that under IC 32-24. The judgment of the circuit or superior court is final. All shares acquired by the domestic company upon payment of the value of the shares shall be canceled by the board of directors of the domestic company upon the plan of exchange becoming effective or at any time after the plan becomes effective and the capital stock of the domestic company shall be decreased in accordance with IC 27-1-8-12. If the plan of exchange does not become effective, the right of shareholders or transferees to be paid the fair value of their shares under this subsection shall cease, and their status shall be the same as that of shareholders who voted in favor of the plan. If a shareholder or the shareholder's transferee with respect to any share or shares for which objection and demand has been made:

(1) withdraws the objection and demand in the manner provided by this subsection;

(2) fails to submit a certificate or certificates at the time and in the manner required by this subsection;

(3) does not file a petition for the determination of fair value within the time and in the manner provided in this subsection and neither the domestic company nor the acquiring corporation files a petition for such determination; or

(4) is adjudged by a court of competent jurisdiction not to be entitled to the relief provided by this subsection;

the right of the shareholder or the shareholder's transferee to be paid the fair value of the share or shares under this subsection shall cease, and the shareholder's status with respect to the share or shares is the same as that of a shareholder who voted in favor of the plan.
(Formerly: Acts 1967, c.61, s.3.) As amended by P.L.252-1985, SEC.140; P.L.7-1987, SEC.143; P.L.2-2002, SEC.82.

IC 27-3-1-4
Filing; time plan becomes effective

Sec. 4. Not earlier than thirty-one (31) days after the date of the meeting of shareholders of the domestic company at which the plan of exchange was approved by such shareholders, a certificate setting forth the plan of exchange, the manner of the approval thereof by the directors of the acquiring corporation and the domestic company and the manner of its adoption and the vote by which adopted by the shareholders of the domestic company or setting forth that the plan of exchange has been abandoned shall be signed on behalf of each such corporation by its president or a vice-president and shall then be presented in triplicate to the department at its office for filing. The department shall file one (1) copy of such certificate in its offices and shall deliver copies bearing the date and time of filing endorsed thereon to the domestic company and the acquiring corporation. Upon the filing of such certificate, the plan of exchange and the issuance and exchange provided for therein shall become effective, unless a later date and time is specified in the plan of exchange, in which event the plan of exchange and the issuance and exchange provided for therein shall become effective upon such later date and time.
(Formerly: Acts 1967, c.61, s.4.)

IC 27-3-1-5
Vesting of title to shares without physical transfer or deposit of certificates; rights represented by outstanding certificates

Sec. 5. (a) Upon the plan of exchange becoming effective, the exchange provided for therein shall be deemed to have been consummated, each shareholder of the domestic company shall cease to be a shareholder of such company, the ownership of all shares of the issued and outstanding stock of the domestic company, except shares payment of the value of which is required to be made by the domestic company or the acquiring corporation pursuant to section 3 of this chapter, shall vest in the acquiring corporation automatically without any physical transfer or deposit of certificates representing such shares, and all shares payment of the value of which is required to be made by the domestic company or the acquiring corporation pursuant to section 3 of this chapter shall be deemed no longer outstanding shares of the domestic company. The acquiring corporation shall thereupon become the sole shareholder of the domestic company and shall have all of the rights, privileges,

immunities, and powers and, except as otherwise provided in this chapter, shall be subject to all of the duties and liabilities to the extent provided by law of a shareholder of an insurance company organized or reorganized under IC 27-1 or any statute enacted prior to March 8, 1935.

(b) Certificates representing shares of the domestic company prior to the plan of exchange becoming effective, except certificates representing shares payment of the value of which is required to be made pursuant to section 3 of this chapter and bearing a notation thereon that objection and demand pursuant to such section have been made, shall, after the plan of exchange becomes effective, represent:

(i) shares of the issued and outstanding capital stock or other securities issued by the acquiring corporation; and

(ii) the right, if any, to receive such cash or other consideration upon such terms as shall be specified in the plan of exchange;

provided, that the plan of exchange may specify that all certificates representing shares of stock of the domestic company, except certificates representing shares payment of the value of which is required to be made pursuant to section 3 of this chapter, shall after the plan of exchange becomes effective represent only the right to receive shares of stock or other securities issued by the acquiring corporation or cash or other consideration or any combination thereof upon such terms as shall be specified in the plan of exchange. Certificates representing shares of the domestic company with respect to which an objection and demand have been made pursuant to section 3 of this chapter and bearing a notation thereon that such objection and demand have been made, shall, after the plan of exchange becomes effective, represent only the right to receive payment therefor, subject to the provisions of this chapter.

(Formerly: Acts 1967, c.61, s.5.) As amended by P.L.252-1985, SEC.141.

IC 27-3-1-6

Effect of acquisition on insurance business conducted

Sec. 6. Nothing contained in this chapter shall be construed to authorize any insurance company to engage in any kind or kinds of insurance business not authorized by its articles of incorporation, or to authorize any acquiring corporation which is not an insurance company to engage directly in the business of insurance. Subsequent to the effective date of the plan of exchange, the insurance department, pursuant to the authority vested in it by IC 27-1-3-7 and IC 27-1-3.1 and having regard to the findings stated in section 3(b) of this chapter, shall have the authority to require that the affairs of the domestic company be conducted in such manner as to assure the continuing safe conduct and transaction of the domestic company's business of insurance.

(Formerly: Acts 1967, c.61, s.7.) As amended by P.L.252-1985,

SEC.142; P.L.26-1991, SEC.25.

IC 27-3-1-7
Continuation of domestic corporation and acquiring corporation as separate entities

Sec. 7. The domestic company and the acquiring corporation shall in all respects stand before the law as separate and distinct corporations, with neither of such corporations having any liability to the creditors, policyholders, if any, or shareholders of the other, any acts or omissions of the officers, directors, or shareholders of either or both of such corporations notwithstanding.
(Formerly: Acts 1967, c.61, s.8.)

IC 27-3-2

Chapter 2. Assessment Plans–Reorganization Into Stock Companies

IC 27-3-2-1

Authority to issue stock

Sec. 1. Any insurance company organized and doing business under the laws of this state on what is known as the assessment plan, and having more than one thousand (1,000) members, and a reserve fund of not less than one hundred thousand dollars ($100,000), is hereby authorized subject to the limitations hereinafter contained, to issue stock in shares of fifty dollars ($50.00) each, to an amount of not less than one hundred thousand (100,000) nor more than five hundred thousand dollars ($500,000), and to receive subscriptions therefor.

(Formerly: Acts 1895, c.158, s.1.)

IC 27-3-2-2

Notice of meeting; vote of members

Sec. 2. Before issuing any stock as provided in section 1 of this chapter, such company shall, at least four (4) weeks before the meeting provided for in this chapter, cause a printed notice of the time, place, and purpose of such meeting to be mailed to each of its members, and shall cause public notice to be given by publication thereof, at least once a week, for four (4) weeks, in a newspaper of general circulation in the county wherein is located the principal office of said company, that the proposal to issue stock in pursuance of this act, will be submitted to the members of such company at a meeting to be held at a time and place to be named in such notice. If, after due mailing and publication of such notice, two-thirds (2/3) of all the members (present at such meeting), either in person or by proxy, shall vote in favor of a proposal to issue stock as aforesaid, then the authority conferred by section 1 of this chapter, shall take effect, and subscription books may be opened.

(Formerly: Acts 1895, c.158, s.2.) As amended by P.L.252-1985, SEC.143.

IC 27-3-2-3

Subscription rights

Sec. 3. Every person who is a member of such company on the day of such meeting shall, for thirty (30) days after the opening of subscription books as aforesaid, be entitled to subscribe to that proportionate number of shares of the capital stock, agreed upon to be issued, which the premium note or notes owing by such member and held by such company on unexpired policies, in force on the day of such meeting aforesaid, shall bear to the entire amount of such notes then held by such company, and upon the payment of such subscription, said note or notes shall be canceled and delivered to

such members. If at the end of thirty (30) days from the opening of subscription books, the full amount of the capital stock designated has not been subscribed under the provisions of this section, then other subscriptions may be received, to be paid for as the directors of said company may require within eighteen (18) months.
(Formerly: Acts 1895, c.158, s.3.)

IC 27-3-2-4
By-laws; directors

Sec. 4. When all the stock shall have been subscribed as aforesaid, the stockholders shall adopt by-laws for the government of such company not inconsistent with the laws of the state of Indiana, naming therein the number of directors, which shall not be less than seven (7) nor more than thirteen (13), who shall manage the affairs of said company, and shall at once elect the new directors for the ensuing year, a majority of whom shall constitute a quorum for the transaction of business.
(Formerly: Acts 1895, c.158, s.4.)

IC 27-3-2-5
Certificate of incorporation; body corporate; deposit of securities; change of deposited securities

Sec. 5. And thereupon, when all of said stock shall have been subscribed, a statement shall be filed with the secretary of state, and that officer shall give to such company a certificate of incorporation under his seal of office, declaring the corporate name of such company, the amount of capital stock, and the amount of securities deposited with the auditor of state, as hereinafter provided, the names of the directors who are to conduct the business of the company for the first year, and henceforth upon the payment to such officer of the fee provided by law to be paid for the incorporation of joint stock companies; and said company shall then become a body corporate, with the power and authority to sue and be sued as such, in any proper court, and such company may carry on the business of insuring property against loss or damage by fire, in a manner not inconsistent with the laws of this state, as a stock company: Provided, however, That before such company shall issue any policies of insurance, such company shall deposit in the office of the auditor of state of Indiana, stocks, bonds or notes to be approved by said auditor, to the amount of twenty-five per cent (25%) of the capital stock of said company, the interest on which is to be paid to said company: Provided, That the securities so held may be replaced by other securities to be first approved by said auditor, when by reason of their maturity or other good cause, it shall seem necessary or proper for the best interest of such company to replace them.
(Formerly: Acts 1895, c.158, s.5.)

IC 27-3-2-6

Officers; election; bond

Sec. 6. Said directors shall, upon the receipt by the company of said certificate of incorporation, immediately elect a president, vice-president, secretary and treasurer from their number, who shall be sworn to perform faithfully the duties of their respective offices, and who shall give bond for a sum and in a manner to be prescribed in the by-laws of such company.

(Formerly: Acts 1895, c.158, s.6.)

IC 27-3-2-7

Option to discontinue writing insurance on mutual or assessment plan

Sec. 7. It shall not be obligatory upon any company, after the issuing of stock as aforesaid, to accept applications for insurance upon the mutual or assessment plan.

(Formerly: Acts 1895, c.158, s.7.)

IC 27-3-2-8

Treatment of assets

Sec. 8. No part of the assets now possessed by such company, or that shall be possessed at the time of the meeting at which it is determined to issue stock, or which may be acquired in the interim, shall be divided among the members of such company, or be expended, except for the ordinary disbursements of such company made in the usual course of its business, including losses incurred upon its policies, but such assets shall remain and constitute as heretofore a fund in the hands of such company for the security of the holders of its policies.

(Formerly: Acts 1895, c.158, s.8.)

IC 27-3-2-9

Annual report

Sec. 9. Such company shall, by its board of directors make a report, upon the first day of January of each year, of the condition of stock, showing the amount of capital stock, the number and amount of policies issued, the nature and kind of risks taken, the losses sustained, and the assets of every nature on hand or belonging to the company, which report shall be signed and sworn to by a majority of the directors of such company and published in a newspaper of general circulation in the county in which the company shall have its principal office.

(Formerly: Acts 1895, c.158, s.9.)

IC 27-3-3

Chapter 3. Acquisition of Certain Minority Interests in Subsidiary Domestic Stock Insurance Companies

IC 27-3-3-1

Definitions

Sec. 1. As used in this chapter:

(a) "Commissioner" means the insurance commissioner of this state.

(b) "Domestic insurer" means a stock insurance company organized under the laws of this state.

(c) "Parent corporation" means a corporation organized for any purpose under the laws of this state or any other jurisdiction that owns, directly or indirectly, at least ninety percent (90%) of the issued and outstanding voting stock of a domestic insurer.

(d) "Subsidiary insurer" means a domestic insurer, at least ninety percent (90%) of the issued and outstanding voting stock of which is owned by a parent corporation.

(e) "Voting stock" means shares issued by a domestic insurer, the record holders of which are entitled to vote at each election of directors of the domestic insurer, and securities convertible into or evidencing a right to acquire the shares.

(Formerly: Acts 1973, P.L.278, SEC.1.) As amended by P.L.245-1989, SEC.2.

IC 27-3-3-2

Manner of acquisition

Sec. 2. Any parent corporation may acquire all of the issued and outstanding voting stock of its subsidiary insurer not owned by the parent corporation in exchange for shares or other securities of the parent corporation, or cash, other consideration, or any combination of the foregoing, in the manner provided in this section. The board of directors of the parent corporation, by resolution approved by a majority of the whole board, shall adopt a plan of acquisition setting forth:

(1) the name of the subsidiary insurer;

(2) the designation and a description of the voting rights of each class, and any series thereof, of voting stock of the subsidiary insurer;

(3) the total number of issued and outstanding shares of each class, and any series thereof, of voting stock of the subsidiary insurer, the number of such shares owned by the parent corporation and, if either of the foregoing is subject to change prior to the proposed acquisition, the manner in which any change may occur;

(4) the terms and conditions of the acquisition, including the consideration to be paid and the proposed effective date of acquisition, and a statement clearly describing the rights of

shareholders dissenting from the plan of acquisition;

(5) if the parent corporation is not authorized to do business in this state, its consent to the enforcement against it in this state of the rights of shareholders pursuant to the plan of acquisition or the rights of shareholders dissenting from that plan, and a designation of the commissioner as the agent upon whom process may be served against the parent corporation in any action or proceeding to enforce those rights; and

(6) such other provisions with respect to the acquisition as the board of directors of the parent corporation deems necessary or appropriate.

(b) Upon adoption of a plan of acquisition, the parent corporation shall submit that plan to the commissioner in duplicate, certified by the secretary or an assistant secretary of the parent corporation as having been adopted in accordance with the provisions of this chapter. Within thirty (30) days from the date the plan is submitted to the commissioner, he shall endorse his approval or disapproval and the date thereof on both copies of the plan, file one (1) copy of the plan in his offices, and deliver the other copy to the parent corporation. No plan of acquisition shall take effect unless the approval of the commissioner has been obtained. The commissioner shall approve the plan of acquisition if he is satisfied that the plan complies with this chapter and that the terms and conditions of the plan of acquisition are fair and reasonable. If the commissioner disapproves the plan, he shall advise the parent corporation in writing of the reasons for his disapproval. The commissioner's disapproval of a plan of acquisition shall be subject to judicial review upon the petition of the parent corporation in accordance, so far as practical, with IC 4-21.5-5.

(c) If the commissioner approves the plan of acquisition, and if the plan has not been abandoned, the parent corporation shall deliver a copy of the plan or a summary thereof approved by the commissioner to each person who, as of the date of delivery, is a holder of record of voting stock to be acquired pursuant to the plan. Delivery shall be made either in person or by depositing a copy of the plan or an approved summary thereof in the United States mails, postage prepaid, addressed to the shareholder at his address of record as furnished by the subsidiary insurer or its transfer agent. The parent corporation shall thereafter file with the commissioner an affidavit of its secretary or assistant secretary setting forth that the delivery was made and the date of delivery.

(d) Notwithstanding approval by the commissioner of the plan of acquisition or delivery of the plan or of an approved summary thereof to shareholders, the plan of acquisition may be abandoned at any time prior to the proposed effective date of acquisition pursuant to a provision for abandonment, if any, contained in the plan.

(e) Upon compliance with the requirements of this section and if the plan of acquisition has not been abandoned, ownership of the

voting stock to be acquired pursuant to the plan shall automatically vest in the parent corporation on the date of acquisition proposed in the plan, without any physical transfer or deposit of certificates representing that voting stock, and the parent corporation shall be entitled to have new certificates therefor registered in its name. Shareholders whose voting stock is so acquired shall cease to be shareholders and shall have only the right to receive the consideration to be paid in exchange for their voting stock pursuant to the plan of acquisition.

(Formerly: Acts 1973, P.L.278, SEC.1.) As amended by P.L.7-1987, SEC.144.

IC 27-3-3-3

Dissent and demand by subsidiary stockholder; withdrawal; notice and offer; acceptance; appraisal; procedure

Sec. 3. Within thirty (30) days after delivery of the plan of acquisition or an approved summary thereof to shareholders as hereinabove provided, any shareholder of the subsidiary insurer may notify the subsidiary insurer in writing of his dissent from the plan and of his demand for payment of fair value of his voting stock, and, if the acquisition proposed in the plan is effected, the subsidiary insurer shall pay to each dissenting shareholder, upon surrender of the certificate or certificates representing the affected voting stock, the fair value thereof as of the day prior to the date on which the plan of acquisition was adopted by the board of directors of the parent corporation, excluding any appreciation or depreciation in anticipation of, or resulting from, that corporate action. Dissent and demand under this section shall be accompanied by the certificate or certificates representing the dissenting shareholder's voting stock for notation thereon that dissent and demand have been made, unless a court of competent jurisdiction, for good and sufficient cause shown, shall otherwise direct. Dissent and demand shall only be made jointly by holders of voting stock jointly held. Any shareholder failing to make the dissent and demand accompanied by certificates representing his voting stock within the thirty (30) day period shall be bound by the terms and conditions of the plan of acquisition. Any shareholder making dissent and demand accompanied by certificates representing his voting stock shall thereafter have no rights with respect to that voting stock except the right to receive payment therefor under this section, and a transferee of voting stock shall acquire by the transfer no rights other than those which the original dissenting shareholder had after making dissent and demand.

No dissent and demand may be withdrawn unless the president or a vice-president of the subsidiary insurer shall consent thereto in writing. If, however, dissent and demand is withdrawn upon such consent, or if the plan of acquisition is abandoned, or if a dissenting shareholder fails to submit for notation or surrender for payment the certificate or certificates representing his voting stock at the time and

in the manner required by this section, or if a dissenting shareholder does not file a petition for a determination of fair value of his voting stock within the time and in the manner provided in this section and the subsidiary insurer does not file a petition for such determination, or if a court of competent jurisdiction determines that a dissenting shareholder is not entitled to the relief provided by this section, then the right of the dissenting shareholder to be paid the fair value of his voting stock shall cease and his status and rights shall be the same as a shareholder failing to make dissent and demand, without prejudice to any corporate proceedings which may have been taken during the interim.

Within sixty (60) days after the acquisition proposed in the plan is effected, the subsidiary insurer shall give written notice thereof to each shareholder who has made dissent and demand as in this section provided, and shall make a written offer to each such dissenting shareholder to pay for his voting stock a specified price deemed by the subsidiary insurer to be the fair value thereof. This notice and offer shall be made when deposited in the United States mails, postage prepaid, addressed to the dissenting shareholder at his address of record. If the offer is accepted in writing by the dissenting shareholder, the subsidiary insurer shall pay the specified price to the dissenting shareholder upon surrender of the certificate or certificates representing his voting stock. Upon such payment the dissenting shareholder shall cease to have any interest in such voting stock and such voting stock shall be retired by the subsidiary insurer pursuant to IC 1971, 27-1-8-12.

If within thirty (30) days after the date of the mailing of the written offer the subsidiary insurer and a dissenting shareholder do not agree in writing upon the fair value, the subsidiary insurer or the dissenting shareholder may, within ninety (90) days after the date of the mailing of the written offer, petition the circuit or superior court of the county in which the principal office of the subsidiary insurer is located to appraise the fair value of the voting stock as of the day prior to the date on which the plan of acquisition was adopted by the board of directors of the parent corporation, excluding any appreciation or depreciation in anticipation of, or resulting from, that corporate action. If more than one (1) petition is filed, the petitions may be consolidated or joint hearings may be held thereon. The practice, procedure and judgment in the circuit or superior court shall be the same, so far as practical, as that under the eminent domain laws in this state. The judgment of the circuit or superior court shall be final. A judgment shall be payable only upon and concurrently with the surrender by such dissenting shareholder to the subsidiary insurer of the certificate or certificates representing the voting stock. Upon payment of the judgment, the dissenting shareholder shall cease to have any interest in the voting stock and such voting stock shall be retired by the subsidiary insurer pursuant to IC 1971, 27-1-8-12.

This section shall provide the exclusive method for dissenting from a plan of acquisition effected pursuant to this chapter and demanding payment of fair value of the voting stock acquired or to be acquired under such a plan.
(Formerly: Acts 1973, P.L.278, SEC.1.)

IC 27-3-3-4
Parent and subsidiary as separate corporations

Sec. 4. Notwithstanding a plan of acquisition effected pursuant to this chapter, the parent corporation and its subsidiary insurer shall in all respects stand before the law as separate and distinct corporations, with neither of the corporations having any liability to the creditors, policyholders, if any, or shareholders of the other, notwithstanding any actions or omissions of the officers, directors, or shareholders of either or both of the corporations.
(Formerly: Acts 1973, P.L.278, SEC.1.)

IC 27-3-3-5
Application of chapter

Sec. 5. The method authorized by this chapter for acquiring voting stock of a subsidiary insurer is not exclusive, but is in addition to any other lawful method for the acquisition of such voting stock.
(Formerly: Acts 1973, P.L.278, SEC.1.)

IC 27-4

ARTICLE 4. UNFAIR COMPETITION; UNAUTHORIZED INSURERS; FOREIGN INSURERS

IC 27-4-1

Chapter 1. Unfair Competition; Unfair or Deceptive Acts and Practices

IC 27-4-1-1

Purpose

Sec. 1. The purpose of this chapter is to regulate the trade practices in the business of insurance, in accordance with the intent of Congress as expressed in 15 U.S.C. 1011 et seq., by defining, or providing for the determination of, all such practices which constitute in this state unfair methods of competition and unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

(Formerly: Acts 1947, c.112, s.1.) As amended by P.L.252-1985, SEC.144.

IC 27-4-1-2

Definitions

Sec. 2. When and as used in this chapter:

(a) The term "person" shall mean any individual, corporation, company including any farm mutual insurance company, association, partnership, firm, reciprocal exchange, inter-insurer, Lloyds insurers, society, fraternal benefit society, lodge, order, council, corps, and any other association or legal entity, engaged in the business of insurance, including but not in limitation of the foregoing, insurance producers, brokers, solicitors, advisors, auditors, and adjusters.

(b) "Department" shall mean the department of insurance of this state created and defined as a department in the state government of the state of Indiana by IC 27-1.

(c) "Commissioner" shall mean the insurance commissioner of this state appointed pursuant to, and on and in whom the powers, duties, management, and control of the department are conferred and vested by, the provisions of IC 27-1.

(Formerly: Acts 1947, c.112, s.2.) As amended by P.L.252-1985, SEC.145; P.L.129-2003, SEC.7; P.L.178-2003, SEC.34.

IC 27-4-1-3

Prohibited use of unfair methods of competition and deceptive acts or practices

Sec. 3. No person shall engage in this state in any trade practice which is defined in this chapter or determined pursuant to this chapter as an unfair method of competition or as an unfair or deceptive act or practice in the business of insurance as defined in IC 27-1-2-3.

(Formerly: Acts 1947, c.112, s.3.) As amended by P.L.252-1985, SEC.146.

IC 27-4-1-4
Enumeration of unfair methods of competition and deceptive acts and practices

Sec. 4. (a) The following are hereby defined as unfair methods of competition and unfair and deceptive acts and practices in the business of insurance:

(1) Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement:

(A) misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon;

(B) making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies;

(C) making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(D) using any name or title of any policy or class of policies misrepresenting the true nature thereof; or

(E) making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender the policyholder's insurance.

(2) 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 any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading.

(3) 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) Entering into any agreement to commit, or individually or by a 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) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive. Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to 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, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer.

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

(7) Making or permitting any of the following:

(A) Unfair discrimination between individuals of the same class and equal expectation of life in the rates or assessments 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. However, 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) Unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, assessments, or rates charged or made for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever. However, in determining the class, consideration may be given to the nature of the risk, the plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(C) Excessive or inadequate charges for premiums, policy fees, assessments, or rates, or making or permitting any unfair discrimination between persons of the same class involving essentially the same hazards, in the amount of premiums, policy fees, assessments, or rates charged or made for:

(i) policies or contracts of reinsurance or joint reinsurance,

or abstract and title insurance;

(ii) policies or contracts of insurance against loss or damage to aircraft, or against liability arising out of the ownership, maintenance, or use of any aircraft, or 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; or

(iii) policies or contracts of any other kind or kinds of insurance whatsoever.

However, nothing contained in clause (C) shall be construed to apply to any of the kinds of insurance referred to in clauses (A) and (B) nor to reinsurance in relation to such kinds of insurance. Nothing in clause (A), (B), or (C) shall be construed as making or permitting any excessive, inadequate, or unfairly discriminatory charge or rate or any charge or rate determined by the department or commissioner to meet the requirements of any other insurance rate regulatory law of this state.

(8) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract or policy of insurance of any kind or kinds whatsoever, including but not in limitation, life annuities, or agreement as to such contract or policy other than as plainly expressed in such contract or policy 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, savings, or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract or policy; 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 stocks, bonds, or other securities of any insurance company or other corporation, association, limited liability company, or partnership, or any dividends, savings, or profits accrued thereon, or anything of value whatsoever not specified in the contract. Nothing in this subdivision and subdivision (7) 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, so long as any such bonuses or abatement of premiums are fair and equitable to policyholders and for the best interests of the company and its policyholders.

(B) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium

payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense.

(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) Paying by an insurer or insurance producer thereof duly licensed as such under the laws of this state of money, commission, or brokerage, or giving or allowing by an insurer or such licensed insurance producer thereof anything of value, for or on account of the solicitation or negotiation of policies or other contracts of any kind or kinds, to a broker, an insurance producer, or a solicitor duly licensed under the laws of this state, but such broker, insurance producer, or solicitor receiving such consideration shall not pay, give, or allow credit for such consideration as received in whole or in part, directly or indirectly, to the insured by way of rebate.

(9) Requiring, as a condition precedent to loaning money upon the security of a mortgage upon real property, that the owner of the property to whom the money is to be loaned negotiate any policy of insurance covering such real property through a particular insurance producer or broker or brokers. However, this subdivision shall not prevent the exercise by any lender of the lender's right to approve or disapprove of the insurance company selected by the borrower to underwrite the insurance.

(10) Entering into any contract, combination in the form of a trust or otherwise, or conspiracy in restraint of commerce in the business of insurance.

(11) Monopolizing or attempting to monopolize or combining or conspiring with any other person or persons to monopolize any part of commerce in the business of insurance. However, participation as a member, director, or officer in the activities of any nonprofit organization of insurance producers or other workers in the insurance business shall not be interpreted, in itself, to constitute a combination in restraint of trade or as combining to create a monopoly as provided in this subdivision and subdivision (10). The enumeration in this chapter of specific unfair methods of competition and unfair or deceptive acts and practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the commissioner or department or of any court of review under section 8 of this chapter.

(12) Requiring as a condition precedent to the sale of real or personal property under any contract of sale, conditional sales contract, or other similar instrument or upon the security of a chattel mortgage, that the buyer of such property negotiate any

policy of insurance covering such property through a particular insurance company, insurance producer, or broker or brokers. However, this subdivision shall not prevent the exercise by any seller of such property or the one making a loan thereon of the right to approve or disapprove of the insurance company selected by the buyer to underwrite the insurance.

(13) Issuing, offering, or participating in a plan to issue or offer, any policy or certificate of insurance of any kind or character as an inducement to the purchase of any property, real, personal, or mixed, or services of any kind, where a charge to the insured is not made for and on account of such policy or certificate of insurance. However, this subdivision shall not apply to any of the following:

(A) Insurance issued to credit unions or members of credit unions in connection with the purchase of shares in such credit unions.

(B) Insurance employed as a means of guaranteeing the performance of goods and designed to benefit the purchasers or users of such goods.

(C) Title insurance.

(D) Insurance written in connection with an indebtedness and intended as a means of repaying such indebtedness in the event of the death or disability of the insured.

(E) Insurance provided by or through motorists service clubs or associations.

(F) Insurance that is provided to the purchaser or holder of an air transportation ticket and that:

(i) insures against death or nonfatal injury that occurs during the flight to which the ticket relates;

(ii) insures against personal injury or property damage that occurs during travel to or from the airport in a common carrier immediately before or after the flight;

(iii) insures against baggage loss during the flight to which the ticket relates; or

(iv) insures against a flight cancellation to which the ticket relates.

(14) Refusing, because of the for-profit status of a hospital or medical facility, to make payments otherwise required to be made under a contract or policy of insurance for charges incurred by an insured in such a for-profit hospital or other for-profit medical facility licensed by the state department of health.

(15) Refusing to insure an individual, refusing to continue to issue insurance to an individual, limiting the amount, extent, or kind of coverage available to an individual, or charging an individual a different rate for the same coverage, solely because of that individual's blindness or partial blindness, except where the refusal, limitation, or rate differential is based on sound

actuarial principles or is related to actual or reasonably anticipated experience.
(16) Committing or performing, with such frequency as to indicate a general practice, unfair claim settlement practices (as defined in section 4.5 of this chapter).
(17) Between policy renewal dates, unilaterally canceling an individual's coverage under an individual or group health insurance policy solely because of the individual's medical or physical condition.
(18) Using a policy form or rider that would permit a cancellation of coverage as described in subdivision (17).
(19) Violating IC 27-1-22-25, IC 27-1-22-26, or IC 27-1-22-26.1 concerning motor vehicle insurance rates.
(20) Violating IC 27-8-21-2 concerning advertisements referring to interest rate guarantees.
(21) Violating IC 27-8-24.3 concerning insurance and health plan coverage for victims of abuse.
(22) Violating IC 27-8-26 concerning genetic screening or testing.
(23) Violating IC 27-1-15.6-3(b) concerning licensure of insurance producers.
(24) Violating IC 27-1-38 concerning depository institutions.
(25) Violating IC 27-8-28-17(c) or IC 27-13-10-8(c) concerning the resolution of an appealed grievance decision.
(26) Violating IC 27-8-5-2.5(e) through IC 27-8-5-2.5(j) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).
(27) Violating IC 27-2-21 concerning use of credit information.
(28) Violating IC 27-4-9-3 concerning recommendations to consumers.
(29) Engaging in dishonest or predatory insurance practices in marketing or sales of insurance to members of the United States Armed Forces as:
(A) described in the federal Military Personnel Financial Services Protection Act, P.L.109-290; or
(B) defined in rules adopted under subsection (b).
(30) Violating IC 27-8-19.8-20.1 concerning stranger originated life insurance.
(31) Violating IC 27-2-22 concerning retained asset accounts.
(32) Violating IC 27-8-5-29 concerning health plans offered through a health benefit exchange (as defined in IC 27-19-2-8).
(33) Violating a requirement of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), that is enforceable by the state.
(34) After June 30, 2015, violating IC 27-2-23 concerning unclaimed life insurance, annuity, or retained asset account benefits.

(35) Willfully violating IC 27-1-12-46 concerning a life insurance policy or certificate described in IC 27-1-12-46(a).

(b) Except with respect to federal insurance programs under Subchapter III of Chapter 19 of Title 38 of the United States Code, the commissioner may, consistent with the federal Military Personnel Financial Services Protection Act (P.L.109-290), adopt rules under IC 4-22-2 to:

(1) define; and

(2) while the members are on a United States military installation or elsewhere in Indiana, protect members of the United States Armed Forces from;

dishonest or predatory insurance practices.

(Formerly: Acts 1947, c.112, s.4; Acts 1955, c.10, s.1; Acts 1971, P.L.389, SEC.1; Acts 1974, P.L.124, SEC.1.) As amended by Acts 1981, P.L.247, SEC.1; P.L.259-1983, SEC.1; P.L.271-1987, SEC.5; P.L.5-1988, SEC.144; P.L.160-1988, SEC.1; P.L.2-1992, SEC.783; P.L.122-1992, SEC.2; P.L.8-1993, SEC.417; P.L.8-1993, SEC.418; P.L.225-1993, SEC.1; P.L.223-1993, SEC.6; P.L.1-1994, SEC.134; P.L.133-1994, SEC.1; P.L.116-1994, SEC.49; P.L.2-1995, SEC.104; P.L.188-1996, SEC.1; P.L.185-1996, SEC.10; P.L.150-1997, SEC.2; P.L.132-2001, SEC.8; P.L.130-2002, SEC.3; P.L.178-2003, SEC.35; P.L.201-2003, SEC.2; P.L.211-2003, SEC.1; P.L.97-2004, SEC.97; P.L.39-2005, SEC.2; P.L.138-2005, SEC.1; P.L.1-2006, SEC.487; P.L.131-2007, SEC.1; P.L.3-2008, SEC.211; P.L.112-2008, SEC.2; P.L.1-2009, SEC.146; P.L.67-2011, SEC.2; P.L.278-2013, SEC.22; P.L.90-2014, SEC.2; P.L.227-2015, SEC.6.

IC 27-4-1-4.5

Enumeration of unfair claim settlement practices

Sec. 4.5. The following are unfair claim settlement practices:

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

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

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

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

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

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

(7) 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.

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

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

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

(11) 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.

(12) Delaying the investigation or payment of claims by requiring an insured, a 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.

(13) Failing to promptly settle claims, where liability has become reasonably clear, under one (1) portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(14) 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.

(15) In negotiations concerning liability insurance claims, ascribing a percentage of fault to a person seeking to recover from an insured party, in spite of an obvious absence of fault on the part of that person.

(16) The unfair claims settlement practices defined in IC 27-4-1.5.

As added by P.L.259-1983, SEC.2. Amended by P.L.271-1987, SEC.6; P.L.194-1991, SEC.1; P.L.203-2001, SEC.7.

IC 27-4-1-5

Statement of charges; notice and hearing; intervention

Sec. 5. (a) Whenever the commissioner shall have reason to believe that any such person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice defined in section 4 of this chapter and that a proceeding by him in respect thereto would be to the interest of the public, he shall issue and cause to be served upon such person a statement of the charges in that respect and a notice in writing of a

hearing thereon to be held under IC 4-21.5-3.

(b) Whenever the hearing involves the claim, averment, or complaint of, or made by, a person who is not an investigator, deputy, examiner, or other employee of the department, a copy of the substance of such claim, averment, or complaint shall be included in or exhibited with such notice. The commissioner and department shall afford all interested persons or parties the right and opportunity for the settlement or adjustment of all claims, controversies, and issues when such persons or parties shall join in a request in writing for such opportunity.

(Formerly: Acts 1947, c.112, s.5.) As amended by P.L.252-1985, SEC.147; P.L.7-1987, SEC.145.

IC 27-4-1-5.5

(Repealed by P.L.1-1991, SEC.165.)

IC 27-4-1-5.6

Unfair claim settlement practice complaint; response; investigation; report; notice of remedies

Sec. 5.6. (a) A person who believes the person has been adversely affected by an unfair claim settlement practice under section 4.5 of this chapter may file a complaint with the commissioner. If the commissioner believes an unfair claim settlement practice has occurred, the commissioner shall, within ten (10) business days from the date of receipt of a written complaint, deliver a copy of the complaint to the insurer and shall respond in writing to the complaining party, at the address provided in the complaint, advising the party of the following:

(1) The specific action taken by the department on the complaint.

(2) Any further investigations or other actions that are intended by the department.

(b) An insurer who receives a written notice of complaint under subsection (a) shall promptly conduct an investigation of the matters alleged in the complaint. Within twenty (20) business days from the date of receipt of the complaint, the insurer shall provide to the commissioner and the complaining party a written report containing the following information:

(1) The specific reasons for actions taken by the insurer with respect to the claim.

(2) The specific reasons for any inaction by the insurer with respect to the claim.

(3) If the claim has not been settled, a good faith estimate of the time required for settlement.

(c) An insurer who commits an unfair claims settlement practice or who fails to comply with this section is subject to action by the commissioner under section 6 of this chapter.

(d) Each insurer shall provide to each current policyholder a one

(1) time written notice of the remedies provided under this section. Future policyholders shall be notified by the insurer at the time the insurance policy is issued.
As added by P.L.1-1991, SEC.166.

IC 27-4-1-6
Cease and desist order; penalties

Sec. 6. (a) If after a hearing under IC 4-21.5-3, the commissioner determines that the method of competition or the act or practice in question is defined in section 4 of this chapter and that the person complained of has engaged in such method of competition, act, or practice in violation of this chapter, he shall reduce his findings to writing and shall issue and cause to be served on the person charged with the violation an order requiring such person to cease and desist from such method of competition, act, or practice, and the commissioner may at his discretion order one (1) or more of the following:

(1) Payment of a civil penalty of not more than twenty-five thousand dollars ($25,000) for each act or violation. If the person knew or reasonably should have known that he was in violation of this chapter, the penalty may be not more than fifty thousand dollars ($50,000) for each act or violation.

(2) Suspension or revocation of the person's license, or certificate of authority, if he knew or reasonably should have known he was in violation of this chapter.

(b) In determining the amount of a civil penalty under subsection (a)(1), the commissioner shall consider the remediation efforts undertaken by the person.

(c) All civil penalties imposed and collected under this section shall be deposited in the state general fund.
(Formerly: Acts 1947, c.112, s.6.) As amended by P.L.259-1983, SEC.3; P.L.7-1987, SEC.146; P.L.121-1990, SEC.4; P.L.149-1990, SEC.2; P.L.203-2001, SEC.8.

IC 27-4-1-7
Judicial review; civil enforcement orders

Sec. 7. (a) Any person required by an order of the commissioner under section 6 of this chapter to cease and desist from engaging in any unfair method of competition or any unfair or deceptive act or practice defined in section 4 of this chapter may obtain judicial review of such order under IC 4-21.5-5.

(b) The commissioner may file a petition for civil enforcement of an order under IC 4-21.5-6.
(Formerly: Acts 1947, c.112, s.7.) As amended by P.L.252-1985, SEC.148; P.L.7-1987, SEC.147.

IC 27-4-1-8
Determination of additional methods of unfair competition or

deceptive acts or practices; notice and hearing

Sec. 8. Whenever the commissioner shall have reason to believe that any person engaged in the business of insurance is engaging in this state in any method of competition or in any act or practice in the conduct of such business which is not defined in section 4 of this chapter, that such method of competition is unfair, or that such act or practice is unfair or deceptive, and that a proceeding by him in respect thereto would be to the interest of the public, he may issue and cause to be served upon such person a statement of the charges in that respect and a notice of a hearing thereon. Each such hearing shall be conducted under IC 4-21.5-3 in the same manner as the hearings provided for in section 5 of this chapter.

(Formerly: Acts 1947, c.112, s.8.) As amended by P.L.252-1985, SEC.149; P.L.7-1987, SEC.148.

IC 27-4-1-9

Judicial review

Sec. 9. Any party to a proceeding under this chapter, including any intervenor, may obtain judicial review under IC 4-21.5-5.

(Formerly: Acts 1947, c.112, s.9.) As amended by P.L.252-1985, SEC.150; P.L.7-1987, SEC.149.

IC 27-4-1-10

Application of other laws

Sec. 10. No order of the commissioner under this chapter or judgment of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other statute of this state.

(Formerly: Acts 1947, c.112, s.10.) As amended by P.L.252-1985, SEC.151.

IC 27-4-1-11

Foreign or alien insurer's unfair competition or unfair or deceptive practice by periodical or radio; notice to supervisory official of domiciliary state

Sec. 11. If any foreign or alien insurer engages in this state in an unfair method of competition or in an unfair or deceptive practice as defined in section 4(1) or 4(2) of this chapter by means of any advertisement, announcement, or statement, in any magazine or other periodical publication having a general circulation in more than five (5) states, or by means of any radio broadcast to more than five (5) states, including the state of domicile of such insurer, and if the laws of the state where such insurer is domiciled make provision for enjoining of such method of competition or practice, it shall be the duty of the commissioner to advise the insurance supervisory official of such domiciliary state of the violation in order that he may take appropriate action, but the commissioner shall have no authority to proceed, with respect to such violation, under either section 5 or 8 of

this chapter. For the purpose of this section the domiciliary state of an alien insurer shall be deemed to be its state of entry, or the state of the principal office in the United States.
(Formerly: Acts 1947, c.112, s.11.) As amended by P.L.252-1985, SEC.152.

IC 27-4-1-12
Violations; penalties

Sec. 12. Any person who violates a cease and desist order of the commissioner under section 6 of this chapter, or an order of the court under IC 4-21.5, after it has become final, and while such order is in effect, may, after notice and hearing under IC 4-21.5 and upon order of the commissioner, be subject at the discretion of the commissioner to one (1) or more of the following:

(1) A civil penalty of not more than twenty-five thousand dollars ($25,000) for each act or violation.

(2) Suspension or revocation of the person's license or certificate of authority.

(Formerly: Acts 1947, c.112, s.12.) As amended by P.L.259-1983, SEC.4; P.L.7-1987, SEC.150; P.L.121-1990, SEC.5; P.L.149-1990, SEC.3.

IC 27-4-1-13
Cumulative powers and remedies

Sec. 13. The powers vested in the commissioner and the department by this chapter shall be additional to any other powers to enforce any penalties or forfeitures authorized by law with respect to the methods, acts, and practices declared hereby to be unfair or deceptive.
(Formerly: Acts 1947, c.112, s.13.) As amended by P.L.252-1985, SEC.153.

IC 27-4-1-14
Repealed

(Repealed by P.L.7-1987, SEC.151.)

IC 27-4-1-15
Enforcement; additional personnel

Sec. 15. (a) For the purpose of maintaining the affirmative, active, and definite administration of the provisions of this chapter, the commissioner, with the approval of the governor, may appoint such additional actuaries, agents, deputies, examiners, assistants, stenographers, reporters, and other employees in the department as may be found necessary to carry out the provisions of this chapter. Except as otherwise provided in this chapter, such additional deputies, examiners, assistants, reporters, and employees so appointed shall be chosen for their fitness, either professional or practical, as the nature of the position may require, irrespective of

their political beliefs or affiliations. The technical or professional qualifications of any applicant shall be determined by examination, professional rating, or otherwise, as the commissioner with the approval of the governor may determine. Subject to the approval of the governor and the state budget director, the salaries of such additional actuaries, agents, deputies, examiners, assistants, stenographers, reporters, and other employees shall be fixed by the commissioner. Any actuary agent, deputy, examiner, assistant, stenographer, or employee so employed may be removed at any time by the commissioner.

(b) In the absence of the commissioner, he may, by written order, designate a deputy to conduct any hearing, and, in such case, such deputy commissioner shall possess and may exercise all powers of the commissioner with respect to the matter in hearing.

(c) Neither the commissioner nor any actuary, deputy, examiner, assistant, or employee in the department shall be liable in their individual capacity, except to the state of Indiana, for any act done or omitted in connection with the performance of their respective duties under the provisions of this chapter.

(Formerly: Acts 1947, c.112, s.15.) As amended by P.L.252-1985, SEC.155.

IC 27-4-1-16

Inapplicable laws

Sec. 16. No provision of IC 4-22-2 shall be construed to apply to any hearings held or proceedings had pursuant to the provisions of this chapter.

(Formerly: Acts 1947, c.112, s.16.) As amended by P.L.252-1985, SEC.156.

IC 27-4-1-17

Construction and application

Sec. 17. (a) This chapter shall be, and shall be construed as being, in addition to IC 27-1, and in addition to IC 27-7-2, and in addition to any and all statutes supplemental to either, and in addition to any and all other laws of the state of Indiana concerning insurance or the business of insurance, whether enacted at any time in the 1947 regular session or at any preceding session of the general assembly of the state of Indiana.

(b) Whereas certain unlawful practices are set forth in other insurance statutes of the state of Indiana which unlawful practices are similar or identical to those enumerated in section 4 of this chapter and are characterized in other insurance statutes as criminal in nature, it is deemed desirable to retain the criminal penalties imposed by other insurance statutes; for that purpose, nothing contained in this chapter shall be construed to repeal, amend, or otherwise to affect in any way IC 27-1, IC 27-7-2, or any other law of the state of Indiana concerning insurance or the business of

insurance whether enacted at any time in the 1947 regular session or at any preceding session of the general assembly of the state of Indiana, it being the intent of this chapter to provide additional administrative remedies for the purpose of controlling unfair methods of competition and unfair and deceptive acts and practices in and affecting the business of insurance.

(c) Nothing in this chapter shall be construed as exempting or excepting from the provisions of this chapter any person engaged in the business of insurance in this state, except as in this chapter otherwise expressly provided.

(Formerly: Acts 1947, c.112, s.18.) As amended by P.L.252-1985, SEC.157.

IC 27-4-1-18

Causes of action created

Sec. 18. This article does not create a cause of action other than an action by:

(1) the commissioner to enforce his order; or

(2) a person, as defined in section 1 of this chapter, to appeal an order of the commissioner.

As added by P.L.259-1983, SEC.6.

IC 27-4-1-19

Annual report of consumer complaints

Sec. 19. (a) The commissioner shall, on an annual basis and in a manner determined by the commissioner, publish figures and produce a report containing the following information:

(1) The ratio of valid consumer complaints lodged against each company weighted by the direct premiums earned in Indiana by each company.

(2) A separate listing of any company determined by the commissioner to have committed a practice that is designated an unfair claim settlement practice under section 4.5 of this chapter if the practice is committed flagrantly and in conscious disregard of section 4.5 of this chapter or if the practice is committed with a frequency that indicates a general business practice.

(3) Any enforcement action taken by the commissioner as a result of a practice described in subdivision (2).

(b) The commissioner shall provide a copy of the report required under subsection (a) to the house of representatives and senate committees of the general assembly that are assigned responsibility for insurance issues.

As added by P.L.121-1990, SEC.6 and P.L.149-1990, SEC.4. Amended by P.L.203-2001, SEC.9.

IC 27-4-1.5

Chapter 1.5. Auto Repair Claims Settlement

IC 27-4-1.5-0.1

Application of chapter

Sec. 0.1. The addition of this chapter by P.L.194-1991 applies to the repair of motor vehicles under insurance policies issued or renewed after June 30, 1991.

As added by P.L.220-2011, SEC.430.

IC 27-4-1.5-1

"Body part" defined

Sec. 1. (a) As used in this chapter, "body part" means a replacement for any of the nonmechanical sheet metal or plastic parts that generally constitute the exterior of a motor vehicle.

(b) The term includes the inner and outer panels of the body of a motor vehicle.

As added by P.L.194-1991, SEC.2.

IC 27-4-1.5-2

"Body shop" defined

Sec. 2. As used in this chapter, "body shop" means a business that repairs damage to the exterior of motor vehicles.

As added by P.L.194-1991, SEC.2.

IC 27-4-1.5-3

"Insured" defined

Sec. 3. As used in this chapter, "insured" means a person who is entitled to the coverage provided by an insurance policy.

As added by P.L.194-1991, SEC.2.

IC 27-4-1.5-4

"Insurer" defined

Sec. 4. As used in this chapter, "insurer" has the meaning set forth in IC 27-1-2-3.

As added by P.L.194-1991, SEC.2.

IC 27-4-1.5-5

"Motor vehicle" defined

Sec. 5. As used in this chapter, "motor vehicle" has the meaning set forth in IC 9-13-2-105.

As added by P.L.194-1991, SEC.2. Amended by P.L.1-1992, SEC.150.

IC 27-4-1.5-6
"New body part" defined

Sec. 6. As used in this chapter, "new body part" means a body part that has not previously been attached to a motor vehicle.
As added by P.L.194-1991, SEC.2.

IC 27-4-1.5-7
"Used body part" defined

Sec. 7. As used in this chapter, "used body part" means a body part that has previously been attached to a motor vehicle.
As added by P.L.194-1991, SEC.2.

IC 27-4-1.5-8
Insurer notice to insured; body parts to be used in repair

Sec. 8. (a) An insurer that is obligated to pay at least part of the cost of repairing the exterior of a motor vehicle under an insurance policy issued by the insurer may not direct a body shop to repair the motor vehicle until the insurer has presented the insured with a written notice that meets the requirements set forth in subsections (b) and (c).

(b) An insurer described in subsection (a) shall present the insured with a written notice that does the following:

(1) Informs the insured that the insured has a right to approve the type of body parts to be used in the repair of the motor vehicle.

(2) Gives the insured an opportunity, in approving the type of body parts to be used in the repair of the motor vehicle, to select from among the following:

(A) New body parts manufactured by or for the manufacturer of the motor vehicle.

(B) New body parts that were not manufactured by or for the manufacturer of the motor vehicle.

(C) Used body parts.

(c) An insurer described in subsection (a) shall give the insured an opportunity to indicate in writing the type of body part that the insured approves for use in the repair of the motor vehicle.

(d) This section applies only in the five (5) years after the model year of the motor vehicle.
As added by P.L.194-1991, SEC.2.

IC 27-4-1.5-9
Failure to give insured notice; unfair claim settlement practice

Sec. 9. An insurer that:

(1) is required to give a written notice to an insured under

section 8 of this chapter concerning the repair of a motor vehicle;

(2) does not give the insured a written notice that meets the requirements set forth in section 8(b) of this chapter; and

(3) directs a body shop to repair the motor vehicle;

commits an unfair claim settlement practice under IC 27-4-1-4.5.

As added by P.L.194-1991, SEC.2.

IC 27-4-1.5-10

Failure to permit selection of body parts by insured; unfair claim settlement practice

Sec. 10. An insurer that:

(1) is subject to the requirement set forth in section 8(c) of this chapter with respect to the repair of a motor vehicle;

(2) does not satisfy this requirement; and

(3) directs a body shop to repair the motor vehicle;

commits an unfair claims settlement practice under IC 27-4-1-4.5.

As added by P.L.194-1991, SEC.2.

IC 27-4-1.5-11

Direction by insurer to use different body parts from those directed by insured; unfair claims settlement practice

Sec. 11. An insurer that:

(1) under section 8(c) of this chapter gives an insured an opportunity to indicate in writing the type of body part that the insured approves for use in the repair of the motor vehicle; and

(2) directs a body shop to repair the motor vehicle using a type of body part different from the type of body part that the insured approved for use in the repair of the motor vehicle;

commits an unfair claim settlement practice under IC 27-4-1-4.5.

As added by P.L.194-1991, SEC.2.

IC 27-4-1.5-12

Refusal to direct use of or pay for body parts directed by insured; unfair claim settlement practice

Sec. 12. An insurer that:

(1) under section 8(c) of this chapter gives an insured an opportunity to indicate in writing the type of body parts that the insured approves for use in the repair of a motor vehicle; and

(2) refuses to:

(A) pay for; or

(B) direct a body shop to use;

the type of body parts approved by the insured under section 8(c) of this chapter in the repair of the motor vehicle;

commits an unfair claims settlement practice under IC 27-4-1-4.5.
As added by P.L.194-1991, SEC.2.

IC 27-4-1.5-13
Insurer duties performed by agent or body shop

Sec. 13. An act that an insurer is required to perform under this chapter shall be considered to have been performed by the insurer if the act is performed by:

(1) an agent of the insurer; or

(2) a body shop that the insurer directs to repair a motor vehicle.

As added by P.L.194-1991, SEC.2.

IC 27-4-2
Repealed

(Repealed by Acts 1978, P.L.2, SEC.2728.)

IC 27-4-3

Chapter 3. Restrictions on Unlawful Insurance Producer Representation

IC 27-4-3-1

Two or more companies coercing or inducing insurance producer to refrain from representing additional companies

Sec. 1. It is hereby declared unlawful for any two (2) or more insurance companies writing the same class, or classes, of risks and doing business in this state, directly or indirectly, to enter into any arrangement, contract, agreement, understanding, combination or association to require, coerce or induce any insurance producer or representative of any two (2) or more of such insurance companies within the state of Indiana to refrain from representing other such insurance companies, or to afford any advantage to any insurance producer to refrain from representing other such insurance companies or to impose upon the insurance producer any disadvantage by reason of the insurance producer's acting as representative of other such insurance companies.

(Formerly: Acts 1937, c.46, s.1.) As amended by P.L.178-2003, SEC.36.

IC 27-4-3-2

Insurance producer's agreement not to represent additional companies; exclusive representation of single company

Sec. 2. (a) It is unlawful for any insurance producer representing or acting for two (2) or more insurance companies writing the same class or classes, of risks to enter, either directly or indirectly, into any agreement, arrangement, contract or understanding with one (1) or more of such companies that the insurance producer will refrain from representing any other like company or companies, and it is unlawful for any such insurance company, not having a contract requiring an insurance producer to represent the insurance company alone, in any manner to require, coerce, or induce any insurance producer to refrain from representing any other like company or companies.

(b) This section does not prevent any insurance company or insurance producer from at any time entering into a bona fide contract whereby an insurance producer agrees that the insurance producer will thereafter represent a single company exclusively.

(Formerly: Acts 1937, c.46, s.2.) As amended by P.L.178-2003, SEC.37.

IC 27-4-3-3

Violations; license suspension; public hearing; appeal

Sec. 3. For violation of any provision of this chapter, the license of the offending company or insurance producer to transact the business of insurance within the state of Indiana shall be suspended for a period of three (3) years. Whenever information of any such

violation shall come to the knowledge of the commissioner of insurance, the commissioner shall issue an order fixing a day certain, not more than thirty (30) nor less than twenty (20) days from the making thereof, upon which the offender shall appear and show cause why such penalty should not be enforced, such order specifying with reasonable certainty the violation charged, and if, after hearing, the commissioner shall determine that the company or insurance producer is guilty of such violation, the commissioner shall forthwith suspend the license of the offender for a period of three (3) years. Such hearing shall be public, and at any such hearing any person or corporation having lodged information of such violation with the commissioner shall be entitled to be present and submit evidence. Within thirty (30) days after the suspension of any such license, the insurance producer or company whose license has been suspended may appeal from the ruling of the commissioner of insurance to the circuit or superior court of the county in which the insurance producer resides or in which such company has its principal place of business, and if such company be a foreign insurance company then such appeal may be taken by such company to the circuit or superior court of Marion County.

(Formerly: Acts 1937, c.46, s.3.) As amended by P.L.252-1985, SEC.158; P.L.178-2003, SEC.38.

IC 27-4-4
Chapter 4. Unauthorized Insurers Process Act

IC 27-4-4-1
Purpose; legislative declaration

Sec. 1. (a) The purpose of this chapter is to subject certain insurers to the jurisdiction of courts of this state in suits by or on behalf of the insureds or beneficiaries under insurance contracts.

(b) The general assembly declares that it is a subject of concern that many residents of this state hold policies of insurance issued or delivered in this state by insurers while not authorized to do business in this state, thus presenting to such residents the often insuperable obstacle of resorting to distant forums for the purpose of asserting legal rights under such policies. In furtherance of such state interest, the general assembly provides in this chapter a method of substituted service of process upon such insurers and declares that in so doing it exercises its power to protect its residents and to define, for the purpose of this chapter, what constitutes doing business in this state, and also exercises powers and privileges available to the state by virtue of 15 U.S.C. 1011 et seq., which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states.

(Formerly: Acts 1955, c.203, s.1.) As amended by P.L.252-1985, SEC.159.

IC 27-4-4-2
Definitions

Sec. 2. As used in this chapter and unless a different meaning appears from the context:

(a) The term "insurer" means a company, firm, partnership, association, order, society, or system making any kind or kinds of insurance and shall include associations operating as Lloyds, reciprocal, or interinsurers, or individual underwriters.

(b) The term "unauthorized foreign insurer" means an insurer organized under the laws of, or whose place of domicile is in any state of the United States other than this state or organized under the laws of, or whose place of domicile is in any territory or insular possession of the United States or the District of Columbia, and which insurer is not admitted, authorized, and licensed in accordance with the laws of this state to do and transact the business of insurance in the state of Indiana.

(c) The term "unauthorized alien insurer" means an insurer organized under the laws of, or whose place of domicile is in any country other than the United States or territory or insular possession thereof, or the District of Columbia, and which insurer is not admitted, authorized, and licensed in accordance with the laws of this state to do and transact the business of insurance in the state of Indiana.

(Formerly: Acts 1955, c.203, s.2.) As amended by P.L.252-1985, SEC.160.

IC 27-4-4-3
Acts constituting appointment of commissioner as attorney for service of process; methods of service

Sec. 3. (a) Any of the following acts in this state, effected by mail, or otherwise, by an unauthorized foreign or alien insurer; (1) the issuance or delivery of contracts of insurance to residents of this state or to corporations authorized to do business therein, (2) the solicitation of applications for such contracts, (3) the collection of premiums, membership fees, assessments or other considerations for such contracts, or (4) any other transaction of insurance business, is equivalent to and shall constitute an appointment by such insurer of the insurance commissioner of the state of Indiana and his successor or successors in office, to be its true and lawful attorney, upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of an insured or beneficiary arising out of any such contract of insurance, and any such act shall be signification of its agreement that such service of process is of the same legal force and validity as personal service of process in this state upon such insurer.

(b) Such service of process shall be made by delivering to and leaving with the insurance commissioner of the state of Indiana, or in his office, two (2) copies thereof and the payment to him at the time of such service a fee as required under IC 27-1-3-15. The insurance commissioner shall forthwith mail by registered mail one (1) of the copies of such process to the defendant at its last known principal place of business, and shall keep a record of all process so served upon him. Such service of process is sufficient, provided notice of such service and a copy of the process are sent within ten (10) days thereafter by registered mail by plaintiff or plaintiff's attorney to the defendant at its last known principal place of business, and the defendant's receipt, or receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff or plaintiff's attorney showing a compliance herewith are filed with the clerk of the court in which such action is pending on or before the date the defendant is required to appear, or within such further time as the court may allow.

(c) Service of process in any such action, suit or proceeding shall in addition to the manner provided in subsection (b) of this section be valid if served upon any person within this state who, in this state on behalf of such insurer, is (1) soliciting insurance, or (2) making, issuing, or delivering any contract of insurance, or (3) collecting or receiving any premium, membership fee, assessment or other consideration for insurance; and a copy of such process is sent within

ten (10) days thereafter by registered mail by the plaintiff or plaintiff's attorney to the defendant at the last known principal place of business of the defendant, and the defendant's receipt, or the receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff or plaintiff's attorney showing a compliance herewith are filed with the clerk of the court in which such action is pending on or before the date the defendant is required to appear, or within such further time as the court may allow.

(d) No plaintiff or complainant shall be entitled to a judgment by default under this section until the expiration of thirty (30) days from the date of the filing of the affidavit of compliance.

(e) Nothing in this section shall limit or abridge the right to serve any process, notice, or demand upon any insurer in any other manner now or hereafter permitted by law.

(Formerly: Acts 1955, c.203, s.3.) As amended by P.L.130-1994, SEC.38; P.L.116-1994, SEC.50.

IC 27-4-4-4

Deposit or bond; motion to quash service

Sec. 4. (a) Before any unauthorized foreign or alien insurer shall file or cause to be filed any pleading in any action, suit, or proceeding instituted against it, such unauthorized insurer shall:

(1) deposit, with the clerk of the court in which such action, suit, or proceeding is pending, cash or securities, or file with such clerk a bond with good and sufficient sureties, to be approved by the court, in an amount to be fixed by the court sufficient to secure the payment of any final judgment which may be rendered in such action; or

(2) procure a certificate of authority to transact the business of insurance in this state.

(b) The court in any action, suit, or proceeding, in which service is made in the manner provided in section 3 of this chapter may, in its discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of subsection (a) and to defend such action.

(c) Nothing in subsection (a) is to be construed to prevent an unauthorized foreign or alien insurer from filing a motion to quash a writ or to set aside service made in the manner provided in section 3 of this chapter on the ground either:

(1) that such unauthorized insurer has not done any of the acts enumerated in section 3(a) of this chapter; or

(2) that the person on whom service was made pursuant to section 3(c) of this chapter was not doing any of the acts therein enumerated.

(Formerly: Acts 1955, c.203, s.4.) As amended by P.L.252-1985, SEC.161.

IC 27-4-4-5
Vexatious refusal to pay without reasonable cause; attorney's fees

Sec. 5. In any action against an unauthorized foreign or alien insurer upon a contract of insurance issued or delivered in this state to a resident thereof or to a corporation authorized to do business therein, if the insurer has failed for thirty (30) days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract, and it appears to the court that such refusal was vexatious and without reasonable cause, the court may allow to the plaintiff a reasonable attorney fee and include such fee in any judgment that may be rendered in such action. Such fee shall not exceed twelve and one-half per cent (12 1/2%) of the amount which the court or jury finds the plaintiff is entitled to recover against the insurer, but in no event shall such fee be less than twenty-five dollars ($25.00). Failure of an insurer to defend any such action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause.
(Formerly: Acts 1955, c.203, s.5.)

IC 27-4-4-6
Exclusions from act

Sec. 6. The provisions of this chapter shall not apply to any action, suit, or proceeding against any unauthorized insurer arising out of any contract of:

(1) reinsurance effectuated in accordance with the laws of Indiana;
(2) aircraft insurance;
(3) insurance on property or operations of railroads engaged in interstate commerce;
(4) insurance against legal liability arising out of the ownership, operation or maintenance of any property having a permanent situs outside of this state; or
(5) insurance against loss of or damage to any property having a permanent situs outside of this state;

where such contract contains a provision designating the department or the commissioner or a bona fide resident of the state of Indiana to be its true and lawful attorney upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of an insured or beneficiary arising out of any such contract.
(Formerly: Acts 1955, c.203, s.6.) As amended by P.L.252-1985, SEC.162.

IC 27-4-4-7
Construction

Sec. 7. This chapter is declared to be in addition and supplemental to other laws of the state of Indiana and shall be construed accordingly.
(Formerly: Acts 1955, c.203, s.7.) As amended by P.L.252-1985,

SEC.163.

IC 27-4-4-8
Short title

Sec. 8. This chapter may be cited as the Unauthorized Insurers Process Act.

(Formerly: Acts 1955, c.203, s.9.) As amended by P.L.252-1985, SEC.164.

IC 27-4-5
Chapter 5. Unauthorized Insurers Act

IC 27-4-5-1
Purpose; legislative declaration

Sec. 1. The purpose of this chapter is to subject certain insurers to the jurisdiction of the insurance commissioner and the courts of this state in suits by or on behalf of the state. The general assembly declares that it is concerned with the protection of residents of this state against acts by insurers not authorized to do an insurance business in this state, by the maintenance of fair and honest insurance markets, by protecting authorized insurers which are subject to regulation from unfair competition by unauthorized insurers, and by protecting against the evasion of the insurance regulatory laws of this state. In furtherance of such state interest, the general assembly provides methods in this chapter for substituted service of process upon such insurers in any proceeding, suit, or action in any court and substituted service of any notice, order, pleading, or process upon such insurers in any proceeding by the commissioner of insurance to enforce or effect full compliance with this title. In so doing, the state exercises its powers to protect residents of this state and to define what constitutes transacting an insurance business in this state, and also exercises powers and privileges available to this state by virtue of 15 U.S.C. 1011 through 1015, as amended, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states.

(Formerly: Acts 1969, c.194, s.1.) As amended by P.L.252-1985, SEC.165.

IC 27-4-5-2
Prohibition of unauthorized insurance business; exceptions; business by mail; venue; validity of contract; right to defend; prerequisites to action

Sec. 2. (a) It is a Class A infraction for an insurer to transact insurance business in this state, as set forth in subsection (b), without a certificate of authority from the commissioner. However, this section does not apply to the following:

(1) The lawful transaction of surplus lines insurance.

(2) The lawful transaction of reinsurance by insurers.

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

(4) Attorneys acting in the ordinary relation of attorney and client in the adjustment of claims or losses.

(5) Transactions in this state involving group life and group sickness and accident or blanket sickness and accident

insurance or group annuities where the master policy of such groups was lawfully issued and delivered in and pursuant to the laws of a state in which the insurer was authorized to do an insurance business, to a group organized for purposes other than the procurement of insurance, and where the policyholder is domiciled or otherwise has a bona fide situs.

(6) Transactions in this state relative to a policy issued or to be issued outside this state involving insurance on vessels, craft or hulls, cargos, marine builder's risk, marine protection and indemnity or other risk, including strikes and war risks commonly insured under ocean or wet marine forms of policy.

(7) Transactions in this state involving life insurance, health insurance, or annuities provided to religious or charitable institutions organized and operated without profit to any private shareholder or individual for the benefit of such institutions and individuals engaged in the service of such institutions.

(8) Transactions in this state involving contracts of insurance not readily obtainable in the ordinary insurance market and issued to one (1) or more industrial insureds. For purposes of this section, an "industrial insured" means an insured:

(A) who procures the insurance of any risk or risks by use of the services of a full-time employee acting as an insurance manager or buyer or the services of a regularly retained and continuously qualified insurance consultant;

(B) whose aggregate annual premium for insurance on all risks totals at least twenty-five thousand dollars ($25,000);

(C) who has at least twenty-five (25) full-time employees;

(D) who, on or before February 1 (for the preceding six (6) month period ending December 31) and August 1 (for the preceding six (6) month period ending June 30) of each year, remits to the department an amount equal to two and one-half percent (2.5%) of all gross premiums upon all policies and contracts procured by the insured under this section, plus:

(i) ten percent (10%) of the amount due for the first month after the date specified in this clause, during which the amount described in this clause is not remitted in compliance with this clause; and

(ii) an additional one percent (1%) of the amount due for each additional month during which the amount due under this clause is unpaid; and

(E) who files with the department, with the amount remitted under clause (D), an affidavit specifying all transactions undertaken and policies and contracts procured during the preceding calendar year, including the following:

(i) The description and location of the insured property or risk and the name of the insured.

(ii) The gross premiums charged for the policy or contract.

(iii) The name and home office address of the insurer that issues the policy or contract and the kind of insurance affected.

(iv) A statement that the insured, after diligent effort, was unable to procure from any insurer authorized to transact the particular kind of insurance business in Indiana the full amount of insurance coverage required to protect the insured.

(9) Transactions in Indiana involving the rendering of any service by any ambulance service provider and all fees, costs, and membership payments charged for the service. To qualify under this subdivision, the ambulance service provider:

(A) must have its ambulance service program approved by an ordinance of the legislative body of the county or city in which it operates; and

(B) may not offer any membership program that includes benefits exceeding one (1) year in duration.

(b) Any of the following acts in this state effected by mail or otherwise by or on behalf of an unauthorized insurer constitutes the transaction of an insurance business in this state. The venue of an act committed by mail is at the point where the matter transmitted by mail is delivered and takes effect. Unless otherwise indicated, the term "insurer" as used in this section includes all persons engaged as principals in the business of insurance and also includes interinsurance exchanges and mutual benefit societies.

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

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

(3) The taking or receiving of any application for insurance.

(4) The receiving or collection of any premium, commission, membership fees, assessments, dues, or other consideration for any insurance or any part thereof.

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

(6) Acting as an agent for or otherwise representing or aiding on behalf of another person or insurer in the solicitation, negotiation, procurement, or effectuation of insurance or renewals thereof or in the dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, a fixing of rates or investigation or adjustment of claims or losses or in the transaction of matters subsequent to effectuation of the contract and arising out of it, or representing or assisting a person or an insurer in the transaction of insurance with respect to subjects

of insurance resident, located, or to be performed in this state. This subdivision does not prohibit full-time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance in behalf of the employer.

(c)(1) The failure of an insurer transacting insurance business in this state to obtain a certificate of authority does not impair the validity of any act or contract of such insurer and does not prevent such insurer from defending any action at law or suit in equity in any court of this state, but no insurer transacting insurance business in this state without a certificate of authority may maintain an action in any court of this state to enforce any right, claim, or demand arising out of the transaction of such business until such insurer obtains a certificate of authority.

(2) In the event of failure of any such unauthorized insurer to pay any claim or loss within the provisions of such insurance contract, any person who assisted or in any manner aided directly or indirectly in the procurement of such insurance contract is liable to the insured for the full amount of the claim or loss in the manner provided by the insurance contract.

(Formerly: Acts 1969, c.194, s.2.) As amended by Acts 1978, P.L.2, SEC.2720; P.L.161-1988, SEC.1; P.L.130-1994, SEC.39; P.L.116-1994, SEC.51; P.L.252-1995, SEC.2; P.L.11-2011, SEC.25.

IC 27-4-5-3
Injunction

Sec. 3. Whenever the commissioner believes, from evidence satisfactory to the commissioner, that any insurer is violating or about to violate the provisions of section 2 of this chapter, the commissioner may cause a complaint to be filed in the circuit or superior court to enjoin and restrain such insurer from continuing such violation or engaging therein or doing any act in furtherance thereof. The court shall have jurisdiction of the proceeding and shall have the power to make and enter an order or judgment awarding such preliminary or final injunctive relief as in its judgment is proper.

(Formerly: Acts 1969, c.194, s.3.) As amended by P.L.252-1985, SEC.166; P.L.255-1995, SEC.5.

IC 27-4-5-4
Appointment of attorney for service of process; method of service

Sec. 4. (a) Any act of transacting an insurance business as set forth in section 2 of this chapter by any unauthorized insurer is equivalent to and shall constitute an irrevocable appointment by such insurer, binding upon him, his executor or administrator, or successor in interest if a corporation, of the secretary of state or his successor in office, to be the true and lawful attorney of such insurer upon whom may be served all lawful process in any action, suit, or

proceeding in any court by the commissioner of insurance or by the state and upon whom may be served any notice, order, pleading, or process in any proceeding before the commissioner of insurance and which arises out of transacting an insurance business in this state by such insurer. Any act of transacting an insurance business in this state by any unauthorized insurer shall be signification of its agreement that any such lawful process in such court action, suit, or proceeding and any such notice, order, pleading, or process in such administrative proceeding before the commissioner of insurance so served shall be of the same legal force and validity as personal service of process in this state upon such insurer.

(b) Service of process in such action shall be made by delivering to and leaving with the secretary of state, or some person in apparent charge of his office, two (2) copies thereof and by payment to the secretary of state of the fee prescribed by law. Service upon the secretary of state as such attorney shall be service upon the principal.

(c) The secretary of state shall forthwith forward by certified mail one (1) of the copies of such process or such notice, order, pleading, or process in proceedings before the commissioner to the defendant in such court proceeding or to whom the notice, order, pleading, or process in such administrative proceeding is addressed or directed at its last known principal place of business and shall keep a record of all process so served on him which shall show the day and hour of service. Such service is sufficient, provided:

(1) notice of such service and a copy of the court process or the notice, order, pleading, or process in such administrative proceeding are sent within ten (10) days thereafter by certified mail by the plaintiff or the plaintiff's attorney in the court proceeding or by the commissioner of insurance in the administrative proceeding to the defendant in the court proceeding or to whom the notice, order, pleading, or process in such administrative proceeding is addressed or directed at the last known place of business of the defendant in the court or administrative proceeding; and

(2) the defendant's receipt or receipts issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person or insurer to whom the letter is addressed, and an affidavit of the plaintiff or the plaintiff's attorney in court proceeding or of the commissioner of insurance in administrative proceeding, showing compliance therewith are filed with the clerk of the court in which such action, suit, or proceeding is pending or with the commissioner in administrative proceedings, on or before the date the defendant in the court or administrative proceeding is required to appear or respond thereto, or within such further time as the court or commissioner of insurance may allow.

(d) No plaintiff shall be entitled to a judgment or a determination

by default in any court or administrative proceeding in which court process or notice, order, pleading, or process in proceedings before the commissioner of insurance is served under this section until the expiration of forty-five (45) days from the date of filing of the affidavit of compliance.

(e) Nothing in this section shall limit or affect the right to serve any process, notice, order, or demand upon any person or insurer in any other manner permitted by law.

(Formerly: Acts 1969, c.194, s.4; Acts 1971, P.L.1, SEC.10.) As amended by P.L.252-1985, SEC.167.

IC 27-4-5-5

Prerequisites to pleading; deposit to secure payment of judgment; procuring certificate of authority; motion to quash

Sec. 5. (a) Before any unauthorized insurer files or causes to be filed in any pleading in any court action, suit, or proceeding or in any notice, order, pleading, or process in such administrative proceeding before the commissioner instituted against such person or insurer, by services made as provided in section 4 of this chapter, such insurer shall either:

(1) deposit with the clerk in which such action, suit, or proceeding is pending, or with the commissioner of insurance in administrative proceedings before the commissioner, cash or securities, or file with such clerk or commissioner a bond with good and sufficient sureties, to be approved by the clerk or commissioner in an amount to be fixed by the court or commissioner sufficient to secure the payment of any final judgment which may be rendered in such action or administrative proceeding; or

(2) procure a certificate of authority to transact the business of insurance in this state.

In considering the application of an insurer for a certificate of authority, for the purposes of this section the commissioner need not assert the provisions of IC 27-1-20-12 against such insurer with respect to its application if he determines that such company would otherwise comply with the requirements for such certificate of authority.

(b) The commissioner of insurance, in any administrative proceeding in which service is made as provided in section 4 of this chapter, may in his discretion order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of subsection (a) and to defend such action.

(c) Nothing in subsection (a) shall be construed to prevent an unauthorized insurer from filing a motion to quash a writ or to set aside service thereof made in the manner provided in section 4 of this chapter on the ground that such unauthorized insurer has not done any of the acts enumerated in section 2 of this chapter.

(Formerly: Acts 1969, c.194, s.5.) As amended by P.L.252-1985,

IC 27-4-5-6
Enforcement of orders in domestic or foreign courts; definitions; list of reciprocal states; enforcement of foreign decrees; stay; fees

Sec. 6. (a) The attorney general upon request of the commissioner may proceed in the courts of this state or any reciprocal state to enforce an order or decision in any court proceeding or in any administrative proceeding before the commissioner of insurance.

(b) The following definitions apply throughout this section:

(1) "Reciprocal state" means any state or territory of the United States the laws of which contain procedures substantially similar to those specified in this section for the enforcement of decrees or orders in equity issued by courts located in other states or territories of the United States, against any insurer incorporated or authorized to do business in said state or territory.

(2) "Foreign decree" means any decree or order in equity of a court located in a "reciprocal state," including a court of the United States located therein, against any insurer incorporated or authorized to do business in this state.

(3) "Qualified party" means a state regulatory agency acting in its capacity to enforce the insurance laws of its state.

(c) The insurance commissioner of this state shall determine which states and territories qualify as reciprocal states and shall maintain at all times an up-to-date list of such states.

(d) A copy of any foreign decree authenticated in accordance with the statutes of this state may be filed in the office of the clerk of any circuit or superior court of this state. The clerk, upon verifying with the insurance commissioner that the decree or order qualifies as a "foreign decree" shall treat the foreign decree in the same manner as a decree of a circuit or superior court of this state. A foreign decree so filed has the same effect and shall be deemed as a decree of a circuit or superior court of this state, and is subject to the same procedures, defenses and proceedings for reopening, vacating, or staying as a decree of a circuit or superior court of this state and may be enforced or satisfied in like manner.

(e) At the time of the filing of the foreign decree, the attorney general shall make and file with the clerk of the court an affidavit setting forth the name and last known post office address of the defendant.

(f) Promptly upon the filing of the foreign decree and the affidavit, the clerk shall mail notice of the filing of the foreign decree to the defendant at the address given and to the insurance commissioner of this state and shall make a note of the mailing in the docket. In addition, the attorney general may mail a notice of the filing of the foreign decree to the defendant and to the insurance commissioner of this state and may file proof of mailing with the

clerk. Lack of mailing notice of filing by the clerk shall not affect the enforcement proceedings if proof of mailing by the attorney general has been filed.

(g) No execution or other process for enforcement of a foreign decree filed under this section shall issue until 30 days after the date the decree is filed.

(h) If the defendant shows the circuit or superior court that an appeal from the foreign decree is pending or will be taken, or that a stay of execution has been granted, the court shall stay enforcement of the foreign decree until the appeal is concluded, the time for appeal expires, or the stay of execution expires or is vacated, upon proof that the defendant has furnished the security for the satisfaction of the decree required by the state in which it was rendered.

(i) If the defendant shows the circuit or superior court any ground upon which enforcement of a decree of any circuit or superior court of this state would be stayed, the court shall stay enforcement of the foreign decree for an appropriate period, upon requiring the same security for satisfaction of the decree which is required in this state.

(j) Any person filing a foreign decree shall pay to the clerk of court six dollars ($6). Fees for docketing, transcription, or other enforcement proceedings shall be as provided for decrees of the circuit or superior court.

(Formerly: Acts 1969, c.194, s.6.) As amended by P.L.1-1993, SEC.201.

IC 27-4-5-7
Repealed

(Repealed by Acts 1978, P.L.2, SEC.2728.)

IC 27-4-5-8
Short title

Sec. 8. This chapter may be cited as the Uniform Unauthorized Insurers Act.

(Formerly: Acts 1969, c.194, s.8.) As amended by P.L.252-1985, SEC.169.

IC 27-4-6

Chapter 6. Unauthorized Insurers False Advertising Process Act

IC 27-4-6-1

Purpose; liberal construction

Sec. 1. (a) The purpose of this chapter is to subject to the jurisdiction of the insurance commissioner of this state and to the jurisdiction of the courts of this state insurers, not authorized to transact business in this state, which place in or send into this state any false advertising designed to induce residents of this state to purchase insurance from insurers not authorized to transact business in this state. The legislature declares it is in the interest of the citizens of this state who purchase insurance from insurers which solicit insurance business in this state in the manner set forth in the preceding sentence that such insurers be subject to the provisions of this chapter. In furtherance of such state interest, the legislature provides in this chapter a method of substituted service of process upon such insurers and declares that in so doing, it exercises its power to protect its residents and also exercises powers and privileges available to the state by virtue of 15 U.S.C. 1011 et seq., which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states; the authority provided in this chapter to be in addition to any other powers of this state.

(b) The provisions of this chapter shall be liberally construed.

(Formerly: Acts 1963, c.163, s.1.) As amended by P.L.252-1985, SEC.170.

IC 27-4-6-2

Definitions

Sec. 2. When used in this chapter:

"Commissioner" shall mean the commissioner of insurance of this state.

"Residents" shall mean and include person, partnership, limited liability company, or corporation, domestic, alien, or foreign.

(Formerly: Acts 1963, c.163, s.2.) As amended by P.L.252-1985, SEC.171; P.L.8-1993, SEC.419.

IC 27-4-6-3

Advertising in violation of Unfair Trade Practice Act by unauthorized foreign or alien insurer; notice to insurer and supervisory official of domiciliary state

Sec. 3. No unauthorized foreign or alien insurer of the kind described in section 1 of this chapter shall make, issue, circulate, or cause to be made, issued, or circulated, to residents of this state any estimate, illustration, circular, pamphlet, or letter, or cause to be made in any newspaper, magazine, or other publication or over any

radio or television station, any announcement or statement to such residents misrepresenting its financial condition or the terms of any contracts issued or to be issued or the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon in violation of IC 27-4-1, and whenever the commissioner shall have reason to believe that any such insurer is engaging in such unlawful advertising, he shall give notice of such fact by registered mail to such insurer and to the insurance supervisory official of the domiciliary state of such insurer. For the purpose of this section, the domiciliary state of an alien insurer shall be deemed to be the state of entry or the state of the principal office in the United States.
(Formerly: Acts 1963, c.163, s.3.) As amended by P.L.252-1985, SEC.172.

IC 27-4-6-4
Failure of unauthorized foreign or alien insurer to cease unlawful advertising after notice; action under Unfair Trade Practice Act

Sec. 4. If after thirty (30) days following the giving of the notice mentioned in section 3 of this chapter such insurer has failed to cease making, issuing, or circulating such misrepresentations or causing the same to be made, issued, or circulated in this state, and if the commissioner has reason to believe that a proceeding by him in respect to such matters would be to the interest of the public, and that such insurer is issuing or delivering contracts of insurance to residents of this state or collecting premiums on such contracts or doing any of the acts enumerated in section 5 of this chapter, he shall take action against such insurer under IC 27-4-1.
(Formerly: Acts 1963, c.163, s.4.) As amended by P.L.252-1985, SEC.173.

IC 27-4-6-5
Acts of unauthorized foreign or alien insurer appointing commissioner as attorney for service of process; method of service

Sec. 5. (a) Any of the following acts in this state, effected by mail or otherwise, by any such unauthorized foreign or alien insurer:

(1) the issuance or delivery of contracts of insurance to residents of this state;
(2) the solicitation of applications for such contracts;
(3) the collection of premiums, membership fees, assessments or other considerations for such contracts; or
(4) any other transaction of insurance business;

is equivalent to and shall constitute an appointment by such insurer of the commissioner of insurance, and his successor or successors in office, to be its true and lawful attorney, upon whom may be served all statements of charges, notices and lawful process in any proceeding instituted in respect to the misrepresentations set forth in section 3 of this chapter under the provisions of IC 27-4-1 or in any

action, suit, or proceeding for the recovery of any penalty therein provided, and any such act shall be signification of its agreement that such service of statement of charges, notices, or process is of the same legal force and validity as personal service of such statement of charges, notices, or process in this state, upon such insurer.

(b) Service of a statement of charges and notices under IC 27-4-1 shall be made by any deputy or employee of the department of insurance delivering to and leaving with the commissioner or some person in apparent charge of his office, two (2) copies thereof. Service of process issued by any court in any action, suit, or proceeding to collect any penalty under IC 27-4-1 shall be made by delivering and leaving with the commissioner, or some person in apparent charge of his office, two (2) copies thereof. The commissioner shall forthwith cause to be mailed by registered mail one (1) of the copies of such statement of charges, notices, or process to the defendant at its last known principal place of business, and shall keep a record of all statements of charges, notices, and process so served. Such service of statement of charges, notices, or process shall be sufficient provided they shall have been so mailed and the defendant's receipt or receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the person mailing such letter showing a compliance with this section are filed with the commissioner in the case of any statement of charges or notices, or with the clerk of the court in which such action is pending in the case of any process, on or before the date the defendant is required to appear or within such further time as may be allowed.

(c) Service of statement of charges, notices, and process in any such proceeding, action, or suit shall, in addition to the manner provided in subsection (b), be valid if served upon any person within this state who on behalf of such insurer is:

(1) soliciting insurance;

(2) making, issuing, or delivering any contract of insurance; or

(3) collecting or receiving in this state any premium for insurance;

and a copy of such statement of charges, notices, or process is sent within ten (10) days thereafter by registered mail by or on behalf of the commissioner to the defendant at the last known principal place of business of the defendant, and the defendant's receipt, or the receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter, the name and address of the person to whom the letter is addressed, and the affidavit of the person mailing the same showing a compliance with this section are filed with the commissioner in the case of any statement of charges or notices, or with the clerk of the court in which such action is pending in the case of any process, on or before the date the defendant is required to appear or within such further time as the

court may allow.

(d) No cease or desist order or judgment by default or a judgment by confession under this section shall be entered until the expiration of thirty (30) days from the date of the filing of the affidavit of compliance.

(e) Service of process and notice under the provisions of this chapter shall be in addition to all other methods of service provided by law, and nothing in this chapter shall limit or prohibit the right to serve any statement of charges, notices, or process upon any insurer in any other manner permitted by law.

(Formerly: Acts 1963, c.163, s.5.) As amended by P.L.252-1985, SEC.174.

IC 27-4-6-6

Short title

Sec. 6. This chapter may be cited as the Unauthorized Insurers False Advertising Process Act.

(Formerly: Acts 1963, c.163, s.7.) As amended by P.L.252-1985, SEC.175.

IC 27-4-7
Repealed
(Repealed by P.L.1-1993, SEC.202.)

IC 27-4-8

Chapter 8. Foreign Plate Glass Insurers

IC 27-4-8-1

Capital requirements

Sec. 1. Any person or persons, or any copartnership, company, or corporation organized under the laws of any other state than this state, or any foreign country, and engaged in the business of insuring plate glass, shall be allowed and permitted to do and transact such business in this state when such company is possessed of at least one hundred thousand dollars ($100,000) of actual capital invested in the stock or bonds of some one (1) or more of the states of this Union or of the United States, or the bonds of some one (1) or more of the counties, cities, or towns of this state at the current value thereof, and when such company and its agents shall have fully complied with all the provisions and requirements of the laws of this state regulating foreign insurance companies, except so much thereof as requires a capital of two hundred thousand dollars ($200,000); provided, that companies engaged in insuring plate glass and having less than two hundred thousand dollars ($200,000) capital invested as required in this chapter shall not engage in or transact any other kind of business; provided, that whenever it shall appear to the insurance commissioner that any such company, having one hundred thousand dollars ($100,000) capital, shall have been, directly or indirectly, doing business in this state prior to March 9, 1889, he shall not issue license to such company, or authorize it to do business in this state, until it shall have paid all taxes, fees, and penalties which should have been chargeable to it had it, during such time, been authorized to do business in this state, and not violated any of the laws governing foreign insurance companies.

(Formerly: Acts 1889, c.199, s.1.) As amended by P.L.252-1985, SEC.179.

IC 27-4-9

Chapter 9. Recommendations to Senior Consumers

IC 27-4-9-1

"Securities commissioner"

Sec. 1. As used in this chapter, "securities commissioner" refers to the commissioner appointed by the secretary of state under IC 23-19-6-1(a).

As added by P.L.138-2005, SEC.2. Amended by P.L.27-2007, SEC.28.

IC 27-4-9-2

"Consumer"

Sec. 2. As used in this chapter, "consumer" means an individual who receives a recommendation to purchase or exchange an annuity that results in the recommended purchase or exchange.

As added by P.L.138-2005, SEC.2. Amended by P.L.131-2007, SEC.2.

IC 27-4-9-3

Suitability of annuity recommendations

Sec. 3. (a) An insurance producer, or an insurer in a case in which an insurance producer is not involved, shall not recommend to a consumer the:

(1) purchase of an annuity; or

(2) exchange of an annuity that results in another insurance transaction;

that is unsuitable for the consumer.

(b) A determination regarding whether a purchase or an exchange under subsection (a) is unsuitable for a consumer must be made:

(1) based on the facts disclosed by the consumer concerning the consumer's:

(A) investments and other insurance products; and

(B) financial situation and needs; and

(2) according to the rule adopted under section 4 of this chapter.

As added by P.L.138-2005, SEC.2. Amended by P.L.131-2007, SEC.3.

IC 27-4-9-4

Rules

Sec. 4. (a) The department shall adopt rules under IC 4-22-2 to implement this chapter.

(b) The rules adopted under subsection (a) must set forth the duties that apply to an insurer or an insurance producer in determining whether reasonable grounds exist to believe that a recommendation to purchase or exchange an annuity is suitable for a consumer to whom the recommendation is made based on the facts disclosed by the consumer concerning the consumer's investments,

other insurance products, and financial situation and needs.
As added by P.L.138-2005, SEC.2. Amended by P.L.131-2007, SEC.4.

IC 27-4-9-5
Violations

Sec. 5. (a) Except as provided in subsection (b), a recommendation made in violation of section 3 of this chapter is an unfair method of competition or an unfair and deceptive act or practice under IC 27-4-1-4.

(b) A recommendation made in violation of section 3 of this chapter is not an unfair method of competition or an unfair and deceptive act or practice under IC 27-4-1-4 if the recommendation is made in compliance with the National Association of Securities Dealers Conduct Rules concerning suitability, as determined by the commissioner.
As added by P.L.138-2005, SEC.2.

IC 27-4-9-6
Commissioner actions concerning compliance

Sec. 6. (a) The commissioner may conduct an investigation, pursue an enforcement action, and take other official action that the commissioner considers appropriate to ensure compliance with section 3 of this chapter.

(b) With regard to a variable annuity, the commissioner may:

(1) consult with the securities commissioner; and

(2) use the resources of the securities commissioner;

in making a final determination regarding any issue concerning compliance with section 3 of this chapter.

(c) If the securities commissioner is informed of a violation or suspected violation of section 3 of this chapter or other insurance laws of the state, the securities commissioner shall timely advise the commissioner of the violation or suspected violation.
As added by P.L.138-2005, SEC.2.

IC 27-5

ARTICLE 5. REPEALED

(Repealed by P.L.129-2003, SEC.15.)

IC 27-5.1

ARTICLE 5.1. FARM MUTUAL INSURANCE COMPANIES

IC 27-5.1-1

Chapter 1. Definitions

IC 27-5.1-1-1

Application

Sec. 1. The definitions in this chapter apply throughout this article.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-1-2

"Assessment"

Sec. 2. "Assessment" means an amount or a policyholder's share of an amount that a farm mutual insurance company determines is necessary for any of the following:

(1) To pay the farm mutual insurance company's accrued liabilities.

(2) To meet or defray the farm mutual insurance company's anticipated needs.

(3) To add to or restore the policyholder surplus of the farm mutual insurance company.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-1-3

"Certificate of authority"

Sec. 3. "Certificate of authority" has the meaning set forth in IC 27-1-2-3(v).

As added by P.L.129-2003, SEC.8.

IC 27-5.1-1-4

"Commissioner"

Sec. 4. "Commissioner" means the insurance commissioner appointed under IC 27-1-1-2.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-1-5

"Department"

Sec. 5. "Department" means the department of insurance created by IC 27-1-1-1.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-1-6

"Extended company"

Sec. 6. "Extended company" means a farm mutual insurance company that is authorized to provide coverage as described in

IC 27-5.1-4.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-1-7
"Farm mutual insurance company"
Sec. 7. "Farm mutual insurance company" means a company (as defined in IC 27-1-2-3) that is authorized to provide insurance coverage under this article.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-1-8
"First class city"
Sec. 8. "First class city" refers to a first class city as classified under IC 36-4-1-1.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-1-9
"Initial charge"
Sec. 9. "Initial charge" means a charge that is collected by a farm mutual insurance company before or at the time of the issuance or renewal of an insurance policy under this article.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-1-10
"Person"
Sec. 10. "Person" means an individual or a business entity.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-1-11
"Policyholder"
Sec. 11. "Policyholder" means a person who is insured by a farm mutual insurance company.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-1-12
"Policyholder surplus"
Sec. 12. "Policyholder surplus" means the accumulated assets of a farm mutual insurance company that exceed the farm mutual insurance company's accrued losses and expenses.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-1-13
"Premium"
Sec. 13. "Premium" means money given in consideration to a farm mutual insurance company on account of or in connection with an insurance policy for a specified policy period.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-1-14
"Premium plus assessment"

Sec. 14. "Premium plus assessment" refers to an insurance policy under which the policyholder is:

(1) obligated to pay a premium; and
(2) subject to potential assessment.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-1-15
"Principal office"

Sec. 15. "Principal office" means the primary office maintained by a farm mutual insurance company in Indiana.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-1-16
"Standard company"

Sec. 16. "Standard company" means a farm mutual insurance company that may provide insurance coverage under IC 27-5.1-3. The term does not include an extended company.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2

Chapter 2. Farm Mutual Insurance Companies

IC 27-5.1-2-0.1

Application of certain amendments to chapter

Sec. 0.1. The amendments made to section 8 of this chapter by P.L.137-2006 and P.L.162-2006 apply only to taxable years beginning after December 31, 2005.

As added by P.L.220-2011, SEC.431.

IC 27-5.1-2-1

Applicability

Sec. 1. This chapter applies to a farm mutual insurance company regulated under this article.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-2

Farm mutual insurance companies existing on June 30, 2003

Sec. 2. (a) A farm mutual insurance company that holds a certificate of authority to do business in Indiana on June 30, 2003, is a standard company under this article unless the farm mutual insurance company:

(1) elects to become an extended company under IC 27-5.1-4; and

(2) is authorized by the commissioner to do business as an extended company.

(b) A standard company described in subsection (a) may elect to become an extended company at any time by:

(1) complying with IC 27-5.1-4-2(b); and

(2) submitting to an examination that may be conducted at the discretion of the commissioner.

(c) An election made under this section is effective upon the date the commissioner issues a new certificate of authority.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-3

Proposed farm mutual insurance companies; application for certificate of authority

Sec. 3. (a) If a proposed farm mutual insurance company does not hold a certificate of authority to do business in Indiana on June 30, 2003, an application may be made to the commissioner on a form prescribed by the commissioner for a certificate of authority for the proposed farm mutual insurance company to do business in Indiana as a standard company.

(b) An application described in subsection (a) must include the following concerning the proposed farm mutual insurance company:

(1) The name.

(2) The location and address of the principal office.

(3) The names and addresses of the officers and directors.
(4) Three (3) copies of the articles of incorporation.
(5) A copy of the bylaws.

(c) A standard company described in subsection (a), not earlier than three (3) years after it is granted a certificate of authority to do business as a standard company, may elect to obtain a certificate of authority to do business as an extended company if the standard company:

(1) has an annual direct written premium of more than one million dollars ($1,000,000); and
(2) complies with IC 27-5.1-4-2.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-4
Proposed farm mutual insurance company requirements for certificate of authority

Sec. 4. A farm mutual insurance company that is established after June 30, 2003, must have at least:

(1) two hundred fifty (250) applications for insurance policies; and
(2) one hundred thousand dollars ($100,000) in annual direct written premiums;

before issuing an insurance policy.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-5
Powers and duties

Sec. 5. (a) A farm mutual insurance company has all the powers, rights, privileges, duties, and obligations of a company organized under IC 27-1-6 except where IC 27-1-6 is inconsistent with this article.

(b) A farm mutual insurance company has the following:

(1) The power to borrow money.
(2) The ability to sue or be sued.
(3) The power to make contracts of insurance or indemnity with:
    (A) a person;
    (B) a firm;
    (C) a public corporation;
    (D) a private corporation;
    (E) a board;
    (F) an association;
    (G) an estate; or
    (H) a trustee or legal representative of an estate.
(4) The power to cede or obtain reinsurance from an insurance company legally operating in Indiana.
(5) The power to participate with a financially stable insurance company in:

(A) a plan for reinsurance; or
(B) catastrophe protection.
(6) The power to determine the qualifications and the manner by which to admit or withdraw policyholders.
(7) The power to use a common seal, which the farm mutual insurance company may change or alter.
(8) The power to purchase, lease, hold, and dispose of:
(A) real property; and
(B) personal property;
in the farm mutual insurance company's name for use in carrying out the purposes of the farm mutual insurance company.
(9) The power to classify risks according to the hazards involved.
(10) The power to establish rates according to the classification of risk.
(11) The power to determine the acceptability of risk and hazards insured.
(12) The power to determine the cost of insurance issued by the farm mutual insurance company and the adjustment and payment of losses.
(13) The power to determine the compensation of directors and officers of the farm mutual insurance company.
(14) The power to require that directors and officers of the farm mutual insurance company be bonded in the performance of the duties of the directors and officers.
(15) The power to adopt or amend bylaws and articles of incorporation of the farm mutual insurance company.
(16) The power to adopt or amend policy forms and application forms used by the farm mutual insurance company.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-6
Exclusion of companies
Sec. 6. A farm mutual insurance company with an annual direct written premium of more than ten million dollars ($10,000,000) may not function as a farm mutual insurance company and shall be regulated as a domestic mutual insurance company described in IC 27-1-6-15.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-7
Exemption from Indiana insurance laws
Sec. 7. Except as provided in section 8 of this chapter, a farm mutual insurance company that operates under this article is exempt from any other Indiana insurance law unless the law expressly states that the law is applicable to a farm mutual insurance company.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-8
Application of Indiana insurance laws

Sec. 8. The following provisions apply to standard companies and extended companies:

(1) IC 27-1-3.
(2) IC 27-1-3.1.
(3) IC 27-1-5-3.
(4) IC 27-1-7-14 through IC 27-1-7-16.
(5) IC 27-1-7-21 through IC 27-1-7-23.
(6) IC 27-1-9.
(7) IC 27-1-10.
(8) IC 27-1-13-3 through IC 27-1-13-4.
(9) IC 27-1-13-6 through IC 27-1-13-9.
(10) IC 27-1-15.6.
(11) IC 27-1-18-2.
(12) IC 27-1-20-1.
(13) IC 27-1-20-4.
(14) IC 27-1-20-6.
(15) IC 27-1-20-9 through IC 27-1-20-11.
(16) IC 27-1-20-14.
(17) IC 27-1-20-19 through IC 27-1-20-21.3.
(18) IC 27-1-20-23.
(19) IC 27-1-20-30.
(20) IC 27-1-20-35.
(21) IC 27-1-22.
(22) IC 27-4-1.
(23) Except as provided in IC 27-6-1.1-6, IC 27-6-1.1-2.
(24) IC 27-6-2.
(25) IC 27-7-2.
(26) IC 27-9.
(27) IC 34-30-17.

As added by P.L.129-2003, SEC.8. Amended by P.L.137-2006, SEC.14 and P.L.162-2006, SEC.47; P.L.81-2012, SEC.21.

IC 27-5.1-2-9
Location of insurance business

Sec. 9. A farm mutual insurance company may engage in the business of insurance in any location in Indiana other than a first class city. However, a farm mutual insurance company may continue to insure property in a first class city in Indiana if the insurance policy under which the property is insured was originally issued before July 1, 2003, or if the insurance policy was originally issued before the city became a first class city.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-10
Annual policyholder meeting

Sec. 10. (a) A farm mutual insurance company shall hold an

annual meeting of the policyholders of the farm mutual insurance company on the date, time, and location set forth in the articles of incorporation of the farm mutual insurance company. If the articles of incorporation do not specify the date, time, and location of the annual meeting, the meeting shall be held on the first Monday in April at the registered principal office of the farm mutual insurance company.

(b) A quorum for purposes of an annual policyholder meeting must be defined in a farm mutual insurance company's articles of incorporation.

(c) Each policyholder of a farm mutual insurance company is entitled to one (1) vote on any issue voted upon at a policyholder meeting.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-11
Board of directors

Sec. 11. (a) A farm mutual insurance company shall elect a board of directors consisting of at least five (5) policyholders.

(b) To be elected to the board of directors of a farm mutual insurance company, an individual must be the owner of an insurance policy issued by the farm mutual insurance company.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-12
Election of director; term of office; election of officers; annual board meeting

Sec. 12. (a) Unless a farm mutual insurance company's articles of incorporation specify otherwise, a director of a farm mutual insurance company must be elected at the farm mutual insurance company's annual policyholder meeting by the affirmative vote of a majority of:

(1) the policyholders present and voting; and

(2) the policyholders voting by proxy, if voting by proxy is allowed by the farm mutual insurance company's articles of incorporation.

(b) The term of office of a director must be at least one (1) year but not more than five (5) years. A farm mutual insurance company's articles of incorporation may provide for the classification of directors into three (3) groups, and the terms of the directors may be staggered. A vacancy on the board of directors may be filled for the unexpired term through an appointment made by the remaining directors.

(c) The board of directors of a farm mutual insurance company shall, by vote of a majority of the directors, elect the officers designated in the farm mutual insurance company's bylaws. The directors may also elect any additional officers that the directors determine are necessary. An officer elected under this subsection is

not required to be a director.

(d) The term of an officer elected under subsection (c) may not be less than one (1) year or more than three (3) years. An outgoing officer shall hold office until the officer's successor is either elected or selected and qualified.

(e) The board of directors of a farm mutual insurance company shall hold a separate meeting of the board of directors immediately after the farm mutual insurance company's annual meeting.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-13

Articles of incorporation; amendment

Sec. 13. (a) Unless a farm mutual insurance company's articles of incorporation specify otherwise, the articles of incorporation of a farm mutual insurance company may be amended by an affirmative vote of two-thirds (2/3) of the farm mutual insurance company's policyholders who are voting in person or by proxy at any policyholder meeting if the policyholders are given at least thirty (30) days notice of:

(1) the meeting; and

(2) the subject matter of the proposed amendments.

(b) After a farm mutual insurance company has adopted an amendment to the farm mutual insurance company's articles of incorporation, three (3) copies of the amendment must be filed with the commissioner.

(c) The commissioner shall determine whether to approve an amendment specified under subsection (b) and, if the amendment is approved, shall return a copy of the filed amendment and a certificate of approval to the farm mutual insurance company.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-14

Bylaws; amendment

Sec. 14. (a) Bylaws of a farm mutual insurance company may be amended by the farm mutual insurance company in accordance with the farm mutual insurance company's articles of incorporation. All amendments to the bylaws must be filed with the commissioner.

(b) Bylaws of a farm mutual insurance company may not be inconsistent with this article, other applicable laws, or the farm mutual insurance company's articles of incorporation.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-15

Commissioner filing fee

Sec. 15. The commissioner may charge a farm mutual insurance company a reasonable fee, as provided in IC 27-1-3-15, for a filing under this article.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-16
Form and rate filing file and use; commissioner disapproval; judicial review

Sec. 16. (a) A farm mutual insurance company may not deliver or issue for delivery an insurance policy or an endorsement or a rider to an insurance policy until a copy of the form and the rates charged for the insurance policy are filed with the commissioner.

(b) A farm mutual insurance company may use any form or rate filed with the commissioner unless the commissioner notifies the farm mutual insurance company in writing that the form is disapproved not more than thirty (30) days after the commissioner's receipt of the rate or form filing. The commissioner may disapprove a rate or form for the following reasons:

(1) An inconsistency with this article or another applicable state law.

(2) A provision that is:

(A) deceptive;

(B) ambiguous; or

(C) misleading.

(c) If the commissioner disapproves a rate or form under this section, the commissioner shall notify the farm mutual insurance company of the reason that the rate or form was disapproved. The farm mutual insurance company may request a hearing before the commissioner under IC 4-21.5 concerning the disapproval.

(d) A farm mutual insurance company may seek judicial review under IC 4-21.5-5 of the commissioner's final disapproval of a rate or form under this section.

(e) The commissioner may charge a farm mutual insurance company a reasonable fee as provided in IC 27-1-3-15 for the filing of a rate or form.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-17
Commissioner examination

Sec. 17. (a) The commissioner may examine the affairs of a farm mutual insurance company under IC 27-1-3.1.

(b) The commissioner may take an action that may protect a policyholder's interest if the commissioner determines that a farm mutual insurance company conducts business in a manner that is:

(1) contrary to law applying to a farm mutual insurance company; or

(2) detrimental to policyholder interests.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-18
Unsafe business practice; insufficient assets; commissioner notice; remedies; court proceedings; injunction; liquidation

Sec. 18. (a) If the commissioner determines from:

(1) a statement filed by a farm mutual insurance company;
(2) an examination under section 17 of this chapter; or
(3) other information obtained by the commissioner;

that a farm mutual insurance company is conducting business in an unsafe manner or that a farm mutual insurance company's assets are insufficient to justify continuing the business, the commissioner shall send written notice of the commissioner's concerns regarding the farm mutual insurance company to the officers and directors of the farm mutual insurance company.

(b) Not more than thirty (30) days after receiving a notice under subsection (a), the farm mutual insurance company's officers and directors shall:

(1) remedy; or
(2) establish a plan to remedy;

the commissioner's concerns.

(c) If:

(1) a farm mutual insurance company does not remedy or establish a plan to remedy the commissioner's concerns under subsection (b); or
(2) the commissioner determines that the continuation of a farm mutual insurance company is not in the best interests of the farm mutual insurance company's policyholders;

the commissioner shall institute proceedings in the Marion County circuit court to enjoin the farm mutual insurance company from conducting any further business transactions.

(d) If the commissioner seeks a permanent injunction against a farm mutual insurance company under subsection (c), the commissioner shall also institute proceedings to settle and wind up the affairs of the farm mutual insurance company and liquidate and dissolve the farm mutual insurance company, as provided in IC 27-9.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-19
Application for coverage; policyholder status

Sec. 19. (a) A person, including a person described in subsection (b), that has a risk that is insurable under this article in a territory in which a farm mutual insurance company operates may apply for insurance coverage with the farm mutual insurance company. If the farm mutual insurance company accepts the person as a policyholder, the person becomes a policyholder of the farm mutual insurance company and is entitled to all the rights and privileges of a policyholder.

(b) Any of the following that own property within the territory of a farm mutual insurance company may apply for insurance, enter into an agreement for an insurance policy, and hold an insurance policy issued by a farm mutual insurance company:

(1) A corporation.
(2) An estate.

(3) An association.

(c) An officer, a trustee, a board member, or a legal representative of an entity described in subsection (b) may be recognized as acting for or on behalf of the entity for the purpose of membership.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-20

Insurance producers

Sec. 20. A person that solicits or negotiates insurance on behalf of a farm mutual insurance company must be licensed as an insurance producer under IC 27-1-15.6.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-21

Merger; plan; policyholder notice

Sec. 21. (a) Two (2) or more farm mutual insurance companies may merge into one (1) farm mutual insurance company upon approval of a merger plan by the policyholders of each farm mutual insurance company as provided in subsection (b).

(b) Before a merger described in subsection (a) may take place:

(1) the board of directors of each farm mutual insurance company must approve a merger plan; and

(2) the merger plan must be approved by the affirmative vote of two-thirds (2/3) of the policyholders of each farm mutual insurance company who vote in person or by proxy.

(c) Before a meeting at which a proposed merger under this section may be considered:

(1) the policyholders of a farm mutual insurance company for which the merger is proposed must be provided, by first class mail:

(A) written notice of the date, time, and location of the meeting;

(B) written notice that a proposed merger will be discussed and voted on at the meeting; and

(C) a copy or summary of the merger plan; and

(2) a general notice stating:

(A) the date, time, and location of the meeting; and

(B) that a proposed merger or transfer will be discussed and voted on at the meeting;

must be published in a newspaper of general circulation in the county in which the principal office of the farm mutual insurance company is located.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-22

Merger files; commissioner review; notice and hearing; approval; modification; experts; costs

Sec. 22. (a) Each farm mutual insurance company that decides to

merge under section 21 of this chapter shall file the following documents with the commissioner:

(1) A petition for merger.

(2) The farm mutual insurance company's merger plan.

(3) Articles of merger.

(4) A copy of the minutes of a meeting at which the merger plan was approved.

(5) Proof of compliance with section 21 of this chapter.

(b) The commissioner shall:

(1) review a filing submitted under subsection (a); and

(2) schedule a hearing under IC 4-21.5 if the commissioner considers a hearing necessary.

The commissioner may waive a hearing under this subsection if the commissioner determines that a proposed merger does not prejudice the interests of policyholders of the farm mutual insurance company.

(c) If the commissioner determines under subsection (b) that a hearing is necessary, the commissioner shall provide written notice of the hearing to the farm mutual insurance company that filed the petition for merger. The commissioner may require the farm mutual insurance company to provide the farm mutual insurance company's policyholders with written notice of the hearing, including the date, time, and place of the hearing.

(d) If the commissioner requires a farm mutual insurance company to provide the farm mutual insurance company's policyholders with notice of a hearing under subsection (c), the notice must meet the following requirements:

(1) Be published in at least two (2) daily newspapers that the commissioner may designate.

(2) Be published in the newspapers designated under subdivision (1):

(A) not less than one (1) time per week;

(B) for two (2) successive weeks; and

(C) on the same day of the week.

(3) The last publication of notice must appear not more than five (5) calendar days before the date of the hearing.

(e) The commissioner may require a farm mutual insurance company to provide more notice than is required by subsection (d) if the commissioner determines that more notice is required under the circumstances concerning the farm mutual insurance company.

(f) In a hearing conducted under this section, the commissioner may examine a farm mutual insurance company's business affairs by:

(1) requiring and compelling the production of documents, records, books, papers, contracts, or other evidence; and

(2) compelling the attendance of, and examining under oath, a director, an officer, an agent, an employee, a solicitor, or an attorney of the farm mutual insurance company, or another person.

(g) A person who has an interest in a hearing conducted under this

section may appear and testify at the hearing.

(h) The commissioner shall approve and authorize a proposed merger if the commissioner determines the following:

(1) That the interests of policyholders of the merging farm mutual insurance companies are properly protected.

(2) That a reasonable objection to the proposed merger does not exist.

(i) The commissioner may order a modification of the merger plan or articles of merger for a proposed merger if the commissioner determines that the modification is in the best interest of policyholders.

(j) The commissioner may hire experts the commissioner considers necessary to review a merger plan filed under this section.

(k) A farm mutual insurance company that files a petition for merger shall pay the costs of a hearing under this section.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-23

Merger plan performance; surviving company

Sec. 23. (a) The commissioner may establish the time frame in which a farm mutual insurance company must perform the terms of a merger plan approved under section 22 of this chapter.

(b) After a farm mutual insurance company that is a party to a merger under sections 21 and 22 of this chapter performs the terms of the merger plan, the surviving farm mutual insurance company shall file with the commissioner written notice of the surviving farm mutual insurance company's compliance with the merger plan.

(c) The commissioner shall determine whether the terms of a merger plan are performed adequately by a farm mutual insurance company that is a party to a merger under sections 21 and 22 of this chapter. If the commissioner determines that the terms of the merger plan are met, the commissioner shall issue a certificate of merger to the surviving farm mutual insurance company.

(d) The commissioner may charge a farm mutual insurance company the fee set forth in IC 27-1-3-15 for a filing made under this section.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-24

Certificate of merger

Sec. 24. Upon the commissioner's issuance of a certificate of merger under section 23 of this chapter, the farm mutual insurance companies that are parties to the merger plan become a single surviving farm mutual insurance company. The separate existence of each farm mutual insurance company that is a party to the merger plan ceases upon the issuance of the certificate of merger.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-25
Notice of contract to manage or control; commissioner determination; managing general agent

Sec. 25. (a) A person that intends to enter into a contract for the exclusive or dominant right to manage or control a farm mutual insurance company shall file notice of the contract with the commissioner at least thirty (30) days before entering into the contract.

(b) The commissioner may approve a contract or proposed contract described in subsection (a) only if the contract is not detrimental to:

(1) the policyholders of the farm mutual insurance company; or
(2) the public.

(c) If the commissioner disapproves a contract or proposed contract described in subsection (a), the commissioner shall provide written notice of the disapproval to the parties to the contract. A person that entered into a contract described in subsection (a) may not manage or control the farm mutual insurance company under the contract after receiving notice of the commissioner's disapproval of the contract.

(d) A person that enters into a contract for the exclusive or dominant right to manage or control a farm mutual insurance company is the managing general agent (as defined in IC 27-1-33-4) of the farm mutual insurance company and shall comply with the requirements that apply to a managing general agent under IC 27.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-26
Violations of law; commissioner orders

Sec. 26. If the commissioner determines, after notice and a hearing under IC 4-21.5, that a farm mutual insurance company has violated a provision of this article or a rule or order issued under this article, the commissioner may issue an order requiring the farm mutual insurance company to refrain from the unlawful practice or to take an affirmative action that the commissioner considers necessary to carry out the purposes of this article.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-27
Judicial review

Sec. 27. (a) A decision, a determination, or an order of the commissioner under section 26 of this chapter is subject to judicial review under IC 4-21.5-5.

(b) If a farm mutual insurance company does not seek judicial review of the commissioner's determination to issue an order under section 26 of this chapter less than thirty (30) days after the commissioner notifies the farm mutual insurance company of the commissioner's determination, the order is final.

(c) If a farm mutual insurance company seeks judicial review of the commissioner's determination under section 26 of this chapter and the commissioner's determination is upheld, the order is final.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-28
Willful violation; penalties

Sec. 28. If a farm mutual insurance company willfully violates a provision of an order under section 26 of this chapter, the commissioner may do the following:

(1) Impose a civil penalty on the farm mutual insurance company of not more than ten thousand dollars ($10,000).

(2) Suspend or revoke the farm mutual insurance company's certificate of authority.

(3) Institute proceedings to enjoin the farm mutual insurance company from conducting further business.

(4) Institute proceedings to wind up the affairs of the farm mutual insurance company.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-29
Notice of intent to waive term of policy, right, or defense

Sec. 29. (a) A farm mutual insurance company may not waive:

(1) a term of an insurance policy; or

(2) a right or defense of the farm mutual insurance company;

unless the farm mutual insurance company states in a letter or other written or printed document to a policyholder that the farm mutual insurance company intends to specifically waive the term, right, or defense.

(b) A letter or other written or printed document required under subsection (a) must include the signature of an officer or other representative of the farm mutual insurance company who is authorized to execute the particular type of waiver.

(c) A letter or other written or printed document under this section is the only admissible evidence of a waiver by the farm mutual insurance company.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-30
Premium plus assessment basis; policyholder liability

Sec. 30. (a) A policyholder of a farm mutual insurance company operating on a premium plus assessment basis under this article is liable for the policyholder's share of the amount necessary to:

(1) pay the losses and necessary expenses incurred by the farm mutual insurance company; and

(2) maintain an adequate reserve or safety fund as determined by the farm mutual insurance company's directors;

while the policyholder's insurance policy is in effect.

(b) Notwithstanding subsection (a), a farm mutual insurance company shall limit a policyholder's contingent liability during any one (1) year to an amount not to exceed the limitation set forth in the farm mutual insurance company's bylaws. The limitation set forth in the farm mutual insurance company's bylaws under this subsection must be an amount equal to not less than three percent (3%) of the insurance carried by the policyholder.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-31
Assessment collection; verification of loss

Sec. 31. (a) A farm mutual insurance company shall collect an assessment from a policyholder in the manner prescribed by the farm mutual insurance company's bylaws.

(b) After a farm mutual insurance company that operates on a premium plus assessment basis receives:

(1) notice of a loss or damage to a policyholder's property; or

(2) a judgment against the farm mutual insurance company;

the directors of the farm mutual insurance company shall verify the loss, damage, or judgment and shall, subject to the limitation set forth in the farm mutual insurance company's bylaws under section 30 of this chapter, assess each policyholder an amount proportionate to the amount of risk the policyholder has with the farm mutual insurance company.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-32
Policyholder failure to pay assessment

Sec. 32. (a) If a policyholder is assessed and fails to pay the assessment, the farm mutual insurance company may, upon providing written notice of failure to pay:

(1) suspend the farm mutual insurance company's liability for loss under the policyholder's insurance policy for the time during which the assessment is not paid; or

(2) cancel the policyholder's insurance policy if the assessment is not paid less than thirty (30) days after notice of the assessment is sent to the policyholder.

The farm mutual insurance company may deduct the assessment from the policyholder's deposit before returning the remainder of a deposit, if any, to the policyholder.

(b) If an assessment is paid by a policyholder after a farm mutual insurance company takes an action under subsection (a), the farm mutual insurance company may reinstate the policyholder's insurance policy effective beginning on the date on which the payment is received, but a deduction or credit may not be made to an assessment because of the suspension of the insurance policy.

(c) A farm mutual insurance company may file an action to compel a policyholder to pay an assessment.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-33
Policyholder liability after policy termination

Sec. 33. (a) A policyholder is not liable for an assessment of losses or expenses that are incurred by a farm mutual insurance company after the policyholder has terminated the policyholder's insurance policy.

(b) A former policyholder is not liable for an assessment for obligations incurred by a farm mutual insurance company before the policyholder terminated the insurance policy on which the assessment is made unless the farm mutual insurance company gives the former policyholder notice of the assessment less than one (1) year after the date of termination of the insurance policy.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-34
Notice of premium plus assessment policy; civil actions; limitation

Sec. 34. (a) A premium plus assessment insurance policy must expressly and prominently state on the face page of the insurance policy that the insurance policy is a premium plus assessment insurance policy.

(b) A suit or action for a loss under a premium plus assessment insurance policy may not be commenced until:

(1) the loss is due in accordance with the premium plus assessment insurance policy; or

(2) not less than sixty (60) days after proof of loss was given to the farm mutual insurance company that issued the premium plus assessment insurance policy.

(c) Requirements that a policyholder must meet to sustain a legal cause of action under this section must be disclosed clearly and prominently on the face page of the premium plus assessment insurance policy.

(d) Notwithstanding IC 34-11-2-11, the statute of limitations for a claim on a premium plus assessment insurance policy under this section is two (2) years after the date of the loss.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-35
Payment of losses and judgments; insufficient funds; assessments

Sec. 35. (a) A farm mutual insurance company that operates on a premium plus assessment basis must pay losses and judgments of the farm mutual insurance company from premiums received or amounts collected on promissory notes. The amount:

(1) deducted from a policyholder's premium paid; or

(2) demanded from a policyholder's promissory note;

must bear the same relationship to the total loss as the policyholder's total premium bears to the total premiums collected in the calendar

year that the loss is incurred.

(b) If funds collected under subsection (a) are insufficient to cover a loss or judgment, the directors of the farm mutual insurance company may, subject to the limitation set forth in the farm mutual insurance company's bylaws under section 30 of this chapter, assess each policyholder in the same manner. However, a farm mutual insurance company may not assess policyholders more than one (1) time in a calendar year for losses incurred by the farm mutual insurance company.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-36

Borrowing funds; assessment

Sec. 36. (a) A farm mutual insurance company may borrow money for the payment of accrued losses and expenses.

(b) A farm mutual insurance company that borrows money under subsection (a) shall assess policyholders the full amount necessary to fully repay the loan in the assessment immediately following the date the money is borrowed. Unless the commissioner authorizes a longer period, the assessment must be levied not more than twelve (12) months after the losses or expenses paid by the farm mutual insurance company through the loan are incurred.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-37

Policy cancellation; notice

Sec. 37. (a) A farm mutual insurance company may cancel, in whole or in part, a policyholder's insurance policy after giving the policyholder written notice of the cancellation as follows:

(1) The written notice must be delivered or mailed to the policyholder at the last known address of the policyholder.

(2) The written notice must specify the effective date of the cancellation.

(3) Upon request of the policyholder, the written notice must be accompanied by a written explanation of the specific reasons for the cancellation.

(b) A farm mutual insurance company shall provide the written notice specified in subsection (a) at least:

(1) ten (10) days before canceling the insurance policy, if the cancellation is for nonpayment of premium;

(2) twenty (20) days before canceling the insurance policy, if the cancellation occurs more than sixty (60) days after the date of issuance of the policy; and

(3) ten (10) days before canceling the insurance policy, if the cancellation occurs less than sixty-one (61) days after the date of issuance of the policy.

(c) If the insurance policy was procured by an independent insurance producer licensed in Indiana, the farm mutual insurance

company shall deliver or mail notice of cancellation to the insurance producer not less than ten (10) days before the farm mutual insurance company delivers or mails the notice to the policyholder, unless the obligation to notify the insurance producer is waived in writing by the insurance producer.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-38
Discontinuation of company

Sec. 38. A farm mutual insurance company may vote to discontinue operations and settle its affairs under IC 27-1-10.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-39
Misconduct; penalty

Sec. 39. A director, an officer, a member, an insurance producer, or an employee of a farm mutual insurance company who knowingly or intentionally, directly or indirectly, uses or employs, or allows another person to use or employ, money, funds, securities, or assets of the farm mutual insurance company for private profit or gain commits a Level 5 felony.
As added by P.L.129-2003, SEC.8. Amended by P.L.158-2013, SEC.297.

IC 27-5.1-2-40
Investment gain; policyholder surplus

Sec. 40. This article does not prohibit a farm mutual insurance company from doing the following:

(1) Distributing underwriting or investment gain to policyholders of a farm mutual insurance company.

(2) Accumulating a reasonable policyholder surplus for the payment of losses or other expenses.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-41
Election to be subject to Indiana insurance law

Sec. 41. (a) A farm mutual insurance company may elect to be subject to the provisions of IC 27-1, as provided by IC 27-1-11-1, with the rights, privileges, and franchises provided under IC 27-1.

(b) An election under subsection (a) becomes effective on the date of issuance of a new certificate of authority under IC 27-1-11-7.

(c) An insurance policy that is:

(1) issued or bound by a farm mutual insurance company that makes an election under subsection (a); and

(2) in effect on the date the election becomes effective;

is not invalidated by IC 27-1, but remains in full force and effect until expiration or termination of the insurance policy. However, IC 27-1 applies to an insurance policy described in this subsection

beginning three (3) years after the date the election becomes effective.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-42
Exemption from regulation

Sec. 42. A company or association organized before January 1, 1870, that provides the kind of insurance described in this article and has not made an election under IC 27-5-1-14 (before its repeal) is not subject to this article unless the company or association elects to conduct the company's or association's business under this article by a resolution:

(1) adopted by the company's or association's board of directors or policyholders;
(2) filed with the commissioner; and
(3) approved by the commissioner.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-43
Administrative rules

Sec. 43. The commissioner may adopt rules under IC 4-22-2 to implement this article.
As added by P.L.129-2003, SEC.8.

IC 27-5.1-2-44
Validity of rate or form filed under prior law

Sec. 44. A rate or form filed by a farm mutual insurance company before July 1, 2003, is valid and remains in effect notwithstanding the repeal of IC 27-5 and the addition of this article.
As added by P.L.16-2009, SEC.28.

IC 27-5.1-3

Chapter 3. Standard Farm Mutual Insurance Companies

IC 27-5.1-3-1

Standard company; supplementation of chapter; limitation on types of insurance provided

Sec. 1. (a) This chapter supplements the requirements set forth for a standard company in IC 27-5.1-2.

(b) A standard company may not insure a policyholder of the farm mutual insurance company:

(1) against loss to a motor vehicle owned by the policyholder from peril;

(2) against liability resulting from the use of a motor vehicle owned by the policyholder;

(3) for property loss in connection with a specific loan or other credit transaction; or

(4) for personal, commercial, and farm liability.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-3-2

Powers; kinds of insurance coverage

Sec. 2. A standard company that is issued a certificate of authority under this article may:

(1) perform the business of insurance on:

(A) an assessable;

(B) a mutual; and

(C) a nonprofit;

basis;

(2) insure the property of policyholders of the standard company against loss or damage that is caused by:

(A) fire;

(B) windstorm;

(C) causes specified under an extended coverage provision; and

(D) other perils that are not specifically excluded in the policy form; and

(3) insure the property of policyholders of the standard company against:

(A) loss of use;

(B) loss of occupancy;

(C) loss of rents; and

(D) additional expenses;

that result from direct loss or damage to covered property.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-3-3

Company territory expansion; net retention per risk; investments

Sec. 3. (a) A standard company may not insure property located

outside the standard company's territory, as described in the standard company's articles of incorporation, unless the standard company meets the following requirements for expansion:

(1) A standard company with annual direct written premiums that total not less than one hundred thousand dollars ($100,000) may expand the territory in which the standard company insures property to not more than ten (10) counties if the expansion is approved by the affirmative vote of a majority of the standard company's:

(A) board of directors; or

(B) policyholders present and voting at a meeting of the policyholders.

(2) A standard company with annual direct written premiums that total not less than two hundred fifty thousand dollars ($250,000) may expand the territory in which the standard company insures property to more than ten (10) counties if the expansion is approved by the affirmative vote of a majority of the standard company's:

(A) board of directors; or

(B) policyholders present and voting at a meeting of the policyholders.

(b) The net retention per risk of a standard company may not exceed two-tenths percent (0.2%) of the standard company's insurance in force.

(c) A standard company shall make investments in accordance with IC 27-1-13-3.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-3-4

Policyholder surplus; reinsurance

Sec. 4. A standard company may issue an insurance policy insuring against loss or damage to property of a policyholder of the standard company from the perils specified in section 2 of this chapter in a county located in Indiana if the standard company maintains a policyholder surplus or reinsurance that the commissioner determines is sufficient to protect the financial stability of the standard company.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-3-5

Annual statements

Sec. 5. (a) A standard company shall, not later than March 1, prepare and file with the commissioner an annual statement:

(1) that is on a form prescribed by the commissioner;

(2) that is verified by an affidavit of the:

(A) president; and

(B) secretary;

of the board of the standard company and individuals who are

authorized to do business on behalf of the standard company; and

(3) that reflects the financial condition of the standard company as of the end of the calendar year immediately preceding the date of the annual statement.

(b) An annual statement prepared and filed under subsection (a) must be presented at the annual meeting of the standard company.

(c) An annual statement filed under subsection (a) must be accompanied by the filing fee set forth under IC 27-1-3-15.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-4

Chapter 4. Extended Farm Mutual Insurance Companies

IC 27-5.1-4-1

Extended company requirements

Sec. 1. An extended company is subject to the requirements of IC 27-5.1-2 and this chapter.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-4-2

Companies existing on June 30, 2003; extended company election; amended certificate of authority

Sec. 2. (a) A farm mutual insurance company that was authorized to provide insurance in Indiana on June 30, 2003, may elect to obtain a certificate of authority as an extended company.

(b) An election under subsection (a) is made by:

(1) an affirmative vote by the board of directors of the farm mutual insurance company:

(A) on a resolution to convert to an extended company; and

(B) on an amendment of the articles of incorporation of the farm mutual insurance company; and

(2) filing:

(A) the resolution;

(B) the amended articles of incorporation; and

(C) other information that the commissioner considers necessary for review;

with the commissioner.

(c) The commissioner shall, upon:

(1) receiving a filing specified under subsection (b)(2); and

(2) determining that the farm mutual insurance company is in compliance with the requirements of this article and other applicable law;

issue an amended certificate of authority to the farm mutual insurance company authorizing the farm mutual insurance company as an extended company.

(d) A farm mutual insurance company, after receiving an amended certificate of authority under subsection (c):

(1) is subject to the requirements of this chapter; and

(2) may commence the business of insurance as an extended company.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-4-3

Kinds of insurance coverage

Sec. 3. An extended company may:

(1) insure the property of policyholders of the extended company against loss or damage that is caused by:

(A) fire;

(B) windstorm;
(C) causes specified under an extended coverage provision; and
(D) other perils that are specified in the policy form;
(2) insure the property of policyholders of the extended company against:
(A) loss of use;
(B) loss of occupancy;
(C) loss of rents; and
(D) additional expenses;
that result from direct loss or damage to covered property; and
(3) provide other kinds of insurance that are approved by the commissioner.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-4-4
Financial and reinsurance requirements

Sec. 4. An extended company shall comply with the following financial and reinsurance requirements if the extended company provides the types of insurance described in section 3 of this chapter:
(1) The extended company shall maintain a policyholder surplus as required under IC 27-1-6-15.
(2) The net retention per risk that an extended company may maintain may not exceed two-tenths percent (0.2%) of the extended company's insurance in force.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-4-5
Collections through assessments and premiums

Sec. 5. (a) An extended company:
(1) may collect a membership fee and an initial premium charge that are prescribed by the board of directors of the extended company; and
(2) shall collect, not less than annually, an amount that is sufficient to enable the extended company to:
(A) pay losses and expenses; and
(B) create and maintain a policyholder surplus in accordance with the articles of incorporation and bylaws of the extended company.

(b) Collections under subsection (a) are subject to the following requirements:
(1) Collections must be made through assessments or premiums charged by the extended company on certain insurance policies issued by the extended company as determined by the board of directors of the extended company.
(2) A policyholder that holds an insurance policy that is issued on a basis other than a premium basis:
(A) may be charged an advance assessment that is payable

not later than the time at which the insurance policy is issued, as determined by the board of directors of the extended company; and

(B) may be assessed if a further assessment is required under the articles of incorporation of the extended company.

(c) The terms and conditions of assessments made under this section must be clearly disclosed in the insurance policy.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-4-6

Policyholder surplus

Sec. 6. The following requirements apply to the policyholder surplus of an extended company:

(1) The articles of incorporation of the extended company must provide for the existence, maintenance, and use of the policyholder surplus.

(2) The policyholder surplus may be used only for the payment of losses and expenses considered necessary by the board of directors of the extended company.

(3) The existence or maintenance of the policyholder surplus does not relieve a policyholder of any assessment or other obligation that the:

(A) policyholder owes to the extended company; or

(B) extended company has levied against the policyholder.

(4) If the extended company is dissolved, the policyholder surplus must be treated in the same manner as any other asset of the extended company.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-4-7

Investments

Sec. 7. An extended company shall make investments in accordance with IC 27-1-13-3.

As added by P.L.129-2003, SEC.8.

IC 27-5.1-4-8

Annual statement

Sec. 8. (a) An extended company shall, not later than March 1, prepare and file with the commissioner an annual statement:

(1) that is on a form prescribed by the commissioner;

(2) that is verified by an affidavit of the:

(A) president; and

(B) secretary;

of the board of directors of the extended company; and

(3) that reflects the condition of the extended company as of the end of the calendar year immediately preceding the date of the annual statement.

(b) An annual statement prepared and filed under subsection (a)

must be presented at the annual meeting of the extended company.

(c) An annual statement filed under subsection (a) must be accompanied by the filing fee set forth in IC 27-1-3-15.

As added by P.L.129-2003, SEC.8.

IC 27-6

ARTICLE 6. REINSURANCE; INTERINSURANCE; RECIPROCAL INSURANCE

IC 27-6-1

Repealed

(Repealed by P.L.260-1983, SEC.8.)

IC 27-6-1.1

Chapter 1.1. Reinsurance

IC 27-6-1.1-1

Definitions

Sec. 1. As used in this chapter:

"Accepting insurer" means the insurer that is a party to a reinsurance transaction and that reinsures insurance, annuity, and endowment risks or liabilities of another insurer.

"Assumption reinsurance" means a transaction in which one (1) insurer assumes all or a portion of the insurance, annuity, and endowment risks or liabilities of another insurer and thereby becomes directly and primarily liable to the insured, beneficiary, or policyholder under the policies and contracts subject to the reinsurance transaction.

"Ceding insurer" means the insurer that is a party to a reinsurance transaction and whose insurance, annuity, and endowment risks or liabilities are reinsured.

"Indemnity reinsurance" means a transaction in which one (1) insurer agrees to indemnify another insurer for all or a portion of the insurance, annuity, and endowment risks or liabilities of the ceding insurer.

As added by P.L.260-1983, SEC.1.

IC 27-6-1.1-2

Indemnity reinsurance; ceding agreements

Sec. 2. (a) A domestic insurer may cede indemnity reinsurance to any insurer authorized to do business in this state, in any other state of the United States, or in the District of Columbia, or to any alien insurer.

(b) A domestic ceding insurer must file with the commissioner for approval any proposed agreement that would cede indemnity reinsurance of previously retained insurance if the reserves and other liabilities with respect to previously retained insurance that are transferred by the insurer under the proposed agreement and under all other agreements that cede previously retained insurance exceed twenty-five percent (25%) of the total reserves and other liabilities of the domestic ceding insurer. As used in this subsection, "previously retained insurance" means insurance issued before the date of reinsurance and not previously reinsured.

(c) Any agreement that is filed as provided in subsection (b) shall be deemed approved unless the commissioner notifies the insurer within thirty (30) days after submission of an intent to hold a hearing in accordance with section 4 of this chapter.

(d) A transaction of indemnity reinsurance does not create any legal right or relation between the insured, beneficiary, or policyholder and the accepting insurer.

As added by P.L.260-1983, SEC.1.

IC 27-6-1.1-3

(Repealed by P.L.116-1994, SEC.78.)

IC 27-6-1.1-4

Termination of indemnity reinsurance transaction

Sec. 4. The commissioner may require the termination of any indemnity reinsurance transaction, whether or not the applicable agreement was required to be filed for approval, if after a hearing under IC 4-21.5-3, the commissioner finds that the transaction creates an unsafe condition for the policyholders of a domestic insurer.

As added by P.L.260-1983, SEC.1. Amended by P.L.7-1987, SEC.152.

IC 27-6-1.1-5

Assumption reinsurance agreement; approval; exemptions; notice to policyholders

Sec. 5. (a) A domestic insurer must file any proposed agreement of assumption reinsurance with the commissioner for the commissioner's approval. The agreement must be executed by each insurer in a manner consistent with its articles and bylaws and the applicable law.

(b) The requirement for filing and approval provided in subsection (a) is not applicable to an agreement if:

(1) the ceding insurer is not a domestic insurer; and

(2) the reserves and liabilities assumed under the agreement are not greater than twenty percent (20%) of the corresponding outstanding reserves and liabilities of the domestic accepting insurer without regard to the agreement.

(c) The commissioner shall approve a reinsurance agreement within sixty (60) days after it is filed as provided in subsection (a) if the commissioner determines that:

(1) the agreement was legally executed by both insurers;

(2) in case one (1) of the parties to the agreement is a foreign or alien insurer, the agreement received the sanction and approval of the law of the foreign or alien jurisdiction, if necessary; and

(3) the agreement deals equitably and fairly with the contract and property rights of insurance, annuity, and endowment policy or contract holders of both insurers.

(d) The commissioner's approval of any agreement of reinsurance that is required to be filed as provided in subsection (a) shall be a condition precedent to the validity of the agreement. On the commissioner's approval, the agreement shall become effective as of the date of the agreement or as of such other date as may be specifically provided in the agreement.

(e) Within the period of forty-five (45) days following the commissioner's approval of an agreement of assumption reinsurance, or within the period of forty-five (45) days following the effective

date of an agreement of assumption reinsurance for which the approval of the commissioner is not required, the accepting insurer shall mail a written notification to each reinsured insurance, annuity, and endowment policy or contract holder. The notification must:

(1) specify each policy or contract subject to reinsurance and the effective date of the reinsurance transaction;

(2) offer to provide a copy of the agreement of assumption of reinsurance upon the written request of the policy or contract holder;

(3) state that the accepting insurer assumes all of the rights and obligations of the ceding insurer with respect to the policies and contracts that are subject to the agreement of assumption reinsurance; and

(4) state that the rights and benefits of the policy or contract holder under the policy or contract that is subject to reinsurance, including the right to surrender the policy or contract subject to the terms of the policy or contract, are not affected by the reinsurance.

(f) This section does not apply to an assumption reinsurance agreement to which a domestic ceding insurer is a party if the insurer is the subject of a proceeding under IC 27-9-3.

As added by P.L.260-1983, SEC.1. Amended by P.L.256-1985, SEC.1; P.L.248-1989, SEC.1.

IC 27-6-1.1-6

Application of chapter

Sec. 6. This chapter does not apply to any of the parties to a contract of merger or consolidation under IC 27-5.1-2-21.

As added by P.L.260-1983, SEC.1. Amended by P.L.129-2003, SEC.9.

IC 27-6-2

Chapter 2. Farmers' Mutual Insurance Companies–Additional Reinsurance

IC 27-6-2-1

Authorization

Sec. 1. Every farm mutual insurance company authorized on or after March 11, 1955, to make the kinds of insurance and reinsurance permitted under and pursuant to the provisions of IC 27-5.1-2 is hereby authorized to write, make, or take, in addition to the kinds of reinsurance authorized under IC 27-5.1-2, any kind or kinds of reinsurance on lines of insurance or hazards which they cede and shall not write, make, or take reinsurance on any hazard or lines of insurance that they do not themselves cede to other reinsurers.

(Formerly: Acts 1955, c.330, s.1.) As amended by P.L.252-1985, SEC.211; P.L.129-2003, SEC.10.

IC 27-6-2-2

Construction of acts

Sec. 2. The rights and powers conferred in this chapter shall be supplemental and in addition to those conferred by law as of March 11, 1955, upon such farm mutual insurance companies.

(Formerly: Acts 1955, c.330, s.2.) As amended by P.L.252-1985, SEC.212; P.L.129-2003, SEC.11.

IC 27-6-3
Chapter 3. Reciprocal Exchange May Reinsure

IC 27-6-3-1
Authorization

Sec. 1. From and after April 1, 1963, any reciprocal exchange authorized to make insurance under the provisions of IC 27-1 may be authorized to reinsure any other reciprocal exchange or insurance company authorized to make insurance pursuant to the provisions of IC 27-1, under the same regulations and restrictions as are applicable to insurance companies authorized to make insurance pursuant to IC 27-1.

(Formerly: Acts 1963, c.313, s.1.) As amended by P.L.252-1985, SEC.213.

IC 27-6-4

Chapter 4. Reinsurance–Effect on Worker's Compensation Insurers

IC 27-6-4-1

Construction of act

Sec. 1. Nothing in IC 27-6-6-3, IC 27-6-6-6, or IC 27-6-6-7 shall be construed to annul, restrict, or in any manner interfere with the licensing and supervision of mutual insurance associations and reciprocal associations formed and operating on or before January 1, 1991, solely for the writing of worker's compensation insurance as provided under IC 22-3.

(Formerly: Acts 1963, c.315, s.4.) As amended by P.L.252-1985, SEC.214; P.L.28-1988, SEC.82; P.L.170-1991, SEC.27.

IC 27-6-5
Chapter 5. Federal Reinsurance

IC 27-6-5-1
Cooperation with United States; report

Sec. 1. (a) In order to obtain for the citizens of the state of Indiana and for their insurers the benefit of federal reinsurance against property losses resulting from riots and civil disorders, as provided in the Urban Property Protection and Reinsurance Act of 1968 (12 U.S.C. 1749bbb et seq.), the state of Indiana is hereby authorized to cooperate with the United States government and its Secretary of Housing and Urban Development. The Indiana insurance commissioner is hereby designated as the state agency to cooperate with the federal government pursuant to that act.

(b) The insurance commissioner shall annually report to the general assembly on the statewide plan to assure fair access to insurance requirements (FAIR plan, as provided in 12 U.S.C. 1749bbb-3). The report must be submitted no later than November 1 of each year. The report must contain information concerning the classes of coverage provided under the plan during the preceding year and any other information requested by the general assembly. The report must be in an electronic format under IC 5-14-6.

(Formerly: Acts 1969, c.429, s.1.) As amended by P.L.252-1985, SEC.215; P.L.162-1988, SEC.1; P.L.28-2004, SEC.167.

IC 27-6-5-2
Appropriations

Sec. 2. There is hereby appropriated to the insurance commissioner of the state of Indiana from any moneys in the general fund of the state not otherwise appropriated the amount of money, if any, which may be required to maintain the availability of federal reinsurance in the state of Indiana pursuant to the federal act referred to in section 1 of this chapter, up to a maximum amount in a current year of five percent (5%) of the aggregate property insurance premiums earned in Indiana during the preceding calendar year on those lines of insurance reinsured by the Secretary in Indiana during a current year, said amount to be ordered by the said insurance commissioner to be paid to the Secretary of Housing and Urban Development as provided in the said federal act.

(Formerly: Acts 1969, c.429, s.2.) As amended by P.L.252-1985, SEC.216.

IC 27-6-6

Chapter 6. Interinsurance

IC 27-6-6-1

Subscribers; authority to exchange reciprocal or interinsurance contracts; title insurance exception

Sec. 1. Individuals, partnerships, limited liability companies, and corporations of this state, hereby designated "subscribers," are hereby authorized to exchange reciprocal or interinsurance contracts with each other or with individuals, partnerships, limited liability companies, and corporations of other states and countries, providing indemnity among themselves from any loss which may be insured against under the fire or casualty classifications as authorized by the insurance laws of this state, except title insurance.

(Formerly: Acts 1919, c.102, s.1; Acts 1967, c.232, s.1.) As amended by P.L.8-1993, SEC.421.

IC 27-6-6-2

Execution of contracts; attorneys; location of office of attorney

Sec. 2. Such contracts may be executed by an attorney, agent or other representative, herein designated "attorney," duly authorized and acting for such subscribers. The office or offices of such attorney may be maintained at such place or places as may be designated by the subscribers in the power of attorney.

(Formerly: Acts 1919, c.102, s.2.)

IC 27-6-6-3

Declaration of subscribers

Sec. 3. Such subscribers so contracting among themselves shall, through their attorney, file with the insurance department a declaration verified by the oath of such attorney, or where such attorney is a corporation, by the oath of a chief officer thereof, setting forth the following:

(a) The name or title adopted by such subscribers proposing to exchange such indemnity contracts. Such name or title shall not be so similar to any other name or title previously adopted by a similar organization or by any insurance corporation or association as in the opinion of the insurance department is likely to result in confusion or deception.

(b) The kind or kinds of insurance to be effected or exchanged.

(c) A copy of the form of policy contract or agreement under or by which such insurance is to be effected or exchanged.

(d) A copy of the form of power of attorney or other authority of such attorney under which such insurance is to be effected or exchanged; provided, that a copy of any amendment to or substitution of such form shall be filed with the insurance department prior to its use.

(e) The location of the office or offices from which such

contracts or agreements are to be issued.

(f) That applications have been made for indemnity upon at least one hundred (100) separate risks aggregating not less than one and one-half million dollars ($1,500,000) as represented by executed contracts or bona fide applications to become concurrently effective in the case of fire insurance, and in the case of automobile insurance, executed contracts or bona fide applications for indemnity upon two hundred and fifty (250) separate risks aggregating not less than one and one-half million dollars ($1,500,000) or any or all classes of automobile insurance effected by said subscriber through said attorney.

(g) That there is in the possession of such attorney and available for the payment of losses, assets conforming to the requirements of section 6 of this chapter.

(h) A financial statement under oath in form prescribed for the annual statement.

(i) The instrument authorizing service of process as provided for in this chapter.

(Formerly: Acts 1919, c.102, s.3; Acts 1963, c.315, s.1; Acts 1967, c.232, s.2.) As amended by P.L.252-1985, SEC.217.

IC 27-6-6-4

Instrument authorizing service of process on subscriber's agent; procedure for service

Sec. 4. (a) Concurrently with the filing of the declaration provided for by the terms of section 3 of this chapter, the attorney (as defined in section 2 of this chapter) shall file with the department of insurance, state of Indiana, an instrument in writing, executed by him for said subscribers, conditioned that, upon the issuance of a certificate of authority provided for in section 9 of this chapter, service of process may be had upon the individual resident of Indiana, corporate resident of Indiana, or authorized Indiana insurer, appointed by the subscribers as the subscribers' agent for service of process in all suits in this state arising out of such policies, contracts, or agreements, which service shall be valid and binding upon all subscribers exchanging at any time reciprocal or interinsurance contracts through such attorney.

(b) Service of process under subsection (a) shall be made by delivering to the subscribers' agent two (2) copies of process with a complaint attached.

(c) It shall be the duty of the subscribers' agent, upon service, to promptly send one (1) copy of such summons, by registered letter, to the attorney specified in subsection (a) and to file the other copy of summons in the office of the subscribers' agent.

(Formerly: Acts 1919, c.102, s.4; Acts 1967, c.232, s.3.) As amended by P.L.252-1985, SEC.218; P.L.130-1994, SEC.40; P.L.116-1994, SEC.52; P.L.268-1999, SEC.15.

IC 27-6-6-5

Statement of maximum amount of single fire insurance risk; limitation on amount assumed

Sec. 5. There shall be filed with the department of insurance, state of Indiana, by such attorney, whenever the department of insurance shall so require, a statement under oath of such attorney, showing, in the case of fire or casualty classifications as authorized by the insurance laws of Indiana, except title insurance, the maximum amount of indemnity upon a single risk, and no reciprocal shall assume on any single fire or casualty classifications as authorized by the insurance laws of Indiana, except title insurance, risk in an amount greater than ten percent (10%) of the net worth of the reciprocal.

(Formerly: Acts 1919, c.102, s.5; Acts 1967, c.232, s.4.) As amended by P.L.116-1994, SEC.53; P.L.255-1995, SEC.6.

IC 27-6-6-6

Assets and reserves

Sec. 6. There shall at all times be maintained as assets a sum in cash or securities of the kind designated by the laws of the state where the principal office is located for the investment of funds of insurance companies, doing the same kinds of business, amounting to fifty per cent (50%) of the net annual deposits, collected, and credited to the accounts of subscribers on policies having one (1) year or less to run and pro rata on those for longer periods; in addition to which there shall be maintained in cash or such securities assets sufficient to discharge all liabilities on all outstanding losses arising under policies issued, same to be calculated on the basis of net premiums or deposits as in this section defined and in accordance with the laws of the state relating to similar reserves for companies insuring similar risks. For the purpose of computing said reserves and assets, net deposits shall be construed to mean the payments of subscribers collected or in the course of collection after deducting therefrom the amounts provided in the subscribers' agreement for expenses except payments or credits to the attorney-in-fact. If at any time the assets so held in cash or such securities shall be less than required above, or be less than three hundred thousand dollars ($300,000), the subscribers or their attorney for them shall make up the deficiency within thirty (30) days after notice from the department of insurance so to do: Provided, however, That as to reciprocal or interinsurance exchanges now licensed and authorized to do business in Indiana, the alternative minimum of cash or securities required to be held shall be one hundred thousand dollars ($100,000).

(Formerly: Acts 1919, c.102, s.6; Acts 1963, c.315, s.2; Acts 1967, c.232, s.5.)

IC 27-6-6-7

Annual financial report; examination; acceptance of examination of another state

Sec. 7. Such attorney shall, within the time limited for filing the annual statement by insurance companies transacting the same kind of business, make a report under oath to the insurance department for each calendar year showing the financial condition of affairs at the office where such contracts are issued and shall furnish such additional information and reports as may be required. The business affairs, records, and assets of any such organization shall be subject to examination by the insurance department at any reasonable time, and such examination shall be at the expense of the organization examined. Where the principal office of the attorney is located in another state, the insurance department may in lieu of the examination provided for in this section, accept a certified copy of the report of examination made by the insurance department of the state where the principal office is located.

(Formerly: Acts 1919, c.102, s.7; Acts 1963, c.315, s.3; Acts 1967, c.232, s.6.)

IC 27-6-6-8

Right of domestic corporation to exchange contracts

Sec. 8. Any corporation now or hereafter organized under the laws of this state, shall, in addition to the rights, powers and franchises specified in its articles of incorporation, have full power and authority, as a subscriber, to exchange insurance contracts of the kind and character herein mentioned. The right to exchange such contracts is hereby declared to be incidental to the purposes for which such corporations are organized and as much granted as the rights and powers expressly conferred.

(Formerly: Acts 1919, c.102, s.8.)

IC 27-6-6-9

Certificate of authority

Sec. 9. Upon compliance with the requirements of this chapter, the insurance department shall issue a certificate of authority or a license to the attorney authorizing him to make such contracts of insurance and shall contain the name of the attorney, the location of the principal office, and the name or the designation under which such contracts of insurance are issued. Such license shall be renewed annually, upon a showing that the standard of solvency required in this section has been maintained and all fees and taxes required have been paid; provided, no certificate of authority shall be issued under this section unless and until the subscribers and the attorney shall have complied with the same character and fitness qualifications, plan of operation, and standards for officers and directors as is required of stock and mutual insurance companies under this title.

(Formerly: Acts 1919, c.102, s.9; Acts 1967, c.232, s.7.) As amended by P.L.252-1985, SEC.219.

IC 27-6-6-10
Violations

Sec. 10. An attorney who exchanges a contract of insurance of the kind and character specified in this chapter, or solicits or negotiates any application for such a contract, without complying with this chapter, commits a Class C infraction. For the purpose of organization and upon issuance of permit by the insurance department, powers of attorney and applications for such contracts may be solicited without compliance with this chapter, but a person may not make or issue any such contracts until this chapter is complied with.

(Formerly: Acts 1919, c.102, s.10; Acts 1967, c.232, s.8.) As amended by Acts 1978, P.L.2, SEC.2722.

IC 27-6-6-11
Refusal, suspension, or revocation of certificate of authority

Sec. 11. In addition to the penalties in section 10 of this chapter and where not otherwise provided, the penalty for failure or refusal to comply with any or all of the terms and provisions of this chapter, upon the part of the attorney, shall be the refusal, suspension, or revocation of certificate of authority or license by the insurance department, after due notice and opportunity for hearing has been given such attorney, so that he may appear and show cause why such action should not be taken.

(Formerly: Acts 1919, c.102, s.11; Acts 1967, c.232, s.9.) As amended by P.L.252-1985, SEC.220.

IC 27-6-6-12
Taxation

Sec. 12. In lieu of all other taxes, licenses or fees, state or local, such attorney shall pay annually, on account of the transaction of such business in this state, the same taxes, licenses and fees as are required to be paid by mutual insurance companies with principal office similarly located and transacting the same kind of business. In the application of the retaliatory law, the taxes and fees exacted by another state from an exchange with principal office in Indiana shall apply.

(Formerly: Acts 1919, c.102, s.12.)

IC 27-6-6-13
Terms inserted in policy; conformity to state law

Sec. 13. The attorney may insert in any form of policy prescribed by the laws of this state any provisions or conditions required by the plan of reciprocal or interinsurance, Provided That same shall not be inconsistent with or in conflict with the law of this state. Such policy in lieu of conforming to the language and form prescribed by such law, shall be held to conform thereto in substance if such policy includes a provision or endorsement reciting that the policy shall be

construed as if in the language and form prescribed by such law. Any such endorsement shall first be filed with the insurance department. *(Formerly: Acts 1919, c.102, s.13; Acts 1967, c.232, s.10.)*

IC 27-6-6-14
Application of state insurance law

Sec. 14. Except as herein provided, no law of this state relating to insurance shall apply to the exchange of indemnity contracts described herein, unless they are specifically mentioned therein. *(Formerly: Acts 1919, c.102, s.14.)*

IC 27-6-6-15
Loans or advances; purposes; repayment; approval; interest rate; restrictions

Sec. 15. The attorney for the subscribers at a reciprocal or interinsurance exchange organized under this law may on behalf of the subscribers borrow or assume a loan or advance for the repayment of a sum of money sufficient to defray the reasonable expenses in the establishment of such an exchange or to enable the attorney for the subscribers at the exchange to comply with any requirement of the law or as a guarantee fund upon agreement. The borrowing or assumption shall first be submitted to and approved by the department, and shall be repaid only out of the surplus, earnings or profits at the exchange with the approval of the department. The department shall withhold its approval of any repayment whenever in its judgment the financial condition of the attorney for the subscribers at such exchange shall warrant, but shall not withhold its approval if after the repayment the attorney-in-fact for subscribers at the exchange shall have and be in possession of a surplus equal to ten percent (10%) or more of the gross annual premium of the subscribers. Any such loan or advance shall not form a part of the legal liabilities of the attorney for the subscribers at the exchange but until repaid, all statements published by the attorney for the subscribers or filed with the department, shall show the amount thereof then remaining unpaid. However, this section shall not be construed as an extension of the liability of any subscriber beyond that expressly provided for in the subscribers' agreement or power of attorney. The per annum interest rate on any loan or advance shall not exceed three-quarters of one percent (.75%) above the prevailing prime bank rate charged by national banks and banks chartered by the state of Indiana with their principal offices in Indiana, or ten percent (10%), whichever is less. The department shall establish the prevailing prime bank rate for each calendar quarter equal to this rate for the first working day of the subsequent calendar quarter. The prime bank rate for any bank on a given day is the rate of interest it charges on unsecured loans made that day to its most credit-worthy customers. In establishing the prevailing prime bank rate the department may use the prime bank rate charged by the fifteen (15)

largest banks with their principal offices in Indiana, or such other number as the department deems adequate. The total amount of interest shall be calculated on a three hundred sixty (360) day basis. *(Formerly: Acts 1919, c.102, s.14a; Acts 1967, c.232, s.11.) As amended by Acts 1977, P.L.287, SEC.1.*

IC 27-6-7

Chapter 7. Lawsuits Concerning Interinsurance–Procedure

IC 27-6-7-1

Actions by or against attorney in fact for subscribers; effect of judgment

Sec. 1. All suits with reference to any matter or claim arising out of, or having any connection with any contract or agreement issued or executed, or any obligation or liability incurred at any reciprocal or interinsurance exchange, shall be brought only by, or against, the attorney in fact for subscribers at said reciprocal or interinsurance exchange, and any judgment obtained or rendered against said attorney in fact, as such, shall be valid and binding on all subscribers exchanging reciprocal or interinsurance contracts through such attorney in fact at said exchange, to the extent to which such subscribers are obligated or may be obligated.

(Formerly: Acts 1937, c.35, s.1.)

IC 27-6-8

Chapter 8. Property and Casualty Insurance and Guaranty Association Law

IC 27-6-8-0.1

Application of certain amendments to chapter

Sec. 0.1. (a) The amendments made to sections 4 and 7 of this chapter by P.L.163-1988 apply to cases involving an order of liquidation entered after June 30, 1988. For cases involving an order of liquidation entered before July 1, 1988, the laws that apply are sections 4 and 7 of this chapter, as in effect before July 1, 1988, as if P.L.163-1988 had not been enacted.

(b) The amendments made to sections 4, 5, 6, 7, 8, 11, and 11.5 of this chapter during the 2013 regular session of the general assembly do not apply to the following:

(1) A member insurer that has been placed under an order of rehabilitation or liquidation before July 1, 2013.

(2) The association's obligations under this chapter with respect to a covered claim filed by a claimant or member insurer that has a coverage date before July 1, 2013.

The law of this chapter that applies to a member insurer described in subdivision (1) or to the association's obligations described in subdivision (2) is the law of this chapter as in effect before July 1, 2013, as if the amendments made to sections 4, 5, 6, 7, 8, 11, and 11.5 of this chapter during the 2013 regular session of the general assembly had not been made.

As added by P.L.220-2011, SEC.432. Amended by P.L.52-2013, SEC.1.

IC 27-6-8-1

Short title

Sec. 1. (Short Title) This chapter may be cited as the "Indiana Insurance Guaranty Association Law of 1971."

(Formerly: Acts 1971, P.L.390, SEC.1.)

IC 27-6-8-2

Purpose

Sec. 2. (Purpose) The purpose of this chapter is to provide a mechanism for the payment of claims under certain insurance policies to avoid excessive delay in payment and to avoid excessive financial loss to claimants or policyholders because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies, and to provide an association to assess the cost of this protection among insurers.

(Formerly: Acts 1971, P.L.390, SEC.1.)

IC 27-6-8-3

Scope

Sec. 3. This chapter applies to all kinds of direct insurance except:

(1) life, annuity, health, or disability insurance;

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

(3) fidelity or surety bonds, or any other bonding obligations;

(4) credit insurance, vendors' single interest insurance, or collateral protection insurance or similar insurance with the primary purpose of protecting the interests of a creditor arising out of a creditor-debtor transaction;

(5) warranty or service contract insurance;

(6) title insurance;

(7) ocean marine insurance;

(8) a transaction between a person or an affiliate of a person and an insurer or an affiliate of an insurer that involves the transfer of investment or credit risk without a transfer of insurance risk;

(9) insurance provided by or guaranteed by a government entity; and

(10) insurance written on a retroactive basis to cover known losses for which a claim has already been made and the claim is known to the insurer at the time the insurance is bound.

(Formerly: Acts 1971, P.L.390, SEC.1.) As amended by P.L.163-1988, SEC.1; P.L.31-1988, SEC.20.

IC 27-6-8-4
Definitions

Sec. 4. As used in this chapter, unless otherwise provided:

(1) The term "account" means any one (1) of the three (3) accounts created by section 5 of this chapter.

(2) The term "association" means the Indiana Insurance Guaranty Association created by section 5 of this chapter.

(3) The term "commissioner" means the commissioner of insurance of this state.

(4) The term "covered claim" means an unpaid claim which arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this chapter applies issued by an insurer, if the insurer becomes an insolvent insurer after the effective date (January 1, 1972) of this chapter and (a) the claimant or insured is a resident of this state at the time of the insured event or (b) the property from which the claim arises is permanently located in this state. "Covered claim" shall be limited as provided in section 7 of this chapter, and shall not include the following:

(A) Any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise. However, a claim for any such amount, asserted against a person insured under a policy issued by an insurer which has become an insolvent insurer, which if it were not a claim by or for the benefit of a reinsurer, insurer, insurance

pool or underwriting association, would be a "covered claim" may be filed directly with the receiver or liquidator of the insolvent insurer, but in no event may any such claim be asserted in any legal action against the insured of such insolvent insurer.

(B) Any supplementary obligation including but not limited to adjustment fees and expenses, attorney fees and expenses, court costs, interest and bond premiums, whether arising as a policy benefit or otherwise, prior to the appointment of a liquidator.

(C) Any unpaid claim that is filed with the association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer. For the purpose of filing a claim under this clause, notice of a claim to the liquidator of the insolvent insurer is considered to be notice to the association or the agent of the association and a list of claims must be periodically submitted to the association (or another state's association that is similar to the association) by the liquidator.

(D) A claim that is excluded under section 11.5 of this chapter due to the high net worth of an insured.

(E) Any claim by a person who directly or indirectly controls, is controlled, or is under common control with an insolvent insurer on December 31 of the year before the order of liquidation.

All covered claims filed in the liquidation proceedings shall be referred immediately to the association by the liquidator for processing as provided in this chapter.

(5) The term "high net worth insured" means the following:

(A) For purposes of section 11.5(a) of this chapter, an insured that has a net worth (including the aggregate net worth of the insured and all subsidiaries and affiliates of the insured, calculated on a consolidated basis) that exceeds twenty-five million dollars ($25,000,000) on December 31 of the year immediately preceding the year in which the insurer becomes an insolvent insurer.

(B) For purposes of section 11.5(b) of this chapter, an insured that has a net worth (including the aggregate net worth of the insured and all subsidiaries and affiliates of the insured, calculated on a consolidated basis) that exceeds fifty million dollars ($50,000,000) on December 31 of the year immediately preceding the year in which the insurer becomes an insolvent insurer.

(6) The term "insolvent insurer" means (a) a member insurer holding a valid certificate of authority to transact insurance in this state either at the time the policy was issued or when the insured event occurred and (b) against whom a final order of liquidation, with a finding of insolvency, to which there is no

further right of appeal, has been entered by a court of competent jurisdiction in the company's state of domicile. "Insolvent insurer" shall not be construed to mean an insurer with respect to which an order, decree, judgment or finding of insolvency whether preliminary or temporary in nature or order to rehabilitation or conservation has been issued by any court of competent jurisdiction prior to January 1, 1972 or which is adjudicated to have been insolvent prior to that date.

(7) The term "member insurer" means any person who is licensed or holds a certificate of authority under IC 27-1-6-18 or IC 27-1-17-1 to transact in Indiana any kind of insurance for which coverage is provided under section 3 of this chapter, including the exchange of reciprocal or inter-insurance contracts. The term includes any insurer whose license or certificate of authority to transact such insurance in Indiana may have been suspended, revoked, not renewed, or voluntarily surrendered. A "member insurer" does not include farm mutual insurance companies organized and operating pursuant to IC 27-5.1 other than a company to which IC 27-5.1-2-6 applies.

(8) The term "net direct written premiums" means direct gross premiums written in this state on insurance policies to which this chapter applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct premiums written" does not include premiums on contracts between insurers or reinsurers.

(9) The term "person" means an individual, an aggregation of individuals, a corporation, a partnership, or another entity.

(Formerly: Acts 1971, P.L.390, SEC.1; Acts 1973, P.L.279, SEC.1.) As amended by Acts 1977, P.L.281, SEC.5; P.L.163-1988, SEC.2; P.L.8-1993, SEC.422; P.L.255-1995, SEC.7; P.L.129-2003, SEC.12; P.L.52-2013, SEC.2.

IC 27-6-8-5
Creation of the association

Sec. 5. There is created a nonprofit unincorporated legal entity to be known as the Indiana Insurance Guaranty Association (referred to in this chapter as the "association"). All insurers defined as member insurers in section 4(7) of this chapter shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under a plan of operation established and approved under section 8 of this chapter and shall exercise its powers through a board of directors established under section 6 of this chapter. For purposes of administration and assessment, the association shall be divided into three (3) separate accounts:

(1) The worker's compensation insurance account.

(2) The automobile insurance account.

(3) The account for all other insurance to which this chapter

applies.

(Formerly: Acts 1971, P.L.390, SEC.1.) As amended by P.L.252-1985, SEC.221; P.L.28-1988, SEC.83; P.L.52-2013, SEC.3.

IC 27-6-8-6

Board of directors

Sec. 6. (a) The board of directors of the association shall consist of nine (9) persons serving terms as established in the association's plan of operation. The directors who represent member insurers must be selected by member insurers, subject to the approval of the commissioner.

(b) Not more than one (1) member insurer in a group of insurers under the same management or ownership shall serve as a director at the same time.

(c) Directors shall serve such terms as shall be established in the plan of operation.

(d) Vacancies on the board shall be filled for the remaining period of the term in the same manner as the initial selection.

(e) If no directors are selected by March 1, 1972, the commissioner may appoint the initial members of the board of directors.

(f) In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.

(g) Directors may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors.

(Formerly: Acts 1971, P.L.390, SEC.1.) As amended by P.L.252-1985, SEC.222; P.L.233-1999, SEC.6 and P.L.268-1999, SEC.16; P.L.52-2013, SEC.4.

IC 27-6-8-7

Powers and duties of the association

Sec. 7. (a) The association shall do all of the following:

(1) Be obligated to pay covered claims existing before the order of liquidation, or arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:

(A) The full amount of a covered claim for benefits under worker's compensation insurance.

(B) With respect to a claim for the return of unearned premium, the lesser of:

(i) eighty percent (80%) of the paid but unearned premium; or

(ii) six hundred fifty dollars ($650) multiplied by the

number of months or partial months remaining in the policy term, not to exceed twelve (12) months.

(C) An amount not to exceed three hundred thousand dollars ($300,000) per covered claim. For purposes of this clause, all claims of any kind that arise out of or are related to the bodily injury to or death of one (1) person constitute a single claim, regardless of the number of claims made or the number of claimants.

The association is not, in any event, obligated to pay a claimant any amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises.

In the case of a claim for wrongful death, the foregoing obligation of the association shall, in addition to the limits set forth above, be subject to the limitations provided by the wrongful death statutes of the state. Such amounts which are legally payable because of the death of a claimant shall be paid to the claimant's estate, to the claimant's father or mother or guardian, to the surviving spouse or children, or to the next of kin as set out in IC 34-23-1 and IC 34-23-2.

The amount for which the association shall be obligated may also include payments in fact made to others, not members of claimant's household, which were reasonably incurred to obtain from such other persons ordinary and necessary services for the production of income in lieu of those services the claimant would have performed for the claimant had the claimant not been injured.

In the case of claims arising from bodily injury, sickness, or disease, including those in which death results, under IC 22-3 or similar state or federal laws providing benefits for occupational injury or disease, the association is obligated only to the extent provided under IC 22-3.

A third party having a covered claim against any insured of an insolvent member insurer may file such claim in the liquidation proceeding under IC 27-9-3 if such insolvent member insurer is a domestic insurer and pursuant to the applicable provisions of law of the state of domicile if such insolvent member insurer is not a domestic insurer. The liquidator shall immediately refer said claim to the association to process as provided in this chapter unless the claimant shall within thirty (30) days from the date of filing said claim in the liquidation proceeding, file with the commissioner as liquidator a written demand that said claim be processed in liquidation proceedings as a claim not covered by this chapter.

(2) Be deemed the insurer to the extent of its obligation on the covered claims as limited by this chapter and to this extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent, including those relating to reinsurance contracts and treaties entered into by the

insolvent insurer. However, the association's obligation to defend any insured of the insolvent insurer or to indemnity against the costs of such defense terminates as soon as the claimant or claimants have been paid all benefits that they are entitled to under this chapter.

(3) Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account amounts necessary to pay the obligation of the association under subdivision (1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, the cost of examination under IC 27-6-8-12 and other expenses authorized by this chapter. The assessments of each member insurer shall be on a uniform percentage basis in the proportion that the net direct written premiums in this state of the member insurer for the preceding calendar year on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the preceding calendar year on the kinds of insurance in the account. However, in addition to the pro rata assessments already described, an assessment may be made against each member insurer in a stated amount up to fifty dollars ($50) per year for the purpose of paying the administrative expenses of the association. There shall be no assessment for any account so long as assets held in such account are sufficient to cover all estimated payments for liquidation in process under such account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. No member insurer may be assessed in any year on any account an amount greater than one percent (1%) of that member insurer's net direct written premiums in this state for the preceding calendar year on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one (1) year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. 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. However, during the period of deferment no dividends shall be paid to shareholders or policyholders by a company whose assessment has been deferred. A deferred assessment shall be paid when such payment will not reduce capital or surplus below required minimums. Such payments shall be refunded to those companies whose assessments were increased as the result of

such deferment, or at the option of any such company, shall be credited to future assessments against such company.

(4) Investigate, adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims and may review settlements, releases, and judgments to which the insolvent insurer or its insured were parties to determine the extent to which such settlements, releases, and judgments may be properly contested, and as appropriate to contest them.

(5) Notify such persons as the commissioner directs under IC 27-6-8-9(b)(i).

(6) Handle claims through its employees or through one (1) 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.

(7) 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 chapter. Any unreimbursed obligation of the association to a member insurer designated a servicing facility shall constitute an admitted asset of such member insurer.

(8) Be entitled to and permitted to examine all claims, files, and records of an insolvent insurer at such times and to such extent as necessary or appropriate to obtain information regarding covered claims individually and in the aggregate, and to establish such procedures as appropriate to obtain prompt notice of all covered claims and information pertaining thereto during the course of liquidation.

(b) The association may do the following:

(1) Appear in, defend, and appeal any action on a covered claim, but the association shall have no obligation to pay any amount in excess of the provisions of IC 27-6-8-7.

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

(3) Borrow funds necessary to effect the purposes of this chapter in accord with the plan of operation.

(4) Sue or be sued.

(5) Negotiate and become a party to any contracts as are necessary to carry out the purpose of this chapter.

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

(7) Refund to the then member insurers in proportion to the contribution of each such member insurer to that account that amount by which the assets of the account exceed the liabilities if, at the end of the calendar year, the board of directors finds that the assets of the association in any account exceed the

liabilities of that account as estimated by the board of directors for the coming year, provided that the association may retain as a reserve fund from the excess of the assets over liabilities at the end of any calendar year an amount not to exceed ten percent (10%) of such excess assets of such account. Any such reserve fund or earnings from its investment shall be used only for the payment of covered claims and authorized association expenses. Upon appropriate action by the board of directors such reserve fund shall be refunded to the then member insurers in proportion to the total contribution of each such member insurer to such account.

(c) The following apply with respect to an action involving the association:

(1) Except for an action by the receiver, an action related to or arising out of this chapter against the association must be brought in an Indiana court.

(2) Indiana courts have exclusive jurisdiction over all actions against the association related to or arising out of this chapter.

(3) The exclusive venue for an action by or against the association is in the Marion County Circuit Court, Marion County, Indiana. However, the association may waive this venue for a particular action.

(Formerly: Acts 1971, P.L.390, SEC.1; Acts 1975, P.L.280, SEC.2.) As amended by Acts 1977, P.L.281, SEC.6; P.L.163-1988, SEC.3; P.L.3-1990, SEC.95; P.L.1-1998, SEC.150; P.L.52-2013, SEC.5.

IC 27-6-8-8

Plan of operation

Sec. 8. (a)(i) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and amendments thereto shall become effective upon approval in writing by the commissioner.

(ii) If the association fails to submit a suitable plan of operation by March 31, 1972, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate reasonable rules as are necessary or advisable to effectuate the provisions of this chapter. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall:

(i) Establish the procedures whereby all the powers and duties of the association under section 7 of this chapter will be performed.

(ii) Establish procedures for handling assets of the association.

(iii) Establish the amount and method of reimbursing members

of the board of directors under section 6 of this chapter.

(iv) Establish procedures by which claims may be filed with the association by the liquidator and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of these claims shall be periodically submitted to the association or similar organization in another state by the receiver or liquidator.

(v) Establish regular places and times for meetings of the board of directors.

(vi) Establish procedures for records to be kept of financial transactions of the association, its agents, and the board of directors.

(vii) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision.

(viii) Establish the procedures whereby selections for the board of directors will be submitted to the commissioner.

(ix) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(d) The plan of operation may provide that any or all powers and duties of the association, except those under section 7(a)(3) and 7(b)(3) of this chapter, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. Such a corporation, association, or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

(Formerly: Acts 1971, P.L.390, SEC.1.) As amended by P.L.252-1985, SEC.223; P.L.52-2013, SEC.6.

IC 27-6-8-9

Powers and duties of commissioner

Sec. 9. (a) The commissioner shall:

(i) Notify the association of the existence of an insolvent insurer not later than three (3) working days after the commissioner receives an order of liquidation.

(ii) Upon request of the board of directors, provide the association with a statement of the net direct written premiums of each member insurer.

(b) The commissioner may:

(i) Require that the association notify the insureds of the

insolvent insurer and any other interested parties of the order of liquidation and of their rights under this chapter. This notification shall be by mail at their last known address, where available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation in all counties in which the insolvent insurer transacted insurance business shall be sufficient.

(ii) Require each insurance producer of the insolvent insurer to give prompt written notice by first class mail of such insolvency and the rights of the insured under this chapter to each insured of the insolvent insurer for whom the insurance producer is insurance producer of record, at such insured's last known address.

(iii) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any member insurer which fails to pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that no fine shall be less than one hundred dollars ($100) per month.

(iv) Revoke the designation of any servicing facility if the commissioner finds claims are being handled unsatisfactorily.

(v) Any final action or order of the commissioner under this chapter shall be subject to judicial review in a court of competent jurisdiction.

(Formerly: Acts 1971, P.L.390, SEC.1.) As amended by P.L.163-1988, SEC.4; P.L.178-2003, SEC.41.

IC 27-6-8-10

Effect of paid claims

Sec. 10. (Effect of Paid Claims) (a) Any person recovering under this chapter shall be deemed to have assigned the person's rights under the policy to the association to the extent of the person's recovery from the association. Every insured or claimant seeking the protection of this chapter shall cooperate with the association to the same extent as the 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. 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 previously made and no assessment shall be thereafter made for the purpose of reimbursing the association.

(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 functioning pursuant to IC 27-6-8-8(d). The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this chapter 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 shall have a right to recover from the insurance producer of record any part of the paid claim for unearned premium that represents unearned commission to the insurance producer.

(Formerly: Acts 1971, P.L.390, SEC.1.) As amended by Acts 1977, P.L.281, SEC.7; P.L.178-2003, SEC.42.

IC 27-6-8-11

Nonduplication of recovery

Sec. 11. (a) For purposes of this section, "coverage provided by any other insurance policy" includes:

(1) coverage under an insured health plan, a health maintenance organization, a hospital plan corporation, a professional health service corporation, or a disability insurance policy; and

(2) any amount payable by or on behalf of a self-insurer.

However, the term does not include coverage under a life insurance policy.

(b) Any person having a claim against an insurer shall, in accordance with subsection (c), be required first to exhaust all coverage provided by any other insurance policy, including the right to a defense under the other insurance policy, if the claim under the other insurance policy arises from the same facts, injury, or loss that gave rise to the covered claim against the association under this chapter.

(c) The requirement to exhaust coverage provided by any other insurance policy under subsection (b):

(1) applies regardless of whether the other insurance policy is written by a member insurer; and

(2) does not apply to a right under a:

(A) policy written by an insolvent insurer; or

(B) life insurance policy.

(d) Any person having a claim which may be recovered under more than one (1) 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, the person shall seek recovery first from the association of the location of the property, and if it is a worker's compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this chapter shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

(Formerly: Acts 1971, P.L.390, SEC.1.) As amended by P.L.28-1988, SEC.84; P.L.52-2013, SEC.7.

IC 27-6-8-11.5

High net worth insureds; financial information

Sec. 11.5. (a) The association is not obligated to pay a first party claim by a high net worth insured described in section 4(5)(A) of this chapter.

(b) The association has the right to recover from a high net worth insured described in section 4(5)(B) of this chapter all amounts paid by the association to or on behalf of the high net worth insured, regardless of whether the amounts were paid for indemnity, defense, or otherwise.

(c) The association is not obligated to pay a claim that:

(1) would otherwise be a covered claim;

(2) is an obligation to or on behalf of a person who has a net worth greater than the net worth allowed by the insurance guaranty association law of the state of residence of the claimant at the time specified by the applicable law of the state of residence of the claimant; and

(3) has been denied by the association of the state of residence of the claimant on the basis described in subdivision (2).

(d) The association shall establish reasonable procedures, subject to the approval of the commissioner, for requesting financial information from insureds:

(1) on a confidential basis; and

(2) in the application of this section.

(e) The procedures established under subsection (d) must provide for sharing of the financial information obtained from insureds with:

(1) any other association that is similar to the association; and

(2) the liquidator for an insolvent insurer;

on the same confidential basis.

(f) If an insured refuses to provide financial information that is:

(1) requested under the procedures established under subsection (d); and

(2) available;

the association may, until the time that the financial information is provided to the association, consider the insured to be a high net worth insured for purposes of subsections (a) and (b).

(g) In an action contesting the applicability of this section to an

insured that refuses to provide financial information under the procedures established under subsection (d), the insured bears the burden of proof concerning the insured's net worth at the relevant time. If the insured fails to prove that the insured's net worth at the relevant time was less than the applicable amount set forth in section 4(5)(A) or 4(5)(B) of this chapter, the court shall award to the association the association's full costs, expenses, and reasonable attorney's fees incurred in contesting the claim.
As added by P.L.52-2013, SEC.8.

IC 27-6-8-12
Prevention of insolvencies

Sec. 12. To aid in the detection and prevention of insurer insolvencies:

(1) Every member insurer shall file with the National Association of Insurance Commissioners for use in their Early Warning System on or before March 1, of each year a financial statement of the same type and content as required by IC 27-1-20-21.

(2) It shall be the duty of the commissioner:

(A) To notify the commissioners of all of the other states, territories of the United States, and the District of Columbia in which a member insurer is licensed to do business when he takes any of the following actions against a member insurer:

(i) revocation of license;

(ii) suspension of license;

(iii) makes any formal order that such company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or an increase in capital, surplus, or any other account for the security of policyholders or creditors. Such notice shall be mailed to all commissioners within thirty (30) days following the action taken or the date on which such action occurs.

(B) To report to the board of directors when he has taken any of the actions set forth in (A) of this paragraph or has received a report from any other commissioner indicating that any such action has been taken in another state. Such report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(C) To report to the board of directors when he has reasonable cause to believe from any examination, whether completed or in process, of any member company, that such company may be insolvent or in a financial condition hazardous to the policyholders or the public.

(3) The commissioner may seek the advice and

recommendations of the board of directors concerning any matter affecting his duties and responsibilities regarding the financial condition of member companies and companies seeking admission to transact insurance business in this state.

(4) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. Such reports and recommendations shall not be considered public documents.

(5) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be in a financial condition hazardous to the policyholders or the public. Within thirty (30) days of the receipt of such request, the commissioner shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the commissioner designates provided such persons are qualified insurance accountants or actuaries. The cost of such examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with subsection (1). The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but it shall not be open to public inspection prior to the release of the examination report to the public.

(6) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(Formerly: Acts 1971, P.L.390, SEC.1.) As amended by Acts 1977, P.L.281, SEC.8; P.L.163-1988, SEC.5.

IC 27-6-8-13
Examination of the association

Sec. 13. (Examination of the Association) The Association shall be subject to examination and regulation by the commissioner. The board of directors shall submit, not later than March 30th of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

(Formerly: Acts 1971, P.L.390, SEC.1.)

IC 27-6-8-14
Tax exemption

Sec. 14. (Tax Exemption) The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real or personal property.
(Formerly: Acts 1971, P.L.390, SEC.1.)

IC 27-6-8-15
Recoupment of assessments; tax credits

Sec. 15. (a) Member insurers, which during any preceding calendar year shall have paid one (1) or more assessments levied pursuant to section 7 of this chapter, shall be allowed a credit against premium taxes, adjusted gross income taxes, or any combination thereof upon revenue or income of member insurers which may be imposed by the state, up to twenty percent (20%) of the assessment described in section 7 of this chapter for each calendar year following the year the assessment was paid until the aggregate of all assessments paid to the guaranty association shall have been offset by either credits against such taxes or refunds from the association. The provisions herein are applicable to all assessments levied after the passage of this article.

(b) To the extent a member insurer elects not to utilize the tax credits authorized by subsection (a), the member insurer may utilize the provisions of subsection (c) as a secondary method of recoupment.

(c) The rates and premiums charged for insurance policies to which this chapter applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association and the rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurer.
(Formerly: Acts 1971, P.L.390, SEC.1.) As amended by Acts 1977, P.L.281, SEC.9; P.L.163-1986, SEC.1; P.L.192-2002(ss), SEC.167.

IC 27-6-8-16
Immunity

Sec. 16. (Immunity) There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the association or its agents or employees, the board of directors, or the commissioner or his representatives for any action taken by them in the performance of their powers and duties under this chapter.
(Formerly: Acts 1971, P.L.390, SEC.1.)

IC 27-6-8-17
Stay of proceedings; reopening of default judgments

Sec. 17. (Stay of Proceedings; Reopening of Default Judgments) All proceedings in which the insolvent insurer is a party or is obligated to defend a party in court in this state shall be stayed for up

to six (6) months and such additional time thereafter as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the state whichever is later to permit proper defense by the association of all pending causes of action. 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 an insured, the association either on its own behalf or on behalf of such insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that made the judgment, order, decision, verdict or findings and shall be permitted to defend against the claim on the merits.
(Formerly: Acts 1971, P.L.390, SEC.1; Acts 1973, P.L.279, SEC.2.)

IC 27-6-8-18
Records of insolvent insurers; access; copies

Sec. 18. The liquidator, receiver, or statutory successor of an insolvent insurer covered by this chapter shall permit access by the board or its authorized representative to such of the insolvent insurers records which are necessary for the board in carrying out its functions under this chapter with regard to covered claims. In addition, the liquidator, receiver, or statutory successor shall provide the board or its representative with copies of such records upon the request by the board and at the expense of the board.
(Formerly: Acts 1971, P.L.390, SEC.1; Acts 1973, P.L.279, SEC.3.)

IC 27-6-8-19
Advertising

Sec. 19. No person, including an insurer, insurance producer, or affiliate of an insurer, shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement which uses the existence of the insurance guaranty association of this state for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the Indiana insurance guaranty association law. However, this section does not apply to Indiana insurance guaranty association or to any other entity which does not sell or solicit insurance.
(Formerly: Acts 1973, P.L.279, SEC.4.) As amended by Acts 1977, P.L.281, SEC.10; P.L.178-2003, SEC.43.

IC 27-6-9

Chapter 9. Reinsurance Intermediaries

IC 27-6-9-1

Actuary

Sec. 1. As used in this chapter, "actuary" means a person who is a member in good standing of the American Academy of Actuaries.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-2

Commissioner

Sec. 2. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-3

Controlling person

Sec. 3. As used in this chapter, "controlling person" means any person, firm, association, limited liability company, or corporation who directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of a reinsurance intermediary.

As added by P.L.26-1991, SEC.26. Amended by P.L.8-1993, SEC.423.

IC 27-6-9-4

Insurer

Sec. 4. As used in this chapter, "insurer" means any person, firm, association or corporation duly licensed in Indiana pursuant to the applicable provisions of the insurance law as an insurer.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-5

Licensed producer

Sec. 5. As used in this chapter, "licensed producer" means an insurance producer, broker, or reinsurance intermediary licensed pursuant to the applicable provision of the insurance law.

As added by P.L.26-1991, SEC.26. Amended by P.L.178-2003, SEC.44.

IC 27-6-9-6

Reinsurance intermediary

Sec. 6. As used in this chapter, "reinsurance intermediary" means:

(1) a reinsurance intermediary-broker; or

(2) a reinsurance intermediary-manager.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-7

Reinsurance intermediary-broker

Sec. 7. As used in this chapter, "reinsurance intermediary-broker" or, "RB" means any person, other than an officer or employee of the ceding insurer, "firm," association, or corporation who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of that insurer.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-8

Reinsurance intermediary-manager

Sec. 8. (a) As used in this chapter, "reinsurance intermediary-manager" (or, RM) means any person, firm, association or corporation that:

(1) has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer (including the management of a separate division, department, or underwriting office); and

(2) acts as an agent for that reinsurer;

whether known as a RM, manager, or other similar term.

(b) Notwithstanding subsection (a), the following persons may not be considered a RM, with respect to a reinsurer, for the purposes of this chapter:

(1) An employee of the reinsurer.

(2) A United States manager of the United States branch of an alien reinsurer.

(3) An underwriting manager which, pursuant to contract:

(A) manages all or part of the reinsurance operations of the reinsurer;

(B) is under common control with the reinsurer, subject to IC 27-1-23; and

(C) whose compensation is not based on the volume of premiums written.

(4) The manager of a group, association, pool, or organization of insurers which engage in joint underwriting or joint reinsurance and who are subject to examination by the insurance commissioner of the state in which the manager's principal business office is located.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-9

Reinsurer

Sec. 9. As used in this chapter, "reinsurer" means any person, firm, association, or corporation duly licensed in Indiana pursuant to the applicable provisions of the insurance law as an insurer with the authority to assume reinsurance.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-10

To be in violation

Sec. 10. As used in this chapter, "to be in violation" means that the reinsurance intermediary, insurer, or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with the provisions of this chapter.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-11

Qualified United States financial institution

Sec. 11. As used in this chapter, "qualified United States financial institution" means an institution that:

(1) is organized or (in the case of a United States office of a foreign banking organization) licensed, under the laws of the United States or any state;

(2) is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(3) has been determined by:

(A) the commissioner; or

(B) the Securities Valuation Office of the National Association of Insurance Commissioners;

to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-12

Reinsurance intermediary-broker; requirements

Sec. 12. No person, firm, association, or corporation may act as a RB in Indiana if the RB maintains an office either directly, or as a member or employee of a firm or association, or as an officer, director, or employee of a corporation:

(1) in Indiana, unless the RB is a licensed producer in Indiana; or

(2) in another state, unless the RB:

(A) is a licensed producer in Indiana or another state having a law substantially similar to this chapter; or

(B) is licensed in Indiana as a nonresident reinsurance intermediary.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-13

Reinsurance intermediary-manager; requirements

Sec. 13. No person, firm, association, or corporation may act as a RM:

(1) for a reinsurer domiciled in this state, unless the RM is a licensed producer in this state;

(2) in this state, if the RM maintains an office either directly, or as a member or employee of a firm, limited liability company, or association, or as an officer, director, or employee of a corporation in this state, unless the RM is a licensed producer in this state;

(3) in another state for a nondomestic insurer, unless the RM is:

(A) a licensed producer in Indiana or another state having a law substantially similar to this chapter; or

(B) the person is licensed in this state as a nonresident reinsurance intermediary.

As added by P.L.26-1991, SEC.26. Amended by P.L.8-1993, SEC.424.

IC 27-6-9-14

Bond; errors and omissions policy

Sec. 14. The commissioner may require a RM subject to section 13 of this chapter to:

(1) file a bond from an insurer in an amount acceptable to the commissioner for the protection of the reinsurer; and

(2) maintain an errors and omissions policy in an amount acceptable to the commissioner.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-15

Reinsurance intermediary license; issuance; application; authority to act; nonresidents

Sec. 15. (a) The commissioner may issue a reinsurance intermediary license to any person, firm, association, or corporation who has complied with the requirements of this chapter. Any license issued to a firm or association under this section authorizes all the members of the firm or association and any designated employees to act as reinsurance intermediaries under the license, and all such persons must be named in the application and any supplements thereto. Any license issued to a corporation under this section authorizes all of the officers of the corporation, and any designated employees and directors of the corporation, to act as reinsurance intermediaries on behalf of the corporation, and all such persons must be named in the application and any supplements thereto.

(b) If the applicant for a reinsurance intermediary license is a nonresident, the applicant, as a condition precedent to receiving or holding a license, must:

(1) designate the commissioner as agent for service of process in the manner, and with the same legal effect, provided for by this chapter for designation of service of process upon unauthorized insurers; and

(2) furnish the commissioner with the name and address of a resident of Indiana upon whom notices or orders of the commissioner or process affecting such nonresident reinsurance

intermediary may be served.

(c) A licensee who receives a license under subsection (b) shall promptly notify the commissioner in writing of every change in its designated agent for service of process, and a change in the licensee's designated agent does not become effective until acknowledged by the commissioner.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-16

Refusal to issue license; conditions; summary

Sec. 16. (a) The commissioner may refuse to issue a reinsurance intermediary license if, in the commissioner's judgment:

(1) the applicant, anyone named on the application, or any member, principal, officer, or director of the applicant, is not trustworthy;

(2) any controlling person of the applicant is not trustworthy to act as a reinsurance intermediary; or

(3) any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of such license.

(b) Upon written request therefor, the commissioner shall furnish a summary of the basis for refusal to issue a license. A summary furnished under this subsection is declared confidential for the purposes of IC 5-14-3-4(a)(1) and is not subject to inspection and copying as a public record.

As added by P.L.26-1991, SEC.26. Amended by P.L.1-2002, SEC.110.

IC 27-6-9-17

Attorneys; exemptions

Sec. 17. Attorneys licensed to practice in Indiana, when acting in their professional capacity, are exempt from sections 12 through 16 of this chapter.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-18

Transactions between reinsurance intermediary-broker and insurer; written authorization; contents

Sec. 18. Transactions between a RB and the insurer it represents in the capacity of RB shall only be entered into pursuant to a written authorization, specifying the responsibilities of each party. The authorization shall, at a minimum, contain provisions stating the following:

(1) The insurer may terminate the RB's authority at any time.

(2) The RB will:

(A) render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by,

or owing to, the RB; and

(B) remit all funds due to the insurer within thirty (30) days of receipt.

(3) All funds collected for the insurer's account will be held by the RB in a fiduciary capacity in a bank which is a qualified United States financial institution.

(4) The RB will comply with section 19 of this chapter.

(5) The RB will comply with the written standards established by the insurer for the cession or retrocession of all risks.

(6) The RB will disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-19

Record of transactions; contents; insurer access

Sec. 19. (a) For at least ten (10) years after the expiration of each contract of reinsurance transacted by the RB, the RB will keep a complete record for each transaction showing the following:

(1) The type of contract, limits, underwriting restrictions, classes or risks and territory.

(2) Period of coverage, including effective and expiration dates, cancellation provisions, and notice required of cancellation.

(3) Reporting and settlement requirements of balances.

(4) Rate used to compute the reinsurance premium.

(5) Names and addresses of assuming reinsurers.

(6) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the RB.

(7) Related correspondence and memoranda.

(8) Proof of placement.

(9) Details regarding retrocessions handled by the RB, including the identity of retrocessionaires and percentage of each contract assumed or ceded.

(10) Financial records, including but not limited to, premium and loss accounts.

(11) When the RB procures a reinsurance contract on behalf of a licensed ceding insurer:

(A) directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(B) if placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.

(b) The insurer shall have access to and the right to copy and audit all accounts and records maintained by the RB related to its business in a form usable by the insurer.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-20

Engagement of services of reinsurance intermediary-broker; employment of an individual employed by an RB; financial condition; requirements

Sec. 20. (a) An insurer may not engage the services of any person, firm, association, or corporation to act as a RB on its behalf unless such person is licensed as required by section 12 of this chapter.

(b) An insurer may not employ an individual who is employed by a RB with which it transacts business unless the RB is under common control with the insurer and subject to IC 27-1-23.

(c) The insurer shall annually obtain a copy of statements of the financial condition of each RB with which it transacts business.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-21

Transactions between reinsurance intermediary-manager and reinsurer; written contract; contents

Sec. 21. Transactions between a RM and the reinsurer it represents in the capacity of RM may only be entered into pursuant to a written contract, specifying the responsibilities of each party, which must be approved by the reinsurer's board of directors. At least thirty (30) days before a reinsurer assumes or cedes business through a RM, a true copy of the approved contract must be filed with the commissioner for approval. The contract must, at a minimum, contain provisions that state the following:

(1) The reinsurer may terminate the contract for cause upon written notice to the RM, and may suspend the authority of the RM to assume or cede business during the pendency of any dispute regarding the cause for termination.

(2) The RM will:

(A) render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to, the RM; and

(B) remit all funds due under the contract to the reinsurer on not less than a monthly basis.

(3) All funds collected for the reinsurer's account will be held by the RM in a fiduciary capacity in a bank which is a qualified United States financial institution. The RM may retain no more than three (3) months estimated claims payments and allocated loss adjustment expenses. The RM shall maintain a separate bank account for each reinsurer that it represents.

(4) For at least ten (10) years after expiration of each contract of reinsurance transacted by the RM, the RM will keep a complete record for each transactions showing the following:

(A) The type of contract, limits, underwriting restrictions, classes or risks, and territory.

(B) Period of coverage, including effective and expiration dates, cancellation provisions and notice required of

cancellation, and disposition of outstanding reserves on covered risks.

(C) Reporting and settlement requirements of balances.

(D) Rate used to compute the reinsurance premium.

(E) Names and addresses of reinsurers.

(F) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the RM.

(G) Related correspondence and memoranda.

(H) Proof of placement.

(I) Details regarding retrocessions handled by the RM, as permitted by section 23(d) of this chapter, including the identity of retrocessionaires and percentage of each contract assumed or ceded.

(J) Financial records, including premium and loss accounts.

(K) When the RM places a reinsurance contract on behalf of a ceding insurer:

(i) directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(ii) if placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.

(5) The reinsurer will have access and the right to copy all accounts and records maintained by the RM related to its business in a form usable by the reinsurer.

(6) The contract cannot be assigned in whole or in part by the RM.

(7) The RM will comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks.

(8) The rates, terms, and purposes of commissions, charges, and other fees which the RM may levy against the reinsurer.

(9) If the contract permits the RM to settle claims on behalf of the reinsurer the following apply:

(A) All claims will be reported to the reinsurer in a timely manner.

(B) A copy of the claim file will be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(i) has the potential to exceed the lesser of an amount determined by the commissioner or the limit set by the reinsurer;

(ii) involves a coverage dispute;

(iii) may exceed the RM's claims settlement authority;

(iv) is open for more than six (6) months; or

(v) is closed by payment of the lesser of an amount set by the commissioner or an amount set by the reinsurer.

(C) All claim files will be the joint property of the reinsurer

and RM. However, upon an order of liquidation of the reinsurer, the files shall become the sole property of the reinsurer or its estate, and the RM shall have reasonable access to and the right to copy the files on a timely basis.

(D) Any settlement authority granted to the RM may be terminated for cause upon the reinsurer's written notice to the RM or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

(10) If the contract provides for a sharing of interim profits by the RM, that those interim profits will not be paid until one (1) year after the end of each underwriting period for property business and five (5) years after the end of each underwriting period for casualty business (or a later period set by the commissioner for specified lines of insurance) and not until the adequacy of reserves on remaining claims has been verified under section 23(c) of this chapter.

(11) The RM will annually provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant.

(12) The reinsurer shall periodically (at least semiannually) conduct an on-site review of the underwriting and claims processing operations of the RM.

(13) The RM will disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with that insurer pursuant to the contract.

(14) The acts of the RM shall be considered to be the acts of the reinsurer on whose behalf the RM is acting.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-22

Binding of retrocessions on behalf of reinsurers by RM; conditions; reinsurance syndicates; appointment of producers; payment of claims; collection of payment; settlements; employment of reinsurer employee; sub-RMs

Sec. 22. (a) A RM may not bind retrocessions on behalf of the reinsurer, except that the RM may bind facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for such retrocessions. Guidelines referred to in this subsection must include a list of reinsurers with which the automatic agreements are in effect, and, for each such reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(b) A RM may not commit the reinsurer to participate in reinsurance syndicates.

(c) A RM may not appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which the producer is appointed.

(d) A RM may not, without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of:

(1) an amount specified by the reinsurer; or

(2) one percent (1%) of the reinsurer's policyholder's surplus as of December 31 of the last complete calendar year before the payment or commitment.

(e) A RM may not collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer.

(f) A RM may not jointly employ an individual who is employed by the reinsurer.

(g) A RM may not appoint a sub-RM.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-23

Engagement of services of a reinsurance intermediary-manager; statement of financial condition; loss reserves; authority to contract; termination; board of directors

Sec. 23. (a) A reinsurer may not engage the services of any person, firm, association, or corporation to act as a RM on its behalf unless the person engaged is licensed as required by section 13 of this chapter.

(b) A reinsurer shall annually obtain a copy of statements of the financial condition of each RM which the reinsurer has engaged, prepared by an independent certified accountant in a form acceptable to the commissioner.

(c) If a RM establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the RM. This opinion shall be in addition to any other required loss reserve certification.

(d) Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer, who must not be affiliated with the RM.

(e) Within thirty (30) days of termination of a contract with a RM, the reinsurer shall provide written notification of the termination to the commissioner.

(f) A reinsurer may not appoint to its board of directors any officer, director, employee, controlling shareholder, or subproducer of its RM. This subsection does not apply to relationships governed by IC 27-1-23.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-24

Examination by commissioner; access to records

Sec. 24. (a) A reinsurance intermediary is subject to examination

by the commissioner. The commissioner shall have access to all books, bank accounts, and records of the reinsurance intermediary in a form usable to the commissioner.

(b) A RM may be examined as if it were the reinsurer.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-25

Violations; penalties; review; effect on third parties

Sec. 25. (a) A reinsurance intermediary, insurer, or reinsurer found by the commissioner, after a hearing conducted in accordance with IC 4-21.5, to be in violation of any provision of this chapter, shall:

(1) for each separate violation, pay an administrative penalty in an amount not exceeding five thousand dollars ($5,000);

(2) be subject to revocation or suspension of its license; and

(3) if a violation was committed by the reinsurance intermediary, the reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator, or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to the reinsurance intermediary's violation.

(b) The decision, determination, or order of the commissioner pursuant to subsection (a) is subject to judicial review pursuant to IC 4-21.5.

(c) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided by law.

(d) Nothing contained in this chapter is intended to, or shall in any manner, limit or restrict the rights of policyholders, claimants, creditors, or other third parties, or confer any rights upon those persons.

As added by P.L.26-1991, SEC.26.

IC 27-6-9-26

Rules for implementation and administration of chapter

Sec. 26. The commissioner may adopt rules under IC 4-22-2 for the implementation and administration of this chapter.

As added by P.L.26-1991, SEC.26.

IC 27-6-10

Chapter 10. Credit for Reinsurance

IC 27-6-10-1

"Accredited reinsurer"

Sec. 1. (a) As used in this chapter, "accredited reinsurer" means an insurer that:

(1) files with the commissioner evidence of the insurer's submission to Indiana jurisdiction;

(2) submits to Indiana authority to examine the insurer's books and records;

(3) is:

(A) licensed to transact insurance or reinsurance in at least one (1) state; or

(B) in the case of a United States branch of an alien assuming insurer, entered through and licensed to transact insurance or reinsurance in at least one (1) state;

(4) files annually with the commissioner a copy of the insurer's annual statement filed with the insurance department of the insurer's state of domicile and a copy of the insurer's most recent audited financial statement; and

(5) demonstrates to the commissioner's satisfaction that the insurer:

(A) has adequate financial capacity to meet the insurer's reinsurance obligations; and

(B) is otherwise qualified to assume reinsurance from domestic insurers.

(b) An assuming insurer is considered to meet the requirement specified in subsection (a)(5) as of the time of the assuming insurer's application for accreditation if:

(1) the assuming insurer maintains a surplus as regards policyholders in an amount not less than twenty million dollars ($20,000,000); and

(2) the assuming insurer's accreditation has not been denied by the commissioner within ninety (90) days after submission of the assuming insurer's application.

As added by P.L.116-1994, SEC.54. Amended by P.L.81-2012, SEC.22.

IC 27-6-10-2

"Ceding insurer"

Sec. 2. As used in this chapter, "ceding insurer" has the meaning set forth in IC 27-6-1.1-1.

As added by P.L.116-1994, SEC.54.

IC 27-6-10-2.2

"Certified reinsurer"

Sec. 2.2. As used in this chapter, "certified reinsurer" means an

assuming insurer that is certified by the commissioner under section 11.5 of this chapter.
As added by P.L.81-2012, SEC.23.

IC 27-6-10-3
"Commissioner"

Sec. 3. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.
As added by P.L.116-1994, SEC.54.

IC 27-6-10-4
"Department"

Sec. 4. As used in this chapter, "department" refers to the department of insurance created under IC 27-1-1-1.
As added by P.L.116-1994, SEC.54.

IC 27-6-10-5
"Qualified United States financial institution" as used in IC 27-6-10-14(c)(3)

Sec. 5. As used in section 14(c)(3) of this chapter, "qualified United States financial institution" means an institution that:

(1) is organized, or in the case of a United States office of a foreign banking organization licensed, under the laws of the United States or any state thereof;

(2) is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(3) has been determined by the commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet the standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

As added by P.L.116-1994, SEC.54. Amended by P.L.81-2012, SEC.24.

IC 27-6-10-6
"Qualified United States financial institution" as used in IC 27-6-10-11(a) and IC 27-6-10-14(b)

Sec. 6. As used in sections 11(a) and 14(b) of this chapter, "qualified United States financial institution" means an institution that:

(1) is organized, or in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(2) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust

companies.

As added by P.L.116-1994, SEC.54.

IC 27-6-10-7

Asset or reduction from liability; requirements

Sec. 7. Credit for reinsurance shall be allowed to any domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only as follows:

(1) The reinsurer meets the requirements of one (1) of the following:

(A) Only with respect to cessions of the kind of insurance or reinsurance business for which the assuming insurer is licensed or otherwise permitted to assume in:

(i) the assuming insurer's state of domicile; or

(ii) with respect to a United States branch of an alien assuming insurer, the state through which the alien assuming insurer is entered and licensed to engage in the business of insurance or reinsurance;

section 8, 9, or 10 of this chapter.

(B) Sections 10 and 12 of this chapter.

(C) Sections 11 and 12 of this chapter.

(D) Section 11.5 of this chapter.

(E) Section 13 of this chapter.

(2) The reinsurance contract provides in substance that, in the event of the insolvency of the ceding insurer, the reinsurance is payable under a contract reinsured by the assuming insurer on the basis of reported claims allowed in the liquidation proceedings, subject to court approval, without diminution because of the insolvency of the ceding insurer. Payments under this subdivision must be made directly to the ceding insurer or to the ceding insurer's domiciliary liquidator except as provided in IC 27-9-3-30.1. The reinsurance agreement may provide that the domiciliary liquidator of an insolvent ceding insurer shall give written notice to an assuming insurer of the pendency of a claim against the ceding insurer on the contract reinsured within a reasonable time after the claim is filed in the liquidation proceeding. During the pendency of the claim, any assuming insurer may investigate the claim and interpose in the proceeding where the claim is to be adjudicated, at the assuming insurer's expense, any defenses that the assuming insurer considers available to the ceding insurer or the liquidator. If two (2) or more assuming insurers are involved in the same claim and a majority in interest elect to interpose a defense to the claim, the expense must be apportioned under the terms of the reinsurance agreement as though the expense had been incurred by the ceding insurer.

As added by P.L.116-1994, SEC.54. Amended by P.L.233-1999, SEC.7; P.L.11-2011, SEC.26; P.L.81-2012, SEC.25.

IC 27-6-10-8
Assuming insurer licensed to transact insurance or reinsurance

Sec. 8. As provided in section 7 of this chapter, credit for reinsurance shall be allowed a domestic ceding insurer when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in Indiana.

As added by P.L.116-1994, SEC.54.

IC 27-6-10-9
Credit for reinsurance ceded to accredited reinsurer

Sec. 9. As provided in section 7 of this chapter, credit for reinsurance shall be allowed a domestic ceding insurer when the reinsurance is ceded to an assuming insurer that is an accredited reinsurer in Indiana.

As added by P.L.116-1994, SEC.54. Amended by P.L.81-2012, SEC.26.

IC 27-6-10-10
Assuming insurer domiciled or entering through another state

Sec. 10. As provided in section 7 of this chapter, credit shall be allowed a domestic ceding insurer when the reinsurance is ceded to an assuming insurer:

(1) that:

(A) is domiciled in; or

(B) in the case of a United States branch of an alien assuming insurer, is entered through;

a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this chapter;

(2) that:

(A) maintains a surplus as regards policyholders in an amount not less than twenty million dollars ($20,000,000); and

(B) submits to the authority of Indiana to examine the insurer's books and records;

provided, however, that the requirement of clause (A) does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system; and

(3) that complies with section 12 of this chapter.

As added by P.L.116-1994, SEC.54. Amended by P.L.81-2012, SEC.27.

IC 27-6-10-11
Assuming insurer maintenance of trust fund; requirements for form and content of trust; reports

Sec. 11. (a) As provided in section 7 of this chapter and subject to section 13.3 of this chapter, credit for reinsurance shall be allowed a domestic ceding insurer when the reinsurance is ceded to an

assuming insurer that maintains a trust fund in a qualified United States financial institution (as defined in section 6 of this chapter) for the payment of the valid claims of its United States ceding insurers, their assigns, and successors in interest, and the assuming insurer complies with section 12 of this chapter. In order for the commissioner to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the commissioner substantially the same information as that required to be reported by licensed insurers on the National Association of Insurance Commissioners' annual statement form. The assuming insurer shall submit to the examination of the assuming insurer's books and records by the commissioner and shall bear the expense of the examination. A trust maintained under this section shall comply with the provisions of this section.

(b) The form of a trust described in subsection (a) and any amendments to the trust must:

(1) have been approved by:

(A) the commissioner of the state where the trust is domiciled; or

(B) the commissioner of another state who, under the terms of the trust instrument, has accepted principal regulatory oversight of the trust; and

(2) be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled.

(c) The following requirements apply to the following categories of assuming insurer:

(1) In the case of a trust of a single assuming insurer, the following apply:

(A) The trust fund shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers.

(B) Except as provided in clause (C), the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars ($20,000,000).

(C) After the assuming insurer has, for at least three (3) full years, permanently discontinued underwriting new business secured by the trust and the commissioner that has principal regulatory oversight of the trust has performed a risk assessment:

(i) that may involve an actuarial review, including an independent analysis of reserves and cash flows; and

(ii) that considers all material risk factors, including the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements specified in clause (B) on the assuming insurer's liquidity or solvency;

and determined that a surplus level that is less than the

amount required by clause (B) is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development, the commissioner may authorize a reduction in the trusteed surplus amount required by clause (B). However, the amount required by clause (B) may not be reduced to an amount less than thirty percent (30%) of the assuming insurer's liabilities that are attributable to reinsurance ceded by United States ceding insurers covered by the trust.

(2) In the case of a group including incorporated and individual unincorporated underwriters that is an assuming insurer, the following apply:

(A) For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date after December 31, 1992, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by United States ceding insurers to any underwriter of the group.

(B) Notwithstanding any other provision of this chapter, for reinsurance ceded under reinsurance agreements with an inception date before January 1, 1993, and not amended or renewed after December 31, 1992, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States.

(C) In addition to the trusts described in clauses (A) and (B), the group shall maintain in trust a trusteed surplus of which one hundred million dollars ($100,000,000) shall be held jointly for the benefit of United States ceding insurers of any member of the group for all years of account.

(D) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

Not more than ninety (90) days after the group's financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the commissioner an annual certification by the group's domiciliary regulator of the solvency of each underwriter member. However, if a certification is unavailable, the group shall provide to the commissioner financial statements of each underwriter member of the group, prepared by independent public accountants.

(3) In the case of a group of incorporated underwriters under common administration that is an assuming insurer, the group:

(A) must have continuously transacted an insurance

business outside the United States for at least three (3) years immediately before making application for accreditation;

(B) shall maintain an aggregate policyholders' surplus of at least ten billion dollars ($10,000,000,000);

(C) shall maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group under reinsurance contracts issued in the name of the group;

(D) shall maintain a joint trusteed surplus of which one hundred million dollars ($100,000,000) shall be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities; and

(E) shall, not more than ninety (90) days after the group's financial statements are due to be filed with the group's domiciliary regulator, make available to the commissioner:

(i) an annual certification of each underwriter member's solvency by the member's domiciliary regulator; and

(ii) financial statements of each underwriter member of the group prepared by the member's independent public accountant.

(d) The trust instrument of a trust shall provide that contested claims are valid and enforceable upon the final order of any court with jurisdiction in the United States.

(e) A trust shall vest legal title to the trust's assets in the trustees of the trust for the benefit of the assuming insurer's United States ceding insurers, their assigns, and successors in interest.

(f) A trust and the assuming insurer shall be subject to examination as determined by the commissioner.

(g) A trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(h) Not later than February 28 of each year the trustee of a trust permitted under this section shall report in writing to the commissioner the following information:

(1) The balance of the trust.

(2) A listing of the trust's investments at the preceding year end.

(3) A certification of the date of termination of the trust, if applicable, or a certification that the trust shall not expire before the following December 31.

(i) Credit may only be permitted under this section if an assuming insurer also complies with section 12 of this chapter.

As added by P.L.116-1994, SEC.54. Amended by P.L.81-2012, SEC.28.

IC 27-6-10-11.5

Credit for reinsurance ceded to certified reinsurer; certification

requirements; qualified jurisdictions; ratings

Sec. 11.5. (a) As provided in section 7 of this chapter and subject to section 13.3 of this chapter, credit for reinsurance shall be allowed a domestic ceding insurer when the reinsurance is ceded to an assuming insurer that:

(1) has been certified as a certified reinsurer by the commissioner in Indiana; and

(2) secures the assuming insurer's obligations as required by this section.

(b) An assuming insurer must do all of the following to be eligible for certification under this section:

(1) Be domiciled and licensed to engage in insurance or reinsurance business in a jurisdiction that has been determined under subsection (d) or (e) by the commissioner to be a qualified jurisdiction.

(2) Maintain minimum capital and surplus, or the equivalent, in an amount determined by the commissioner in rules adopted under IC 4-22-2.

(3) Maintain financial strength ratings from at least two (2) rating agencies that the commissioner determines acceptable under rules adopted under IC 4-22-2.

(4) Agree to submit to the jurisdiction of Indiana.

(5) Appoint the commissioner as the assuming insurer's agent for service of process in Indiana.

(6) Agree to provide security for one hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if the assuming insurer resists enforcement of a final United States judgment.

(7) Agree to meet information filing requirements determined by the commissioner, at the time of application for certification and on an ongoing basis.

(8) Satisfy any other requirements specified by the commissioner.

(c) An association that includes incorporated and individual unincorporated underwriters may be certified under this section if all of the following requirements are met:

(1) The association must meet all of the requirements described in subsection (b).

(2) The association must satisfy the association's minimum capital and surplus requirements through the capital and surplus equivalents (net of liabilities) of the association and the association's members, including a joint central fund:

(A) that may be applied to any unsatisfied obligation of the association or any of the association's members; and

(B) in an amount determined by the commissioner to provide adequate protection.

(3) The incorporated members of the association:

(A) may not engage in any business other than underwriting

as a member of the association; and

(B) are subject to the same level of regulation and solvency control by the association's domiciliary regulator as the level that applies to the unincorporated members of the association.

(4) Not more than ninety (90) days after the association's financial statements are due to be filed with the association's domiciliary regulator, the association must provide to the commissioner:

(A) an annual certification by the association's domiciliary regulator of the solvency; or

(B) if a certification is unavailable, financial statements prepared by the independent public accountant;

of each underwriter member of the association.

(d) The commissioner shall create and publish a list of non-United States jurisdictions that the commissioner determines are qualified jurisdictions. The following requirements apply to the commissioner's creation, publication, maintenance, and use of the list created and published under this subsection:

(1) In determining whether a jurisdiction is a qualified jurisdiction, the commissioner shall:

(A) initially and on an ongoing basis, evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction;

(B) consider the rights, benefits, and extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the United States;

(C) consider the list of qualified jurisdictions that is published by the National Association of Insurance Commissioners committee process; and

(D) consider any other factors that the commissioner considers necessary, including any of the following:

(i) The framework under which the assuming insurer is regulated.

(ii) The structure and authority of the domiciliary regulator with respect to solvency requirements and financial surveillance.

(iii) The substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction.

(iv) The form and substance of financial reports required to be filed or made public by reinsurers in the domiciliary jurisdiction, and the accounting principals used.

(v) The domiciliary regulator's willingness to cooperate with United States regulators and the commissioner.

(vi) The history of performance by assuming insurers in the domiciliary jurisdiction.

(vii) Documented evidence of substantial problems in the domiciliary jurisdiction with the enforcement of final

United States judgments.

(viii) Relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the International Association of Insurance Supervisors or a successor organization.

(2) A jurisdiction considered for qualification under this subsection must:

(A) agree to share information and cooperate with the commissioner with respect to all certified reinsurers that are domiciled in the jurisdiction; and

(B) not have been determined by the commissioner not to have adequately and promptly enforced final United States judgments and arbitration awards;

to be determined to be a qualified jurisdiction.

(3) If the commissioner determines that a jurisdiction is qualified, but the qualified jurisdiction does not appear on the National Association of Insurance Commissioners list described in subdivision (1)(C), the commissioner must thoroughly document the commissioner's justification for the determination in accordance with criteria established by the commissioner in rules adopted under IC 4-22-2.

(e) The commissioner:

(1) shall consider a United States jurisdiction that meets the requirements for accreditation under the National Association of Insurance Commissioners financial standards and accreditation program to be a qualified jurisdiction; and

(2) may, instead of revocation, indefinitely suspend a certified reinsurer's certification under this section if the certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction.

(f) The commissioner shall:

(1) after considering the financial strength ratings assigned to the certified reinsurer by rating agencies considered acceptable to the commissioner according to rules adopted under IC 4-22-2, assign a rating to each certified reinsurer; and

(2) publish a list of all certified reinsurers and the rating assigned to each certified reinsurer under subdivision (1).

(g) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this section at a level consistent with the rating assigned by the commissioner under subsection (f), as follows:

(1) For a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security:

(A) in a form acceptable to the commissioner and consistent with section 14 of this chapter; or

(B) in a multibeneficiary trust under section 11 of this chapter.

(2) If a certified reinsurer:

(A) maintains a trust to fully secure the certified reinsurer's obligations under section 11 of this chapter; and

(B) chooses to secure the certified reinsurer's obligations incurred as a certified reinsurer under this section in the form of a multibeneficiary trust;

the certified reinsurer shall maintain separate trust accounts for the certified reinsurer's obligations under section 11 of this chapter and for the certified reinsurer's obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security under this section or comparable laws of other United States jurisdictions.

(3) If a certified reinsurer described in subdivision (2) has not agreed:

(A) in the language of the trust; and

(B) under an agreement with the commissioner that has principal regulatory oversight of each trust account described in subdivision (2);

to fund, upon termination of any of the trust accounts and from the surplus of the terminated trust account, any deficiency of any of the other trust accounts, the commissioner shall revoke the certified reinsurer's certification under this section.

(4) The minimum trusteed surplus requirements of section 11 of this chapter do not apply with respect to a multibeneficiary trust that is maintained by a certified reinsurer for the purpose of securing obligations incurred by the certified reinsurer under this section. However, the multibeneficiary trust must maintain a minimum trusteed surplus of at least ten million dollars ($10,000,000).

(5) If the security for obligations incurred by a certified reinsurer under this section is insufficient, the commissioner:

(A) shall reduce the allowable credit by an amount in proportion to the deficiency; and

(B) may impose further reductions in the allowable credit if the commissioner determines that a material risk exists that the certified reinsurer's obligations will not be paid in full when the obligations are due.

(6) If the certification of an assuming insurer under this section is revoked, suspended, inactivated, or voluntarily surrendered, the commissioner shall, for purposes of reinsurance in force:

(A) except as provided in clause (B), regulate the assuming insurer as if the assuming insurer were a certified reinsurer; and

(B) require that the assuming insurer provide security for one hundred percent (100%) of the assuming insurer's obligations attributable to the reinsurance in force.

However, clause (B) does not apply to an assuming insurer after certification is suspended or inactivated if, after suspension or

inactivation, the commissioner assigns a new rating to the assuming insurer that is higher than the rating assigned under subsection (f)(1) before certification was suspended or inactivated.

(h) If an assuming insurer that applies for certification under this section is a certified reinsurer in a jurisdiction that is accredited by the National Association of Insurance Commissioners, the commissioner may:

(1) defer to the:

(A) accredited jurisdiction's certification of the assuming insurer; and

(B) rating assigned to the assuming insurer by the accredited jurisdiction; and

(2) consider the assuming insurer a certified reinsurer in Indiana without the assuming insurer meeting the requirements of subsection (b)(2) and (b)(3).

(i) A certified reinsurer that ceases to assume new business in Indiana may request that the commissioner allow the certified reinsurer to maintain certification in inactive status to continue to qualify for the reduction in security for the certified reinsurer's in-force business in Indiana. If inactive status is granted by the commissioner, the certified reinsurer shall continue to comply with this section and the commissioner shall, after considering the reasons that the certified reinsurer has ceased assuming new business in Indiana, assign a new rating to the certified reinsurer.

(j) If a certified reinsurer continues throughout the year to pay claims in a timely manner, the certified reinsurer is not, for one (1) year after the date of the first liability reserve entry by a ceding company resulting from a loss from a catastrophic occurrence recognized by the commissioner, required to post security for the catastrophe recoverables in the following lines of business (as reported on the National Association of Insurance Commissioners annual financial statement and specifically related to the catastrophic occurrence):

(1) Fire.

(2) Allied lines.

(3) Farmowners multiple peril.

(4) Homeowners multiple peril.

(5) Commercial multiple peril.

(6) Inland marine.

(7) Earthquake.

(8) Motor vehicle physical damage.

As added by P.L.81-2012, SEC.29.

IC 27-6-10-12

Assuming insurers not licensed, accredited, or certified in Indiana

Sec. 12. If an assuming insurer is not licensed, accredited, or certified to transact insurance or reinsurance in Indiana, the credit

permitted by sections 10 and 11 of this chapter shall not be allowed unless the assuming insurer agrees in the reinsurance agreements to all of the following:

(1) That in the event of the failure of the assuming insurer to perform the assuming insurer's obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall:

(A) submit to the jurisdiction of any court with jurisdiction in any state of the United States;

(B) comply with all requirements necessary to give the court described in clause (A) jurisdiction; and

(C) abide by the final decision of the court or of any appellate court in the event of an appeal.

(2) To designate the commissioner or an attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

This section is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the agreement.

As added by P.L.116-1994, SEC.54. Amended by P.L.81-2012, SEC.30.

IC 27-6-10-13

Assuming insurer failure to meet requirements

Sec. 13. Credit shall be allowed to a domestic ceding insurer when the reinsurance is ceded to an assuming insurer not meeting the requirements of sections 8, 9, 10, 11, or 11.5 of this chapter, but only with respect to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

As added by P.L.116-1994, SEC.54. Amended by P.L.81-2012, SEC.31.

IC 27-6-10-13.3

Assuming insurer failure to meet requirements; requirements for exception to disallowance of credit

Sec. 13.3. If an assuming insurer does not meet the requirements of section 8, 9, or 10 of this chapter, a credit allowed under section 11 or 11.5 of this chapter is not allowed unless the assuming insurer agrees in the trust agreements under section 11 or 11.5 of this chapter to the following:

(1) That if the trust fund is inadequate because the:

(A) trust fund contains less than the amount required by section 11(c) of this chapter; or

(B) grantor of the trust is declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the law of the grantor's domiciliary state

or country;

the trustee shall comply with an order of the commissioner that has regulatory oversight of the trust or of a court with jurisdiction directing the trustee to transfer all assets of the trust fund to the commissioner that has regulatory oversight of the trust.

(2) That:

(A) the assets of the trust will be distributed by, and claims will be filed with and valued by, the commissioner that has regulatory oversight of the trust; and

(B) the assets of the trust will be distributed under, and claims will be filed and valued under, the laws of the domiciliary state of the trust that apply to liquidation of domestic insurers.

(3) That if the commissioner that has regulatory oversight of the trust determines that any part of the assets of the trust fund is unnecessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the commissioner that has regulatory oversight of the trust shall return the unnecessary part of the assets to the trustee for distribution under the trust agreement.

(4) That the grantor of the trust waives any legal right under United States law that is inconsistent with this section.

As added by P.L.81-2012, SEC.32.

IC 27-6-10-13.6

Accredited or certified reinsurer failure to meet requirements; suspension or revocation

Sec. 13.6. If an accredited reinsurer or a certified reinsurer ceases to meet the requirements for accreditation or certification under this chapter, the commissioner may suspend or revoke the accreditation or certification as follows:

(1) After the reinsurer receives from the commissioner notice and the opportunity for a hearing, the commissioner may order suspension or revocation of the accreditation or certification, which takes effect after the hearing unless one (1) of the following occurs:

(A) The reinsurer waives the right to a hearing.

(B) The commissioner's order is based on:

(i) regulatory action by the reinsurer's domiciliary jurisdiction; or

(ii) the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in the reinsurer's domiciliary jurisdiction or in the reinsurer's primary certifying jurisdiction described in section 11.5(h) of this chapter.

(C) The commissioner determines that an emergency requires immediate action and a court with jurisdiction has

not stayed the commissioner's action based on the determination.

(2) If a reinsurer's accreditation or certification is suspended under this section, credit for reinsurance is not allowed for a reinsurance contract that is issued or renewed by the reinsurer during the period of suspension except to the extent that the reinsurer's obligations under the reinsurance contract are secured under section 14 of this chapter.

(3) If a reinsurer's accreditation or certification is revoked under this section, credit for reinsurance is not allowed for a reinsurance contract that is issued or renewed by the reinsurer after the effective date of the revocation except to the extent that the reinsurer's obligations under the reinsurance contract are secured under section 11.5(g) or 14 of this chapter.

As added by P.L.81-2012, SEC.33.

IC 27-6-10-13.8

Ceding insurer exposure management requirements

Sec. 13.8. (a) A ceding insurer shall manage the ceding insurer's reinsurance recoverables in proportion to the ceding insurer's own book of business. A domestic ceding insurer shall, not more than thirty (30) days after reinsurance recoverables from any single assuming insurer or group of affiliated assuming insurers:

(1) exceeds; or

(2) is determined by the domestic ceding insurer to be likely to exceed;

fifty percent (50%) of the domestic ceding insurer's last reported surplus to policyholders, notify the commissioner concerning the actual or likely exposure.

(b) A ceding insurer shall diversify the ceding insurer's reinsurance program. A domestic ceding insurer shall, not more than thirty (30) days after:

(1) ceding to any single assuming insurer or group of affiliated assuming insurers reinsurance in excess of; or

(2) determining that the reinsurance ceded to any single assuming insurer or group of affiliated assuming insurers is likely to exceed;

twenty percent (20%) of the domestic ceding insurer's gross written premium in the preceding calendar year, notify the commissioner concerning the actual or likely exposure.

(c) A notice required by subsection (a) or (b) must include evidence that the domestic ceding insurer is safely managing the actual or likely exposure.

As added by P.L.81-2012, SEC.34.

IC 27-6-10-14

Reduction from liability for reinsurance ceded to assuming insurer not meeting statutory requirements; amount; security

Sec. 14. (a) An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of section 8, 9, 10, 11, 11.5, 12, 13, 13.3, 13.6, or 13.8 of this chapter shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer.

(b) The reduction permitted under subsection (a) shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder. The security must be held:

(1) in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or

(2) in the case of a trust, in a qualified United States financial institution (as defined in section 6 of this chapter).

(c) The security described under subsection (b) may be in the following forms:

(1) Cash.

(2) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including securities that are considered exempt from filing (as defined by the Purposes and Procedures Manual of the Securities Valuation Office), and qualifying as admitted assets.

(3) Clean, irrevocable, unconditional letters of credit:

(A) issued or confirmed by a qualified United States financial institution (as defined in section 5 of this chapter);

(B) effective not later than December 31 in the year for which the filing is being made; and

(C) in the possession of or in trust for the ceding insurer on or before the filing date of the ceding insurer's annual statement.

Letters of credit that meet applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until the earlier of their expiration, extension, renewal, modification, or amendment.

(4) Any other form of security acceptable to the commissioner.

As added by P.L.116-1994, SEC.54. Amended by P.L.2-1995, SEC.105; P.L.81-2012, SEC.35.

IC 27-6-10-15

Implementation of chapter

Sec. 15. The commissioner may adopt rules under IC 4-22-2 to implement this chapter.

As added by P.L.116-1994, SEC.54.

IC 27-6-10-16

Repealed

(As added by P.L.11-2011, SEC.27. Repealed by P.L.81-2012, SEC.36.)

IC 27-7

ARTICLE 7. SPECIAL TYPES OF INSURANCE

IC 27-7-1

Chapter 1. Lloyds Insurance

IC 27-7-1-1

Participating underwriters; certificate of authority; application

Sec. 1. No persons, partnerships or corporations shall engage in the business of such insurance as is herein specified as "Lloyds" unless twenty-five (25) or more persons, partnerships or corporations, a majority of whom shall be bona fide residents of the state of Indiana shall have a certificate of authority from the auditor of state (commissioner of insurance) so to do. The application for such certificate of authority shall be signed by the attorney or attorneys in fact of those persons desiring such certificate, and must be accompanied by a declaration which must set forth the following provisions:

1. The name under which the business is to be conducted, which name shall contain the word "Lloyds," and shall not be similar to that of any existing Lloyds association or corporation in this state, as, in the opinion of the auditor of state, is calculated to deceive or mislead.

2. The exact location of the principal office in which the business is to be conducted, which office must be in the state of Indiana.

3. The kind of insurance intended to be written, which shall be only as hereinafter stated.

4. An exact copy of the articles of association or copartnership agreement, made by and between such underwriters.

5. Name, address and amount subscribed by each of the underwriters so proposing to engage in said business.

6. The designation or appointment of one (1) or more attorneys in fact, who shall have residence in Indiana, with full name and address, upon any one of whom summons or consent legal process can be served.

7. That amounts subscribed by said underwriters have been paid as follows: Not less than twenty-five per cent (25%) of said subscriptions in cash, not more than fifty percent (50%) of said subscription secured by collateral note (payable on thirty (30) days' demand) duly approved by a committee selected by the subscribers to pass thereon, and not over twenty-five per cent (25%) of said subscription evidenced by subscriber's individual note.

8. That the total of said subscription shall not be less than two hundred and fifty thousand dollars ($250,000), and that at least twenty-five per cent (25%) thereof has been paid in cash.

(Formerly: Acts 1919, c.177, s.1.)

IC 27-7-1-2

Policies; filing; contents; special provisions

Sec. 2. There shall be filed with the auditor of state a copy of each form of policy by it issued. Said policies shall show the name and address, as well as the amount of the subscription of each subscriber, and shall be signed by the attorneys in fact, and they shall contain the following special provisions:

First: Whenever, under the terms of this policy, notice or consent is required to be given to or by the company, notice or consent given to or by the attorney or attorneys in fact shall be sufficient compliance therewith, and each underwriter hereon shall be bound thereby, the same as though notice or consent had been given to or by each of such underwriters individually.

Second: In no event, shall the liability of any underwriter exceed the sum underwritten by him or them hereon, and, in no event, shall any underwriter be liable for any part of the sum underwritten hereon by any other underwriter.

Third: The insured agrees by the acceptance of this policy that no underwriter hereon shall, in any event, be liable for claims exceeding, in the aggregate, on all policies, certificates or contracts issued on his or their behalf, in the name of this Lloyds for an amount in excess of the unpaid portion, if any, of his or their original subscription or contribution to said Lloyds, as indorsed hereon.

Fourth: In case of action brought to enforce the provisions of this policy, same shall be brought against the attorney or attorneys in fact for the underwriters, as representing all of the said underwriters, and each of the underwriters hereto hereby agrees to abide by the final results of any suit so brought as fixing the proportionate amount of his or their individual liability.

Fifth: This policy is made and accepted subject to all the stipulations and conditions contained therein, together with such other provisions, agreements or conditions as may be indorsed hereon, or added hereto, and as to such provisions and conditions, no officer, agent or representative shall have such power or be deemed or held to have waived such provisions or conditions unless such waiver, if any, shall be indorsed upon or attached hereto, nor shall any privilege or permission affecting the insurance under this policy exist or be claimed by the assured unless so indorsed or attached.

(Formerly: Acts 1919, c.177, s.2.)

IC 27-7-1-3

Additional underwriters

Sec. 3. After any Lloyds is authorized to do business in this state pursuant to this law, it may be joined by other and additional underwriters, but, in that event, such underwriters who may thereafter join such authorized Lloyds shall be held to be bound by the documents on file with the auditor of state concerning such Lloyds.

(Formerly: Acts 1919, c.177, s.3.)

IC 27-7-1-4
Examination; issuance of certificate of authority

Sec. 4. After such documents specified shall have been filed, the auditor of state shall cause an examination of such Lloyds to be made, and after he has specified that all of the facts alleged in the declaration are true, and that the articles of association or copartnership agreement is of such character that the rights of the policyholders will be protected thereunder, he shall issue, or cause to be issued, a certificate of authority to such Lloyds to do such business as is specified in the declaration, which certificate shall be issued to such Lloyds under the name designated and approved, authorizing the underwriters thereof to do the business permitted through its attorney or attorneys in fact.
(Formerly: Acts 1919, c.177, s.4.)

IC 27-7-1-5
Investments

Sec. 5. Any such Lloyds as may be thus authorized to do business in this state shall not invest its funds except in accordance with the laws of this state relative to the investment of the funds of domestic stock insurance companies doing a similar business, except in such securities as may be held by said Lloyds as a guaranty for the payment of any subscription.
(Formerly: Acts 1919, c.177, s.5.)

IC 27-7-1-6
Unearned premium reserve

Sec. 6. Such Lloyds shall maintain the same unearned premium reserve as is required of all domestic stock companies writing a like business.
(Formerly: Acts 1919, c.177, s.6.)

IC 27-7-1-7
Insurance authorized under Lloyds plan; deposits; additional deposits; withdrawal of deposits

Sec. 7. The following insurance shall be authorized and permitted to be written by Lloyds under this chapter:

(1) For the purpose of making insurance on dwelling-houses, stores and all kinds of buildings and household furniture, and other property against loss or damage, including loss of use or occupancy, by fire, lightning, windstorm, tornado, cyclone, earthquake, hail, frost or snow, bombardment, invasion, insurrection, riots or civil war or commotion, military or usurped power, and by explosion, whether fire ensues or not, except explosions on risks specified in this section, and also against loss or damage by water to any goods or premises arising from the breakage or leakage of sprinklers, pumps, or other apparatuses erected for extinguishing fires, and of water

pipes, and against accidental injury to such sprinklers, pumps, or other apparatuses, and upon vessels, boats, cargoes, goods, merchandise, freight, and other property against loss or damage by all or any of the risks of lake, river, canal, and inland navigation and transportation, as well as by any or all of the risks of credit and upon automobiles, whether stationary or being operated under their power, which shall include all or any of the hazards of fire, explosions, transportation, collision, loss by legal liability for damage to property and to persons resulting from the maintenance and use of automobiles and loss by burglary or theft or both.

(2) For the purpose of making insurance upon vessels, freights, goods, wares, merchandise, specie, bullion, jewels, profits, commissions, bank notes, bills of exchange and other evidence of debt, bottomry and respondentia interests, and every insurance appertaining to or connected with marine risks and risks of transportation and navigation, including the risks of lake, river, canal, and inland transportation and navigation, and to effect reinsurance on any risk of the subscribers hereto, or any of said risks wholly or in part, or the transfer thereof, and to accept any authorized risk whether direct or by reinsurance.

(3) For the purpose of making insurance against loss or damage resulting from accident to or injury sustained by an employee or other person for which accident or injury the insured is liable.

Provided, that no such insurance shall be written by any Lloyds under this chapter until such Lloyds shall have deposited with the department of insurance of the state of Indiana the sum of twenty-five thousand dollars ($25,000) in the direct or indirect obligations of the United States or of any state of the United States. In the event the total of all unsatisfied and unappealed from final awards made by the worker's compensation board under IC 22-3-2 through IC 22-3-6 against any Lloyds having made the above deposit shall exceed the amount of the above said deposit, then the department of insurance may require such Lloyds to make an additional deposit or deposits in cash in direct or indirect obligations of the United States or of any state of the United States in a sum equal to the difference between the amount of the unsatisfied final awards and the amount of the deposit with the department of insurance. The department of insurance is hereby authorized and directed to receive such deposit or deposits and to hold them exclusively for the protection of the holders of such insurance policies. Any deposit so made shall not be withdrawn except upon filing with the department of insurance evidence satisfactory to it that such Lloyds has no unsecured liability outstanding in this state upon any such insurance policy, and upon the approval of the department of insurance such Lloyds may withdraw such deposit, except that the above mentioned additional deposit may be withdrawn with the

approval of the department of insurance upon filing satisfactory evidence that the total of all unsatisfied and unappealed from final awards made by the worker's compensation board do not exceed the amount of twenty-five thousand dollars ($25,000).
(Formerly: Acts 1919, c.177, s.7; Acts 1937, c.143, s.1.) As amended by P.L.252-1985, SEC.224; P.L.28-1988, SEC.85.

IC 27-7-1-8
Supervision and control

Sec. 8. The auditor of state shall have the same supervision and control over Lloyds as he has over stock insurance companies incorporated under the laws of Indiana.
(Formerly: Acts 1919, c.177, s.8.)

IC 27-7-1-9
Foreign Lloyds association; certificate of authority; application; unearned premium reserve

Sec. 9. The insurance commissioner may, in his discretion, issue a certificate of authority to a Lloyds domiciled in another state to do business in this state, for permission to do which application is made as may be authorized by the articles of association or copartnership agreement under which said Lloyds is operated, provided, however, that in no event shall authority be given to any such Lloyds to do any kind of insurance business other than those specified in section 7 of this chapter. The application for such certificate shall specify the kind of business such Lloyds desires the authority to transact in this state. It must be signed by the attorney or attorneys in fact for such Lloyds, and must file with the auditor of state a certificate from the insurance department of its home state that it has and maintains at all times an unearned premium reserve as is required of stock companies of said state, and that the total subscription of its subscribers shall not be less than two hundred and fifty thousand dollars ($250,000), and that at least twenty-five percent (25%) thereof is paid in cash.
(Formerly: Acts 1919, c.177, s.9.) As amended by P.L.252-1985, SEC.225.

IC 27-7-1-10
Foreign Lloyds association; documents required; appointment of attorney for service of process

Sec. 10. A true copy of the articles of association or copartnership agreement, power of attorney, and a copy of each form of policy by it issued, verified by the attorney or attorneys in fact, shall be filed with the auditor of state, as well as a copy of the last report filed with the insurance department of its home state, and also a declaration and agreement, duly executed and acknowledged by the attorneys in fact of said Lloyds, appointing the auditor of state as a true and lawful attorney for such Lloyds and the underwriters thereof in and for this state, upon whom all legal process in any action or proceedings

against said Lloyds or the underwriters thereof may be served, and that any service upon him shall be equivalent to the personal service within the state of such persons of each and every such underwriter.
(Formerly: Acts 1919, c.177, s.10.)

IC 27-7-1-11
Revocation of certificate of authority; grounds

Sec. 11. The certificate of authority of any such Lloyds, whether domestic or foreign, shall be revoked by the insurance commissioner if at any time it appears that any underwriters are issuing policies of insurance within the state under apparent authority of such certificate without filing such declaration and agreement as aforesaid, or if such Lloyds does not maintain at all times the funds specified in this chapter, or has violated its agreement or the law, or is found to be in such a condition that the further transaction of business by it will be hazardous to the policyholders, its creditors, or the public.
(Formerly: Acts 1919, c.177, s.11.) As amended by P.L.252-1985, SEC.226.

IC 27-7-1-12
Taxation

Sec. 12. In lieu of all other taxes, licenses and fees, state or local, such Lloyds shall pay annually, on account of the transaction of such business in this state, the same taxes, licenses and fees as are required to be paid by mutual companies with principal offices similarly located and transacting the same kind of business. In the application of the retaliatory law, the taxes and fees exacted by another state from a Lloyds insurance with principal offices in Indiana shall apply.
(Formerly: Acts 1919, c.177, s.12.)

IC 27-7-2

Chapter 2. Worker's Compensation

IC 27-7-2-1

Repealed

(Repealed by P.L.249-1989, SEC.19.)

IC 27-7-2-1.1

Purposes of chapter

Sec. 1.1. The purposes of this chapter are as follows:

(1) To prohibit price fixing agreements and other anticompetitive behavior by companies.

(2) To protect policyholders and the public against the adverse effects of excessive, inadequate, or unfairly discriminatory rates.

(3) To promote price competition among companies so as to provide rates that are responsive to competitive market conditions.

(4) To provide regulatory procedures for the maintenance of appropriate data reporting systems.

(5) To improve availability, fairness, and reliability of insurance.

(6) To authorize essential cooperative action among companies in the ratemaking process and to regulate such activity to prevent practices that tend to substantially lessen competition or create a monopoly.

(7) To encourage the most efficient and economic marketing practices.

As added by P.L.249-1989, SEC.1.

IC 27-7-2-1.2

Insurers and underwriters subject to chapter

Sec. 1.2. This chapter applies to all persons, firms, partnerships, corporations, associations, and systems and to associations operating as Lloyds, interinsurers, or individual underwriters authorized on or after July 1, 1935, to transact the business of making worker's compensation insurance in Indiana. All domestic, foreign, and alien companies authorized to issue worker's compensation insurance policies in Indiana are subject to this chapter.

As added by P.L.249-1989, SEC.2.

IC 27-7-2-2

Definitions

Sec. 2. As used in this chapter and unless a different meaning appears from the context:

(a) "Department" means the department of insurance of this state.

(b) "Worker's compensation board" means the worker's compensation board of Indiana.

(c) "Company" means an insurance company and includes all persons, partnerships, corporations, or associations engaged in making worker's compensation insurance under the laws of this state.

(d) "Domestic company" means a company organized under the laws of this state.

(e) "Foreign company" means a company organized under the laws of any state of the United States, other than this state or under the laws of any territory or insular possession of the United States or the District of Columbia.

(f) "Alien company" means a company organized under the laws of any country other than the United States or a territory or insular possession thereof or of the District of Columbia.

(g) "Person" includes individuals, corporations, firms, companies, associations, and partnerships. The personal pronoun includes all genders. The singular includes the plural, and the plural includes the singular.

(h) "Commissioner" means the insurance commissioner of this state.

(i) "Bureau" means the worker's compensation rating bureau of Indiana.

(j) "Interested person" means any person who has filed with the department a request to be notified under sections 4(b) and 20.2(c) of this chapter of each filing of rates by the bureau or a company.

(k) "Assigned risk plan" means the plan by which members of the worker's compensation rating bureau provide for the insurance of rejected risks.

(l) "Classification system" or "classification" means the plan, system, or arrangement for recognizing differences in exposure to hazards among industries, occupations, or operations of insurance policyholders.

(m) "Experience rating" means a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit, or unity modification.

(n) "Rate" means the cost of insurance per exposure base unit, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premiums.

(o) "Schedule rating plan" means an independent rating plan that measures hazard differences that have an immediate bearing on the probability or severity of loss and applies debits and credits to modify the premium for a risk.

(p) "Statistical plan" means the plan, system, or arrangement used in collecting data.

(q) "Supplementary rate information" means any manual or plan of rates, classification system, rating schedule, minimum premium, rating rule, rating plan, and any other similar information needed to determine the applicable premium for an insured.

(r) "Supporting information" means the experience and judgment of the filer and the experience or data of other companies or organizations relied on by the filer, the interpretation of any statistical data relied on by the filer, descriptions of methods used in making the rates, and any other similar information required to be filed by the commissioner.

(Formerly: Acts 1935, c.323, s.2; Acts 1959, c.231, s.2.) As amended by P.L.252-1985, SEC.228; P.L.28-1988, SEC.87; P.L.249-1989, SEC.3.

IC 27-7-2-3

Worker's compensation rating bureau; membership

Sec. 3. After July 1, 1935, every insurance company authorized to effect worker's compensation insurance in this state shall be a member of the worker's compensation rating bureau of Indiana. The bureau shall be composed of all insurance companies lawfully engaged on July 1, 1935, wholly or in part in making worker's compensation insurance in Indiana or who shall after July 1, 1935, be issued a certificate of authority to make worker's compensation insurance in this state.

(Formerly: Acts 1935, c.323, s.3.) As amended by P.L.252-1985, SEC.229; P.L.28-1988, SEC.88.

IC 27-7-2-3.1

Duties of bureau

Sec. 3.1. The bureau, in addition to other activities not prohibited, is authorized to do the following:

(1) Develop a statistical plan including class definitions.

(2) Collect statistical data from members, subscribers or any other source.

(3) Prepare and distribute rate data, adjusted for loss development and loss trending, in accordance with its statistical plan. Such data and adjustments shall be in sufficient detail so as to permit companies to modify such rates or minimum premiums based on their own rating methods or interpretations of underlying data.

(4) Prepare and distribute manuals of rating rules and rating schedules.

(5) Distribute information that is filed with the commissioner and open to public inspection.

(6) Conduct research and collect statistics in order to discover, identify, and classify information relating to cause or prevention of losses.

(7) Prepare and file policy forms and endorsements and consult with members, subscribers, and others relative to their use and application.

(8) Collect, compile, and distribute past and current prices of individual companies if such information is made available to

the general public.

(9) Conduct research and collect information to determine the impact of benefit level changes on rates.

(10) Prepare and distribute rules and rating values for the experience rating plan. Calculate and disseminate individual risk premium modification.

(11) Assist an individual company to develop minimum premiums, rates, supplementary rate information, or supporting information when so authorized by the individual company.

As added by P.L.249-1989, SEC.4.

IC 27-7-2-4

Rate filings; notice

Sec. 4. (a) The bureau shall file not less than once each calendar year recommended minimum premiums and rates for worker's compensation insurance subject to the approval of the commissioner.

(b) There shall accompany each filing adequate proof that notice of the filing has been mailed, by first class United States mail, to each interested person at the person's address as shown on the records of the department.

(Formerly: Acts 1935, c.323, s.4; Acts 1959, c.231, s.3.) As amended by P.L.28-1988, SEC.89; P.L.249-1989, SEC.5.

IC 27-7-2-5

Management of bureau

Sec. 5. The management of said bureau shall be in the hands of duly elected officers or committees provided for in the bylaws of said bureau; each member of the bureau or member group with affiliate or subsidiary companies shall be entitled to only one (1) vote on any subject coming before the bureau for determination.

(Formerly: Acts 1935, c.323, s.5.) As amended by P.L.116-1994, SEC.55.

IC 27-7-2-6

By-laws of bureau

Sec. 6. The bureau shall make by-laws for its government and for the government of its members. Such by-laws and amendments thereto shall be filed with and approved by the insurance commissioner before they shall be effective.

(Formerly: Acts 1935, c.323, s.6.)

IC 27-7-2-7

Representation of stock and nonstock companies; resolution of tie votes

Sec. 7. Stock companies and nonstock companies shall be represented in the bureau management and on all committees. In case of a tie vote in any committee or governing body of said bureau, the insurance commissioner shall decide the matter.

(Formerly: Acts 1935, c.323, s.7.)

IC 27-7-2-8
Membership in bureau

Sec. 8. The bureau shall admit to membership every company lawfully engaged in whole or in part in writing worker's compensation insurance in Indiana.
(Formerly: Acts 1935, c.323, s.8.) As amended by P.L.28-1988, SEC.90.

IC 27-7-2-9
Charges and expenses of bureau; apportionment; review

Sec. 9. The charges and expenses incident to the establishment and operation of the bureau shall be borne equitably and without discrimination among the members of the bureau. If any member is aggrieved by an apportionment of the cost or costs made by the bureau or by failure of the bureau to make such equitable apportionment, it may in writing petition the commissioner for a review of such apportionment or failure to act. The commissioner shall upon not less than five (5) days' notice to each member hold a hearing upon such petition at which time all members shall be entitled to be heard. And said commissioner shall determine the matter or matters and mail a copy of his decision to each member of the bureau. The decision of the commissioner shall be final.
(Formerly: Acts 1935, c.323, s.9.)

IC 27-7-2-10
Repealed

(Repealed by P.L.249-1989, SEC.19.)

IC 27-7-2-11
Approval of classifications, premiums, or rates; consultations with worker's compensation board; duty of board to furnish information

Sec. 11. (a) In approving classifications, premiums, or rates, the department may in all cases consult with the worker's compensation board or member thereof. The department may also consult with the worker's compensation board or members thereof on any other matter arising under this chapter.

(b) The worker's compensation board shall furnish the department all available information at its disposal and permit the department to have access to all records of the worker's compensation board which the department may wish to consult in the performance of its duties under this chapter.
(Formerly: Acts 1935, c.323, s.11.) As amended by P.L.252-1985, SEC.231; P.L.28-1988, SEC.92; P.L.249-1989, SEC.6.

IC 27-7-2-12

Representative of department; appointment; powers and duties

Sec. 12. The department may authorize any person to attend meetings of the rating bureau, hold hearings, make investigations, and make examinations with reference to any subject over which it has jurisdiction under this chapter. The person so appointed shall have all the powers of the department in relation to said hearings, investigations, or examinations, and shall report in writing to the department the results of such hearings, examinations, or investigations, and any testimony taken by him.

(Formerly: Acts 1935, c.323, s.12.) As amended by P.L.252-1985, SEC.232.

IC 27-7-2-13

Repealed

(Repealed by P.L.249-1989, SEC.19.)

IC 27-7-2-14

Repealed

(Repealed by P.L.249-1989, SEC.19.)

IC 27-7-2-15

Approval of system of schedule rating

Sec. 15. The department shall after consultation with members of the bureau and after investigation approve a system of schedule rating for use in this state. Only the system filed by the bureau and approved by the department may be used in Indiana.

(Formerly: Acts 1935, c.323, s.15.) As amended by P.L.249-1989, SEC.7.

IC 27-7-2-16

Repealed

(Repealed by P.L.249-1989, SEC.19.)

IC 27-7-2-17

Repealed

(Repealed by P.L.249-1989, SEC.19.)

IC 27-7-2-18

Exclusion of physical impairment of employees in rate making

Sec. 18. The physical impairment of employees shall not be taken into account in establishing rates or system of schedule or merit rating.

(Formerly: Acts 1935, c.323, s.18.)

IC 27-7-2-19

Repealed

(Repealed by P.L.249-1989, SEC.19.)

IC 27-7-2-20
Adherence to approved rules, forms, plans, and systems; annual reports

Sec. 20. (a) Every company shall adhere to manual rules, policy forms, a statistical plan, a classification system, and experience rating plan filed by the bureau and approved by the commissioner.

(b) The commissioner shall designate the bureau to assist in gathering, compiling, and reporting relevant statistical information. Every company shall record and report its worker's compensation experience to the bureau according to the statistical plan approved by the commissioner. The report shall include any deviation from the filed recommended minimum premiums and rates, in total and by classification. The bureau shall annually submit data concerning these deviations to the department. Upon receipt, the department shall evaluate the data and prepare a report concerning the effect of competitive rating in Indiana. The department shall make the report available not later than October 31 of each year.

(c) Every company shall adhere to the approved manual rules, policy forms, statistical plan, classification system, and experience rating plan in the recording and reporting of data to the bureau.

(d) Copies of all approved classifications, rules, and forms shall be provided to the worker's compensation board.

(Formerly: Acts 1935, c.323, s.20.) As amended by P.L.28-1988, SEC.95; P.L.249-1989, SEC.8; P.L.91-1998, SEC.8.

IC 27-7-2-20.1
Minimum premiums and rates

Sec. 20.1. Minimum premiums and rates may not be excessive, inadequate, or unfairly discriminatory.

As added by P.L.249-1989, SEC.9.

IC 27-7-2-20.2
Minimum premiums, rates, and supplementary rate information; filing; approval; proof of notice; public inspection

Sec. 20.2. (a) Every company and the bureau shall file with the commissioner all minimum premiums, rates, and supplementary rate information that are to be used in Indiana. Such minimum premiums, rates, and supplementary rate information must be submitted to the commissioner at least thirty (30) days before the effective date. The commissioner shall disapprove a filing that does not meet the requirements of section 20.1 of this chapter. A filing shall be deemed approved unless disapproved by the commissioner within thirty (30) days after the filing is made. A company may adopt by reference, with or without deviation, the minimum premiums, rates, and supplementary rate information filed by another company or by the bureau.

(b) Minimum premiums, rates, and supplementary information filed under this section shall be filed in the form and manner

prescribed by the commissioner.

(c) There shall accompany each filing adequate proof that notice of the filing has been mailed, by first class United States mail, to each interested person at the person's address as shown on the records of the department.

(d) All material filed by the bureau or any company as part of any official rate filing shall, as soon as filed, be open to the public for inspection and copying under IC 5-14-3. This requirement is not applicable to information and data transmitted to the department or the worker's compensation board, or to both, under section 20 or 40 of this chapter.

As added by P.L.249-1989, SEC.10. Amended by P.L.275-2013, SEC.19.

IC 27-7-2-20.3

Minimum premiums or rates; disapproval

Sec. 20.3. (a) Minimum premiums or rates may be disapproved at the following times:

(1) At any time subsequent to the effective date.

(2) Before the effective date.

(b) Minimum premiums or rates may be disapproved for any of the following reasons:

(1) If the company fails to comply with the filing requirements under section 20.2 of this chapter.

(2) If the commissioner finds that the minimum premium or rate is excessive, inadequate, or unfairly discriminatory.

(c) The following procedure shall be used for disapproval of minimum premiums or rates:

(1) The commissioner may disapprove, without hearing, minimum premiums or rates filed under section 20.2 or 28.1 of this chapter that have not become effective. However, the bureau or a company whose minimum premiums or rates have been disapproved shall be given a hearing upon a written request made within thirty (30) days after the date of the disapproval order.

(2) Every company or the bureau shall provide within Indiana reasonable means whereby any person aggrieved by the application of its filings may be heard on written request to review the manner in which such rating system has been applied in connection with the insurance afforded or offered. If the company or the bureau fails to grant or reject such request within thirty (30) days, the aggrieved person may proceed in the same manner as if the request had been rejected. Any aggrieved person affected by the action of such company or the bureau on such request may, within thirty (30) days after written notice of such action, appeal to the commissioner who, after a hearing held upon not less than ten (10) days written notice to the aggrieved person and to such company or the bureau, may

affirm, modify, or reverse such action.

(d) If the commissioner disapproves a minimum premium or rate, the commissioner shall issue an order specifying in what respects minimum premium or the rate fails to meet the requirements of this chapter and stating when within a reasonable period thereafter such minimum premium or rate shall be discontinued for any policy issued or renewed after a date specified in the order. The order shall be issued within thirty (30) days after the close of the hearing or within such reasonable time extension as the commissioner may fix. Such order may include a provision for premium adjustment for the period after the effective date of the order for policies in effect on such date.

(e) Whenever a company has no legally effective minimum premiums or rates as a result of the commissioner's disapproval of minimum premiums or rates or other act, the commissioner shall specify interim minimum premiums or rates for the company that are adequate to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by the commissioner. When new minimum premiums or rates become legally effective, the commissioner shall order the escrowed funds or any overcharge in the interim minimum premiums or rates to be distributed appropriately, except that refunds of less than ten dollars ($10) per policyholder shall not be required.

As added by P.L.249-1989, SEC.11.

IC 27-7-2-20.4

Arrangements in restraint of trade; presumption; subsidiary companies

Sec. 20.4. (a) A company or the bureau may not make any arrangement with any other company or other person that has the purpose or effect of restraining trade unreasonably or of substantially lessening competition in the business of insurance.

(b) A company may not agree with any other company or the bureau to adhere to or use any rate, rating plan (other than the experience rating plan), or rating rule except as needed to comply with the requirements of section 20 of this chapter.

(c) The fact that two (2) or more companies use consistently or intermittently the same rules, rating plans, rating schedules, rating rules, policy forms, rate classifications, underwriting rules, surveys, or inspections or similar materials is not sufficient in itself to support a finding that an agreement prohibited by subsection (b) exists.

(d) Two (2) or more companies having a common ownership or operating in Indiana under common management or control may act in concert between or among themselves with respect to any matters pertaining to those authorized in this chapter as if they constituted a single company.

As added by P.L.249-1989, SEC.12.

IC 27-7-2-21

Repealed

(Repealed by P.L.249-1989, SEC.19.)

IC 27-7-2-22

Repealed

(Repealed by P.L.249-1989, SEC.19.)

IC 27-7-2-23

Repealed

(Repealed by P.L.249-1989, SEC.19.)

IC 27-7-2-24

Appointment of resident agent for service of process

Sec. 24. Every person lawfully engaged wholly or in part in writing worker's compensation insurance in this state shall, upon July 1, 1935, by written notice to the insurance commissioner, appoint an individual resident of Indiana, a corporate resident of Indiana, or an authorized Indiana insurer as the person's resident agent in Indiana upon whom service of process may be had for the enforcement of this chapter.

(Formerly: Acts 1935, c.323, s.24.) As amended by P.L.252-1985, SEC.235; P.L.28-1988, SEC.98; P.L.268-1999, SEC.17.

IC 27-7-2-25

Annual license of rating bureau

Sec. 25. The bureau shall procure annually from the department a license to carry on its business for which license a fee of one hundred dollars ($100) shall be paid to the state of Indiana through the insurance department of this state. The license year shall terminate on the thirtieth day of April of each year.

(Formerly: Acts 1935, c.323, s.25.)

IC 27-7-2-26

Effect of chapter on mutual insurance associations and reciprocal associations

Sec. 26. Nothing in this chapter shall be construed to annul, restrict, or in any manner interfere with the licensing and supervision of mutual insurance associations and reciprocal associations formed and operating on or before January 1, 1991, solely for the writing of worker's compensation insurance as provided under IC 22-3-2 through IC 22-3-6.

(Formerly: Acts 1935, c.323, s.26.) As amended by P.L.252-1985, SEC.236; P.L.28-1988, SEC.99; P.L.170-1991, SEC.28.

IC 27-7-2-27

Jurisdiction of courts of Marion County; review

Sec. 27. (a) The courts of Marion County, Indiana, shall have jurisdiction in all matters arising under this chapter except such

rulings by the department as are made final by this chapter.

(b) Any order or decision of the commissioner made under this chapter is subject to review in the circuit or superior court of Marion County by any party in interest. An appeal must be taken within thirty (30) days after the date of the order or decision of the commissioner. The court shall determine whether the filing of the petition for review shall operate as a stay of the order or decision of the commissioner. The court may, in disposing of the issue before it, affirm or set aside the order or decision of the commissioner. If the order or decision of the commissioner is affirmed, the court shall make its own order and judgment commanding obedience to the order or decision of the commissioner. An appeal may be taken to the supreme court as in civil actions from any order or judgment of the circuit or superior court made under this section.

(Formerly: Acts 1935, c.323, s.27.) As amended by P.L.252-1985, SEC.237; P.L.249-1989, SEC.13.

IC 27-7-2-28

Duty to insure and accept certain rejected risks

Sec. 28. From and after July 1, 1935, all insurance companies authorized to effect worker's compensation insurance in this state, and being members of the worker's compensation rating bureau of Indiana, shall insure and accept any worker's compensation risk tendered to and rejected in writing by any three (3) members of the bureau in the manner provided in this chapter.

(Formerly: Acts 1935, c.323, s.28.) As amended by P.L.252-1985, SEC.238; P.L.28-1988, SEC.100.

IC 27-7-2-28.1

Assigned risk plan; filing; approval

Sec. 28.1. (a) All companies authorized to write worker's compensation insurance shall participate in the assigned risk plan providing for the equitable apportionment among them of insurance that may be afforded to applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods. The bureau shall file, at least thirty (30) days before their effective date, the plan of operation, rates, rating plans, rules, policy forms, and any future modifications thereof, with the commissioner for approval. Such rates shall reflect experience in the assigned risk plan to the extent it is actuarially appropriate. The rates must reflect the varied categories of rejected risks covered by the assigned risk plan and must include at least two (2) rating plans, one (1) of which may not exceed the recommended minimum premiums and rates filed by the bureau under section 4 of this chapter.

(b) The commissioner shall disapprove any filing that does not meet the requirements of section 20.1 of this chapter. A filing shall be deemed to meet such requirements unless disapproved by the commissioner within thirty (30) days after the filing is made. In

disapproving a filing made under this section, the commissioner shall have the same authority and follow the same procedure as in disapproving a filing under section 20.3 of this chapter.
As added by P.L.249-1989, SEC.14.

IC 27-7-2-28.2
Examination of records; costs

Sec. 28.2. (a) The commissioner may examine any company, the bureau, or the assigned risk plan as the commissioner considers necessary to ascertain compliance with this chapter.

(b) Every company, the bureau, and the assigned risk plan shall maintain reasonable records of the type and kind reasonably adapted to its method of operation containing its experiences or the experience of its staff members including the data, statistics, or information collected or used by it in its activities. These records shall be available at all reasonable times to enable the commissioner to determine whether the activities of the bureau, company, and the assigned risk plan comply with this chapter. Such records shall be maintained in an office within Indiana or shall be made available to the commissioner for examination or inspection at any time upon reasonable notice.

(c) The reasonable cost of an examination made under this section shall be paid by the examined party upon presentation of a detailed account of such costs.

(d) Instead of an examination the commissioner may accept the report of an examination by the insurance supervisory official of another state, made under the laws of that state.
As added by P.L.249-1989, SEC.15.

IC 27-7-2-29
Rejected risks; designation of insurer; reinsurance

Sec. 29. (a) When any such rejected risk is called to the attention of the worker's compensation board and it appearing to the board that said risk is in good faith entitled to coverage, said bureau upon the order of the board shall fix the initial premium for the coverage.

(b) Upon payment, of the premium fixed under subsection (a), the bureau shall designate a member of said bureau whose duty it shall be to issue a policy containing the usual and customary provisions found in such policies therefor. However, for this undertaking all members of said bureau shall be reinsurers as among themselves in the amount which the compensation insurance written in this state during the preceding calendar year by such member bears to the total compensation insurance written in this state during the preceding year by all members of said bureau.
(Formerly: Acts 1935, c.323, s.29.) As amended by P.L.28-1988, SEC.101.

IC 27-7-2-30

Rules; adoption

Sec. 30. The bureau shall, by July 31, 1935, make and adopt such rules as may be necessary to carry out the provisions of this chapter, subject to the approval of the insurance commissioner.

(Formerly: Acts 1935, c.323, s.30.) As amended by P.L.252-1985, SEC.239.

IC 27-7-2-31

Loss of coverage for nonpayment of premiums; report of conditions precluding insurance; coverage pending decision

Sec. 31. No employer who does not pay the advance premiums or premium when due, shall be entitled to insurance, nor shall any coverage be extended until all obligations to pay worker's compensation insurance premiums contracted during the previous twelve (12) months have been paid. If, in the opinion of the designated carrying company or the bureau, physical or moral conditions exist in any risk which shall preclude the risk from obtaining insurance, that risk shall be reported to the worker's compensation board and to the department. The bureau shall, in those cases, furnish the board and the department with its recommendations for improving safety conditions, which, if complied with, would entitle the risk to insurance. Pending a decision by the board or the department, insurance shall be effective as otherwise provided in this chapter. However, the board, or the department, or both shall make that decision within sixty (60) days after such recommendations are furnished by the bureau.

(Formerly: Acts 1935, c.323, s.31.) As amended by P.L.252-1985, SEC.240; P.L.28-1988, SEC.102.

IC 27-7-2-32

Considerations in designating insurer to assume rejected risk; review of reasons

Sec. 32. In designating the bureau member to insure a rejected risk, the bureau shall have due regard for the service facilities and compensation premium volume in Indiana of the member so designated as the carrying company. Any grievance on the part of such bureau member with the respect of such designation shall be brought to the attention of the bureau for review and such action as the circumstances may justify.

(Formerly: Acts 1935, c.323, s.32.)

IC 27-7-2-33

Designated insurer carrying rejected risk; additional inspection; renewal rates

Sec. 33. At any time while a policy, written pursuant to designation by the bureau, is in force, the carrying company, upon its own initiative, may make a further careful inspection of the risk for the purpose of measuring its hazards, making recommendation for

the promotion of the safety of employees and determining the rate or rates which should apply to insurance issued in renewal of such policy. Rates for the renewal of any policy issued pursuant to this chapter shall take into account the available experience of the risk for the previous five (5) years, and such rates shall be made in contemplation of the facts disclosed by the most recent inspection of the risk by the rating bureau as provided in this chapter, subject to the approval of the department.
(Formerly: Acts 1935, c.323, s.33.) As amended by P.L.252-1985, SEC.241.

IC 27-7-2-34
Information concerning rejected risks; automatic insurance
Sec. 34. The management of the bureau shall furnish to all members of the bureau complete information concerning each rejected risk and any member of such bureau may write any rejected risk as regular business in which event the risk so written shall no longer be treated as provided for in section 29 of this chapter. If, at expiration, the risk is still uninsured on voluntary basis, it shall automatically be insured as provided in section 29 of this chapter.
(Formerly: Acts 1935, c.323, s.34.) As amended by P.L.252-1985, SEC.242; P.L.202-2001, SEC.12.

IC 27-7-2-35
Record of rejected risks referred by bureau to members; effect of writing rejected risk as regular business
Sec. 35. The bureau shall keep a record of all risks referred to members as carrying company, coming within the provisions of section 29 of this chapter, and this record shall be open to any bureau member or its authorized representative. Any member may at any time write as regular business any risk which is carried by any other member as a carrying company, under the provisions of section 29 and such carrying company shall cancel such policy on a pro rata premium basis or thereafter carry such risk in its entirety as regular business.
(Formerly: Acts 1935, c.323, s.35.) As amended by P.L.252-1985, SEC.243.

IC 27-7-2-36
Repealed
(Repealed by P.L.249-1989, SEC.19.)

IC 27-7-2-37
Cancellation of rejected risk coverage; grounds; effect
Sec. 37. (a) If, after the issuance of a policy, it develops that an employer is not or ceases to be in good faith entitled to compensation insurance, the carrying company which issued the policy shall have the right, upon authorization of the bureau and the worker's

compensation board, to cancel the insurance in accordance with the conditions of the policy.

(b) If a policy is cancelled under the circumstances described in subsection (a), the risk shall not be assigned again by the bureau to any of its members as a carrying company until it is fully satisfied that the employer is entitled to insure as a proper rejected risk under this chapter.

(c) In the event of a cancellation under this section, the facts justifying such action shall be referred to the worker's compensation board and the department.

(Formerly: Acts 1935, c.323, s.37.) As amended by P.L.252-1985, SEC.245; P.L.28-1988, SEC.103.

IC 27-7-2-37.5

Refund of dividends, savings, or unabsorbed premium deposits

Sec. 37.5. (a) Nothing in this chapter prohibits or regulates the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by companies to their policyholders, members, or subscribers, but in the payment of such dividends there shall be no unfair discrimination between policyholders.

(b) A plan for the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by companies to their policyholders, members, or subscribers is not considered a rating plan or system.

(c) It is an unfair trade practice to make the payment of a dividend or any portion thereof conditioned upon renewal of the policy or contract.

As added by P.L.249-1989, SEC.16.

IC 27-7-2-38

Violations; penalties; suspension or revocation of license

Sec. 38. (a) A person who fails to comply with this chapter or fails to comply with any lawful order or ruling made by the department in the administration of this chapter commits a Class C infraction. If a person is fined for violating this section and fails to pay the fine within thirty (30) days after final judgment, the insurance commissioner shall suspend the license of the person to transact any form of insurance business in Indiana until the fine and costs incident to the final judgment are paid in full.

(b) The commissioner may, if the commissioner finds that any person or organization has violated this chapter, impose a penalty of not more than one thousand dollars ($1,000) for each such violation but if the commissioner finds the violation is willful the commissioner may impose a penalty of not more than ten thousand dollars ($10,000) for each such violation. These penalties are in addition to any other penalty provided by law.

(c) For purposes of this section, any company using a rate for which the company has failed to file the rate, supplementary rate

information, or supporting information, as required by this chapter, shall have committed a separate violation for each day such failure continues.

(d) The commissioner may suspend or revoke the license of the bureau or any company that fails to comply with an order of the commissioner within the time limit specified by such order, or any extension of time that the commissioner may grant.

(e) The commissioner may determine when a suspension of license becomes effective and it shall remain in effect for the period fixed by the commissioner, unless the commissioner modifies or rescinds such suspension, or until the order upon which such suspension is based is modified, rescinded, or reversed.

(f) No penalty shall be imposed and no license shall be suspended or revoked except on a written order of the commissioner, stating the commissioner's findings, made after a hearing.

(Formerly: Acts 1935, c.323, s.38.) As amended by Acts 1978, P.L.2, SEC.2723; P.L.249-1989, SEC.17.

IC 27-7-2-39

Appointment and compensation of personnel; appropriation

Sec. 39. The commissioner shall appoint such deputies, examiners, actuaries, assistants, and other employees in the department of insurance as may be found necessary to carry out the provisions of this chapter and fix the compensation thereof, subject to the approval of the state budget agency. There is hereby appropriated out of funds not otherwise appropriated in the general fund such sums as may be necessary to carry out the provisions of this chapter.

(Formerly: Acts 1935, c.323, s.38a.) As amended by P.L.252-1985, SEC.246; P.L.100-2012, SEC.66.

IC 27-7-2-40

Confidential data; data sharing with department or worker's compensation board

Sec. 40. The bureau may collect data from its members under this chapter, including:

(1) claims data;

(2) policy data such as policy number, policy term, and employer and employee identification information; and

(3) proof of coverage data such as employer identification information, classification information, carrier information, agency identification information, premium information, and payroll data.

Unless this chapter specifically states otherwise, all data collected by the bureau from its members is confidential and shall not be disclosed or disseminated to third parties unless consented to by the bureau. To the extent this chapter authorizes the bureau to share the data with the department or the worker's compensation board, the

data must remain confidential. The department and the worker's compensation board shall not publish the data or distribute the data to third parties.
As added by P.L.275-2013, SEC.20.

IC 27-7-3

Chapter 3. Abstract and Title Insurance

IC 27-7-3-1

Citation

Sec. 1. This chapter shall be known and may be cited as The Indiana Abstract and Title Insurance Law.

(Formerly: Acts 1937, c.104, s.1.) As amended by P.L.252-1985, SEC.247.

IC 27-7-3-2

Definitions

Sec. 2. As used in this chapter and unless a different meaning appears from the context:

(a) The term "title insurance" means a contract of insurance against loss or damage on account of encumbrances upon or defects in the title to real estate.

(b) The term "closing protection letter" means a written indemnification of or undertaking to a party to a real estate transaction by a principal that specifies the extent to which the principal is responsible for intentional or unintentional misconduct or errors of an agent of the principal in connection with the closing of the real estate transaction.

(c) The term "company" shall mean and include any corporation, domestic or foreign, to which this chapter is applicable.

(d) The term "department" shall mean the department of insurance of the state of Indiana.

(e) The term "commissioner" shall mean the insurance commissioner.

(f) The term "public record" has the meaning set forth in IC 5-14-3-2.

(g) The term "title policy" means a policy issued by a company that:

(1) is authorized to do business as a title insurance company under section 3 of this chapter; and

(2) insures or indemnifies persons with an interest in real property against loss or damage caused by a lien on, an encumbrance on, a defect in, or the unmarketability of the title to the real property.

(h) The term "title search" means a search and examination of the public records sufficient to determine:

(1) ownership of;

(2) encumbrances on;

(3) liens on; and

(4) defects in the title to;

the real estate that is the subject of the search.

(Formerly: Acts 1937, c.104, s.2.) As amended by P.L.252-1985, SEC.248; P.L.68-2002, SEC.1; P.L.80-2013, SEC.3.

IC 27-7-3-3

Title insurance business; authorization of domestic and foreign corporations; application of business corporation law

Sec. 3. (a) Any domestic corporation having:

(1) among its purposes the insuring against loss or damage on account of encumbrances upon or defects in the title to real estate; and

(2) a physical office in Indiana;

is hereby authorized to organize under IC 23-1, and any foreign corporation, having among its purposes the insuring against loss or damage on account of encumbrances upon or defects in the title to real estate, is hereby authorized to and may be admitted to do business in this state under IC 23-1. Any domestic or foreign corporation, organized or admitted to do business before or after June 7, 1937, as provided in this section, may engage in business as a title insurance company by complying with the provisions of this chapter.

(b) A domestic corporation admitted to do business as described in subsection (a) shall provide written notice to the department of insurance and all policyholders of a change in location of the domestic corporation's physical office in Indiana, including the address and telephone number of the new location.

(Formerly: Acts 1937, c.104, s.3.) As amended by P.L.252-1985, SEC.249; P.L.11-2011, SEC.28.

IC 27-7-3-3.5

Requirements applicable to issuers of title insurance

Sec. 3.5. (a) A domestic corporation admitted to do business as described in section 3 of this chapter is subject to the following:

(1) IC 27-1-6-21.

(2) IC 27-1-7-11.

(3) IC 27-9.

(b) A foreign corporation admitted to do business as described in section 3 of this chapter is subject to IC 27-1-17-9.

As added by P.L.11-2011, SEC.29.

IC 27-7-3-4

Corporate rights; powers and privileges

Sec. 4. Every such company shall possess and may exercise all the rights, powers, and privileges conferred upon domestic corporations by IC 23-1 but only to the extent that the same may be necessary, convenient or expedient to accomplish the purposes for which it is organized, and in addition thereto, but subject to the restrictions and limitations contained in this chapter, every such company shall possess and may exercise the power of making insurance to insure against the loss or damage on account of encumbrances upon or defects in the title to real estate. In all things not specifically provided for in this chapter, the provisions of IC 23-1 shall apply.

(Formerly: Acts 1937, c.104, s.4.) As amended by P.L.252-1985, SEC.250.

IC 27-7-3-5
Capital stock

Sec. 5. The capital stock of any company engaged in business under the provisions of this chapter shall be not less than one hundred thousand dollars ($100,000), which shall be fully paid in.
(Formerly: Acts 1937, c.104, s.5.) As amended by P.L.252-1985, SEC.251.

IC 27-7-3-6
Certificate of authority; requirements; issuance; necessity to do business

Sec. 6. (a) Whenever any such company shall have shown to the department by a sworn statement, verified by the oaths of the president or a vice president and the secretary or an assistant secretary of the company and bearing the corporate seal of such company, that it has complied with all the requirements of this chapter necessary for beginning business and that it has deposited the amount as required in section 7 of this chapter, the commissioner shall issue a certificate of authority reciting that such company has complied with the provisions of this chapter and is authorized to insure against the loss or damage on account of encumbrances upon or defects in the title to real estate, which certificate shall expire as of midnight of April 30 of each calendar year. The certificate shall be issued under the seal of the department.

(b) No person, firm, partnership, corporation, association, or company shall transact any business of insuring against loss or damage on account of encumbrances upon or defects in the title to real estate until it or they shall have received a certificate of authority as provided for in this section.
(Formerly: Acts 1937, c.104, s.6.) As amended by P.L.252-1985, SEC.252.

IC 27-7-3-7
Deposits; title insurance fund

Sec. 7. Every company described in section 3 of this chapter, before engaging in business, shall deposit with the department the sum of fifty thousand dollars ($50,000) either out of its capital or surplus. The deposit shall be known as the title insurance fund and must be deposited in securities of the kind and character designated by IC 27-1-13-3(b).
(Formerly: Acts 1937, c.104, s.7.) As amended by P.L.252-1985, SEC.253; P.L.159-1986, SEC.5; P.L.161-1986, SEC.2; P.L.184-1996, SEC.3.

IC 27-7-3-8

Additional deposit to meet requirements of another state; withdrawal

Sec. 8. In the event any such domestic company shall be required by the laws of any other state, country, or province, as a requirement prior to doing such business as defined in this chapter therein, to deposit, with the duly appointed officer of such other state, country, or province or with the department of this state, any securities or cash in excess of the deposit required of the company by this chapter, such company may deposit with the department securities of the character authorized by this chapter sufficient to meet such requirement. The department is hereby authorized and directed to receive such deposit and to hold it exclusively for the protection of all policyholders of the company. Any deposit so made to meet the requirement of any such other state, country, or province shall not be withdrawn by the company except upon filing with the department evidence satisfactory to it that the company has withdrawn from business, and has no unsecured liability outstanding in any such other state, country, or province by which such additional deposit was required, and upon the filing of such evidence, and the approval of the department, the company may withdraw such additional deposit. Upon the approval of the department, any such domestic company may deposit and use the reserve fund, provided for in section 9 of this chapter, for the purpose of complying with the additional deposit requirement of any other state, country, or province.

(Formerly: Acts 1937, c.104, s.8.) As amended by P.L.252-1985, SEC.254.

IC 27-7-3-9

Title insurance reserve fund

Sec. 9. Every company described in section 3 of this chapter shall annually set apart, accumulate, and maintain, in a fund to be known as the title insurance reserve fund, securities of the kind and character designated by IC 27-1-13-3(b) of the face amount equal to ten percent (10%) of the actual premiums collected during the preceding year by the company on account of such title insurance, until the fund totals fifty thousand dollars ($50,000). The fund shall be maintained in the treasury of the company as additional security to the holders of policies issued by the company. However, at its option, the company may deposit the title insurance reserve fund with the department in the amount of ten thousand dollars ($10,000), or any multiple thereof up to fifty thousand dollars ($50,000). This deposit shall be known as the title insurance reserve fund deposit.

(Formerly: Acts 1937, c.104, s.9.) As amended by P.L.252-1985, SEC.255; P.L.159-1986, SEC.6; P.L.161-1986, SEC.3; P.L.184-1996, SEC.4.

IC 27-7-3-10

Deficiency in title insurance reserve fund

Sec. 10. Whenever the amount of the title insurance reserve fund of any such company shall fall below the amount required in section 9 of this chapter, no further title insurance shall be made or issued by such company until the deficiency has been supplied.

(Formerly: Acts 1937, c.104, s.10.) As amended by P.L.252-1985, SEC.256.

IC 27-7-3-11

Interest on deposited securities

Sec. 11. The department shall permit such companies having on deposit with it stocks or bonds as security to collect the interest accruing on such deposits, delivering to their authorized agents, respectively, the coupons or other evidences of interest as the same become due.

(Formerly: Acts 1937, c.104, s.11.)

IC 27-7-3-12

Foreign corporations; capital and deposit requirements; certificate of authority; rights and privileges

Sec. 12. Every foreign corporation duly authorized to do a title insurance business in the state in which it is incorporated or organized and admitted to do business in this state under IC 23-1 may be authorized by the department to transact a title insurance business in this state upon filing with the department proof which satisfies it that the corporation has complied with sections 5 and 9 of this chapter and has deposited with the proper official of the state in which it is incorporated or organized, or has deposited with the department, the amount as required by section 7 of this chapter, and that it has complied with the provisions of this chapter. Upon the receipt of such proof, the commissioner may issue to such foreign corporation a certificate of authority as provided for in section 6 of this chapter. A foreign corporation admitted to do business under this chapter shall have the same but no greater rights and privileges than a domestic corporation under this chapter.

(Formerly: Acts 1937, c.104, s.12.) As amended by P.L.252-1985, SEC.257.

IC 27-7-3-13

Examination of company; appointment of examiners; report of examination

Sec. 13. (a) The department may examine into the affairs of any such company doing business in this state under the provisions of this chapter. For such purpose it may appoint as examiners competent persons, and upon such examination the commissioner, his deputy, or any examiner authorized by him may examine under oath the officers and agents of such company and all persons deemed to have material information regarding the company's property or

business. Every such company, its officers, and agents shall produce at the office of the company where the same are kept, its books and all papers in its or their possession relating to its business or affairs, and any other person may be required to produce any book or paper in his custody relevant to the examination for the inspection of the commissioner, his deputy, or examiners whenever required, and the officers and agents of such company shall facilitate such examination and aid the examiners in making the same so far as it is within their power to do so.

(b) Upon the conclusion of such examination a full, true, and detailed report of such company shall be made to the department, by the person or persons making the examination, in such form as the department may prescribe.

(Formerly: Acts 1937, c.104, s.13.) As amended by P.L.252-1985, SEC.258.

IC 27-7-3-14

Annual financial statement; effect of certification by certified public accountant

Sec. 14. (a) Every such company doing business in this state shall file with the department on or before March 15 in each year a financial statement for the year ending December 31 immediately preceding on forms furnished by the department. Such statement shall include a showing that the sum of ten percent (10%) of all actual premiums received by such company, on account of such title insurance business, during the year ending on December 31 prior thereto, as required by section 9 of this chapter, has been duly set apart and is held by such company in said title insurance reserve fund or is held on deposit by the department as provided in section 9 of this chapter. Such statement shall be verified by the oaths of the president or a vice president and the secretary or an assistant secretary.

(b) If the annual statement, as required by this section, shall be certified to by a certified public accountant, then such statement shall be prima facie evidence of the facts stated therein, and the department may in its discretion accept such certified statements in lieu of an examination under this chapter.

(Formerly: Acts 1937, c.104, s.14.) As amended by P.L.252-1985, SEC.259.

IC 27-7-3-15

Collection of charges, fees, and taxes; disposition

Sec. 15. The department shall collect the charges, fees and taxes provided for in this section, and give proper acquittances therefor, and on or before the end of every calendar month shall pay into the state treasury the amounts collected by it during such month, as hereinafter provided:

Fees. Domestic Companies: Every such domestic company shall

pay to the department the following stipulated fees: For filing annual statement, twenty dollars ($20.00); for license to such company, and for each renewal thereof, five dollars ($5.00); for affixing seal or certifying to any paper, one dollar ($1.00). The department may require payment of fees on or before the first day of the month next after the same are chargeable.

Fees. Foreign Companies: Every such foreign company shall pay to the department the following stipulated fees: For filing annual statement, twenty dollars ($20.00); for license to such company, and for each annual renewal thereof, five dollars ($5.00); for filing withdrawal and cancellation of certificate, twenty dollars ($20.00); for affixing seal or certifying to any paper, one dollar ($1.00).
(Formerly: Acts 1937, c.104, s.15.)

IC 27-7-3-15.5
Mortgage transactions and real estate transactions; electronic storage of data on persons involved; closing agents to input data and submit form; duty to provide information; failure to comply; civil penalty; access to data; rules; administrative fee

Sec. 15.5. (a) This section applies to the following transactions:

(1) A mortgage transaction (as defined in IC 24-9-3-7(a)) that:

(A) is:

(i) a first lien purchase money mortgage transaction; or

(ii) a refinancing transaction; and

(B) is closed by a closing agent after December 31, 2009.

(2) A real estate transaction (as defined in IC 24-9-3-7(b)) that:

(A) does not involve a mortgage transaction described in subdivision (1); and

(B) is closed by a closing agent (as defined in IC 6-1.1-12-43(a)(2)) after December 31, 2011.

(b) For purposes of this subsection, a person described in this subsection is involved in a transaction to which this section applies if the person participates in or assists with, or will participate in or assist with, a transaction to which this section applies. The department shall establish and maintain an electronic system for the collection and storage of the following information, to the extent applicable, concerning a transaction to which this section applies:

(1) In the case of a transaction described in subsection (a)(1), the name and license number (under IC 23-2-5) of each loan brokerage business involved in the transaction.

(2) In the case of a transaction described in subsection (a)(1), the name and license or registration number of any mortgage loan originator who is:

(A) either licensed or registered under state or federal law as a mortgage loan originator consistent with the Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (H.R. 3221 Title V); and

(B) involved in the transaction.

(3) The name and license number (under IC 25-34.1) of each:
(A) broker company; and
(B) broker if any;
involved in the transaction.
(4) The following information:
(A) The:
(i) name of; and
(ii) code assigned by the National Association of Insurance Commissioners (NAIC) to;
each title insurance underwriter involved in the transaction.
(B) The type of title insurance policy issued in connection with the transaction.
(5) The name and license number (under IC 27-1-15.6) of each title insurance agency and agent involved in the transaction as a closing agent (as defined in IC 6-1.1-12-43(a)(2)).
(6) The following information:
(A) The name and:
(i) license or certificate number (under IC 25-34.1-3-8) of each licensed or certified real estate appraiser; or
(ii) license number (under IC 25-34.1) of each broker;
who appraises the property that is the subject of the transaction.
(B) The name and registration number (under IC 25-34.1-11-10) of any appraisal management company that performs appraisal management services (as defined in IC 25-34.1-11-3) in connection with the transaction.
(7) In the case of a transaction described in subsection (a)(1), the name of the creditor and, if the creditor is required to be licensed under IC 24-4.4, the license number of the creditor.
(8) In the case of a transaction described in subsection (a)(1)(A)(i) or (a)(2), the name of the seller of the property that is the subject of the transaction.
(9) In the case of a transaction described in subsection (a)(1)(A)(i), the following information:
(A) The name of the buyer of the property that is the subject of the transaction.
(B) The purchase price of the property that is the subject of the transaction.
(C) The loan amount of the mortgage transaction.
(10) In the case of a transaction described in subsection (a)(2), the following information:
(A) The name of the buyer of the property that is the subject of the transaction.
(B) The purchase price of the property that is the subject of the transaction.
(11) In the case of a transaction described in subsection (a)(1)(A)(ii), the following information:
(A) The name of the borrower in the mortgage transaction.

(B) The loan amount of the refinancing.

(12) The:

(A) name; and

(B) license number, certificate number, registration number, or other code, as appropriate;

of any other person that is involved in a transaction to which this section applies, as the department may prescribe.

(c) The system established by the department under this section must include a form that:

(1) is uniformly accessible in an electronic format to the closing agent (as defined in IC 6-1.1-12-43(a)(2)) in the transaction; and

(2) allows the closing agent to do the following:

(A) Input information identifying the property that is the subject of the transaction by lot or parcel number, street address, or some other means of identification that the department determines:

(i) is sufficient to identify the property; and

(ii) is determinable by the closing agent.

(B) Subject to subsection (d) and to the extent determinable, input the applicable information described in subsection (b).

(C) Respond to the following questions, if applicable:

(i) "On what date did you receive the closing instructions from the creditor in the transaction?".

(ii) "On what date did the transaction close?".

(D) Submit the form electronically to a data base maintained by the department.

(d) Not later than the time of the closing or the date of disbursement, whichever is later, each person described in subsection (b), other than a person described in subsection (b)(8), (b)(9), (b)(10), or (b)(11), shall provide to the closing agent in the transaction the person's:

(1) legal name; and

(2) license number, certificate number, registration number, or NAIC code, as appropriate;

to allow the closing agent to comply with subsection (c)(2)(B). In the case of a transaction described in subsection (a)(1), the person described in subsection (b)(7) shall, with the cooperation of any person involved in the transaction and described in subsection (b)(6)(A) or (b)(6)(B), provide the information described in subsection (b)(6). In the case of a transaction described in subsection (a)(1)(A)(ii), the person described in subsection (b)(7) shall also provide the information described in subsection (b)(11). A person described in subsection (b)(3)(B) who is involved in the transaction may provide the information required by this subsection for a person described in subsection (b)(3)(A) that serves as the broker company for the person described in subsection (b)(3)(B). The closing agent shall determine the information described in subsection (b)(8),

(b)(9), and (b)(10) from the HUD-1 settlement statement, or in the case of a transaction described in subsection (a)(2), from the contract or any other document executed by the parties in connection with the transaction.

(e) The closing agent in a transaction to which this section applies shall submit the information described in subsection (d) to the data base described in subsection (c)(2)(D) not later than twenty (20) business days after the date of closing or the date of disbursement, whichever is later.

(f) Except for a person described in subsection (b)(8), (b)(9), (b)(10), or (b)(11), a person described in subsection (b) who fails to comply with subsection (d) or (e) is subject to a civil penalty of one hundred dollars ($100) for each closing with respect to which the person fails to comply with subsection (d) or (e). The penalty:

(1) may be enforced by the state agency that has administrative jurisdiction over the person in the same manner that the agency enforces the payment of fees or other penalties payable to the agency; and

(2) shall be paid into the home ownership education account established by IC 5-20-1-27.

(g) Subject to subsection (h), the department shall make the information stored in the data base described in subsection (c)(2)(D) accessible to:

(1) each entity described in IC 4-6-12-4; and

(2) the homeowner protection unit established under IC 4-6-12-2.

(h) The department, a closing agent who submits a form under subsection (c), each entity described in IC 4-6-12-4, and the homeowner protection unit established under IC 4-6-12-2 shall exercise all necessary caution to avoid disclosure of any information:

(1) concerning a person described in subsection (b), including the person's license, registration, or certificate number; and

(2) contained in the data base described in subsection (c)(2)(D);

except to the extent required or authorized by state or federal law.

(i) The department may adopt rules under IC 4-22-2, including emergency rules under IC 4-22-2-37.1, to implement this section. Rules adopted by the department under this subsection may establish procedures for the department to:

(1) establish;

(2) collect; and

(3) change as necessary;

an administrative fee to cover the department's expenses in establishing and maintaining the electronic system required by this section.

(j) If the department adopts a rule under IC 4-22-2 to establish an administrative fee to cover the department's expenses in establishing and maintaining the electronic system required by this section, as allowed under subsection (i), the department may:

(1) require the fee to be paid:

(A) to the closing agent responsible for inputting the information and submitting the form described in subsection (c)(2); and

(B) by the borrower, the seller, or the buyer in the transaction;

(2) allow the closing agent described in subdivision (1)(A) to retain a part of the fee collected to cover the closing agent's costs in inputting the information and submitting the form described in subsection (c)(2); and

(3) require the closing agent to pay the remainder of the fee collected to the department for deposit in the title insurance enforcement fund established by IC 27-7-3.6-1, for the department's use in establishing and maintaining the electronic system required by this section.

As added by P.L.145-2008, SEC.31. Amended by P.L.105-2009, SEC.16; P.L.35-2010, SEC.96; P.L.226-2011, SEC.22; P.L.127-2012, SEC.47; P.L.116-2015, SEC.21; P.L.72-2016, SEC.17.

IC 27-7-3-16

Retirement or withdrawal from business; reinsurance; cancellation of certificate of authority; return of deposit

Sec. 16. (a) Whenever any domestic company desires to retire from the business provided for in this chapter, it shall furnish to the department satisfactory evidence that it no longer has outstanding any liability upon any policy of insurance made by it in the conduct of its business as a title insurance company, or that it has reinsured its outstanding policies with a solvent company, authorized to do business under this chapter in this state, or with a company approved by the department. At the same time the company shall surrender to the department its certificate of authority. If the department is satisfied that there is no outstanding liability upon any policy issued by such company, or, that its outstanding policies have been properly reinsured, then the department shall cancel the surrendered certificate of authority and shall return to the company any and all deposits made by such company under the provisions of this chapter.

(b) Whenever any foreign company desires to withdraw from doing a title insurance business in this state, it shall furnish to the department satisfactory evidence that it no longer has outstanding any liability upon any policy of title insurance made by it in the conduct of its business in this state, or that it has reinsured its outstanding policies with a solvent company, authorized to do business in this state, or with a company approved by the department. At the same time such company shall surrender to the department its certificate of authority. If the department is satisfied that there is no outstanding liability upon any policy issued by such company in the conduct of its business in this state, or that its outstanding policies

have been properly reinsured, then the department shall cancel the surrendered certificate of authority and shall return to the company any and all deposits made with it by such company under the provisions of this chapter.
(Formerly: Acts 1937, c.104, s.16.) As amended by P.L.252-1985, SEC.260.

IC 27-7-3-17
Violations
Sec. 17. A person who recklessly violates this chapter or fails to fulfill any of the requirements of this chapter commits a Class B misdemeanor.
(Formerly: Acts 1937, c.104, s.17.) As amended by Acts 1978, P.L.2, SEC.2724.

IC 27-7-3-18
Exemptions from chapter
Sec. 18. The provisions of this chapter shall not apply to any insurance company organized or desiring to organize under and pursuant to IC 27-1 nor to any person, firm, partnership, corporation, limited liability company, association, or company whose business is the making of abstracts of title to real estate and attaching their certificate thereto and not engaging in the business of making title insurance, nor to any person, firm, partnership, corporation, limited liability company, or association acting as an authorized agent for a duly qualified title insurance company.
(Formerly: Acts 1937, c.104, s.18.) As amended by P.L.252-1985, SEC.261; P.L.8-1993, SEC.425.

IC 27-7-3-19
Construction of chapter
Sec. 19. This chapter shall be deemed to create an additional and separate method for engaging in the business of title insurance, as defined in this chapter, and providing for the incorporation of such companies and their licensing to do such business. This chapter shall not be deemed to alter, amend, or repeal any other statutes of the state of Indiana. No requirements or proceedings shall be necessary for the incorporation and licensing of a title insurance company under this chapter except such as are prescribed in this chapter, any provision of the laws of the state of Indiana or IC 27-1 to the contrary notwithstanding.
(Formerly: Acts 1937, c.104, s.20.) As amended by P.L.252-1985, SEC.262.

IC 27-7-3-20
Limitation on risks
Sec. 20. (a) As used in this section, "any one (1) risk" means a risk or hazard that arises in connection with any one (1) piece or

parcel of property, whether or not the policy insures other property.

(b) Any company organized to issue title insurance in Indiana may not expose itself to any one (1) risk in an amount exceeding fifty percent (50%) of the aggregate amount of its total capital and surplus and its reserves other than its loss of claim reserves.

(c) Any risk or portion of any risk that has been reinsured as authorized under IC 27-7, must be deducted in determining the limitation of risk prescribed in this section.

As added by Acts 1982, P.L.162, SEC.2.

IC 27-7-3-21

Requirement of title search

Sec. 21. A company described in section 3 of this chapter that issues a title insurance policy shall perform or cause to be performed a title search for the real estate in conjunction with a mortgage secured by the real estate unless the mortgage meets all of the following requirements:

(1) The principal amount of the mortgage is not more than fifty thousand dollars ($50,000).

(2) The mortgage is subordinate to a prior mortgage where a title search was conducted and a title policy was issued.

(3) The mortgage is not a reverse mortgage.

As added by P.L.68-2002, SEC.2.

IC 27-7-3-22

Closing protection letter; fee

Sec. 22. (a) In a residential real estate transaction described in section 15.5(a) and 15.5(b) of this chapter in which:

(1) a title policy is issued by a company or title insurance producer on behalf of a company; and

(2) the company or title insurance producer will also act as a settlement or closing agent;

the company or title insurance producer shall issue a closing protection letter to the lender, borrower, buyer, and seller of the property. A company authorized to do business under section 3 of this chapter shall charge a fee approved under subsection (e) to each party receiving the benefit of a closing protection letter.

(b) In a nonresidential real estate transaction in which:

(1) a title policy is issued by a company or title insurance producer on behalf of a company; and

(2) the company or title insurance producer will also act as a settlement or closing agent;

the company or title insurance producer may issue a closing protection letter to the lender, borrower, buyer, and seller of the property on request.

(c) A closing protection letter issued under this section must indemnify the party to which the closing protection letter is issued against any loss of settlement funds (under the terms and conditions

of the closing protection letter) that results from the following acts of the company or title insurance producer that issues the closing protection letter:

(1) Theft or misappropriation of settlement funds in connection with a transaction in which the title policy is issued, only to the extent that the theft or misappropriation relates to the:

(A) status of title to; or

(B) validity, enforceability, and priority of the lien of the mortgage on;

the party's interest in land.

(2) Failure to comply with the written closing instructions agreed to by the company or title insurance producer acting as the settlement agent, only to the extent that the failure relates to the:

(A) status of title to; or

(B) validity, enforceability, and priority of the lien of the mortgage on;

the party's interest in land.

(d) The issuance of a closing protection letter under this section in contemplation of or in conjunction with the issuance of a title insurance policy is part of the business of title insurance for purposes of section 3 of this chapter.

(e) The amount of the fee that a company authorized to do business under section 3 of this chapter charges to each party receiving the benefits of a closing protection letter:

(1) must be submitted to and approved by the commissioner under IC 27-1-22-28; and

(2) is not subject to an agreement requiring a division of fees or premiums collected on behalf of the company.

As added by P.L.80-2013, SEC.4.

IC 27-7-3.6

Chapter 3.6. Title Insurance Enforcement Fund

IC 27-7-3.6-1

Title insurance enforcement fund established; uses of fund

Sec. 1. The title insurance enforcement fund is established for the following purposes:

(1) To provide supplemental funding for department operations that are related to title insurance, including any of the following:

(A) The investigation of any matter concerning title insurance transactions in Indiana, to the extent necessary to determine compliance with this title.

(B) Appropriate administrative and civil actions to redress instances of noncompliance with this title.

(C) Cooperative efforts with federal, state, and local law enforcement agencies in investigating the following:

(i) Deceptive acts in connection with title insurance transactions.

(ii) Criminal violations involving deceptive acts in connection with title insurance transactions.

(iii) Violations of the Real Estate Settlement Procedures Act (12 U.S.C. 2601 et seq.) and any other federal laws or regulations concerning title insurance transactions. To the extent authorized by federal law, the department may enforce compliance with the federal statutes or regulations described in this item or refer suspected violations of the statutes or regulations to the appropriate federal regulatory agencies.

(D) Actions to enjoin violations of 12 U.S.C. 2607, as permitted under 12 U.S.C. 2607(d) and 12 U.S.C. 2614.

(2) To pay the costs of hiring and employing staff in the area of enforcement of title insurance law.

(3) To provide funding for educational materials or services designed to provide information to consumers about residential title insurance transactions.

As added by P.L.171-2006, SEC.5. Amended by P.L.145-2008, SEC.32.

IC 27-7-3.6-2

Administration of title insurance enforcement fund

Sec. 2. The title insurance enforcement fund shall be administered by the commissioner. The expenses of administering the title insurance enforcement fund shall be paid from money in the fund.

As added by P.L.171-2006, SEC.5.

IC 27-7-3.6-3

Investments

Sec. 3. The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money may be invested.
As added by P.L.171-2006, SEC.5.

IC 27-7-3.6-4
Reversions to state general fund prohibited
Sec. 4. Money in the fund at the end of a state fiscal year does not revert to the state general fund.
As added by P.L.171-2006, SEC.5.

IC 27-7-3.6-5
Augmentation authorized
Sec. 5. The budget agency may augment the appropriation for the department of insurance from balances in the fund.
As added by P.L.171-2006, SEC.5.

IC 27-7-3.6-6
Deposits
Sec. 6. The following shall be deposited in the title insurance enforcement fund:
(1) Policy reporting fees remitted by title insurers to the commissioner under section 7 of this chapter.
(2) Other amounts remitted to the commissioner or the department that are required by law to be deposited into the title insurance enforcement fund.
As added by P.L.171-2006, SEC.5. Amended by P.L.1-2007, SEC.185.

IC 27-7-3.6-7
Fees
Sec. 7. (a) A person that purchases a title insurance policy shall pay to the title insurer that issues the title insurance policy a fee of five dollars ($5) as a fee for the title insurance enforcement fund at the time of payment for the title insurance policy.
(b) A title insurer shall:
(1) retain two dollars ($2) of the fee collected under subsection (a) as an administrative fee; and
(2) pay to the department three dollars ($3) of the fee collected under subsection (a) for deposit in the title insurance enforcement fund.
As added by P.L.171-2006, SEC.5.

IC 27-7-3.7

Chapter 3.7. Escrow Transactions in Real Estate Transactions

IC 27-7-3.7-1

"Closing agent"

Sec. 1. (a) As used in this chapter, "closing agent" means a person that:

(1) closes an escrow transaction in connection with the purchase, sale, or financing of an interest in real estate; and

(2) is required to be licensed as an insurance producer under IC 27-1-15.6.

(b) The term does not include a lender or an employee of a lender that conducts a settlement or closing of a real estate secured loan provided by the lender in the office of the lender.

As added by P.L.92-2009, SEC.1.

IC 27-7-3.7-2

"Escrow account"

Sec. 2. As used in this chapter, "escrow account" means a checking account established by a closing agent with a:

(1) bank;

(2) savings and loan association;

(3) credit union; or

(4) savings bank;

that is chartered under the laws of a state or the United States and used exclusively for the deposit and disbursement of funds for an escrow transaction.

As added by P.L.92-2009, SEC.1.

IC 27-7-3.7-3

"Escrow transaction"

Sec. 3. (a) As used in this chapter, "escrow transaction" means a transaction in which a person deposits with a closing agent funds that are to be held until:

(1) a specified event occurs; or

(2) the performance of a prescribed condition;

in connection with the purchase, sale, or financing of an interest in real estate.

(b) The term does not include a loan financing if:

(1) the only parties to the loan transaction are the lender and the borrower; and

(2) the lender is responsible for disbursing all of the funds to the borrower or to a third party in order to pay fees and charges associated with the loan transaction.

As added by P.L.92-2009, SEC.1.

IC 27-7-3.7-4

"Good funds"

Sec. 4. As used in this chapter, "good funds" means funds in any of the following forms:

(1) United States currency.

(2) Wired funds unconditionally held by and irrevocably credited to the escrow account of the closing agent.

(3) Certified or cashier's checks that are drawn on an existing account at a:

(A) bank;

(B) savings and loan association;

(C) credit union; or

(D) savings bank;

chartered under the laws of a state or the United States.

(4) A check drawn on the trust account of a real estate broker licensed under IC 25-34.1, if the closing agent has reasonable and prudent grounds to believe that sufficient funds will be available for withdrawal from the account on which the check is drawn at the time of disbursement of funds from the closing agent's escrow account.

(5) A personal check not to exceed five hundred dollars ($500) per closing.

(6) A check issued by the state, the United States, or a political subdivision of the state or the United States.

(7) A check drawn on the escrow account of another closing agent, if the closing agent in the escrow transaction has reasonable and prudent grounds to believe that sufficient funds will be available for withdrawal from the account upon which the check is drawn at the time of disbursement of funds from the escrow account of the closing agent in the escrow transaction.

(8) A check issued by a farm credit service authorized under the Farm Credit Act of 1971 (12 U.S.C. 2001 et seq.).

(9) A check that is deposited and held in the escrow account of the closing agent for at least fourteen (14) days before the date of closing.

As added by P.L.92-2009, SEC.1. Amended by P.L.72-2016, SEC.18.

IC 27-7-3.7-5

"Real estate transaction"

Sec. 5. (a) As used in this section, "real estate transaction" refers to any:

(1) escrow transaction;

(2) settlement; or

(3) closing;

conducted in connection with the purchase, sale, or financing of an interest in real estate.

(b) The term does not include a real estate secured loan financing if:

(1) the only parties to the loan transaction are the lender and the

borrower; and

(2) the lender is responsible for disbursing all of the funds to the borrower or to a third party in order to pay fees and charges associated with the loan transaction.

As added by P.L.92-2009, SEC.1.

IC 27-7-3.7-6

Funds received in escrow transaction to be deposited in escrow account; exception

Sec. 6. Funds received in connection with an escrow transaction must be deposited in an escrow account unless the parties to the escrow transaction agree in writing to another arrangement.

As added by P.L.92-2009, SEC.1.

IC 27-7-3.7-7

Disbursements; requirements for funds of at least $10,000 received from single party

Sec. 7. (a) This section applies to an escrow account that contains funds that:

(1) are received from any single party to a real estate transaction; and

(2) in the aggregate are at least ten thousand dollars ($10,000).

(b) A closing agent may make disbursements from an escrow account described in subsection (a) in connection with a real estate transaction only if both of the following apply:

(1) All the funds described in subsection (a) are good funds.

(2) Any funds described in subsection (a) in excess of ten thousand dollars ($10,000) are good funds described in section 4(2) of this chapter.

As added by P.L.92-2009, SEC.1. Amended by P.L.72-2016, SEC.19.

IC 27-7-3.7-8

Disbursements; requirements for funds less than $10,000 received from single party

Sec. 8. A closing agent may not make disbursements from an escrow account in connection with a real estate transaction unless any funds that:

(1) are received from any single party to the real estate transaction; and

(2) in the aggregate are less than ten thousand dollars ($10,000);

are good funds.

As added by P.L.92-2009, SEC.1.

IC 27-7-3.7-9

Mortgage holder's right to receive proceeds from real estate transaction through funds electronically transferred to specified account

Sec. 9. If:

(1) the closing agent in a real estate transaction receives wired funds unconditionally held and irrevocably credited to the escrow account of the closing agent; and

(2) a holder of a mortgage lien encumbering real estate so requests, as part of written closing instructions or a written payoff statement in advance of closing;

the holder of the mortgage lien is entitled to receive its proceeds from the real estate transaction through funds electronically transferred to an account specified by the holder of the mortgage lien.

As added by P.L.92-2009, SEC.1.

IC 27-7-3.7-10

Advance of fees from escrow account to pay incidental fees

Sec. 10. A closing agent may advance an amount not to exceed five hundred dollars ($500) from an escrow account on behalf of a party to an escrow transaction for the purpose of paying incidental fees, including conveyance and recording fees. Incidental fees may be paid in order to:

(1) effect and close the sale of;

(2) purchase;

(3) exchange;

(4) transfer;

(5) encumber; or

(6) lease;

real property that is the subject of the escrow transaction.

As added by P.L.92-2009, SEC.1.

IC 27-7-4
Repealed

(Repealed by Acts 1974, P.L.142, SEC.3.)

IC 27-7-5

Chapter 5. Uninsured Motorist Coverage and Underinsured Motorist Coverage

IC 27-7-5-0.1

Application of certain amendments to chapter

Sec. 0.1. The following amendments to this chapter apply as follows:

(1) The amendments made to section 2 of this chapter by P.L.391-1987(ss) apply only to policies first issued after December 31, 1987.

(2) Notwithstanding the effective date of P.L.124-2009, SECTION 1, the amendments made to section 2 of this chapter by P.L.124-2009 apply to a case in which:

(A) a claim under a policy's uninsured motorist coverage or underinsured motorist coverage arises after December 31, 2009;

(B) a rejection is made under section 2 of this chapter, as amended by P.L.124-2009 of the uninsured motorist coverage or underinsured motorist coverage under which the claim described in subdivision (1) is made; and

(C) the rejection described in clause (B) is made after December 31, 2009.

As added by P.L.220-2011, SEC.433.

IC 27-7-5-1

Repealed

(Repealed by Acts 1982, P.L.166, SEC.6.)

IC 27-7-5-1.5

Repealed

(As added by P.L.72-2005, SEC.1. Repealed by P.L.124-2009, SEC.4.)

IC 27-7-5-2

Uninsured and underinsured motorist coverage; required coverage; rejection; exemptions

Sec. 2. (a) Except as provided in subsections (d), (f), and (h), the insurer shall make available, in each automobile liability or motor vehicle liability policy of insurance which is delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state, insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any person and for injury to or destruction of property to others arising from the ownership, maintenance, or use of a motor vehicle, or in a supplement to such a policy, the following types of coverage:

(1) in limits for bodily injury or death and for injury to or destruction of property not less than those set forth in

IC 9-25-4-5 under policy provisions approved by the commissioner of insurance, for the protection of persons insured under the policy who are legally entitled to recover damages from owners or operators of uninsured or underinsured motor vehicles because of bodily injury, sickness or disease, including death, and for the protection of persons insured under the policy who are legally entitled to recover damages from owners or operators of uninsured motor vehicles for injury to or destruction of property resulting therefrom; or

(2) in limits for bodily injury or death not less than those set forth in IC 9-25-4-5 under policy provisions approved by the commissioner of insurance, for the protection of persons insured under the policy provisions who are legally entitled to recover damages from owners or operators of uninsured or underinsured motor vehicles because of bodily injury, sickness or disease, including death resulting therefrom.

The uninsured and underinsured motorist coverages must be provided by insurers for either a single premium or for separate premiums, in limits at least equal to the limits of liability specified in the bodily injury liability provisions of an insured's policy, unless such coverages have been rejected in writing by the insured. However, underinsured motorist coverage must be made available in limits of not less than fifty thousand dollars ($50,000). At the insurer's option, the bodily injury liability provisions of the insured's policy may be required to be equal to the insured's underinsured motorist coverage. Insurers may not sell or provide underinsured motorist coverage in an amount less than fifty thousand dollars ($50,000). Insurers must make underinsured motorist coverage available to all existing policyholders on the date of the first renewal of existing policies that occurs on or after January 1, 1995, and on any policies newly issued or delivered on or after January 1, 1995. Uninsured motorist coverage or underinsured motorist coverage may be offered by an insurer in an amount exceeding the limits of liability specified in the bodily injury and property damage liability provisions of the insured's policy.

(b) A named insured of an automobile or motor vehicle liability policy has the right, in writing, to:

(1) reject both the uninsured motorist coverage and the underinsured motorist coverage provided for in this section; or

(2) reject either the uninsured motorist coverage alone or the underinsured motorist coverage alone, if the insurer provides the coverage not rejected separately from the coverage rejected.

A rejection of coverage under this subsection by a named insured is a rejection on behalf of all other named insureds, all other insureds, and all other persons entitled to coverage under the policy. No insured may have uninsured motorist property damage liability insurance coverage under this section unless the insured also has uninsured motorist bodily injury liability insurance coverage under

this section. Following rejection of either or both uninsured motorist coverage or underinsured motorist coverage, unless later requested in writing, the insurer need not offer uninsured motorist coverage or underinsured motorist coverage in or supplemental to a renewal or replacement policy issued to the same insured by the same insurer or a subsidiary or an affiliate of the originally issuing insurer. Renewals of policies issued or delivered in this state which have undergone interim policy endorsement or amendment do not constitute newly issued or delivered policies for which the insurer is required to provide the coverages described in this section.

(c) A rejection under subsection (b) must specify:

(1) that the named insured is rejecting:

(A) the uninsured motorist coverage;

(B) the underinsured motorist coverage; or

(C) both the uninsured motorist coverage and the underinsured motorist coverage;

that would otherwise be provided under the policy; and

(2) the date on which the rejection is effective.

(d) An insurer is not required to make available the coverage described in subsection (a) in a commercial umbrella or excess liability policy, including a commercial umbrella or excess liability policy that is issued or delivered to a motor carrier (as defined in IC 8-2.1-17-10) that is in compliance with the minimum levels of financial responsibility set forth in 49 CFR Part 387.

(e) A rejection under subsection (b) of uninsured motorist coverage or underinsured motorist coverage in an underlying commercial policy of insurance is also a rejection of uninsured motorist coverage or underinsured motorist coverage in a commercial umbrella or excess liability policy.

(f) An insurer is not required to make available the coverage described in subsection (a) in connection with coverage that:

(1) is related to or included in a commercial policy of property and casualty insurance described in Class 2 or Class 3 of IC 27-1-5-1; and

(2) covers a loss related to a motor vehicle:

(A) of which the insured is not the owner; and

(B) that is used:

(i) by the insured or an agent of the insured; and

(ii) for purposes authorized by the insured.

(g) For purposes of subsection (f), "owner" means:

(1) a person who holds the legal title to a motor vehicle;

(2) a person who rents or leases a motor vehicle and has exclusive use of the motor vehicle for more than thirty (30) days;

(3) the conditional vendee or lessee under an agreement for the conditional sale or lease of a motor vehicle; or

(4) the mortgagor under an agreement for the conditional sale or lease of a motor vehicle under which the mortgagor has:

(A) the right to purchase; and

(B) an immediate right of possession of;

the motor vehicle upon the performance of the conditions stated in the agreement.

(h) The following apply to the coverage described in subsection (a) in relation to a personal umbrella or excess liability policy:

(1) An insurer is not required to make available the coverage described in subsection (a) under a personal umbrella or excess liability policy.

(2) An insurer that reduces or removes, through a rider or an endorsement, coverage described in subsection (a) under a personal umbrella or excess liability policy shall:

(A) through the United States mail; or

(B) by electronic means;

provide to the named insured written notice of the reduction or removal.

(3) An insurer that makes available the coverage described in subsection (a) under a personal umbrella or excess liability policy:

(A) may make available the coverage in limits determined by the insurer; and

(B) is not required to make available the coverage in limits equal to the limits specified in the personal umbrella or excess liability policy.

As added by Acts 1982, P.L.166, SEC.1. Amended by P.L.391-1987(ss), SEC.1; P.L.5-1988, SEC.145; P.L.2-1991, SEC.88; P.L.1-1992, SEC.151; P.L.1-1993, SEC.203; P.L.130-1994, SEC.41; P.L.116-1994, SEC.56; P.L.233-1999, SEC.8; P.L.124-2009, SEC.1; P.L.116-2011, SEC.2; P.L.125-2012, SEC.403; P.L.148-2013, SEC.1.

IC 27-7-5-3

Property damage coverage; authorization

Sec. 3. (a) Insurers shall additionally offer to provide uninsured motorist property damage coverage without any deductible amount and may offer uninsured motorist property damage coverage with a deductible of not more than the first three hundred dollars ($300.00) of property damage caused by collision. However, any such deductible amount for property damage shall be waived for damage resulting from collision if the insured motor vehicle is legally parked and unoccupied when involved in a motor vehicle accident for which the insured is legally entitled to recover damages from an uninsured motorist.

(b) Property damage losses recoverable under the provisions of this chapter are limited to damages to the insured motor vehicle and the personal property owned by the insured which is contained in the insured motor vehicle and shall not include the loss of use of damaged or destroyed property.

(c) Any claim for property damage submitted under an uninsured motorist coverage must include the name and address of the at-fault operator and any other information to establish the at-fault operator is without motor vehicle liability insurance. There shall be no liability imposed upon an insurer where the owner or operator of the other vehicle cannot be identified.

As added by Acts 1982, P.L.166, SEC.2. Amended by P.L.259-1983, SEC.5.

IC 27-7-5-4

"Uninsured motor vehicle" and "underinsured motor vehicle" defined; insurer's insolvency protection

Sec. 4. (a) For the purpose of this chapter, the term uninsured motor vehicle, subject to the terms and conditions of such coverage, means a motor vehicle without liability insurance or a motor vehicle not otherwise in compliance with the financial responsibility requirements of IC 9-25 or any similar requirements applicable under the law of another state, and includes an insured motor vehicle where the liability insurer of the vehicle is unable to make payment with respect to the legal liability of its insured within the limits specified in IC 9-25-4-5 because of insolvency.

(b) For the purpose of this chapter, the term underinsured motor vehicle, subject to the terms and conditions of such coverage, includes an insured motor vehicle where the limits of coverage available for payment to the insured under all bodily injury liability policies covering persons liable to the insured are less than the limits for the insured's underinsured motorist coverage at the time of the accident, but does not include an uninsured motor vehicle as defined in subsection (a).

(c) An insurer's insolvency protection applies only to accidents occurring during a policy period in which its insured's uninsured motorist coverage is in effect and where the liability insurer of the tortfeasor becomes insolvent within two (2) years after such an accident. However, nothing contained in this section shall be construed to prevent any insurer from affording insolvency protection under terms and conditions more favorable to its insured than is provided under this section.

As added by Acts 1982, P.L.166, SEC.3. Amended by P.L.391-1987(ss), SEC.2; P.L.2-1991, SEC.89; P.L.1-1992, SEC.152; P.L.1-1993, SEC.204.

IC 27-7-5-5

Limitations on coverage

Sec. 5. (a) The policy or endorsement affording coverage specified in this chapter may provide that the total limit of all insurers' liability arising out of any one (1) accident shall not exceed the highest limits under any one (1) policy applicable to the loss, but in no event may coverage be less than the minimum set forth in

IC 9-25-4-5.

(b) When the coverage specified in this chapter is written to apply to one (1) or more motor vehicles under a single automobile liability policy, such coverage applies only to the operation of those motor vehicles for which a specific uninsured or underinsured motorist premium charge has been made and does not apply to the operation of any motor vehicles insured under the policy or owned by the named insured for which a premium charge has not been made.

(c) The maximum amount payable for bodily injury under uninsured or underinsured motorist coverage is the lesser of:

(1) the difference between:

(A) the amount paid in damages to the insured by or for any person or organization who may be liable for the insured's bodily injury; and

(B) the per person limit of uninsured or underinsured motorist coverage provided in the insured's policy; or

(2) the difference between:

(A) the total amount of damages incurred by the insured; and

(B) the amount paid by or for any person or organization liable for the insured's bodily injury.

As added by Acts 1982, P.L.166, SEC.4. Amended by P.L.391-1987(ss), SEC.3; P.L.2-1991, SEC.90; P.L.1-1992, SEC.153; P.L.1-1993, SEC.205.

IC 27-7-5-6
Subrogation

Sec. 6. (a) The policy or endorsement affording the coverage specified in this chapter may also provide that payment to any person of sums as damages under such coverage shall operate to subrogate the insurer to any cause of action in tort which such person may have against any other person or organization legally responsible for the bodily injury or death, or property damage, because of which such payment is made. The insurer shall be subrogated, to the extent of such payment, to the proceeds of any settlement or judgment that may later result from the exercise of any rights of recovery of such person against any person or organization legally responsible for said bodily injury or death, or property damage, for which payment is made by the insurer. Such insurer may enforce such rights in its own name or in the name of the person to whom payment has been made, as in their interest may appear, by proper action in any court of competent jurisdiction.

(b) An insurer providing underinsured motorist coverage does not have a right of subrogation against an underinsured motorist if:

(1) the insurer has been provided with a written notice that:

(A) informs the insurer of the existence of a bona fide offer of agreement or settlement between its insured and the underinsured motorist; and

(B) includes a certification of the liability coverage limits of

the underinsured motorist; and

(2) the insurer fails to advance payment to the insured in an amount equal to the amount provided for in the offer of agreement or settlement within thirty (30) days after the insurer receives the notice described in subdivision (1).

However, an insurer that, under the circumstances described in subdivision (1), advances payment to the insured in an amount equal to the amount provided for in the offer of agreement or settlement, has full rights of subrogation as provided in its policy or endorsement affording the underinsured motorist coverage.

(c) When an insurer makes payment under uninsured motorist coverage or underinsured motorist coverage because of the insolvency of an insolvent insurer (as defined in IC 27-6-8), the paying insurer's rights of reimbursement and subrogation do not include any rights of recovery against:

(1) the insured of the insolvent insurer; or

(2) the Indiana Insurance Guaranty Association created by IC 27-6-8-5;

except that the paying insurer may recover from the insured of the insolvent insurer that part of its payment that exceeds the limits of liability of the policy of the insolvent insurer.

As added by Acts 1982, P.L.166, SEC.5. Amended by P.L.121-1990, SEC.7.

IC 27-7-5.1

Chapter 5.1. Miscellaneous Motor Vehicle Insurance Provisions

IC 27-7-5.1-1

"Financial responsibility"

Sec. 1. As used in this chapter, "financial responsibility" means the ability to respond in damages as described in IC 9-25-2-3.

As added by P.L.136-2015, SEC.1.

IC 27-7-5.1-2

"Motor vehicle insurance policy"

Sec. 2. As used in this chapter, "motor vehicle insurance policy" means a policy that provides the kind of coverage described in Class 2(f) of IC 27-1-5-1.

As added by P.L.136-2015, SEC.1.

IC 27-7-5.1-3

"Noneconomic damages"

Sec. 3. (a) As used in this chapter, "noneconomic damages" means costs for the following:

(1) Physical and emotional pain and suffering.
(2) Physical impairment.
(3) Emotional distress.
(4) Mental anguish.
(5) Loss of enjoyment.
(6) Loss of companionship, services, and consortium.
(7) Any other nonpecuniary loss proximately caused by a motor vehicle accident.

(b) The term does not include costs for the following:

(1) Treatment and rehabilitation.
(2) Medical expenses.
(3) Loss of economic or educational potential.
(4) Loss of productivity.
(5) Absenteeism.
(6) Support expenses.
(7) Accidents or injury.
(8) Any other pecuniary loss proximately caused by a motor vehicle accident.

As added by P.L.136-2015, SEC.1.

IC 27-7-5.1-4

"Uninsured motorist with a previous violation"

Sec. 4. As used in this chapter, "uninsured motorist with a previous violation" means an individual who:

(1) owns a motor vehicle:
(A) that is involved in an accident; and
(B) for which financial responsibility is not in effect as

required by IC 9-25-4; and

(2) during the immediately preceding five (5) years, has been required to provide proof of future financial responsibility for any period under IC 9-25-8-6(b);

regardless of whether the individual is operating the motor vehicle at the time of the accident.

As added by P.L.136-2015, SEC.1.

IC 27-7-5.1-5

Prohibition on payment of noneconomic damages

Sec. 5. An insurer may not pay noneconomic damages on a claim for coverage under a motor vehicle insurance policy issued by the insurer if the claim is for coverage for a loss incurred by an uninsured motorist with a previous violation.

As added by P.L.136-2015, SEC.1.

IC 27-7-5.1-6

Application of prohibition

Sec. 6. (a) Section 5 of this chapter does not apply to a claim for coverage for a loss incurred by an uninsured motorist with a previous violation who is less than eighteen (18) years of age.

(b) Section 5 of this chapter does not apply to a claim for coverage for a loss incurred by any person other than an uninsured motorist with a previous violation.

(c) Section 5 of this chapter does not apply if a person other than the uninsured motorist with a previous violation:

(1) operates a motor vehicle involved in the accident; and

(2) is convicted of a crime in connection with the accident.

As added by P.L.136-2015, SEC.1.

IC 27-7-6

Chapter 6. Cancellation of Automobile Insurance Policies

IC 27-7-6-1

Limitations on power of issuance, cancellation, and nonrenewal

Sec. 1. The issuance, cancellation, and nonrenewal of automobile insurance policies by insurers shall be subject to the limitations set out in this chapter.

(Formerly: Acts 1969, c.332, s.1.) As amended by P.L.252-1985, SEC.263; P.L.121-1990, SEC.8.

IC 27-7-6-2

"Automobile insurance policy", "automobile liability coverage", and "policy"

Sec. 2. "Automobile insurance policy" means a policy delivered or issued for delivery in this state or covering a motor vehicle required to be registered in this state providing coverage for bodily injury and property damage liability, medical payments, and uninsured motorists or any combination thereof, and insuring as the named insured a natural person or more than one (1) natural persons related to each other, resident of the same household, and under which the insured vehicles therein designated are as:

(a) a motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers, nor rented to others; or

(b) any other four-wheel motor vehicle with a load capacity of one thousand five hundred (1,500) pounds or less which is not used in the occupation, profession, or business of the insured; provided, however, that this chapter shall not apply:

(1) to any policy issued under an automobile assigned risk plan; or

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

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

"Policy" shall be deemed to mean a policy providing automobile liability coverage.

(Formerly: Acts 1969, c.332, s.2.) As amended by P.L.252-1985, SEC.264; P.L.146-2015, SEC.30.

IC 27-7-6-3

"Renewal" or "to renew" defined

Sec. 3. "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 insuring the same insured, or the issuance and delivery of a certificate or

notice extending the term of a policy beyond its policy period or term; provided, however, that any policy with a policy period or term of six (6) months or less and any policy with no fixed expiration date shall for the purposes of this chapter be considered as if written for a policy period or term of six (6) months; and provided further, that any policy written for a term longer than one (1) year shall for the purposes of this chapter be considered as if written for successive policy periods or terms of one (1) year, and such policy may be terminated by the insurer at the expiration of any annual period upon giving twenty (20) days notice of cancellation prior to such anniversary date, and such cancellation shall not be subject to any other provisions of this chapter.
(Formerly: Acts 1969, c.332, s.3.) As amended by P.L.252-1985, SEC.265.

IC 27-7-6-4
Notice of cancellation; authorized reasons

Sec. 4. A notice of cancellation by an insurer of an automobile insurance policy as defined in this chapter shall be effective only if such cancellation is for one (1) or more of the following reasons:

(a) Nonpayment of premium which is defined to mean for the purposes of this chapter the 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) 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 denied or has been under suspension or revocation during the policy period or the existence of one (1) or more grounds for such denial, suspension, or revocation has become known.

(c) The named insured or any other operator who either resides in the same household or customarily operates an automobile insured under the policy:

(1) is under treatment for epilepsy or heart disease and does not produce a certificate from a physician testifying to the operator's unqualified ability to operate a motor vehicle safely; or

(2) uses drugs or alcoholic beverages to excess.

(d) Fraud, willful misrepresentation, or concealment on the part of any insured in respect to any material fact or circumstance relating to the issuance or continuance of the policy or relating to a loss.

(e) Violation of any terms or conditions of the policy.

(f) The place of residence of the insured or the state of

registration or license of the insured automobile is changed to a state or country in which the insurer is not licensed.

Provided, however, that a change or substitution in policy form shall not be deemed to be a cancellation within the intent of this chapter; provided, further, that nothing in this section shall apply to nonrenewals. This section shall not apply to any policy or coverage which has been in effect less than sixty (60) days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy.

(Formerly: Acts 1969, c.332, s.4.) As amended by P.L.252-1985, SEC.266.

IC 27-7-6-5

Notice of cancellation; time for mailing or delivery; notice to insurance producer

Sec. 5. No notice of cancellation of a policy to which section 4 of this chapter applies shall be effective unless mailed or delivered by the insurer to the named insured at least twenty (20) days prior to the effective date of cancellation; provided, however, that where cancellation is for nonpayment of premium at least ten (10) days notice of cancellation accompanied by the reason therefor shall be given. In the event such policy was procured by an insurance producer duly licensed by the state of Indiana, notice of intent to cancel shall be mailed or delivered to the insurance producer at least ten (10) days prior to such mailing or delivery to the named insured unless such notice of intent is or has been waived in writing by the insurance producer. Unless the reason accompanies or is included in 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 not less than fifteen (15) days prior to the effective date of cancellation, the insurer will specify the reason for such cancellation. This section shall not apply to nonrenewal.

(Formerly: Acts 1969, c.332, s.5.) As amended by P.L.252-1985, SEC.267; P.L.178-2003, SEC.45.

IC 27-7-6-6

Notice of intention not to renew; time for mailing or delivery; notice to insurance producer

Sec. 6. (a) 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 (20) days' advance notice of its intention not to renew. In the event such policy was procured by an insurance producer duly licensed by the state of Indiana notice of intent not to renew shall be mailed or delivered to the insurance producer at least ten (10) days prior to such mailing or delivery to the named insured unless such notice of intent is or has been waived in writing by the insurance producer.

(b) This section shall not apply:

(1) if the insurer has manifested its willingness to renew; or

(2) in case of nonpayment of premium.

However, notwithstanding the failure of an insurer to comply with this section, the policy shall terminate on the effective date of any other insurance policy with respect to any automobile designated in both policies.

(c) A notice of intention not to renew is not required if:

(1) the insured is transferred from an insurer to an affiliate of the insurer for future coverage as a result of a merger, an acquisition, or a company restructuring;

(2) the transfer results in the same or broader coverage; and

(3) the insured approves the transfer.

(d) 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.

(Formerly: Acts 1969, c.332, s.6.) As amended by P.L.160-2003, SEC.24; P.L.178-2003, SEC.46; P.L.97-2004, SEC.98.

IC 27-7-6-7

Proof of mailing notice

Sec. 7. 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.

(Formerly: Acts 1969, c.332, s.7.)

IC 27-7-6-8

Notice of possible eligibility under assigned risk plan

Sec. 8. When a policy providing automobile liability coverage is cancelled, other than for nonpayment of premium, or in the event of failure to renew a policy providing automobile liability coverage to which section 6 of this chapter applies, the insurer shall notify the named insured of his possible eligibility for automobile liability insurance through other insurers or 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.

(Formerly: Acts 1969, c.332, s.8.) As amended by P.L.252-1985, SEC.268.

IC 27-7-6-9

Compliance with request for reason for cancellation or nonrenewal; time limits

Sec. 9. Where the reason for cancellation does not accompany or is not included in the notice of cancellation, the insurer shall upon written request of the named insured, mailed or delivered to the insurer not less than fifteen (15) days prior to the effective date of cancellation, specify in writing the reason for such cancellation. Such reason shall be mailed or delivered to the named insured within five

(5) days after receipt of such request.
(Formerly: Acts 1969, c.332, s.9.)

IC 27-7-6-10
Exemption from liability for statements made in giving reasons for cancellation or nonrenewal

Sec. 10. There shall be no liability on the part of and no cause of action of any nature shall arise against the commissioner of insurance or against any insurer, its authorized representative, its insurance producers, its employees, or any firm, person, limited liability company, 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.
(Formerly: Acts 1969, c.332, s.10.) As amended by P.L.8-1993, SEC.426; P.L.178-2003, SEC.47.

IC 27-7-6-11
Dispute as to truth of reason for cancellation; hearing; findings; effect; fee

Sec. 11. (a) In the event the truth of the reason or reasons for cancellation is disputed by the named insured, the insured may, not later than ten (10) days prior to the effective date of such cancellation, apply in writing to the commissioner of insurance for a hearing. Such application shall state wherein such reason or reasons are false and a copy of such application shall be mailed or delivered to the insurer on the same date it is submitted to the commissioner.

(b) If the commissioner finds that the application was made in good faith and does in fact present a dispute as to the truth or existence of valid grounds for cancellation, the commissioner shall, within a reasonable time after receipt of such application and upon ten (10) days notice to the named insured and the insurer, hold a hearing on the matter. The findings of the commissioner shall be final and shall be issued in writing to the parties within five (5) days after the hearing.

(c) In the event of a finding that no reason for cancellation in fact exists, the cancellation shall be of no effect and the notice shall be rescinded.

(d) In the event of a finding that one (1) or more reasons for cancellation do in fact exist, the cancellation shall be effective as of the date stated in the cancellation notice.

(e) No investigation, defense, or other action undertaken by the insurer during the period between the date of cancellation stated in the notice and the date the commissioner issued findings shall be

deemed a waiver of any rights or defenses on the part of such insurer.

(f) Any application for a hearing shall be accompanied by a filing fee of twenty dollars ($20) as a condition precedent to such hearing. Such fee shall be returned to the named insured if the finding is in the insured's favor, but otherwise shall be retained by the department of insurance.

(Formerly: Acts 1969, c.332, s.11.) As amended by P.L.3-1989, SEC.154.

IC 27-7-6-12

Person with a disability; automobile policy

Sec. 12. (a) As used in this section, "person with a disability" means a person who is under a disability as defined by the federal Social Security Administration guidelines (42 U.S.C. 416).

(b) After June 30, 1990, an insurer may not cancel, fail to renew, or refuse to issue an automobile insurance policy to a person with a disability who holds a valid driver's license solely because of the disability, nor may an insurer cancel, fail to renew, or refuse to issue an automobile insurance policy under conditions less favorable to persons with a disability than persons without a disability.

As added by P.L.121-1990, SEC.9. Amended by P.L.99-2007, SEC.191.

IC 27-7-7
Repealed
(Repealed by P.L.262-1985, SEC.2.)

IC 27-7-8

Chapter 8. Legal Insurance

IC 27-7-8-1

Definitions

Sec. 1. Definitions. As used in this chapter:

"Advertising" means any communication to the public the purpose of which is to convey information purporting to describe a legal insurance plan.

"Commissioner" refers to the commissioner of insurance.

"Department" refers to the department of insurance.

"Employee" means an individual employed or permitted to work or perform services for remuneration under a contract of hire, written or oral, by an employer.

"Employer" means a person who hires an employee.

"Group legal insurance" refers to legal insurance issued under a master policy covering the individuals set out in subdivisions (1) and (2) of section 3 of this chapter, applying a rate that is lower than the rate shown in the insurer's manual for individual policies of the same type and class.

"Insurer" means a person who obtains a certificate of authority under IC 27-1-3-20.

"Legal insurance" means insurance against class 2(m) risk of loss as described in IC 27-1-5-1.

"Person" means an individual, partnership, corporation, limited liability company, business trust, or association.

"Solicitation" means any invitation or request to enroll in a legal insurance plan, or attempt to obtain consideration for the coverage of a legal insurance plan, or any other device the purpose of which is to induce an individual to enroll in, or pay consideration for, a legal insurance plan.

As added by Acts 1978, P.L.129, SEC.2. Amended by P.L.8-1993, SEC.427.

IC 27-7-8-2

Provisions governing legal insurance

Sec. 2. In addition to the other applicable provisions of IC 27, an insurer providing legal insurance must comply with the provisions of this chapter.

As added by Acts 1978, P.L.129, SEC.2.

IC 27-7-8-3

Authority to issue insurance to individuals and groups

Sec. 3. Legal insurance may be issued to an individual or, as a group policy to:

(1) ten (10) or more employees; or

(2) ten (10) or more members of a trade or professional association, labor union, or any other association of members in

the same or related occupation, profession, or industry in existence for two (2) years, having a constitution, and formed for a purpose other than obtaining insurance.

As added by Acts 1978, P.L.129, SEC.2.

IC 27-7-8-4

Payment of premiums; persons authorized

Sec. 4. The following may periodically pay to the insurer, as provided in the contract to insure, the premiums on a group legal insurance policy:

(1) An employer for its employees.

(2) An association for its members.

(3) A labor union for its members.

As added by Acts 1978, P.L.129, SEC.2.

IC 27-7-8-5

Group policies; rights to obtain individual coverage

Sec. 5. (a) A group policy must contain a provision that allows an insured member who no longer qualifies for group coverage to obtain an individual policy with similar coverage.

(b) An individual desiring to obtain an individual policy as provided under subsection (a) must apply for the policy not later than thirty-one (31) days from the date on which the individual is no longer a qualified member of the group.

(c) The individual policy shall be issued on one (1) of the forms issued by the insurer for individual policies, and the premium on the policy must be at the insurer's customary rate for the class of risk to which the individual belongs.

As added by Acts 1978, P.L.129, SEC.2.

IC 27-7-8-6

Master group policy; individual certificates; filing; contents

Sec. 6. An insurer shall issue an individual or master policy that serves as evidence of a contractual obligation. A certificate of coverage must be issued to each individual under a group policy. All such documents must be filed with the commissioner as required under this title. In addition to those provisions, each policy or certificate concerning legal insurance must contain a complete and clear statement of:

(1) the legal benefits to which the insured is entitled;

(2) any limitation or exclusion on the services, kinds of services, benefits to be provided, including deductible or copayment features; and

(3) where information is available as to how services may be obtained.

As added by Acts 1978, P.L.129, SEC.2.

IC 27-7-8-7

Regulations

Sec. 7. The commissioner may promulgate regulations under IC 4-22-2 that he considers necessary for the proper administration of this chapter.

As added by Acts 1978, P.L.129, SEC.2.

IC 27-7-9

Chapter 9. Mine Subsidence Insurance

IC 27-7-9-1
"Commissioner"

Sec. 1. As used in this chapter, "commissioner" refers to the insurance commissioner.
As added by P.L.164-1986, SEC.1.

IC 27-7-9-2
"Insurer"

Sec. 2. As used in this chapter, "insurer" has the meaning set forth in IC 27-1-2-3(x).
As added by P.L.164-1986, SEC.1.

IC 27-7-9-3 Version a
"Mine subsidence"

Note: This version of section effective until 1-1-2017. See also following version of this section, effective 1-1-2017.

Sec. 3. As used in this chapter, "mine subsidence" means the collapse of inactive underground coal mines abandoned before August 3, 1977, resulting in damage to a structure. The term does not include loss caused by earthquake, landslide, volcanic eruption, or collapse of storm or sewer drains.
As added by P.L.164-1986, SEC.1. Amended by P.L.124-1992, SEC.1.

IC 27-7-9-3 Version b
"Mine subsidence"

Note: This version of section effective 1-1-2017. See also preceding version of this section, effective until 1-1-2017.

Sec. 3. As used in this chapter, "mine subsidence" means the collapse of an underground coal mine resulting in damage to a structure. The term does not include loss caused by earthquake, landslide, volcanic eruption, or collapse of storm or sewer drains.
As added by P.L.164-1986, SEC.1. Amended by P.L.124-1992, SEC.1; P.L.101-2016, SEC.2.

IC 27-7-9-3.5
"Peril"

Sec. 3.5. As used in this chapter, "peril" means the cause of a loss, such as a fire, an explosion, or a flood.
As added by P.L.124-1992, SEC.2.

IC 27-7-9-4
"Premium"

Sec. 4. As used in this chapter, "premium" has the meaning set forth in IC 27-1-2-3(w).

As added by P.L.164-1986, SEC.1.

IC 27-7-9-5 Version a
"Structure"

Note: This version of section effective until 1-1-2017. See also following version of this section, effective 1-1-2017.

Sec. 5. As used in this chapter, "structure" means any dwelling, building, or fixture permanently fixed to real property. The term does not include land, trees, crops, or other plants, nor does the term include a dwelling, building, or fixture that is owned by a public or governmental entity.

As added by P.L.164-1986, SEC.1. Amended by P.L.124-1992, SEC.3.

IC 27-7-9-5 Version b
"Structure"

Note: This version of section effective 1-1-2017. See also preceding version of this section, effective until 1-1-2017.

Sec. 5. As used in this chapter, "structure" means any dwelling, building, or fixture permanently fixed to real property. The term does not include land, trees, crops, or other plants.

As added by P.L.164-1986, SEC.1. Amended by P.L.124-1992, SEC.3; P.L.101-2016, SEC.3.

IC 27-7-9-6
List of counties in which mine subsidence insurance available

Sec. 6. The department of natural resources shall identify and maintain a list of counties that are:

(1) at least partially within the Illinois Coal Basin; or

(2) underlain by coal-bearing rock formations of the Pennsylvanian system.

The mine subsidence insurance provided under this chapter is available only to cover structures located in counties identified by the department of natural resources under this section.

As added by P.L.164-1986, SEC.1.

IC 27-7-9-7
Mine subsidence insurance fund; deposits; investment

Sec. 7. (a) The mine subsidence insurance fund is established for the purpose of making mine subsidence insurance available to owners of property located in counties identified under section 6 of this chapter. The fund shall be administered by the commissioner. Money shall be deposited in the fund from:

(1) premiums for mine subsidence insurance remitted by insurers to the commissioner; and

(2) funds obtained through federal grants or any other source.

(b) The expenses of administering the fund shall be paid from money in the fund.

(c) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. Interest that accrues from these investments shall be deposited in the fund.

(d) Money in the fund at the end of a particular fiscal year does not revert to the state general fund.

As added by P.L.164-1986, SEC.1.

IC 27-7-9-8 Version a

Extent of coverage necessary; deductible

Note: This version of section effective until 1-1-2017. See also following version of this section, effective 1-1-2017.

Sec. 8. (a) Coverage for damage due to mine subsidence must be available as an additional form of coverage under any insurance policy providing the type of insurance described in Class 3(a) of IC 27-1-5-1 to directly cover one (1) or more structures located in a county identified under section 6 of this chapter. The mine subsidence coverage must be available in an amount adequate to indemnify the insured to the extent of the loss in actual cash value of the covered structure due to mine subsidence, less a deductible equal to two percent (2%) of the insured value of the structure under the policy. However, the deductible must be no less than two hundred fifty dollars ($250) and no more than five hundred dollars ($500).

(b) An insurer proposing to issue a policy providing the type of insurance described in Class 3(a) of IC 27-1-5-1 to cover one (1) or more structures located in a county identified under section 6 of this chapter shall inform the prospective policyholder of the availability of mine subsidence coverage under this section. An insurer shall inform the prospective policyholder of the availability of mine subsidence coverage under this subsection when a policy described in this subsection is issued.

(c) When an insurer informs a prospective policyholder of the amount of the premium for the mine subsidence coverage that is available as an additional form of coverage under a policy as required by subsection (a), the premium for the mine subsidence coverage must be stated separately from the premium for the other coverage provided by the policy. The amount of the premium for mine subsidence coverage provided by an insurer under this section must be set according to the premium level set by the commissioner under section 10 of this chapter.

(d) Except as provided in subsection (f), an insurance policy providing the type of insurance described in Class 3(a) of IC 27-1-5-1 to directly cover one (1) or more structures located in a county identified under section 6 of this chapter must include the mine subsidence coverage provided for under subsection (a) if the prospective insured (before issuance of the policy) or the insured (before renewal of the policy) indicates that the coverage is to be included in the policy.

(e) An insurer is not required to provide mine subsidence coverage under subsection (a) under any insurance policy in an amount exceeding the amount that is reimbursable from the fund under section 9(a)(4) of this chapter.

(f) An insurer must decline to make the mine subsidence coverage provided for under subsection (a) available to cover a structure evidencing unrepaired mine subsidence damage, until necessary repairs are made. An insurer may also decline to make the mine subsidence coverage available under an insurance policy if the insurer has:

(1) declined to issue the policy;

(2) declined to renew the policy; or

(3) canceled all coverage under the policy for underwriting reasons unrelated to mine subsidence.

As added by P.L.164-1986, SEC.1. Amended by P.L.29-1987, SEC.2; P.L.150-1990, SEC.1; P.L.124-1992, SEC.4; P.L.1-1993, SEC.206; P.L.116-1994, SEC.57; P.L.91-1998, SEC.9; P.L.132-2001, SEC.3; P.L.182-2001, SEC.3.

IC 27-7-9-8 Version b

Extent of coverage necessary; deductible

Note: This version of section effective 1-1-2017. See also preceding version of this section, effective until 1-1-2017.

Sec. 8. (a) Coverage for damage due to mine subsidence must be available as an additional form of coverage under any insurance policy providing the type of insurance described in Class 3(a) of IC 27-1-5-1 to directly cover one (1) or more structures located in a county identified under section 6 of this chapter. The mine subsidence coverage must be available in an amount adequate to indemnify the insured to the extent of:

(1) the loss in actual cash value of the covered structure due to mine subsidence, less a deductible that:

(A) must be equal to two percent (2%) of the insured value of the structure under the policy; but

(B) must be:

(i) no less than two hundred fifty dollars ($250); and

(ii) no more than five hundred dollars ($500); and

(2) up to fifteen thousand dollars ($15,000) for additional living expenses reasonably and necessarily incurred by an insured who is temporarily displaced as a direct result of damage caused by mine subsidence to the covered structure in which the insured resides, if no other type of coverage provided by the policy of the insured indemnifies the insured for these living expenses.

An insured who elects to purchase coverage under subdivision (1) may waive coverage under subdivision (2) at the election of the insured.

(b) An insurer proposing to issue a policy providing the type of insurance described in Class 3(a) of IC 27-1-5-1 to cover one (1) or

more structures located in a county identified under section 6 of this chapter shall inform the prospective policyholder of the availability of mine subsidence coverage under this section. An insurer shall inform the prospective policyholder of the availability of mine subsidence coverage under this subsection when a policy described in this subsection is issued.

(c) When an insurer informs a prospective policyholder of the amount of the premium for the mine subsidence coverage that is available as an additional form of coverage under a policy as required by subsection (a), the premium for the mine subsidence coverage must be stated separately from the premium for the other coverage provided by the policy. The amount of the premium for mine subsidence coverage provided by an insurer under this section must be set according to the premium level set by the commissioner under section 10 of this chapter.

(d) Except as provided in subsection (f), an insurance policy providing the type of insurance described in Class 3(a) of IC 27-1-5-1 to directly cover one (1) or more structures located in a county identified under section 6 of this chapter must include the mine subsidence coverage provided for under subsection (a) if the prospective insured (before issuance of the policy) or the insured (before renewal of the policy) indicates that the coverage is to be included in the policy.

(e) An insurer is not required to provide mine subsidence coverage under subsection (a) under any insurance policy in an amount exceeding the amount that is reimbursable from the fund under section 9(a)(4) of this chapter.

(f) An insurer must decline to make the mine subsidence coverage provided for under subsection (a) available to cover a structure evidencing unrepaired mine subsidence damage, until necessary repairs are made. An insurer may also decline to make the mine subsidence coverage available under an insurance policy if the insurer has:

(1) declined to issue the policy;

(2) declined to renew the policy; or

(3) canceled all coverage under the policy for underwriting reasons unrelated to mine subsidence.

As added by P.L.164-1986, SEC.1. Amended by P.L.29-1987, SEC.2; P.L.150-1990, SEC.1; P.L.124-1992, SEC.4; P.L.1-1993, SEC.206; P.L.116-1994, SEC.57; P.L.91-1998, SEC.9; P.L.132-2001, SEC.3; P.L.182-2001, SEC.3; P.L.101-2016, SEC.4.

IC 27-7-9-8.4

Additional forms of coverage; application to structures

Sec. 8.4. If coverage for damage due to mine subsidence is added under this chapter as an additional form of coverage to a policy providing the coverage described in Class 3(a) of IC 27-1-5-1, the mine subsidence coverage of the policy must apply to structures in

the same manner as coverage for other perils under the policy.
As added by P.L.124-1992, SEC.5.

IC 27-7-9-8.5
Limitation on amount payable; one mine subsidence occurrence; damage occurring before issuance of policy; duty to investigate; liability

Sec. 8.5. (a) The amount payable through mine subsidence insurance provided under this chapter for all damage caused by one (1) mine subsidence occurrence is limited to the amount of insurance that:

(1) is in force with respect to the structure or structures damaged in the occurrence; and

(2) is reinsured under section 9 of this chapter;

at the time when the damage to the structure or structures occurs.

(b) For the purposes of this section, all damage that is caused by:

(1) a single mine subsidence event; or

(2) two (2) or more mine subsidence events that are continuous;

shall be considered as having been caused by one (1) mine subsidence occurrence.

(c) Neither an insurer, an agent of an insurer, nor an employee of an insurer is obligated to investigate for mine subsidence damage that may have occurred before the issuance or renewal of a policy including mine subsidence coverage under this chapter, unless specifically informed of such damage by the insured or prospective insured.

(d) Neither an insurer, an agent of an insurer, nor an employee of an insurer is liable for mine subsidence damage that occurs before the issuance of a policy including mine subsidence coverage under this chapter.
As added by P.L.150-1990, SEC.2. Amended by P.L.124-1992, SEC.6.

IC 27-7-9-9
Reinsurance; terms; ceding commission

Sec. 9. (a) An insurer making the type of insurance described in Class 3(a) of IC 27-1-5-1 shall enter into a reinsurance agreement with the commissioner. The reinsurance agreement must include the following terms:

(1) The insurer agrees to cede to the commissioner one hundred percent (100%) of any mine subsidence coverage issued under this chapter, subject to a maximum limit of five hundred thousand dollars ($500,000) per structure insured.

(2) The insurer shall collect the premiums for mine subsidence insurance, may retain a ceding commission in an amount set by the commissioner, and shall remit the remainder of the premiums to the commissioner for deposit in the mine subsidence insurance fund.

(3) The insurer, in consideration of the ceding commission, shall:

(A) undertake the adjustment of losses under the mine subsidence coverage issued under this chapter by the insurer, with technical assistance provided under section 9.5 of this chapter; and

(B) pay the taxes and absorb all other expenses necessarily incurred by the insurer in the sale of policies and the administration of the mine subsidence insurance program under this chapter.

(4) The commissioner shall reimburse the insurer from the mine subsidence insurance fund for all amounts paid to policyholders for mine subsidence insurance claims.

(5) The insurer is not required to pay a claim for any mine subsidence loss insured under this chapter if the amount available in the mine subsidence insurance fund is insufficient to reimburse the insurer for the claim.

(b) The determination of the commissioner as to the amount of the ceding commission that an insurer may retain under subsection (a)(2) must be based on a consideration of the insurer's reasonable administrative costs (including insurance producers' commissions). *As added by P.L.164-1986, SEC.1. Amended by P.L.150-1990, SEC.3; P.L.124-1992, SEC.7; P.L.189-1996, SEC.1; P.L.182-2001, SEC.4; P.L.178-2003, SEC.48; P.L.35-2015, SEC.1.*

IC 27-7-9-9.5 Version a

Assistance with adjusting of claims; responsibility of insurer; costs paid from fund

Note: This version of section effective until 1-1-2017. See also following version of this section, effective 1-1-2017.

Sec. 9.5. (a) The commissioner shall provide insurers with assistance from one (1) or more individuals with technical expertise in mine subsidence for the purpose of assisting with the adjusting of claims under coverage issued under this chapter. To comply with this section, the commissioner may:

(1) expand the staff of the department of insurance; or

(2) enter into contracts providing for the services of persons with the necessary technical expertise to provide assistance to insurers in the determination of subsidence events.

(b) The adjustment of a claim against a policy that includes mine subsidence coverage under this chapter is the sole responsibility of the insurer until the insurer makes a preliminary determination that the loss may involve mine subsidence. Upon such a determination, those persons retained by the commissioner as set out in subsection (a) of this section shall assist the commissioner and insurer in determining the existence of a mine subsidence event and the costs therein shall be paid from the fund established by section 7 of this chapter.

As added by P.L.124-1992, SEC.8.

IC 27-7-9-9.5 Version b
Assistance with adjusting of claims; responsibility of insurer; costs paid from fund

Note: This version of section effective 1-1-2017. See also preceding version of this section, effective until 1-1-2017.

Sec. 9.5. (a) The commissioner shall provide insurers with assistance from one (1) or more individuals with technical expertise in mine subsidence for the purpose of assisting with the adjusting of claims under coverage issued under this chapter. If the commissioner considers it necessary in order to comply with this section, the commissioner may:

(1) expand the staff of the department of insurance; or

(2) enter into contracts providing for the services of persons with the necessary technical expertise to provide assistance to insurers in the determination of subsidence events.

(b) The adjustment of a claim against a policy that includes mine subsidence coverage under this chapter is the sole responsibility of the insurer until the insurer makes a preliminary determination that the loss may involve mine subsidence. Upon such a determination, those persons retained by the commissioner as set out in subsection (a) shall assist the commissioner and insurer in determining the existence of a mine subsidence event and the costs therein shall be paid from the fund established by section 7 of this chapter.

As added by P.L.124-1992, SEC.8. Amended by P.L.101-2016, SEC.5.

IC 27-7-9-10
Premiums

Sec. 10. (a) Premiums for mine subsidence insurance under this chapter shall be established by the commissioner, who shall review at least annually the premium level and the experience data concerning operation of the fund and make changes in the premiums as required.

(b) Premiums shall be established at a rate or within a schedule of rates sufficient to:

(1) satisfy all foreseeable claims on the mine subsidence insurance fund during the period of coverage, giving due consideration to relevant loss or claims experience or trends;

(2) cover normal costs of operation of the mine subsidence insurance fund; and

(3) provide a reasonable reserve fund for unexpected contingencies.

(c) Deviations from the premium level or premiums set by the commissioner may not be allowed.

As added by P.L.164-1986, SEC.1.

IC 27-7-9-11
Report to commissioner

Sec. 11. An insurer that enters into a reinsurance agreement with the commissioner under section 9 of this chapter shall:

(1) report the amounts of premiums collected, at times designated by the commissioner; and

(2) present an itemized list of losses paid, including the policy number and the location of the structures, semiannually on dates selected by the commissioner.

As added by P.L.164-1986, SEC.1.

IC 27-7-9-12
Payment to insurer upon receipt of loss report

Sec. 12. The commissioner shall pay an insurer all amounts due under section 9(a)(4) of this chapter within ninety (90) days after receiving a loss report. The commissioner shall require that each loss report include:

(1) an itemized statement of the damage, repairs made, and the cost of each repair; and

(2) any other documentation the commissioner believes will substantiate the reported loss.

As added by P.L.164-1986, SEC.1.

IC 27-7-9-13
Nature of claims

Sec. 13. Mine subsidence insurance claims made under this chapter do not constitute a debt, liability, or obligation of the state or a pledge of faith and credit of the state, except to the extent that the mine subsidence insurance fund has accumulated reserves from premiums, state or federal grants, investment income, or state appropriations.

As added by P.L.164-1986, SEC.1.

IC 27-7-9-14
Subrogation rights; reports

Sec. 14. (a) The commissioner and each insurer issuing mine subsidence insurance under this chapter have the right of subrogation. In enforcing this subrogation right, the commissioner or the insurer shall be considered the real party in interest and shall pursue any action under the insurer's or commissioner's own name.

(b) The insurer shall include in its semiannual report under section 11(2) of this chapter an itemized list of all losses in subrogation. An insurer shall remit to the commissioner all money, less expenses, recovered as a result of subrogation actions.

As added by P.L.164-1986, SEC.1.

IC 27-7-9-15
Recourse against insurer or policyholder; fraud or policy

violations

Sec. 15. (a) Except in case of fraud by an insurer, the commissioner has no right of recourse against an insurer. An insurer may settle losses under this chapter in the customary manner.

(b) The commissioner may require an insurer to attempt to recover from a policyholder for amounts paid to the policyholder if, in the judgment of the commissioner, the policyholder was not entitled to the amounts paid because of fraud or violation of the policy conditions. The cost of a recovery attempt under this subsection shall be borne equally by the insurer and the commissioner.

As added by P.L.164-1986, SEC.1.

IC 27-7-9-16

Delegation of powers

Sec. 16. The commissioner may delegate the task of executing the powers conferred upon the commissioner under this chapter to officers of the department of insurance or other persons. However, the commissioner remains fully responsible for the proper execution of those powers.

As added by P.L.164-1986, SEC.1.

IC 27-7-9-17

Authority to adopt rules

Sec. 17. In order to establish guidelines and procedures necessary to implement this chapter, the commissioner shall have authority to adopt rules pursuant to IC 4-22-2.

As added by P.L.124-1992, SEC.9.

IC 27-7-9-18

Reports; claims

Sec. 18. The department of insurance shall, every three (3) years beginning not later than November 1, 2001, publish a report regarding mine subsidence insurance provided under this chapter, including the:

(1) number of claims filed;

(2) amount paid for each claim; and

(3) amount remaining in the mine subsidence insurance fund established under section 7 of this chapter;

since the date of the previous publication of the report under this section.

As added by P.L.182-2001, SEC.5.

IC 27-7-10
Chapter 10. Risk Retention Groups

IC 27-7-10-1
"Commissioner" defined

Sec. 1. As used in this chapter, "commissioner" means:

(1) the insurance commissioner of Indiana appointed under IC 27-1-1-2; or

(2) the commissioner, director, or superintendent of insurance of any other state.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-2
"Completed operations liability" defined

Sec. 2. As used in this chapter, "completed operations liability" means liability arising out of the installation, maintenance, or repair of any product at a site that is not owned or controlled by:

(1) any person who performs that work; or

(2) any person who hires an independent contractor to perform that work.

However, the term includes liability for activities that are completed or abandoned before the date of the occurrence giving rise to the liability.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-3
"Domicile" defined

Sec. 3. As used in this chapter to determine the state in which a purchasing group is domiciled, "domicile" means the following:

(1) For a corporation, the state in which the purchasing group is incorporated.

(2) For an unincorporated entity, the state of its principal place of business.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-4
"Hazardous financial condition" defined

Sec. 4. As used in this chapter, "hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able to:

(1) meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(2) pay other obligations in the normal course of business.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-5
"Insurance" defined

Sec. 5. As used in this chapter, "insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk that is determined to be insurance under the laws of Indiana.
As added by P.L.162-1988, SEC.2.

IC 27-7-10-6
"Liability" defined

Sec. 6. (a) As used in this chapter, "liability" means legal liability for damages (including costs of defense, legal costs and fees, and other claims expenses) because of injuries to other persons, damage to their property, or other damage or loss to other persons, resulting from or arising out of:

(1) any business (whether profit or nonprofit), trade, product, services (including professional services), premises, or operations; or

(2) any activity of any state or local government, or any agency or political subdivision of state or local government.

(b) The term "liability" does not include:

(1) personal risk liability; or

(2) an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act (45 U.S.C. 51 et seq.).

As added by P.L.162-1988, SEC.2.

IC 27-7-10-7
"Personal risk liability" defined

Sec. 7. As used in this chapter, "personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities, rather than from responsibilities or activities referred to in section 6(a) of this chapter.
As added by P.L.162-1988, SEC.2.

IC 27-7-10-8
"Plan of operation or feasibility study" defined

Sec. 8. As used in this chapter, "plan of operation or feasibility study" means an analysis that presents the expected activities and results of a risk retention group including, at a minimum, the following:

(1) Information sufficient to verify that the members of the risk retention group are engaged in businesses or activities similar or related with respect to the liability to which those members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations.

(2) For each state in which the risk retention group intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group

intends to offer.

(3) Historical and expected loss experience of the proposed members of the risk retention group and national experience of similar exposures to the extent that this experience is reasonably available.

(4) Pro forma financial statements and projections.

(5) Appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition.

(6) Identification of management, underwriting, and claims procedures, marketing methods, managerial oversight methods, investment policies, and reinsurance agreements.

(7) Identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each state.

(8) Such other matters as may be prescribed by the commissioner of the state in which the risk retention group is chartered for liability insurance companies authorized by the insurance laws of that state.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-9

"Product liability" defined

Sec. 9. (a) As used in this chapter, "product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage (including damages resulting from the loss of use of property) arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product.

(b) The term "product liability" does not include the liability of a person for damages described in subsection (a) if the product involved was in the possession of that person when the incident giving rise to the liability occurred.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-10

"Purchasing group" defined

Sec. 10. As used in this chapter, "purchasing group" means any group that:

(1) has as one of its purposes the purchase of liability insurance on a group basis;

(2) purchases liability insurance:

(A) only for its group members; and

(B) only to cover the liability with respect to which the businesses or activities of the group members are similar or related;

(3) is composed of members whose businesses or activities are

similar or related with respect to the liability to which the members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations; and

(4) is domiciled in any state.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-11

"Risk retention group" defined

Sec. 11. (a) As used in this chapter, "risk retention group" means any corporation or other limited liability association:

(1) whose primary activity consists of assuming and spreading all or any portion of the liability exposure of its group members;

(2) that is organized for the primary purpose of conducting the activity described in subdivision (1);

(3) that:

(A) is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

(B) before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before January 1, 1985, had certified to the insurance commissioner of at least one (1) state that it satisfied the capitalization requirements of that state;

(4) that does not exclude any person from membership in the group solely to provide the members of the group a competitive advantage over that person;

(5) that:

(A) has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by that group; or

(B) has as its sole owner an organization which:

(i) has as its members only persons who comprise the membership of the risk retention group; and

(ii) is owned entirely by persons who comprise the membership of the risk retention group and who are provided insurance by that group;

(6) whose members are engaged in businesses or activities similar or related with respect to the liability to which the members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations;

(7) whose activities do not include the provision of insurance other than:

(A) liability insurance for assuming and spreading all or any portion of the liability of its group members; and

(B) reinsurance with respect to the liability of:

(i) any other risk retention group; or

(ii) any member of any other risk retention group;

that is engaged in business or activities that would make the group or group member eligible for membership, under subdivision (6), in the risk retention group that provides the reinsurance;

(8) whose name includes the phrase "Risk Retention Group".

(b) The term "risk retention group" includes a corporation or limited liability association described in subsection (a)(3)(B):

(1) only if that corporation or association has been engaged in business continuously since January 1, 1985; and

(2) only for the purpose of continuing to provide insurance to cover product liability or completed operations liability.

As used in this subsection, the terms "product liability" and "completed operations liability" have the meanings set forth in 15 U.S.C. 3901 before October 27, 1986.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-12

"State" defined

Sec. 12. As used in this chapter, "state" means any state of the United States or the District of Columbia.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-13

Establishment of risk retention groups; certificate of authority; submission of plan of operation or feasibility study; revision of plan; required information

Sec. 13. (a) This section governs the establishment of a risk retention group in Indiana.

(b) A risk retention group may be organized and may obtain a certificate of authority under IC 27-1-6 to write only liability insurance pursuant to this chapter. Except as otherwise provided in this chapter, a risk retention group established under this section shall comply with:

(1) all laws and rules that apply to insurers that are chartered and licensed in Indiana; and

(2) sections 14 through 22 of this chapter;

to the extent that the requirements referred to in subdivisions (1) and (2) are not a limitation on the laws, rules, or requirements of this state.

(c) Before a risk retention group to be established under this section may offer insurance in any state, the organizers of the risk retention group shall submit for approval to the commissioner of this state a plan of operation or feasibility study. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in an item of the plan of operation or feasibility study, within ten (10) days of the change. A risk retention group

established under this section may not offer any additional kinds of liability insurance, in Indiana or any other state, until a revision of the plan of operation or feasibility study is approved by the commissioner.

(d) At the time that an application is submitted for a certificate of authority for a risk retention group, the organizers of the risk retention group shall provide to the commissioner of this state, in summary form, the following information:

(1) The identity of the initial members of the group.

(2) The identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group.

(3) The amount and nature of initial capitalization of the group.

(4) The types of insurance coverage to be afforded by the group.

(5) The states in which the group intends to operate.

(e) Upon receiving the information required by subsection (d), the commissioner of this state shall forward the information to the National Association of Insurance Commissioners. The requirement to provide information to the National Association of Insurance Commissioners under this section is in addition to all other requirements of this chapter, and providing this information does not satisfy the requirements of sections 14 through 22 or any other sections of this chapter.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-14

Foreign risk retention groups seeking to do or doing business in Indiana; required information

Sec. 14. (a) A risk retention group that is chartered and licensed in a state other than Indiana and that seeks to do business in Indiana shall comply with this section and with sections 15 through 22 of this chapter.

(b) Before offering insurance in Indiana, a risk retention group shall submit to the commissioner the following:

(1) A statement that sets forth the following:

(A) The state or states in which the risk retention group is chartered and licensed as a liability insurance company.

(B) The date on which the charter of the group was issued.

(C) The group's principal place of business.

(D) Any other information (including information on the membership of the group) that the commissioner may require to verify that the group meets the definition of risk retention group in section 11 of this chapter.

(2) A copy of the plan of operations or feasibility study, and of any revisions of that plan or study, submitted by the risk retention group to the state in which the group is chartered and licensed.

(3) A copy of the group's charter or license from its chartering

state.

(4) A statement of registration (for which a filing fee shall be determined by the commissioner) that designates the commissioner as its agent for the purpose of receiving service of legal documents or process.

(c) A risk retention group that is chartered and licensed in a state other than Indiana and that is doing or seeks to do business in Indiana shall submit a copy of any revision of its plan of operation or feasibility study to the commissioner of this state at the same time that the revision is submitted to the commissioner of the group's chartering state.

(d) A risk retention group that is chartered and licensed in a state other than Indiana and that is doing business in Indiana shall submit to the commissioner of this state the following:

(1) A copy of the group's financial statement submitted to the state in which the risk retention group is chartered and licensed, which must be certified by an independent public accountant and must contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist (under criteria established by the National Association of Insurance Commissioners).

(2) A copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination.

(3) Upon request by the commissioner, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group.

(4) Such information as may be required to verify that the group continues to meet the definition of risk retention group in section 11 of this chapter.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-15

Premium taxes and taxes on premiums; liability; report of premiums; policy records

Sec. 15. (a) A risk retention group is liable for the payment of premium taxes and taxes on premiums of direct business for risks resident or located within Indiana, and shall report to the commissioner of this state the net premiums written for risks resident or located within Indiana. A risk retention group that is chartered and licensed in a state other than Indiana is subject to taxation, and any applicable fines and penalties related thereto, on the same basis as a foreign admitted insurer.

(b) A licensed insurance producer who is utilized under section 30 of this chapter in soliciting, negotiating, or procuring liability insurance from a risk retention group that is chartered and licensed in a state other than Indiana shall report to the commissioner the

premiums for direct business for risks resident or located within Indiana that the insurance producer has placed with or on behalf of a risk retention group that is not chartered in Indiana.

(c) A licensed insurance producer who is utilized under section 30 of this chapter in soliciting, negotiating, or procuring liability insurance from a risk retention group that is chartered and licensed in a state other than Indiana shall keep a complete and separate record of all policies procured from each such risk retention group. The record kept under this subsection must be open to examination by the commissioner and must, for each policy and each kind of insurance provided, include the following information:

(1) The limit of liability.
(2) The time period covered.
(3) The effective date.
(4) The name of the risk retention group that issued the policy.
(5) The gross premium charged.
(6) The amount of return premiums, if any.

As added by P.L.162-1988, SEC.2. Amended by P.L.178-2003, SEC.49.

IC 27-7-10-16
Foreign risk retention groups; compliance with business practice provisions

Sec. 16. (a) All risk retention groups that are chartered and licensed in other states and that are doing business in Indiana and all agents and representatives of those risk retention groups shall comply with:

(1) IC 27-4-1-4.5 concerning unfair claims settlement practices; and
(2) IC 27-4 concerning deceptive, false, or fraudulent acts or practices.

(b) However, any injunction sought by the commissioner of this state regarding conduct described in subsection (a)(2) must be obtained from a court.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-17
Examination of foreign risk retention groups

Sec. 17. A risk retention group that is licensed and chartered in a state other than Indiana shall submit to an examination by the commissioner of this state to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within sixty (60) days after a request by the commissioner of this state. Any examination conducted by the commissioner of this state under this section shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the NAIC's Examiner Handbook.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-18
Notice; applications and policies

Sec. 18. Every application form for insurance from a risk retention group, and every policy (on its front and declaration pages) issued by a risk retention group, must contain in ten (10) point type the following notice:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-19
Prohibited acts

Sec. 19. The following acts by a risk retention group are prohibited:

(1) The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in the group.

(2) The solicitation or sale of insurance by, or operation of, a risk retention group that is in hazardous financial condition or financially impaired.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-20
Insurance company membership in risk retention group

Sec. 20. A risk retention group may not do business in Indiana if an insurance company is directly or indirectly a member or owner of that risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-21
Prohibited coverage

Sec. 21. The terms of any insurance policy issued by any risk retention group may not provide, or be construed to provide, coverage prohibited generally by Indiana law or declared unlawful by the Indiana supreme court.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-22
Financial impairment of foreign risk retention group; violations of chapter; compliance requirements

Sec. 22. (a) A risk retention group that is not chartered in Indiana and that is doing business in Indiana shall comply with a lawful order

issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a state commissioner if there has been a finding of financial impairment after an examination under section 17 of this chapter.

(b) A risk retention group that violates any provision of this chapter is subject to fines and penalties, including revocation of its right to do business in Indiana, that are applicable to licensed insurers generally.

(c) In addition to complying with the other requirements of sections 14 through 22 of this chapter, a risk retention group operating in Indiana before April 1, 1988, shall, before May 1, 1988, comply with section 14(a) of this chapter.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-23

Insurance insolvency guaranty fund

Sec. 23. (a) A risk retention group may not be required or permitted to join or contribute financially to any insurance insolvency guaranty fund, or similar mechanism, in Indiana. Neither a risk retention group, nor its insureds, nor claimants against its insureds may receive any benefit from any such fund for claims arising under the insurance policies issued by the risk retention group.

(b) When a purchasing group obtains insurance covering its members' risks from an insurer that is not authorized in Indiana or from a risk retention group, no risks, wherever resident or located, are covered by an insurance guaranty fund or similar mechanism in Indiana.

(c) When a purchasing group obtains insurance covering its members' risks from an authorized insurer, only risks resident or located in Indiana are covered by the state guaranty fund under IC 27-6-8.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-24

Countersignature on policies

Sec. 24. A policy of insurance issued to a risk retention group or to any member of that group is not required to be countersigned.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-25

Purchasing groups and their insurers; application of Indiana law; exemptions

Sec. 25. A purchasing group and its insurer or insurers are subject to all applicable Indiana laws, except that a purchasing group and its insurer or insurers are exempt, in regard to liability insurance for the purchasing group, from any law that would:

(1) prohibit the establishment of a purchasing group;

(2) make it unlawful for an insurer to provide or offer to provide insurance on a basis providing, to a purchasing group or its members, advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages, or other matters;
(3) prohibit a purchasing group or its members from purchasing insurance on a group basis as described in subdivision (2);
(4) prohibit a purchasing group from obtaining insurance on a group basis because the group has not been in existence for a minimum period of time or because any member has not belonged to the group for a minimum period of time;
(5) require that a purchasing group have a minimum number of members, common ownership or affiliation, or certain legal form;
(6) require that a certain percentage of a purchasing group must obtain insurance on a group basis; or
(7) otherwise discriminate against a purchasing group or any of its members.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-26

Purchasing groups; notice of intent to do business; required information; agent for service of process; exemptions

Sec. 26. (a) A purchasing group, before doing business in Indiana, shall furnish notice to the commissioner. The notice must:
(1) identify the state in which the group is domiciled;
(2) identify all other states in which the group intends to do business;
(3) specify the lines and classifications of liability insurance that the purchasing group intends to purchase;
(4) identify the insurance company or companies from which the group intends to purchase its insurance and the domicile of the company or companies;
(5) specify the method by which, and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in Indiana;
(6) identify the principal place of business of the group; and
(7) provide such other information as may be required by the commissioner to verify that the purchasing group meets the definition of a purchasing group under section 10 of this chapter.

(b) A purchasing group shall, within ten (10) days, notify the commissioner of any changes in any of the facts set forth in the notice provided to the commissioner under this section.

(c) A purchasing group, before doing business in Indiana, shall register with and designate the commissioner as its agent solely for the purpose of receiving service of legal documents or process in Indiana (for which a filing fee shall be determined by the

commissioner). However, this requirement does not apply in the case of a purchasing group that only purchases insurance that was authorized under the federal Product Liability Risk Retention Act of 1981, P.L.97-45, and:

(1) that in any state of the United States:

(A) was domiciled before April 1, 1986; and

(B) is domiciled on and after October 27, 1986;

(2) that:

(A) before October 27, 1986, purchased insurance from an insurance carrier licensed in any state; and

(B) since October 27, 1986, purchased its insurance from an insurance carrier licensed in any state; or

(3) that was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 before October 27, 1986.

(d) Each purchasing group that is required to give notice under subsection (a) shall also furnish information required by the commissioner to:

(1) verify that the entity qualifies as a purchasing group;

(2) determine where the purchasing group is located; and

(3) determine appropriate tax treatment.

(e) Any purchasing group that was doing business in Indiana before April 1, 1988, shall, before May 1, 1988, furnish notice to the commissioner under subsection (a) and furnish information required under subsections (c) through (d).

As added by P.L.162-1988, SEC.2.

IC 27-7-10-27

Purchasing groups; purchase of insurance from risk retention groups; limitations; notice to members; deductibles; aggregate limits

Sec. 27. (a) A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected through a licensed insurance producer or broker acting under the surplus lines laws and regulations of that state.

(b) A purchasing group that obtains liability insurance from an insurer that is not admitted in Indiana or from a risk retention group shall inform each of the members of the group who have a risk resident or located in Indiana that the risk is not protected by an insurance insolvency guaranty fund in Indiana and that the risk retention group or insurer may not be subject to all insurance laws and rules of Indiana.

(c) No purchasing group may purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole. However, coverage may provide for a deductible or self-insured retention applicable to individual members of the

purchasing group.

(d) Purchases of insurance by purchasing groups are subject to the same standards regarding aggregate limits that are applicable to all purchases of group insurance.

As added by P.L.162-1988, SEC.2. Amended by P.L.178-2003, SEC.50.

IC 27-7-10-28

Premium taxes; taxes on premiums; calculations

Sec. 28. Premium taxes and taxes on premiums paid for coverage of risks resident or located in Indiana by a purchasing group or any member of a purchasing group shall be:

(1) imposed at the same rate and subject to the same interest, fines, and penalties that apply to premium taxes and taxes on premiums paid for similar coverage from a similar insurance source by other insureds; and

(2) paid first by the insurance source, and if not by the insurance source, then by the insurance producer or broker for the purchasing group, and if not by the insurance producer or broker, then by the purchasing group, and if not by the purchasing group, then by each of its members.

As added by P.L.162-1988, SEC.2. Amended by P.L.178-2003, SEC.51.

IC 27-7-10-29

Enforcement; scope of authority

Sec. 29. The commissioner may make use of any of the powers established under this title to enforce the laws of Indiana not specifically preempted by the Risk Retention Act of 1986, 15 U.S.C. 3901 et seq., including the commissioner's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, impose penalties, and seek injunctive relief. With regard to any investigation, administrative proceedings, or litigation, the commissioner shall rely on Indiana procedural laws. The injunctive authority of the commissioner, in regard to risk retention groups, is restricted by the requirement under section 16 of this chapter that any injunction be issued by a court.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-30

Solicitation, negotiation, or procurement of liability insurance; license requirements

Sec. 30. No individual, firm, association, limited liability company, or corporation may act or aid in any manner in soliciting, negotiating, or procuring liability insurance in Indiana from a risk retention group unless the individual, firm, association, or corporation is licensed as an insurance producer under IC 27-1-15.6.

As added by P.L.162-1988, SEC.2. Amended by P.L.8-1993,

SEC.428; P.L.132-2001, SEC.11; P.L.178-2003, SEC.52.

IC 27-7-10-31
Purchasing groups; solicitation, negotiation, or procurement of liability insurance; license requirements

Sec. 31. (a) No individual, firm, association, or corporation may act or aid in any manner in soliciting, negotiating, or procuring liability insurance in Indiana for a purchasing group from an authorized insurer or a risk retention group chartered in a state unless the individual, firm, association, or corporation is licensed as an insurance producer under IC 27-1-15.6.

(b) No individual, firm, association, or corporation may act or aid in any manner in soliciting, negotiating, or procuring liability insurance coverage in Indiana for any member of a purchasing group under a purchasing group's policy unless the individual, firm, association, or corporation is licensed as an insurance producer under IC 27-1-15.6.

(c) No individual, firm, association, or corporation may act or aid in any manner in soliciting, negotiating, or procuring liability insurance from an insurer not authorized to do business in Indiana on behalf of a purchasing group located in Indiana unless the individual, firm, association, or corporation is licensed as a surplus lines producer under IC 27-1-15.8.

As added by P.L.162-1988, SEC.2. Amended by P.L.132-2001, SEC.12; P.L.178-2003, SEC.53.

IC 27-7-10-32
Insurance producers for risk retention groups; residence; notice

Sec. 32. (a) For purposes of acting as an insurance producer for a risk retention group or purchasing group under section 30 or 31 of this chapter, the requirement of residence in Indiana does not apply.

(b) Every individual, firm, association, or corporation licensed under IC 27-1-15.6, in regard to business placed with risk retention groups or written through a purchasing group, shall inform each prospective insured of the provisions of the notice required by section 18 of this chapter in the case of a risk retention group and section 27(c) of this chapter in the case of a purchasing group.

As added by P.L.162-1988, SEC.2. Amended by P.L.132-2001, SEC.13; P.L.178-2003, SEC.54.

IC 27-7-10-33
Injunctions

Sec. 33. An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance, or operating in any state (or in all states, or in any territory or possession of the United States), upon a finding that the risk retention group is in hazardous financial or financially impaired condition is enforceable in the courts of this state.

As added by P.L.162-1988, SEC.2.

IC 27-7-10-34
Rules to implement chapter

Sec. 34. The commissioner, under IC 4-22-2, may adopt rules necessary to implement this chapter.
As added by P.L.162-1988, SEC.2.

IC 27-7-11

Chapter 11. Drought Insurance

IC 27-7-11-1

"Drought insurance" defined

Sec. 1. As used in this chapter, "drought insurance" means insurance that covers the loss of or damage to crops caused by an insufficient amount of rainfall.

As added by P.L.250-1989, SEC.1.

IC 27-7-11-2

Policy effective date; cancellation

Sec. 2. A drought insurance policy becomes effective and is not subject to cancellation:

(1) at the time stated in the application for the insurance; or

(2) fourteen (14) days after the applicant submits the premium payment;

whichever occurs first, unless the application is refused in writing and the premium payment is returned within fourteen (14) days after the premium payment is submitted.

As added by P.L.250-1989, SEC.1.

IC 27-7-12

Chapter 12. Termination of Residential Policies

IC 27-7-12-1

Applicability of chapter; exceptions

Sec. 1. (a) This chapter applies to policies of insurance covering risks to property located in Indiana that take effect or are renewed after June 30, 2001, and that insure loss of or damage to:

(1) real property consisting of not more than four (4) residential units, one (1) of which is the principal place of residence of the named insured; or

(2) personal property:

(A) in which the named insured has an insurable interest; and

(B) that is used within a residential dwelling for personal, family, or household purposes.

(b) This chapter does not apply to the following:

(1) A policy of inland marine insurance.

(2) The cancellation or nonrenewal of an automobile insurance policy under IC 27-7-6.

(3) The cancellation or nonrenewal of a commercial property and casualty insurance policy under IC 27-1-31-2.5.

As added by P.L.203-2001, SEC.10.

IC 27-7-12-2

Definitions

Sec. 2. (a) As used in this chapter, "cancellation" refers to a termination of property insurance coverage that occurs during the policy term.

(b) As used in this chapter, "nonpayment of premium" means the failure of the named insured to discharge any obligation in connection with the payment of premiums on policies of insurance subject to this chapter, regardless of whether the payments are directly payable to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit. The term includes the failure to pay dues or fees where payment of the dues or fees is a prerequisite to obtaining or continuing property insurance coverage.

(c) As used in this chapter, "nonrenewal" or "nonrenewed" refers to a termination of property insurance coverage that occurs at the end of the policy term.

(d) As used in this chapter, "renewal" or "to renew" refers to:

(1) the issuance and delivery by an insurer at the end of a policy period of a policy superseding a policy previously issued and delivered by the same insurer; or

(2) the issuance and delivery of a certificate or notice extending the term of an existing policy beyond its policy period or term.

(e) As used in this chapter, "termination" means a cancellation or nonrenewal. The term does not include:

(1) the requirement of a reasonable deductible;
(2) reasonable changes in the amount of insurance; or
(3) reasonable reductions in policy limits or coverage;
if the requirements or changes are directly related to the hazard involved and are made on the renewal date for the policy. The term does not include a transfer of a policy to another insurer.
As added by P.L.203-2001, SEC.10.

IC 27-7-12-3
Notice of cancellation

Sec. 3. (a) Notice of cancellation of property insurance coverage by an insurer must:
(1) be in writing;
(2) be delivered or mailed to the named insured at the last known address of the named insured;
(3) state the effective date of the cancellation; and
(4) upon request of the named insured, be accompanied by a written explanation of the specific reasons for the cancellation.

(b) An insurer shall provide written notice of cancellation to the named insured at least:
(1) ten (10) days before canceling a policy, if the cancellation is for nonpayment of a premium;
(2) twenty (20) days before canceling a policy, if:
(A) the cancellation occurs more than sixty (60) days after the date of issuance of the policy; or
(B) the insurer has received a copy of a complaint under IC 32-30-10.5-8(d)(2) concerning the property; and
(3) ten (10) days before canceling a policy, if the cancellation occurs not more than sixty (60) days after the date of issuance of the policy.

(c) If the policy was procured by an independent insurance producer licensed in Indiana, the insurer shall deliver or mail notice of cancellation to the insurance producer not less than ten (10) days before the insurer delivers or mails the notice to the named insured, unless the obligation to notify the insurance producer is waived in writing by the insurance producer.
As added by P.L.203-2001, SEC.10. Amended by P.L.178-2003, SEC.55; P.L.116-2011, SEC.3.

IC 27-7-12-4
Notice of nonrenewal

Sec. 4. (a) Notice of nonrenewal by an insurer must:
(1) be in writing;
(2) be delivered or mailed to the named insured at the last known address of the named insured;
(3) state the insurer's intention not to renew the policy upon expiration of the current policy period;
(4) upon request of the named insured, be accompanied by a

written explanation of the specific reasons for the nonrenewal; and

(5) be provided to the named insured at least twenty (20) days before the expiration of the current policy period.

(b) If the policy was procured by an independent insurance producer licensed in Indiana, the insurer shall deliver or mail notice of nonrenewal to the insurance producer not less than ten (10) days before the insurer delivers or mails the notice to the named insured, unless the obligation to notify the insurance producer is waived in writing by the insurance producer.

(c) If an insurer mails or delivers to an insured a renewal notice, bill, certificate, or policy indicating the insurer's willingness to renew a policy and the insured does not respond, the insurer is not required to provide to the insured notice of intention not to renew.

As added by P.L.203-2001, SEC.10. Amended by P.L.178-2003, SEC.56.

IC 27-7-12-5

Sufficiency of explanations; coverage considered renewed where notice not given

Sec. 5. (a) A written explanation provided under section 3 or 4 of this chapter must be of sufficient clarity and specificity to enable a reasonable lay person to identify the basis for the insurer's decision without further inquiry.

(b) If notice is not provided under section 4 of this chapter, coverage is considered to be renewed only for the ensuing policy period upon payment of the appropriate premiums under the same terms and conditions, and subject to section 6 of this chapter, unless the named insured has accepted replacement coverage with another insurer or unless the named insured has agreed to the nonrenewal.

As added by P.L.203-2001, SEC.10.

IC 27-7-12-6

Grounds for cancellation of policies in effect for more than 60 days

Sec. 6. After coverage has been in effect for more than sixty (60) days or after the effective date of a renewal policy, a notice of cancellation shall not be issued unless cancellation is based on at least one (1) of the following:

(1) Nonpayment of a premium.

(2) Discovery of 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.

(3) Discovery of willful or reckless acts or omissions on the part of the named insured that increase a hazard insured against.

(4) The occurrence of a change in the risk that substantially increases a hazard insured against after insurance coverage has been issued or renewed.

(5) A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to an insured property or the occupancy of the property that substantially increases any hazard insured against.

(6) A determination by the insurance commissioner that the continuation of the policy would place the insurer in violation of the insurance laws of Indiana.

(7) Real property taxes owing on the insured property have been delinquent for two (2) or more years and continue to be delinquent at the time notice of cancellation is issued.

As added by P.L.203-2001, SEC.10.

IC 27-7-12-7

Prohibited grounds for termination

Sec. 7. Termination of property insurance coverage by an insurer is prohibited if the termination is based on any of the following:

(1) Upon the race, religion, nationality, ethnic group, age, sex, or marital status of the applicant or named insured.

(2) Solely upon the lawful occupation or profession of the applicant or named insured. However, this subdivision does not apply to an insurer that limits its market to one (1) lawful occupation or profession or to several related lawful occupations or professions.

(3) Upon the age or location of the residence of the applicant or named insured, unless that decision is for a business purpose that is not a mere pretext for a decision based on factors prohibited in this chapter or any other provision of this title.

(4) Upon the fact that another insurer previously declined to insure the applicant or terminated an existing policy in which the applicant was the named insured.

(5) Upon the fact that the applicant or named insured previously obtained insurance coverage through a residual market insurance mechanism.

As added by P.L.203-2001, SEC.10.

IC 27-7-12-8

Notice of transfer of policies

Sec. 8. The named insured must be given notice of a transfer of a policy, including a transfer between insurers within the same insurance group. The notice must:

(1) be in writing;

(2) be delivered or mailed to the named insured at the last known address of the named insured;

(3) be provided to the named insured at least twenty (20) days before the transfer; and

(4) identify the insurer to which the policy will be transferred.

As added by P.L.203-2001, SEC.10.

IC 27-7-12-9

Immunity from civil liability

Sec. 9. (a) The following persons are immune from civil liability for any communication giving notice of or specifying the reasons for a termination or for any statement made in connection with an attempt to discover or verify the existence of conditions that would be a reason for a termination under this chapter:

(1) Employees of the department of insurance.

(2) An insurer or its authorized representative, agent, or employee.

(3) A licensed insurance producer.

(4) A person furnishing information to an insurer as to reasons for a termination.

(b) This section does not apply to statements made in bad faith with malice in fact.

As added by P.L.203-2001, SEC.10. Amended by P.L.178-2003, SEC.57.

IC 27-7-13

Chapter 13. Required Notice of Flood Coverage in a Residential Policy

IC 27-7-13-1

Applicability of chapter; exceptions

Sec. 1. (a) This chapter applies to policies of insurance covering risks to property located in Indiana that are issued or renewed after December 31, 2001, and that insure against loss of or damage to:

(1) real property consisting of not more than four (4) residential units, one (1) of which is the principal place of residence of the named insured; or

(2) personal property:

(A) in which the named insured has an insurable interest; and

(B) that is used within a residential dwelling for personal, family, or household purposes.

(b) This chapter does not apply to the following:

(1) A policy of inland marine insurance.

(2) An automobile insurance policy under IC 27-7-6.

(3) A commercial property and casualty insurance policy under IC 27-1-31.

As added by P.L.203-2001, SEC.11.

IC 27-7-13-2

Required notices for policies not covering flood damage

Sec. 2. If a policy of insurance described in section 1 of this chapter does not provide coverage for flood damage:

(1) the policy jacket must contain a prominently printed notice stating; or

(2) the policyholder must be given written notice when the policy is issued, or upon the first renewal after December 31, 2001;

that coverage for flood damage may be available through the National Flood Insurance Program.

As added by P.L.203-2001, SEC.11.

IC 27-7-14

Chapter 14. Group Insurance for Members of the Armed Forces

IC 27-7-14-1

"Armed forces"

Sec. 1. As used in this chapter, "armed forces" means the active and reserve components of the following:

(1) The United States Army.
(2) The United States Navy.
(3) The United States Air Force.
(4) The United States Marine Corps.
(5) The United States Coast Guard.
(6) The Indiana National Guard.

As added by P.L.146-2015, SEC.31.

IC 27-7-14-2

"Casualty insurance company"

Sec. 2. As used in this chapter, "casualty insurance company" has the meaning set forth in IC 27-1-2-3(t).

As added by P.L.146-2015, SEC.31.

IC 27-7-14-3

"Group"

Sec. 3. As used in this chapter, "group" means a group of individuals who:

(1) have similar professional attributes;
(2) belong to the group for purposes other than that of obtaining insurance; and
(3) are eligible to purchase motor vehicle insurance.

As added by P.L.146-2015, SEC.31.

IC 27-7-14-4

"Group administrator"

Sec. 4. As used in this chapter, "group administrator" means:

(1) the officers or directors of; or
(2) another person legally vested with the responsibility to manage the affairs of;

a group of members of the armed forces.

As added by P.L.146-2015, SEC.31.

IC 27-7-14-5

"Group motor vehicle insurance policy"

Sec. 5. As used in this chapter, "group motor vehicle insurance policy" means a policy of insurance that provides motor vehicle insurance to participating members of the armed forces under one (1) master policy:

(1) that is issued to a group administrator; and

(2) under which individual certificates, each with separate limits of liability and coverage, are issued to participating group members.

As added by P.L.146-2015, SEC.31.

IC 27-7-14-6

"Motor vehicle insurance"

Sec. 6. As used in this chapter, "motor vehicle insurance" means the type of insurance described in IC 27-1-5-1, Class 2(f).

As added by P.L.146-2015, SEC.31.

IC 27-7-14-7

Provision of group motor vehicle insurance policy

Sec. 7. An insurer that is authorized under IC 27-1-3-20 to:

(1) transact business as a casualty insurance company; and

(2) offer motor vehicle insurance;

may provide a group motor vehicle insurance policy.

As added by P.L.146-2015, SEC.31.

IC 27-7-15

Chapter 15. Group Non-Trucking Liability Insurance

IC 27-7-15-1

"Casualty insurance company"

Sec. 1. As used in this chapter, "casualty insurance company" has the meaning set forth in IC 27-1-2-3(t).

As added by P.L.146-2015, SEC.32.

IC 27-7-15-2

"Group"

Sec. 2. As used in this chapter, "group" means a group of individuals who:

(1) have similar professional attributes;

(2) belong to the group for purposes other than that of obtaining insurance; and

(3) are eligible to purchase motor vehicle insurance.

As added by P.L.146-2015, SEC.32.

IC 27-7-15-3

"Group non-trucking liability insurance policy"

Sec. 3. As used in this chapter, "group non-trucking liability insurance policy" means a policy of insurance that provides non-trucking liability insurance, and may provide optional physical damage insurance coverage, to participating group members under one (1) master policy:

(1) that is issued to a named insured; and

(2) under which individual certificates, each with separate limits of liability and coverage, are issued to participating group members.

As added by P.L.146-2015, SEC.32.

IC 27-7-15-4

"Motor vehicle insurance"

Sec. 4. As used in this chapter, "motor vehicle insurance" means the type of insurance described in IC 27-1-5-1, Class 2(f).

As added by P.L.146-2015, SEC.32.

IC 27-7-15-5

"Non-trucking liability insurance"

Sec. 5. As used in this chapter, "non-trucking liability insurance" means insurance that provides third party liability coverage for property damage or bodily injury caused by the operation of a for hire motor carrier truck for purposes other than for hire motor carrier truck purposes.

As added by P.L.146-2015, SEC.32.

IC 27-7-15-6

Provision of group non-trucking liability insurance policy

Sec. 6. An insurer that is authorized under IC 27-1-3-20 to:

(1) transact business as a casualty insurance company; and

(2) offer motor vehicle insurance;

may provide a group non-trucking liability insurance policy.

As added by P.L.146-2015, SEC.32.

IC 27-7-16

Chapter 16. Group Tenant Users Liability Insurance

IC 27-7-16-1

"Casualty and liability insurance"

Sec. 1. As used in this chapter, "casualty and liability insurance" means the type of insurance described in IC 27-1-5-1, Class 2(h).

As added by P.L.146-2015, SEC.33.

IC 27-7-16-2

"Casualty insurance company"

Sec. 2. As used in this chapter, "casualty insurance company" has the meaning set forth in IC 27-1-2-3(t).

As added by P.L.146-2015, SEC.33.

IC 27-7-16-3

"Group"

Sec. 3. As used in this chapter, "group" means a group of individuals who:

(1) have similar professional attributes;

(2) belong to the group for purposes other than that of obtaining insurance; and

(3) are eligible to purchase casualty and liability insurance.

As added by P.L.146-2015, SEC.33.

IC 27-7-16-4

"Group tenant users liability insurance policy"

Sec. 4. As used in this chapter, "group tenant users liability insurance policy" means a policy of insurance that provides tenant users liability insurance to participating group members under one (1) master policy:

(1) that is issued to a named insured; and

(2) under which individual certificates, each with separate limits of liability and coverage, are issued to participating group members.

As added by P.L.146-2015, SEC.33.

IC 27-7-16-5

"Tenant users liability insurance"

Sec. 5. As used in this chapter, "tenant users liability insurance" means insurance that provides liability coverage for property damage or bodily injury to a third party caused by a vendor, exhibitor, or performer during a special event.

As added by P.L.146-2015, SEC.33.

IC 27-7-16-6

Provision of group tenant users liability insurance policy

Sec. 6. An insurer that is authorized under IC 27-1-3-20 to:

(1) transact business as a casualty insurance company; and
(2) offer casualty and liability insurance;

may provide a group tenant users liability insurance policy.

As added by P.L.146-2015, SEC.33.

IC 27-8

ARTICLE 8. LIFE, ACCIDENT, AND HEALTH

IC 27-8-1

Chapter 1. Life Insurance–Assessment Plan

IC 27-8-1-1

Authority to incorporate

Sec. 1. Any number of persons not less than five (5) nor more than thirteen (13), citizens of the United States, one (1) or more of whom shall be bona fide citizens and voters of this state, may associate themselves together as a body corporate for the purpose of organizing a corporation, association or society to transact the business of life insurance on the assessment plan, subject to the conditions and restrictions hereinafter provided.

(Formerly: Acts 1883, c.136, s.1.)

IC 27-8-1-2

Corporate status and powers

Sec. 2. A corporation, association, or society organized under the provisions of this chapter shall be a body corporate and politic by the name stated in certificate of organization, and by that name, they and their successors:

(1) may have succession, and shall be persons in law capable of suing and being sued;

(2) may have power to make and enforce contracts in relation to the legitimate business of their corporation, association or society;

(3) may have and use a common seal, and may change or alter the same at pleasure, and they or their successors in their corporate name shall in law be capable of taking, purchasing, holding, and disposing of real and personal estate for purposes of their association or society; and

(4) may make bylaws not inconsistent with the constitution and law of this state or the United States, in which bylaws shall be defined the manner and form of electing directors and officers of the corporation, association, or society, and the qualifications and duties of the same, and also the qualifications and privileges of members thereof.

(Formerly: Acts 1883, c.136, s.2.) As amended by P.L.252-1985, SEC.269.

IC 27-8-1-3

Name; approval; misleading similarity

Sec. 3. The corporators shall submit the title or name of the proposed corporation to the auditor of state, who shall approve the same, provided it indicates the object or purpose for which the corporation is formed, and does not too closely resemble a title in

use. Before approving a title, it shall be the duty of the auditor of state to examine the titles of corporations appearing in all the published insurance reports at his command, and not to approve any title that would tend to mislead the public on account of its too closely resembling some other title.
(Formerly: Acts 1883, c.136, s.3.)

IC 27-8-1-4
Statement of initial applications and deposit of first assessment

Sec. 4. Before the charter is granted to any such corporation, it shall file its statement, sworn to by at least two (2) of its executive officers, with the proper state officers, showing that application has been made for not less than two hundred thousand dollars ($200,000) insurance by not less than one hundred (100) persons, and that the amount of the first assessment on each policy or certificate has been deposited in the bank to the credit of the mortuary fund; and it shall be lawful for any corporation, association or society, or its agents, to solicit and secure business to that amount, for the purpose herein provided, before its charter shall have been granted.
(Formerly: Acts 1883, c.136, s.4.)

IC 27-8-1-5
Assessment; statement of object

Sec. 5. Assessment notices sent to members by any such an association shall state the object for which the money to be collected from the insured is intended, and no part of the proceeds of any assessment shall be applied to any other purpose than the stated purpose for which it was collected.
(Formerly: Acts 1883, c.136, s.5.)

IC 27-8-1-6
Exemption of certificates from valuation; insurable interest

Sec. 6. A policy or certificate issued by any such an association shall be exempt from the valuation based upon the American Experience Table, or any other table of mortality, in consequence of such association conducting its business on the plan of assessing members, and such policy or certificate, when the payments thereon are made by any person other than the insured, and without the written consent of the insured, to be valid must be supported by an insurable interest.
(Formerly: Acts 1883, c.136, s.6.)

IC 27-8-1-7
Restriction on kinds of certificates; expenses; segregation of expense and mortuary funds

Sec. 7. No corporation, association, or society organized under the provisions of this chapter shall issue endowment certificates or policies undertaking or promising to pay members during life, except

for accident or temporary illness, any stipulated sum of money. The expenses of such corporation, association, or society shall be provided for by admission fees, and either fixed annual payments or assessments made and designated to be for such expenses, and no part of the expense fund shall in any case be used to pay death claims, and no part of the mortuary fund shall in any case be used to pay expenses.
(Formerly: Acts 1883, c.136, s.7.) As amended by P.L.252-1985, SEC.270.

IC 27-8-1-8
Annual statement; examination

Sec. 8. Any corporation, association, or society carrying on the business of life or accident insurance on the assessment plan shall submit annually, on or before February 28, under oath, to the insurance commissioner a detailed statement of assets, liabilities, insurance in force, and number of persons upon whom risks are in force on the preceding December 31, and answer such interrogatories as the commissioner, who shall furnish a blank for the purpose, may, under the provisions of this chapter make in order to ascertain its financial character and condition, and shall pay to the commissioner, upon filing such statement, a fee of ten dollars ($10), and the commissioner shall publish such statement in his annual report. For the purpose of verifying such statement, the commissioner shall, on petition of a majority of the officers or of ten (10) members of such association supported by the affidavit of one (1) or more of the petitioners showing the necessity therefor, institute an examination of its affairs to ascertain its true character and condition.
(Formerly: Acts 1883, c.136, s.8; Acts 1891, c.189, s.1.) As amended by P.L.252-1985, SEC.271.

IC 27-8-1-9
Repealed

(Repealed by Acts 1978, P.L.2, SEC.2728.)

IC 27-8-1-10
Quo warranto to remove officers or close business

Sec. 10. Whenever any such corporation or association shall fail to make its annual statement to the insurance commissioner before August 31, or if, in the opinion of the commissioner it is conducting its business fraudulently or not in compliance with this chapter or is not carrying out its contract with the members in good faith, then it shall be the duty of the commissioner to communicate the fact to the attorney general, who may thereupon commence proceeding, by writ of quo warranto against such corporation, association, or society, requiring it to show cause why its officers should not be removed or its business closed, and the court shall thereupon hear the allegations and proofs of the respective parties; and if it shall appear to the

satisfaction of such court that the officers of such corporation, association, or society, or any one (1) or more of them, have been guilty of any material irregularity or violation of law to the injury of such corporation, association, or society, the said court shall decree a removal from office of the guilty party or parties and substitute suitable persons to serve until the regular annual election, or until a successor is regularly chosen; or if it shall appear to the court that the interest of the public so requires, the court shall decree a dissolution of such corporation, association, or society and a distribution of its effects.
(Formerly: Acts 1883, c.136, s.10.) As amended by P.L.252-1985, SEC.272.

IC 27-8-1-11
Bonds of officers and agents

Sec. 11. No agent or officer of such corporation, association or society, shall be permitted to collect or receive any dues or assessments for or on account of the same until he executes, jointly with two (2) responsible sureties, a bond to the corporation, approved by the board of directors thereof, in such sum as they shall prescribe, conditioned upon the payment of all dues, assessments or funds over to the proper officer of such corporation, and all receipts of any such corporation shall be paid into the hands of the treasurer thereof, who shall, before assuming the duties of his office, give a bond in the sum of not less than ten thousand dollars ($10,000), with not less than two (2) sureties, to be approved by the board of directors, and conditioned for the faithful performance of his duties, and the accounting for, and the proper payment and disbursement by him of, all moneys thereof which come into his hands.
(Formerly: Acts 1883, c.136, s.11.)

IC 27-8-1-12
Examination of sufficiency of treasurer's bond

Sec. 12. Said bond of treasurer shall be examined as to its efficiency annually by the auditor of state, and it shall then be renewed if he shall deem the present bond insufficient. Said bond shall be recorded in the recorder's office in the county in this state in which one (1) of the incorporators resides, and a certified copy of said record shall, by said recorder, be forwarded to the auditor of state, who shall file and preserve the same in his office.
(Formerly: Acts 1883, c.136, s.12.)

IC 27-8-1-13
Qualification of foreign corporation

Sec. 13. Any corporation, association or society, organized under the laws of any other state or government to insure lives on the assessment plan, or any corporation carrying on the business of life or accident insurance on the assessment plan, shall be licensed by the

auditor of state, upon the payment to the auditor of state of a fee of twenty-five dollars ($25.00), to do business in this state. However, the corporation or association shall first deposit with the auditor of state a certified copy of its charter or articles of incorporation, a copy of its statement of business for the preceding year, with the names and residence of its officers, sworn to by the president and secretary, or like officers, showing a detailed account of expenses and income, the amount of insurance in force, its assets and liabilities in detail, and setting forth that it has the ability to pay its policies or certificates to the full limit named therein; a certificate from the insurance commissioner or from a judge or clerk of a court of record of its home state, certifying that corporations or associations insuring life in the assessment plan, and paying policies in full, or providing accident indemnities, and chartered under the laws of this state are legally entitled to do business in its home state; a copy of its policy or certificate of membership, application and by-laws, which must show that death losses are, in the main, provided for by assessment upon the surviving members; and it shall legally designate an individual resident of Indiana, a corporate resident of Indiana, or an authorized Indiana insurer as its agent or attorney in fact, residing in this state, upon whom service of process for said company or association may be made, and the agent or attorney in fact shall immediately notify any corporation or association thus served.
(Formerly: Acts 1883, c.136, s.13.) As amended by P.L.268-1999, SEC.18.

IC 27-8-1-14
Retaliatory provision

Sec. 14. When any other state or government shall impose any obligation upon such corporation, association or society of this state, or their agents transacting business in such other state or government, the like obligations are hereby imposed on similar corporations, associations or societies of such other state or government, and their agents or representatives, transacting business in this state.
(Formerly: Acts 1883, c.136, s.14; Acts 1889, c.169, s.2.)

IC 27-8-1-15
Foreign corporations; annual statement and fee; license revocation for failure to file statement; solvency statement from foreign state

Sec. 15. Such corporation, association or society, shall pay to the auditor of state, upon filing each annual statement, a fee of ten dollars ($10.00). And in the event of its failure to make such statement on or before the thirty-first day of August of each year, the auditor of state shall revoke its license, and thereafter, or until such statement is made, it shall be deemed to be doing business unlawfully in this state. When the auditor of state of this state shall have reason to doubt the solvency of any such foreign corporation, association or society, he shall accept a statement from the insurance commissioner,

or like officer of the state under whose authority it was organized, as prima facie evidence of its solvency.
(Formerly: Acts 1883, c.136, s.15.)

IC 27-8-1-16
Foreign corporations; fraudulent practices; quo warranto to revoke license

Sec. 16. When, in the auditor's opinion, such corporation or association is in this state conducting its business fraudulently, or is not carrying out its contracts with members residing in this state, in good faith, he shall report the same to the attorney-general, who shall thereupon commence proceedings by writ of quo warranto against such corporation or association, requiring it to show cause why its license to do business in this state should not be revoked.
(Formerly: Acts 1883, c.136, s.16.)

IC 27-8-1-17
Noncompliance; violations

Sec. 17. An officer, agent, or employee of a corporation or association who knowingly permits the corporation or association to do business in Indiana, unless it has complied with the laws of this state applicable to the same, commits a Class B misdemeanor.
(Formerly: Acts 1883, c.136, s.17.) As amended by Acts 1978, P.L.2, SEC.2725.

IC 27-8-1-18
Exemption of fraternal societies

Sec. 18. The provisions of this chapter shall in no way apply to any secret or fraternal society or lodge or association which, under the supervision of a grand or supreme lodge, secures membership through the lodge system exclusively, and provides insurance to its members, nor to insurance organizations of a purely benevolent character which pay no commission nor employ any paid insurance producer, organized under the laws of this or any other state.
(Formerly: Acts 1883, c.136, s.18.) As amended by P.L.252-1985, SEC.273; P.L.178-2003, SEC.58.

IC 27-8-2
Chapter 2. Assessment Policy–Specified Payment

IC 27-8-2-1
Specification of exact payment upon each contingency insured against

Sec. 1. Every policy or certificate hereafter issued by any insurance corporation of this state doing business on the assessment plan, or any insurance corporation of any other state authorized to do an assessment insurance business in this state, and providing a payment to be made upon a contingency of death, sickness, disability or accident, shall specify the exact sum of money which it promises to pay upon each contingency insured against, and the number of days after satisfactory proof of the happening of such contingency at which such payment shall be made, and upon the occurrence of such contingency, unless the contract shall have been voided for fraud or breach of its conditions, the corporation shall be obligated to the beneficiary for such payment at the time and to the amount specified in the policy or certificate.

(Formerly: Acts 1901, c.214, s.1.)

IC 27-8-2-2
Failure to pay amount specified; proceedings to close business

Sec. 2. Failure to pay the amount, whether in friendly settlement or by judgment of court, within thirty (30) days of its adjudication, shall constitute a forfeiture of the right of the delinquent corporation to further continue in business in this state, in the case of an insurance corporation of another state, and in the case of an insurance corporation of this state, it shall be the duty of the insurance commissioner to report the facts to the attorney general, who shall immediately bring suit to close up the business of the delinquent corporation. Nothing in this chapter shall be construed as affecting any organization doing business under IC 27-11.

(Formerly: Acts 1901, c.214, s.2.) As amended by P.L.252-1985, SEC.274; P.L.3-1990, SEC.98.

IC 27-8-3
Chapter 3. Mutual Life and Accident–Formation

IC 27-8-3-1
Authority to incorporate; purposes; articles of incorporation; initial applications; approval and filing documents; license

Sec. 1. Any number of persons not less than five (5), a majority of whom are citizens of this state, may associate themselves together as a corporation, association, or society for the purpose of transacting the business of life or accident, or life and accident insurance, and for the payment of partial and permanent disability claims to living members, upon the assessment plan, for the purpose of mutual protection and relief of its members, and for the payment of stipulated sums of money to the families, heirs, executors, administrators, or assigns of the deceased members, or for the payment of total and permanent disability claims to living members of such company, association, or society, as the member may direct, in such manner as may be provided in the bylaws; and may receive money, either by voluntary donation or contribution, for which purpose, they shall make, sign, and acknowledge, before any officer authorized to take acknowledgment of deeds in this state, articles of incorporation or association, in which shall be stated the name or title by which such corporation, association, or society shall be known in law, the location of its principal business office (which office must be located in this state), the names and residence of the persons signing the articles of incorporation or association, the object of the corporation, association, or society, with its plan of doing business clearly and fully defined, the number of its directors, trustees or managers and the names of those selected to serve until its first annual meeting, and, in case of life corporations, associations, or societies, the limit as to age of applicants for membership, which shall not exceed sixty-five (65) years, and that medical examinations are required, but no medical examination shall be required in case of accident corporations, associations, or societies, and that bona fide applications have been secured for two hundred thousand dollars ($200,000) by not less than two hundred (200) persons, who have each made application for membership in such proposed corporation, association, or society, and, in case of a life corporation, have each been examined and recommended by a reliable physician, and in all cases have each deposited with the parties asking the certificate for such corporation, association, or society the sum of two dollars ($2) on each one thousand dollars ($1,000) of insurance applied for as an advance assessment for mortuary or accident or disability indemnity purposes, as the case may be; which certificate of association and applications, together with the certificate of some solvent bank or banks that all such advance funds are deposited therein to be turned over to the treasurer of such corporation, association, or society when organized, shall be

submitted to the insurance commissioner, who shall carefully examine the same, and, if he shall find that the objects and purposes are fully and definitely set forth and are clearly within the provisions of this chapter, and that the name or title is not the same or does not so closely resemble a title in use as to have a tendency to mislead the public, the commissioner shall submit the same to the attorney general for examination, and if found by him to be in accordance with this chapter and not inconsistent with the constitution and laws of the United States and of this state, he shall certify to and deliver the same to the secretary of state, who shall cause the same, with the certificate of the attorney general, to be recorded in a book to be kept for that purpose; and, upon application of the signers thereof, the secretary of state shall furnish to them a certified copy of such articles and certificates, under his hand and the seal of this state, and the secretary of state shall thereupon file in the office of the commissioner a certified copy of all papers pertaining to the organization of such corporation, association, or society. Thereupon, the commissioner shall issue a license, authorizing said corporation, association, or society to transact the business set forth in the certificate of incorporation. Such corporation, association, or society shall deposit with the commissioner a copy of all its forms of policy issued by them, together with a copy of its bylaws and all forms of application for insurance.
(Formerly: Acts 1897, c.195, s.1.) As amended by P.L.252-1985, SEC.275.

IC 27-8-3-2
Corporate powers

Sec. 2. A corporation, association, or society, organized under the provisions of this chapter, shall, by the name adopted by such corporation, association, or society, in law, be capable of suing and being sued, and may have power to make and enforce contracts in relation to the business of such corporation, association, or society, may have and use a common seal and may change or alter the same at pleasure, and, in the name of the corporation, association, or society, or by a trustee chosen by their board of directors, shall, in law, be capable of taking, purchasing, holding, and disposing of real and personal property for the purposes of their organization, may by their board of directors, trustees or managers, make bylaws not inconsistent with the constitution and laws of this state or of the United States, which bylaws shall define the manner of electing directors, trustees, or managers, or officers of such corporation, association, or society, and the qualifications and duties of the same, with terms of office not exceeding three (3) years, also the qualifications and privileges of the members thereof.
(Formerly: Acts 1897, c.195, s.2.) As amended by P.L.252-1985, SEC.276.

IC 27-8-3-3
Directors, trustees, or managers

Sec. 3. The affairs of all corporations, associations, or societies organized or doing business under the provisions of this chapter shall be managed by not less than five (5) directors, trustees, or managers, a majority of whom shall be residents of the state of Indiana, who shall be elected from and by the members, at such time and place and for such period, not exceeding three (3) years, as may be provided for in the bylaws, and may be eligible for reelection, provided that as near as practicable, an equal number shall be elected each year. Whenever directors, trustees, or managers shall be elected, a certificate, under the seal of the corporation, association, or society, giving the names and residences of those elected and the term of their office, shall be filed in the office of the insurance commissioner. Vacancies in the board of directors, trustees, or managers shall be filled in the manner provided in the bylaws. Such board of directors, trustees, or managers shall fix the compensation to be paid to all officers and managers of such corporation, association, or society.

(Formerly: Acts 1897, c.195, s.3.) As amended by P.L.252-1985, SEC.277.

IC 27-8-3-4
Determination of fee rates and amount of premiums, assessments, or periodical calls; risks

Sec. 4. The trustees, directors, or managers, or the persons designated in the bylaws of the corporation, association, or society, subject to the provisions of this chapter, shall fix the fee rates and amounts of premiums, assessments, or periodical calls, and the time and manner of the payment thereof, and the risks to be assumed by such corporation, association, or society, and the duration thereof, and may change the same, from time to time, as the experience of the corporation, association, or society may require. An affidavit made by the person having charge of the mailing of notices of premiums, assessments, or periodical calls that any such notice was mailed to his last postoffice address, stating the date of mailing, shall be prima facie evidence thereof.

(Formerly: Acts 1897, c.195, s.4.) As amended by P.L.252-1985, SEC.278.

IC 27-8-3-5
Reincorporation of domestic assessment plan companies; exceptions

Sec. 5. Any domestic corporation, association, or society, transacting business of life or accident or life and accident insurance and providing for the payment of total and permanent disability claims to living members, upon the assessment plan, may be reincorporated or reorganized under the provisions of this chapter

under its existing corporate name, by filing with the insurance commissioner a declaration of their desire to do so, signed and duly acknowledged by a majority of its board of directors, trustees, or managers, with a statement in like manner signed and acknowledged by them that such corporation, association, or society, having insured the lives or provided for the payment of accident indemnity, has accumulated the fund required by section 7 of this chapter, or having engaged in the business of accident insurance only, has accumulated the fund required by section 11 of this chapter, and that such funds are safely invested and held for the purposes for which the same were accumulated, as provided in the bylaws of such corporation, association or society, whereupon the commissioner, if approved by him, shall file the same, together with his certificate of such approval, with the secretary of state, who shall issue to such corporation, association, or society a certificate of such reincorporation or reorganization, under the seal of the state, and attach thereto copies of all papers so filed with the secretary of state, and the same shall be recorded in the office of the secretary of state, and copies thereof filed in the office of the commissioner, and such corporation, association, or society shall thereupon be deemed to be reincorporated and reorganized under the provisions of this chapter. It shall not be obligatory upon any such existing corporation, association or society to incorporate or reincorporate under this chapter, and any such domestic corporation, association, or society may continue to exercise all the rights, powers, and privileges not inconsistent with this chapter, pursuant to its articles of incorporation or association, the same as if incorporated or reincorporated under this chapter.

(Formerly: Acts 1897, c.195, s.5.) As amended by P.L.252-1985, SEC.279.

IC 27-8-3-6

Application of chapter to assessment plan companies; exceptions

Sec. 6. Any incorporation, association or society organized to insure lives, which provides for the payment of policy claims, or the accumulation of reserve or emergency funds, and the expenses of the management and prosecution of the business by payments to be made either at periods named in the contract or upon assessments as required, by persons holding similar contracts, and wherein the insured's liability to contribute to the payment of policy claims accrued or to accrue is not limited to a fixed sum, shall be deemed to be engaged in the business of life insurance upon the assessment plan, and shall be subject only to the provisions of this chapter. However, nothing contained in this chapter shall be construed as applicable to any association of religious or secret societies, or to any class of mechanics, express, telegraph or railroad employees, or veterans described in IC 10-17-5-2 or IC 10-17-5-1 formed for the mutual benefit of the members thereof and their families exclusively,

or to any secret or fraternal societies, lodges or councils that may be organized, or that are now organized and doing business in this state, which conduct their business and secure members on the lodge system exclusively, having ritualistic work and ceremonies in their societies, lodges or councils, and which are under the supervision of the grand or supreme body, nor to any association organized solely for benevolent purposes and not for profit.
(Formerly: Acts 1897, c.195, s.6.) As amended by Acts 1980, P.L.38, SEC.17; P.L.2-2003, SEC.69.

IC 27-8-3-7
Accumulation of reserve or emergency fund; investment; additional funds; use of excess

Sec. 7. Every such life insurance corporation, association, or society shall accumulate and maintain a reserve or emergency fund equal to such sum as might be realized from one (1) assessment on, or periodical payment by, policy or certificate holders thereof, and, in no event, less than the amount of its maximum policy or certificate. Such fund, if not already accumulated, shall be accumulated by every such corporation, association, or society existing on March 9, 1897, by September 9, 1897, and by every corporation, association, or society formed under this chapter after March 9, 1897, within six (6) months from the date of its incorporation or organization, and shall be held as a trust fund for the purposes for which such fund was created or accumulated. In case such fund or any portion thereof shall have been used by the corporation, association, or society for the purpose or purposes for which the same was created or accumulated and the amount thereof thereby reduced to less than the amount of one (1) death assessment or periodical payment, the amount of such reduction below the amount of one (1) death assessment or periodical payment shall be made up and restored to said fund within six (6) months thereafter. Such fund may be held in cash or invested in the same class of securities required by law for the investment of funds by insurance corporations; and nothing contained in this chapter shall prevent the creation and accumulation of other funds in excess of the amount required in this chapter to provide for the purposes of such corporation, association, or society. If such fund is in excess of the amount of one (1) death assessment or periodical payment upon all certificate or policyholders and not less than the sum of fifty thousand dollars ($50,000), the excess or any portion thereof may be used in the reduction of assessment or periodical payments by policy or certificate holders by ratable cash dividends or credits, or in such other equitable division or apportionment thereof as its bylaws or rules may provide, and such use shall not be deemed or construed to mean a profit received by members within the meaning of the statutes of this state, or the pro rata excess on any policy or certificate terminated by death or surrender may be refunded to the holder or

beneficiary, as may be provided for in said policy or contract; provided, that nothing contained in this chapter shall be construed to permit any contract promising any fixed cash payment to any living certificate or policyholder excepting in the contingency of physical disability.
(Formerly: Acts 1897, c.195, s.7.) As amended by P.L.252-1985, SEC.280.

IC 27-8-3-8
Assignment of policy to person without insurable interest void

Sec. 8. No corporation, association or society doing business of life insurance under this chapter shall issue any policy of life insurance in which the beneficiary named has no insurable interest. Any assignment of the policy or certificate to a person having no insurable interest in the insured life, except as security for actual debt, with remainder over to the beneficiary or to the estate of the insured, shall render such a policy or certificate void.
(Formerly: Acts 1897, c.195, s.8; Acts 1971, P.L.391, SEC.1.)

IC 27-8-3-9
Annual report; failure to file report and pay fees; suspension from doing business

Sec. 9. Every such life insurance corporation, association, or society doing business under this chapter shall, on or before March 1 in each year, make and file with the insurance commissioner a report of its affairs and operations during the year ending on December 31 immediately preceding, which report shall be in lieu of all other reports required by this title and shall be in such form as the commissioner may require. Such report shall be verified by such of the officers of the corporation, association, or society as the commissioner may require. Any corporation, association, or society refusing or neglecting to make such report, or to make payment of any of the fees required by law, shall, upon the order of the commissioner, cease to do business in this state until such report and payment shall be made and until the costs of such action be paid.
(Formerly: Acts 1897, c.195, s.9.) As amended by P.L.252-1985, SEC.281.

IC 27-8-3-10
Accident insurance business on assessment plan

Sec. 10. Any corporation, association, or society organized to insure against the contingency of death or physical disability of the assured thereunder resulting from accidental injuries, and which provides for the payment of policy claims, the accumulation of reserve or emergency funds and the expenses of the management and prosecution of the business, by payments to be made, either at periods named in the contract or upon assessments as required by persons holding similar contracts, and where the assured's liability to

contribute to the payment of benefits accrued or to accrue is not limited to a fixed sum, shall be deemed to be engaged in the business of accident insurance upon the assessment plan, and the business involving the issuance of such contracts shall be carried on in this state only by duly organized and authorized corporations, associations, or societies, which shall be subject only to the provisions and requirements of this chapter.
(Formerly: Acts 1897, c.195, s.10.) As amended by P.L.252-1985, SEC.282.

IC 27-8-3-11
Reserve emergency fund

Sec. 11. Every such accident insurance corporation, association, or society shall accumulate and maintain a reserve emergency fund of at least two thousand dollars ($2,000). Such fund, if not already accumulated, shall be accumulated by every such corporation, association, or society existing on March 9, 1897, by September 9, 1897, and by every corporation, association, or society organized under this chapter within six (6) months of the completion of its organization and the receipt of its certificate of authority to transact business in this state, and every corporation, association, or society subject to the provisions of this chapter shall add to such emergency fund thereafter two and one-half percent (2 1/2%) of the amount realized from every premium, assessment, or periodical call until such fund shall be equal to the amount of two dollars ($2) for every five thousand dollars ($5,000) of insurance in force. Such emergency fund, or any part thereof, may be used for the payment of death and indemnity claims; provided, that if the amount of such fund be thereby reduced below the amount contemplated in this chapter, the amount by which such fund is reduced be made up and restored within six (6) months thereafter. Such fund may be held in cash or invested in the same class of securities required by law for the investment of funds by insurance corporations, and nothing contained in this chapter shall prevent the creation and accumulation of other funds in excess of the amount required in this chapter to provide for the purposes of such corporation, association, or society.
(Formerly: Acts 1897, c.195, s.11.) As amended by P.L.252-1985, SEC.283.

IC 27-8-3-12
Report of affairs and operations; suspension for failure to file

Sec. 12. (a) Every such accident insurance corporation, association, or society doing business under this chapter shall, on or before March 1 in each year, make and file with the insurance commissioner a report of its affairs and operations during the year ending on December 31 immediately preceding, which report shall be in lieu of all other reports required by this title and shall be verified by such officers of the corporation, association or society, as

the commissioner may require, and shall contain answers to the following questions:

(1) First, what number of certificates or policies were issued during the year or applicants admitted?

(2) Second, what was the amount of death indemnity affected thereby?

(3) Third, what number of death losses were incurred?

(4) Fourth, what number of death losses were paid and amount thereof?

(5) Fifth, what were the total number of indemnity claims paid and amount thereof?

(6) Sixth, what were the number of death and number of indemnity claims unpaid?

(7) Seventh, does the corporation, association, or society charge annual dues or membership fee? If so, how much?

(8) Eighth, what was the total amount received and whether from assessment, annual dues, membership fees, or other sources, and the disposition thereof?

(9) Ninth, does corporation, association, or society use moneys received for payment of claims to pay expenses, in whole or in part? And, if so, state the amount used.

(10) Tenth, what is the amount of the emergency fund and how invested?

(11) Eleventh, if organized under the laws of this state, state such fact and the date of organization.

(12) Twelfth, what were the number of policies in force and death insurance in force at the beginning of the year, and such other information as may be required by the superintendent of insurance?

(b) Any corporation, association, or society refusing or neglecting to make such report or to make payment of any one of the fees required by this chapter shall, upon the order of the insurance commissioner, cease to do business in this state until such report and payment shall be made and until the costs of such action be paid.

(Formerly: Acts 1897, c.195, s.12.) As amended by P.L.252-1985, SEC.284.

IC 27-8-3-13

Authority to deposit securities; investment of reserve funds

Sec. 13. This chapter shall not be construed to limit the accumulation of a reserve or emergency fund by any corporation, association, or society subject to the provisions of this chapter. Any such corporation, association, or society may, in its discretion, through its officers or directors, deposit with the insurance commissioner such securities and for such amounts as may be approved by him, and, when so deposited, shall be retained by him for the purposes described in this chapter. All other investments of reserve funds shall be made in the same class of securities as are

allowed by law for the investment of funds by insurance corporations.
(Formerly: Acts 1897, c.195, s.13.) As amended by P.L.252-1985, SEC.285.

IC 27-8-3-14
Specification of amount payable upon particular contingency; obligation for payment; suspension of right to issue new policies until payment made

Sec. 14. Every policy or certificate issued after March 9, 1897, by any corporation, association, or society doing business under this chapter and promising payment to be made upon a contingency of death or physical disability shall specify the sum of money which it promises to pay under such contingency, and the number of days after satisfactory proof of the happening thereof on which such payment shall be made. Upon the occurrence of such contingency, unless the contract shall have been avoided by fraud, or by breach of its conditions, the corporation, association, or society shall be obligated to the beneficiary for such payment, at the time and to the amount specified in the policy or certificate. If such corporation, association, or society shall refuse or fail to make such payment for sixty (60) days after final judgment has been obtained against such claim, the insurance commissioner shall notify the corporation, association, or society not to issue any new policies or certificates until such indebtedness is fully paid; and no officer or agent of the corporation, association, or society shall make, sign, or issue any policy or certificate of insurance while such notice is in force.
(Formerly: Acts 1897, c.195, s.14.) As amended by P.L.252-1985, SEC.286.

IC 27-8-3-15
Transfer or reinsurance of risks; approval; notice of preference for transfer to different corporation

Sec. 15. No such corporation, association or society, organized under the laws of this state, shall transfer its risks to, or reinsure them in any other corporation, association or society unless the contract of transfer or reinsurance is first submitted to and approved by a two-thirds (2/3) vote of a meeting of the insured, called to consider the same, of which meeting, a written or printed notice shall be mailed to each member, certificate or policyholder, at least thirty (30) days before the day fixed for such meeting. If such transfer or reinsurance shall be approved, every member, certificate or policyholder of the corporation, association or society, who shall file with the secretary thereof, within ten (10) days after the meeting, a written notice of his preference to be transferred to some other corporation, association or society, than that named in the contract, shall be accorded all the rights and privileges, if any, in aid of such transfer as would have been accorded under the terms of such

contract had he been transferred to the corporation, association or society named therein. No such corporation, association or society, organized under the laws of this state, shall transfer its risks or assets, or any part thereof, to, or reinsure its risks, or any part thereof, in any insurance corporation, association or society of any other state or country which is not at the time of such transfer or reinsurance authorized to do business in this state under the laws thereof.
(Formerly: Acts 1897, c.195, s.15.)

IC 27-8-3-16
Examination at request of corporation; certificate of results; expense

Sec. 16. The insurance commissioner shall, at the request of any corporation, association, or society doing business under the provisions of this chapter in this state on the assessment plan, make an examination of such corporation, association, or society, and shall furnish a certificate of the results of such examination, showing all its assets and how invested, and such other particulars as may be deemed necessary to show the character and condition of said corporation, association, or society, and the necessary expense of said examination shall be paid by the corporation, association, or society requesting it.
(Formerly: Acts 1897, c.195, s.16.) As amended by P.L.252-1985, SEC.287.

IC 27-8-3-17
Visitation and inspection; insolvency or improper business practices; report; order to show cause for termination of business

Sec. 17. All corporations, associations, and societies to which this chapter is applicable, with their books, papers, and vouchers, shall be subject to visitation and inspection by the insurance commissioner or such person as he may designate, at the expense of said association. The commissioner may address any inquiries to such corporation, association, or society, in relation to its doings or condition, or any other matter connected with its transactions relative to the business contemplated by this chapter. All officers of such corporation, association, or society shall promptly reply in writing to all such inquiries, under the oath of its president, secretary, or other officers, if required. When the commissioner on investigation, shall be satisfied that any corporation, association, or society, organized under the laws of this state, doing business in this state of the character defined in this chapter, is insolvent because of matured death claims or other obligations due and unpaid, exceeding its assets and death assessments or periodical payments, called or in process of collection, or has exceeded its powers, failed to comply with any provision of law, or is conducting business fraudulently, he shall report the facts to the attorney general, who, if he shall be of the

opinion that the facts require such action, may thereupon apply to any court having jurisdiction thereof, within the county in which the principal office of such corporation, association, or society in this state is located, for an order requiring the officers of such corporation, association, or society to show cause, at a reasonable time and place within such county, why such corporation, association, or society should not be restrained from continuing to transact business, with power to the court to adjourn the hearing thereon from time to time, not exceeding sixty (60) days in all.
(Formerly: Acts 1897, c.195, s.17.) As amended by P.L.252-1985, SEC.288.

IC 27-8-3-18
Attorney general; exclusive power to apply for accounting, injunction, or receivership

Sec. 18. No order, judgment, or decree providing for an accounting or enjoining, restraining, or interfering with the prosecution of the business of any domestic insurance corporation, association, or society subject to the provisions of this chapter, or appointing a temporary or permanent receiver thereof, shall be made or granted otherwise than upon the application of the attorney general on his own motion, or after his approval of a request in writing thereof by the insurance commissioner, except in an action by a judgment creditor or in proceedings supplementary to execution.
(Formerly: Acts 1897, c.195, s.18.) As amended by P.L.252-1985, SEC.289.

IC 27-8-3-19
Foreign corporations; requirements for authority to do business; revocation of authority; retaliation clause

Sec. 19. Any corporation, association, or society organized under the authority of another state or government to issue, or which is engaged in the business of issuing, policies or certificates of life or accident or life and accident insurance, and for the payment of total and permanent disability claims to living members on the assessment plan, as a condition precedent to transacting business in this state, shall deposit with the insurance commissioner:

(1) a certified copy of its articles of incorporation or association;

(2) a certified copy of a vote or resolution of the board of directors of said company consenting that service of process in any suit against such company may be served upon an individual resident of Indiana, a corporate resident of Indiana, or an authorized Indiana insurer, appointed by the company as the company's agent for service of process, with like effect as if such company was chartered, organized, or incorporated in the state of Indiana, and agreeing that any process served upon such agent shall be of the same legal force and validity as if

served upon said company, and agreeing that such service may be so made with such effect while any liability remains outstanding against such company in this state;

(3) a statement, under oath of its president and secretary, in the form by the commissioner required, of its business for the preceding year;

(4) a certificate, under oath of its president and secretary, that it is paying, and for the twelve (12) months then next preceding, has paid, the maximum amount named in its policies or certificates in full;

(5) a certificate from the proper authority in its home state that corporations, associations or societies of this state, engaged according to the provisions of this chapter in life or accident, or life and accident insurance, and for the payment of total and permanent disability claims to living members upon the assessment plan, are legally entitled to do business in such state;

(6) a copy of its policy or certificate, application, and bylaws, which must show that the insured's liability to contribute to the payments of benefits is not limited to the payment of a fixed periodical sum; and

(7) evidence satisfactory to the commissioner that the corporation, association, or society accumulates a fund equal in amount to that required of similar corporations, associations, or societies of this state and that such accumulation is permitted by the law of the corporation, association, or society and is for the benefit of policy or certificate-holders only, and is invested in securities authorized under the law of its incorporation or association.

The insurance commissioner shall thereupon issue or renew the authority of such corporation, association, or society to do business in this state, and such authority shall be revoked whenever the commissioner, on investigation, is satisfied that such corporation, association, or society is not paying the maximum amount named in its policies or certificates in full. Upon such revocation, the commissioner shall cause notice thereof to be published in a newspaper of general circulation, published in the city of Indianapolis, Indiana, and no new business shall be thereafter done by its agents in this state. If any such corporation, association, or society is authorized by the law under which it is incorporated to issue contracts of insurance not contemplated in this chapter, it shall nevertheless be permitted to transact in this state the character of business authorized by this chapter upon complying in all other respects with the requirements thereof and filing with the commissioner an agreement duly executed by the proper officers that such corporation, association, or society will not enter into or issue within this state any contract of insurance, policy, or agreement not authorized by this chapter. Upon a breach of such agreement by any

such corporation, association, or society, the commissioner shall forthwith revoke and cancel its authority to transact business in this state. When any other state or country shall impose any obligation upon any such corporation, association, or society of this state, the like obligation shall be imposed upon similar corporations, associations, or societies and their agents of such state or country doing business in this state. If the laws of such state where such corporation, association, or society is organized will not admit corporations, associations, or societies organized in this state, or doing business under this chapter, to do business in such state, then such corporations, associations, or societies shall not be admitted to do business in this state.

(Formerly: Acts 1897, c.195, s.19.) As amended by P.L.252-1985, SEC.290; P.L.268-1999, SEC.19.

IC 27-8-3-20

Foreign corporations; service of process

Sec. 20. All processes in any action or proceeding against any foreign corporation, association, or society doing business in this state under the provisions of this chapter may be served upon an individual resident of Indiana, a corporate resident of Indiana, or an authorized Indiana insurer, appointed by the corporation, association, or society as its agent for service of process, and any lawful process against it which is served on the agent shall be of the same legal force and validity as if served on the corporation, association, or society, and this provision shall continue in force so long as any liability remains outstanding against the corporation, association, or society in this state, service upon such agent shall be deemed sufficient service upon the principal. When legal process against any such corporation, association, or society is served upon such agent, the agent shall immediately notify the corporation, association, or society of such service by registered letter, prepaid, directed to its secretary, or, in case of a corporation, association or society of a foreign country, to the resident manager, if any, in this country, and shall, within two (2) days after such service, forward in the same manner a copy of the process served on the agent to such secretary or manager, or to any person previously designated by the corporation, association, or society, in writing. The agent shall keep a record of all processes served upon the agent which record shall show the day and hour when such service was made.

(Formerly: Acts 1897, c.195, s.20.) As amended by P.L.252-1985, SEC.291; P.L.130-1994, SEC.42; P.L.116-1994, SEC.58; P.L.268-1999, SEC.20.

IC 27-8-3-21

Fraudulent representations; offenses

Sec. 21. A person who knowingly makes a false or fraudulent statement or representation in or with reference to any application for

insurance, or for the purpose of obtaining any money or benefit in or to any corporation, association, or society transacting business under this chapter, commits a Class A misdemeanor.
(Formerly: Acts 1897, c.195, s.21.) As amended by Acts 1978, P.L.2, SEC.2726.

IC 27-8-3-22
Eligible beneficiaries; change of beneficiary

Sec. 22. Any member of such corporation, association or society may name as his payee or beneficiary any person or persons, natural or artificial, permitted by the by-laws of such corporations, associations or society, or, if the by-laws thereof permit, the insurance of such member may be made payable to his estate. Any member of such corporation, association or society, naming as his payee or beneficiary any such person or persons, may make such designation either revocable or irrevocable, and the option which he elects to exercise shall be set out in and be made a part of his application for a certificate or policy of insurance. When the right of revocation has been reserved, or in case of the death of any payee or beneficiary under either a revocable or an irrevocable designation, the insured, subject to any existing assignment of the policy, may designate a new payee or beneficiary, with or without reserving the right of revocation, by filing written notice thereof at the home office of the corporation, association or society, accompanied by the policy for suitable endorsement thereon. No person who shall have been designated as a payee or beneficiary by the insured shall have or obtain any vested interest in the death benefits which may accrue in the event of the death of the insured until such death benefits shall have become due and payable upon the death of the insured.
(Formerly: Acts 1897, c.195, s.22; Acts 1923, c.185, s.1.)

IC 27-8-3-23
Exemption of benefits and premiums from judicial process

Sec. 23. (a) As used in this section, "premium" includes any deposit or contribution.

(b) The money or benefit provided or rendered by any corporation, association, or society authorized to do business under this chapter shall not be liable to attachment by garnishee or other process, and shall not be seized, taken, appropriated, or applied by any legal or equitable process, nor by any operation of law, to pay any debt or liability of a policy or certificate holder or any beneficiary named therein.

(c) A premium paid for an individual life insurance policy that names as a beneficiary, or is legally assigned to, a spouse, child, or relative who is dependent upon the policy owner is not exempt from the claims of the creditors of the policy owner if the premium is paid:

(1) not more than one (1) year before the date of the filing of a voluntary or involuntary bankruptcy petition by; or

(2) to defraud the creditors of;
the policy owner.

(d) The insurer issuing the policy is discharged from all liability by payment of the proceeds and avails of the policy (as defined in IC 27-1-12-14(b)) in accordance with the terms of the policy unless, before payment, the insurer has received at the insurer's home office, written notice by or on behalf of a creditor of the policy owner that specifies the amount claimed against the policy owner.

(Formerly: Acts 1897, c.195, s.23.) As amended by P.L.252-1985, SEC.292; P.L.253-1995, SEC.4.

IC 27-8-3-24

Violations; revocation of power to do business

Sec. 24. An officer or agent of any corporation, association, or society subject to this chapter who fails to comply with this chapter, knowingly makes in any report or statement any false or fraudulent statement, or refuses to permit the insurance commissioner or any examiner duly authorized by him for the purpose to make examination of its condition and business, books, papers, and vouchers commits a Class C infraction. A person who fails to comply with or violates this chapter commits a Class C infraction. If an examination of the condition and business of any such corporation, association, or society transacting business in this state is prevented by an offense under this section, the insurance commissioner shall revoke the certificate of authority issued to such corporation, association, or society, and it is unlawful for it to do business in this state until it has submitted to an examination, and the insurance commissioner has issued to it a new certificate of authority authorizing it to continue business in this state.

(Formerly: Acts 1897, c.195, s.24.) As amended by Acts 1978, P.L.2, SEC.2727.

IC 27-8-3-25

Fees

Sec. 25. The fees to be paid by each such corporation, association, or society to the insurance commissioner for the authority to such corporation, association, or society, and its insurance producers under the license granted by him to each corporation, association, or society, to transact business in the state of Indiana shall be as follows:

For filing copy of charter or articles of incorporation, twenty-five dollars ($25).

For filing each annual statement, twenty dollars ($20).

For issuing certificate of authority or license to company, corporation, association or society, one dollar ($1).

For issuing license to each insurance producer, one dollar ($1).

For affixing seal and certifying to any paper, one dollar ($1).

For renewal of license, each such corporation, association, or

society shall file with the commissioner its annual statement, for which it shall pay the sum of twenty dollars ($20).

For the privilege of transacting business in this state, a foreign or alien company, association, or society, admitted and licensed under this chapter, shall pay an annual tax upon premiums or assessments derived from business written within this state, such tax to be as defined and determined under IC 27-1-18-2, which is declared to be applicable in its terms and provisions to such a company, association, or society; provided also, that when any other state or country shall impose any obligations in excess of those imposed by this chapter upon any such corporation, association, or society of this state, a like obligation shall be imposed on similar corporations and their agents of such state or country doing business in this state; and provided also, that such corporation, association, or society, in transacting business in this state, shall be subject only to the provisions of this chapter.

(Formerly: Acts 1897, c.195, s.25; Acts 1955, c.55, s.1.) As amended by P.L.252-1985, SEC.293; P.L.178-2003, SEC.59.

IC 27-8-3-26

Exempt organizations

Sec. 26. Nothing contained in sections one through twenty-five of this chapter shall be construed to apply to secret or fraternal societies, lodges or councils that are now organized, or that may hereafter be organized, which conduct their business and secure members on the lodge system, exclusively, having ritualistic work and ceremonies in their societies, lodges or councils, and which are under the supervision of a grand or supreme body, nor to any association organized solely for benevolent purposes and not for profit; nor to any association of religious or secret societies, nor to any class of mechanics, express, telegraph or railroad employees or veterans described in IC 10-17-5-2 or IC 10-17-5-1 or any existing societies now doing business and formed for the mutual benefit of the members thereof and their families exclusively.

(Formerly: Acts 1897, c.195, s.26.) As amended by Acts 1980, P.L.38, SEC.18; P.L.2-2003, SEC.70.

IC 27-8-3-27

Legal reserves; compulsory deposits; filing of forms; exceptions

Sec. 27. (a) Notwithstanding any of the provisions of sections 1 through 26 of this chapter, every corporation or association organized and operating under the provisions of this chapter shall on or before July 1, 1970, comply with the provisions of IC 27-1 relative to the maintenance of legal reserves required on all life insurance and health and accident insurance policies issued in this state, and relative to compulsory deposit of assets by life insurance companies, and relative to filing of forms, with particular reference to but not limited to IC 27-1-12-11 through IC 27-1-12-13, IC 27-1-12.8,

IC 27-1-13-8, and IC 27-1-20-1 through IC 27-1-20-11.

(b) Provided, that this section shall not apply to any corporation or association that has prior to July 1, 1970, reorganized and accepted the provisions of IC 27-1, as provided in IC 27-1-11. Nor shall this section apply to any insurance policies issued or sold prior to July 1, 1970, or prior to any such reorganization under IC 27-1, whichever occurs earlier.

(c) Provided, further, that with respect to insurance policies issued by any corporation or association on a pure assessment basis, no premiums having been collected in advance, which corporation or association is incorporated and operating under this chapter as of August 18, 1969, and which has had in force between August 18, 1964, and August 18, 1969, insurance policies covering not less than fifteen thousand (15,000) members, such company or association shall maintain, beginning January 1, 1971, a legal reserve on its life assessment business on the basis of monthly renewable term insurance, and said monthly unearned premium reserve shall be calculated at one dollar and thirty cents ($1.30) per member.

(d) Such legal reserve shall be deposited with the insurance department under compulsory deposit provisions referred to in subsection (a).

(Formerly: Acts 1897, c.195, s.26a; Acts 1969, c.236, s.1.) As amended by P.L.252-1985, SEC.294; P.L.276-2013, SEC.29.

IC 27-8-4

Chapter 4. Credit Life and Credit Accident and Health Insurance

IC 27-8-4-0.1

Application of certain amendments to chapter

Sec. 0.1. The addition of section 9.5 of this chapter by P.L.226-1993 applies to policies issued after June 30, 1993.

As added by P.L.220-2011, SEC.434.

IC 27-8-4-1

Purpose

Sec. 1. The purpose of this chapter is to promote the public welfare through the establishment of unified and consistent rules relating to the implementation and administration of the laws of this state pertaining to credit life insurance and credit accident and health insurance, as such insurances are defined and limited in this chapter.

(Formerly: Acts 1961, c.47, s.1.) As amended by P.L.252-1985, SEC.295.

IC 27-8-4-2

Citation; scope; definitions

Sec. 2. (a) Citation and Scope:

(1) This chapter may be cited as the Model Act for the Regulation of Credit Life Insurance and Credit Accident and Health Insurance.

(2) All life insurance and all accident and health insurance of the nature in this chapter defined in connection with loans or other credit transactions shall be subject to the provisions of this chapter, except such insurance issued in relation to an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor.

(b) Definitions. For the purpose of this chapter:

(1) "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.

(2) "Credit accident and health insurance" means insurance on a debtor to provide funds for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy.

(3) "Creditor" means the lender of money or vendor or lessor of goods, services, property, rights, or privileges, for which payment is arranged through a credit transaction, or any successor to the right, title, or interest of any such lender, vendor, or lessor, and any affiliate, associate, or subsidiary of any of them or any director, officer, or employee of any of them or any other person in any way associated with any of them.

(4) "Debtor" means a borrower of money or a purchaser or

lessee of goods, services, property, rights, or privileges for which payment is arranged through a credit transaction. The term includes the following:

(A) A joint debtor.

(B) A co-maker.

(C) An endorser.

(D) A guarantor.

(5) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

(6) "Commissioner" means insurance commissioner of Indiana.

(7) The term "accident and health insurance" has the same meaning as "accident and sickness insurance" sometimes used in other statutes relating to insurance against accident and sickness.

(Formerly: Acts 1961, c.47, s.2.) As amended by P.L.252-1985, SEC.296; P.L.153-1986, SEC.4; P.L.132-1994, SEC.2.

IC 27-8-4-3

Forms of insurance

Sec. 3. Credit life insurance and credit accident and health insurance shall be issued only in the following forms:

A. Individual policies of life insurance issued to debtors on the term plan;

B. Individual policies of accident and health insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;

C. Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan;

D. Group policies of accident and health insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage.

(Formerly: Acts 1961, c.47, s.3.)

IC 27-8-4-4

Limitations on amount of insurance

Sec. 4. A. Credit Life Insurance. The initial amount of credit life insurance shall not exceed the total amount repayable under the contract of indebtedness and, when an indebtedness is repayable in substantially equal installments, the amount of insurance shall at no time exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater. Notwithstanding the provisions of this paragraph, insurance on agriculture credit transaction commitments, not exceeding one (1) year in duration, may be written up to the amount of the loan commitment on a non-decreasing or level term plan.

B. Credit Accident and Health Insurance. The aggregate amount

of periodic benefits payable by credit accident and health insurance in the event of disability, as defined in the policy, shall not, in the case of an indebtedness payable in installments, exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness or in the case of an indebtedness payable in one sum, the unpaid amount of such indebtedness; and the amount of each periodic benefit payment shall not exceed the original indebtedness divided by the number of periodic installments.
(Formerly: Acts 1961, c.47, s.4.)

IC 27-8-4-5
Term of insurance

Sec. 5. The term of any credit life insurance or credit accident and health insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. This rule shall apply when no evidence of insurability is required and, as well, when such evidence is required and is furnished within the period of thirty (30) days after the date when the debtor becomes obligated to the creditor; but should such evidence of insurability be furnished after such thirty (30) day period, the term of the insurance may commence on the date on which the insurance company determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of such insurance shall not extend more than fifteen (15) days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in section 8 of this chapter.
(Formerly: Acts 1961, c.47, s.5.) As amended by P.L.252-1985, SEC.297.

IC 27-8-4-6
Policy or certificate; delivery; rejection of risk; to another insurer; credit for lower premium

Sec. 6. (a) All credit life insurance and credit accident and health insurance shall be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance, which individual policy of group certificate of insurance shall be delivered to the debtor.

(b) Each individual policy or group certificate of credit life insurance or credit accident and health insurance shall, in addition to

other requirements of law, set forth:

(1) the name and home office address of the insurer;

(2) the name or names of the debtor or in the case of a certificate under a group policy, the identity by name or otherwise of the debtor;

(3) the premium or amount of payment, if any, by the debtor separately for credit life insurance and credit accident and health insurance;

(4) a description of the coverage including the amount and term thereof;

(5) any exceptions, limitations, and restrictions; and

(6) that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate.

(c) Said individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred except as provided in this chapter.

(d) If said individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for such policy or a notice of proposed insurance, signed by the debtor and setting forth:

(1) the name and home office address of the insurer;

(2) the name or names of the debtor;

(3) the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit accident and health insurance; and

(4) the amount, term, and a brief description of the coverage provided;

shall be delivered to the debtor at the time such indebtedness is incurred. The copy of the application for, or notice of proposed insurance, shall also refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale, or other credit statement of account, instrument, or agreement, unless the information required by this subsection is prominently set forth therein. Upon acceptance of the insurance by the insurer and within thirty (30) days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. Said application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in section 5 of this chapter.

(e) If the named insurer does not accept the risk, then and in such event the debtor shall receive a policy or certificate of insurance, if one can be obtained from another insurer, setting forth the name and home office address of the substituted insurer and the amount of the premium to be charged, and if the amount of premium is less than

that set forth in the notice of proposed insurance an appropriate refund shall be made.

(Formerly: Acts 1961, c.47, s.6.) As amended by P.L.252-1985, SEC.298; P.L.255-1995, SEC.8.

IC 27-8-4-7

Filing of documents; disapproval of form of policy; effect; withdrawal of approval; review

Sec. 7. (a) All policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the commissioner.

(b) The commissioner shall, within thirty (30) days after the filing of any such policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders, disapprove any such form if the benefits provided therein are not reasonable in relation to the premium charge, or if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation of the coverage, or are contrary to any provision of this title or of a rule promulgated under this title.

(c) If the commissioner notifies the insurer that the form is disapproved, it shall be unlawful thereafter for such insurer to issue or use such form. In such notice, the commissioner shall specify the reason for his disapproval and state that a hearing will be granted within twenty (20) days after request in writing by the insurer. No such policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement, or rider, shall be issued or used until the expiration of thirty (30) days after it has been so filed, unless the commissioner shall give his prior written approval thereto.

(d) The commissioner may, at any time after a hearing held not less than twenty (20) days after written notice to the insurer, withdraw his approval of any such form on any ground set forth in subsection (b). The written notice of such hearing shall state the reason for the proposed withdrawal.

(e) It shall be unlawful for the insurer to issue such forms or use them after the effective date of such withdrawal.

(f) If a group policy of credit life insurance or credit accident and health insurance:

(1) has been delivered by an insurer in this state before July 6, 1961; or

(2) has been or is delivered by an insurer in another state before or after July 6, 1961;

such insurer shall be required to file only the group certificate and notice of proposed insurance delivered or issued for delivery in this state as specified in sections 6(b) and 6(d) of this chapter, and such forms shall be approved by the commissioner if they conform with

the requirements specified in sections 6(b) and 6(d) and if the schedules of premium rates applicable to the insurance evidenced by such certificate or notice are not in excess of the insurer's schedules of premium rates on file with the commissioner; provided, however, that the premium rate in effect on group policies existing on July 6, 1961, may be continued until the first policy anniversary date following the date this section becomes operative as provided in section 12 of this chapter.

(g) Any order or final determination of the commissioner under the provisions of this section shall be subject to judicial review.

(Formerly: Acts 1961, c.47, s.7.) As amended by P.L.252-1985, SEC.299.

IC 27-8-4-8

Revision of rate schedules; credit or refund of premiums

Sec. 8. A. Any insurer may revise its schedules of premium rates from time to time, and shall file such revised schedules with the commissioner. No insurer shall issue any credit life insurance policy or credit accident and health insurance policy for which the premium rate exceeds that determined by the schedules of such insurer as then on file with the commissioner.

B. Each individual policy, or group certificate shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto; Provided, however, That the commissioner shall prescribe a minimum refund and no refund which would be less than such minimum need be made. The formula to be used in computing such refund shall be filed with and approved by the commissioner.

C. If a creditor requires a debtor to make any payment for credit life insurance or credit accident and health insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.

D. The amount charged to a debtor for any credit life or credit health and accident insurance shall not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

(Formerly: Acts 1961, c.47, s.8.)

IC 27-8-4-9

Persons authorized to issue or deliver policies

Sec. 9. All policies of credit life insurance and credit accident and health insurance shall be delivered or issued for delivery in this state only by an insurer authorized to do an insurance business therein, and shall be issued only through holders of licenses issued by the commissioner.

(Formerly: Acts 1961, c.47, s.9.)

IC 27-8-4-9.5
Debtor's right to cancel policy; required provisions in application form; time limit

Sec. 9.5. (a) An individual or group policy of credit life insurance or credit accident and health insurance may not be delivered or issued for delivery in Indiana unless the application or authorized form:

(1) provides the debtor with a right to cancel the policy not more than fourteen (14) days after the policy is issued; and

(2) informs the debtor of the right to cancel in plain and conspicuous language.

(b) The language informing the debtor of the right to cancel under subsection (a)(2) must explain the way in which the debtor may cancel the policy and, if applicable, the address to which the debtor may mail the notice of cancellation.

(c) After the debtor cancels a policy under a provision required by subsection (a), the insurer or creditor shall return to the debtor the premium paid by the debtor.

As added by P.L.226-1993, SEC.1.

IC 27-8-4-10
Report, adjustment, and settlement of claims

Sec. 10. A. All claims shall be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

B. All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of such claimant to one specified.

C. No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims; Provided, That a group policyholder may, by arrangement with the group insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

(Formerly: Acts 1961, c.47, s.10.)

IC 27-8-4-11
Debtor's choice of insurer; use of existing policies

Sec. 11. When life insurance or accident and health insurance is required as additional security for any indebtedness, the debtor shall have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or

of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within this state. As used in this section, "life insurance" and "accident and health insurance" includes any form and any amount of life insurance or accident and health insurance that affords security to the creditor for the indebtedness involved.
(Formerly: Acts 1961, c.47, s.11.)

IC 27-8-4-12
Rules; order for compliance

Sec. 12. The commissioner may, after notice and hearing, issue such rules as he deems appropriate for the supervision of this chapter. Whenever the commissioner finds that there has been a violation of this chapter or any rules issued pursuant to this chapter and after written notice thereof and hearing given to the insurer or other person authorized or licensed by the commissioner, he shall set forth the details of his findings together with an order for compliance by a specified date. Such order shall be binding on the insurer and other person authorized or licensed by the commissioner on the date specified unless sooner withdrawn by the commissioner or a stay thereof has been ordered by a court of competent jurisdiction. The provisions of sections 5, 6, 7, and 8 of this chapter shall not be operative until October 4, 1961, and the commissioner in his discretion may extend until not later than January 2, 1962, the initial period within which the provisions of sections 5, 6, 7, and 8 shall not be operative.
(Formerly: Acts 1961, c.47, s.12.) As amended by P.L.252-1985, SEC.300.

IC 27-8-4-13
Judicial review

Sec. 13. Any party to the proceeding affected by an order of the commissioner shall be entitled to judicial review under IC 4-21.5-5.
(Formerly: Acts 1961, c.47, s.13.) As amended by P.L.252-1985, SEC.301; P.L.7-1987, SEC.153.

IC 27-8-4-14
Violations; civil penalty; revocation or suspension of license or certificate of authority

Sec. 14. In addition to any other penalty provided by law, any person, firm, or corporation which violates an order of the commissioner after it has become final, and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the state of Indiana a sum not to exceed two hundred fifty dollars ($250), which may be recovered in a civil action, except that if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed one thousand dollars ($1000). The commissioner, in his discretion, may revoke or suspend

the license or certificate of authority of the person, firm, or corporation guilty of such violation. Such order for suspension or revocation shall be upon notice and hearing, and shall be subject to judicial review as provided in section 13 of this chapter.
(Formerly: Acts 1961, c.47, s.14.) As amended by P.L.252-1985, SEC.302.

IC 27-8-5

Chapter 5. Accident and Sickness Insurance–Policy Provisions

IC 27-8-5-0.1

Application of certain amendments to chapter

Sec. 0.1. The following amendments to this chapter apply as follows:

(1) The amendments made to section 1 of this chapter by P.L.257-1985 apply to insurance policies issued after December 31, 1985.

(2) The amendments made to section 21 of this chapter by P.L.98-1990 apply to a policy issued for delivery in Indiana after June 30, 1990.

(3) The addition of section 23 of this chapter by P.L.152-1990 applies to a statute or rule mandating the offering of health care coverage enacted or adopted after December 31, 1990.

(4) The amendments made to section 23 of this chapter by P.L.119-1991 apply to an insurance policy that is issued or renewed after June 30, 1991.

(5) The addition of section 2.5 of this chapter by P.L.93-1995 applies to all individual accident and sickness policies issued or renewed after December 31, 1997.

(6) The addition of section 2.6 of this chapter (before its repeal) by P.L.93-1995 applies to all individual accident and sickness policies issued or renewed after December 31, 1995.

(7) The amendments made to sections 3 and 19 of this chapter by P.L.91-1998 apply to all accident and sickness policies in force on April 1, 1998.

(8) The amendments made to section 26 of this chapter by P.L.204-2003 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2003.

(9) The amendments made to section 15.6 of this chapter by P.L.226-2003 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2003.

(10) The amendments made to section 2.5 of this chapter by P.L.127-2006 apply to a certificate of coverage under a nonemployer based association group policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2006.

(11) The amendments made to section 16.5 of this chapter by P.L.127-2006 apply to a certificate of coverage under a nonemployer based association group policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2006.

(12) The amendments made to section 19 of this chapter by

P.L.127-2006 apply to a certificate of coverage under a nonemployer based association group policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2006.

(13) The amendments made to section 3 of this chapter by P.L.98-2007 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after December 31, 2007.

(14) The amendments made to section 2 of this chapter by P.L.218-2007 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.

(15) The addition of section 28 of this chapter by P.L.218-2007 applies to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.

As added by P.L.220-2011, SEC.435.

IC 27-8-5-1

Policy of accident and sickness insurance; filing; review; conformity with federal act

Sec. 1. (a) The term "policy of accident and sickness insurance", as used in this chapter, includes any policy or contract covering one (1) or more of the kinds of insurance described in Class 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the individual basis under this section and sections 2 through 9 of this chapter, on the group basis under this section and sections 16 through 19 of this chapter, on the franchise basis under this section and section 11 of this chapter, or on a blanket basis under section 15 of this chapter and (except as otherwise expressly provided in this chapter) shall be exclusively governed by this chapter.

(b) No policy of accident and sickness insurance may be issued or delivered to any person in this state, nor may any application, rider, or endorsement be used in connection with an accident and sickness insurance policy, until a copy of the form of the policy and of the classification of risks and the premium rates, or, in the case of assessment companies, the estimated cost pertaining thereto, have been filed with and reviewed by the commissioner under section 1.5 of this chapter. This section is applicable also to assessment companies and fraternal benefit associations or societies.

(c) This chapter shall be applied in conformity with the requirements of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), as in effect on September 23, 2010.

(d) A policy of accident and sickness insurance that is issued or delivered through a health benefit exchange established under the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation

Act of 2010 (P.L. 111-152), is subject to the requirements of this chapter. The commissioner may adopt rules under IC 4-22-2 to implement this subsection, including rules concerning:

(1) certification or decertification of a qualified health plan (as defined in IC 27-19-2-16); and

(2) open enrollment.

(Formerly: Acts 1953, c.15, s.169.1; Acts 1975, P.L.281, SEC.1.) As amended by P.L.257-1985, SEC.1; P.L.7-1987, SEC.154; P.L.173-2007, SEC.21; P.L.160-2011, SEC.17; P.L.278-2013, SEC.23.

IC 27-8-5-1.5

Filing, review, approval, and disapproval process

Sec. 1.5. (a) This section applies to a policy of accident and sickness insurance issued on an individual, a group, a franchise, or a blanket basis, including a policy issued by an assessment company or a fraternal benefit society.

(b) As used in this section, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

(c) As used in this section, "grossly inadequate filing" means a policy form filing:

(1) that fails to provide key information, including state specific information, regarding a product, policy, or rate; or

(2) that demonstrates an insufficient understanding of applicable legal requirements.

(d) As used in this section, "policy form" means a policy, a contract, a certificate, a rider, an endorsement, an evidence of coverage, or any amendment that is required by law to be filed with the commissioner for approval before use in Indiana.

(e) As used in this section, "type of insurance" refers to a type of coverage listed on the National Association of Insurance Commissioners Uniform Life, Accident and Health, Annuity and Credit Product Coding Matrix, or a successor document, under the heading "Continuing Care Retirement Communities", "Health", "Long Term Care", or "Medicare Supplement".

(f) Each person having a role in the filing process described in subsection (i) shall act in good faith and with due diligence in the performance of the person's duties.

(g) A policy form, including a policy form of a policy, contract, certificate, rider, endorsement, evidence of coverage, or amendment that is issued through a health benefit exchange (as defined in IC 27-19-2-8), may not be issued or delivered in Indiana unless the policy form has been filed with and approved by the commissioner.

(h) The commissioner shall do the following:

(1) Create a document containing a list of all product filing requirements for each type of insurance, with appropriate citations to the law, administrative rule, or bulletin that specifies the requirement, including the citation for the type of

insurance to which the requirement applies.

(2) Make the document described in subdivision (1) available on the department of insurance Internet site.

(3) Update the document described in subdivision (1) at least annually and not more than thirty (30) days following any change in a filing requirement.

(i) The filing process is as follows:

(1) A filer shall submit a policy form filing that:

(A) includes a copy of the document described in subsection (h);

(B) indicates the location within the policy form or supplement that relates to each requirement contained in the document described in subsection (h); and

(C) certifies that the policy form meets all requirements of state law.

(2) The commissioner shall review a policy form filing and, not more than thirty (30) days after the commissioner receives the filing under subdivision (1):

(A) approve the filing; or

(B) provide written notice of a determination:

(i) that deficiencies exist in the filing; or

(ii) that the commissioner disapproves the filing.

A written notice provided by the commissioner under clause (B) must be based only on the requirements set forth in the document described in subsection (h) and must cite the specific requirements not met by the filing. A written notice provided by the commissioner under clause (B)(i) must state the reasons for the commissioner's determination in sufficient detail to enable the filer to bring the policy form into compliance with the requirements not met by the filing.

(3) A filer may resubmit a policy form that:

(A) was determined deficient under subdivision (2) and has been amended to correct the deficiencies; or

(B) was disapproved under subdivision (2) and has been revised.

A policy form resubmitted under this subdivision must meet the requirements set forth as described in subdivision (1) and must be resubmitted not more than thirty (30) days after the filer receives the commissioner's written notice of deficiency or disapproval. If a policy form is not resubmitted within thirty (30) days after receipt of the written notice, the commissioner's determination regarding the policy form is final.

(4) The commissioner shall review a policy form filing resubmitted under subdivision (3) and, not more than thirty (30) days after the commissioner receives the resubmission:

(A) approve the resubmitted policy form; or

(B) provide written notice that the commissioner disapproves the resubmitted policy form.

A written notice of disapproval provided by the commissioner under clause (B) must be based only on the requirements set forth in the document described in subsection (h), must cite the specific requirements not met by the filing, and must state the reasons for the commissioner's determination in detail. The commissioner's approval or disapproval of a resubmitted policy form under this subdivision is final, except that the commissioner may allow the filer to resubmit a further revised policy form if the filer, in the filer's resubmission under subdivision (3), introduced new provisions or materially modified a substantive provision of the policy form. If the commissioner allows a filer to resubmit a further revised policy form under this subdivision, the filer must resubmit the further revised policy form not more than thirty (30) days after the filer receives notice under clause (B), and the commissioner shall issue a final determination on the further revised policy form not more than thirty (30) days after the commissioner receives the further revised policy form.

(5) If the commissioner disapproves a policy form filing under this subsection, the commissioner shall notify the filer, in writing, of the filer's right to a hearing as described in subsection (m). A disapproved policy form filing may not be used for a policy of accident and sickness insurance unless the disapproval is overturned in a hearing conducted under this subsection.

(6) If the commissioner does not take any action on a policy form that is filed or resubmitted under this subsection in accordance with any applicable period specified in subdivision (2), (3), or (4), the policy form filing is considered to be approved.

(j) Except as provided in this subsection, the commissioner may not disapprove a policy form resubmitted under subsection (i)(3) or (i)(4) for a reason other than a reason specified in the original notice of determination under subsection (i)(2)(B). The commissioner may disapprove a resubmitted policy form for a reason other than a reason specified in the original notice of determination under subsection (i)(2) if:

(1) the filer has introduced a new provision in the resubmission;

(2) the filer has materially modified a substantive provision of the policy form in the resubmission;

(3) there has been a change in requirements applying to the policy form; or

(4) there has been reviewer error and the written disapproval fails to state a specific requirement with which the policy form does not comply.

(k) The commissioner may return a grossly inadequate filing to the filer without triggering a deadline set forth in this section.

(l) The commissioner may disapprove a policy form if:

(1) the benefits provided under the policy form are not reasonable in relation to the premium charged; or

(2) the policy form contains provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.

(m) Upon disapproval of a filing under this section, the commissioner shall provide written notice to the filer or insurer of the right to a hearing within twenty (20) days of a request for a hearing.

(n) Unless a policy form approved under this chapter contains a material error or omission, the commissioner may not:

(1) retroactively disapprove the policy form; or

(2) examine the filer of the policy form during a routine or targeted market conduct examination for compliance with a policy form filing requirement that was not in existence at the time the policy form was filed.

As added by P.L.173-2007, SEC.22. Amended by P.L.111-2008, SEC.3; P.L.278-2013, SEC.24.

IC 27-8-5-2

Requirements for issuance and delivery of policy

Sec. 2. (a) No individual policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless it complies with each of the following:

(1) The entire money and other considerations for the policy are expressed in the policy.

(2) The time at which the insurance takes effect and terminates is expressed in the policy.

(3) The policy purports to insure only one (1) person, except that a policy must insure, originally or by subsequent amendment, upon the application of any member of a family who shall be deemed the policyholder and who is at least eighteen (18) years of age, any two (2) or more eligible members of that family, including husband, wife, dependent children, or any children who are less than twenty-six (26) years of age, and any other person dependent upon the policyholder.

(4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightface type of a style in general use, the size of which shall be uniform and not less than ten point with a lower-case unspaced alphabet length not less than one hundred and twenty point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions).

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 3 of

this chapter, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.

(6) Each such form of the policy, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page of the policy.

(7) The policy contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short-rate table filed with the commissioner.

(8) If an individual accident and sickness insurance policy or hospital service plan contract or medical service plan contract provides that hospital or medical expense coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in such policy or contract, the policy or contract must also provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both:

(A) incapable of self-sustaining employment by reason of mental, intellectual, or physical disability; and

(B) chiefly dependent upon the policyholder for support and maintenance.

Proof of such incapacity and dependency must be furnished to the insurer by the policyholder within thirty-one (31) days of the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two (2) year period, the insurer may require subsequent proof not more than once each year. The foregoing provision shall not require an insurer to insure a dependent who is a child who has a mental, intellectual, or physical disability where such dependent does not satisfy the conditions of the policy provisions as may be stated in the policy or contract required for coverage thereunder to take effect. In any such case the terms of the policy or contract shall apply with regard to the coverage or exclusion from coverage of such dependent. This subsection applies only to policies or contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after August 18, 1969.

(b) If any policy is issued by an insurer domiciled in this state for

delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subsection (a) and in section 3 of this chapter.

(c) An insurer may issue a policy described in this section in electronic or paper form. However, the insurer shall:

(1) inform the insured that the insured may request the policy in paper form; and

(2) issue the policy in paper form upon the request of the insured.

(Formerly: Acts 1953, c.15, s.169.2; Acts 1969, c.266, s.1; Acts 1973, P.L.275, SEC.3.) As amended by Acts 1977, P.L.2, SEC.79; P.L.23-1993, SEC.153; P.L.207-1999, SEC.3 and P.L.233-1999, SEC.9; P.L.125-2005, SEC.2; P.L.99-2007, SEC.192; P.L.218-2007, SEC.45; P.L.160-2011, SEC.18; P.L.117-2015, SEC.37.

IC 27-8-5-2.5

Coverage under individual, and certain association group, policies of accident and sickness insurance; waivers

Sec. 2.5. (a) As used in this section, the term "policy of accident and sickness insurance" does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(7) Worker's compensation or similar insurance.

(8) A student health plan.

(9) A supplemental plan that always pays in addition to other coverage.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

(b) The benefits provided by:

(1) an individual policy of accident and sickness insurance; or

(2) a certificate of coverage that is issued under a nonemployer based association group policy of accident and sickness insurance to an individual who is a resident of Indiana;

may not be excluded, limited, or denied for more than twelve (12) months after the effective date of the coverage because of a preexisting condition of the individual.

(c) An individual policy of accident and sickness insurance or a certificate of coverage described in subsection (b) may not define a preexisting condition, a rider, or an endorsement more restrictively than as:

(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve (12) months immediately preceding the effective date of the plan;

(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve (12) months immediately preceding the effective date of the plan; or

(3) a pregnancy existing on the effective date of the plan.

(d) An insurer shall reduce the period allowed for a preexisting condition exclusion described in subsection (b) by the amount of time the individual has continuously served under a preexisting condition clause for a policy of accident and sickness insurance issued under IC 27-8-15 if the individual applies for a policy under this chapter not more than thirty (30) days after coverage under a policy of accident and sickness insurance issued under IC 27-8-15 expires.

As added by P.L.93-1995, SEC.6. Amended by P.L.190-1996, SEC.1; P.L.211-2003, SEC.2; P.L.127-2006, SEC.1; P.L.173-2007, SEC.23; P.L.3-2008, SEC.212.

IC 27-8-5-2.6
Repealed

(As added by P.L.93-1995, SEC.7. Amended by P.L.190-1996, SEC.2. Repealed by P.L.1-2001, SEC.51.)

IC 27-8-5-2.7
Individual policy of accident and sickness insurance; waiver of coverage

Sec. 2.7. (a) Notwithstanding section 2.5 of this chapter and any other law, and except as provided in subsection (b), an individual policy of accident and sickness insurance that is issued after June 30, 2005, may contain a waiver of coverage for a specified condition and any complications that arise from the specified condition if:

(1) the waiver period does not exceed ten (10) years; and

(2) all the following conditions are met:

(A) The insurer provides to the applicant before issuance of the policy written notice explaining the waiver of coverage for the specified condition and complications arising from

the specified condition.

(B) The:

(i) offer of coverage; and

(ii) policy;

include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition.

(C) The:

(i) offer of coverage; and

(ii) policy;

do not include more than two (2) waivers per individual.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) The insurer agrees to:

(i) review the underwriting basis for the waiver upon request one (1) time per year; and

(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage and apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(G) An insurance benefit card issued by the insurer to the applicant includes a telephone number for verification of coverage waived.

The insurer shall require an applicant to initial the written notice provided under subdivision (2)(A) and the waiver included in the offer of coverage and in the policy under subdivision (2)(B) to acknowledge acceptance of the waiver of coverage. An offer of coverage under a policy that includes a waiver under this subsection does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.

(b) An individual policy of accident and sickness insurance may not include a waiver of coverage for a:

(1) mental health condition; or

(2) developmental disability.

(c) An insurer may not, on the basis of a waiver contained in a policy as provided in subsection (a), deny coverage for any condition or complication that is not specified as required in the:

(1) written notice under subsection (a)(2)(A); and

(2) offer of coverage and policy under subsection (a)(2)(B).

(d) An insurer that removes a waiver under subsection (a)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.

(e) Upon the expiration of the waiver period allowed under this section, the insurer shall:

(1) remove the waiver;

(2) not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and

(3) renew the policy in accordance with 45 CFR 148.122.

As added by P.L.211-2005, SEC.1.

IC 27-8-5-3

Required provisions; statutory option provisions; inapplicable or inconsistent provisions; order of provisions; third party ownership; requirements of other jurisdictions; filing procedure

Sec. 3. (a) Except as provided in subsection (c), each policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear in this section. However, the insurer may, at its option, substitute for one (1) or more of the provisions corresponding provisions of different wording approved by the commissioner that are in each instance no less favorable in any respect to the insured or the beneficiary. The provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows: ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No insurance producer has authority to change this policy or to waive any of its provisions.

(2) A provision as follows: TIME LIMIT ON CERTAIN DEFENSES: (A) After two (2) years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two (2) year period.

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy of denial of a claim during such initial two (2) year period, nor to limit the application of subsection (b), (1), (2), (3), (4), and (5) in the event of misstatement with respect to age or occupation or other insurance.

A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium:

(1) until at least age fifty (50); or

(2) in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue;

may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's

option) under the caption "INCONTESTABLE": After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(B) No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of coverage of this policy.

(3) A provision as follows: GRACE PERIOD: A grace period of (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

A policy in which the insurer reserves the right to refuse renewal shall have, at the beginning of the above provision: "Unless not less than thirty (30) days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.".

Each policy in which the insurer reserves the right to refuse renewal on an individual basis shall provide, in substance, in a provision of the policy, in an endorsement on the policy, or in a rider attached to the policy, that subject to the right to terminate the policy upon non-payment of premium when due, such right to refuse renewal shall not be exercised before the renewal date occurring on, or after and nearest, each anniversary, or in the case of lapse and reinstatement at the renewal date occurring on, or after and nearest, each anniversary of the last reinstatement, and that any refusal or renewal shall be without prejudice to any claim originating while the policy is in force. The preceding sentence shall not apply to accident insurance only policies.

(4) A provision as follows: REINSTATEMENT: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. Provided, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover

only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the insured and insurer shall have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

(1) until at least fifty (50) years of age; or

(2) in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue.

(5) A provision as follows: NOTICE OF CLAIM: Written notice of claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

In a policy providing a loss-of-time benefit which may be payable for at least two (2) years, an insurer may insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two (2) years, the insured shall, at least once in every six (6) months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six (6) months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insurer's right to any indemnity which would otherwise have accrued during the period of six (6) months preceding the date on which such notice is actually given.

(6) A provision as follows: CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the

loss for which claim is made.

(7) A provision as follows: PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

(8) A provision as follows: TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid:

(1) immediately upon receipt of due written proof of such loss; or

(2) in accordance with IC 27-8-5.7;

whichever is more favorable to the policyholder. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid _____ (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. This provision must reflect compliance with IC 27-8-5.7.

(9) A provision as follows: PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $ _____ (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this

policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

For the purposes of this section a "minor" is a person under the age of eighteen (18) years. A person eighteen (18) years of age or over is competent, insofar as the person's age is concerned, to sign a valid release.

(10) A provision as follows: PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) A provision as follows: LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

(12) A provision as follows: CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

(13) A provision as follows: GUARANTEED RENEWABILITY: In compliance with the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191), renewability is guaranteed.

(b) Except as provided in subsection (c), no policy delivered or issued for delivery to any person in Indiana shall contain provisions respecting the matters set forth below unless the provisions are in the words in which the provisions appear in this section. However, the insurer may use, instead of any provision, a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any substitute provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows: CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed the insured's occupation to one classified by the insurer as more

hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes the insured's occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(2) A provision as follows: MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(3) A provision as follows: OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured are in force concurrently herewith, making the aggregate indemnity for _____ (insert type of coverage or coverages) in excess of $ _____ (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to the insured's estate. Or, instead of that provision: Insurance effective at any one (1) time on the insured under a like policy or policies, in this insurer is limited to the one (1) such policy elected by the insured, the insured's beneficiary or the insured's estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(4) A provision as follows: INSURANCE WITH OTHER INSURER: If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss

of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion of the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "EXPENSE INCURRED BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".

(5) A provision as follows: INSURANCE WITH OTHER INSURERS: If there is other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined. If the foregoing policy provision is included in a policy which also contains the next preceding policy provision, there shall be added to the caption of the foregoing provision the phrase "-OTHER BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject

matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage to the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".

(6) A provision as follows: RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or the insured's average monthly earnings for the period of two (2) years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two (2) years as shall exceed the pro rata amount of the premiums for the benefits actually paid; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars ($200) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

(1) until at least fifty (50) years of age; or

(2) in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue.

The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be

approved by the commissioner or any combination of such coverages. In the absence of such definition the term shall not include any coverage provided for the insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.

(7) A provision as follows: UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(8) A provision as follows: CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(9) A provision as follows: ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(10) A provision as follows: INTOXICANTS AND NARCOTICS: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

The policy provision under this subdivision may not be used with respect to a policy that provides coverage for hospital, medical, or surgical expenses.

(c) If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(d) The provisions which are the subject of subsections (a) and (b), or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

(e) "Insured", as used in this chapter, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering

the insured or from being entitled under such a policy to any indemnities, benefits, and rights provided therein.

(f)(1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than is provided in this chapter and which is prescribed or required by the law of the state under which the insurer is organized.

(f)(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

(g) The commissioner may make reasonable rules under IC 4-22-2 concerning the procedure for the filing or submission of policies subject to this chapter as are necessary, proper, or advisable to the administration of this chapter. This provision shall not abridge any other authority granted the commissioner by law.

(Formerly: Acts 1953, c.15, s.169.3; Acts 1971, P.L.392, SEC.1; Acts 1973, P.L.275, SEC.4; Acts 1974, P.L.1, SEC.13.) As amended by P.L.28-1988, SEC.104; P.L.93-1995, SEC.8; P.L.91-1998, SEC.10; P.L.162-2001, SEC.2; P.L.178-2003, SEC.60; P.L.98-2007, SEC.1.

IC 27-8-5-4

Effect of other policy provisions or policy conflicting with chapter

Sec. 4. (a) No policy provision which is not subject to section 3 of this chapter shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this chapter.

(b) A policy delivered or issued for delivery to any person in this state in violation of this chapter shall be held valid but shall be construed as provided in this chapter. When any provision in a policy subject to this chapter is in conflict with any provision of this chapter, the rights, duties, and obligations of the insurer, the insured, and the beneficiary shall be governed by the provisions of this chapter.

(Formerly: Acts 1953, c.15, s.169.4.) As amended by P.L.252-1985, SEC.303.

IC 27-8-5-5

Application; attaching copy to policy; furnishing copy to insured; alterations; effect of false statements

Sec. 5. (a) The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this state shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within fifteen (15) days after the receipt of such request at its home office or any branch

office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

(b) No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(c) The falsity of any statement in the application for any policy covered by this chapter may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

(Formerly: Acts 1953, c.15, s.169.5.) As amended by P.L.252-1985, SEC.304.

IC 27-8-5-6

Defenses of insurer; acts not constituting waiver

Sec. 6. The acknowledgment by any insurer of the receipt of notice given under any policy covered by this chapter, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

(Formerly: Acts 1953, c.15, s.169.6.) As amended by P.L.252-1985, SEC.305.

IC 27-8-5-7

Acceptance of premium for period beyond termination date; effect; misstatement of age

Sec. 7. If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

(Formerly: Acts 1953, c.15, s.169.7.)

IC 27-8-5-8

Exemption of accident and sickness coverage incidental to

designated other forms of insurance

Sec. 8. Except as otherwise expressly indicated in this section, nothing contained in sections 1 through 7 of this chapter shall apply to or affect:

(1) any policy of worker's compensation insurance or any policy of liability insurance with or without supplementary coverage in the policy;

(2) any policy or contract of reinsurance;

(3) as to sections 2 through 7 of this chapter, any blanket or group policy of insurance;

(4) life insurance, endowment, or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as:

(A) provide additional benefits in case of death or dismemberment or loss of sight by accident; or

(B) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract;

(5) as to sections 2 through 5 of this chapter, any policies of accident and sickness insurance issued on the industrial plan with premiums payable on a weekly basis; or

(6) transportation ticket policies sold only at public transportation stations or at public transportation ticket offices by public transportation employees, as to such of the required provisions set out in section 3 of this chapter as are incongruous with the coverage and conditions of the policies.

(Formerly: Acts 1953, c.15, s.169.8; Acts 1955, c.129, s.1.) As amended by P.L.252-1985, SEC.306; P.L.28-1988, SEC.105.

IC 27-8-5-9

Exemption of certain individual policies

Sec. 9. An individual accident and sickness insurance policy form or any form of rider or endorsement appertaining to such a policy form, which could have been lawfully used or delivered or issued for delivery to any person in this state immediately before February 20, 1953, may be used or delivered or issued for delivery to any such person at any time prior to January 1, 1956, without being subject to the provisions of sections 2, 3, and 4 of this chapter.

(Formerly: Acts 1953, c.15, s.169.9.) As amended by P.L.252-1985, SEC.307.

IC 27-8-5-10

Repealed

(Repealed by P.L.257-1985, SEC.6.)

IC 27-8-5-11

Franchise plan; accident and sickness insurance; definitions, limitations, requirements, and standards

Sec. 11. No policy of accident and sickness insurance on a franchise plan shall be delivered or issued for delivery to any person in this state unless it conforms to the definitions, limitations, requirements and standards in this section prescribed:

(A) Qualified Groups.

(1) Two (2) or more employees of any employer, inclusive of any governmental division, department or agency.

(2) Ten (10) or more members of any trade, occupational or professional association or of a labor union, or of any other association or group which has had an active existence for at least two (2) years and which has a constitution or by-laws and was formed in good faith for purposes other than that of obtaining insurance.

(3) Members of the family and dependents of persons eligible under (1) or (2) above may be included in the group with such eligible persons.

(B) Nature of Insurance Coverage. The insurance policies issued to members of a qualified group shall be written on identical individual policy form or forms, varying only as to amounts and kinds of coverage applied for by such persons, and such policy form or forms shall otherwise fulfill the requirements of sections 2 through 9 of this chapter. The premiums for such policies may be paid to the insurer periodically by the employer, with or without payroll deduction, or by the association for its members, or by some designated person acting on behalf of such employer or association.

(C) Rates, Benefits, Underwriting Procedures. Premium rates, benefits and underwriting procedures relating to such individual policies may differ from those relating to comparable individual policies issued singly, but as between comparable groups such rates, benefits and procedures shall be nondiscriminatory.

(Formerly: Acts 1953, c.15, s.169.11.) As amended by Acts 1981, P.L.248, SEC.1.

IC 27-8-5-12

Supplementary character of chapter

Sec. 12. This chapter while independent in its enactment of any other statute, is nevertheless a supplement to IC 27-1 and shall be so considered and construed. Accordingly, all general provisions of IC 27-1 shall be fully and completely applicable to the sections of this chapter in the same manner as though such sections were part of IC 27-1.

(Formerly: Acts 1953, c.15, s.169.12.) As amended by P.L.252-1985, SEC.308.

IC 27-8-5-13

Repeal of 1935 act

Sec. 13. Acts 1935, c.162, s.174 is hereby expressly repealed except as to policies issued before February 20, 1953, and except as to policies which under section 9 of this chapter continue to be issued under said section 174 prior to January 1, 1956.
(Formerly: Acts 1953, c.15, s.169.13.) As amended by P.L.252-1985, SEC.309.

IC 27-8-5-14
Exception of fraternal benefit associations

Sec. 14. The provisions of sections 2 and 3 of this chapter shall not be applicable to fraternal benefit associations or societies.
(Formerly: Acts 1953, c.15, s.169.15; Acts 1957, c.20, s.1.) As amended by P.L.252-1985, SEC.310.

IC 27-8-5-15
Blanket accident and sickness insurance; qualification of groups; policy provisions; payment of benefits

Sec. 15. (a) No policy of blanket accident and sickness insurance shall be delivered or issued for delivery in this state unless it conforms to the requirements of this section.

(1) A policy may be issued to any common carrier or to any operator, owner or lessee of a means of transportation, who or which shall be deemed the policyholder, covering a group of persons who may become passengers defined by reference to their travel status on such common carrier or such means of transportation.

(2) A policy may be issued to an employer, who shall be deemed the policyholder, covering any group of employees, dependents or guests, defined by reference to specified hazards incident to an activity or activities or operations of the policyholder.

(3) A policy may be issued to a college, school, or other institution of learning, a school district or districts, or school jurisdictional unit, or to the head, principal, or governing board of any such educational unit, who or which shall be deemed the policyholder, covering students, teachers, or employees.

(4) A policy may be issued to any religious, charitable, recreational, educational, or civic organization, or branch thereof, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to any activity or activities or operations sponsored or supervised by such policyholder.

(5) A policy may be issued to a sports team, camp, or sponsor thereof, which shall be deemed the policyholder, covering members, campers, employees, officials, or supervisors.

(6) A policy may be issued to any volunteer fire department, first aid, emergency management, or other such volunteer organization, which shall be deemed the policyholder, covering

any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

(7) A policy may be issued to a newspaper or other publisher, which shall be deemed the policyholder, covering its carriers.

(8) A policy may be issued to an association, including a labor union, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

(9) A policy may be issued to cover any other risk or class of risks which, in the discretion of the commissioner, may be properly eligible for blanket accident and sickness insurance. The discretion of the commissioner may be exercised on an individual risk basis or class of risks, or both.

(b) Each such policy shall contain in substance provisions which in the opinion of the commissioner are not less favorable to the policyholder and the individual insured than the following:

(1) A provision that the policy, including endorsements and a copy of the application, if any, of the policyholder and the persons insured shall constitute the entire contract between the parties, and that any statement made by the policyholder or by a person insured shall in absence of fraud, be deemed a misrepresentation and not a warranty, and that no such statements shall be used in defense to a claim under the policy, unless contained in a written application. Such person, his beneficiary, or assignee, shall have the right to make written request to the insurer for a copy of such application and the insurer shall, within fifteen (15) days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action based upon or involving any statements contained therein.

(2) A provision that written notice of sickness or of injury must be given to the insurer within twenty (20) days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

(3) A provision that the insurer will furnish either to the claimant or to the policyholder for delivery to the claimant such forms as are usually furnished by it for filing proof of loss. If

such forms are not furnished before the expiration of fifteen (15) days after giving of such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

(4) A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within ninety (90) days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

(5) A provision that all benefits payable under the policy other than benefits for loss of time will be payable:

(A) immediately upon receipt of due written proof of such loss; or

(B) in accordance with IC 27-8-5.7;

whichever is more favorable to the policyholder, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

(6) A provision that the insurer at its own expense, shall have the right and opportunity to examine the person of the injured or sick individual when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy where it is not prohibited by law.

(7) A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

The insurer may omit from a policy any portion of any of the above provisions which is not applicable to that policy. An individual application need not be required from a person covered under a blanket accident and sickness policy, nor shall it be necessary for the

insurer to furnish each person a certificate.

(c) All benefits under any blanket accident and sickness policy shall be payable to the person insured, or to the insured's designated beneficiary or beneficiaries, or to the insured's estate, except that if the person insured be a minor or otherwise not competent to give a valid release, such benefits may be made payable to the insured's parent, guardian, or other person actually supporting the insured. However, the policy may provide in substance that all or any portion of any benefits provided by any such policy on account of hospital, nursing, medical, or surgical services may, at the option of the insurer and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but, the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligations with respect to the amount of insurance so paid.

(d) This section applies only to policies delivered or issued for delivery in Indiana after August 19, 1975.

(Formerly: Acts 1975, P.L.281, SEC.2.) As amended by P.L.5-1988, SEC.146; P.L.21-1991, SEC.24; P.L.162-2001, SEC.3.

IC 27-8-5-15.5

Inpatient services for treatment of mental illness or substance abuse

Sec. 15.5. (a) As used in this section:

"Alcohol abuse" has the meaning set forth in IC 12-7-2-10.

"Community mental health center" has the meaning set forth in IC 12-7-2-38 and IC 12-7-2-39.

"Division of mental health and addiction" refers to the division created under IC 12-21-1-1.

"Drug abuse" has the meaning set forth in IC 12-7-2-72.

"Inpatient services" means services that require the beneficiary of the services to remain overnight in the facility in which the services are offered.

"Mental illness" has the meaning set forth in IC 12-7-2-130(1).

"Psychiatric hospital" has the meaning set forth in IC 12-7-2-151.

"State department of health" refers to the department established under IC 16-19-1-1.

"Substance abuse" means drug abuse or alcohol abuse.

(b) An insurance policy that provides coverage for inpatient services for the treatment of:

(1) mental illness;

(2) substance abuse; or

(3) both mental illness and substance abuse;

may not exclude coverage for inpatient services for the treatment of mental illness or substance abuse that are provided by a community mental health center or by any psychiatric hospital licensed by the state department of health or the division of mental health and

addiction to offer those services.
As added by P.L.258-1985, SEC.1. Amended by P.L.2-1992, SEC.784; P.L.2-1993, SEC.150; P.L.215-2001, SEC.104.

IC 27-8-5-15.6
Treatment limitations or financial requirements on coverage of services for mental illness

Sec. 15.6. (a) As used in this section, "coverage of services for a mental illness" includes the services defined under the policy of accident and sickness insurance. However, the term does not include services for the treatment of substance abuse or chemical dependency.

(b) This section applies to a policy of accident and sickness insurance that:

(1) is issued on an individual basis or a group basis;

(2) is issued, entered into, or renewed after December 31, 1999; and

(3) is issued to an employer that employs more than fifty (50) full-time employees.

(c) This section does not apply to the following:

(1) A legal business entity that has obtained an exemption under section 15.7 of this chapter.

(2) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(3) Coverage issued as a supplement to liability insurance.

(4) Worker's compensation or similar insurance.

(5) Automobile medical payment insurance.

(6) A specified disease policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(9) A supplemental plan that always pays in addition to other coverage.

(10) A student health plan.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

(d) A group or individual insurance policy or agreement may not permit treatment limitations or financial requirements on the coverage of services for a mental illness if similar limitations or

requirements are not imposed on the coverage of services for other medical or surgical conditions.

(e) An insurer that issues a policy of accident and sickness insurance that provides coverage of services for the treatment of substance abuse and chemical dependency when the services are required in the treatment of a mental illness shall offer to provide the coverage without treatment limitations or financial requirements if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(f) This section does not require a group or individual insurance policy or agreement to offer mental health benefits.

(g) The benefits delivered under this section may be delivered under a managed care system.

As added by P.L.42-1997, SEC.2. Amended by P.L.81-1999, SEC.3; P.L.226-2003, SEC.1; P.L.173-2007, SEC.24.

IC 27-8-5-15.7

Exemption of policies or contracts from laws resulting in certain annual premium increases

Sec. 15.7. (a) The department shall exempt a policy or contract issued by an insurer or health maintenance organization under IC 5-10-8-9, section 15.6 of this chapter, or IC 27-13-7-14.8 by documenting to the department that compliance with the requirements of IC 5-10-8-9(c), section 15.6(d) of this chapter, or IC 27-13-7-14.8(d) have increased the annual premium or rates charged for the policy or health maintenance organization contract by more than four percent (4%) per year. An insurer or a health maintenance organization that applies for an exemption under this section shall provide documentation that is certified by an independent member of the American Academy of Actuaries of actual mental health claims incurred for a period of not less than six (6) months to substantiate the insurer's or health maintenance organization's assertion of increased claims and administrative costs by more than four percent (4%) per year.

(b) Documents submitted under this section must be available for public inspection.

As added by P.L.81-1999, SEC.4.

IC 27-8-5-16

Policy of group accident and sickness insurance; requirements

Sec. 16. Except as provided in sections 17 and 24 of this chapter, no policy of group accident and sickness insurance may be delivered or issued for delivery to a group that has a legal situs in Indiana unless it conforms to one (1) of the following descriptions:

(1) A policy issued to an employer or to the trustees of a fund established by an employer (which employer or trustees must be deemed the policyholder) to insure employees of the employer for the benefit of persons other than the employer, subject to the

following requirements:

(A) The employees eligible for insurance under the policy must be all of the employees of the employer, or all of any class or classes of employees. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, members, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" includes elected or appointed officials.

(B) The premium for the policy must be paid either from the employer's funds, from funds contributed by the insured employees, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two (2) or more creditors (which creditor, holding company, affiliate, trustee, trustees, or agent must be deemed the policyholder) to insure debtors of the creditor, or creditors, subject to the following requirements:

(A) The debtors eligible for insurance under the policy must be all of the debtors of the creditor or creditors, or all of any class or classes of debtors. The policy may provide that the term "debtors" includes:

(i) borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(ii) the debtors of one (1) or more subsidiary corporations; and

(iii) the debtors of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control.

(B) The premium for the policy must be paid either from the creditor's funds, from charges collected from the insured

debtors, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from the funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

(C) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(D) The amount of the insurance payable with respect to any indebtedness may not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments that are delinquent on the date the debtor becomes disabled as defined in the policy.

(E) The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Each payment under this clause must reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment, and any excess of the insurance must be payable to the insured or the estate of the insured.

(F) Notwithstanding clauses (A) through (E), insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan, and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(3) A policy issued to a labor union or similar employee organization (which must be deemed to be the policyholder) to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(A) The members eligible for insurance under the policy must be all of the members of the union or organization, or all of any class or classes of members.

(B) The premium for the policy must be paid either from funds of the union or organization, from funds contributed by the insured members specifically for their insurance, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) A policy issued to a trust or to one (1) or more trustees of a fund established or adopted by two (2) or more employers, or

by one (1) or more labor unions or similar employee organizations, or by one (1) or more employers and one (1) or more labor unions or similar employee organizations (which trust or trustees must be deemed the policyholder) to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(A) The persons eligible for insurance must be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes of employees or members. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(B) The premium for the policy must be paid from funds contributed by the employer or employers of the insured persons, by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and one (1) or more employers, unions, or similar employee organizations. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(5) A policy issued to an association or to a trust or to one (1) or more trustees of a fund established, created, or maintained for the benefit of members of one (1) or more associations. The association or associations must have at the outset a minimum of one hundred (100) persons, must have been organized and maintained in good faith for purposes other than that of obtaining insurance, must have been in active existence for at least one (1) year, and must have a constitution and bylaws that provide that the association or associations hold regular

meetings not less than annually to further purposes of the members, that, except for credit unions, the association or associations collect dues or solicit contributions from members, and that the members have voting privileges and representation on the governing board and committees. The policy must be subject to the following requirements:

(A) The policy may insure members or employees of the association or associations, employees of members, one (1) or more of the preceding, or all of any class or classes of members, employees, or employees of members for the benefit of persons other than the employee's employer.

(B) The premium for the policy must be paid from funds contributed by the association or associations, by employer members, or by both, from funds contributed by the covered persons, or from both the covered persons and the association, associations, or employer members.

(C) Except as provided in clause (D), a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons, except those who reject such coverage in writing.

(D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(6) A policy issued to a credit union, or to one (1) or more trustees or an agent designated by two (2) or more credit unions (which credit union, trustee, trustees, or agent must be deemed the policyholder) to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee, trustees, or agent, or any of their officials, subject to the following requirements:

(A) The members eligible for insurance must be all of the members of the credit union or credit unions, or all of any class or classes of members.

(B) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in clause (C), must insure all eligible members.

(C) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

(7) A policy issued to cover persons in a group specifically described by another law of Indiana as a group that may be covered for group life insurance. The provisions of the group life insurance law relating to eligibility and evidence of insurability apply to a group health policy to which this subdivision applies.

(8) A policy issued to a trustee or agent designated by two (2) or more small employers (as defined in IC 27-8-15-14) as

determined by the commissioner under rules adopted under IC 4-22-2.

As added by P.L.257-1985, SEC.2. Amended by P.L.19-1986, SEC.47; P.L.125-1992, SEC.1; P.L.8-1993, SEC.429; P.L.185-1996, SEC.11; P.L.218-2007, SEC.46.

IC 27-8-5-16.3
"Small employer"; implementation of program for joint purchase of health insurance; rules

Sec. 16.3. (a) As used in this section, "small employer" has the meaning set forth in IC 27-8-15-14.

(b) The commissioner and the office of the secretary of family and social services may implement a program to allow two (2) or more small employers to join together to purchase health insurance, as described in section 16(8) of this chapter.

(c) The commissioner shall adopt rules under IC 4-22-2 necessary to implement this section.

As added by P.L.16-2009, SEC.29.

IC 27-8-5-16.5
Conditions for issuance of certificate to resident of Indiana under group policy delivered or issued in another state

Sec. 16.5. (a) As used in this section, "delivery state" means any state other than Indiana in which a policy is delivered or issued for delivery.

(b) Except as provided in subsection (c), (d), or (e), a certificate may not be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana.

(c) A certificate may be issued to a resident of Indiana pursuant to a group policy not described in subsection (d) that is delivered or issued for delivery in a state other than Indiana if:

(1) the delivery state has a law substantially similar to section 16 of this chapter;
(2) the delivery state has approved the group policy; and
(3) the policy or the certificate contains provisions that are:
  (A) substantially similar to the provisions required by:
    (i) section 19 of this chapter;
    (ii) section 21 of this chapter; and
    (iii) IC 27-8-5.6; and
  (B) consistent with the requirements set forth in:
    (i) section 24 of this chapter;
    (ii) IC 27-8-6;
    (iii) IC 27-8-14;
    (iv) IC 27-8-23;
    (v) 760 IAC 1-38.1; and
    (vi) 760 IAC 1-39.

(d) A certificate may be issued to a resident of Indiana under an association group policy, a discretionary group policy, or a trust

group policy that is delivered or issued for delivery in a state other than Indiana if:

(1) the delivery state has a law substantially similar to section 16 of this chapter;

(2) the delivery state has approved the group policy; and

(3) the policy or the certificate contains provisions that are:

(A) substantially similar to the provisions required by:

(i) section 19 of this chapter or, if the policy or certificate is described in section 2.5(b)(2) of this chapter, section 2.5 of this chapter;

(ii) section 19.3 of this chapter if the policy or certificate contains a waiver of coverage;

(iii) section 21 of this chapter; and

(iv) IC 27-8-5.6; and

(B) consistent with the requirements set forth in:

(i) section 15.6 of this chapter;

(ii) section 24 of this chapter;

(iii) section 26 of this chapter;

(iv) IC 27-8-6;

(v) IC 27-8-14;

(vi) IC 27-8-14.1;

(vii) IC 27-8-14.5;

(viii) IC 27-8-14.7;

(ix) IC 27-8-14.8;

(x) IC 27-8-20;

(xi) IC 27-8-23;

(xii) IC 27-8-24.3;

(xiii) IC 27-8-26;

(xiv) IC 27-8-28;

(xv) IC 27-8-29;

(xvi) 760 IAC 1-38.1; and

(xvii) 760 IAC 1-39.

(e) A certificate may be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana if the commissioner determines that the policy pursuant to which the certificate is issued meets the requirements set forth in section 17(a) of this chapter.

(f) This section does not affect any other provision of Indiana law governing the terms or benefits of coverage provided to a resident of Indiana under any certificate or policy of insurance.

As added by P.L.185-1996, SEC.12. Amended by P.L.96-2002, SEC.1; P.L.211-2003, SEC.3; P.L.127-2006, SEC.2; P.L.11-2011, SEC.30.

IC 27-8-5-17

Exceptions; discretionary groups; group accident and sickness insurance

Sec. 17. (a) A group accident and sickness insurance policy shall

not be delivered or issued for delivery in Indiana to a group that is not described in section 16(1)(A), 16(2)(A), 16(3)(A), 16(4)(A), 16(5)(A), 16(6)(A), 16(7), or 16(8) of this chapter unless:

(1) the group applies to the commissioner for approval as a discretionary group;

(2) the commissioner reviews the group according to the same standards as a group described in section 16 of this chapter; and

(3) the commissioner finds that:

(A) the issuance of the policy is not contrary to the best interest of the public;

(B) the issuance of the policy would result in economies of acquisition or administration; and

(C) the benefits of the policy are reasonable in relation to the premiums charged.

(b) Except as otherwise provided in this chapter, an insurer may exclude or limit the coverage under a policy described in subsection (a) on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

As added by P.L.257-1985, SEC.3. Amended by P.L.268-1987, SEC.2; P.L.125-1992, SEC.2; P.L.185-1996, SEC.13; P.L.218-2007, SEC.47; P.L.11-2011, SEC.31.

IC 27-8-5-18

Extension to family members or dependents; premiums; exclusions; group accident and sickness insurance

Sec. 18. (a) Except for a policy that conforms to the description in section 16(2) of this chapter, a group accident and sickness insurance policy may be extended to insure the employees or members, or any class or classes of employees or members, with respect to their family members or dependents, subject to subsections (b) and (c).

(b) The premium for the insurance must be paid from funds contributed by the employer, union, association, or other person to whom the policy has been issued or from funds contributed by the covered persons, or from both sources of funds. Except as provided in subsection (c), a policy on which no part of the premium for the coverage of family members or dependents is to be derived from funds contributed by the covered persons must insure all eligible employees or members, or any class or classes of eligible employees or members, with respect to their spouses and dependent children.

(c) Except as provided in section 24 of this chapter, an insurer may exclude or limit the coverage on any family member or dependent as to whom evidence of individual insurability is not satisfactory to the insurer.

As added by P.L.257-1985, SEC.4. Amended by P.L.125-1992, SEC.3.

IC 27-8-5-19

Contents; group accident and sickness insurance

Sec. 19. (a) As used in this chapter, "late enrollee" has the meaning set forth in 26 U.S.C. 9801(b)(3).

(b) A policy of group accident and sickness insurance may not be issued to a group that has a legal situs in Indiana unless it contains in substance:

(1) the provisions described in subsection (c); or

(2) provisions that, in the opinion of the commissioner, are:

(A) more favorable to the persons insured; or

(B) at least as favorable to the persons insured and more favorable to the policyholder;

than the provisions set forth in subsection (c).

(c) The provisions referred to in subsection (b)(1) are as follows:

(1) A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the policy will continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period. A provision under this subdivision may provide that the insurer is not obligated to pay claims incurred during the grace period until the premium due is received.

(2) A provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two (2) years after its date of issue, and that no statement made by a person covered under the policy relating to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless:

(A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or

(B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the policy or based upon other provisions in the policy.

(3) A provision that a copy of the application, if there is one, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured person or, in the event of death or incapacity of the insured person, to the

insured person's beneficiary or personal representative.

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

(5) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy and that is not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice, diagnosis, care, or treatment was received by the person or recommended to the person during the six (6) months before the effective date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of:

(i) the end of a continuous period of twelve (12) months beginning on or after the effective date of the person's coverage; or

(ii) the end of a continuous period of eighteen (18) months beginning on the effective date of the person's coverage if the person is a late enrollee.

This subdivision applies only to group policies of accident and sickness insurance other than those described in section 2.5(a)(1) through 2.5(a)(8) and 2.5(b)(2) of this chapter.

(6) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice or treatment was received by the person during a period of three hundred sixty-five (365) days before the effective date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of the following:

(i) The end of a continuous period of three hundred sixty-five (365) days, beginning on or after the effective date of the person's coverage, during which the person did not receive medical advice or treatment in connection with the disease or physical condition.

(ii) The end of the two (2) year period beginning on the

effective date of the person's coverage.

This subdivision applies only to group policies of accident and sickness insurance described in section 2.5(a)(1) through 2.5(a)(8) of this chapter.

(7) If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:

(A) premiums;

(B) benefits; or

(C) both premiums and benefits;

to be made if the age of a covered person has been misstated. A provision under this subdivision must contain a clear statement of the method of adjustment to be used.

(8) A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate, in electronic or paper form, setting forth a statement that:

(A) explains the insurance protection to which the person insured is entitled;

(B) indicates to whom the insurance benefits are payable; and

(C) explains any family member's or dependent's coverage under the policy.

The provision must specify that the certificate will be provided in paper form upon the request of the insured.

(9) A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

(10) A provision stating that:

(A) the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person making a claim, forms usually furnished by the insurer for filing proof of loss; and

(B) if the forms are not furnished within fifteen (15) days after the insurer received notice of a claim, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

(11) A provision stating that:

(A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent

written proofs of the continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;

(B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of the loss; and

(C) the failure to furnish proof within the time required under clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the policy.

(12) A provision that:

(A) all benefits payable under the policy (other than benefits for loss of time) will be paid:

(i) not more than forty-five (45) days after the insurer's (as defined in IC 27-8-5.7-3) receipt of written proof of loss if the claim is filed by the policyholder; or

(ii) in accordance with IC 27-8-5.7 if the claim is filed by the provider (as defined in IC 27-8-5.7-4); and

(B) subject to due proof of loss, all accrued benefits under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and any balance remaining unpaid at the termination of the period for which the insurer is liable will be paid as soon as possible after receipt of the proof of loss.

(13) A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of benefits for loss of life is subject to the provisions of the policy if no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount of five thousand dollars ($5,000), to any relative by blood or connection by marriage of the person who is deemed by the insurer to be equitably entitled to the benefit.

(14) A provision that the insurer, at the insurer's expense, has the right and must be allowed the opportunity to:

(A) examine the person of the individual for whom a claim is made under the policy when and as often as the insurer reasonably requires during the pendency of the claim; and

(B) conduct an autopsy in case of death if it is not prohibited

by law.

(15) A provision that no action at law or in equity may be brought to recover on the policy less than sixty (60) days after proof of loss is filed in accordance with the requirements of the policy and that no action may be brought at all more than three (3) years after the expiration of the time within which proof of loss is required by the policy.

(16) In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

(17) If the policy provides that hospital or medical expense coverage of a dependent child of a group member terminates upon the child's attainment of the limiting age for dependent children set forth in the policy, a provision that the child's attainment of the limiting age does not terminate the hospital and medical coverage of the child while the child is:

(A) incapable of self-sustaining employment because of a mental, intellectual, or physical disability; and

(B) chiefly dependent upon the group member for support and maintenance.

A provision under this subdivision may require that proof of the child's incapacity and dependency be furnished to the insurer by the group member within one hundred twenty (120) days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the child's attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a child who has a mental, intellectual, or physical disability who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or exclusion from coverage of the child.

(18) A provision that complies with the group portability and guaranteed renewability provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191).

(d) Subsection (c)(5), (c)(8), and (c)(13) do not apply to policies insuring the lives of debtors. The standard provisions required under section 3(a) of this chapter for individual accident and sickness insurance policies do not apply to group accident and sickness insurance policies.

(e) If any policy provision required under subsection (c) is in whole or in part inapplicable to or inconsistent with the coverage

provided by an insurer under a particular form of policy, the insurer, with the approval of the commissioner, shall delete the provision from the policy or modify the provision in such a manner as to make it consistent with the coverage provided by the policy.

(f) An insurer that issues a policy described in this section shall include in the insurer's enrollment materials information concerning the manner in which an individual insured under the policy may:

(1) obtain a certificate described in subsection (c)(8); and

(2) request the certificate in paper form.

As added by P.L.257-1985, SEC.5. Amended by P.L.165-1986, SEC.1; P.L.23-1993, SEC.154; P.L.185-1996, SEC.14; P.L.91-1998, SEC.11; P.L.207-1999, SEC.4; P.L.233-1999, SEC.10; P.L.14-2000, SEC.58; P.L.162-2001, SEC.4; P.L.125-2005, SEC.3; P.L.127-2006, SEC.3; P.L.99-2007, SEC.193; P.L.173-2007, SEC.25; P.L.117-2015, SEC.38.

IC 27-8-5-19.2
Repealed

(As added by P.L.211-2003, SEC.4. Repealed by P.L.3-2008, SEC.269.)

IC 27-8-5-19.3
Association and discretionary group policies of accident and sickness insurance; waiver of coverage

Sec. 19.3. (a) This section applies to an association or a discretionary group policy of accident and sickness insurance:

(1) under which a certificate of coverage is issued after June 30, 2005, to an individual member of the association or discretionary group;

(2) under which a member of the association or discretionary group is individually underwritten; and

(3) that is not employer based.

(b) Notwithstanding sections 19 and 19.2 of this chapter and any other law, and except as provided in subsection (e), a policy described in subsection (a) may contain a waiver of coverage for a specified condition and any complications that arise from the specified condition if:

(1) the waiver period does not exceed ten (10) years; and

(2) all of the following conditions are met:

(A) The insurer provides to the applicant before issuance of the certificate written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition.

(B) The:

(i) offer of coverage; and

(ii) certificate of coverage;

include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for

the waived condition.

(C) The:

(i) offer of coverage; and

(ii) certificate of coverage;

do not include more than two (2) waivers per individual.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) The insurer agrees to:

(i) review the underwriting basis for the waiver upon request one (1) time per year; and

(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage, and that any individual to whom the waiver would have applied may apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(G) An insurance benefit card issued by the insurer to the applicant includes a telephone number for verification of coverage waived.

(c) The insurer shall require an applicant to initial the written notice provided under subsection (b)(2)(A) and the waiver included in the offer of coverage and in the certificate of coverage under subsection (b)(2)(B) to acknowledge acceptance of the waiver of coverage.

(d) An offer of coverage under a policy that includes a waiver under this section does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.

(e) A policy described in subsection (a) may not include a waiver of coverage for a:

(1) mental health condition; or

(2) developmental disability.

(f) An insurer may not, on the basis of a waiver contained in a policy as provided in this section, deny coverage for any condition or complication that is not specified as required in the:

(1) written notice under subsection (b)(2)(A); and

(2) offer of coverage and certificate of coverage under subsection (b)(2)(B).

(g) An insurer that removes a waiver under subsection (b)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.

(h) Upon the expiration of the waiver period allowed under this section, the insurer shall:

(1) remove the waiver;

(2) not consider the condition or any complication to which the

waiver previously applied in making policy underwriting determinations; and

(3) renew the policy in accordance with 45 CFR 148.122.

As added by P.L.211-2005, SEC.2.

IC 27-8-5-20

Notice of right to return policy

Sec. 20. (a) All individual accident and health insurance policies, other than those issued pursuant to direct response solicitation, must have a notice prominently printed on the first page of the policy stating in substance that the policyholder has the right to return the policy:

(1) except as provided in subdivision (2), within ten (10) days of its delivery; or

(2) if the policy is a travel accident insurance policy, until the earlier of:

(A) thirty (30) days after the policy is delivered; or

(B) the date of departure;

and to have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason.

(b) All accident and health insurance policies issued pursuant to a direct response solicitation must have a notice prominently printed on the first page stating in substance that the policyholder has the right to return the policy:

(1) except as provided in subdivision (2), within thirty (30) days of its delivery; or

(2) if the policy is a travel accident insurance policy, until the earlier of:

(A) thirty (30) days after the policy is delivered; or

(B) the date of departure;

and to have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason.

(c) Notwithstanding subsection (b), a short term health insurance policy that is written for a period of less than sixty-one (61) days and issued under a direct response solicitation must have a notice prominently printed on the first page stating in substance that the policyholder has the right to return the policy within ten (10) days after the policy's delivery and to have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason.

As added by P.L.267-1987, SEC.5. Amended by P.L.1-1991, SEC.167; P.L.173-2007, SEC.26.

IC 27-8-5-21

Adopted children

Sec. 21. (a) Any individual or group policy or plan of health and accident insurance regulated under this chapter or any health maintenance organization or limited service health maintenance

organization regulated under IC 27-13 that provides coverage under a policy issued for delivery in Indiana must cover newly adopted children of the insured or enrollee. The coverage for newly adopted children will be the same as for other dependents. No policy or plan provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval may be applied to newly adopted children when they are enrolled in accordance with this section.

(b) The coverage required by this section:

(1) is effective upon the earlier of:

(A) the date of placement for the purpose of adoption; or

(B) the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption;

(2) continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; and

(3) continues unless required action as described in subsection (c) is not taken.

(c) If the payment of a specific premium or subscription fee is required to provide coverage for an adopted child, the policy or contract may require that notification of the adoption of the child as described in subsection (b) and the payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one (31) days after the adoption of the child in order to have the coverage continue beyond the thirty-one (31) day period.

As added by P.L.251-1989, SEC.1. Amended by P.L.98-1990, SEC.2; P.L.26-1994, SEC.11; P.L.116-1994, SEC.59; P.L.2-1995, SEC.106.

IC 27-8-5-22

Refund of unused premiums

Sec. 22. (a) All individual policies of accident and sickness insurance issued for delivery in Indiana after June 30, 1990, must provide for the refund of unused premiums upon the death of the insured during the contract period.

(b) The amount of premium refund shall be prorated from the date following the date of death of the insured to the end of the contract period for which the premium has been paid.

(c) The refund required by this section shall be paid as follows:

(1) If a person other than the insured paid the premium, to that person. A person entitled to a refund under this subdivision must furnish proof of payment to the insurer.

(2) If the insured paid the premium, to the surviving spouse of the insured. If there is no surviving spouse, the premium shall be paid in the same manner as distributions of the net estate of a person who dies intestate under IC 29-1-2-1(d). A parent disqualified under IC 29-1-2-1(e) from receiving an intestate share of the parent's child's estate is not entitled to a refund under this section of insurance premiums paid by the child.

(d) A person entitled to receive a refund under this section must do the following:

(1) Submit a written request for the refund.

(2) Furnish proof of the insured's death.

(e) This section does not affect the rights of a dependent under a policy covered by this section to obtain a conversion policy upon the death of the insured.

As added by P.L.151-1990, SEC.1. Amended by P.L.101-2008, SEC.4.

IC 27-8-5-23

Statute or rule mandating particular types of health care coverage; applications to insurer

Sec. 23. (a) This section does not apply to IC 27-8-6.

(b) A statute or rule mandating that one (1) or more particular types of health care coverage be provided does not apply to an insurer unless the statute or rule applies equally to employee welfare benefit plans described in 29 U.S.C. 1001 et seq.

As added by P.L.152-1990, SEC.1. Amended by P.L.119-1991, SEC.2.

IC 27-8-5-24

Insured issued new policy within year after cancellation or nonrenewal; mandatory coverage

Sec. 24. If an insurer cancels or declines to renew a group accident and sickness policy for reasons other than fraud or nonpayment of a premium and issues a new policy to the policyholder within one (1) year after the effective date of cancellation of the policy, the insurer must accept for coverage under the new policy an individual who:

(1) was covered under the old policy; and

(2) has continued to meet the requirements for membership in the group that applied to the old policy.

However, the insurer may not exclude or limit the coverage to the individual or individual's dependent due to evidence of insurability.

As added by P.L.125-1992, SEC.4.

IC 27-8-5-25

Maternity benefits; replacement of discontinued policy; prohibition on preexisting condition limitation or exclusion of coverage

Sec. 25. (a) As used in this section, "employer" means an employer who offers health insurance to the employer's employees.

(b) As used in this section, "insurer" means an insurer subject to IC 27.

(c) When an employer that has a group policy issued by an insurer that contains maternity benefits:

(1) discontinues the group health policy provided by the insurer;

and

(2) replaces the discontinued policy with coverage through a succeeding insurer;

the succeeding insurer's policy may not contain a preexisting condition limitation for maternity or exclude coverage due to pregnancy for employees or spouses of employees who were covered under the prior policy on the date the prior plan was discontinued.

(d) Subsection (c) only applies if the employer obtains a new group insurance policy within thirty-one (31) days after the discontinuance of an insurance policy.

As added by P.L.116-1994, SEC.60.

IC 27-8-5-26

Post-mastectomy coverage

Sec. 26. (a) As used in this section, "mastectomy" means the removal of all or part of the breast for reasons that are determined by a licensed physician to be medically necessary.

(b) A policy of accident and sickness insurance that provides coverage for a mastectomy may not be issued, amended, delivered, or renewed in Indiana unless the policy provides coverage as required under 29 U.S.C. 1185b, including coverage for:

(1) prosthetic devices; and

(2) reconstructive surgery incident to a mastectomy including:

(A) all stages of reconstruction of the breast on which the mastectomy has been performed; and

(B) surgery and reconstruction of the other breast to produce symmetry;

in the manner determined by the attending physician and the patient to be appropriate.

(c) Coverage required under this section is subject to:

(1) the deductible and coinsurance provisions applicable to a mastectomy; and

(2) all other terms and conditions applicable to other benefits.

(d) An insurer that issues a policy of accident and sickness insurance shall provide to an insured, at the time the policy is issued and annually thereafter, written notice of the coverage required under this section. Notice that is sent by the insurer that meets the requirements set forth in 29 U.S.C. 1185b constitutes compliance with this subsection.

(e) The coverage required under this section applies to a policy of accident and sickness insurance that provides coverage for a mastectomy, regardless of whether an individual who:

(1) underwent a mastectomy; and

(2) is covered under the policy;

was covered under the policy at the time of the mastectomy.

(f) This section does not require an insurer to provide coverage related to post mastectomy care that exceeds the coverage required for post mastectomy care under federal law.

As added by P.L.150-1997, SEC.3. Amended by P.L.96-2002, SEC.2; P.L.204-2003, SEC.1.

IC 27-8-5-27
Dental care provisions required

Sec. 27. (a) As used in this section, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis. The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Automobile medical payment insurance.
(4) A specified disease policy.
(5) A short term insurance plan that:
(A) may not be renewed; and
(B) has a duration of not more than six (6) months.
(6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.
(7) Worker's compensation or similar insurance.
(8) A student health plan.
(9) A supplemental plan that always pays in addition to other coverage.
(10) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

(b) As used in this section, "insured" means a child or an individual with a disability who is entitled to coverage under an accident and sickness insurance policy.

(c) As used in this section, "child" means an individual who is less than nineteen (19) years of age.

(d) As used in this section, "individual with a disability" means an individual:

(1) with a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual; and
(2) who:
(A) has a record of; or
(B) is regarded as;
having an impairment described in subdivision (1).

(e) A policy of accident and sickness insurance must include

coverage for anesthesia and hospital charges for dental care for an insured if the mental or physical condition of the insured requires dental treatment to be rendered in a hospital or an ambulatory outpatient surgical center. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the utilization standards for determining whether performing dental procedures necessary to treat the insured's condition under general anesthesia constitutes appropriate treatment.

(f) An insurer that issues a policy of accident and sickness insurance may:

(1) require prior authorization for hospitalization or treatment in an ambulatory outpatient surgical center for dental care procedures in the same manner that prior authorization is required for hospitalization or treatment of other covered medical conditions; and

(2) restrict coverage to include only procedures performed by a licensed dentist who has privileges at the hospital or ambulatory outpatient surgical center.

(g) This section does not apply to treatment rendered for temporal mandibular joint disorders (TMJ).

As added by P.L.189-1999, SEC.2. Amended by P.L.173-2007, SEC.27.

IC 27-8-5-28

Coverage of child to 26 years of age

Sec. 28. A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-six (26) years of age.

As added by P.L.218-2007, SEC.48. Amended by P.L.160-2011, SEC.19.

IC 27-8-5-29

Health plans offered through health benefit exchange

Sec. 29. (a) The definitions in IC 27-19-2 apply throughout this section.

(b) A health plan may not be offered to any person in Indiana through a health benefit exchange unless:

(1) the form of the policy, classification of risks, and premium rates that apply to the health plan have been filed with and reviewed and approved by the commissioner under this chapter; and

(2) the insurer is authorized under this title to engage in the business of insurance in Indiana.

(c) An insurer that offers a multistate health plan under Section 1334 of PPACA through a health benefit exchange shall file, for review and approval, the form of the policy, classification of risks,

and premium rates that apply to the multistate health plan with the commissioner within five (5) business days of the date on which the same filing is made with the federal government.

(d) This title, in conformity with PPACA, applies to a health plan offered through a health benefit exchange to the same extent that this title would apply if the health plan were offered independently of a health benefit exchange.

As added by P.L.278-2013, SEC.25.

IC 27-8-5-30

Step therapy protocol

Sec. 30. (a) As used in this section, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

(b) As used in this section, "insurer" refers to an insurer that issues a policy of accident and sickness insurance. The term includes a person that administers prescription drug benefits on behalf of an insurer.

(c) As used in this section, "policy of accident and sickness insurance" means a policy of accident and sickness insurance that provides coverage for prescription drugs.

(d) As used in this section, "preceding prescription drug" means a prescription drug that, according to a step therapy protocol, must be:

(1) first used to treat an insured's condition; and

(2) as a result of the treatment under subdivision (1), determined to be inappropriate to treat the insured's condition;

as a condition of coverage under a policy of accident and sickness insurance for succeeding treatment with another prescription drug.

(e) As used in this section, "protocol exception" means a determination by an insurer that, based on a review of a request for the determination and any supporting documentation:

(1) a step therapy protocol is not medically appropriate for treatment of a particular insured's condition; and

(2) the insurer will:

(A) not require the insured's use of a preceding prescription drug under the step therapy protocol; and

(B) provide immediate coverage for another prescription drug that is prescribed for the insured.

(f) As used in this section, "step therapy protocol" means a protocol that specifies, as a condition of coverage under a policy of accident and sickness insurance, the order in which certain prescription drugs must be used to treat an insured's condition.

(g) As used in this section, "urgent care situation" means an insured's injury or condition about which the following apply:

(1) If medical care or treatment is not provided earlier than the time frame generally considered by the medical profession to be reasonable for a nonurgent situation, the injury or condition

could seriously jeopardize the insured's:

(A) life or health; or

(B) ability to regain maximum function;

based on a prudent layperson's judgment.

(2) If medical care or treatment is not provided earlier than the time frame generally considered by the medical profession to be reasonable for a nonurgent situation, the injury or condition could subject the insured to severe pain that cannot be adequately managed, based on the insured's treating health care provider's judgment.

(h) An insurer shall publish on the insurer's Internet web site, and provide to an insured in writing, a procedure for the insured's use in requesting a protocol exception. The procedure must include the following provisions:

(1) A description of the manner in which an insured may request a protocol exception.

(2) That the insurer shall make a determination concerning a protocol exception request, or an appeal of a denial of a protocol exception request, not more than:

(A) in an urgent care situation, one (1) business day after receiving the request or appeal; or

(B) in a nonurgent care situation, three (3) business days after receiving the request or appeal.

(3) That a protocol exception will be granted if any of the following apply:

(A) A preceding prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured.

(B) A preceding prescription drug is expected to be ineffective, based on both of the following:

(i) The known clinical characteristics of the insured.

(ii) Known characteristics of the preceding prescription drug, as found in sound clinical evidence.

(C) The insured has previously received:

(i) a preceding prescription drug; or

(ii) another prescription drug that is in the same pharmacologic class or has the same mechanism of action as a preceding prescription drug;

and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

(D) Based on clinical appropriateness, a preceding prescription drug is not in the best interest of the insured because the insured's use of the preceding prescription drug is expected to:

(i) cause a significant barrier to the insured's adherence to or compliance with the insured's plan of care;

(ii) worsen a comorbid condition of the insured; or

(iii) decrease the insured's ability to achieve or maintain reasonable functional ability in performing daily activities.

(4) That when a protocol exception is granted, the insurer shall notify the insured and the insured's health care provider of the authorization for coverage of the prescription drug that is the subject of the protocol exception.

(5) That if:

(A) a protocol exception request; or

(B) an appeal of a denied protocol exception request;

results in a denial of the protocol exception, the insurer shall provide to the insured and the treating health care provider notice of the denial, including a detailed, written explanation of the reason for the denial and the clinical rationale that supports the denial.

(6) That the insurer may request a copy of relevant documentation from the insured's medical record in support of a protocol exception.

As added by P.L.19-2016, SEC.3.

IC 27-8-5-31

Prescription drug coverage

Sec. 31. (a) The definitions in section 30 of this chapter apply throughout this section.

(b) This section applies to an insurer that uses a formulary, cost sharing, or utilization review for prescription drug coverage.

(c) An insurer shall not remove a prescription drug from the insurer's formulary, change the cost sharing requirements that apply to a prescription drug, or change the utilization review requirements that apply to a prescription drug unless the insurer does at least one (1) of the following:

(1) At least sixty (60) days before the removal or change is effective, send written notice of the removal or change to each insured for whom the prescription drug has been prescribed during the preceding twelve (12) month period.

(2) At the time an insured for whom the prescription drug has been prescribed during the preceding twelve (12) month period requests a refill of the prescription drug, provide to the insured:

(A) written notice of the removal or change; and

(B) a sixty (60) day supply of the prescription drug under the terms that applied before the removal or change.

As added by P.L.19-2016, SEC.4.

IC 27-8-5.5

Chapter 5.5. Accident and Sickness Insurance–Claim Forms

IC 27-8-5.5-1

Definitions

Sec. 1. As used in this chapter:

(a) "Commissioner" means the insurance commissioner of Indiana.

(b) "Accident and sickness insurance" means any policy or contract of insurance described in classes 1(b), 2(a), 2(b), or 2(l), as defined in IC 27-1-5-1.

As added by Acts 1977, P.L.288, SEC.1.

IC 27-8-5.5-2

Promulgation of forms; requisites; contents; acceptance of claims; explanation of benefits paid statements or claims summary statements

Sec. 2. (a) The commissioner shall prescribe by rule, after consultation with providers of health care or treatment, accident and sickness insurers, hospital, medical, and dental service corporations and other prepayment organizations, such accident and sickness insurance claim forms as the commissioner determines will provide for uniformity and simplicity in insurance reporting. The forms shall include, but need not be limited to, information regarding the medical diagnosis, treatment and prognosis of the patient, together with the details of charges incident to the providing of care, treatment or services, sufficient for the purpose of meeting the proof requirements of an accident or sickness insurance policy or a hospital, medical, or dental service contract.

(b) An accident and sickness insurer may not refuse to accept a claim submitted on duly promulgated uniform claim forms. However, an insurer may accept claims submitted on any other form.

(c) Accident and sickness insurer explanation of benefits paid statements or claims summary statements sent to an insured by the accident and sickness insurer may be sent in electronic or paper form and shall be in a format and written in a manner that promotes understanding by the insured by setting forth:

(1) the total dollar amount submitted to the insurer for payment;

(2) any reduction in the amount paid due to the application of any co-payment or deductible, along with an explanation of the amount of the co-payment or deductible applied under the insured's policy;

(3) any reduction in the amount paid due to the application of any other policy limitation or exclusion as set forth in the insured's policy along with an explanation thereof;

(4) the total dollar amount paid; and

(5) the total dollar amount remaining unpaid.

In addition, the explanation shall clearly set forth a toll free number

that the insured may call to obtain additional information about any of the items contained in the explanation of benefits paid or claims summary statement.

(d) The commissioner may issue an order under IC 27-1-3-19(a) directing an accident and sickness insurer to comply with subsection (c).

(e) An accident and sickness insurer does not violate subsection (c) by using a document that the accident and sickness insurer has been required to use by the federal government or the state.

(f) An accident and sickness insurer shall:

(1) inform an insured that the insured may request that the statements described in subsection (c) be sent in paper form; and

(2) send the statements in paper form upon the request of the insured.

As added by Acts 1977, P.L.288, SEC.1. Amended by P.L.252-1989, SEC.1; P.L.125-2005, SEC.4.

IC 27-8-5.5-3

Obtaining additional information regarding claims

Sec. 3. The adoption of uniform claim forms by the commissioner pursuant to this chapter does not preclude an insurer, hospital, medical, or dental service corporation or other pre-payment organization, from obtaining any necessary additional information regarding a claim from the claimant, provider of health care or treatment, or certifier of coverage, as may be required.

As added by Acts 1977, P.L.288, SEC.1.

IC 27-8-5.6

Chapter 5.6. Accident and Sickness Insurance–Coverage for Newborns

IC 27-8-5.6-0.1

Application of certain amendments to chapter

Sec. 0.1. The amendments made to section 2 of this chapter by P.L.189-1997 apply only to a policy or contract of accident and sickness insurance that is issued or renewed after June 30, 1997.

As added by P.L.220-2011, SEC.436.

IC 27-8-5.6-1

"Accident and sickness insurance" defined

Sec. 1. (a) As used in this chapter, the term "accident and sickness insurance" means any policy or contract covering one (1) or more of the kinds of insurance described in classes 1(b) or 2(a) of IC 1971, 27-1-5-1, as governed by IC 1971, 27-8-5.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

(Formerly: Acts 1975, P.L.282, SEC.1.) As amended by P.L.173-2007, SEC.28.

IC 27-8-5.6-2

Policy provisions

Sec. 2. (a) Except as provided in subsection (b), all individual and group accident and sickness insurance policies or contracts which

provide coverage on an expense incurred basis or a provision of service basis for:

(1) an individual insured, certificate holder, or subscriber; or

(2) a family member or child of the insured, certificate holder, or subscriber;

shall, as to such individual or family members' coverage, also provide that the insurance benefits applicable for the individual or family member shall be payable with respect to a newly born child of the insured, certificate holder, or subscriber from the moment of birth.

(b) Subsection (a) does not require the coverage of a newly born child of an insured or a subscriber under an individual accident and sickness policy or contract if the pregnancy resulting in the birth of the newly born child was a condition that existed prior to the issuance of the policy or contract. If the pregnancy resulting in the birth of a newly born child was a condition that existed prior to the issuance of the policy or contract, coverage for the newly born child under the policy or contract is subject to the underwriting practices followed by the insurer at the time of the birth of the child.

(c) The coverage for newly born children required by subsection (a) shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage for newly born children required by subsection (a) shall include but not be limited to benefits for inpatient or outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate.

(Formerly: Acts 1975, P.L.282, SEC.1.) As amended by P.L.259-1985, SEC.1; P.L.267-1987, SEC.6; P.L.257-1995, SEC.1; P.L.189-1997, SEC.1.

IC 27-8-5.6-3

Payment of specific premium; notification of birth

Sec. 3. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one (31) days after the date of birth in order to have the coverage continue beyond the thirty-one (31) day period.

(Formerly: Acts 1975, P.L.282, SEC.1.)

IC 27-8-5.6-4

Application of chapter

Sec. 4. This chapter applies to accident and sickness insurance policies and contracts delivered or issued for delivery in Indiana after October 1, 1975.

As added by P.L.5-1988, SEC.148.

IC 27-8-5.7

Chapter 5.7. Accident and Sickness Insurance; Provider Payment

IC 27-8-5.7-1

"Accident and sickness insurance policy" defined

Sec. 1. As used in this chapter, "accident and sickness insurance policy" has the meaning set forth in IC 27-8-5-1.

As added by P.L.162-2001, SEC.5.

IC 27-8-5.7-2

"Clean claim" defined

Sec. 2. As used in this chapter, "clean claim" means a claim submitted by a provider for payment under an accident and sickness insurance policy issued in Indiana that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

As added by P.L.162-2001, SEC.5.

IC 27-8-5.7-3

"Insurer" defined

Sec. 3. As used in this chapter, "insurer" means an insurance company issued a certificate of authority in Indiana to issue accident and sickness insurance policies. The term includes:

(1) a preferred provider plan (as defined in IC 27-8-11-1); and

(2) an insurance administrator that:

(A) collects charges or premiums; and

(B) adjusts or settles claims;

in connection with coverage under an accident and sickness insurance policy.

As added by P.L.162-2001, SEC.5.

IC 27-8-5.7-4

"Provider" defined

Sec. 4. As used in this chapter, "provider" has the meaning set forth in IC 27-8-11-1.

As added by P.L.162-2001, SEC.5.

IC 27-8-5.7-5

Notice of deficiencies in claims

Sec. 5. (a) An insurer shall pay or deny each clean claim in accordance with section 6 of this chapter.

(b) An insurer shall notify a provider of any deficiencies in a submitted claim not more than:

(1) thirty (30) days for a claim that is filed electronically; or

(2) forty-five (45) days for a claim that is filed on paper;

and describe any remedy necessary to establish a clean claim.

(c) Failure of an insurer to notify a provider as required under

subsection (b) establishes the submitted claim as a clean claim.
As added by P.L.162-2001, SEC.5. Amended by P.L.137-2002, SEC.2.

IC 27-8-5.7-6
Payment or denial of claims; interest

Sec. 6. (a) An insurer shall pay or deny each clean claim as follows:

(1) If the claim is filed electronically, within thirty (30) days after the date the claim is received by the insurer.

(2) If the claim is filed on paper, within forty-five (45) days after the date the claim is received by the insurer.

(b) If:

(1) an insurer fails to pay or deny a clean claim in the time required under subsection (a); and

(2) the insurer subsequently pays the claim;

the insurer shall pay the provider that submitted the claim interest on the accident and sickness insurance policy allowable amount of the claim paid under this section.

(c) Interest paid under subsection (b):

(1) accrues beginning:

(A) thirty-one (31) days after the date the claim is filed under subsection (a)(1); or

(B) forty-six (46) days after the date the claim is filed under subsection (a)(2); and

(2) stops accruing on the date the claim is paid.

(d) In paying interest under subsection (b), an insurer shall use the same interest rate as provided in IC 12-15-21-3(7)(A).
As added by P.L.162-2001, SEC.5.

IC 27-8-5.7-7
Permitted forms

Sec. 7. A provider shall submit only the following forms for payment by an insurer:

(1) HCFA-1500.

(2) HCFA-1450 (UB-92).

(3) American Dental Association (ADA) claim form.
As added by P.L.162-2001, SEC.5.

IC 27-8-5.7-8
Civil penalties

Sec. 8. (a) If the commissioner finds that an insurer has failed during any calendar year to process and pay clean claims in compliance with this chapter, the commissioner may assess an aggregate civil penalty against the insurer according to the following schedule:

(1) If the insurer has paid at least eighty-five percent (85%) but less than ninety-five percent (95%) of all clean claims received

from all providers during the calendar year in compliance with this chapter, a civil penalty of up to ten thousand dollars ($10,000).

(2) If the insurer has paid at least sixty percent (60%) but less than eighty-five percent (85%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of at least ten thousand dollars ($10,000) but not more than one hundred thousand dollars ($100,000).

(3) If the insurer has paid less than sixty percent (60%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of at least one hundred thousand dollars ($100,000) but not more than two hundred thousand dollars ($200,000).

(b) In determining the amount of a civil penalty under this section, the commissioner shall consider whether the insurer's failure to achieve the standards established by this chapter is due to circumstances beyond the insurer's control.

(c) An insurer may contest a civil penalty imposed under this section by requesting an administrative hearing under IC 4-21.5 not more than thirty (30) days after the insurer receives notice of the assessment of the fine.

(d) If the commissioner imposes a civil penalty under this section, the commissioner may not impose a penalty against the insurer under IC 27-4-1 for the same activity.

(e) Civil penalties collected under this section shall be deposited in the state general fund.

As added by P.L.162-2001, SEC.5.

IC 27-8-5.7-9
Repealed

(As added by P.L.178-2003, SEC.61. Repealed by P.L.1-2007, SEC.248.)

IC 27-8-5.7-10
Claim payment errors

Sec. 10. (a) An insurer may not, more than two (2) years after the date on which an overpayment on a provider claim was made to the provider by the insurer:

(1) request that the provider repay the overpayment; or

(2) adjust a subsequent claim filed by the provider as a method of obtaining reimbursement of the overpayment from the provider.

(b) An insurer may not be required to correct a payment error to a provider more than two (2) years after the date on which a payment on a provider claim was made to the provider by the insurer.

(c) This section does not apply in cases of fraud by the provider, the insured, or the insurer with respect to the claim on which the overpayment or underpayment was made.

As added by P.L.55-2006, SEC.1.

IC 27-8-5.7-11
Claim overpayment adjustment

Sec. 11. Every subsequent claim that is adjusted by an insurer for reimbursement on an overpayment of a previous provider claim made to the provider must be accompanied by an explanation of the reason for the adjustment, including:

(1) an identification of:
  (A) the claim on which the overpayment was made; and
  (B) if ascertainable, the party financially responsible for the overpaid amount; and
(2) the amount of the overpayment that is being reimbursed to the insurer through the adjusted subsequent claim.

As added by P.L.55-2006, SEC.2.

IC 27-8-5.8

Chapter 5.8. Insurance Benefit Cards

IC 27-8-5.8-1

"Accident and sickness insurance policy" defined

Sec. 1. As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis. The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A limited benefit health insurance policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

(9) A student health insurance policy.

As added by P.L.230-2001, SEC.2.

IC 27-8-5.8-2

"Commissioner" defined

Sec. 2. As used in this chapter, "commissioner" means the insurance commissioner appointed under IC 27-1-1-2.

As added by P.L.230-2001, SEC.2.

IC 27-8-5.8-3

"Insured" defined

Sec. 3. As used in this chapter, "insured" means an individual who is entitled to coverage under an accident and sickness insurance policy.

As added by P.L.230-2001, SEC.2.

IC 27-8-5.8-4

Prescription drug information card

Sec. 4. (a) This section applies to an insurer that:

(1) issues an accident and sickness insurance policy that provides coverage for prescription drugs or devices; and

(2) issues a card or other technology for claims processing.

This section also applies to a third party administrator for self-insured plans, a pharmacy benefit manager, or a health benefit plan administered by the state if the administrator, manager, or plan

issues a card or other technology described in subdivision (2).

(b) The card or other technology issued by an insurer or another entity referred to in subsection (a) must contain uniform prescription drug information that complies with the requirements established under subsection (c).

(c) Prescription drug information cards or other technology must meet either of the following criteria:

(1) Be in a format and contain information fields approved by the National Council for Prescription Drug Programs (NCPDP) as contained in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide in effect on the October 1 most immediately preceding the issuance of the card.

(2) Contain the following information:

(A) The health benefit plan's name.

(B) The insured's name, group number, and identification number.

(C) A telephone number to inquire about pharmacy related issues.

(D) The issuer's international identification number or ANSI BIN number, labeled as RxBIN.

(E) The processor control number, labeled as RxPCN.

(F) The insured's pharmacy benefits group number if different than the medical group number, labeled as RxGRP.

Only those fields listed in clauses (A) through (F) that are required for proper adjudication of the claim must appear on the card. If the card is used to adjudicate non-pharmacy claims, then the designation "Rx" listed in clauses (D) through (F) is not required to be used by the issuer.

(d) An insurer or an insurer's agents, contractors, or administrators, including pharmacy benefits managers, may not be required to issue a prescription drug information card or other technology to a person more than one (1) time during a twelve (12) month period.

(e) The prescription drug information cards or other technology issued under this section may be used for health insurance coverage other than the coverage to which this chapter applies.

As added by P.L.230-2001, SEC.2. Amended by P.L.1-2002, SEC.111.

IC 27-8-6

Chapter 6. Reimbursement for Certain Medical Services

IC 27-8-6-0.1

Application of certain amendments to chapter

Sec. 0.1. The addition of section 4 of this chapter by P.L.153-1990 applies to a group or an individual policy or agreement providing comprehensive accident and health benefits that is issued, entered into, or renewed after June 30, 1990.

As added by P.L.220-2011, SEC.437.

IC 27-8-6-1

Professional services for which reimbursement authorized

Sec. 1. Notwithstanding any provision of any individual or group policy of accident and health insurance, or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, wherever such policy, contract, plan, or agreement provides for reimbursement for any service which is in the lawful scope of practice of a duly licensed dentist, health service provider in psychology, podiatrist, osteopath, optometrist, or chiropractor, the person entitled to benefits or the person performing services under the policy, contract, plan, or agreement shall be entitled to reimbursement on an equal basis for such service, whether the service is performed by a physician, dentist, health service provider in psychology, podiatrist, osteopath, optometrist, or chiropractor duly licensed under the laws of this state.

(Formerly: Acts 1969, c.409, s.1; Acts 1974, P.L.126, SEC.1.) As amended by P.L.260-1985, SEC.1.

IC 27-8-6-2

Prior policies

Sec. 2. The provisions of section 1 of this chapter shall not apply to any policy, contract, plan, or agreement in effect prior to May 1, 1969.

(Formerly: Acts 1969, c.409, s.2.) As amended by P.L.252-1985, SEC.311.

IC 27-8-6-3

Application of amendments by Acts 1974, P.L.126

Sec. 3. The amendments to this chapter made by Acts 1974, P.L.126 do not apply to a policy, contract, plan, or agreement in effect before June 11, 1974.

As added by P.L.1-1989, SEC.55.

IC 27-8-6-4

Reimbursement for services; application of section; prohibitions excluded

Sec. 4. (a) This section does not apply to any of the following:

(1) A health maintenance organization (as defined in IC 27-13-1-19) or limited service health maintenance organization (as defined in IC 27-13-34-4).

(2) A preferred provider plan (as defined in IC 27-8-11-1).

(3) An employee benefit program that is subject to the federal Employee Retirement Income Security Act (29 U.S.C. 1001 et seq.).

(4) Worker's compensation for an injury to or occupational disease of an employee under IC 22-3.

(b) A group or individual policy or agreement providing comprehensive accident and health benefits must reimburse an insured for services rendered by a provider licensed under IC 25-10 within the scope of that provider's license in the same manner as that policy or agreement reimburses an insured for services rendered by a provider licensed under IC 25-22.5 within the scope of that provider's license. The policy or agreement may not exclude or otherwise limit reimbursement for any service that a provider licensed under IC 25-10 renders under the scope of that provider's license in the diagnosis and treatment of any illness or injury. This section does not require that a health care policy or agreement cover a particular illness or injury.

(c) This section does not prohibit the following:

(1) The application of coinsurance and deductible provisions to providers licensed under IC 25-10 on the same basis as those provisions are applied to providers licensed under IC 25-22.5.

(2) The application of cost containment or quality assurance measures to providers licensed under IC 25-10 on the same basis as those measures are applied to providers licensed under IC 25-22.5.

(3) A review of the necessity of services that applies to services rendered by providers licensed under IC 25-10 on the same basis as the review applies to services provided by providers licensed under IC 25-22.5.

As added by P.L.153-1990, SEC.1. Amended by P.L.26-1994, SEC.12.

IC 27-8-6-5

Indemnity for services provided by certified registered nurse anesthetist

Sec. 5. (a) As used in this section, "certified registered nurse anesthetist" has the meaning set forth in IC 25-23-1-1.4.

(b) As used in this section, "insured" means an individual who is entitled to the benefits provided by a policy of accident and sickness insurance. The term includes the following:

(1) The policyholder of an individual policy of accident and sickness insurance.

(2) A member of the group covered by a group policy of accident and sickness insurance.

(3) An individual who is entitled to coverage under a policy of accident and sickness insurance as a spouse or dependent of an individual referred to in subdivision (1) or (2).

(c) As used in this section, "insurer" has the meaning set forth in IC 27-1-2-3.

(d) As used in this section, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

(e) An insurer that issued a policy of accident and sickness insurance that indemnifies an insured for anesthesiology services shall indemnify an insured under the policy for any covered anesthesiology services provided by a certified registered nurse anesthetist.

As added by P.L.258-1995, SEC.1.

IC 27-8-6-6

Coverage for athletic trainer services

Sec. 6. (a) As used in this section, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. However, the term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(7) A supplemental plan that always pays in addition to other coverage.

(b) A policy of accident and sickness insurance that provides coverage for physical medicine and rehabilitative services shall provide the coverage for physical medicine and rehabilitative services that are:

(1) rendered by an athletic trainer who is licensed under IC 25-5.1; and

(2) within the athletic trainer's scope of practice.

(c) This section does not require a policy of accident and sickness insurance to provide coverage for physical medicine or rehabilitative services generally.

As added by P.L.133-2011, SEC.1.

IC 27-8-7
Repealed

(Repealed by P.L.26-1994, SEC.28.)

IC 27-8-8

Chapter 8. Indiana Life and Health Insurance Guaranty Association Law

IC 27-8-8-0.3

Coverage obligations affected by statutory amendments; governing law

Sec. 0.3. (a) The association's coverage obligations under this chapter with respect to a member insurer that has a coverage date before March 28, 2006, are not affected by changes made by P.L.193-2006.

(b) The association's coverage obligations under this chapter with respect to a member insurer that has a coverage date before March 28, 2006, are governed by this chapter as it existed on January 1, 2006.

(c) The amendments made during the 2013 regular session of the general assembly to section 2.1 of this chapter do not apply to a member insurer that has been placed under an order of rehabilitation or liquidation before January 1, 2013.

(d) The amendment made during the 2013 regular session of the general assembly to section 2.3(e) of this chapter does not apply to a member insurer that has a coverage date before January 1, 2012.

(e) The amendments made during the 2013 regular session of the general assembly to section 2.3(f) of this chapter do not apply to a member insurer that has been placed under an order of rehabilitation or liquidation before January 1, 2013.

As added by P.L.220-2011, SEC.438. Amended by P.L.276-2013, SEC.30.

IC 27-8-8-1

Repealed

(As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.1-1989, SEC.56; P.L.192-1991, SEC.3; P.L.1-1992, SEC.154; P.L.251-1995, SEC.18. Repealed by P.L.193-2006, SEC.32.)

IC 27-8-8-1.5

Repealed

(As added by P.L.251-1995, SEC.19. Repealed by P.L.193-2006, SEC.32.)

IC 27-8-8-2

Definitions

Sec. 2. (a) The definitions in this section apply throughout this chapter.

(b) "Account" means one (1) of the two (2) accounts created under section 3 of this chapter.

(c) "Annuity contract", except as provided in section 2.3(e) of this chapter, includes:

(1) a guaranteed investment contract;
(2) a deposit administration contract;
(3) a structured settlement annuity;
(4) an annuity issued to or in connection with a government lottery; and
(5) an immediate or a deferred annuity contract.

(d) "Assessment base year" means, for an impaired insurer or insolvent insurer, the most recent calendar year for which required premium information is available preceding the calendar year during which the impaired insurer's or insolvent insurer's coverage date occurs.

(e) "Association", except when the context otherwise requires, means the Indiana life and health insurance guaranty association created by section 3 of this chapter.

(f) "Benefit plan" means a specific plan, fund, or program that is established or maintained by an employer or an employee organization, or both, that:
(1) provides retirement income to employees; or
(2) results in a deferral of income by employees for a period extending to or beyond the termination of employment.

(g) "Board" refers to the board of directors of the association selected under IC 27-8-8-4.

(h) "Called", when used in the context of assessments, means that notice has been issued by the association to member insurers requiring the member insurers to pay, within a time frame set forth in the notice, an assessment that has been authorized by the board.

(i) "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

(j) "Contractual obligation" means an enforceable obligation under a covered policy for which and to the extent that coverage is provided under section 2.3 of this chapter.

(k) "Coverage date" means, with respect to a member insurer, the date on which the earlier of the following occurs:
(1) The member insurer becomes an insolvent insurer.
(2) The association determines that the association will provide coverage under section 5(a) of this chapter with respect to the member insurer.

(l) "Covered policy" means a:
(1) nongroup policy or contract;
(2) certificate under a group policy or contract; or
(3) part of a policy, contract, or certificate described in subdivisions (1) and (2);

for which coverage is provided under section 2.3 of this chapter.

(m) "Extracontractual claims" includes claims that relate to bad faith in the payment of claims, punitive or exemplary damages, or attorney's fees and costs.

(n) "Funding agreement" has the meaning set forth in IC 27-1-12.7-1.

(o) "Impaired insurer" means a member insurer that is:

(1) not an insolvent insurer; and

(2) placed under an order of rehabilitation or conservation by a court with jurisdiction.

(p) "Insolvent insurer" means a member insurer that is placed under an order of liquidation with a finding of insolvency by a court with jurisdiction.

(q) "Member insurer" means any person that holds a certificate of authority to transact in Indiana any kind of insurance for which coverage is provided under section 2.3 of this chapter. The term includes an insurer whose certificate of authority to transact such insurance in Indiana may have been suspended, revoked, not renewed, or voluntarily withdrawn but does not include the following:

(1) A for-profit or nonprofit hospital or medical service organization.

(2) A health maintenance organization under IC 27-13.

(3) A fraternal benefit society under IC 27-11.

(4) The Indiana Comprehensive Health Insurance Association or any other mandatory state pooling plan or arrangement.

(5) An assessment company or another person that operates on an assessment plan (as defined in IC 27-1-2-3(y)).

(6) An interinsurance or reciprocal exchange authorized by IC 27-6-6.

(7) A prepaid limited service health maintenance organization or a limited service health maintenance organization under IC 27-13-34.

(8) A farm mutual insurance company under IC 27-5.1.

(9) A person operating as a Lloyds under IC 27-7-1.

(10) The political subdivision risk management fund established by IC 27-1-29-10 and the political subdivision catastrophic liability fund established by IC 27-1-29.1-7.

(11) The small employer health reinsurance board established by IC 27-8-15.5-5.

(12) A person similar to any person described in subdivisions (1) through (11).

(r) "Moody's Corporate Bond Yield Average" means:

(1) the monthly average of the composite yield on seasoned corporate bonds as published by Moody's Investors Service, Inc.; or

(2) if the monthly average described in subdivision (1) is no longer published, an alternative publication of interest rates or yields determined appropriate by the association.

(s) "Multiple employer welfare arrangement" has the meaning set forth in IC 27-1-34-1.

(t) "Owner" means the person:

(1) identified as the legal owner of a policy or contract according to the terms of the policy or contract; or

(2) otherwise vested with legal title to a policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer.

The term does not include a person with a mere beneficial interest in a policy or contract.

(u) "Person" means an individual, a corporation, a limited liability company, a partnership, an association, a governmental entity, a voluntary organization, a trust, a trustee, or another business entity or organization.

(v) "Plan sponsor" refers to only one (1) of the following with respect to a benefit plan:

(1) The employer, in the case of a benefit plan established or maintained by a single employer.

(2) The holding company or controlling affiliate, in the case of a benefit plan established or maintained by affiliated companies comprising a consolidated corporation.

(3) The employee organization, in the case of a benefit plan established or maintained by an employee organization.

(4) In a case of a benefit plan established or maintained:

(A) by two (2) or more employers;

(B) by two (2) or more employee organizations; or

(C) jointly by one (1) or more employers and one (1) or more employee organizations;

and that is not of a type described in subdivision (2), the association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the benefit plan.

(w) "Premiums" means amounts, deposits, and considerations received on covered policies, less returned premiums, returned deposits, returned considerations, dividends, and experience credits. The term does not include the following:

(1) Amounts, deposits, and considerations received for policies or contracts or parts of policies or contracts for which coverage is not provided under section 2.3(d) of this chapter, as qualified by section 2.3(e) of this chapter, except that an assessable premium must not be reduced on account of the limitations set forth in section 2.3(e)(3), 2.3(e)(15), or 2.3(f)(2) of this chapter.

(2) Premiums in excess of five million dollars ($5,000,000) on an unallocated annuity contract not issued or not connected with a governmental benefit plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code.

(x) "Principal place of business" refers to the single state in which individuals who establish policy for the direction, control, and coordination of the operations of an entity as a whole primarily exercise the direction, control, and coordination, as determined by the association in the association's reasonable judgment by considering the following factors:

(1) The state in which the primary executive and administrative headquarters of the entity is located.

(2) The state in which the principal office of the chief executive officer of the entity is located.

(3) The state in which the board of directors or similar governing person of the entity conducts the majority of the board of directors' or governing person's meetings.

(4) The state in which the executive or management committee of the board of directors or similar governing person of the entity conducts the majority of the committee's meetings.

(5) The state from which the management of the overall operations of the entity is directed.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the plan sponsor's benefit plan are employed in a single state, that state is considered to be the principal place of business of the plan sponsor. The principal place of business of a plan sponsor of a benefit plan described in subsection (v)(4), if more than fifty percent (50%) of the participants in the plan sponsor's benefit plan are not employed in a single state, is considered to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the benefit plan and, in the absence of a specific or clear designation of a principal place of business, is considered to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question on the coverage date.

(y) "Receivership court" refers to the court in an insolvent insurer's or impaired insurer's state that has jurisdiction over the conservation, rehabilitation, or liquidation of the insolvent insurer or impaired insurer.

(z) "Resident" means the following:

(1) An individual who resides in Indiana on the applicable coverage date.

(2) A person that is not an individual and has the person's principal place of business in Indiana on the applicable coverage date.

(aa) "State" includes a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

(bb) "Structured settlement annuity" means an annuity purchased to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(cc) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract.

(dd) "Unallocated annuity contract" means an annuity contract or group annuity certificate:

(1) the owner of which is not a natural person; and

(2) that does not identify at least one (1) specific natural person as an annuitant;

except to the extent of any annuity benefits guaranteed to a natural person by an insurer under the contract or certificate. For purposes of this chapter, an unallocated annuity contract shall not be considered a group policy or group contract.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.8-1993, SEC.431; P.L.251-1995, SEC.20; P.L.129-2003, SEC.13; P.L.193-2006, SEC.9; P.L.276-2013, SEC.31.

IC 27-8-8-2.1

Policy and contract descriptions; plan sponsor; residency

Sec. 2.1. (a) For purposes of this chapter:

(1) a policy or contract issued on a blanket basis is a group policy or group contract;

(2) each individual insured under a policy or contract issued on a blanket basis is a certificate holder under the policy or contract; and

(3) a policy or contract issued on a franchise plan to members of a qualified group is a nongroup policy or nongroup contract.

(b) For purposes of this chapter, a benefit plan may have only one (1) plan sponsor.

(c) For purposes of this chapter, an individual who, on the applicable coverage date:

(1) is a citizen of the United States; and

(2) resides in a:

(A) foreign country; or

(B) United States possession, territory, or protectorate;

that does not have an association similar to the association created by this chapter;

is considered to be a resident of the state of domicile of the insurer that issued the policies or contracts.

As added by P.L.193-2006, SEC.10. Amended by P.L.276-2013, SEC.32.

IC 27-8-8-2.3

Coverage provided; exclusions; limitations

Sec. 2.3. (a) Except as otherwise excluded or limited by this chapter, this chapter provides coverage for policies and contracts specified in subsection (d) as follows:

(1) To a person, other than a certificate holder under a group policy or a group contract, that, regardless of where the person resides, is the beneficiary, nonowner assignee, or payee of a person covered under subdivision (2).

(2) To a person that is a certificate holder under a group policy or group contract, and to a person that is the owner of a nongroup policy or nongroup contract that is not an unallocated annuity contract or a structured settlement annuity, and that:

(A) is a resident; or

(B) is not a resident if all the following conditions are satisfied:

(i) The member insurer that issued the policy or contract is domiciled in Indiana.

(ii) The state in which the person resides has an association similar to the association.

(iii) The nonresident is not eligible for coverage by the other association referred to in item (ii) solely because the member insurer was not licensed in the state of residence at the time specified in the guaranty association law of the state of residence.

(3) For an unallocated annuity contract, subdivisions (1) and (2) do not apply, and this chapter provides coverage to the following:

(A) A person that is the owner of the unallocated annuity contract, if the contract was issued to or in connection with a benefit plan whose plan sponsor is a resident or, if the plan sponsor is not a resident, if all the following conditions are satisfied:

(i) The member insurer that issued the unallocated annuity contract is domiciled in Indiana.

(ii) The state in which the plan sponsor resides has an association similar to the association.

(iii) The other association referred to in item (ii) does not provide coverage of the unallocated annuity contract solely because the member insurer was not licensed in the state of residence at the time specified in the guaranty association law of the state of residence.

(B) A person that is the owner of an unallocated annuity contract issued to or in connection with a government lottery, if the owner is a resident or, if the owner is not a resident, if all the following conditions are satisfied:

(i) The member insurer that issued the unallocated annuity contract is domiciled in Indiana.

(ii) The state in which the owner resides has an association similar to the association.

(iii) The other association referred to in item (ii) does not provide coverage of the unallocated annuity contract solely because the member insurer was not licensed in the state of residence at the time specified in the guaranty association law of the state of residence.

(4) For a structured settlement annuity, subdivisions (1) and (2) do not apply, and this chapter provides coverage to a person that is a payee under the structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:

(A) is a resident, regardless of where the contract owner resides; or

(B) is not a resident if all the following conditions are satisfied:

(i) The member insurer that issued the structured settlement annuity is domiciled in Indiana.

(ii) The state in which the payee resides has an association similar to the association.

(iii) Neither the payee nor the beneficiary of the payee (if the payee is deceased) is eligible for coverage by the other association referred to in item (ii) solely because the member insurer was not licensed in the state of residence at the time specified in the guaranty association law of the state of residence.

(b) This chapter does not provide coverage to a person that is:

(1) a payee or beneficiary of a contract owner that is a resident, if the payee or beneficiary is afforded any coverage by the association of another state; or

(2) otherwise covered under subsection(a)(3), if any coverage is provided to the person by the association of another state.

(c) To avoid duplicate coverage, if a person that would otherwise receive coverage under this chapter is provided coverage under the laws of another state, the person is not eligible for coverage under this chapter. In determining the application of this subsection when a person may be covered by the association of more than one (1) state as an owner, a payee, a beneficiary, or an assignee, this chapter must be construed in conjunction with the laws of the other state to result in coverage by only one (1) association.

(d) Except as otherwise excluded or limited by this chapter, this chapter provides coverage to the persons specified in subsection (a) for:

(1) direct nongroup life, health, or annuity policies and contracts and supplemental contracts to direct nongroup life, health, or annuity policies and contracts;

(2) certificates under direct group life, health, and annuity policies and contracts; and

(3) unallocated annuity contracts;

issued by member insurers.

(e) This chapter does not provide coverage for or with respect to the following:

(1) A part of a certificate, policy, or contract:

(A) not guaranteed by the insurer; or

(B) under which the risk is borne by the payee, certificate holder, or the policy or contract owner.

(2) A reinsurance policy or contract, unless and to the extent that assumption certificates have been issued under the reinsurance policy or contract.

(3) A part of a certificate, policy, or contract to the extent that the certificate's, policy's, or contract's interest rate, crediting rate, or similar factor employed in calculating returns or

changes in values, whether expressly stated in the certificate, policy, or contract or determined by use of an index or other external referent stated in the certificate, policy, or contract, either:

(A) when averaged over a period of four (4) years immediately before the applicable coverage date, exceeds the rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for the same four (4) year period or for a lesser period if the certificate, policy, or contract was issued less than four (4) years before the applicable coverage date; or

(B) in effect under the certificate, policy, or contract on and after the applicable coverage date, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available on the applicable coverage date.

(4) The obligations of a plan or program of an employer, an association, or another person to provide life, health, or annuity benefits to the employer's, association's, or other person's employees, members, or others, including obligations arising under and benefits payable by the employer, association, or other person under a multiple employer welfare arrangement.

(5) A minimum premium group insurance plan.

(6) A stop-loss or excess loss insurance policy or contract providing for the indemnification of or payment to a policy owner, a contract owner, a plan, or another person obligated to pay life, health, or annuity benefits or to provide services in connection with a benefit plan or another plan, fund, or program for the provision of employee welfare or pension benefits.

(7) An administrative services only contract.

(8) A part of a certificate, policy, or contract to the extent that the certificate, policy, or contract provides for:

(A) dividends or experience rating credits;

(B) voting rights; or

(C) payment of fees or allowances to a person, including the certificate holder or policy or contract owner, in connection with service with respect to or administration of the certificate, policy, or contract.

(9) A certificate, policy, or contract issued in Indiana by a member insurer when the member insurer did not have a certificate of authority to issue the certificate, policy, or contract in Indiana.

(10) An unallocated annuity contract issued to or in connection with a benefit plan protected by the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet been required to make payments with respect to the benefit plan.

(11) An unallocated annuity contract or part of an unallocated annuity contract that is not issued to or in connection with a benefit plan or a government lottery.
(12) A certificate, policy, or contract or part of a certificate, policy, or contract with respect to which the Class B assessments contemplated by section 6 of this chapter may not be made or collected under federal or state law.
(13) An obligation or claim that does not arise under the express written terms of the policy or contract issued by the member insurer to the contract owner or policy owner, including any of the following obligations and claims:
(A) Obligations and claims based on marketing materials.
(B) Obligations and claims based on side letters, riders, or other documents issued by the member insurer without meeting applicable policy form filing or approval requirements.
(C) Obligations and claims based on actual or alleged misrepresentations.
(D) Obligations and claims that are extracontractual claims.
(E) Obligations and claims for penalties or consequential, incidental, punitive, or exemplary damages.
(14) An obligation to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the:
(A) benefit plan; or
(B) benefit plan's trustee;
that is not an affiliate of the member insurer.
(15) A part of a certificate, policy, or contract to the extent the:
(A) certificate, policy, or contract provides for the certificate's, policy's, or contract's interest rate, crediting rate, or similar factor employed in calculating returns or changes in values, to be determined by use of an index or other external referent stated in the certificate, policy, or contract; and
(B) returns or changes in value have not been credited to the certificate, policy, or contract, or as to which the certificate holder's or policy or contract owner's rights are subject to forfeiture, as of the applicable coverage date.
If a certificate's, policy's, or contract's returns or changes in values are credited to the certificate, policy, or contract less frequently than annually, for purposes of determining the returns and values that have been credited and are not subject to forfeiture under this subdivision, the returns and changes in value determined by using the procedures defined in the certificate, policy, or contract must be considered credited as if the contractual date of crediting returns or changes in values were the applicable coverage date, and those credited returns or changes in value are not subject to forfeiture under this

subdivision, but will be subject to any other applicable limitations under this chapter.

(16) A funding agreement.

(17) An annuity not subject to regulation as described in IC 27-1-12.4.

(18) A certificate, policy, or contract that provides a hospital, medical, prescription drug, or other health care benefit under:

(A) Part C of Title XVIII of the federal Social Security Act (42 U.S.C. 1395w-21 through 1395w-28);

(B) Part D of Title XVIII of the federal Social Security Act (42 U.S.C. 1395w-101 through 1395w-153); or

(C) regulations adopted under a law specified in clause (A) or (B).

(f) The benefits that the association is obligated to cover do not exceed the lesser of the following:

(1) The contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an impaired insurer or insolvent insurer.

(2) The applicable limitations as follows:

(A) With respect to certificates, policies, and contracts not subject to clause (B), (C), (E), or (F), with respect to one (1) life, regardless of the number of policies or contracts, the following limitations:

(i) Three hundred thousand dollars ($300,000) in life insurance death benefits, but not more than one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values.

(ii) One hundred thousand dollars ($100,000) in health insurance benefits (other than disability insurance, basic hospital, medical, and surgical insurance, major medical insurance, and long term care insurance), including net cash surrender and net cash withdrawal values.

(iii) Three hundred thousand dollars ($300,000) in health insurance benefits that are disability insurance.

(iv) Three hundred thousand dollars ($300,000) in health insurance benefits under one (1) or more long term care insurance policies (as defined in IC 27-8-12-5).

(v) Five hundred thousand dollars ($500,000) in health insurance benefits that are basic hospital, medical, and surgical insurance or major medical insurance.

(vi) Two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

(B) With respect to unallocated annuity contracts issued to or in connection with a governmental benefit plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code, two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits,

including net cash surrender and net cash withdrawal values, per participant.

(C) With respect to structured settlement annuities, two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, per payee.

(D) In addition to the foregoing limitations, the association is not obligated to cover more than:

(i) an aggregate of three hundred thousand dollars ($300,000) in benefits with respect to any one (1) person under clauses (A), (B), and (C), except with respect to benefits for basic hospital, medical, and surgical insurance and major medical insurance under clause (A)(v), an aggregate of five hundred thousand dollars ($500,000) with respect to any one (1) person; or

(ii) with respect to one (1) owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, a firm, a corporation, or another person, and whether the persons insured are officers, managers, employees, or other persons, five million dollars ($5,000,000) in benefits, including net cash surrender and net cash withdrawal values, regardless of the number of policies and contracts held by the owner.

(E) With respect to unallocated annuity contracts issued to or in connection with a government lottery, five million dollars ($5,000,000) in benefits per contract owner, regardless of the number of contracts held by the contract owner.

(F) With respect to unallocated annuity contracts:

(i) issued to or in connection with a benefit plan; and

(ii) not subject to clause (B);

five million dollars ($5,000,000) in benefits per plan sponsor, regardless of the number of unallocated annuity contracts entitled to coverage under this chapter.

(g) The limitations set forth in subsection (f) are limitations on the benefits for which the association is obligated before taking into account the:

(1) association's subrogation and assignment rights; or

(2) extent to which the benefits could be provided out of the assets of the impaired insurer or insolvent insurer attributable to covered policies.

The costs of discharging the association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association under the association's subrogation and assignment rights.

(h) In discharging the association's obligations to provide coverage under this chapter, the association is not required to:

(1) guarantee, assume, reinsure, or perform;

(2) cause to be guaranteed, assumed, reinsured, or performed; or

(3) otherwise assure the discharge of;

the obligations of the insolvent insurer or impaired insurer under a covered policy that do not materially affect the economic values or economic benefits of the covered policy.

As added by P.L.193-2006, SEC.11. Amended by P.L.276-2013, SEC.33.

IC 27-8-8-3

Creation of association; membership; accounts; supervision

Sec. 3. (a) There is created a nonprofit legal entity referred to as the Indiana Life and Health Insurance Guaranty Association. A member insurer shall be and remain a member of the association as a condition of the member insurer's authority to transact insurance in Indiana. The association shall perform its functions under the plan of operation established and approved under section 7 of this chapter. The association shall exercise its powers through a board of directors established under section 4 of this chapter. For purposes of administration and assessment the association shall maintain the following two (2) accounts:

(1) The health insurance account.

(2) The life insurance and annuity account, which includes the following subaccounts:

(A) The life insurance subaccount.

(B) The annuity subaccount, which includes annuity contracts issued to or in connection with a governmental benefit plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code, but otherwise excludes unallocated annuities.

(C) The unallocated annuity subaccount, which excludes annuity contracts issued to or in connection with a governmental benefit plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code.

(b) The association is under the immediate supervision of the commissioner and subject to the applicable provisions of the insurance laws of Indiana.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.130-1994, SEC.43; P.L.116-1994, SEC.61; P.L.193-2006, SEC.12.

IC 27-8-8-4

Board of directors

Sec. 4. (a) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) member insurers serving terms established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner.

(b) Vacancies on the board shall be filled for the remaining period

of the term by a majority vote of the remaining board members, subject to the approval of the commissioner.

(c) To select the initial board and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. At the organizational meeting, each member insurer is entitled to one (1) vote in person or by proxy. If the board is not selected within sixty (60) days after notice of the organizational meeting, the commissioner may appoint the initial members of the board.

(d) In approving selections to the board, the commissioner shall consider whether all member insurers are fairly represented.

(e) Members of the board may be reimbursed from the assets of the association for expenses incurred by the members as members of the board. The association shall not otherwise compensate members of the board for the members' services on the board.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.13.

IC 27-8-8-5

Impaired insurers; insolvent insurers; liens; association powers and duties

Sec. 5. (a) If a member insurer is an impaired insurer, the association may, in the association's sole discretion and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner:

(1) guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, the contractual obligations of any of the covered policies of the impaired insurer or otherwise assure the discharge of the contractual obligations of the covered policies of the impaired insurer; and

(2) provide money, pledges, loans, notes, guarantees, or use other means as determined by the association in the association's sole discretion to be necessary or appropriate to effectuate subdivision (1).

(b) An obligation undertaken by the association under subsection (a) with respect to a covered policy of an impaired insurer ceases on the date the covered policy is replaced by the policy owner, insured, or association.

(c) If a member insurer is an insolvent insurer, the association shall, in the association's sole discretion, do one (1) of the following for each covered policy:

(1) Guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, the contractual obligations of the covered policy or otherwise assure the discharge of the contractual obligations of the covered policy.

(2) Terminate existing benefits and coverage and provide benefits and coverages in accordance with the following

provisions:

(A) For premiums identical to the premiums that would have been payable under the covered policy, assure payment of benefits arising under the contractual obligations, except for terms of conversion and nonrenewability, for:

(i) with respect to a group covered policy, claims incurred not later than the earlier of the next renewal date under the covered policy or forty-five (45) days, but not less than thirty (30) days, after the coverage date for the insolvent insurer; and

(ii) with respect to a nongroup covered policy, claims incurred not later than the earlier of the next renewal date under the covered policy or one (1) year, but in no event less than thirty (30) days, after the coverage date for the insolvent insurer.

(B) Make diligent efforts to provide each:

(i) known insured or annuitant, for a nongroup covered policy; and

(ii) owner, for a group covered policy;

at least thirty (30) days notice of the termination of the benefits provided.

(C) Make available substitute coverage, on an individual basis, to each:

(i) owner of a nongroup covered policy if the owner had a right to continue the nongroup covered policy in force until a specified age or for a specified period, during which time the insurer had no unilateral right to make changes in the nongroup covered policy's provisions or had only a unilateral right to make changes in premiums only by class; and

(ii) insured or annuitant under a group covered policy if the insured or annuitant is not eligible for any replacement group coverage and had a right, before termination of the group covered policy, to convert to individual coverage.

(D) In making available any substitute coverage under clause (C), the association may offer to reissue the terminated coverage or to issue an alternative policy or contract. If made available under clause (C), alternative or reissued policies and contracts must be offered without requiring evidence of insurability and must not impose any waiting period or coverage exclusion, other than a waiting period or coverage exclusion provided for in this chapter, that would not have applied under the terminated covered policy. The association may cause any alternative or reissued policy or contract to be assumed or reinsured.

(E) Use of alternative policies and contracts by the association is subject to the approval of the domiciliary insurance regulatory authority and the receivership court.

The association may adopt alternative policies and contracts of various types for future issuance without regard to any particular impairment or insolvency. Alternative policies and contracts must contain at least the minimum statutory provisions required in Indiana and provide benefits that are reasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates adopted by the association. The premium must:

(i) reflect the amount of insurance to be provided and the age and class of risk of each insured; and

(ii) not reflect changes in the health of the insured after the terminated covered policy was last underwritten.

Subject to coverage exceptions, exclusions, and limitations provided for in this chapter, an alternative policy or contract issued by the association must provide coverage similar, in material respects, to the coverage under the terminated covered policy as determined by the association.

(F) If the association elects to reissue terminated coverage at a premium rate different from the premium rate charged under the terminated covered policy, the association shall set the premium in accordance with a table of rates adopted by the association. The premium:

(i) must reflect the amount of insurance to be provided and the age and class of risk of each insured; and

(ii) is subject to approval of the domiciliary insurance regulatory authority and the receivership court.

(G) The association's obligations with respect to coverage under a covered policy of an insolvent insurer or under a reissued or alternative policy or contract ceases on the date the coverage or covered policy is replaced by another similar policy by the policy owner, insured, or association.

(H) Subject to subsection (u), when proceeding under this subdivision with respect to a covered policy carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 2.3(e)(3) of this chapter.

(3) Take any combination of the actions set forth in subdivisions (1) and (2).

(d) The association may provide money, pledges, loans, notes, or guarantees, or use other means that the association, in the association's sole discretion, determines are necessary or appropriate to discharge the association's duties under subsection (c).

(e) Failure to pay premiums within thirty-one (31) days after the date that payment is due under the terms of a guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the association's obligations under this chapter with respect to the policy, contract, or coverage, except with respect to claims incurred or net cash surrender value due under this chapter.

(f) Premiums due for coverage after the coverage date for an impaired insurer or insolvent insurer belong to and are payable at the direction of the association, and the association is liable for unearned premiums payable to policy or contract owners with respect to premiums received by the association.

(g) The protection provided by this chapter does not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state of the impaired insurer or insolvent insurer if the domiciliary state is a state other than Indiana.

(h) In carrying out its duties under subsection (c), the association may, subject to approval by a court in Indiana, impose:

(1) permanent policy or contract liens, if the association finds that:

(A) the amounts that can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter; or

(B) economic or financial conditions, as they affect member insurers, are sufficiently adverse so as to render the imposition of the permanent policy or contract liens to be in the public interest; and

(2) temporary moratoriums or liens on payments of cash values and policy loans or any other right to withdraw funds held in conjunction with a covered policy, in addition to any contractual provisions for deferral of cash or policy loan value.

In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payments of cash values or policy loans or any other right to withdraw funds held in conjunction with a covered policy out of the assets of the impaired insurer or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(i) A deposit in Indiana, held by law or required by the commissioner for the benefit of creditors, including policy owners, that is not turned over to the domiciliary receiver before or promptly after the coverage date for an impaired insurer or insolvent insurer under IC 27-9-4-3 must be promptly paid to the association. The association:

(1) may retain a part of an amount paid to the association under this subsection equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to the impairment or insolvency for which the association provides statutory benefits by the aggregate amount of all policy owners' claims in Indiana related to the impairment or insolvency; and

(2) shall remit to the domiciliary receiver the difference between the amount paid to the association and the amount

retained by the association under this subsection.

An amount retained by the association under this subsection must be treated as a distribution of estate assets under IC 27-9-3-32 or similar provision of the state of domicile of the impaired insurer or insolvent insurer.

(j) If the association fails to act within a reasonable period of time as provided in subsection (c) with respect to an insolvent insurer, the commissioner has the powers and duties of the association under this chapter with respect to the insolvent insurer.

(k) The association may, upon the commissioner's request, assist and advise the commissioner concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired insurer or insolvent insurer.

(l) The association has standing and the right to appear or intervene before a court or an agency in Indiana or elsewhere with jurisdiction over an impaired insurer or insolvent insurer for which the association is or may become obligated under this chapter or with jurisdiction over a person or property against which the association may have rights through subrogation or otherwise. Standing extends to all matters germane to the rights, powers, and duties of the association, including proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired insurer or insolvent insurer and the determination of the policies or contracts and contractual obligations.

(m) A person receiving benefits under this chapter is considered to have assigned:

(1) the person's rights under; and

(2) any cause of action against another person for losses arising under, resulting from, or otherwise relating to;

the covered policy to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of or on account of contractual obligations or continuation of coverage or provision of substitute or alternative coverage. The association may require an assignment to it of those rights and causes of action by a payee, policy or contract owner, certificate holder, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter on the person.

(n) The subrogation rights of the association under subsections (m) and (o) have the same priority against the assets of the impaired insurer or insolvent insurer as those possessed by the person entitled to receive benefits under this chapter.

(o) In addition to the rights conferred by subsections (m) and (n), the association has all common law rights of subrogation and any other equitable or legal remedy with respect to a covered policy that would have been available to the:

(1) impaired insurer or insolvent insurer;

(2) owner, beneficiary, or payee of a policy or contract with

respect to the policy or contract, including, in the case of a structured settlement annuity, rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received under this chapter, against a person:

(A) who is originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment for the annuity; and

(B) whose responsibility is not solely because of the person serving as an assignee in respect of a qualified assignment under Section 130 of the Internal Revenue Code; and

(3) certificate holder, or the beneficiary or payee of the certificate holder, with respect to a certificate.

(p) If subsection (m), (n), or (o) is invalid or ineffective with respect to a person or claim, the amount payable by the association with respect to the related covered policies must be reduced by the amount realized by another person with respect to the person or claim that is attributable to the covered policies.

(q) If the association provides benefits with respect to a covered policy and a person recovers amounts to which the association has rights as described in subsection (m), (n), or (o), the person shall pay to the association the part of the recovery attributable to the covered policies.

(r) The association may do the following:

(1) Enter into contracts necessary or appropriate to carry out the provisions and purposes of this chapter.

(2) Sue or, subject to section 14 of this chapter, be sued, including taking legal actions necessary or appropriate to recover unpaid assessments under section 6 of this chapter and to resolve claims or potential claims against or on behalf of the association.

(3) Borrow money to effect the purposes of this chapter and issue notes or other evidences of indebtedness of the association with respect to borrowings. Notes or other evidences of indebtedness described in this subdivision that are not in default are legal investments for domestic insurers and may be carried as admitted assets.

(4) Employ or retain persons necessary or appropriate to handle the financial transactions of the association and to perform other functions necessary or appropriate under this chapter.

(5) Take legal action necessary or appropriate to avoid or recover payment of improper claims.

(6) Exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life or health insurer. However, in no case may the association issue insurance policies or annuity contracts other than those issued to perform the association's obligations under this chapter.

(7) Request information from a person seeking coverage from the association to aid the association in determining and

discharging the association's obligations under this chapter with respect to the person. The person shall promptly comply with the request.

(8) Settle claims and potential claims by or against the association.

(9) Exercise all rights, privileges, and powers granted to the association by any other laws of Indiana or another jurisdiction.

(10) Take other necessary or appropriate action to discharge the association's duties and obligations under this chapter or to exercise the association's rights and powers under this chapter.

(s) The association may belong to one (1) or more organizations of one (1) or more other state associations of similar purpose to further the purpose and administer the powers and duties of the association.

(t) The association has discretion and may exercise reasonable business judgment to determine the means by which the association is to discharge, in an economical and efficient manner, the association's obligations under this chapter.

(u) In discharging the association's obligations and exercising the association's rights and powers under subsections (a) and (c), the association may, subject to approval of the receivership court, provide substitute coverage for a covered policy that provides for the covered policy's interest rate, crediting rate, or similar factor employed in calculating returns or changes in value to be determined by use of an index or other external referent stated in the covered policy by issuing an alternative policy or contract in accordance with the following provisions:

(1) Instead of the index or other external referent stated in the covered policy, the alternative policy or contract may provide for:

(A) a fixed interest rate;

(B) payment of dividends with minimum guarantees; or

(C) a different method for calculating returns or changes in value.

(2) A:

(A) requirement for evidence of insurability; or

(B) waiting period or an exclusion, other than a waiting period or an exclusion provided for in this chapter;

that would not have applied under the covered policy may not be imposed.

(3) The alternative policy or contract must provide coverage similar, in material respects, to the coverage under the covered policy, after taking into account the exceptions, exclusions, and limitations provided for in this chapter, as determined by the association.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.166-1986, SEC.1; P.L.130-1994, SEC.44; P.L.116-1994, SEC.62; P.L.251-1995, SEC.21; P.L.193-2006, SEC.14.

IC 27-8-8-5.2

Association election to succeed to rights and duties of impaired or insolvent insurer; reinsurance

Sec. 5.2. (a) At any time within one (1) year after the coverage date for an impaired insurer or insolvent insurer, the association may elect, subject to subdivisions (1) through (4), to succeed to the rights and obligations of the impaired insurer or insolvent insurer that accrue on or after the coverage date and that relate to covered policies under one (1) or more indemnity reinsurance agreements entered into by the impaired insurer or insolvent insurer as a ceding insurer. However, the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator, or liquidator of the impaired insurer or insolvent insurer has previously and expressly disaffirmed the reinsurance agreement. The election by the association must be effected by a notice to the receiver, rehabilitator, or liquidator and to the affected reinsurers specifying the reinsurance agreement concerning which the association has made the foregoing election. If the association makes an election, the following apply with respect to the agreements selected by the association:

(1) The association is responsible for:

(A) all unpaid premiums due under the agreements for periods before and after the coverage date; and

(B) the performance of all other obligations of the impaired insurer or insolvent insurer to be performed after the coverage date;

that relate to covered policies. The association may charge covered policies that are only partially covered by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association.

(2) The association is entitled to any amount payable by the reinsurer under the selected agreements:

(A) with respect to losses or events that occur during periods after the coverage date; and

(B) that relate to covered policies.

Of the amount received from the reinsurer, the association is obliged to pay to the beneficiary under the covered policy on account of which the amount was paid a portion of the amount equal to the excess of the amount received by the association over benefits paid by the association on account of the covered policy less the retention of the impaired insurer or insolvent insurer applicable to the loss or event.

(3) Within thirty (30) days after the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to all items paid by the:

(A) impaired insurer or insolvent insurer, or the impaired

insurer's or insolvent insurer's receiver, rehabilitator, or liquidator; or

(B) indemnity reinsurer;

during the period between the coverage date and the date of the association's election. Either the association or indemnity reinsurer shall pay the net balance due the other not more than five (5) days after the completion of the calculation. If the receiver, rehabilitator, or liquidator has received any amount due the association under subdivision (2), the receiver, rehabilitator, or liquidator shall remit the amount to the association as promptly as practicable.

(4) If the association, within sixty (60) days of the election, pays the premiums due for periods before and after the coverage date that relate to covered policies, the reinsurer is not entitled to:

(A) terminate the reinsurance agreements insofar as the agreements relate to covered policies; or

(B) set off any unpaid premium due for periods before the coverage date against amounts due the association.

(b) If the association transfers any of the association's obligations to another insurer, and if the association and the other insurer agree, the other insurer succeeds to the rights and obligations of the association under subsection (a) with respect to the transferred obligations effective as of the date agreed upon by the association and the other insurer and regardless of whether the association has made the election referred to in subsection (a), except that the:

(1) indemnity reinsurance agreements automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary; and

(2) obligations of the association described in subsection (a)(2) no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third party insurer.

This subsection does not apply if the association has previously notified the receiver, rehabilitator, or liquidator and the affected reinsurer in writing that the association will not exercise the election referred to in subsection (a).

(c) Subsections (a) and (b) supersede any other law or affected reinsurance agreement that provides for or requires payment of reinsurance proceeds, on account of losses or events that occur after the coverage date, to the receiver, liquidator, or rehabilitator of the impaired insurer or insolvent insurer. The receiver, rehabilitator, or liquidator remains entitled to amounts payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur before the coverage date, subject to applicable setoff provisions.

(d) Except as provided in subsections (a), (b), and (c), this chapter does not alter or modify the terms and conditions of indemnity reinsurance agreements of the insolvent insurer.

(e) This chapter does not:

(1) abrogate or limit the rights of a reinsurer to claim that the reinsurer is entitled to rescind a reinsurance agreement; or

(2) give a policy owner or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

As added by P.L.193-2006, SEC.15.

IC 27-8-8-5.4

Association obligations to person entitled to coverage

Sec. 5.4. If the association has arranged or offered to discharge the association's obligations under this chapter with respect to contractual obligations owed to a person entitled to coverage under this chapter:

(1) the person, and any other person claiming by, through, or under the person, is not entitled to benefits from the association in addition to or other than benefits arranged or offered by the association; and

(2) the association is relieved of further obligation with respect to the contractual obligations if the person rejects, declines, or otherwise fails to accept the association's arrangement or offer.

As added by P.L.193-2006, SEC.16.

IC 27-8-8-5.5

Venue; appeal bond

Sec. 5.5. (a) Venue in a suit against the association is in Marion County.

(b) The association is not required to give an appeal bond in an appeal that relates to a cause of action arising under or with respect to this chapter.

As added by P.L.193-2006, SEC.17.

IC 27-8-8-6

Assessments

Sec. 6. (a) For the purpose of providing funds necessary to carry out the powers and duties of the association and necessary to pay administrative costs and expenses incurred by the commissioner in supervising the association and discharging the commissioner's obligations under this chapter, the board shall assess the member insurers, separately for each account, at a time and for amounts as the board finds necessary. Assessments are due not less than thirty (30) days after prior written notice to the member insurers and accrue interest at six percent (6%) per annum on and after the due date.

(b) There are two (2) classes of assessments as follows:

(1) Class A assessments are assessments that are authorized and called by the board for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired insurer or insolvent insurer.

(2) Class B assessments are assessments that are authorized and called by the board to the extent necessary to carry out the powers and duties of the association under this chapter with regard to an impaired insurer or insolvent insurer.

(c) The amount of a Class A assessment must be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that the assessment be credited against future Class B assessments. The total of all non-pro rata assessments must not exceed one hundred fifty dollars ($150) per member insurer in any one (1) calendar year.

(d) The amount of a Class B assessment must be allocated for assessment purposes among the accounts under an allocation formula that may be based on the premiums or reserves of the impaired insurer or insolvent insurer or another standard considered by the board in the board's sole discretion as fair and reasonable under the circumstances.

(e) Class B assessments against member insurers for each account and subaccount with respect to an impaired insurer or insolvent insurer must be allocated among the assessed member insurers in the proportion that the premiums received in Indiana by each assessed member insurer on policies and contracts covered by the account or subaccount during the assessment base year for the impaired insurer or insolvent insurer bears to premiums received in Indiana by all assessed members on policies and contracts covered by the same account or subaccount during the same assessment base year.

(f) Assessments for funds to meet the requirements of the association with respect to an impaired insurer or insolvent insurer must not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection (b) and computation of assessments under subsections (c), (d), and (e) must be made with a reasonable degree of accuracy, recognizing that exact determinations are not always possible. The association shall notify each member insurer of the member insurer's anticipated share of an assessment that has been authorized but not yet called not more than one hundred eighty (180) days after the assessment is authorized.

(g) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its policy and contract obligations. In the event an assessment against a member insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay assessments that were deferred under a repayment plan approved by the association.

(h) Subject to subsection (i), the total of all assessments

authorized by the association in one (1) calendar year against a member insurer for a given subaccount of the life insurance and annuity account or for the health insurance account with respect to any single assessment base year must not exceed two percent (2%) of the member insurer's premiums received in Indiana on the policies and contracts covered by the subaccount or account during the applicable assessment base year.

(i) If two (2) or more assessments are authorized in one (1) calendar year with respect to impaired insurers or insolvent insurers having different assessment base years, the annual premium used for purposes of determining the aggregate assessment percentage limitation referenced in subsection (h) must be equal to the higher of the annual premiums for the applicable subaccount or account as calculated under this section.

(j) If the maximum assessment, together with other assets of the association in an account, does not provide in one (1) year in the account an amount sufficient to carry out the responsibilities of the association, additional funds must be assessed as soon as permitted by this chapter.

(k) The board may provide in the plan of operation a method of or procedure for allocating funds among claims relating to one (1) or more impaired insurers or insolvent insurers when the maximum assessment is insufficient to cover anticipated claims.

(l) If the maximum assessment for a subaccount of the life insurance and annuity account in one (1) year does not provide an amount sufficient to carry out the responsibilities of the association, the board shall, under subsection (e), access the other subaccounts of the life insurance and annuity account for the necessary additional amount, subject to the maximum stated in subsections (h) and (i).

(m) The board may, by an equitable method or procedure as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to the account, the amount by which the assets of the account exceed the amount the board determines is necessary to carry out the obligations of the association with regard to the account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in an account to provide funds for the continuing expenses of the association and for the future discharge of the association's obligations.

(n) It is proper for a member insurer, in determining its premium rates and policyowner dividends as to any type of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(o) The association shall issue to each member insurer paying an assessment under this chapter, other than a Class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment paid. All outstanding certificates are of equal dignity and priority without reference to amounts or

dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in the form and for the amount and period of time as the commissioner may approve.
As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.16-1984, SEC.17; P.L.166-1986, SEC.2; P.L.130-1994, SEC.45; P.L.116-1994, SEC.63; P.L.193-2006, SEC.18.

IC 27-8-8-6.2
Member protesting assessment

Sec. 6.2. (a) A member insurer that wishes to protest all or part of an assessment made under section 6 of this chapter shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment is available to meet association obligations during the pendency of the protest or a subsequent appeal. Payment must be accompanied by a statement in writing that the payment is made under protest and set forth a brief statement of the grounds for the protest.

(b) Not more than sixty (60) days after the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of the association's determination with respect to the protest (unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest).

(c) Not more than sixty (60) days after receipt of notice of the association's determination with respect to a protest, the protesting member insurer may appeal the determination to the commissioner.

(d) Instead of making a determination with respect to a protest based on a question regarding the assessment base, the association may refer the protest to the commissioner for a determination, with or without a recommendation from the association.

(e) If a protest of an assessment is upheld, the amount paid by the protesting member insurer in error or excess must be returned to the member insurer. Interest on a refund due to a protesting member insurer must be paid at the rate actually earned by the association.
As added by P.L.193-2006, SEC.19.

IC 27-8-8-6.5
Association requests for information

Sec. 6.5. (a) The association may request information from a member insurer to aid in the exercise of the association's power under sections 6 and 6.2 of this chapter.

(b) A member insurer that receives a request under subsection (a) shall promptly comply with the request.
As added by P.L.193-2006, SEC.20.

IC 27-8-8-7
Association plan of operation

Sec. 7. (a) The association shall submit to the commissioner a

plan of operation and any amendments to the plan of operation that are necessary or appropriate to assure the fair, reasonable, and equitable administration of the association. The plan of operation and an amendment to the plan of operation are effective:

(1) if the plan or amendment is not disapproved by the commissioner within thirty (30) days after being submitted to the commissioner; or

(2) upon the commissioner's written approval, if sooner than the time set in subdivision (1).

(b) If the association fails to submit a suitable plan of operation within one hundred eighty (180) days from September 1, 1978, or if at any other time the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules under IC 4-22-2 necessary to effectuate the provisions of this chapter. The rules continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(c) A member insurer shall comply with the plan of operation.

(d) The plan of operation must, in addition to requirements stated elsewhere in this chapter establish:

(1) procedures for handling the assets of the association;

(2) the amount and method of reimbursing members of the board under section 4 of this chapter;

(3) regular places and times for meetings, including, if desired by the association, telephone conference calls, of the board;

(4) procedures for records to be kept of all financial transactions of the association, its agents, and the board;

(5) procedures whereby selections for the board will be made and submitted to the commissioner; and

(6) any additional procedures for assessments under sections 6 and 6.2 of this chapter.

The plan of operation may contain additional provisions necessary or appropriate for the execution of the powers and duties of the association.

(e) The plan of operation may provide that any or all powers and duties of the association, except those under sections 5(r)(3), 6, 6.2, and 6.5 of this chapter, may be delegated to a corporation, association, or other organization that performs or will perform functions similar to those of the association, or its equivalent, in two (2) or more states. The corporation, association, or organization must be reimbursed for payments made on behalf of the association and must be paid for its performance of any function of the association. A delegation under this subsection takes effect only with the approval of both the board and the commissioner and may be made only to a corporation, association, or organization that extends protection that is not substantially less favorable and effective than that provided by this chapter.

(f) To the extent and in the manner specified in the plan of

operation, the board may create one (1) or more committees, each of which may exercise the authority of the board to the extent specified in the plan of operation or by the board.
As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.21.

IC 27-8-8-8
Powers and duties of commissioner; appeals to commissioner; notice of effect of chapter

Sec. 8. (a) The commissioner shall do the following:

(1) Upon request of the board, provide the association with a statement of the premiums in Indiana and other appropriate states for each member insurer.

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand on the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders. The failure of the insurer to promptly comply with the demand shall not excuse the association from the performance of its powers and duties under this chapter.

(3) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

(b) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in Indiana of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on a member insurer that fails to pay an assessment when due. A forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100) per month.

(c) A final action of the association or the board may be appealed to the commissioner by a member insurer if the appeal is taken within sixty (60) days of the member insurer's receipt of notice of the final action being appealed. A final action or order of the commissioner is subject to judicial review in a court with jurisdiction in accordance with the Indiana law that applies to the actions or orders of the commissioner.

(d) The liquidator, rehabilitator, or conservator of an impaired insurer or insolvent insurer may notify all interested persons of the effect of this chapter.
As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.22.

IC 27-8-8-9
Detection and prevention of insurer insolvencies or impairments; actions of board of directors

Sec. 9. (a) To aid in the detection and prevention of insurer insolvencies or impairments, the commissioner shall do the

following:

(1) Notify the insurance regulatory authorities of all the other states not more than thirty (30) days after the date an action taken by the commissioner occurs when the commissioner takes any of the following actions against a member insurer:

(A) Revokes the member insurer's certificate of authority.

(B) Suspends the member insurer's certificate of authority.

(C) Issues a formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from Indiana, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners or creditors.

(2) Report to the association when the commissioner takes any of the actions set forth in subdivision (1) or when the commissioner has received a report from any other insurance regulatory authority indicating that an action has been taken in another state. The report to the association must contain all significant details of the action taken or of the report received from another insurance regulatory authority.

(3) Report to the association when the commissioner has reasonable cause to believe from an examination, whether completed or in process, of a member insurer that the member insurer may be impaired or insolvent.

(4) Furnish to the association the NAIC Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners. The association may use the information contained in the ratios and listings in carrying out its duties and responsibilities under this chapter. The report and the information contained in the report must be kept confidential by the association until made public by the commissioner or other lawful authority.

(b) The commissioner may seek the advice and recommendations of the association concerning a matter affecting the commissioner's duties and responsibilities in regard to the financial condition of member insurers and companies seeking admission to transact insurance business in Indiana.

(c) The association may, upon majority vote by the board, make reports and recommendations to the commissioner on any matter germane to the solvency, liquidation, rehabilitation, or conservation of a member insurer or germane to the solvency of any company seeking to do an insurance business in Indiana. The reports and recommendations are not public documents.

(d) The association may, upon majority vote by the board, notify the commissioner of any information indicating that a member insurer may be impaired or insolvent.

(e) The association may, upon majority vote by the board, make recommendations to the commissioner for the detection and

prevention of insurer insolvencies.
As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.23.

IC 27-8-8-10
Records of board meetings; disclosure of records; association status as creditor; application of impaired or insolvent insurer's assets

Sec. 10. (a) Records must be kept of all meetings of the board to discuss the activities of the association in carrying out its powers and duties under sections 5, 5.2, and 5.4 of this chapter. Records of the association with respect to an impaired insurer or insolvent insurer must not be disclosed except:

(1) after the termination of the liquidation, rehabilitation, or conservation proceeding involving the impaired insurer or insolvent insurer; or

(2) upon the order of a court with jurisdiction if the order is made before the time described in subdivision (1).

This subsection does not limit the duty of the association to submit a report of its activities under section 12 of this chapter.

(b) For the purpose of carrying out its obligations under this chapter, the association is a creditor of the impaired insurer or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts that the association has received, from a person other than the impaired insurer or insolvent insurer, as subrogee under section 5(m), 5(o), and 5(q) of this chapter. Assets of the impaired insurer or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired insurer or insolvent insurer as required by this chapter. "Assets attributable to covered policies", as used in this subsection, is that proportion of the assets that the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired insurer or insolvent insurer.

(c) As a creditor of an impaired insurer or insolvent insurer under subsection (b) and consistent with IC 27-9-3-32, the association and other similar associations are entitled to receive disbursements of assets out of the marshaled assets, as the assets become available to reimburse the association or another similar association, as a credit against contractual obligations under this chapter. If the liquidator has not, within one hundred twenty (120) days after a member insurer becomes an insolvent insurer, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, the association is entitled to make application to the receivership court for approval of the association's own proposal to disburse the assets.

(d) Before the termination of a liquidation, rehabilitation, or

conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders and policy owners of the impaired insurer or insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the impaired insurer or insolvent insurer. In making the determination, the court shall consider the welfare of the policy owners of the continuing or successor insurer.

(e) A distribution to stockholders of an impaired insurer or insolvent insurer must not be made until the total amount of valid claims of the association, with interest, for funds expended in carrying out the association's powers and duties under sections 5, 5.2, 5.4, and 5.5 of this chapter with respect to the impaired insurer or insolvent insurer, have been fully recovered by the association.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.24.

IC 27-8-8-11

Distributions to affiliates; recovery

Sec. 11. (a) Subject to subsections (b) through (d), if an order for liquidation or rehabilitation of an insurer domiciled in Indiana has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five (5) years preceding the filing of the petition for liquidation or rehabilitation.

(b) A distribution described in subsection (a) is not recoverable if the insurer shows that when the distribution was paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill the insurer's policy and contract obligations.

(c) A person who was an affiliate that controlled the insurer at the time a distribution described in subsection (a) was paid is liable up to the amount of distributions the person received. A person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions that would have been received if the distributions had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they are jointly and severally liable.

(d) The maximum amount recoverable under this section shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the policy and contract obligations of the insolvent insurer.

(e) If a person liable under subsection (c) is insolvent, the affiliates that controlled the person at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency

in the amount recovered from the insolvent affiliate.
As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.25.

IC 27-8-8-12
Examination and regulation of association; financial report

Sec. 12. (a) The association is subject to examination and regulation by the commissioner. The association shall annually submit to the commissioner, not later than one hundred twenty (120) days after the end of the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year.

(b) Upon the request of a member insurer, the association shall provide to the member insurer a copy of the reports described in subsection (a).
As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.26.

IC 27-8-8-13
Association tax and fee exemption

Sec. 13. The association is exempt from payment of all fees and all taxes levied by Indiana or any of its political subdivisions, except taxes levied on real property.
As added by Acts 1978, P.L.129, SEC.3.

IC 27-8-8-14
Liability for performance under chapter

Sec. 14. (a) A member insurer and the member insurer's agents and employees, the association and the association's agents and employees, members of the board and representatives of the members of the board, and the commissioner and the commissioner's representatives are not liable for and no cause of action of any nature arises or may be brought against them for or in connection with an action or omission by any of them in the exercise and performance of their rights, powers, and duties under this chapter.

(b) Immunity under this section extends to:

(1) the participation in an organization of one (1) or more other state associations of similar purpose; and

(2) an organization described in subdivision (1) and an agent or employee of the organization.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.27.

IC 27-8-8-15
Insolvent insurer proceedings; stay; setting aside judgment

Sec. 15. All proceedings in which an insolvent insurer is a party in any court in Indiana shall be stayed for one hundred eighty (180) days from the date an order of liquidation is entered to permit proper

legal action by the association on matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default, the association may apply to have the judgment set aside by the same court that made the judgment and is entitled to defend against the suit on the merits.
As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.28; P.L.276-2013, SEC.34.

IC 27-8-8-16
Recoupment of assessments

Sec. 16. A member insurer may take as a credit against premium taxes, adjusted gross income taxes, or any combination of them imposed by the state upon the member insurer's revenue or income not more than twenty percent (20%) of the amount of each assessment described in section 6 of this chapter for each calendar year following the year in which the assessment was paid until the assessment has been offset by either credits against the taxes or refunds from the association. If the member insurer ceases doing business, all uncredited assessments may be credited against the member insurer's premium taxes, adjusted gross income taxes, or a combination of the premium taxes and adjusted gross income taxes of the member insurer for the year the member insurer ceases doing business.
As added by Acts 1978, P.L.129, SEC.3. Amended by Acts 1979, P.L.255, SEC.2; Acts 1980, P.L.173, SEC.1; P.L.163-1986, SEC.2; P.L.192-2002(ss), SEC.168; P.L.193-2006, SEC.29.

IC 27-8-8-17
Refunds from association

Sec. 17. (a) Sums acquired by refund under section 6(m) of this chapter from the association by member insurers and offset against taxes as provided by section 16 of this chapter shall be paid by the member insurers to the state in the manner required by the tax authorities.

(b) The association shall notify the commissioner when refunds under section 6 of this chapter have been made.
As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.30.

IC 27-8-8-18
Advertising referring to association; association summary document

Sec. 18. (a) A person, including an insurer, insurance producer, employee, agent, or affiliate of an insurer, shall not make, publish, disseminate, circulate, or place before the public or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over

any radio station or television station, or in any other way, an advertisement, an announcement, or a statement, written or oral, that uses the existence of the association for the purpose of the sale of, solicitation of, or inducement to purchase any form of insurance covered by this chapter. This section does not apply to the association or any other entity that does not sell or solicit insurance.

(b) Not later than January 1, 2007, the association shall:

(1) prepare a summary document:

(A) describing the general purposes and current limitations of this chapter; and

(B) complying with subsection (c); and

(2) submit the summary document to the commissioner for approval.

Sixty (60) days after the date on which the commissioner approves the summary document, a member insurer may not deliver a policy or contract to a policy or contract owner unless the summary document is delivered to the policy or contract owner at the time of delivery of the policy or contract. The summary document must also be available upon request by a policy owner. The distribution, delivery, or contents or interpretation of the summary document does not guarantee that the policy or contract or the owner of the policy or contract is covered in the event of the impairment or insolvency of a member insurer. The summary document must be revised by the association as amendment to this chapter requires. Failure to receive the summary document does not give a policy owner, a contract owner, a certificate holder, or an insured greater rights than the rights specified in this chapter.

(c) The summary document prepared under subsection (b) must contain a clear and conspicuous disclaimer on the face of the summary document. The commissioner shall approve the form and content of the disclaimer. The disclaimer must, at a minimum, convey all the following:

(1) State the name and address of the association and the department of insurance.

(2) Prominently warn that:

(A) the association might not cover the policy or contract; and

(B) even if coverage were currently provided, coverage is:

(i) subject to substantial limitations and exclusions;

(ii) generally conditioned on continued residence in Indiana; and

(iii) subject to possible change as a result of future amendments to this chapter and court decisions.

(3) State the types of policies for which the association currently provides coverage.

(4) State that the member insurer and the member insurer's agents are prohibited by law from using the existence of the association for the purpose of selling, soliciting, or inducing

purchase of any form of insurance.

(5) State that the policy owner or contract owner should not rely on coverage under this chapter when selecting an insurer.

(6) Explain:

(A) rights available following; and

(B) procedures for filing a complaint to allege;

a violation of any provision of this chapter.

(7) Provide other information as directed by the commissioner, including sources for information that:

(A) is not proprietary; and

(B) is subject to disclosure under IC 5-14-3;

concerning the financial condition of an insurer.

(d) A member insurer shall retain evidence of compliance with subsection (b) until the policy or contract for which the notice is given is no longer in effect.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.178-2003, SEC.62; P.L.193-2006, SEC.31.

IC 27-8-9

Chapter 9. Primary Motor Vehicle Insurance Coverage

IC 27-8-9-0.3

Certain amendments intended as restatement of section 8 of this chapter; P.L.226-1993 does not affect rights, liabilities, penalties, violations, or proceedings before May 10, 1993; treatments of references to section 8 of this chapter

Sec. 0.3. (a) The amendments made to this chapter and the addition of IC 27-8-4-9.5 by P.L.226-1993 are intended to be a restatement of section 8 of this chapter (before its repeal).

(b) The substantive operation and effect of section 8 of this chapter (before its repeal) continues uninterrupted.

(c) P.L.226-1993 does not affect:

(1) rights or liabilities accrued;

(2) penalties incurred;

(3) violations committed; or

(4) proceedings begun;

before May 10, 1993. Those rights, liabilities, penalties, offenses, or proceedings continue and shall be imposed and enforced under section 8 of this chapter (before its repeal) as if P.L.226-1993 had not been enacted.

(d) A reference in a statute or rule to section 8 of this chapter shall be treated after May 10, 1993, as a reference to either of the following, whichever applies:

(1) Section 10 of this chapter, as added by P.L.226-1993.

(2) Section 11 of this chapter, as added by P.L.226-1993.

As added by P.L.220-2011, SEC.439.

IC 27-8-9-1

Repealed

(Repealed by P.L.261-1983, SEC.6.)

IC 27-8-9-2

Repealed

(Repealed by P.L.261-1983, SEC.6.)

IC 27-8-9-3

Repealed

(Repealed by P.L.261-1983, SEC.6.)

IC 27-8-9-4

Repealed

(Repealed by P.L.261-1983, SEC.6.)

IC 27-8-9-5

Application of chapter

Sec. 5. This chapter applies only to policies affording motor

vehicle insurance coverage that are issued or renewed after August 31, 1983.
As added by Acts 1980, P.L.174, SEC.1. Amended by P.L.261-1983, SEC.1; P.L.226-1993, SEC.2.

IC 27-8-9-6
Definitions

Sec. 6. (a) The definitions set forth in this section apply throughout this chapter.

(b) "Garage liability policy" refers to any motor vehicle liability insurance policy that affords coverage to a named insured engaged in the business of selling, leasing, repairing, servicing, delivering, testing, road testing, parking, or storing motor vehicles, but does not refer to a motor vehicle liability insurance policy that affords coverage to a vehicle used in the business of transporting property for hire.

(c) "Motor vehicle insurance coverage" means any type of insurance coverage described in IC 27-1-5-1, Class 2(f).

(d) "Permittee" means any person who is granted permission to operate a motor vehicle by the owner of the motor vehicle.
As added by P.L.261-1983, SEC.2. Amended by P.L.81-1991, SEC.11; P.L.226-1993, SEC.3.

IC 27-8-9-7
Coverage for a permittee or passenger

Sec. 7. (a) This section does not apply to cases covered by section 10 or 11 of this chapter.

(b) In any case arising from a permittee's use of a motor vehicle for which the owner of the vehicle has motor vehicle insurance coverage, the owner's motor vehicle insurance coverage is considered primary if both of the following apply:

(1) The vehicle, at the time damage occurred, was operated with the permission of the owner of the motor vehicle.

(2) The use was within the scope of the permission granted.

(c) The permittee may not recover under any other motor vehicle insurance coverage available to the permittee until the limit of all coverage provided by the owner's policy is first exhausted.

(d) In a case arising from an owner's use of a motor vehicle for which the owner of the vehicle has motor vehicle insurance coverage, the owner's motor vehicle insurance policy is considered primary for any claim made by a passenger in the motor vehicle.

(e) A passenger in a motor vehicle at the time a case described in subsection (b) or (d) arises may not recover under any other motor vehicle insurance coverage available to the passenger until the limit of all coverage available to the passenger under the owner's motor vehicle insurance policy is first exhausted.
As added by P.L.261-1983, SEC.3. Amended by P.L.226-1993, SEC.4; P.L.74-2009, SEC.1; P.L.93-2010, SEC.17.

IC 27-8-9-8
Repealed
(Repealed by P.L.226-1993, SEC.8.)

IC 27-8-9-9
Leased motor vehicles; leased vehicles used in transportation for hire
Sec. 9. (a) When a claim arises from the operation of a motor vehicle leased under a written lease agreement, if under the agreement the lessee agrees to provide coverage for damage resulting from his operation of the vehicle, then the motor vehicle insurance coverage of the lessee is primary. No claim may be made against any coverage available for the vehicle by the lessor until the limits of the motor vehicle insurance coverage provided by the lessee for the vehicle are exhausted.
(b) When a claim arises from the operation of a motor vehicle that is used in the business of transporting property for hire and leased under a written lease agreement, if under the agreement the lessor and lessee agree as to which coverage of the parties' motor vehicle insurance is primary coverage, then the policy of insurance providing that coverage is primary and no claim may be made against any other coverage for the vehicle until the limits of that policy are exhausted.
As added by P.L.261-1983, SEC.5. Amended by P.L.81-1991, SEC.12; P.L.226-1993, SEC.5.

IC 27-8-9-10
Garage liability policy as owner's only coverage; permittee's coverage primary
Sec. 10. (a) This section applies if the only motor vehicle insurance coverage provided by the owner of the motor vehicle is under a garage liability policy.
(b) Notwithstanding section 7 of this chapter, any coverage available to the permittee is primary.
(c) Recovery may not be made under the garage liability policy until the limits of all coverage available to the permittee have been exhausted.
As added by P.L.226-1993, SEC.6.

IC 27-8-9-11
Bailee's coverage primary
Sec. 11. (a) This section applies to a motor vehicle while under the control of either of the following:
(1) A bailee.
(2) An agent or employee of a bailee.
(b) As used in this section, "bailee" refers only to a person who is in the business of storing, parking, servicing, or repairing vehicles.
(c) Notwithstanding section 7 of this chapter, any coverage available to the bailee is primary.

(d) Recovery may not be made under the vehicle owner's policy until the limits of all motor vehicle insurance coverage available to the bailee have been exhausted.
As added by P.L.226-1993, SEC.7.

IC 27-8-10

Chapter 10. Comprehensive Health Insurance

IC 27-8-10-0.1

Application of certain amendments to chapter

Sec. 0.1. The following amendments to this chapter apply as follows:

(1) The addition of section 10 of this chapter by P.L.93-1995 applies to all small employer health insurance plans issued or renewed under IC 27-8-15, as amended by P.L.93-1995, after December 31, 1995.

(2) The addition of sections 3.5 and 3.6 of this chapter by P.L.193-2003 applies to an association policy that is issued, delivered, amended, or renewed after June 30, 2003.

(3) The amendments made to sections 2.1, 5.1, and 6 of this chapter by P.L.193-2003 apply to an association policy that is issued, delivered, amended, or renewed after June 30, 2003.

(4) The addition of section 3.2 of this chapter by P.L.51-2004 applies to any billing that occurs on or after March 16, 2004, regardless of when the health care services to which the bill applies were provided.

As added by P.L.220-2011, SEC.440.

IC 27-8-10-0.5

Dissolution of the association

Sec. 0.5. (a) Except as provided in this section, the insurance operations of the association cease on the later of:

(1) the date on which a health benefit exchange (as defined in IC 27-19-2-8) begins operating in Indiana; or

(2) December 31, 2013.

(b) A claim for payment under an association policy must be made to the association not later than the later of:

(1) sixty (60) days after the date on which the insurance operations cease under subsection (a); or

(2) March 1, 2014.

(c) An appeal or grievance under this chapter must be resolved not later than ninety (90) days after the date on which the insurance operations cease under subsection (a).

(d) Balance billing under this chapter by a health care provider that is not a member of a health care provider network arrangement used by the association is prohibited after the later of:

(1) ninety (90) days after the date on which the insurance operations cease under subsection (a); or

(2) March 30, 2014.

(e) The association shall, not later than June 30, 2013, submit to the commissioner a plan of dissolution for the association. The following apply to a plan of dissolution submitted under this subsection:

(1) The plan of dissolution must provide for the following:
(A) Continuity of care for an individual who is covered under an association policy and is an inpatient on the date on which the insurance operations cease under subsection (a).
(B) A final accounting described in section 2.1(g) of this chapter of the:
(i) assessments; and
(ii) cessation of the liability;
of members of the association.
(C) Resolution of any net asset deficiency.
(D) Cessation of all liability of the association.
(E) Final dissolution of the association.
(2) The plan of dissolution may provide that, with the approval of the board and the commissioner, a power or duty of the association may be delegated to a person that is to perform functions similar to the functions of the association.

(f) The commissioner shall, after notice and hearing, approve a plan of dissolution submitted under subsection (e) if the commissioner determines that the plan:
(1) is suitable to ensure the fair, reasonable, and equitable dissolution of the association; and
(2) complies with subsection (e).

(g) A plan of dissolution submitted under subsection (e) is effective upon the written approval of the commissioner.

(h) An action by or against the association must be filed not more than one (1) year after the date on which the insurance operations cease under subsection (a).

(i) This chapter expires on the date on which final dissolution of the association occurs under the plan of dissolution approved by the commissioner under subsection (f).

(j) Funds remaining in the association on the date on which final dissolution of the association occurs must be transferred into the state general fund.

(k) The association, or the person to which the association delegates powers or duties under subsection (e), may implement this section in accordance with the plan of dissolution approved by the commissioner under subsection (f).

As added by P.L.278-2013, SEC.26.

IC 27-8-10-1
Definitions

Sec. 1. (a) The definitions in this section apply throughout this chapter.

(b) "Association" means the Indiana comprehensive health insurance association established under section 2.1 of this chapter.

(c) "Association policy" means a policy issued by the association that provides coverage specified in section 3 of this chapter. The term does not include a Medicare supplement policy that is issued

under section 9 of this chapter.

(d) "Carrier" means an insurer providing medical, hospital, or surgical expense incurred health insurance policies.

(e) "Church plan" means a plan defined in the federal Employee Retirement Income Security Act of 1974 under 26 U.S.C. 414(e).

(f) "Commissioner" refers to the insurance commissioner.

(g) "Creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

(h) "Eligible expenses" means those charges for health care services and articles provided for in section 3 of this chapter.

(i) "Federal income poverty level" has the meaning set forth in IC 12-15-2-1.

(j) "Federally eligible individual" means an individual:

(1) for whom, as of the date on which the individual seeks coverage under this chapter, the aggregate period of creditable coverage is at least eighteen (18) months and whose most recent prior creditable coverage was under a:

(A) group health plan;

(B) governmental plan; or

(C) church plan;

or health insurance coverage in connection with any of these plans;

(2) who is not eligible for coverage under:

(A) a group health plan;

(B) Part A or Part B of Title XVIII of the federal Social Security Act; or

(C) a state plan under Title XIX of the federal Social Security Act (or any successor program);

and does not have other health insurance coverage;

(3) with respect to whom the individual's most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;

(4) who, if after being offered the option of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (29 U.S.C. 1191b(d)(1)), or under a similar state program, elected such coverage; and

(5) who, if after electing continuation coverage described in subdivision (4), has exhausted continuation coverage under the provision or program.

(k) "Governmental plan" means a plan as defined under the federal Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(d)) and any plan established or maintained for its employees by the United States government or by any agency or instrumentality of the United States government.

(l) "Group health plan" means an employee welfare benefit plan (as defined in 29 U.S.C. 1167(1)) to the extent that the plan provides medical care payments to, or on behalf of, employees or their

dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

(m) "Health care facility" means any institution providing health care services that is licensed in this state, including institutions engaged principally in providing services for health maintenance organizations or for the diagnosis or treatment of human disease, pain, injury, deformity, or physical condition, including a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, home health care agency, bioanalytical laboratory, or central services facility servicing one (1) or more such institutions.

(n) "Health care institutions" means skilled nursing facilities, home health agencies, and hospitals.

(o) "Health care provider" means any physician, hospital, pharmacist, or other person who is licensed in Indiana to furnish health care services.

(p) "Health care services" means any services or products included in the furnishing to any individual of medical care, dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(q) "Health insurance" means hospital, surgical, and medical expense incurred policies, nonprofit service plan contracts, health maintenance organizations, limited service health maintenance organizations, and self-insured plans. However, the term "health insurance" does not include short term travel accident policies, accident only policies, fixed indemnity policies, automobile medical payment, or incidental coverage issued with or as a supplement to liability insurance.

(r) "Insured" means all individuals who are provided qualified comprehensive health insurance coverage under an individual policy, including all dependents and other insured persons, if any.

(s) "Medicaid" means medical assistance provided by the state under the Medicaid program under IC 12-15.

(t) "Medical care payment" means amounts paid for:

(1) the diagnosis, care, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(2) transportation primarily for and essential to Medicare services referred to in subdivision (1); and

(3) insurance covering medical care referred to in subdivisions (1) and (2).

(u) "Medically necessary" means health care services that the association has determined:

(1) are recommended by a legally qualified physician;

(2) are commonly and customarily recognized throughout the physician's profession as appropriate in the treatment of the patient's diagnosed illness; and

(3) are not primarily for the scholastic education or career and technical training of the provider or patient.

(v) "Medicare" means Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).

(w) "Policy" means a contract, policy, or plan of health insurance.

(x) "Policy year" means a twelve (12) month period during which a policy provides coverage or obligates the carrier to provide health care services.

(y) "Health maintenance organization" has the meaning set out in IC 27-13-1-19.

(z) "Resident" means an individual who is:

(1) legally domiciled in Indiana for at least twelve (12) months before applying for an association policy; or

(2) a federally eligible individual and legally domiciled in Indiana.

(aa) "Self-insurer" means an employer who provides services, payment for, or reimbursement of any part of the cost of health care services other than payment of insurance premiums or subscriber charges to a carrier. However, the term "self-insurer" does not include an employer who is exempt from state insurance regulation by federal law, or an employer who is a political subdivision of the state of Indiana.

(bb) "Services of a skilled nursing facility" means services that must commence within fourteen (14) days following a confinement of at least three (3) consecutive days in a hospital for the same condition.

(cc) "Skilled nursing facility", "home health agency", "hospital", and "home health services" have the meanings assigned to them in 42 U.S.C. 1395x.

(dd) "Medicare supplement policy" means an individual policy of accident and sickness insurance that is designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, and surgical expenses of individuals who are eligible for Medicare benefits.

(ee) "Limited service health maintenance organization" has the meaning set forth in IC 27-13-34-4.

As added by Acts 1981, P.L.249, SEC.1. Amended by P.L.253-1989, SEC.1; P.L.1-1990, SEC.260; P.L.2-1992, SEC.785; P.L.26-1994, SEC.13; P.L.116-1994, SEC.64; P.L.2-1995, SEC.107; P.L.188-1995, SEC.8; P.L.91-1998, SEC.12; P.L.1-2001, SEC.33; P.L.193-2003, SEC.3; P.L.234-2007, SEC.165.

IC 27-8-10-2
Repealed

(Repealed by P.L.1-1990, SEC.261.)

IC 27-8-10-2.1
Comprehensive health insurance association; establishment; board of directors; plan of operation; powers and duties

Sec. 2.1. (a) There is established a nonprofit legal entity to be referred to as the Indiana comprehensive health insurance association, which must assure that health insurance is made available throughout the year to each eligible Indiana resident applying to the association for coverage. All carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers providing health insurance or health care services in Indiana must be members of the association. The association shall operate under a plan of operation established and approved under subsection (c) and shall exercise its powers through a board of directors established under this section.

(b) The board of directors of the association consists of nine (9) members whose principal residence is in Indiana selected as follows:

(1) Four (4) members to be appointed by the commissioner from the members of the association, one (1) of which must be a representative of a health maintenance organization.

(2) Two (2) members to be appointed by the commissioner shall be consumers representing policyholders.

(3) Two (2) members shall be the state budget director or designee and the commissioner of the department of insurance or designee.

(4) One (1) member to be appointed by the commissioner must be a representative of health care providers.

The commissioner shall appoint the chairman of the board, and the board shall elect a secretary from its membership. The term of office of each appointed member is three (3) years, subject to eligibility for reappointment. Members of the board who are not state employees may be reimbursed from the association's funds for expenses incurred in attending meetings. The board shall meet at least semiannually, with the first meeting to be held not later than May 15 of each year.

(c) The association shall submit to the commissioner a plan of operation for the association and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation becomes effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. The commissioner shall, after notice and hearing, approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association and provides for the sharing of association losses on an equitable, proportionate basis among the member carriers, health maintenance organizations, limited service health maintenance organizations, and

self-insurers. If the association fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules under IC 4-22-2 necessary or advisable to implement this section. These rules are effective until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. The plan of operation must:

(1) establish procedures for the handling and accounting of assets and money of the association;

(2) establish the amount and method of reimbursing members of the board;

(3) establish regular times and places for meetings of the board of directors;

(4) establish procedures for records to be kept of all financial transactions and for the annual fiscal reporting to the commissioner;

(5) establish procedures whereby selections for the board of directors will be made and submitted to the commissioner for approval;

(6) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and

(7) establish procedures for the periodic advertising of the general availability of the health insurance coverages from the association.

(d) The plan of operation may provide that any of the powers and duties of the association be delegated to a person who will perform functions similar to those of this association. A delegation under this section takes effect only with the approval of both the board of directors and the commissioner. The commissioner may not approve a delegation unless the protections afforded to the insured are substantially equivalent to or greater than those provided under this chapter.

(e) The association has the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner under subsection (c). The association has the general powers and authority granted under the laws of Indiana to carriers licensed to transact the kinds of health care services or health insurance described in section 1 of this chapter and also has the specific authority to do the following:

(1) Enter into contracts as are necessary or proper to carry out this chapter, subject to the approval of the commissioner.

(2) Subject to section 2.6 of this chapter, sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers.

(3) Take legal action necessary to avoid the payment of

improper claims against the association or the coverage provided by or through the association.

(4) Establish a medical review committee to determine the reasonably appropriate level and extent of health care services in each instance.

(5) Establish appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the reasonable operational expenses of the association.

(6) Pool risks among members.

(7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by this chapter.

(8) Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.

(9) Operate and administer any combination of plans, pools, or other mechanisms considered appropriate to best accomplish the fair and equitable operation of the association.

(10) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(11) Hire an independent consultant.

(12) Develop a method of advising applicants of the availability of other coverages outside the association.

(13) Provide for the use of managed care plans for insureds, including the use of:

(A) health maintenance organizations; and

(B) preferred provider plans.

(14) Solicit bids directly from providers for coverage under this chapter.

(15) Subject to section 3 of this chapter, negotiate reimbursement rates and enter into contracts with individual health care providers and health care provider groups.

(f) Rates for coverages issued by the association may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate scales of premium rates based on age apply for individual risks. Premium rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification must be equal to one hundred fifty percent (150%) of the average premium rate for that class charged by the five (5) carriers with the largest premium volume in the state during the preceding calendar year. In determining the average rate of the five (5) largest carriers, the rates charged by the carriers shall be actuarially adjusted to determine the rate that would have been charged for benefits substantially identical to those issued by the

association. All rates adopted by the association must be submitted to the commissioner for approval.

(g) Following the close of the association's fiscal year, the association shall determine the net premiums, the expenses of administration, and the incurred losses for the year. Twenty-five percent (25%) of any net loss shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums as reported to the department of insurance, excluding premiums for Medicaid contracts with the state of Indiana, received in Indiana during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association. Seventy-five percent (75%) of any net loss shall be paid by the state. In sharing losses, the association may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for interim assessments against members of the association if necessary to assure the financial capability of the association to meet the incurred or estimated claims expenses or operating expenses of the association until the association's next fiscal year is completed. Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums. Assessments must be determined by the board members specified in subsection (b)(1), subject to final approval by the commissioner.

(h) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association, and the association shall have an annual audit of its operations by an independent certified public accountant.

(i) The association is subject to examination by the department of insurance under IC 27-1-3.1. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

(j) All policy forms issued by the association must conform in substance to prototype forms developed by the association, must in all other respects conform to the requirements of this chapter, and must be filed with and approved by the commissioner before their use.

(k) The association may not issue an association policy to any individual who, on the effective date of the coverage applied for, does not meet the eligibility requirements of section 5.1 of this chapter.

(l) The association and the premium collected by the association shall be exempt from the premium tax, the adjusted gross income tax, or any combination of these upon revenues or income that may be imposed by the state.

(m) Members who, during any calendar year, have paid one (1) or more assessments levied under this chapter may include in the rates for premiums charged for insurance policies to which this chapter

applies amounts sufficient to recoup a sum equal to the amounts paid to the association by the member less any amounts returned to the member insurer by the association, and the rates shall not be deemed excessive by virtue of including an amount reasonably calculated to recoup assessments paid by the member.

(n) The association shall provide for the option of monthly collection of premiums.

(o) The association shall periodically certify to the budget agency the amount necessary to pay seventy-five percent (75%) of any net loss as specified in subsection (g).

As added by P.L.1-1990, SEC.262. Amended by P.L.26-1991, SEC.27; P.L.1-1994, SEC.136; P.L.116-1994, SEC.65; P.L.26-1994, SEC.14; P.L.2-1995, SEC.108; P.L.255-1995, SEC.9; P.L.91-1998, SEC.13; P.L.192-2002(ss), SEC.169; P.L.178-2003, SEC.63; P.L.193-2003, SEC.4; P.L.97-2004, SEC.99; P.L.51-2004, SEC.1; P.L.1-2007, SEC.186; P.L.229-2011, SEC.251.

IC 27-8-10-2.2

(As added by P.L.51-2004, SEC.2. Repealed by P.L.1-2007, SEC.248.)

IC 27-8-10-2.3

Reporting requirements

Sec. 2.3. (a) A member shall, not later than October 31 of each year, certify an independently audited report to the:

(1) association;
(2) legislative council; and
(3) department of insurance;

of the amount of tax credits taken against assessments by the member under section 2.1 (as in effect December 31, 2004) or 2.4 of this chapter during the previous calendar year. A report certified under this section to the legislative council must be in an electronic format under IC 5-14-6.

(b) A member shall, not later than October 31 of each year, certify an independently audited report to the association of the amount of assessments paid by the member against which a tax credit has not been taken under section 2.1 (as in effect December 31, 2004) or 2.4 of this chapter as of the date of the report.

As added by P.L.167-2002, SEC.1. Amended by P.L.28-2004, SEC.168; P.L.51-2004, SEC.3; P.L.2-2005, SEC.72; P.L.1-2006, SEC.488.

IC 27-8-10-2.4

Tax credits

Sec. 2.4. (a) Beginning January 1, 2005, a member that, before January 1, 2005, has:

(1) paid an assessment; and
(2) not taken a credit against taxes;

under section 2.1 of this chapter (as in effect December 31, 2004) is not entitled to claim or carry forward the unused tax credit except as provided in this section.

(b) A member described in subsection (a) may, for each taxable year beginning after December 31, 2006, take a credit of not more than ten percent (10%) of the amount of the assessments paid before January 1, 2005, against which a tax credit has not been taken before January 1, 2005. A credit under this subsection may be taken against premium taxes, adjusted gross income taxes, or any combination of these, or similar taxes upon revenues or income of the member that may be imposed by the state, up to the amount of the taxes due for each taxable year.

(c) If the maximum amount of a tax credit determined under subsection (b) for a taxable year exceeds a member's liability for the taxes described in subsection (b), the member may carry the unused portion of the tax credit forward to subsequent taxable years. Tax credits carried forward under this subsection are not subject to the ten percent (10%) limit set forth in subsection (b).

(d) The total amount of credits taken by a member under this section in all taxable years may not exceed the total amount of assessments paid by the member before January 1, 2005, minus the total amount of tax credits taken by the member under section 2.1 of this chapter (as in effect December 31, 2004) before January 1, 2005.
As added by P.L.51-2004, SEC.4.

IC 27-8-10-2.5
Members; general requirements

Sec. 2.5. (a) A member shall comply with the association's plan of operation.

(b) A member assessment under section 2.1 of this chapter is due not more than thirty (30) days after the member receives written notice of the assessment. A member that pays an assessment after the due date shall pay interest on the assessment at the rate of six percent (6%) per annum.
As added by P.L.51-2004, SEC.5.

IC 27-8-10-2.6
Member and health care provider grievances

Sec. 2.6. (a) If a:

(1) member is aggrieved by an act of the association; or

(2) health care provider is aggrieved by an act of the association with respect to reimbursement to the provider under an association policy;

the member or health care provider shall, not more than ninety (90) days after the act occurs, appeal to the board of directors for review of the act.

(b) If:

(1) within thirty (30) days after an appeal is filed under

subsection (a), the board of directors has not acted on the appeal; or

(2) a member or health care provider is aggrieved by a final action or decision of the board of directors;

the member or health care provider may appeal to the commissioner.

(c) An appeal to the commissioner under subsection (b) must be filed less than thirty (30) days after the:

(1) expiration of the thirty (30) day period specified in subsection (b)(1); or

(2) action or decision specified in subsection (b)(2).

(d) The commissioner shall, not more than forty-five (45) days after an appeal is filed under subsection (c), take a final action or issue an order regarding the appeal.

(e) A final action or order of the commissioner on an appeal filed under this section is subject to judicial review.

(f) If a member or health care provider sues the association, the court shall not award to the member or health care provider:

(1) attorney's fees or costs; or

(2) punitive damages.

As added by P.L.51-2004, SEC.6.

IC 27-8-10-3

Association policy coverage; reimbursement methods; eligible expenses; managed care

Sec. 3. (a) An association policy issued under this chapter may pay an amount for medically necessary eligible expenses related to the diagnosis or treatment of illness or injury that exceed the deductible and coinsurance amounts applicable under section 4 of this chapter. Payment under an association policy must be based on one (1) or a combination of the following reimbursement methods, as determined by the board of directors:

(1) The association's usual and customary fee schedule in effect on January 1, 2004. If payment is based on the usual and customary fee schedule in effect on January 1, 2004, the rates of reimbursement under the fee schedule must be adjusted annually by a percentage equal to the percentage change in the Indiana medical care component of the Consumer Price Index for all Urban Consumers, as published by the United States Bureau of Labor Statistics during the preceding calendar year.

(2) A health care provider network arrangement. If payment is based on a health care provider network arrangement, reimbursement under an association policy must be made according to:

(A) a network fee schedule for network health care providers and nonnetwork health care providers; and

(B) any additional coinsurance that applies to the insured under the association policy if the insured obtains health care services from a nonnetwork health care provider.

(3) Reimbursement for an eligible expense in an amount equal to not less than the federal Medicare reimbursement rate for the eligible expense plus ten percent (10%).

(b) Eligible expenses are the charges for the following health care services and articles to the extent furnished by a health care provider in an emergency situation or furnished or prescribed by a physician:

(1) Hospital services, including charges for the institution's most common semiprivate room, and for private room only when medically necessary, but limited to a total of one hundred eighty (180) days in a year.

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, that are rendered by a physician or, at the physician's direction, by the physician's staff of registered or licensed nurses, and allied health professionals.

(3) The first twenty (20) professional visits for the diagnosis or treatment of one (1) or more mental conditions rendered during the year by one (1) or more physicians or, at their direction, by their staff of registered or licensed nurses, and allied health professionals.

(4) Drugs and contraceptive devices requiring a physician's prescription.

(5) Services of a skilled nursing facility for not more than one hundred eighty (180) days in a year.

(6) Services of a home health agency up to two hundred seventy (270) days of service a year.

(7) Use of radium or other radioactive materials.

(8) Oxygen.

(9) Anesthetics.

(10) Prostheses, other than dental.

(11) Rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed.

(12) Diagnostic X-rays and laboratory tests.

(13) Oral surgery for:

(A) excision of partially or completely erupted impacted teeth;

(B) excision of a tooth root without the extraction of the entire tooth; or

(C) the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(14) Services of a physical therapist and services of a speech therapist.

(15) Professional ambulance services to the nearest health care facility qualified to treat the illness or injury.

(16) Other medical supplies required by a physician's orders.

An association policy may also include comparable benefits for those who rely upon spiritual means through prayer alone for healing upon

such conditions, limitations, and requirements as may be determined by the board of directors.

(c) A managed care organization that issues an association policy may not refuse to enter into an agreement with a hospital solely because the hospital has not obtained accreditation from an accreditation organization that:

(1) establishes standards for the organization and operation of hospitals;

(2) requires the hospital to undergo a survey process for a fee paid by the hospital; and

(3) was organized and formed in 1951.

(d) This section does not prohibit a managed care organization from using performance indicators or quality standards that:

(1) are developed by private organizations; and

(2) do not rely upon a survey process for a fee charged to the hospital to evaluate performance.

(e) For purposes of this section, if benefits are provided in the form of services rather than cash payments, their value shall be determined on the basis of their monetary equivalency.

(f) The following are not eligible expenses in any association policy within the scope of this chapter:

(1) Services for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay.

(2) Services and charges made for benefits provided under the laws of the United States, including Medicare and Medicaid, military service connected disabilities, medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, medical services financed in the future on behalf of all citizens by the United States.

(3) Benefits which would duplicate the provision of services or payment of charges for any care for injury or disease either:

(A) arising out of and in the course of an employment subject to a worker's compensation or similar law; or

(B) for which benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance.

However, this subdivision does not authorize exclusion of charges that exceed the benefits payable under the applicable worker's compensation or no-fault coverage.

(4) Care which is primarily for a custodial or domiciliary purpose.

(5) Cosmetic surgery unless provided as a result of an injury or medically necessary surgical procedure.

(6) Any charge for services or articles the provision of which is not within the scope of the license or certificate of the

institution or individual rendering the services.

(g) The coverage and benefit requirements of this section for association policies may not be altered by any other inconsistent state law without specific reference to this chapter indicating a legislative intent to add or delete from the coverage requirements of this chapter.

(h) This chapter does not prohibit the association from issuing additional types of health insurance policies with different types of benefits that, in the opinion of the board of directors, may be of benefit to the citizens of Indiana.

(i) This chapter does not prohibit the association or its administrator from implementing uniform procedures to review the medical necessity and cost effectiveness of proposed treatment, confinement, tests, or other medical procedures. Those procedures may take the form of preadmission review for nonemergency hospitalization, case management review to verify that covered individuals are aware of treatment alternatives, or other forms of utilization review. Any cost containment techniques of this type must be adopted by the board of directors and approved by the commissioner.

As added by Acts 1981, P.L.249, SEC.1. Amended by P.L.28-1988, SEC.106; P.L.253-1989, SEC.3; P.L.116-1994, SEC.66; P.L.259-1995, SEC.1; P.L.51-2004, SEC.7; P.L.229-2011, SEC.252.

IC 27-8-10-3.2
Balance billing

Sec. 3.2. Except as provided in section 3.6 of this chapter, a health care provider shall not bill an insured for any amount that exceeds:

(1) the payment made by the association under the association policy for eligible expenses incurred by the insured; and

(2) any copayment, deductible, or coinsurance amounts applicable under the association policy.

As added by P.L.51-2004, SEC.8.

IC 27-8-10-3.5
Chronic disease and pharmaceutical management programs

Sec. 3.5. (a) The association shall:

(1) approve and implement chronic disease management and pharmaceutical management programs based on:

(A) an analysis of the highest cost health care services covered under association policies;

(B) a review of chronic disease management and pharmaceutical management programs used in populations similar to insureds; and

(C) a determination of the chronic disease management and pharmaceutical management programs expected to best improve health outcomes in a cost effective manner;

(2) consider recommendations of the drug utilization review

board established by IC 12-15-35-19 concerning chronic disease management and pharmaceutical management programs;

(3) when practicable, coordinate programs adopted under this section with comparable programs implemented by the state; and

(4) implement a copayment structure for prescription drugs covered under an association policy.

(b) A program approved and implemented under this section may not require prior authorization for a prescription drug that is prescribed for the treatment of:

(1) human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) and is included on the AIDS drug assistance program formulary adopted by the state department of health under the federal Ryan White CARE Act (42 U.S.C. 300ff et seq.); or

(2) hemophilia according to recommendations of the:

(A) Advisory Committee on Blood Safety and Availability of the United States Department of Health and Human Services; or

(B) Medical and Scientific Advisory Council of the National Hemophilia Foundation.

(c) The copayment structure implemented under subsection (a) must be based on an annual actuarial analysis.

(d) A disease management program for which federal funding is available is considered to be approved by the association under this section.

(e) An insured who has a chronic disease for which at least one (1) chronic disease management program is approved under this section shall participate in an approved chronic disease management program for the chronic disease as a condition of coverage of treatment for the chronic disease under an association policy.

As added by P.L.193-2003, SEC.5.

IC 27-8-10-3.6

Mail order or Internet based pharmacy

Sec. 3.6. (a) The association shall approve a mail order or Internet based pharmacy (as defined in IC 25-26-18-1) through which an insured may obtain prescription drugs covered under an association policy.

(b) A prescription drug that is covered under an association policy is covered if the prescription drug is obtained from:

(1) a pharmacy approved under subsection (a); or

(2) a pharmacy that:

(A) is not approved under subsection (a); and

(B) agrees to sell the prescription drug at the same price as a pharmacy approved under subsection (a).

(c) A prescription drug that is:

(1) covered under an association policy; and

(2) obtained from a pharmacy not described in subsection (b); is covered for an amount equal to the price at which a pharmacy described in subsection (b) will sell the prescription drug, with the remainder of the charge for the prescription drug to be paid by the insured.

As added by P.L.193-2003, SEC.6.

IC 27-8-10-4

Policies; deductible and coinsurance requirements; limitations

Sec. 4. (a) Subject to the limitation provided in subsection (c), an association policy offered in accordance with this chapter must impose a five hundred dollar ($500) deductible on a per person per policy year basis. The deductible must be applied to the first five hundred dollars ($500) of eligible expenses incurred by the covered person.

(b) Subject to the limitation provided in subsection (c), a mandatory coinsurance requirement shall be imposed at the rate of twenty percent (20%) of eligible expenses in excess of the mandatory deductible.

(c) The maximum aggregate out-of-pocket payments for eligible expenses by the insured in the form of deductibles and coinsurance may not exceed one thousand five hundred dollars ($1,500) per individual or two thousand five hundred dollars ($2,500) per family, per policy year.

As added by Acts 1981, P.L.249, SEC.1. Amended by P.L.253-1989, SEC.4.

IC 27-8-10-5

Repealed

(Repealed by P.L.1-1990, SEC.263.)

IC 27-8-10-5.1

Policies; eligible persons; dependent coverage; preexisting conditions

Sec. 5.1. (a) A person is not eligible for an association policy if the person is eligible for any of the coverage described in subdivisions (1) and (2). A person other than a federally eligible individual may not apply for an association policy unless the person has applied for:

(1) Medicaid; and

(2) coverage under the:

(A) preexisting condition insurance plan program established by the Secretary of Health and Human Services under Section 1101 of Title I of the federal Patient Protection and Affordable Care Act (P.L. 111-148); and

(B) healthy Indiana plan under IC 12-15-44.2;

not more than sixty (60) days before applying for the association policy.

(b) Except as provided in subsection (c), a person is not eligible for an association policy if, at the effective date of coverage, the person has or is eligible for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana as set forth in IC 27. However, an offer of coverage described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed), IC 27-8-5-2.7, IC 27-8-5-19.2(e) (expired July 1, 2007, and repealed), or IC 27-8-5-19.3 does not affect an individual's eligibility for an association policy under this subsection. Coverage under any association policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

(c) Except as provided in IC 27-13-16-4 and subsection (a), a person is eligible for an association policy upon a showing that:

(1) the person has been rejected by one (1) carrier for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana, as set forth in IC 27, without material underwriting restrictions;

(2) an insurer has refused to issue insurance except at a rate exceeding the association plan rate; or

(3) the person is a federally eligible individual.

For the purposes of this subsection, eligibility for Medicare coverage does not disqualify a person who is less than sixty-five (65) years of age from eligibility for an association policy.

(d) Coverage under an association policy terminates as follows:

(1) On the first date on which an insured is no longer a resident of Indiana.

(2) On the date on which an insured requests cancellation of the association policy.

(3) On the date of the death of an insured.

(4) At the end of the policy period for which the premium has been paid.

(5) On the first date on which the insured no longer meets the eligibility requirements under this section.

(e) An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not operate to terminate a dependent unmarried child's coverage while the dependent is and continues to be both:

(1) incapable of self-sustaining employment by reason of a mental, intellectual, or physical disability; and

(2) chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the

child's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(f) An association policy that provides coverage for a family member of the person in whose name the contract is issued must, as to the family member's coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children must consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium must be furnished to the carrier within thirty-one (31) days after the date of birth in order to have the coverage continued beyond the thirty-one (31) day period.

(g) Except as provided in subsection (h), an association policy may contain provisions under which coverage is excluded during a period of three (3) months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of three (3) months before the effective date of coverage. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(h) If a person applies for an association policy within six (6) months after termination of the person's coverage under a health insurance arrangement and the person meets the eligibility requirements of subsection (c), then an association policy may not contain provisions under which:

(1) coverage as to a given individual is delayed to a date after the effective date or excluded from the policy; or

(2) coverage as to a given condition is denied;

on the basis of a preexisting health condition. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(i) For purposes of this section, coverage under a health insurance arrangement includes, but is not limited to, coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.

As added by P.L.1-1990, SEC.264. Amended by P.L.23-1993, SEC.155; P.L.130-1994, SEC.46; P.L.116-1994, SEC.67; P.L.26-1994, SEC.15; P.L.2-1995, SEC.109; P.L.91-1998, SEC.14; P.L.207-1999, SEC.5 and P.L.233-1999, SEC.11; P.L.193-2003, SEC.7; P.L.211-2003, SEC.5; P.L.97-2004, SEC.100; P.L.211-2005, SEC.3; P.L.3-2008, SEC.213; P.L.229-2011, SEC.253; P.L.117-2015, SEC.39; P.L.213-2015, SEC.252.

IC 27-8-10-6
Policies; renewal provisions; election to continue coverage upon death of policyholder

Sec. 6. (a) An association policy offered under this chapter must contain provisions under which the association is obligated to renew the contract until:

(1) the date on which coverage terminates under section 5.1 of this chapter; or

(2) the day on which the individual in whose name the contract is issued first becomes eligible for Medicare coverage, except that in a family policy covering both husband and wife, the age of the younger spouse must be used as the basis for meeting the durational requirement of this subdivision.

(b) The association may not change the rates for association policies or Medicare supplement policies except on a class basis with a clear disclosure in the policy of the association's right to do so.

(c) An association policy offered under this chapter must provide that upon the death of the individual in whose name the contract is issued, every other individual then covered under the contract may elect, within a period specified in the contract, to continue coverage under the same or a different contract until such time as he would have ceased to be entitled to coverage had the individual in whose name the contract was issued lived.

As added by Acts 1981, P.L.249, SEC.1. Amended by P.L.116-1994, SEC.68; P.L.193-2003, SEC.8.

IC 27-8-10-7
Rules; adoption

Sec. 7. The commissioner may adopt rules, under IC 4-22-2, that:

(1) provide for disclosure by carriers of the availability of insurance coverage from the association; and

(2) implement this chapter.

As added by Acts 1981, P.L.249, SEC.1.

IC 27-8-10-8
Civil or criminal liability of association or members

Sec. 8. Neither the participation by carriers or members in the association, the establishment of rates, forms, or procedures for coverages issued by the association, nor any joint or collective action required by this chapter shall be the basis of any legal action, civil, or criminal liability against the association or members of it either jointly or separately.

As added by Acts 1981, P.L.249, SEC.1.

IC 27-8-10-9
Medicare supplement policies

Sec. 9. (a) The association may issue Medicare supplement policies to individuals who reside in Indiana.

(b) A Medicare supplement policy issued under this section:

(1) must be based on a model policy adopted by the commissioner under IC 27-8-13-10.1; and

(2) must meet the standards for Medicare supplement policy benefits established under IC 27-8-13-10.1.

(c) A Medicare supplement policy issued under this section is not subject to the deductible and coinsurance requirements and the eligibility restrictions applying to association policies under sections 4 and 5.1 of this chapter. However, the association may provide that an individual is not eligible for a Medicare supplement policy issued under this section unless the individual has applied to one (1) carrier for a Medicare supplement policy and the application of the individual has been rejected.

As added by P.L.116-1994, SEC.69.

IC 27-8-10-10

Eligibility guidelines

Sec. 10. Before January 1, 1996, the board of directors of the association shall establish eligibility guidelines for the issuance of an association policy under this chapter to prohibit an:

(1) employer;

(2) insurance producer; or

(3) insurance broker;

from placing in or referring to the association an individual who works for an employer who offers employees an employee welfare benefit plan (as defined in 29 U.S.C. 1002).

As added by P.L.93-1995, SEC.9. Amended by P.L.178-2003, SEC.64.

IC 27-8-10-11.2

Use of diagnostic or procedure codes

Sec. 11.2. (a) Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:

(1) the association shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the association pays claims for services provided under an association policy; and

(2) a health care provider shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);
(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);
(D) current dental terminology (CDT);
(E) Healthcare common procedure coding system (HCPCS); and
(F) third party administrator (TPA);

codes under which the health care provider submits claims for payment for services provided under an association policy.

(b) If a health care provider provides services that are covered under an association policy:

(1) after the effective date of the most current version of a diagnostic or procedure code described in subsection (a); and
(2) before the association begins using the most current version of the diagnostic or procedure code;

the association shall reimburse the health care provider under the version of the diagnostic or procedure code that was in effect on the date that the services were provided.

As added by P.L.161-2001, SEC.3. Amended by P.L.66-2002, SEC.15.

IC 27-8-10-12
Repealed

(As added by P.L.193-2003, SEC.9. Repealed by P.L.51-2004, SEC.10.)

IC 27-8-10-13
Repealed

(As added by P.L.193-2003, SEC.10. Repealed by P.L.51-2004, SEC.10.)

IC 27-8-10-14
Repealed

(As added by P.L.193-2003, SEC.11. Amended by P.L.97-2004, SEC.101; P.L.51-2004, SEC.9. Repealed by P.L.1-2007, SEC.248.)

IC 27-8-10.1
Repealed

(Repealed by P.L.30-2016, SEC.42.)

IC 27-8-11

Chapter 11. Accident and Sickness Insurance–Reimbursement Agreements

IC 27-8-11-0.1

Application of certain amendments to chapter

Sec. 0.1. The addition of section 9 of this chapter by P.L.74-2007 applies to an agreement between an insurer and a provider that is entered into, amended, or renewed on or after April 26, 2007.

As added by P.L.220-2011, SEC.441.

IC 27-8-11-1

Definitions

Sec. 1. (a) The definitions in this section apply throughout this chapter.

(b) "Credentialing" means a process through which an insurer makes a determination:

(1) based on criteria established by the insurer; and

(2) concerning whether a provider is eligible to:

(A) provide health care services to an insured; and

(B) receive reimbursement for the health care services;

under an agreement entered into between the provider and the insurer under section 3 of this chapter.

(c) "Health care services":

(1) means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization; and

(2) includes hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

(d) "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy issued or administered by an insurer.

(e) "Insurer" means an insurance company authorized in this state to issue policies that provide reimbursement for expenses of health care services.

(f) "Person" means an individual, an agency, a political subdivision, a partnership, a corporation, an association, or any other entity.

(g) "Preferred provider plan" means an undertaking to enter into agreements with providers relating to terms and conditions of reimbursements for the health care services of insureds, members, or enrollees relating to the amounts to be charged to insureds, members, or enrollees for health care services.

(h) "Provider" means an individual or entity duly licensed or legally authorized to provide health care services.

As added by P.L.140-1984, SEC.1. Amended by P.L.31-1988, SEC.22; P.L.26-2005, SEC.1.

IC 27-8-11-2
Conflicting provisions

Sec. 2. To the extent of any conflict between this chapter and IC 27-4-1-4, IC 27-8-5-15, IC 27-8-6-1, or any other statutory provision, this chapter prevails over the conflicting provision. Agreements may be entered into under section 3(a)(1) of this chapter notwithstanding any contradictory policy provision prescribed under IC 27-8-5-3(a)(9).

As added by P.L.140-1984, SEC.1. Amended by P.L.1-2010, SEC.111.

IC 27-8-11-3
Reimbursement agreements; immunity

Sec. 3. (a) An insurer may:

(1) enter into agreements with providers relating to terms and conditions of reimbursement for health care services that may be rendered to insureds of the insurer, including agreements relating to the amounts to be charged the insured for services rendered or the terms and conditions for activities intended to reduce inappropriate care;

(2) issue or administer policies in this state that include incentives for the insured to utilize the services of a provider that has entered into an agreement with the insurer under subdivision (1); and

(3) issue or administer policies in this state that provide for reimbursement for expenses of health care services only if the services have been rendered by a provider that has entered into an agreement with the insurer under subdivision (1).

(b) Before entering into any agreement under subsection (a)(1), an insurer shall establish terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1). These terms and conditions may not discriminate unreasonably against or among providers. For the purposes of this subsection, neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiation nor price differences among other providers in different geographical areas or different specialties constitutes unreasonable discrimination. Upon request by a provider seeking to enter into an agreement with an insurer under subsection (a)(1), the insurer shall make available to the provider a written statement of the terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1).

(c) No hospital, physician, pharmacist, or other provider designated in IC 27-8-6-1 willing to meet the terms and conditions of agreements described in this section may be denied the right to enter into an agreement under subsection (a)(1). When an insurer denies a provider the right to enter into an agreement with the insurer under subsection (a)(1) on the grounds that the provider does not satisfy the

terms and conditions established by the insurer for providers entering into agreements with the insurer, the insurer shall provide the provider with a written notice that:

(1) explains the basis of the insurer's denial; and

(2) states the specific terms and conditions that the provider, in the opinion of the insurer, does not satisfy.

(d) In no event may an insurer deny or limit reimbursement to an insured under this chapter on the grounds that the insured was not referred to the provider by a person acting on behalf of or under an agreement with the insurer.

(e) No cause of action shall arise against any person or insurer for:

(1) disclosing information as required by this section; or

(2) the subsequent use of the information by unauthorized individuals.

Nor shall such a cause of action arise against any person or provider for furnishing personal or privileged information to an insurer. However, this subsection provides no immunity for disclosing or furnishing false information with malice or willful intent to injure any person, provider, or insurer.

(f) Nothing in this chapter abrogates the privileges and immunities established in IC 34-30-15 (or IC 34-4-12.6 before its repeal).

As added by P.L.140-1984, SEC.1. Amended by P.L.134-1994, SEC.1; P.L.191-1996, SEC.1; P.L.1-1998, SEC.151; P.L.1-1999, SEC.59.

IC 27-8-11-3.1

Repealed

(As added by P.L.134-1994, SEC.2. Repealed by P.L.1-1999, SEC.60.)

IC 27-8-11-4

Accessibility and availability terms; reasonable standards

Sec. 4. Policies issued under section 3(a)(3) or section 3.1 of this chapter (before its repeal) may not contain terms or conditions that would operate unreasonably to restrict the access and availability of health care services for the insured. The commissioner of insurance may, under IC 4-22-2, adopt rules binding upon insurers prescribing reasonable standards relating to the accessibility and availability of health care services for persons insured under policies described in section 3(a)(3) or section 3.1 of this chapter (before its repeal).

As added by P.L.140-1984, SEC.1. Amended by P.L.134-1994, SEC.3; P.L.1-1999, SEC.61.

IC 27-8-11-4.5

Permitted disclosures by providers; coverage of benefit or service; payment of provider; application

Sec. 4.5. (a) An agreement between an insurer and provider under section 3 of this chapter may not prohibit a provider from disclosing:

(1) financial incentives to the provider;

(2) all treatment options available to an insured, including those not covered by the insured's policy.

(b) An insurer may not penalize a provider financially or in any other manner for making a disclosure permitted under subsection (a).

(c) An insured is not entitled to coverage of a benefit or service under a health insurance policy unless that benefit or service is included in the insured's health insurance policy.

(d) A provider is not entitled to payment under a policy for benefits or services provided to an insured unless the provider has a contract or an agreement with the insurer.

(e) This section applies to a contract entered, renewed, or modified after June 30, 1996.

As added by P.L.192-1996, SEC.1.

IC 27-8-11-5

Preferred provider plans; filing sworn statement

Sec. 5. Each person that organizes a preferred provider plan under this chapter shall file with the commissioner before March 1 of each year a statement, under oath, upon a form prescribed by the commissioner that covers the preceding calendar year and includes the following:

(1) The name and address of each person that has organized a preferred provider plan.

(2) The names and addresses of the providers with whom the preferred provider plan has entered into agreements under section 3 of this chapter.

(3) The geographical area, by counties, within which the preferred provider plan provides or arranges for health care services for insureds, members or enrollees.

(4) The number of insureds, members or enrollees covered by the agreements listed in subdivision (2).

As added by P.L.31-1988, SEC.23.

IC 27-8-11-6

Preferred provider plans; hospital accreditation

Sec. 6. (a) A preferred provider plan may not refuse to enter into an agreement with a hospital solely because the hospital has not obtained accreditation from an accreditation organization that:

(1) establishes standards for the organization and operation of hospitals;

(2) requires the hospital to undergo a survey process for a fee paid by the hospital; and

(3) was organized and formed in 1951.

(b) This section does not prohibit a preferred provider plan from using performance indicators or quality standards that:

(1) are developed by private organizations; and

(2) do not rely upon a survey process for a fee charged to the

hospital to evaluate performance.

As added by P.L.259-1995, SEC.2.

IC 27-8-11-7

Provider credentialing

Sec. 7. (a) This section applies to an insurer that issues or administers a policy that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(b) The department of insurance shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format, which must be used by:

(1) a provider who applies for credentialing by an insurer; and

(2) an insurer that performs credentialing activities.

(c) An insurer shall notify a provider concerning a deficiency on a completed credentialing application form submitted by the provider not later than thirty (30) business days after the insurer receives the completed credentialing application form.

(d) An insurer shall notify a provider concerning the status of the provider's completed credentialing application not later than:

(1) sixty (60) days after the insurer receives the completed credentialing application form; and

(2) every thirty (30) days after the notice is provided under subdivision (1), until the insurer makes a final credentialing determination concerning the provider.

As added by P.L.26-2005, SEC.2.

IC 27-8-11-8

Provider directories

Sec. 8. (a) An insurer may provide to an insured in electronic or paper form a directory of providers with which the insurer has entered into an agreement under section 3 of this chapter.

(b) An insurer that provides a directory described in subsection (a) shall:

(1) inform the insured that the insured may request the directory in paper form; and

(2) provide the directory in paper form upon the request of the insured.

As added by P.L.125-2005, SEC.5.

IC 27-8-11-9

Preferred provider agreement prohibitions

Sec. 9. (a) As used in this section, "insurer" includes the following:

(1) An administrator licensed under IC 27-1-25.

(2) A person that pays or administers claims on behalf of an insurer.

(b) An agreement between an insurer and a provider under this

chapter may not contain a provision that:

(1) prohibits, or grants the insurer an option to prohibit, the provider from contracting with another insurer to accept lower payment for health care services than the payment specified in the agreement;

(2) requires, or grants the insurer an option to require, the provider to accept a lower payment from the insurer if the provider agrees with another insurer to accept lower payment for health care services;

(3) requires, or grants the insurer an option of, termination or renegotiation of the agreement if the provider agrees with another insurer to accept lower payment for health care services; or

(4) requires the provider to disclose the provider's reimbursement rates under contracts with other insurers.

(c) A provision that:

(1) is contained in an agreement between an insurer and a provider under this chapter; and

(2) violates this section;

is void.

As added by P.L.74-2007, SEC.1.

IC 27-8-11-10

Coverage for dialysis treatment

Sec. 10. (a) As used in this section, "dialysis facility" means an outpatient facility in Indiana at which a dialysis treatment provider provides dialysis treatment.

(b) As used in this section, "contracted dialysis facility" means a dialysis facility that has entered into an agreement with a particular insurer under section 3 of this chapter.

(c) Notwithstanding section 1 of this chapter, as used in this section, "insured" refers only to an insured who requires dialysis treatment.

(d) As used in this section, "insurer" includes the following:

(1) An administrator licensed under IC 27-1-25.

(2) An agent of an insurer.

(e) As used in this section, "non-contracted dialysis facility" means a dialysis facility that has not entered into an agreement with a particular insurer under section 3 of this chapter.

(f) An insurer shall not require an insured, as a condition of coverage or reimbursement, to:

(1) if the nearest dialysis facility is located within thirty (30) miles of the insured's home, travel more than thirty (30) miles from the insured's home to obtain dialysis treatment; or

(2) if the nearest dialysis facility is located more than thirty (30) miles from the insured's home, travel a greater distance than the distance to the nearest dialysis facility to obtain dialysis treatment;

regardless of whether the insured chooses to receive dialysis treatment at a contracted dialysis facility or a non-contracted dialysis facility.
As added by P.L.111-2008, SEC.4.

IC 27-8-11-11
Insurer payment to insured for service rendered by noncontracted provider; requirements

Sec. 11. (a) As used in this section, "noncontracted provider" means a provider that has not entered into an agreement with an insurer under section 3 of this chapter.

(b) After September 30, 2009, if an insurer makes a payment to an insured for a health care service rendered by a noncontracted provider, the insurer shall include with the payment instrument written notice to the insured that includes the following:

(1) A statement specifying the claims covered by the payment instrument.

(2) The name and address of the provider submitting each claim.

(3) The amount paid by the insurer for each claim.

(4) Any amount of a claim that is the insured's responsibility.

(5) A statement in at least 24 point bold type that:

(A) instructs the insured to use the payment to pay the noncontracted provider if the insured has not paid the noncontracted provider in full;

(B) specifies that paying the noncontracted provider is the insured's responsibility; and

(C) states that the failure to make the payment violates the law and may result in collection proceedings or criminal penalties.

As added by P.L.144-2009, SEC.2.

IC 27-8-12

Chapter 12. Long Term Care Insurance

IC 27-8-12-1

"Applicant" defined

Sec. 1. As used in this chapter, "applicant" means:

(1) an individual who applies for long term care insurance through an individual insurance policy; or

(2) a prospective holder of a certificate issued under a group long term care insurance policy.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-2

"Certificate" defined

Sec. 2. As used in this chapter, "certificate" means a document issued to a member of the group covered under a group insurance policy, which policy has been delivered or issued for delivery in Indiana, to signify that the individual named in the certificate is covered under the policy.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-3

"Certificate holder" defined

Sec. 3. As used in this chapter, "certificate holder" means an individual to whom a certificate is issued.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-4

"Insurance policy" defined

Sec. 4. As used in this chapter, "insurance policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in Indiana by an insurer, a fraternal benefit society, a nonprofit corporation, a health maintenance organization (as defined in IC 27-13-1-19), a limited service health maintenance organization (as defined in IC 27-13-34-4), a preferred provider arrangement, or any other organization.

As added by P.L.275-1987, SEC.1. Amended by P.L.26-1994, SEC.16.

IC 27-8-12-4.5

"Long term care facility" defined

Sec. 4.5. As used in this chapter, "long term care facility" has the meaning set forth in IC 12-15-39.6-2.

As added by P.L.75-1994, SEC.9. Amended by P.L.24-1997, SEC.63.

IC 27-8-12-5

"Long term care insurance policy" defined

Sec. 5. (a) As used in this chapter, "long term care insurance

policy" means an insurance policy providing coverage for at least twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis for one (1) or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care wing of a hospital.

(b) The term includes the following:

(1) A policy advertised, marketed, or offered as long term care insurance.

(2) A group or individual annuity, a life insurance policy, or riders that provide directly or supplement long term care insurance.

(3) A policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

(c) The term does not include the following:

(1) An insurance policy that is offered primarily to provide basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, comprehensive coverage, catastrophic coverage, or limited benefit health coverage.

(2) A life insurance policy that accelerates the death benefit specifically for terminal illness, a medical condition requiring extraordinary medical intervention, or a permanent institutional confinement, and that provides the option of a lump sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long term care.

(3) An insurance policy that is offered primarily to provide basic Medicare supplemental coverage (as defined under IC 27-8-13).

As added by P.L.275-1987, SEC.1. Amended by P.L.114-1991, SEC.9.

IC 27-8-12-6

Compliance with statutory requirements

Sec. 6. An insurance policy may be marketed, advertised, offered, or sold in Indiana as long term care insurance only if that policy complies with the requirements of this chapter.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-7

Policy disclosure standards; marketing practices; continuing education; penalties; reporting practices; rules

Sec. 7. (a) The insurance commissioner shall adopt rules under IC 4-22-2 establishing standards of full and fair disclosure concerning long term care insurance policies. The standards must

require disclosure of information concerning the following:

(1) The sale of the policies.
(2) Terms of renewability.
(3) Initial and subsequent terms of eligibility.
(4) Nonduplication of coverage provisions.
(5) Coverage of dependents.
(6) Preexisting conditions.
(7) Termination of insurance coverage.
(8) Probationary periods.
(9) Limitations on coverage.
(10) Exceptions to coverage.
(11) Reductions from coverage.
(12) Elimination periods.
(13) Requirements for replacement.
(14) Recurrent conditions.
(15) Definitions of terms.
(16) Continuation or conversion of coverage.

(b) The insurance commissioner shall adopt rules under IC 4-22-2 to establish minimum standards concerning:

(1) marketing practices;
(2) insurance producer continuing education;
(3) penalties; and
(4) reporting practices;

for long term care insurance.

(c) Rules adopted by the insurance commissioner under this section must:

(1) recognize the unique, developing, and experimental nature of long term care insurance; and
(2) where necessary or appropriate, recognize the distinctions between group insurance policies and individual insurance policies.

As added by P.L.275-1987, SEC.1. Amended by P.L.114-1991, SEC.10; P.L.178-2003, SEC.65.

IC 27-8-12-7.1
Qualification of long term care policies; rules

Sec. 7.1. The department of insurance shall adopt rules under IC 4-22-2 that establish standards for the qualification of a long term care policy under IC 12-15-39.6. The rules must include the following:

(1) The standards adopted under section 7 of this chapter.
(2) The requirement that an insurer or other person who issues a qualified long term care policy must at a minimum offer to each policyholder or prospective policyholder a policy that provides both:
    (A) long term care facility coverage; and
    (B) home and community care coverage.
(3) A provision that an insurer or other person who complies

with subdivision (2) may elect to also offer a qualified long term care policy that provides only long term care facility coverage.

(4) The submission of data by insurers that will allow the department of insurance, the office of Medicaid policy and planning, and the division of aging to administer the Indiana long term care program under IC 12-15-39.6.

(5) Other standards needed to administer the Indiana long term care program.

As added by P.L.114-1991, SEC.11. Amended by P.L.9-1991, SEC.94; P.L.2-1992, SEC.786; P.L.4-1993, SEC.260; P.L.5-1993, SEC.273; P.L.75-1994, SEC.10; P.L.24-1997, SEC.64; P.L.141-2006, SEC.109.

IC 27-8-12-8

Loss ratio standards rule

Sec. 8. The insurance commissioner may not adopt a rule establishing loss ratio standards that apply to long term care insurance policies unless the rule exclusively concerns long term care insurance.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-9

Termination of policy on grounds of age or deteriorated health

Sec. 9. An insurer that issues a long term care insurance policy may not cancel, decline to renew, or otherwise terminate the policy solely on the grounds of the age or deterioration in mental or physical health of the insured individual or certificate holder.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-10

"Preexisting condition" defined; exclusion of coverage; limitations

Sec. 10. (a) As used in this section, "preexisting condition" means the existence of:

(1) either:

(A) symptoms that would cause an ordinarily prudent person to seek diagnosis, care, or treatment; or

(B) a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services; within

(2) a period not to exceed either:

(A) twelve (12) months preceding the effective date of coverage of an insured person who is sixty-five (65) years of age or older on the effective date of coverage; or

(B) twenty-four (24) months preceding the effective date of coverage of an insured person who is less than sixty-five (65) years of age on the effective date of coverage.

(b) A long term care insurance policy may exclude coverage for

a loss or confinement that is the result of a preexisting condition only if that loss or confinement begins within:

(1) twelve (12) months following the effective date of coverage of an insured person who is sixty-five (65) years of age or older on the effective date of coverage; or

(2) twenty-four (24) months following the effective date of coverage of an insured person who is under sixty-five (65) years of age on the effective date of coverage.

(c) The insurance commissioner may extend the limitation periods set forth in subsections (a)(2)(A), (a)(2)(B), and (b), concerning specific age group categories in specific policies upon a finding that the extension is in the best interest of the public.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-10.5

Loss or confinement resulting from a preexisting condition; exclusion of coverage; limitation period; rules

Sec. 10.5. (a) As used in this section, "preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six (6) months preceding the effective date of coverage of an insured individual.

(b) A long term care insurance policy may not use a definition of preexisting condition that is more restrictive than the definition contained in subsection (a).

(c) Except for a group long term care policy under IC 27-8-5-16(1) or IC 27-1-12-37, a long term care insurance policy may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six (6) months following the effective date of coverage of an insured individual.

(d) The commissioner may extend the limitation period under subsections (a) and (c) concerning a specific age group category in a specific policy form upon a finding by the commissioner that the extension is in the best interest of the public.

(e) This section does not prohibit an insurer from doing any of the following:

(1) Using an application form designed to elicit the complete health history of an applicant.

(2) Based on an application, underwriting in accordance with the insurer's established underwriting standards.

(f) Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether the condition is disclosed on the application, need not be covered until after the waiting period described in subsection (c).

(g) A long term care insurance policy may not exclude or use a waiver or rider to exclude, limit, or reduce coverage or benefits for a specifically named or described preexisting disease or physical

condition beyond the waiting period described in subsection (c).
As added by P.L.114-1991, SEC.12.

IC 27-8-12-10.6
Conditions on eligibility for benefits; restrictions

Sec. 10.6. (a) A long term care insurance policy may not be delivered or issued for delivery in Indiana if the policy:

(1) conditions eligibility for any benefits on a prior hospitalization requirement;

(2) conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(3) conditions eligibility for a benefit other than:

(A) a waiver of premium;

(B) postconfinement;

(C) postacute care; or

(D) recuperative benefits;

on a prior institutionalization requirement.

(b) A long term care insurance policy containing a postconfinement, postacute, or recuperative benefit must clearly label in a separate paragraph of the policy a statement entitled "limitations or conditions on eligibility for benefits". Under the statement, the policy must outline any limitations or conditions for benefits.

(c) A long term care insurance policy or rider that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care must not require a prior institutional stay of more than thirty (30) days.

(d) A long term care insurance policy or rider that provides benefits only following institutionalization may not condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.
As added by P.L.114-1991, SEC.13.

IC 27-8-12-11
Establishment of new waiting period

Sec. 11. (a) A long term care insurance policy may not:

(1) contain a provision establishing a new waiting period if an existing policy is converted to or replaced by a new form issued by the same insurer, except in the case of an increase in benefits voluntarily selected by the insured individual or group policyholder;

(2) be canceled, nonrenewed, or otherwise terminated on the grounds of age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(3) provide coverage for skilled nursing care only; or

(4) provide significantly more coverage for skilled care than

coverage for a lower level of care.

(b) Subsection (a) does not prohibit an insurer from voluntarily waiving any authorized waiting period.

As added by P.L.275-1987, SEC.1. Amended by P.L.114-1991, SEC.14.

IC 27-8-12-12

No obligation return period; notice

Sec. 12. (a) An individual long term care insurance policyholder may return the policy within thirty (30) days of its delivery and have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

(b) Each individual long term care insurance policy must have prominently printed on, or attached to, its first page a notice setting forth in substance the provisions of subsection (a).

As added by P.L.275-1987, SEC.1. Amended by P.L.114-1991, SEC.15.

IC 27-8-12-13

Direct response solicitation issued policies; no obligation return period; notice

Sec. 13. (a) A person insured under a long term care insurance policy or certificate issued under a direct response solicitation may return the policy or certificate within thirty (30) days of its delivery and have the premium refunded if the insured person is not satisfied for any reason.

(b) Each long term care insurance policy or certificate issued under a direct response solicitation must have printed on, or attached to, its first page a notice setting forth in substance the provisions of subsection (a).

As added by P.L.275-1987, SEC.1.

IC 27-8-12-14

Outline of coverage; contents

Sec. 14. (a) The insurer shall deliver an outline of the coverage provided by an individual long term care insurance policy to the prospective applicant at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and the document's purpose.

(b) The commissioner shall prescribe a standard format regarding:

(1) style;

(2) arrangement;

(3) overall appearance; and

(4) content;

for an outline of coverage.

(c) An insurance producer who solicits a long term care insurance policy shall deliver the outline of coverage before the presentation of an application or enrollment form.

(d) The outline of coverage must be presented in conjunction with any application or enrollment form when there is a direct response solicitation of long term care insurance.

(e) An outline of coverage required under this section must include the following:

(1) A description of the principal benefits and coverage provided in the policy.

(2) A statement of the principal exclusions, reductions, and limitations set forth in the policy.

(3) A statement of the policy's renewal provisions, including any reservation by the insurer of a right to change premiums.

(4) A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine the exact terms of the coverage provided by the policy.

(5) A description of the terms under which the policy may be returned and the premium refunded.

(6) A brief description of the relationship of the cost of care and benefits.

(7) A statement of the terms under which the policy or certificate may continue or be discontinued, including any reservation in the policy of the right to change the premium.

(8) A specific statement of the provisions for continuation or conversion of group coverage.

As added by P.L.275-1987, SEC.1. Amended by P.L.114-1991, SEC.16; P.L.178-2003, SEC.66.

IC 27-8-12-14.5

Policy summary; requirements

Sec. 14.5. (a) A policy summary shall be delivered, at the time of policy delivery, for an individual life insurance policy that provides long term care benefits within the policy or by a rider.

(b) The insurer shall deliver the policy summary upon the applicant's request when there is a direct response solicitation. If there is no request, the insurer shall deliver the policy summary not later than when the policy is delivered.

(c) The policy summary must include the following:

(1) An explanation of how long a long term care benefit interacts with other components of the policy, including deductions from a death benefit.

(2) An illustration of the amount of a benefit, the length of a benefit, and the guaranteed lifetime benefits for each covered person.

(3) Any exclusion, reduction, and limitation on benefits of long term care.

(d) A policy summary required under this section must also include the following information if applicable:

(1) A disclosure of any effect of exercising rights under the

policy other than rights referred to in subsection (c).

(2) A disclosure of any guarantee related to long term care costs of insurance charges.

(3) Current and projected maximum lifetime benefits.

As added by P.L.114-1991, SEC.17.

IC 27-8-12-14.6

Benefits funded through life insurance by acceleration of death benefits; benefit payment status report; contents

Sec. 14.6. If a long term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report containing the following shall be provided to the policyholder:

(1) Any long term care benefit paid out during the month.

(2) An explanation of any change in the policy, including a change in death benefit or cash value due to long term care benefits being paid.

(3) The amount of long term care benefits remaining under the policy.

As added by P.L.114-1991, SEC.18.

IC 27-8-12-15

Group policy certificate; contents

Sec. 15. A certificate issued under a group long term care insurance policy that is delivered or issued for delivery in Indiana must include the following:

(1) A description of the principal benefits and coverage provided in the policy.

(2) A statement of the principal exclusions, reductions, and limitations set forth in the policy.

(3) A statement that the group master policy should be consulted to determine the exact terms of the coverage provided by the policy.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-16

Application of general insurance law

Sec. 16. All other applicable provisions of IC 27 not in conflict with the provisions of this chapter apply to insurance policies issued under this chapter. A long term care insurance policy issued under this chapter is not subject to any rule adopted under IC 27-1-3-7(c).

As added by P.L.275-1987, SEC.1.

IC 27-8-12-17

Group policies issued in another state; requirements

Sec. 17. Group long term care insurance may not be offered to a resident of Indiana under a group policy issued in another state unless the commissioner determines that the group long term care

insurance policy substantially complies with insurance requirements similar to those established under this chapter.
As added by P.L.114-1991, SEC.19.

IC 27-8-12-18
Insurance producer commissions

Sec. 18. (a) An insurer or other entity that provides a commission to an insurance producer or other representative for the sale of a long term care insurance policy may not violate the following conditions:

(1) The insurer or other entity shall, for at least six (6) years, pay to the insurance producer or other representative an annual commission for selling or servicing the policy.

(2) The amount of commission provided in years after the first year must be determined based on the premium charged for the long term care insurance policy during the first year.

(b) If an existing long term care policy or certificate is replaced, the insurer or other entity that issues the replacement policy may not provide, and its insurance producer may not accept, a commission in an amount greater than the renewal commission payable by the replacing insurer on renewal policies, unless the benefits of the replacement policy or certificate are clearly and substantially greater than the benefits under the replaced policy or certificate.

(c) This section does not apply to the following:

(1) Life insurance policies and certificates.

(2) A policy or certificate that is sponsored by an employer for the benefit of:

(A) the employer's employees; or

(B) the employer's employees and their dependents.

As added by P.L.114-1991, SEC.20. Amended by P.L.178-2003, SEC.67; P.L.173-2007, SEC.29; P.L.115-2011, SEC.10.

IC 27-8-12-19
Violations; civil penalty; amount

Sec. 19. (a) In addition to any other sanction provided under this article, the commissioner may impose a civil penalty against an insurer who has violated this chapter or rules adopted under this chapter. A penalty imposed under this section must be the greater of:

(1) three (3) times the amount of the commissions paid for each policy involved in the violation; or

(2) ten thousand dollars ($10,000).

(b) In addition to any other sanction provided under this title, the commissioner may impose a penalty against an insurance producer who has violated this chapter or rules adopted under this chapter. The penalty must be the greater of:

(1) up to three (3) times the amount of the commissions paid to that insurance producer for each policy involved in the violation; or

(2) twenty-five hundred dollars ($2,500).

As added by P.L.114-1991, SEC.21. Amended by P.L.178-2003, SEC.68.

IC 27-8-13

Chapter 13. Medicare Supplement Insurance Solicitations

IC 27-8-13-0.1

Application of certain amendments to chapter

Sec. 0.1. The addition of section 10.1 of this chapter by P.L.195-1991 applies only to policies issued after December 31, 1991.

As added by P.L.220-2011, SEC.442.

IC 27-8-13-1

"Medicare" defined

Sec. 1. As used in this chapter, "medicare" means Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).

As added by P.L.275-1987, SEC.2.

IC 27-8-13-2

"Medicare supplement insurance solicitation" defined

Sec. 2. As used in this chapter, "Medicare supplement insurance solicitation" means a meeting between an insurance producer and another individual at which the insurance producer discusses the possible issuance of a medicare supplement policy to the other individual.

As added by P.L.275-1987, SEC.2. Amended by P.L.178-2003, SEC.69.

IC 27-8-13-3

"Medicare supplement policy" defined

Sec. 3. (a) As used in this chapter, "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of health maintenance organizations that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare benefits.

(b) The term does not include a group policy issued:

(1) to or for the benefit of employees;

(2) to one (1) or more labor organizations; or

(3) to the trustees of a fund established:

(A) by one (1) or more employees or former employees; or

(B) for members or former members of a labor organization.

(c) The term does not include:

(1) a policy issued under a contract under Section 1876 or 1833 of the federal Social Security Act (42 U.S.C. 1395 et seq.); or

(2) a policy issued under a demonstration project authorized under amendments to the federal Social Security Act.

As added by P.L.275-1987, SEC.2. Amended by P.L.255-1989, SEC.1; P.L.126-1992, SEC.1.

IC 27-8-13-4
Receipt for materials received by soliciting insurance producer; "materials" defined

Sec. 4. (a) Following a Medicare supplement insurance solicitation, an insurance producer shall give the individual involved in the solicitation a receipt for materials received by the insurance producer as a result of the solicitation.

(b) The receipt required under subsection (a) must be dated and signed by the insurance producer and must set forth the following:

(1) An itemized list of the materials received by the insurance producer.

(2) The insurance producer's name.

(3) The address and telephone number of the insurance producer's office.

(c) As used in this section, "materials" includes any:

(1) document;

(2) cash;

(3) money order; or

(4) check or draft;

received by the insurance producer. The term does not include an application for a policy.

As added by P.L.275-1987, SEC.2. Amended by P.L.178-2003, SEC.70.

IC 27-8-13-5
"Applicant" defined

Sec. 5. As used in this chapter, "applicant" means:

(1) in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

(2) in the case of a group Medicare supplement policy, the proposed certificate holder.

As added by P.L.255-1989, SEC.2. Amended by P.L.126-1992, SEC.2.

IC 27-8-13-6
"Certificate" defined

Sec. 6. As used in this chapter, "certificate" means a certificate:

(1) issued under a group Medicare supplement policy; and

(2) delivered or issued for delivery in Indiana.

As added by P.L.255-1989, SEC.3.

IC 27-8-13-6.2
"Certificate form" defined

Sec. 6.2. As used in this chapter, "certificate form" means the form on which a certificate is delivered or issued for delivery by the issuer.

As added by P.L.126-1992, SEC.3.

IC 27-8-13-7

(Repealed by P.L.126-1992, SEC.17.)

IC 27-8-13-7.3

"Issuer" defined

Sec. 7.3. As used in this chapter, "issuer" includes:

(1) an insurance company;

(2) a fraternal benefit society;

(3) a health care service plan;

(4) a health maintenance organization; and

(5) any other entity;

that delivers a Medicare supplement policy or certificate in Indiana or issues a Medicare supplement policy or certificate for delivery in Indiana.

As added by P.L.126-1992, SEC.4.

IC 27-8-13-7.6

"Policy form" defined

Sec. 7.6. As used in this chapter, "policy form" means the form on which a policy is delivered or issued for delivery by the issuer.

As added by P.L.126-1992, SEC.5.

IC 27-8-13-8

Application of chapter

Sec. 8. (a) Except as otherwise specifically provided, this chapter applies to the following:

(1) All Medicare supplement policies delivered or issued for delivery in Indiana on or after June 1, 1989.

(2) All certificates issued under group Medicare supplement policies that have been delivered or issued for delivery in Indiana.

(b) This chapter does not apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons that are not marketed or held to be Medicare supplement policies or benefit plans.

As added by P.L.255-1989, SEC.5. Amended by P.L.126-1992, SEC.6.

IC 27-8-13-9

Medicare supplement policies; standards; preexisting medical conditions

Sec. 9. (a) A Medicare supplement policy, contract, or certificate in force in Indiana may not contain benefits that duplicate benefits provided by Medicare. However, a change in Medicare coverage that becomes effective after a Medicare supplement policy, contract, or certificate is in force in Indiana and that causes a duplication of benefits does not void the policy, contract, or certificate.

(b) The commissioner shall adopt rules under IC 4-22-2 to

establish specific standards for policy provisions of Medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with Indiana law. No requirement of IC 27 relating to minimum required policy benefits other than the minimum standards contained in this chapter apply to Medicare supplement policies and certificates. The standards may cover, but are not limited to:

(1) terms of renewability;
(2) initial and subsequent conditions of eligibility;
(3) nonduplication of coverage;
(4) probationary periods;
(5) benefit limitations, exceptions, and reductions;
(6) elimination periods;
(7) requirements for replacement;
(8) recurrent conditions; and
(9) definitions of terms.

(c) The commissioner may adopt rules under IC 4-22-2 that specify prohibited policy provisions not specifically authorized by statute that, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to a person insured or proposed to be insured under a Medicare supplement policy or certificate.

(d) Notwithstanding any other law, a Medicare supplement policy or certificate shall not exclude or limit benefits for a loss incurred more than six (6) months after the effective date of the policy because the loss involves a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

As added by P.L.255-1989, SEC.6. Amended by P.L.126-1992, SEC.7.

IC 27-8-13-10

Medicare supplement policy and certificate standards; conformity with federal law and regulations

Sec. 10. (a) The commissioner shall adopt rules under IC 4-22-2 to establish minimum standards for:

(1) claims payment;
(2) marketing practices;
(3) compensation arrangements; and
(4) reporting practices;

for Medicare supplement policies and certificates.

(b) The commissioner may adopt rules under IC 4-22-2 that are necessary to conform Medicare supplement policies and certificates to the requirements of federal law and federal regulations. A rule adopted under this subsection may do the following:

(1) Require refunds or credits if the policies or certificates do not meet loss ratio requirements.

(2) Establish a uniform methodology for calculating and reporting loss ratios.
(3) Assure public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance.
(4) Establish a process for approving or disapproving policy forms and certificate forms and proposed premium increases.
(5) Establish a policy for holding public hearings before approval of premium increases.
(6) Establish standards for Medicare Select policies and certificates.

As added by P.L.255-1989, SEC.7. Amended by P.L.149-1990, SEC.5; P.L.195-1991, SEC.1; P.L.126-1992, SEC.8.

IC 27-8-13-10.1
Model Medicare supplement policy standards

Sec. 10.1. (a) The commissioner shall adopt rules under IC 4-22-2 to establish standards for model Medicare supplement policies. The standards must include standards for benefits.

(b) An insurer may issue a Medicare supplement policy or certificate in Indiana only if the policy or certificate is one (1) of the model policies adopted by the department under subsection (a).

As added by P.L.195-1991, SEC.2. Amended by P.L.126-1992, SEC.9.

IC 27-8-13-11
Repealed

(Repealed by P.L.126-1992, SEC.17.)

IC 27-8-13-12
Reasonable benefits; loss ratio standards

Sec. 12. (a) Medicare supplement policies must return to policyholders benefits that are reasonable in relation to the premium charged.

(b) The commissioner shall adopt rules under IC 4-22-2 to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses if coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

As added by P.L.255-1989, SEC.9. Amended by P.L.126-1992, SEC.10.

IC 27-8-13-13
Repealed

(Repealed by P.L.149-1990, SEC.6.)

IC 27-8-13-14

Outline of coverage; contents

Sec. 14. (a) In order to provide for full and fair disclosure in the sale of Medicare supplement policies, a Medicare supplement policy or certificate may not be delivered in Indiana unless an outline of coverage is delivered to the applicant at the time application is made.

(b) The commissioner shall prescribe by rule adopted under IC 4-22-2 the form and content of the outline of coverage required by subsection (a). For purposes of this section, "form" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and arrangement of text and captions. The outline of coverage must include the following:

(1) A description of the principal benefits and coverage provided in the policy.

(2) A statement of the renewal provisions, including a reservation by the issuer of a right to change premiums, and a disclosure of the existence of any automatic premium increases based on the policyholder's age.

(3) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

As added by P.L.255-1989, SEC.11. Amended by P.L.126-1992, SEC.11.

IC 27-8-13-15

Informational brochures

Sec. 15. (a) The commissioner may prescribe by rule adopted under IC 4-22-2 a standard form and the contents of an informational brochure for persons eligible for Medicare that is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare.

(b) Except in the case of direct response insurance policies, the commissioner may require by rule adopted under IC 4-22-2 that the information brochure be provided to a prospective insured eligible for Medicare concurrently with delivery of the outline of coverage required under section 14 of this chapter.

(c) With respect to direct response insurance policies, the commissioner may require by rule adopted under IC 4-22-2 that the prescribed brochure be provided upon request to a prospective insured eligible for Medicare, but not later than the time of policy delivery.

As added by P.L.255-1989, SEC.12. Amended by P.L.126-1992, SEC.12.

IC 27-8-13-16

Disclosures distinguishing Medicare supplement coverages from accident and sickness coverages

Sec. 16. (a) The commissioner may adopt rules under IC 4-22-2 for captions or notice requirements that are determined to be in the

public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages. The captions or notice requirements may apply to all accident and sickness insurance policies sold to persons eligible for Medicare by reason of age, other than:

(1) Medicare supplement policies;
(2) disability income policies;
(3) basic, catastrophic, or major medical expense policies; and
(4) single premium, nonrenewable policies.

(b) The commissioner may also adopt rules under IC 4-22-2 to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts, or certificates by persons eligible for Medicare.

As added by P.L.255-1989, SEC.13. Amended by P.L.126-1992, SEC.13.

IC 27-8-13-17
Return privilege notice; refund

Sec. 17. (a) Medicare supplement policies and certificates must have a notice prominently printed on the first page of the policy or certificate or attached to the first page stating in substance that the applicant has the right to return the policy or certificate within thirty (30) days of delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

(b) A refund made under this section shall be paid directly to the applicant by the issuer in a timely manner.

As added by P.L.255-1989, SEC.14. Amended by P.L.126-1992, SEC.14.

IC 27-8-13-18
Review and approval of proposed advertisements

Sec. 18. Every issuer of Medicare supplement insurance policies or certificates in Indiana shall provide a copy of any Medicare supplement advertisement intended for use in Indiana whether through written, radio, or television medium to the commissioner for review or approval by the commissioner to the extent required under Indiana law.

As added by P.L.255-1989, SEC.15. Amended by P.L.126-1992, SEC.15.

IC 27-8-13-19
Penalties for noncompliance

Sec. 19. In addition to any other penalties for violations of IC 27, the commissioner may take either or both of the following actions:

(1) Require issuers violating this chapter or rules adopted under this chapter to cease marketing a Medicare supplement policy or certificate in Indiana that is related directly or indirectly to a

violation.

(2) Require the issuer to take the action necessary to comply with this chapter.

As added by P.L.255-1989, SEC.16. Amended by P.L.126-1992, SEC.16.

IC 27-8-13-20

Refund of unused premiums

Sec. 20. (a) All Medicare supplement policies issued for delivery in Indiana after June 30, 1990, must provide for the refund of unused premiums upon the death of the insured during the contract period.

(b) The amount of premium refund shall be prorated from the date following the date of death of the insured to the end of the contract period for which the premium has been paid.

(c) The refund required by this section shall be paid as follows:

(1) If a person other than the insured paid the premium, to that person. A person entitled to a refund under this subdivision must provide proof of payment to the insurer.

(2) If the insured paid the premium, to the surviving spouse of the insured. If there is no surviving spouse, the premium shall be paid in the same manner as distributions of the net estate of a person who dies intestate under IC 29-1-2-1(d).

(d) A person entitled to receive a refund under this section must do the following:

(1) Submit a written request for the refund.

(2) Furnish proof of the insured's death.

As added by P.L.151-1990, SEC.2.

IC 27-8-13.4

Chapter 13.4. Coverage for Abortion

IC 27-8-13.4-1

Accident and sickness insurance policy; exclusions

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, Class 1(b) and Class 2(a); and

(2) is issued on a group or individual basis.

(b) As used in this chapter, "accident and sickness insurance policy" does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

As added by P.L.124-2014, SEC.1.

IC 27-8-13.4-2

Prohibition on coverage of abortion; exceptions; coverage through rider or endorsement

Sec. 2. (a) An accident and sickness insurance policy that is issued, delivered, amended, or renewed after December 31, 2014, may not provide coverage for abortion, except in the following cases:

(1) The pregnant woman became pregnant through an act of rape or incest.

(2) An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

(b) An insurer that issues an accident and sickness insurance

policy described in subsection (a) may offer coverage for abortion through a rider or an endorsement.
As added by P.L.124-2014, SEC.1.

IC 27-8-13.5

Chapter 13.5. Coverage for Medical Services for Women with High Breast Density

IC 27-8-13.5-1

Application of chapter

Sec. 1. This chapter applies to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2013.

As added by P.L.126-2013, SEC.4.

IC 27-8-13.5-2

"High breast density"

Sec. 2. As used in this chapter, "high breast density" means a condition in which there is a greater amount of breast and connective tissue in comparison to fat in the breast.

As added by P.L.126-2013, SEC.4.

IC 27-8-13.5-3

"Insured"

Sec. 3. As used in this chapter, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

As added by P.L.126-2013, SEC.4.

IC 27-8-13.5-4

"Policy of accident and sickness insurance"

Sec. 4. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(7) Worker's compensation or similar insurance.

(8) A student health plan.

(9) A supplemental plan that always pays in addition to other coverage.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

As added by P.L.126-2013, SEC.4.

IC 27-8-13.5-5

High breast density

Sec. 5. A policy of accident and sickness insurance must provide coverage for an appropriate medical screening, test, or examination for a female insured who is at least forty (40) years of age and who has been determined to have high breast density.

As added by P.L.126-2013, SEC.4.

IC 27-8-14

Chapter 14. Coverage for Services Related to Breast Cancer Screening

IC 27-8-14-0.1

Application of chapter; application of certain amendments to chapter

Sec. 0.1. (a) The addition of this chapter and the amendments made to IC 13-1-2-11 (before its repeal, now codified at IC 16-41-35-30) by P.L.119-1991 apply to an insurance policy that is issued or renewed after June 30, 1991.

(b) The amendments made to section 6 of this chapter by P.L.170-1999 apply to accident and sickness insurance policies that are issued, delivered, or renewed after June 30, 1999.

As added by P.L.220-2011, SEC.443.

IC 27-8-14-1

"Accident and sickness insurance policy"

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a); and

(2) is issued on a group basis.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

As added by P.L.119-1991, SEC.3. Amended by P.L.173-2007,

SEC.30.

IC 27-8-14-2
"Breast cancer screening mammography"

Sec. 2. (a) As used in this chapter, "breast cancer screening mammography" means a standard, two (2) view per breast, low-dose radiographic examination of the breasts that is:

(1) furnished to an asymptomatic woman; and

(2) performed by a mammography services provider using equipment designed by the manufacturer for and dedicated specifically to mammography in order to detect unsuspected breast cancer.

(b) The term includes the interpretation of the results of a breast cancer screening mammography by a physician.

As added by P.L.119-1991, SEC.3.

IC 27-8-14-3
"Insured"

Sec. 3. As used in this chapter, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

As added by P.L.119-1991, SEC.3.

IC 27-8-14-4
"Mammography services provider"

Sec. 4. As used in this chapter, "mammography services provider" means a person or facility that:

(1) has been accredited by the American College of Radiology;

(2) meets equivalent guidelines established by the state department of health; or

(3) certified by the Federal Department of Health and Human Services for participation in the Medicare program (42 U.S.C. 1395 et seq.).

As added by P.L.119-1991, SEC.3. Amended by P.L.2-1992, SEC.787.

IC 27-8-14-5
"Woman at risk"

Sec. 5. As used in this chapter, "woman at risk" means a woman who meets at least one (1) of the following descriptions:

(1) A woman who has a personal history of breast cancer.

(2) A woman who has a personal history of breast disease that was proven benign by biopsy.

(3) A woman whose mother, sister, or daughter has had breast cancer.

(4) A woman who is at least thirty (30) years of age and has not given birth.

As added by P.L.119-1991, SEC.3.

IC 27-8-14-6

Breast cancer screening mammography; coverage

Sec. 6. (a) Except as provided in subsection (f), an insurer must provide coverage for breast cancer screening mammography in any accident and sickness insurance policy that the insurer issues in Indiana.

(b) Except as provided in subsection (f), the coverage that an insurer must provide under this section must include the following:

(1) If the insured is at least thirty-five (35) but less than forty (40) years of age, coverage for at least one (1) baseline breast cancer screening mammography performed upon the insured before she becomes forty (40) years of age.

(2) If the insured is:

(A) less than forty (40) years of age; and

(B) a woman at risk;

one (1) breast cancer screening mammography performed upon the insured every year.

(3) If the insured is at least forty (40) years of age, one (1) breast cancer screening mammography performed upon the insured every year.

(4) Any additional mammography views that are required for proper evaluation.

(5) Ultrasound services, if determined medically necessary by the physician treating the insured.

(c) Except as provided in subsection (f), the coverage that an insurer must provide under this section must provide reimbursement for breast cancer screening mammography at a level at least as high as:

(1) the limitation on payment for screening mammography services established in 42 CFR 405.534(b)(3) according to the Medicare Economic Index at the time the breast cancer screening mammography is performed; or

(2) the rate negotiated by a contract provider according to the provisions of the insurance policy;

whichever is lower.

(d) Except as provided in subsection (f), the coverage that an insurer must provide under this section may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions applying to physical illness generally under the accident and sickness insurance policy.

(e) Except as provided in subsection (f), the coverage that an insurer must provide is in addition to any benefits specifically provided for x-rays, laboratory testing, or wellness examinations.

(f) In the case of insurance policies that are not employer based, the insurer must offer to provide the coverage described in subsections (a) through (e).

As added by P.L.119-1991, SEC.3. Amended by P.L.170-1999,

SEC.3.

IC 27-8-14.1

Chapter 14.1. Coverage for Services Related to Morbid Obesity

IC 27-8-14.1-0.1

Application of certain amendments to chapter

Sec. 0.1. The amendments made to section 4 of this chapter by P.L.196-2005 apply to an accident and sickness insurance policy that is issued, delivered, amended, or renewed after June 30, 2005.

As added by P.L.220-2011, SEC.444.

IC 27-8-14.1-1

"Accident and sickness insurance policy" defined

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a); and

(2) is issued on a group basis.

(b) As used in this chapter, "accident and sickness insurance policy" does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

As added by P.L.78-2000, SEC.2. Amended by P.L.173-2007, SEC.31.

IC 27-8-14.1-2

"Health care provider" defined

Sec. 2. As used in this chapter, "health care provider" means a:

(1) physician licensed under IC 25-22.5; or

(2) hospital licensed under IC 16-21;

that provides health care services for surgical treatment of morbid obesity.

As added by P.L.78-2000, SEC.2.

IC 27-8-14.1-3

"Morbid obesity" defined

Sec. 3. As used in this chapter, "morbid obesity" means:

(1) a body mass index of at least thirty-five (35) kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or

(2) a body mass index of at least forty (40) kilograms per meter squared without comorbidity.

For purposes of this section, body mass index is equal to weight in kilograms divided by height in meters squared.

As added by P.L.78-2000, SEC.2. Amended by P.L.196-2005, SEC.4.

IC 27-8-14.1-4

Coverage for nonexperimental, surgical treatment of morbid obesity

Sec. 4. (a) Except as provided in subsection (b), an insurer that issues an accident and sickness insurance policy shall offer coverage for nonexperimental, surgical treatment by a health care provider of morbid obesity:

(1) that has persisted for at least five (5) years; and

(2) for which nonsurgical treatment that is supervised by a physician has been unsuccessful for at least six (6) consecutive months.

(b) An insurer that issues an accident and sickness insurance policy may not provide coverage for a surgical treatment of morbid obesity for an insured who is less than twenty-one (21) years of age unless two (2) physicians licensed under IC 25-22.5 determine that the surgery is necessary to:

(1) save the life of the insured; or

(2) restore the insured's ability to maintain a major life activity (as defined in IC 4-23-29-6);

and each physician documents in the insured's medical record the reason for the physician's determination.

As added by P.L.78-2000, SEC.2. Amended by P.L.196-2005, SEC.5; P.L.102-2006, SEC.4.

IC 27-8-14.2

Chapter 14.2. Insurance Coverage for Pervasive Developmental Disorders

IC 27-8-14.2-1

"Accident and sickness insurance policy" defined

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a).

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

As added by P.L.148-2001, SEC.2. Amended by P.L.173-2007, SEC.32.

IC 27-8-14.2-2

"Insured" defined

Sec. 2. As used in this chapter, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

As added by P.L.148-2001, SEC.2.

IC 27-8-14.2-3

"Autism spectrum disorder"

Sec. 3. As used in this chapter, "autism spectrum disorder" means a neurological condition, including Asperger's syndrome and autism,

as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
As added by P.L.148-2001, SEC.2. Amended by P.L.188-2013, SEC.21.

IC 27-8-14.2-4
Group coverage required

Sec. 4. (a) An accident and sickness insurance policy that is issued on a group basis must provide coverage for the treatment of an autism spectrum disorder of an insured. Coverage provided under this section is limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan. An insurer may not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage on an individual under an insurance policy solely because the individual is diagnosed with an autism spectrum disorder.

(b) The coverage required under this section may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the accident and sickness insurance policy.
As added by P.L.148-2001, SEC.2. Amended by P.L.188-2013, SEC.22.

IC 27-8-14.2-5
Individual coverage required

Sec. 5. (a) An insurer that issues an accident and sickness insurance policy on an individual basis must offer to provide coverage for the treatment of an autism spectrum disorder of an insured. Coverage provided under this section is limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan. An insurer may not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage on an individual under an insurance policy solely because the individual is diagnosed with an autism spectrum disorder.

(b) The coverage that must be offered under this section may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the accident and sickness insurance policy.
As added by P.L.148-2001, SEC.2. Amended by P.L.188-2013, SEC.23.

IC 27-8-14.5

Chapter 14.5. Coverage for Services Related to Diabetes

IC 27-8-14.5-0.1

Application of chapter

Sec. 0.1. The addition of this chapter by P.L.190-1997 applies to all health insurance plans issued or renewed after December 31, 1997.

As added by P.L.220-2011, SEC.445.

IC 27-8-14.5-1

"Health insurance plan" defined

Sec. 1. (a) As used in this chapter, "health insurance plan" means any:

(1) hospital or medical expense incurred policy or certificate;

(2) hospital or medical service plan contract; or

(3) health maintenance organization subscriber contract;

provided to an insured.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

As added by P.L.190-1997, SEC.1. Amended by P.L.173-2007, SEC.33.

IC 27-8-14.5-2

"Insured" defined

Sec. 2. As used in this chapter, "insured" refers to an individual

with:

(1) insulin-using diabetes;

(2) non-insulin using diabetes; or

(3) elevated blood glucose levels induced by pregnancy or another medical condition;

who is covered by a health insurance plan issued by an insurer.

As added by P.L.190-1997, SEC.1.

IC 27-8-14.5-3

"Insurer" defined

Sec. 3. As used in this chapter, "insurer" means any person who provides health insurance and issues health insurance plans in Indiana. The term includes the following:

(1) A licensed insurance company.

(2) A prepaid hospital or medical service plan.

(3) A health maintenance organization.

(4) A state employee health benefit plan.

(5) The state Medicaid plan.

(6) Any person providing a plan of health insurance subject to state insurance law.

As added by P.L.190-1997, SEC.1.

IC 27-8-14.5-4

Coverage for treatments, supplies, and equipment

Sec. 4. A health insurance plan issued by an insurer must provide coverage to the insured for the medically necessary treatment for diabetes, including medically necessary supplies and equipment as ordered in writing by a physician licensed under IC 25-22.5 or a podiatrist licensed under IC 25-29, subject to the general provisions of the health insurance plan.

As added by P.L.190-1997, SEC.1.

IC 27-8-14.5-5

Deductible, copayment, and coinsurance provisions

Sec. 5. (a) An insured may not be required to pay an annual deductible or copayment that is greater than an annual deductible or copayment established for similar benefits under the health insurance plan. If the plan does not cover a similar benefit, the copayment or deductible may not be set at a level that materially diminishes the value of the diabetes benefit required by this chapter.

(b) An insured may be subject to coinsurance that is not greater than coinsurance established for similar benefits under the health insurance plan. If the plan does not cover a similar benefit, the coinsurance may not be set at a level that materially diminishes the value of the diabetes benefit required by this chapter.

As added by P.L.190-1997, SEC.1.

IC 27-8-14.5-6

Coverage for diabetes self-management training

Sec. 6. (a) A health insurance plan issued by an insurer must provide coverage for diabetes self-management training that is:

(1) medically necessary;

(2) ordered in writing by a physician licensed under IC 25-22.5 or a podiatrist licensed under IC 25-29; and

(3) provided by a health care professional who:

(A) is licensed, registered, or certified under IC 25; and

(B) has specialized training in the management of diabetes.

(b) Coverage for diabetes self-management training may be limited to the following:

(1) One (1) or more visits after receiving a diagnosis of diabetes.

(2) One (1) or more visits after receiving a diagnosis by a physician licensed under IC 25-22.5 or a podiatrist licensed under IC 25-29 that:

(A) represents a significant change in the insured's symptoms or condition; and

(B) makes changes in the insured's self-management medically necessary.

(3) One (1) or more visits for reeducation or refresher training.

(c) Coverage for diabetes self-management training is subject to the requirements of the health insurance plan regarding the use of participating providers.

As added by P.L.190-1997, SEC.1.

IC 27-8-14.5-7

Adoption of rules

Sec. 7. The department may adopt rules under IC 4-22-2 to carry out this chapter.

As added by P.L.190-1997, SEC.1.

IC 27-8-14.7

Chapter 14.7. Coverage for Services Related to Prostate Cancer Screening

IC 27-8-14.7-0.1

Application of chapter

Sec. 0.1. The addition of this chapter by P.L.170-1999 applies to accident and sickness insurance policies that are issued, delivered, or renewed after June 30, 1999.

As added by P.L.220-2011, SEC.446.

IC 27-8-14.7-1

"Accident and sickness insurance policy" defined

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and

(2) is issued on a group basis.

(b) "Accident and sickness insurance policy" does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

As added by P.L.170-1999, SEC.4. Amended by P.L.173-2007, SEC.34.

IC 27-8-14.7-2

"Insured" defined

Sec. 2. As used in this chapter, "insured" means a male individual who is entitled to coverage under a policy of accident and sickness insurance.
As added by P.L.170-1999, SEC.4.

IC 27-8-14.7-3
"Prostate specific antigen test" defined

Sec. 3. As used in this chapter, "prostate specific antigen test" means a standard blood test performed to determine the level of prostate specific antigen in the blood.
As added by P.L.170-1999, SEC.4.

IC 27-8-14.7-4
Coverage required

Sec. 4. (a) Except as provided in subsection (f), an insurer shall provide coverage for prostate specific antigen testing in any accident and sickness insurance policy that the insurer issues in Indiana.

(b) Except as provided in subsection (f), the coverage required under subsection (a) must include the following:

(1) At least one (1) prostate specific antigen test annually for an insured who is at least fifty (50) years of age.

(2) At least one (1) prostate specific antigen test annually for an insured who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

(c) An insured may not be required to pay an annual deductible or coinsurance that is greater than an annual deductible or coinsurance established for similar benefits under the accident and sickness insurance policy. If the policy does not cover a similar benefit, the deductible or coinsurance may not be set at a level that materially diminishes the value of the prostate specific antigen testing benefit required by this chapter.

(d) Except as provided in subsection (f), the coverage that an insurer must provide under this chapter may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions applying to physical illness generally under the accident and sickness insurance policy.

(e) Except as provided in subsection (f), the coverage that an insurer must provide is in addition to any benefits specifically provided for x-rays, laboratory testing, or wellness examinations.

(f) In the case of insurance policies that are not employer based, the insurer must offer to provide the coverage described in subsections (a) through (e).
As added by P.L.170-1999, SEC.4.

IC 27-8-14.8

Chapter 14.8. Coverage for Services Related to Colorectal Cancer Screening

IC 27-8-14.8-1

"Accident and sickness insurance policy" defined

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and

(2) is issued on a group basis.

(b) "Accident and sickness insurance policy" does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

As added by P.L.54-2000, SEC.2. Amended by P.L.173-2007, SEC.35.

IC 27-8-14.8-2

"Insured" defined

Sec. 2. As used in this chapter, "insured" means an individual who is entitled to coverage under an accident and sickness insurance policy.

As added by P.L.54-2000, SEC.2.

IC 27-8-14.8-3

Colorectal cancer testing coverage

Sec. 3. (a) Except as provided in subsection (d), an insurer shall provide coverage for colorectal cancer examinations and laboratory tests for cancer for any nonsymptomatic insured, in accordance with the current American Cancer Society guidelines, in any accident and sickness insurance policy that the insurer issues in Indiana or issues for delivery in Indiana.

(b) For an insured who is:

(1) at least fifty (50) years of age; or

(2) less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society;

the coverage required under this section must meet the requirements set forth in subsection (c).

(c) An insured may not be required to pay an additional annual deductible or coinsurance for the colorectal cancer examination and laboratory testing benefit that is greater than an annual deductible or coinsurance established for similar benefits under an accident and sickness insurance policy. If the accident and sickness insurance policy does not cover a similar benefit, a deductible or coinsurance may not be set at a level that materially diminishes the value of the colorectal cancer examination and laboratory testing benefit required under this section.

(d) In the case of an accident and sickness insurance policy that is not employer based, the insurer shall offer to provide the coverage described in this section.

As added by P.L.54-2000, SEC.2.

IC 27-8-15
Chapter 15. Small Employer Group Health Insurance

IC 27-8-15-0.1
Application of certain amendments to chapter

Sec. 0.1. The following amendments to this chapter apply as follows:

(1) The addition of sections 8.5, 10.5, 27, 28, 29, 30, 31, 32, 33, and 34 (before its repeal) of this chapter by P.L.93-1995 applies to all small employer health insurance plans issued or renewed under this chapter, as amended by P.L.93-1995, after December 31, 1995.

(2) The amendments made to sections 9, 14, and 19 of this chapter by P.L.93-1995 apply to all small employer health insurance plans issued or renewed under this chapter, as amended by P.L.93-1995, after December 31, 1995.

(3) Subject to section 31.1(a) of this chapter, as added by P.L.93-1995, section 16 of this chapter, as amended by P.L.93-1995, and section 31.1 of this chapter, as added by P.L.93-1995, apply to all small employer health insurance plans issued or renewed under this chapter, as amended by P.L.93-1995, after December 31, 1997.

(4) The addition of section 34.1 of this chapter by P.L.91-1998 applies to all small employer health insurance plans in force under this chapter on April 1, 1998.

(5) The amendments made to sections 10.5, 14, 19, 27, and 28 of this chapter by P.L.91-1998 apply to all small employer health insurance plans in force under this chapter on April 1, 1998.

As added by P.L.220-2011, SEC.447.

IC 27-8-15-1
Application of chapter

Sec. 1. This chapter applies to any group health insurance plan that is issued for delivery in Indiana to at least two (2) employees of a small employer located in Indiana if one (1) of the following conditions is met:

(1) Any part of the premium or benefits is paid by a small employer or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any part of the premium not including the administrative expenses of administering a payroll deduction plan where the employee contributes one hundred percent (100%) of the premium without reimbursement.

(2) The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for purposes of Section 106 or 162 of the United States Internal Revenue Code.

As added by P.L.127-1992, SEC.1. Amended by P.L.11-2011, SEC.32.

IC 27-8-15-2
Repealed

(As added by P.L.127-1992, SEC.1. Repealed by P.L.11-2011, SEC.46.)

IC 27-8-15-3
"Actuarial certification"

Sec. 3. As used in this chapter, "actuarial certification" means a written statement by a member of the American Academy of Actuaries that a small employer insurer is in compliance with section 16 of this chapter, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the insurer in establishing premium rates for applicable health insurance plans.
As added by P.L.127-1992, SEC.1.

IC 27-8-15-4
"Base premium rate"

Sec. 4. As used in this chapter, "base premium rate" means the lowest premium rate charged or that could have been charged under a rating system by the small employer insurer to small employers with similar case characteristics and benefit design characteristics.
As added by P.L.127-1992, SEC.1.

IC 27-8-15-5
"Benefit design characteristics"

Sec. 5. As used in this chapter, "benefit design characteristics" means the following:

(1) Covered services.
(2) Cost sharing.
(3) Utilization management.
(4) Managed care networks.
(5) Any other features differentiating plan or benefit design.

As added by P.L.127-1992, SEC.1.

IC 27-8-15-6
"Case characteristics"

Sec. 6. As used in this chapter, "case characteristics" means demographic or other relevant characteristics of a small employer, as determined by a small employer insurer, that are considered by the insurer in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage since issue are not case characteristics.
As added by P.L.127-1992, SEC.1.

IC 27-8-15-7
"Commissioner"

Sec. 7. As used in this chapter, "commissioner" refers to the commissioner of the department of insurance.

As added by P.L.127-1992, SEC.1.

IC 27-8-15-8
"Department"

Sec. 8. As used in this chapter, "department" refers to the department of insurance.

As added by P.L.127-1992, SEC.1.

IC 27-8-15-8.5
"Eligible employee"

Sec. 8.5. (a) As used in this chapter, "eligible employee" means an employee:

(1) who is employed to work at least thirty (30) hours each week; and

(2) who meets an applicable waiting period required by a small employer before gaining coverage under a health insurance policy.

(b) The term includes:

(1) a sole proprietor;

(2) a partner in a partnership; and

(3) an owner of an S corporation;

regardless of whether the sole proprietor, partner, or owner is included as an employee for purposes of taxation of a small employer.

(c) The term does not include:

(1) an employee who works on a temporary or substitute basis; or

(2) a seasonal employee.

As added by P.L.93-1995, SEC.10. Amended by P.L.11-2011, SEC.33.

IC 27-8-15-9
"Health insurance plan"

Sec. 9. (a) Except as provided in section 28 of this chapter, as used in this chapter, "health insurance plan" or "plan" means any:

(1) hospital or medical expense incurred policy or certificate;

(2) hospital or medical service plan contract; or

(3) health maintenance organization subscriber contract;

provided to the employees of a small employer.

(b) The term does not include the following:

(1) Accident-only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
(A) may not be renewed; and
(B) has a duration of not more than six (6) months.
(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
(A) hospital confinement, critical illness, or intensive care; or
(B) gaps for deductibles or copayments.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(10) An employer sponsored health benefit plan that is:
(A) provided to individuals who are eligible for Medicare; and
(B) not marketed as, or held out to be, a Medicare supplement policy.

As added by P.L.127-1992, SEC.1. Amended by P.L.93-1995, SEC.11; P.L.11-2011, SEC.34.

IC 27-8-15-10
"Insurer"

Sec. 10. As used in this chapter, "insurer" means any person who provides health insurance in Indiana. The term includes the following:
(1) A licensed insurance company.
(2) A prepaid hospital or medical service plan.
(3) A health maintenance organization.
(4) A multiple employer welfare arrangement.
(5) Any person providing a plan of health insurance subject to state insurance law.

As added by P.L.127-1992, SEC.1.

IC 27-8-15-10.5
"Late enrollee"

Sec. 10.5. (a) As used in this chapter, "late enrollee" means an eligible employee or a dependent of an eligible employee who did not request enrollment in a health insurance plan of a small employer during the initial enrollment period during which the individual was entitled to enroll under the health insurance plan.

(b) The term "late enrollee" does not include an eligible employee or the dependent of an eligible employee:
(1) who was covered under a health insurance plan or had health insurance coverage at the time coverage was previously offered to the employee or to the dependent of the employee;
(2) who stated in writing at the time coverage was offered that

coverage under another health insurance plan was the reason for declining the enrollment, but only if the insurer required such a statement at the time and provided the employee with notice of the requirement (and the consequences of the requirement) at the time;

(3) whose coverage under this subsection:

(A) was under a COBRA continuation provision and the coverage under the provision was exhausted; or

(B) was not under a COBRA continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward the coverage were terminated; and

(4) who requests enrollment under the terms of the plan not later than thirty (30) days after the date of exhaustion of coverage as described in subdivision (3)(A) or the termination of coverage or employer contributions as described in subdivision (3)(B).

(c) The term "late enrollee" does not include an eligible employee who is employed by a small employer that offers multiple health insurance plans and who elects a different plan during an open enrollment period.

(d) The term "late enrollee" does not include an eligible employee or the eligible employee's spouse or minor or dependent child where:

(1) a court has ordered that health insurance coverage be provided for the spouse or minor or dependent child of an eligible employee under the eligible employee's insurance plan; and

(2) the request for enrollment is made not more than thirty (30) days after the issuance of the court order.

As added by P.L.93-1995, SEC.12. Amended by P.L.190-1996, SEC.3; P.L.91-1998, SEC.15.

IC 27-8-15-11
"Midpoint rate"

Sec. 11. As used in this chapter, "midpoint rate" means for small employers with similar case and benefit design characteristics the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

As added by P.L.127-1992, SEC.1.

IC 27-8-15-12
"New business premium rate"

Sec. 12. As used in this chapter, "new business premium rate" means the premium rate charged or offered by the small employer insurer to small employers with similar case characteristics and

benefit design characteristics for newly issued health insurance plans.
As added by P.L.127-1992, SEC.1.

IC 27-8-15-13
"Rating period"

Sec. 13. As used in this chapter, "rating period" means the calendar period for which premium rates established by a small employer insurer are assumed to be in effect, as determined by the small employer insurer.
As added by P.L.127-1992, SEC.1.

IC 27-8-15-14
"Small employer"

Sec. 14. (a) This subsection applies only with respect to grandfathered health plan coverage described in 45 CFR 147.140. As used in this chapter, "small employer" means any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

(b) If the commissioner of insurance determines that it is necessary or appropriate, the department of insurance may adopt emergency rules under IC 4-22-2-37.1 to conform the definition set forth in subsection (a) with PPACA (as defined in IC 27-19-2-14). Notwithstanding IC 4-22-2-37.1(g), an emergency rule adopted under this subsection expires on the date occurring one (1) year after the date on which the emergency rule takes effect. This subsection expires January 1, 2017.

(c) This subsection applies only with respect to a health insurance plan that does not provide grandfathered health plan coverage described in 45 CFR 147.140. As used in this chapter, "small employer" means any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least one (1) but not more than fifty (50) employees. In determining the number of employees, companies that are treated as a single employer under Section 414(b), 414(c), 414(m), or 414(o) of the Internal Revenue Code are treated as one (1) employer.
As added by P.L.127-1992, SEC.1. Amended by P.L.8-1993, SEC.432; P.L.93-1995, SEC.13; P.L.190-1996, SEC.4; P.L.91-1998, SEC.16; P.L.146-2015, SEC.34; P.L.72-2016, SEC.20.

IC 27-8-15-15
"Small employer insurer"

Sec. 15. As used in this chapter, "small employer insurer" means any insurer that offers a health insurance plan covering the employees of a small employer.

As added by P.L.127-1992, SEC.1.

IC 27-8-15-16
Premium rates

Sec. 16. Premium rates for a health insurance plan are subject to the following:

(1) For all small employer business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar benefit design characteristics, or the rates that could be charged to small employers under the rating system may not vary from the midpoint rate by more than thirty-five percent (35%) above or below the midpoint rate.

(2) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) The percentage change in the new business premium rate for a plan with the same or similar benefit design characteristics measured from the first day of the prior rating period to the first day of the new rating period. For a plan for which the small employer insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate.

(B) An adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer.

(C) Any adjustment due to change in benefit design characteristics or change in the case characteristics of the small employer.

(3) For health insurance plans issued before July 1, 1992, a premium rate for a rating period may exceed the ranges described in subdivisions (1) and (2) for five (5) years following July 1, 1992. The percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(A) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. For a plan for which the small employer insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate.

(B) Any adjustment due to change in benefit design characteristics or change in the case characteristics of the small employer.

As added by P.L.127-1992, SEC.1.

IC 27-8-15-17

Rating factors

Sec. 17. (a) This chapter is not intended to affect the use by a small employer insurer of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates.

(b) A small employer insurer shall apply rating factors, including case characteristics, consistently with respect to all small employers in a plan with substantially the same benefit design characteristics.

As added by P.L.127-1992, SEC.1.

IC 27-8-15-18

Offer to transfer

Sec. 18. A small employer insurer may not offer to transfer a small employer into or out of a plan with substantially the same benefit design unless the offer is made to transfer all small employers in that plan without regard to case characteristics, claim experience, health status, or duration since issue.

As added by P.L.127-1992, SEC.1.

IC 27-8-15-19

Cancellation or refusal of renewal of plans

Sec. 19. Except as provided in section 20 of this chapter, a small employer insurer may only cancel or refuse to renew a health insurance plan for the following reasons:

(1) Nonpayment of required premiums.

(2) Fraud or misrepresentation of the small employer, or with respect to coverage of an insured individual, fraud or misrepresentation by the insured individual or the individual's representative.

(3) The small employer has failed to comply with a material plan provision relating to employer contribution or group participation rules.

(4) In the case of a small employer insurer that offers coverage in a market through a network plan, there is no longer any insured individual in connection with the plan who lives, resides, or works:

(A) in the service area of the small employer insurer; or

(B) in the area for which the issuer is authorized to do business.

(5) In the case of coverage that is made available through one (1) or more bona fide associations, the membership of the small employer in the association ceases, but only if the coverage is

terminated under this subdivision uniformly without regard to any health status related factor relating to an insured individual.

(6) In a case in which an insurer decides to discontinue offering a particular type of group health insurance coverage offered in the small employer market, that coverage may be discontinued by the insurer only if:

(A) the insurer provides notice of the insurer's intent to discontinue the coverage to each small employer provided with the coverage;

(B) the insurer offers the option to purchase all other health insurance coverage currently being offered by the insurer to the small employer to each small employer that is provided with the coverage; and

(C) in exercising the option to discontinue the coverage in offering the option of coverage under clause (B), the insurer acts uniformly without regard to:

(i) the claims experience of the small employer groups; or

(ii) any health status related factor relating to any eligible employee or dependent of an eligible employee who is covered or who may become eligible for the coverage.

As added by P.L.127-1992, SEC.1. Amended by P.L.93-1995, SEC.14; P.L.91-1998, SEC.17.

IC 27-8-15-20

Renewal cessation; notice

Sec. 20. (a) A small employer insurer may cease to renew all small employer plans.

(b) The insurer shall provide notice to all affected health insurance plans and to the commissioner at least one (1) year before termination of coverage unless the coverage is placed with another insurer.

As added by P.L.127-1992, SEC.1.

IC 27-8-15-21

Renewal cessation; prohibitions

Sec. 21. (a) An insurer who ceases to renew all small employer plans may not do the following:

(1) Accept any new small employer business for five (5) years after the notice of nonrenewal of the plans.

(2) Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the insurer offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status, or duration of coverage.

(b) The commissioner may suspend the penalty under subsection (a)(1) upon a finding by the commissioner that the suspension would enhance the efficiency and fairness of the marketplace for small

employer health insurance.
As added by P.L.127-1992, SEC.1.

IC 27-8-15-22
Disclosure of premium rate changes

Sec. 22. Each small employer insurer shall make reasonable disclosure in solicitation and sales materials provided to small employers of the provisions affecting premium rate changes.
As added by P.L.127-1992, SEC.1.

IC 27-8-15-23
Maintenance of rating and renewal practice information and documentation

Sec. 23. Each small employer insurer shall maintain for three (3) years at the insurer's principal place of business a complete and detailed description of the insurer's rating practices and renewal underwriting practices, including information and documentation that demonstrate that the insurer's rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.
As added by P.L.127-1992, SEC.1.

IC 27-8-15-24
Maintenance of actuarial certification; submission to department

Sec. 24. (a) Each small employer insurer shall maintain an actuarial certification verifying that the insurer is in compliance with this chapter and that the rating methods of the insurer are actuarially sound. A copy of the certification shall be retained by the insurer at the insurer's principal place of business for three (3) years.

(b) Before March 1 of each year, each small employer insurer shall submit to the department a copy of the actuarial certification maintained under subsection (a).
As added by P.L.127-1992, SEC.1. Amended by P.L.190-1996, SEC.5.

IC 27-8-15-25
Availability of information and documentation to commissioner; disclosure by commissioner

Sec. 25. A small employer insurer shall make the information and documentation described in section 23 of this chapter available to the commissioner upon request. The information is proprietary and trade secret information and is not subject to disclosure by the commissioner to a person outside of the department except as agreed to by the insurer or as ordered by a court with jurisdiction.
As added by P.L.127-1992, SEC.1.

IC 27-8-15-26
Suspension of premium rate provisions

Sec. 26. The commissioner may suspend all or any part of section 16 of this chapter as to the premium rates applicable to one (1) small employer for at least one (1) rating period upon a filing by the small employer insurer and a finding by the commissioner that either:

(1) the suspension is reasonable in light of the financial condition of the insurer; or

(2) the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

As added by P.L.127-1992, SEC.1.

IC 27-8-15-27

Application in conformity with act; compliance

Sec. 27. (a) This section shall be applied in conformity with the requirements of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), as in effect on September 23, 2010.

(b) A health insurance plan provided by a small employer insurer to a small employer must comply with the following:

(1) The benefits provided by a plan to an eligible employee enrolled in the plan may not be excluded, limited, or denied for more than nine (9) months after the effective date of the coverage because of a preexisting condition of the eligible employee, the eligible employee's spouse, or the eligible employee's dependent.

(2) The plan may not define a preexisting condition, rider, or endorsement more restrictively than as a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately preceding the effective date of enrollment in the plan.

As added by P.L.93-1995, SEC.15. Amended by P.L.91-1998, SEC.18; P.L.160-2011, SEC.20.

IC 27-8-15-28

Waiver of exclusion and limitation period

Sec. 28. (a) As used in this section, "health insurance plan" means coverage provided under any of the following:

(1) A hospital or medical expense incurred policy or certificate.

(2) A hospital or medical service plan contract.

(3) A health maintenance organization subscriber contract.

(4) Medicare or Medicaid.

(5) An employer based health insurance arrangement.

(6) An individual health insurance policy.

(7) A policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(8) An employee welfare benefit plan (as defined in 29 U.S.C. 1002) that is self-funded.

(9) A conversion policy issued under section 31 or 31.1 of this

chapter.

(b) Except as provided in section 29 of this chapter, a small employer insurer shall waive the exclusion period described in section 27 of this chapter applicable to a preexisting condition or the limitation period with respect to a particular service in a health insurance plan for the time an eligible employee or a dependent of an eligible employee was previously covered by a health insurance plan if the following conditions are met:

(1) The eligible employee or a dependent of the eligible employee was previously covered by a health insurance plan that provided benefits with respect to the particular service.

(2) Coverage under the health insurance plan was continuous to a date not more than sixty-three (63) days before the effective date of enrollment by:

(A) the eligible employee; or

(B) a dependent of the eligible employee.

(c) In determining whether an eligible employee or a dependent of the eligible employee meets the requirements of subsection (b)(2), a waiting period imposed by a small employer insurer or small employer before new coverage may become effective must be excluded from the calculation.

(d) This section does not preclude the application of any waiting period applicable to all new enrollees under a plan.

As added by P.L.93-1995, SEC.16. Amended by P.L.190-1996, SEC.6; P.L.91-1998, SEC.19.

IC 27-8-15-29

Application in conformity with act; exclusion of coverage

Sec. 29. (a) This section shall be applied in conformity with the requirements of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), as in effect on September 23, 2010.

(b) A plan may exclude coverage for a late enrollee or the late enrollee's covered spouse or dependent for not more than fifteen (15) months.

(c) If a late enrollee or the late enrollee's covered spouse or dependent has a preexisting condition, a plan may exclude coverage for the preexisting condition for not more than fifteen (15) months.

(d) If a period of exclusion from coverage under subsection (b) and a preexisting condition exclusion under subsection (c) are applicable to the late enrollee, the combined period of exclusion may not exceed fifteen (15) months from the date that the eligible employee enrolls for coverage under the health insurance plan.

As added by P.L.93-1995, SEC.17. Amended by P.L.160-2011, SEC.21.

IC 27-8-15-30

Plan modifications prohibited

Sec. 30. Except as permitted under sections 27 and 29 of this chapter, a small employer insurer shall not modify a health insurance plan with respect to:

(1) a small employer; or

(2) an eligible employee or dependent;

through riders, endorsements, or otherwise to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

As added by P.L.93-1995, SEC.18.

IC 27-8-15-31

Conversion policy

Sec. 31. (a) If an eligible employee who has been continuously covered under a health insurance plan for at least ninety (90) days:

(1) loses coverage under the plan as the result of:

(A) termination of employment;

(B) reduction of hours;

(C) marriage dissolution; or

(D) attainment of any age specified in the plan;

(2) is not eligible for continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act of 1985; and

(3) requests a conversion policy from the small employer insurer that insured the health insurance plan;

the individual is entitled to receive a conversion policy from the small employer insurer.

(b) A request under subsection (a) must be made within thirty (30) days after the individual loses coverage under the health insurance plan.

(c) The premium for a conversion policy issued under this section shall not exceed one hundred fifty percent (150%) of the rate that would have been charged under the small employer health insurance plan with respect to the individual if the individual had been covered as an eligible employee under the plan during the same period. If the health insurance plan under which the individual was covered is canceled or is not renewed, the rates shall be based on the rate that would have been charged with respect to the individual if the plan had continued in force, as determined by the small employer insurer in accordance with standard actuarial principles.

(d) A conversion policy issued under this section must be approved by the insurance commissioner as described in IC 27-8-5-1. The commissioner may not approve a conversion policy unless the policy and its benefits are:

(1) comparable to those required under IC 27-13-1-4(a)(2) through IC 27-13-1-4(a)(5);

(2) reasonable in relation to the premium charged; and

(3) in compliance with IC 27-8-6-1.

If the benefit limits of the conversion policy are not more than the

benefit limits of the small employer's health insurance plan, the small employer insurer shall credit the individual with any waiting period, deductible, or coinsurance credited to the individual under the small employer's health insurance plan.

(e) This section expires on the effective date of a mechanism enacted by the general assembly to offset the potential fiscal impact on small employers and small employer insurers that results from the establishment of a continuation policy under section 31.1 of this chapter.

As added by P.L.93-1995, SEC.19. Amended by P.L.11-2011, SEC.35.

IC 27-8-15-31.1
Continuing coverage

Sec. 31.1. (a) This section becomes effective on the effective date of a mechanism enacted by the general assembly to offset the potential fiscal impact on small employers and small employer insurers that results from the establishment of a continuation policy under this section. This section does not apply to an individual who is eligible for coverage under a group health plan (as defined in 29 U.S.C. 1167).

(b) If an eligible employee who has been employed by the same small employer for at least one (1) year and continuously covered under a health insurance plan for at least ninety (90) days, or a dependent of such eligible employee:

(1) loses coverage under the plan as the result of:
(A) termination of the eligible employee's employment;
(B) reduction of the eligible employee's hours;
(C) dissolution of marriage; or
(D) attainment of any age specified in the plan; and

(2) requests continuing coverage from the small employer insurer that insured the health insurance plan;

the individual and any dependents of the individual are entitled to receive continuing coverage from the small employer insurer.

(c) A small employer shall notify an individual of the individual's possible right to continuing coverage under subsection (b) by presenting notice to the individual in writing within ten (10) days after the individual becomes an eligible employee. The notice must be presented directly to the eligible employee and must include:

(1) the conditions under which the eligible employee may qualify for continuing coverage;

(2) the name, address, and telephone number of the small employer insurer providing insurance to the small employer; and

(3) a statement that emphasizes the eligible employee's responsibility to contact the small employer insurer that insures the small employer at the time the eligible employee qualifies for continuing coverage under this section within thirty (30)

days after becoming eligible for continuing coverage.

(d) An individual who wishes to receive continuing coverage must request continuing coverage from the small employer insurer in writing within thirty (30) days after losing coverage under subsection (b)(1).

(e) An individual electing continuing coverage must pay to the employer, in advance of the date the employer is required to make payments for insurance, but not more than one (1) time each month, the total premium amount required for continuing coverage.

(f) An individual who fails to:

(1) provide notice to a small employer insurer under subsection (d); or

(2) timely pay the premium as described in subsection (e);

relieves the employer and the small employer insurer of any responsibility to the individual for continuing coverage.

(g) A notification of the continuation privilege must accompany or be included in each certificate of coverage.

(h) Continuing coverage shall not be available to an individual who was discharged because the individual committed a felony or theft in connection with the individual's work, provided that:

(1) the individual admits participating in the felony or theft;

(2) the discharge is upheld through binding arbitration; or

(3) the act resulted in a conviction or an order of or supervision by a court.

(i) The premium for continuing coverage referred to in subsection (b) for any given period shall not exceed one hundred two percent (102%) of the rate that would have been charged under the health insurance plan with respect to the individual if the individual had been covered as an eligible employee under the plan during the same period. If the health insurance plan under which the individual was covered is canceled or is not renewed, the individual may apply for a conversion policy under this section.

(j) Benefits provided under the continuing coverage referred to in subsection (b) may not be less than the benefits provided under the health insurance plan. If the plan limits of the continuing coverage are not greater than the plan limits of the health insurance plan, the small employer insurer shall credit the insured with any waiting period, deductible, and coinsurance to the extent that the waiting period, deductible, or coinsurance was credited to the individual under the health insurance plan.

(k) Continuing coverage provided under this section may not last longer than twelve (12) months. If a small employer changes the health insurance plan during the time that continuing coverage is provided to an individual under this section, the small employer shall notify the individual in writing within thirty (30) days of the change, and the individual is entitled to apply for a conversion policy under this section within thirty (30) days of receiving the notice.

(l) A small employer insurer who provides continuing coverage

under this section may not refuse to accept for coverage under a conversion policy any individual who remained continuously covered under this section if the individual can prove that:

(1) the individual is entitled to and has exhausted the benefits available under continuing coverage or the health insurance plan under which the individual was covered is canceled or is not renewed under the provisions of section 19 of this chapter;

(2) the continuing coverage was continuous to a date not more than thirty (30) days before the effective date of the coverage the individual is applying for under this subsection; and

(3) the individual is not eligible for coverage under any other employer health insurance plan.

The premium for a conversion policy issued under this subsection shall not exceed one hundred thirty-five percent (135%) of the rate that would have been charged under the health insurance plan with respect to the individual if the individual had been covered as an eligible employee under the plan during the same period. If the health insurance plan under which the individual was covered is canceled or is not renewed, the rate shall be based on the rate that would have been charged with respect to the individual if the plan had continued in force, as determined by the small employer insurer in accordance with standard actuarial principles.

As added by P.L.93-1995, SEC.20.

IC 27-8-15-32

Employees becoming eligible after employer's commencement of health insurance plan entitled to coverage

Sec. 32. (a) If an individual:

(1) becomes an eligible employee of a small employer after the date that a small employer insurer first insures an eligible employee of the small employer under a health insurance plan; and

(2) is not a late enrollee;

the individual and all dependents of the individual are entitled to coverage under section 33 of this chapter, subject to the provisions of sections 27 and 28 of this chapter.

As added by P.L.93-1995, SEC.21.

IC 27-8-15-33

Mandatory coverage by employer insurer to all employer's eligible employees and employees' dependents; employees declining coverage; minimum participation and contribution requirements

Sec. 33. (a) If a small employer insurer offers coverage under a health insurance plan to a small employer, the small employer insurer shall provide the employer coverage under the plan for:

(1) all eligible employees of the small employer; and

(2) the dependents of all eligible employees of the small employer.

(b) Except as provided in section 29 of this chapter with respect to late enrollees, a small employer insurer shall not limit the insurer's provision of coverage to:

(1) certain individuals in a small employer group; or

(2) a part of a small employer group.

(c) This section does not prohibit an eligible employee from declining coverage under this section.

(d) Nothing in this chapter prohibits a small employer insurer from including minimum participation and contribution requirements in its offer of coverage.

As added by P.L.93-1995, SEC.22.

IC 27-8-15-34
Repealed

(Repealed by P.L.91-1998, SEC.24.)

IC 27-8-15-34.1
All products required to be offered; all employers required to be accepted

Sec. 34.1. Except as provided in 29 U.S.C. 1191a and 42 U.S.C. 300gg, a small employer insurer must:

(1) offer to any small employer all products that are approved for sale in the small group market and that the insurer is actively marketing; and

(2) accept any employer that applies for any of those products.

As added by P.L.91-1998, SEC.20.

IC 27-8-15.5

Chapter 15.5. Small Employer Insurer Voluntary Reinsurance Program

IC 27-8-15.5-1

Applicability of definitions

Sec. 1. The definitions set forth in IC 27-8-15 apply throughout this chapter.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-2

"Board" defined

Sec. 2. As used in this chapter, "board" refers to the Indiana small employer health reinsurance board established by section 5 of this chapter.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-3

"Program" defined

Sec. 3. As used in this chapter, "program" refers to the program of reinsurance established by section 6 of this chapter.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-4

"Reinsuring carrier" defined

Sec. 4. As used in this chapter, "reinsuring carrier" means a small employer insurer that obtains reinsurance under this chapter.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-5

Establishment of board

Sec. 5. The Indiana small employer health reinsurance board is established. The board shall supervise and control the program of reinsurance established under this chapter.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-6

Establishment of program

Sec. 6. The Indiana small employer health reinsurance program is established. Any small employer insurer that is doing or planning to do business in Indiana may become a member of the program as described in section 12 of this chapter.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-7

Members of board

Sec. 7. (a) The board consists of the commissioner or the commissioner's designated representative, who serves as an ex

officio member of the board, and ten (10) members. The members of the board shall be appointed by the commissioner, who shall name a chairman of the board one (1) time every three (3) years.

(b) The members of the board appointed under subsection (a) must include the following:

(1) One (1) representative of health maintenance organizations.

(2) One (1) representative of providers (as defined in IC 27-13-1-28).

(3) Six (6) representatives of small employer insurers.

(4) Two (2) representatives of small employers.

(c) A member of the board is appointed for a term of three (3) years.

(d) The term of a board member appointed under subsection (a) continues until the board member's successor is appointed.

(e) The commissioner shall fill a vacancy in an appointive member's position on the board.

(f) A board member may be removed by the commissioner for cause.

(g) At least six (6) members of the board must be present for the board to conduct official business. The affirmative vote of at least six (6) members of the board is necessary for the board to take official action.

(h) The board shall meet at least one (1) time each calendar quarter at the call of the commissioner.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-8

Plan of operation; submission; approval; amendments

Sec. 8. (a) Not later than two hundred seventy (270) days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation.

(b) The commissioner may adopt the plan of operation as a rule under IC 4-22-2 if the commissioner determines the plan will:

(1) ensure the fair, reasonable, and equitable administration of the program; and

(2) provide for the sharing of program gains or losses on an equitable and a proportionate basis in accordance with this chapter.

(c) After the adoption of a plan of operation under this section, the board may submit to the commissioner any proposed amendments to the plan the board considers necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may adopt under IC 4-22-2 proposed amendments submitted under this subsection as amendments to the rule adopted under subsection (b).

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-9

Plan of operation; temporary plan

Sec. 9. (a) If the board fails to submit a suitable plan of operation within the time allowed under section 8 of this chapter, the commissioner shall adopt rules under IC 4-22-2 establishing a temporary plan of operation.

(b) The commissioner shall amend or rescind under IC 4-22-2 any temporary plan of operation adopted under this section when a plan of operation is submitted by the board and approved by the commissioner.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-10

Plan of operation; requirements

Sec. 10. The plan of operation submitted and adopted under section 8 of this chapter must do the following:

(1) Establish procedures for the handling and accounting of program assets and money.

(2) Provide for an annual fiscal report to the commissioner.

(3) Establish procedures for selecting an insurer to administer the program.

(4) Establish the powers and duties of the administering insurer, including:

(A) notifying all members regarding annual assessments; and

(B) collecting of assessments.

(5) Establish procedures for reinsuring risks under this chapter.

(6) Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses that are incurred or estimated to be incurred by the program.

(7) Establish a methodology for applying the dollar thresholds contained in this chapter in the case of small employer insurers that pay or reimburse health care providers through capitation or salary.

(8) Provide for any additional matters necessary for the implementation and administration of the program.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-11

Powers of board

Sec. 11. (a) The board, in supervising and controlling the program, has the general powers and authority granted under IC 27 to insurance companies and health maintenance organizations authorized to transact business in Indiana, except the power to issue health insurance plans directly to groups or individuals.

(b) In addition to exercising the powers conferred by subsection (a), the board may do the following:

(1) Enter into contracts that are necessary or proper to carry out the provisions and purposes of this chapter, including, with the approval of the commissioner, contracts with:

(A) similar programs of other states for the joint performance of common functions; or

(B) persons or other organizations for the performance of administrative functions.

(2) Sue or be sued, including taking any legal action necessary or proper to recover assessments and penalties for, on behalf of, or against the program or any reinsuring insurer.

(3) Take any legal action necessary to avoid the payment of improper claims against the program.

(4) Define the health insurance plans for which reinsurance is provided.

(5) Issue reinsurance policies under this chapter.

(6) Establish rules, conditions, and procedures for reinsuring risks under the program.

(7) Establish actuarial functions as appropriate for the operation of the program.

(8) Impose assessments on reinsuring carriers under this chapter, and make advance interim assessments that are reasonable and necessary for organizational and interim operating expenses.

(9) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, policy, and other contract design, and any other function within the authority of the program.

(c) Any interim assessments imposed under subsection (b)(8) shall be credited as offsets against any regular assessments due from reinsuring carriers after the close of the fiscal year.

(d) Any notes or other evidence of indebtedness of the program that are not in default:

(1) are legal investments for small employer insurers; and

(2) may be carried by small employer insurers as admitted assets.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-12

Election to become member of program

Sec. 12. (a) A small employer insurer may elect to become a member of the program by filing a written intention to participate with the commissioner not later than sixty (60) days after the:

(1) board submits a plan of operation to the commissioner and the commissioner adopts the plan under section 8 of this chapter; or

(2) commissioner establishes a temporary plan of operation for the program under section 9 of this chapter;

whichever occurs first.

(b) A small employer insurer that fails to become a member of the program under subsection (a) may only become a member by filing a written intention with the commissioner to participate in the

program:

(1) three (3) years; or

(2) at the end of any three (3) year interval;

after the program begins under subsection (a)(1) or (a)(2).

(c) Notwithstanding subsections (a) and (b), the commissioner may permit a small employer insurer to become a member of the program at other times for reasons based on financial solvency.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-13

Maximum level of coverage; other limits on coverage

Sec. 13. (a) The board may establish a maximum level of coverage up to which the program will reinsure a health insurance plan and beyond which the program will not reinsure a health insurance plan.

(b) A member of the program must allow any employer insured by the member to maintain the same health insurance plan and may reinsure only that part of the health insurance plan that is consistent with the program established by the board.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-14

Time requirements for reinsurance

Sec. 14. (a) A small employer insurer may reinsure an entire small employer group not later than sixty (60) days after the commencement of the coverage of the small employer group under a health insurance plan.

(b) A small employer insurer may reinsure coverage of an eligible employee or the dependent of an eligible employee under a health insurance plan issued to a small employer not later than sixty (60) days after the coverage of the eligible employee or dependent of the eligible employee commences.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-15

Reimbursement of reinsuring carriers

Sec. 15. The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the reinsuring carrier has incurred an initial level of claims for the employee or dependent of five thousand dollars ($5,000) in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for ten percent (10%) of the next fifty thousand dollars ($50,000) of benefit payments during a calendar year, and the program shall reinsure the remainder. The liability of a reinsuring carrier under this section may not exceed ten thousand dollars ($10,000) in any calendar year with respect to any reinsured individual.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-16
Adjustments in initial level of claims and maximum limit to be retained

Sec. 16. The board may annually adjust the initial level of claims and the maximum limit to be retained by a reinsuring carrier to reflect increases in costs and utilization within the standard market for health insurance plans in Indiana. The adjustment may not be lower than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the United States Department of Labor unless the board proposes and the commissioner approves a lower adjustment factor.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-17
Termination of reinsurance

Sec. 17. A small employer insurer that issues a health insurance plan to a small employer and obtains reinsurance for the health insurance plan under this chapter may terminate the reinsurance for one (1) or more of the reinsured employees or dependents of the small employer:

(1) on any anniversary of the health insurance plan; or

(2) when the reinsured employee leaves the employment of the small employer.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-18
Reduction of premium rates for reinsurance of federally qualified HMOs

Sec. 18. Premium rates charged under this chapter for reinsurance to a health maintenance organization that is federally qualified under 42 U.S.C. 300e et seq., and as such is subject to limits on the amount of risk that may be ceded to the program that are more restrictive than those set forth in section 15 of this chapter, must be reduced to reflect the part of the risk, if any, that may not be ceded to the program due to the more restrictive limits.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-19
Managed care and claims handling techniques

Sec. 19. A reinsuring carrier shall apply all managed care and claims handling techniques, including:

(1) utilization review;

(2) individual case management;

(3) preferred provider provisions; and

(4) other managed care provisions or methods of operation;

consistently with respect to reinsured and nonreinsured business.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-20
Methodology for determining premium rates

Sec. 20. (a) The board, as part of the plan of operation adopted under section 8 of this chapter, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals under this chapter.

(b) The methodology established under this section must include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer insurers in Indiana.

(c) The methodology established under this section must provide for the development of base reinsurance premium rates. The base reinsurance premium rates are multiplied by the factors set forth in section 21 of this chapter to determine the premium rates for the program.

(d) The base reinsurance premium rates referred to in subsection (c) shall be established by the board, subject to the approval of the commissioner.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-21
Multiplication factors for premium rates

Sec. 21. (a) Premiums charged by the program for reinsurance are as follows:

(1) An entire small employer group may be reinsured for a rate that is one hundred fifty percent (150%) of the base reinsurance premium rate for the group that is developed under section 20(c) of this chapter.

(2) An eligible employee or the dependent of an eligible employee may be reinsured for a rate that is five hundred percent (500%) of the base reinsurance premium rate for the individual established under this section.

(b) The board shall periodically review the methodology established under section 20 of this chapter, including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the program. The board may propose changes in the methodology. The changes proposed by the board take effect upon approval by the commissioner.

(c) The board may consider adjustments to the premium rates charged for reinsurance under the program to reflect the use of effective cost containment and managed care arrangements.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-22
Premium rates for health insurance plans to comply with IC 27-8-15

Sec. 22. If a health insurance plan issued to a small employer is entirely or partially reinsured under the program, the premium

charged to the small employer for any rating period for the coverage issued must meet the requirements relating to premium rates set forth in IC 27-8-15.
As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-23
Determination and report of net loss

Sec. 23. (a) Before March 1 of each year, the board shall determine and report to the commissioner the program's net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) Any net loss for the year shall be recouped by assessments of reinsuring carriers.
As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-24
Determination of assessments against reinsuring carriers

Sec. 24. (a) The board, as part of the plan of operation adopted under section 8 of this chapter, shall establish a formula by which to impose assessments against reinsuring carriers.

(b) The assessment formula established under subsection (a) must result in assessments apportioned by the board among all small employer insurers participating in the program in proportion to:

(1) the small employer insurers' respective shares of the total premiums;

(2) the net of reinsurance premiums paid for coverage under the program earned from health insurance plans covering small employers that are issued by participating small employer insurers during the calendar year coinciding with or ending during the fiscal year of the program; or

(3) any other equitable basis reflecting coverage of small employers as may be provided in the plan of operation.

(c) Health insurance plan premiums and benefits paid by a reinsuring carrier that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

(d) An assessment determined under this section may not exceed one percent (1%) of total net premiums annually. If an excess is actuarially projected, the commissioner may take any action necessary to lower the assessment to the maximum level of one percent (1%) of total net premiums.

(e) The board, with the approval of the commissioner, may change the assessment formula established under this section from time to time as appropriate.

(f) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations and federally

qualified under 42 U.S.C. 300e et seq., to the extent that restrictions are placed on them that are not imposed on other small employer insurers.
As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-25
Estimates of assessments needed to fund losses

Sec. 25. (a) Before March 1 of each year the board shall determine and file with the commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(b) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed two percent (2%) of total premiums earned in the previous calendar year from health insurance plans delivered or issued for delivery to small employers by reinsuring carriers, the board shall evaluate the operation of the program and report the board's findings, including any recommendations for changes in the plan of operation adopted under section 8 of this chapter, to the commissioner not more than ninety (90) days after the end of the calendar year in which the losses were incurred. The evaluation must:

(1) include an estimate of future assessments; and
(2) consider the:
(A) administrative costs of the program;
(B) appropriateness of the premiums charged;
(C) level of insurer retention under the program; and
(D) costs of coverage for small employers.

(c) If the board fails to file a report with the commissioner under subsection (b) not later than ninety (90) days after the end of the calendar year, the commissioner may:

(1) evaluate the operation of the program; and
(2) implement the amendments to the plan of operation adopted under section 8 of this chapter that the commissioner considers necessary to reduce future losses and assessments.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-26
Use of excess assessments

Sec. 26. If assessments paid by reinsuring carriers under this chapter exceed the net losses of the program, the excess is held at interest and used by the board to:

(1) offset future losses, including reserves for incurred but not reported claims; or
(2) reduce program premiums.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-27
Determination of reinsuring carrier's proportion of assessments

Sec. 27. (a) The board shall annually determine each reinsuring carrier's proportion of the assessment for reinsurance under this chapter based on annual statements and other reports considered necessary by the board and filed with the board by the reinsuring carriers.

(b) The plan of operation adopted under section 8 of this chapter must provide for the imposition of an interest penalty on reinsuring carriers for late payment of assessments.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-28

Deferments from assessments

Sec. 28. (a) A reinsuring carrier may seek from the commissioner a deferment from all or part of an assessment imposed by the board. The commissioner may defer all or part of the assessment of a reinsuring carrier if the commissioner determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition.

(b) If all or part of an assessment against a reinsuring carrier is deferred under subsection (a), the amount deferred is assessed against the other reinsuring carriers in a manner consistent with the basis for assessment under this chapter.

(c) A reinsuring carrier that receives a deferment under this section:

(1) remains liable to the program for the amount deferred; and

(2) may not reinsure an individual or a group with the program until the reinsuring carrier pays the assessment.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-29

Participation not to be basis for legal action, liability, or penalty

Sec. 29. The participation of small employer insurers in the program as reinsuring carriers, the establishment of rates, forms, or procedures under this chapter, or any other joint or collective action required by this chapter may not be the basis of any legal action, criminal or civil liability, or penalty against the program or any of the program's reinsuring carriers, either jointly or separately.

As added by P.L.193-1996, SEC.1.

IC 27-8-15.5-30

Tax exemption

Sec. 30. The program is exempt from all taxes imposed by the state.

As added by P.L.193-1996, SEC.1.

IC 27-8-16

Chapter 16. Medical Claims Review

IC 27-8-16-0.5

Applicability of chapter

Sec. 0.5. (a) This chapter applies to the following:

(1) A person who conducts medical claims review concerning health care services delivered to an enrollee in Indiana.

(2) A person who acts as a claim review consultant concerning the:

(A) appropriateness of; or

(B) amount charged for;

a health care service delivered to an enrollee in Indiana.

(b) This chapter does not apply to:

(1) the payment of benefits or compensation;

(2) the furnishing of medical, surgical, hospital, or nursing services; or

(3) the payment by an insurer or employer to the provider of health care services for services provided;

under IC 22.

As added by P.L.260-1995, SEC.1.

IC 27-8-16-1

"Claim review agent" defined

Sec. 1. (a) As used in this chapter, "claim review agent" means any entity performing medical claims review on behalf of an insurance company, a health maintenance organization, or another benefit program providing payment, reimbursement, or indemnification for health care costs to an enrollee.

(b) The term does not include the following:

(1) An insurance company authorized under IC 27-1-3 or IC 27-1-17 to do business in Indiana or the company's affiliated companies.

(2) An entity acting on behalf of the federal or state government. However, an agent described in this subdivision who performs medical claims review for a person other than the federal or state government is a claim review agent who is subject to the requirements of this chapter.

(3) A health maintenance organization or limited service health maintenance organization that holds a certificate of authority to operate under IC 27-13.

(4) An insurance administrator that is licensed under IC 27-1-25.

(5) An individual qualified and acting as an expert witness under the Indiana Rules of Trial Procedure.

As added by P.L.128-1992, SEC.2. Amended by P.L.26-1994, SEC.17; P.L.160-2003, SEC.25.

IC 27-8-16-1.5
"Claim review consultant" defined

Sec. 1.5. (a) As used in this chapter, "claim review consultant" means a person who:

(1) makes a recommendation or provides consultation to:

(A) an entity engaged in performing medical claims review; or

(B) an insurance company, a health maintenance organization, or another benefit program providing payment, reimbursement, or indemnification for health care costs to an enrollee;

concerning the appropriateness of a health care service or the amount charged for a health care service delivered to an enrollee in Indiana; and

(2) is not an employee of an entity referred to in subdivision (1)(A) or (1)(B).

(b) Making a recommendation or providing consultation concerning a health care service does not render a person a claim review consultant under this section if the recommendation or consultation concerns:

(1) coverage provided; or

(2) medical services rendered;

under IC 22.

(c) The term "claim review consultant" does not include the following:

(1) An insurance company authorized under IC 27 to do business in Indiana.

(2) An entity acting on behalf of the federal or state government. However, an agent described in this subdivision who performs medical claims review for a person other than the federal or state government is a claim review agent who is subject to the requirements of this chapter.

(3) A health maintenance organization or limited service health maintenance organization that holds a certificate of authority to operate under IC 27-13.

(4) An insurance administrator that is licensed under IC 27-1-25.

(5) An individual qualified and acting as an expert witness under the Indiana Rules of Trial Procedure.

(6) A person who engages in the prospective, concurrent, or retrospective utilization review of health care services.

(7) A person who engages in the identification of alternative, optional medical care that:

(A) requires the approval of the enrollee or covered individual; and

(B) does not affect coverage or benefits if rejected by the enrollee or covered individual.

(8) An individual who is a licensed health care provider who

makes a recommendation or provides consultation concerning the appropriateness of health care service. However, this exception does not apply if the individual:

(A) makes any recommendations or provides consultation concerning the amount charged for a health care service delivered in Indiana;

(B) makes any recommendations or provides consultation concerning the appropriateness of hospital services provided by a hospital licensed under IC 12-25 or IC 16-21;

(C) is employed by or under contract with an entity that is required to be registered under this chapter; or

(D) has received more than five thousand dollars ($5,000) in compensation during the present calendar year for providing consultation services concerning the appropriateness of health care services delivered to enrollees in Indiana.

(9) A claim review agent under section 1 of this chapter.

As added by P.L.260-1995, SEC.2. Amended by P.L.160-2003, SEC.26.

IC 27-8-16-2
"Department" defined

Sec. 2. As used in this chapter, "department" refers to the department of insurance.

As added by P.L.128-1992, SEC.2.

IC 27-8-16-3
"Enrollee" defined

Sec. 3. As used in this chapter, "enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy, a health maintenance organization contract, or another benefit program providing payment, reimbursement, or indemnification for the costs of health care for:

(1) the individual;

(2) eligible dependents of the individual; or

(3) both the individual and the individual's eligible dependents.

As added by P.L.128-1992, SEC.2.

IC 27-8-16-4
"Medical claims review" defined

Sec. 4. (a) As used in this chapter, "medical claims review" means the determination of the reimbursement to be provided under the terms of an insurance policy, a health maintenance organization contract, or another benefit program providing payment, reimbursement, or indemnification for health care costs based on the appropriateness of health care services or the amount charged for a health care service delivered to an enrollee.

(b) The term does not include the prospective, concurrent, or retrospective utilization review of health care services.

(c) The term does not include the identification of alternative, optional medical care that:

(1) requires the approval of the enrollee or covered individual; and

(2) does not affect coverage or benefits if rejected by the enrollee or covered individual.

As added by P.L.128-1992, SEC.2. Amended by P.L.135-1994, SEC.1.

IC 27-8-16-4.5
"Person" defined

Sec. 4.5. As used in this chapter, "person" means an individual, a corporation, a limited liability company, a partnership, or an unincorporated association.

As added by P.L.260-1995, SEC.3.

IC 27-8-16-5
Certificate of registration; issuance to agent

Sec. 5. (a) A claim review agent may not conduct medical claims review concerning health care services delivered to an enrollee in Indiana unless the claim review agent holds a certificate of registration issued by the department under this chapter.

(b) To obtain a certificate of registration under this chapter, a claim review agent must submit to the department an application containing the following:

(1) The name, address, telephone number, and normal business hours of the claim review agent.

(2) The name and telephone number of a person that the department may contact concerning the information in the application.

(3) Documentation necessary for the department to determine that the claim review agent is capable of satisfying the minimum requirements set forth in section 7 of this chapter.

(c) An application submitted under this section must be:

(1) signed and verified by the applicant; and

(2) accompanied by an application fee in the amount established under subsection (d).

The commissioner shall deposit an application fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.

(d) The department shall set the amount of the application fee required by subsection (c) and section 6(a) of this chapter in the rules adopted under section 14 of this chapter. The amount may not be more than is reasonably necessary to generate revenue sufficient to offset the costs incurred by the department in carrying out the department's responsibilities under this chapter.

(e) The department shall issue a certificate of registration to a claim review agent that satisfies the requirements of this section.

As added by P.L.128-1992, SEC.2. Amended by P.L.260-1995, SEC.4; P.L.173-2007, SEC.36; P.L.234-2007, SEC.193.

IC 27-8-16-5.2
Certificate of registration; application; requirements; application fee

Sec. 5.2. (a) A person may not act as a claim review consultant concerning health care services delivered to an enrollee in Indiana unless the person holds a certificate of registration issued by the department under this chapter.

(b) To obtain a certificate of registration under this chapter, a person must submit to the department an application containing the following:

(1) The name, address, telephone number, and normal business hours of the person.

(2) The name and telephone number of a person that the department may contact concerning the information in the application.

(3) Documentation necessary for the department to determine that the person is capable of satisfying the minimum requirements set forth in this chapter.

(c) An application submitted under this section must be:

(1) signed and verified by the applicant; and

(2) accompanied by an application fee in the amount established under subsection (d).

The commissioner shall deposit an application fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.

(d) The department shall set the amount of the application fee required by subsection (c) and section 6(a) of this chapter in the rules adopted under section 14 of this chapter. The amount may not be more than is reasonably necessary to generate revenue sufficient to offset the costs incurred by the department in carrying out the department's responsibilities under this chapter.

(e) The department shall issue a certificate of registration to a claim review consultant that satisfies the requirements of this section.

As added by P.L.260-1995, SEC.5. Amended by P.L.173-2007, SEC.37; P.L.234-2007, SEC.194.

IC 27-8-16-6
Certificate of registration; renewal; transfer; notice of change in information

Sec. 6. (a) To remain in effect, a certificate of registration issued under this chapter must be renewed annually. To obtain the renewal of a certificate of registration, a claim review agent or a claim review consultant must submit an application to the commissioner. The application must be accompanied by a registration fee in the amount

set under section 5(d) of this chapter. The commissioner shall deposit a registration fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.

(b) A certificate of registration issued under this chapter may not be transferred unless the department determines that the person to which the certificate of registration is to be transferred has satisfied the requirements of this chapter.

(c) If there is a material change in any of the information set forth in an application submitted under this chapter, the claim review agent or claim review consultant that submitted the application shall notify the department of the change in writing not more than thirty (30) days after the change.

As added by P.L.128-1992, SEC.2. Amended by P.L.260-1995, SEC.6; P.L.173-2007, SEC.38; P.L.234-2007, SEC.195; P.L.146-2015, SEC.35.

IC 27-8-16-7

Minimum claim review agent requirements

Sec. 7. A claim review agent must satisfy the following minimum requirements:

(1) Provide toll free telephone access at least forty (40) hours each week during normal business hours.

(2) Maintain a telephone call recording system capable of accepting or recording incoming telephone calls or providing instructions during hours other than normal business hours.

(3) Respond to each telephone call left on the recording system maintained under subdivision (2) within two (2) business days after receiving the call.

(4) Protect the confidentiality of the medical records disclosed to the claim review agent.

(5) Include in every notification of a medical review determination based on the appropriateness of health care services delivered to an enrollee the principal reason for the determination.

(6) Ensure that every medical claims review determination based on the appropriateness of health care services delivered to an enrollee is:

(A) made by a provider; or

(B) determined in accordance with standards or guidelines approved by a provider;

who holds a license in the same discipline as the provider who rendered the service.

(7) Include in every notification of a medical review determination based on the appropriateness of the amount charged for a health care service delivered to an enrollee the following:

(A) An explanation of the factual basis for the determination.

(B) If the determination is based on any information from a claims data base, the name and address of the person or entity compiling the data base.

(C) If the determination is based on any information from a claims data base, a statement whether any of the information was obtained from a data base regarding amounts charged for health services performed outside Indiana.

(D) Any percentile limiter applied to determine the appropriateness of an amount charged for a health service provided to an enrollee.

(8) Ensure that every provider referred to in subdivision (6) who makes medical claims review determinations or approves standards or guidelines for medical claims review determinations for the claim review agent has a current license issued by a state licensing agency in the United States.

(9) Develop a medical claims review plan and file a summary of the plan with the department.

As added by P.L.128-1992, SEC.2. Amended by P.L.135-1994, SEC.2.

IC 27-8-16-8

Appeals procedure; written description; minimum standards; notice of appeal procedure on limitation or reduction of benefits

Sec. 8. (a) An insurance company, a health maintenance organization, or another benefit program providing payment, reimbursement, or indemnification for health care costs that contracts with a claim review agent for medical claims review services shall maintain and make available upon request a written description of the appeals procedure by which an enrollee may seek a review of a determination by the claim review agent.

(b) The appeals procedure referred to in subsection (a) must meet the following requirements:

(1) On appeal, the determination must be made by a provider who holds a license in the same discipline as the provider who rendered the service.

(2) The adjudication of an appeal of a determination must be completed within thirty (30) days after:

(A) the appeal is filed; and

(B) all information necessary to complete the appeal is received.

(c) If a medical review determination results in a limitation or reduction of benefits, a notice of the appeals procedure shall be provided by the claim review agent to the provider who rendered the health care services.

As added by P.L.128-1992, SEC.2.

IC 27-8-16-9

Provider's statement; documentation of review agent capability

Sec. 9. To provide documentation demonstrating that a claim review agent is capable of satisfying the requirement of section 7(6) of this chapter, the claim review agent must provide a signed statement of a provider employed by the claim review agent verifying that determinations are:

(1) made by; or

(2) determined in accordance with standards or guidelines approved by;

a provider licensed in the same discipline as the provider who rendered the service.

As added by P.L.128-1992, SEC.2.

IC 27-8-16-9.5

Claim determinations based on data base information

Sec. 9.5. (a) As used in this section, "data base" means a data base that provides information concerning health care services or amounts charged for health care services.

(b) If a claim review agent bases a medical claims review determination concerning a health care service provided by a hospital licensed under IC 12-25 or IC 16-21 in whole or in part on information obtained from a data base, the information must relate exclusively to services provided by a hospital licensed under IC 12-25 or IC 16-21.

(c) If a claim review consultant makes a recommendation or provides consultation concerning the appropriateness of or the amount charged for services provided by a hospital licensed under IC 12-25 or IC 16-21 based in whole or in part on information obtained from a data base, the information must relate exclusively to services provided by a hospital licensed under IC 12-25 or IC 16-21.

(d) This section does not apply to:

(1) medical claims review determinations made under subsection (b); or

(2) consultations or recommendations made under subsection (c);

regarding medical services provided under IC 22.

As added by P.L.260-1995, SEC.7.

IC 27-8-16-10

Fraudulent or misleading information; penalties

Sec. 10. A provider, an enrollee, or an agent of a provider or enrollee who provides fraudulent or misleading information to a claim review agent is subject to the appropriate administrative, civil, and criminal penalties.

As added by P.L.128-1992, SEC.2.

IC 27-8-16-11

Prohibited bases for compensation of claim review agents and consultants

Sec. 11. (a) The compensation of a claim review agent for the performance of medical claims review may not be based on the amount by which claims are reduced for payment.

(b) The compensation of a claim review consultant for making a recommendation or providing consultation concerning the appropriateness of or amount charged for a health care service delivered to an enrollee in Indiana may not be based on the amount by which a claim relating to the service is reduced for payment.

As added by P.L.128-1992, SEC.2. Amended by P.L.260-1995, SEC.8.

IC 27-8-16-12

Violations; claims review agent; notice; cease and desist orders; penalties; revocation or suspension of registration; review

Sec. 12. (a) If the department believes that a claim review agent or claim review consultant has violated this chapter, the department shall notify the claim review agent or claim review consultant of the alleged violation.

(b) The claim review agent or claim review consultant shall respond to a notice given under subsection (a) within thirty (30) days after receiving the notice.

(c) If the department:

(1) believes that a claim review agent or claim review consultant has violated this chapter; and

(2) is not satisfied, based on the response given by the claim review agent or claim review consultant under subsection (b), that the violation has been corrected;

the department shall order the claim review agent or claim review consultant under IC 4-21.5-3-6 to cease all claims review activities in Indiana.

(d) If the department determines that a claim review agent or claim review consultant has violated this chapter, the department:

(1) shall order the claim review agent or claim review consultant to cease and desist from engaging in the violation; and

(2) may do either or both of the following:

(A) Order the claim review agent or claim review consultant to pay a civil penalty of not more than five thousand dollars ($5,000) if the claim review agent or claim review consultant has committed violations with a frequency that indicates a general business practice.

(B) Suspend or revoke the certificate of registration of the claim review agent or claim review consultant.

(e) An order issued or a ruling made by the department under this section is subject to review under IC 4-21.5.

As added by P.L.128-1992, SEC.2. Amended by P.L.260-1995, SEC.9.

IC 27-8-16-13
Confidential information

Sec. 13. (a) This chapter does not require a claim review agent or claim review consultant to disclose information that is proprietary.

(b) Any:

(1) information concerning standards, criteria, or medical protocols used by a claim review agent in conducting medical claims review; and

(2) other proprietary information concerning medical claims review conducted by a claim review agent;

that is disclosed to the department under this chapter is confidential for the purposes of IC 5-14-3-4(a)(1).

As added by P.L.128-1992, SEC.2. Amended by P.L.260-1995, SEC.10.

IC 27-8-16-14
Rules

Sec. 14. The department shall adopt rules under IC 4-22-2 necessary to carry out this chapter.

As added by P.L.128-1992, SEC.2.

IC 27-8-17

Chapter 17. Health Care Utilization Review

IC 27-8-17-1

"Covered individual" defined

Sec. 1. As used in this chapter, "covered individual" means:

(1) an enrollee; or

(2) an eligible dependent of an enrollee.

As added by P.L.128-1992, SEC.1.

IC 27-8-17-2

"Department" defined

Sec. 2. As used in this chapter, "department" refers to the department of insurance.

As added by P.L.128-1992, SEC.1.

IC 27-8-17-3

"Enrollee" defined

Sec. 3. As used in this chapter, "enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy issued under insurance classes 1(b) and 2(a) of IC 27-1-5-1, health maintenance organization contract, or other benefit program providing payment, reimbursement, or indemnification for the costs of health care for:

(1) the individual;

(2) eligible dependents of the individual; or

(3) both the individual and the individual's eligible dependents.

As added by P.L.128-1992, SEC.1.

IC 27-8-17-4

"Health maintenance organization" defined

Sec. 4. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

As added by P.L.128-1992, SEC.1. Amended by P.L.26-1994, SEC.18.

IC 27-8-17-5

"Provider of record" defined

Sec. 5. As used in this chapter, "provider of record" means the physician or other licensed practitioner identified to a utilization review agent as having primary responsibility for the care, treatment, and services rendered to a covered individual.

As added by P.L.128-1992, SEC.1.

IC 27-8-17-6

"Utilization review" defined

Sec. 6. (a) As used in this chapter, "utilization review" means a system for prospective, concurrent, or retrospective review of the

medical necessity and appropriateness of health care services provided or proposed to be provided to a covered individual.

(b) The term does not include the following:

(1) Elective requests for clarification of coverage, eligibility, or benefits verification.

(2) Medical claims review (as defined in IC 27-8-16-4).

As added by P.L.128-1992, SEC.1.

IC 27-8-17-7

"Utilization review agent" defined

Sec. 7. (a) As used in this chapter, "utilization review agent" means any entity performing utilization review, except the following:

(1) An agency of the state or federal government.

(2) An agent acting on behalf of the federal or state government.

(3) Entities conducting general in-house utilization review for hospitals, home health agencies, health maintenance organizations, preferred provider organizations or other managed care entities, clinics, private offices, or any other health facility, so long as the review does not result in the approval or denial of an enrollee's coverage for hospital or medical services.

(b) However, an agent described in subsection (a)(2) who performs utilization review for a person other than the federal or state government is a utilization review agent who is subject to the requirements of this chapter.

As added by P.L.128-1992, SEC.1.

IC 27-8-17-8

"Utilization review determination" defined

Sec. 8. (a) As used in this chapter, "utilization review determination" means the rendering of a decision based on utilization review that denies or affirms either of the following:

(1) The necessity or appropriateness of the allocation of resources.

(2) The provision or proposed provision of health care services to a covered individual.

(b) The term does not include the identification of alternative, optional medical care that:

(1) requires the approval of the covered individual; and

(2) does not affect coverage or benefits if rejected by the covered individual.

As added by P.L.128-1992, SEC.1.

IC 27-8-17-9

Certificate of registration; issuance to agent

Sec. 9. (a) A utilization review agent may not conduct utilization review in Indiana unless the utilization review agent holds a certificate of registration issued by the department under this chapter.

(b) To obtain a certificate of registration under this chapter, a utilization review agent must submit to the department an application containing the following:

(1) The name, address, telephone number, and normal business hours of the utilization review agent.

(2) The name and telephone number of a person that the department may contact concerning the information in the application.

(3) Documentation necessary for the department to determine that the utilization review agent is capable of satisfying the minimum requirements set forth in section 11 of this chapter.

(c) An application submitted under this section must be:

(1) signed and verified by the applicant; and

(2) accompanied by an application fee in the amount established under subsection (d).

The commissioner shall deposit an application fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.

(d) The department shall set the amount of the application fee required by subsection (c) and section 10(a) of this chapter in the rules adopted under section 20 of this chapter. The amount may not be more than is reasonably necessary to generate revenue sufficient to offset the costs incurred by the department in carrying out its responsibilities under this chapter.

(e) The department shall issue a certificate of registration to a utilization review agent that satisfies the requirements of this section.

As added by P.L.128-1992, SEC.1. Amended by P.L.173-2007, SEC.39; P.L.234-2007, SEC.196.

IC 27-8-17-10

Certificate of registration; renewal; transfer; notice of change in information

Sec. 10. (a) To remain in effect, a certificate of registration issued under this chapter must be renewed annually. To obtain the renewal of a certificate of registration, a utilization review agent must submit an application to the commissioner. The application must be accompanied by a registration fee in the amount set under section 9(d) of this chapter. The commissioner shall deposit a registration fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.

(b) A certificate of registration issued under this chapter may not be transferred unless the department determines that the entity to whom the certificate is to be transferred has satisfied the requirements of this chapter.

(c) If there is a material change in any of the information set forth in an application submitted under this chapter, the utilization review agent that submitted the application shall notify the department of the change in writing within thirty (30) days after the change.

As added by P.L.128-1992, SEC.1. Amended by P.L.173-2007, SEC.40; P.L.234-2007, SEC.197; P.L.146-2015, SEC.36.

IC 27-8-17-11
Minimum utilization review agent requirements

Sec. 11. A utilization review agent must satisfy the following minimum requirements:

(1) Provide toll free telephone access at least forty (40) hours each week during normal business hours.

(2) Maintain a telephone call recording system capable of accepting or recording incoming telephone calls or providing instructions during hours other than normal business hours.

(3) Respond to each telephone call left on the recording system maintained under subdivision (2) within two (2) business days after receiving the call.

(4) Protect the confidentiality of the medical records of covered individuals.

(5) Within two (2) business days after receiving a request for a utilization review determination that includes all information necessary to complete the utilization review determination, notify the enrollee or the provider of record of the utilization review determination by mail or another means of communication.

(6) Include in the notification of a utilization review determination not to certify an admission, a service, or a procedure:

(A) if the determination not to certify is based on medical necessity or appropriateness of the admission, service, or procedure, the principal reason for that determination; and

(B) the procedures to initiate an appeal of the determination.

(7) Ensure that every utilization review determination as to the necessity or appropriateness of an admission, a service, or a procedure is:

(A) reviewed by a physician; or

(B) determined in accordance with standards or guidelines approved by a physician.

(8) Ensure that every physician making a utilization review determination for the utilization review agent has a current license issued by a state licensing agency in the United States.

(9) Provide a period of at least forty-eight (48) hours following an emergency admission, service, or procedure during which:

(A) an enrollee; or

(B) the representative of an enrollee;

may notify the utilization review agent and request certification or continuing treatment for the condition involved in the admission, service, or procedure.

(10) Provide an appeals procedure satisfying the requirements set forth in section 12 of this chapter.

(11) Develop a utilization review plan and file a summary of the plan with the department.

As added by P.L.128-1992, SEC.1.

IC 27-8-17-12

Appeals procedure

Sec. 12. (a) A utilization review agent shall make available to an enrollee, and to a provider of record upon request, at the time an adverse utilization review determination is made:

(1) a written description of the appeals procedure by which an enrollee or a provider of record may appeal the utilization review determination by the utilization review agent; and

(2) in the case of an enrollee covered under an accident and sickness policy or a health maintenance organization contract described in subsection (d), notice that the enrollee has the right to appeal the utilization review determination under IC 27-8-28 or IC 27-13-10 and the toll free telephone number that the enrollee may call to request a review of the determination or obtain further information about the right to appeal.

(b) The appeals procedure provided by a utilization review agent must meet the following requirements:

(1) On appeal, the determination not to certify an admission, a service, or a procedure as necessary or appropriate must be made by a health care provider licensed in the same discipline as the provider of record.

(2) The determination of the appeal of a utilization review determination not to certify an admission, service, or procedure must be completed within thirty (30) days after:

(A) the appeal is filed; and

(B) all information necessary to complete the appeal is received.

(c) A utilization review agent shall provide an expedited appeals process for emergency or life threatening situations. The determination of an expedited appeal under the process required by this subsection shall be made by a physician and completed within forty-eight (48) hours after:

(1) the appeal is initiated; and

(2) all information necessary to complete the appeal is received by the utilization review agent.

(d) If an enrollee is covered under an accident and sickness insurance policy (as defined in IC 27-8-28-1) or a contract issued by a health maintenance organization (as defined in IC 27-13-1-19), the enrollee's exclusive right to appeal a utilization review determination is provided under IC 27-8-28 or IC 27-13-10, respectively.

(e) A utilization review agent shall make available upon request a written description of the appeals procedure that an enrollee or provider of record may use to obtain a review of a utilization review determination by the utilization review agent.

As added by P.L.128-1992, SEC.1. Amended by P.L.66-2001, SEC.1; P.L.203-2001, SEC.12; P.L.1-2002, SEC.112.

IC 27-8-17-13
Physician's statement; documentation of review agent capability

Sec. 13. To provide documentation demonstrating that a utilization review agent is capable of satisfying the requirement of section 11(7) of this chapter, as required by section 9(b)(3) of this chapter, the utilization review agent may provide a signed statement of a physician employed by or under contract to the utilization review agent verifying that determinations made by the utilization review agent as to the necessity or appropriateness of admissions, services, and procedures are reviewed by a physician or determined in accordance with standards or guidelines approved by a physician.
As added by P.L.128-1992, SEC.1.

IC 27-8-17-14
Accreditation and approval of review agent; determination; new certificate of registration; order to cease activities

Sec. 14. (a) The department may, according to the rules adopted under section 20 of this chapter, determine that a utilization review agent satisfies the requirements set forth in section 11 of this chapter if the utilization review agent:

(1) has, at the time of issuance of the agent's certificate of registration, received; and

(2) maintains;

the approval or accreditation of a utilization review accreditation organization that has been approved by the department for the purposes of this section. The department may not make a determination under this subsection before July 1, 1993.

(b) If a utilization review agent:

(1) is determined to satisfy the requirements of section 11 of this chapter by obtaining accreditation from a utilization review accreditation organization; and

(2) subsequently loses the accreditation from the accrediting organization;

the utilization review agent must, within sixty (60) days after losing its accreditation, obtain a new certificate of registration under this chapter to continue to conduct utilization review in Indiana. During the sixty (60) day period, the utilization review agent may continue to conduct utilization review subject to all other requirements of this chapter, unless ordered to cease under subsection (c).

(c) If the department determines, before the expiration of the sixty (60) day period referred to in subsection (b), that the utilization review agent cannot satisfy the requirements for issuance of a certificate of registration under this chapter, the department shall order the utilization review agent to immediately cease all utilization review activities in Indiana.

As added by P.L.128-1992, SEC.1.

IC 27-8-17-15

Certification of admission, service, or procedure; enrollee request; notice and information; assistance; denial under terms of benefit program

Sec. 15. (a) The following requirements apply to an enrollee's request for certification by a utilization review agent of an admission, a service, or a procedure:

(1) In the absence of contractual terms to the contrary, the enrollee is responsible for notifying the utilization review agent of the admission, service, or procedure in a timely manner and for obtaining certification of health care services.

(2) A utilization review agent shall allow the provider of record or a responsible patient representative, including a family member, to assist the enrollee in fulfilling the enrollee's responsibility under subdivision (1).

(3) The provider of record shall, within a reasonable time, provide to the utilization review agent all relevant information necessary to certify the admission, service, or procedure. For an emergency admission or procedure, the information shall be provided within two (2) business days after the emergency admission or procedure. For an elective admission, procedure, or treatment, the information shall be provided not later than two (2) business days before the admission or the provision of the procedure or treatment.

(b) The failure to provide the information required by this section may result in the denial of certification in accordance with the terms of the enrollee's insurance policy, health maintenance organization contract, or other benefit program.

As added by P.L.128-1992, SEC.1.

IC 27-8-17-16

Fraudulent or misleading information; penalties

Sec. 16. A provider of record, an enrollee, or the agent of a provider of record or an enrollee who provides fraudulent or misleading information is subject to appropriate administrative, civil, and criminal penalties, including the penalty for deception under IC 35-43-5-3.

As added by P.L.128-1992, SEC.1.

IC 27-8-17-17

Violations; notice to agent; cease and desist orders; penalties; revocation or suspension of registration; review

Sec. 17. (a) If the department believes that a utilization review agent has violated this chapter, the department shall notify the utilization review agent of the alleged violation.

(b) The utilization review agent shall respond to a notice given

under subsection (a) within thirty (30) days after receiving the notice.

(c) If the department:

(1) believes that a utilization review agent has violated this chapter; and

(2) is not satisfied, based on the response given by the utilization review agent under subsection (b), that the violation has been corrected;

the department shall order the utilization review agent under IC 4-21.5-3-6 to cease all utilization review activities in Indiana.

(d) If the department determines that a utilization review agent has violated this chapter, the department:

(1) shall order the utilization review agent to cease and desist from engaging in the violation; and

(2) may do either or both of the following:

(A) Order the utilization review agent to pay a civil penalty of not more than five thousand dollars ($5,000) if the utilization review agent has committed violations with a frequency that indicates a general business practice.

(B) Suspend or revoke the certificate of registration of the utilization review agent.

(e) Any order issued or ruling made by the department under this section is subject to review under IC 4-21.5.

As added by P.L.128-1992, SEC.1.

IC 27-8-17-18

Confidential information

Sec. 18. (a) This chapter does not require a utilization review agent to disclose information that is proprietary.

(b) Any:

(1) information concerning standards, criteria, or medical protocols used by a utilization review agent in conducting utilization review; or

(2) other proprietary information concerning utilization review conducted by a utilization review agent;

that is disclosed to the department of insurance under this chapter is confidential for the purposes of IC 5-14-3-4(a)(1) and may not be disclosed by the department.

As added by P.L.128-1992, SEC.1. Amended by P.L.1-1993, SEC.207.

IC 27-8-17-19

Prohibited bases for compensation of agent

Sec. 19. The compensation of a utilization review agent for the performance of utilization review may not be based on:

(1) the extent to which certifications are denied; or

(2) the amount by which subsequent claims are reduced for payment.

As added by P.L.128-1992, SEC.1.

IC 27-8-17-20
Rules

Sec. 20. The department shall adopt rules under IC 4-22-2 necessary to carry out this chapter.

As added by P.L.128-1992, SEC.1.

IC 27-8-18

Chapter 18. Charitable Entity's Insurable Interest in Life of Donor

IC 27-8-18-1

Application of chapter

Sec. 1. This chapter applies to every life insurance policy issued in Indiana or issued for delivery in Indiana, irrespective of the date of issue.

As added by P.L.129-1992, SEC.1.

IC 27-8-18-2

"Charitable entity" defined

Sec. 2. As used in this chapter, "charitable entity" means an entity that is exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code.

As added by P.L.129-1992, SEC.1.

IC 27-8-18-3

"Life insurance policy" defined

Sec. 3. As used in this chapter, "life insurance policy" means an insurance policy that provides the type of insurance described in Class 1(a) of IC 27-1-5-1.

As added by P.L.129-1992, SEC.1.

IC 27-8-18-4

Purchase, ownership, or transfer of ownership; consent; insurable interest

Sec. 4. (a) A charitable entity may:

(1) purchase;

(2) own; or

(3) be transferred ownership of;

a life insurance policy on the life of an individual if the individual consents to the charitable entity's purchase or ownership of the policy.

(b) A charitable entity that purchases or is transferred ownership of a life insurance policy under subsection (a) has an insurable interest in the life of the individual who consents to the charitable entity's purchase or ownership of the policy.

As added by P.L.129-1992, SEC.1.

IC 27-8-18-5

Inquiry into legal status of charitable entity

Sec. 5. A life insurance company that is requested to:

(1) issue a life insurance policy; or

(2) transfer ownership of a life insurance policy;

to an entity that is purported to be a charitable entity has no obligation to inquire into the legal status of that entity under any law.

As added by P.L.129-1992, SEC.1.

IC 27-8-18-6
Reliance on good faith representations

Sec. 6. A life insurance company is entitled to rely on the representations made in apparent good faith by the owner or putative owner of a life insurance policy for the purpose of inducing the life insurance company to accept an entity as the owner or beneficiary of the life insurance policy.

As added by P.L.129-1992, SEC.1.

IC 27-8-19
Repealed
(Repealed by P.L.1-1994, SEC.137.)

IC 27-8-19.8

Chapter 19.8. Viatical Settlements

IC 27-8-19.8-1

"Applicant" defined

Sec. 1. As used in this chapter, "applicant" refers to a person that applies for a viatical settlement provider license under this chapter.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.1; P.L.223-2005, SEC.3.

IC 27-8-19.8-2

"Department" defined

Sec. 2. As used in this chapter, "department" refers to the department of insurance.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70.

IC 27-8-19.8-3

"Insured" defined

Sec. 3. As used in this chapter, "insured" refers to an individual whose life is the subject of insurance under a life insurance policy or contract.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.2; P.L.223-2005, SEC.4.

IC 27-8-19.8-4

Repealed

(Repealed by P.L.32-1998, SEC.32.)

IC 27-8-19.8-4.3

"Viatical settlement agent" defined

Sec. 4.3. As used in this chapter, "viatical settlement agent" means a person that solicits, offers, or attempts to negotiate a viatical settlement contract with a viator.

As added by P.L.32-1998, SEC.3.

IC 27-8-19.8-4.5

"Viatical settlement broker" defined

Sec. 4.5. As used in this chapter, "viatical settlement broker" means a person that represents a viator and for a fee, commission, or other valuable consideration, solicits, offers, or attempts to negotiate viatical settlements between a viator and one (1) or more viatical settlement providers.

As added by P.L.32-1998, SEC.4.

IC 27-8-19.8-5

"Viatical settlement provider" defined

Sec. 5. (a) As used in this chapter, "viatical settlement provider" means a person, other than a viator, that:

(1) enters into a viatical settlement contract with a viator; or
(2) obtains financing for the purchase, acquisition, transfer, or other assignment of one (1) or more viatical settlement contracts, viaticated policies, or interests therein, or otherwise sells, assigns, transfers, pledges, hypothecates, or disposes of one (1) or more viatical settlement contracts, viaticated policies, or interests therein.

(b) The term does not include any of the following:
(1) A bank, savings bank, savings association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan.
(2) The issuer of a life insurance policy that makes a policy loan, permits surrender of the policy, or pays other policy benefits, including accelerated benefits, in accordance with the terms of the policy.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.5; P.L.79-1998, SEC.32.

IC 27-8-19.8-6
"Viatical settlement contract" defined

Sec. 6. As used in this chapter, "viatical settlement contract" means an agreement for the purchase, sale, assignment, transfer, devise, or bequest of a portion of the death benefit or ownership of a life insurance policy or contract for consideration that is less than the expected death benefit of the life insurance policy or contract. The term does not include the following:
(1) A loan by an insurer under the terms of a life insurance policy, including a loan secured by the cash value of a policy.
(2) An agreement with a bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan.
(3) The provision of accelerated death benefits by an insurer to an insured under the provisions of a life insurance contract.
(4) Agreements between an insurer and a reinsurer.
(5) An agreement by a person who enters into not more than one (1) such agreement in any five (5) year period to purchase a life insurance policy or contract for the transfer of a life insurance policy for a value that is less than the expected death benefit.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.6; P.L.128-2000, SEC.2.

IC 27-8-19.8-6.5
"Viaticated policy" defined

Sec. 6.5. As used in this chapter, "viaticated policy" means a life insurance policy or certificate that has been acquired by a viatical settlement provider under a viatical settlement contract.

As added by P.L.32-1998, SEC.7.

IC 27-8-19.8-7
"Person" defined

Sec. 7. As used in this chapter, "person" means an individual, an association, a corporation, a limited liability corporation, an estate, a partnership, a trust, or any other business or legal entity.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.8.

IC 27-8-19.8-7.8
"Stranger originated life insurance" defined

Sec. 7.8. (a) As used in this chapter, "stranger originated life insurance" means a practice or plan to initiate a life insurance policy for the benefit of a third party investor who, at the time the life insurance policy is originated, has no insurable interest in the insured.

(b) The term includes the following:

(1) An arrangement under which, at the time of life insurance policy inception:

(A) a life insurance policy is purchased with resources or guarantees from or through a person that is not legally permitted to initiate the life insurance policy; and

(B) a written or verbal arrangement or agreement is made to transfer the ownership of the life insurance policy or policy benefits to a third party.

(2) A trust that is:

(A) created to give an appearance of the existence of an insurable interest; and

(B) used to initiate a life insurance policy for an investor.

As added by P.L.112-2008, SEC.3.

IC 27-8-19.8-8
"Viator" defined

Sec. 8. As used in this chapter, "viator" refers to the owner of a life insurance policy or a certificate holder under a group policy that insures the life of an insured who enters or seeks to enter into a viatical settlement contract.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.9.

IC 27-8-19.8-8.5
Persons required to be licensed as insurance producer with life qualification

Sec. 8.5. The following must be licensed as an insurance producer with a life qualification under IC 27-1-15.6-7:

(1) A viatical settlement broker.

(2) A person who solicits, offers, or attempts to negotiate a

viatical settlement contract with a viator.

As added by P.L.32-1998, SEC.10. Amended by P.L.132-2001, SEC.14; P.L.178-2003, SEC.71.

IC 27-8-19.8-8.6

Exemptions from licensing requirement

Sec. 8.6. The following are exempt from the licensing requirement under IC 27-8-19.8-8.5:

(1) An accountant, an attorney, or a financial planner retained to represent the viator, and whose compensation is paid directly by or at the direction of the viator.

(2) A regularly salaried officer or employee of a viatical settlement broker or viatical settlement provider, if the officer or employee's duties and responsibilities do not include the solicitation or negotiation of viatical settlement contracts.

(3) The following persons, to the extent that the person is engaged in the administration or operation of a program of employee benefits for the person's employees or the employees of the person's subsidiaries or affiliates involving the use of viatical settlement contracts issued by a licensed viatical settlement provider, if the person is not in any manner directly or indirectly compensated by the viatical settlement provider:

(A) An employer.

(B) An officer or employee of an employer.

(C) A trustee of an employee trust plan.

As added by P.L.32-1998, SEC.11.

IC 27-8-19.8-8.7

Fiduciary duties of viatical settlement brokers

Sec. 8.7. A viatical settlement broker:

(1) represents only the viator; and

(2) owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator;

regardless of the manner in which the viatical settlement broker is compensated.

As added by P.L.32-1998, SEC.12.

IC 27-8-19.8-9

License required for viatical settlement providers

Sec. 9. After December 31, 1998, a person may not act as a viatical settlement provider unless the person holds an unexpired license issued under this chapter.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.13.

IC 27-8-19.8-9.2

Insurance producer remuneration

Sec. 9.2. An insurance producer that:

(1) is licensed under IC 27-1-15.6; and
(2) sells a life insurance policy or contract that, less than two (2) years after the insurance producer sells the policy or contract, is the subject of a viatical settlement contract;

shall not accept a commission or other remuneration in connection with the viatical settlement contract.

As added by P.L.223-2005, SEC.5.

IC 27-8-19.8-10

Application and fee for license

Sec. 10. (a) An applicant must do the following to obtain a license as a viatical settlement provider:

(1) Apply for the license on forms prescribed by the department.
(2) Provide information required by the department.
(3) Pay the license fee.

(b) The application must include the name of each officer, member, or employee of the applicant who will be authorized by the applicant to act as a viatical settlement provider under the license if issued to the applicant.

(c) The department shall adopt rules under IC 4-22-2 to set the licensing fee required by this section.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.14.

IC 27-8-19.8-11

Investigation of applicant; issuance of license

Sec. 11. The department shall investigate an applicant and issue a license to the applicant if the department finds all of the following:

(1) The applicant is competent and trustworthy and intends to act in good faith as a viatical settlement provider.
(2) The applicant has a good business reputation.
(3) The applicant has had the experience, training, or education to qualify the applicant as a viatical settlement provider.
(4) If the applicant is a corporation, or limited liability corporation, it is either:
    (A) incorporated under Indiana law; or
    (B) authorized to do business in Indiana.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.15.

IC 27-8-19.8-12

Refusal to issue license

Sec. 12. The department may refuse to issue a license to an applicant if the department is not satisfied that any officer, employee, partner, or stockholder who could materially influence the applicant's conduct meets the standards of this chapter.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70.

IC 27-8-19.8-13
Nonresident licenses

Sec. 13. The department may not issue a license to an applicant who is not an Indiana resident unless the applicant does either of the following:

(1) Files and maintains with the department a written designation of an agent for service of process.

(2) Files with the department the applicant's written irrevocable consent that any action against the applicant may be begun against the applicant by the service of process on the department.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70.

IC 27-8-19.8-14
Individuals authorized to act as viatical settlement benefits providers

Sec. 14. A license issued under this chapter authorizes all officers, members, and employees of the license holder designated under section 10(b) of this chapter to act as viatical settlement providers under the license.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.16.

IC 27-8-19.8-15
Expiration and renewal of license

Sec. 15. (a) A license issued or renewed under this chapter expires on July 1 after its issuance or renewal.

(b) A viatical settlement provider may renew a license by:

(1) applying for renewal on forms prescribed by the department; and

(2) paying the renewal fee.

(c) The department shall adopt rules under IC 4-22-2 to do the following:

(1) Set the renewal fee required by this section.

(2) Set a date before July 1 and before which receipt of a license renewal application can be processed without a lapse in the license.

(d) A viatical settlement provider that submits an application for renewal after the date set under subsection (c)(2):

(1) is not entitled to have the license renewed before July 1; and

(2) may not act as a viatical settlement provider until the department issues the license renewal, if the department is unable to process the renewal before July 1.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.17.

IC 27-8-19.8-16
Disclosure of identity of individuals associated with viatical

settlement providers

Sec. 16. The department may at any time require a viatical settlement provider or an applicant for a license to disclose fully the identity of all of the viatical settlement provider's or applicant's officers, employees, partners, and stockholders.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.18.

IC 27-8-19.8-17

Annual reports

Sec. 17. (a) A viatical settlement provider shall file with the department an annual report containing information prescribed in rules adopted by the department under IC 4-22-2.

(b) The rules adopted by the department under subsection (a) shall set the date by which annual reports must be submitted.

(c) A viatical settlement provider shall maintain records of each viatical settlement at least five (5) years after the death of the insured.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.19.

IC 27-8-19.8-18

Examination of viatical settlement provider or applicant

Sec. 18. (a) When the department reasonably considers it necessary for the protection of the public, the department may examine the business and other affairs of a viatical settlement provider or an applicant.

(b) The department may order a viatical settlement provider or an applicant to produce records, books, files, or other information reasonably necessary to ascertain whether the viatical settlement provider or the applicant has violated or is violating the law or otherwise has acted or is acting contrary to the public interest.

(c) The viatical settlement provider or applicant shall pay the expenses of an examination conducted under this section.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.20.

IC 27-8-19.8-19

Suspension, revocation, or refusal to renew license

Sec. 19. After a hearing under IC 4-21.5, the department may suspend, revoke, or refuse to renew a viatical settlement provider's license, or impose a civil penalty, or both, if the department finds any of the following:

(1) There was a misrepresentation in the application for the license.

(2) The viatical settlement provider is untrustworthy or incompetent to act as a viatical settlement provider.

(3) The viatical settlement provider demonstrates a pattern of

unreasonable payments to viators.

(4) The viatical settlement provider has been convicted of, or pleaded guilty or nolo contendere to, an offense the definition of which includes fraudulent acts as an element of the offense regardless of whether a judgement has been entered by the court.

(5) The viatical settlement provider no longer meets the requirements for initial licensure.

(6) The viatical settlement provider has failed to honor the contractual obligations of a viatical settlement contract.

(7) The viatical settlement provider has violated this chapter.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.21.

IC 27-8-19.8-20
Repealed

(Repealed by P.L.32-1998, SEC.32.)

IC 27-8-19.8-20.1
Stranger originated life insurance; prohibition

Sec. 20.1. (a) A person shall not issue, solicit, market, or otherwise promote the purchase of a life insurance policy in connection with stranger originated life insurance.

(b) A violation of this section is an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4.

As added by P.L.112-2008, SEC.4.

IC 27-8-19.8-21
Required terms of viatical settlement contract

Sec. 21. (a) A viatical settlement contract must establish the terms under which the viatical settlement provider will pay value, in return for the viator's assignment, bequest, devise, sale, or transfer of the death benefit, certificate, or ownership of the insurance policy to the viatical settlement provider.

(b) A viatical settlement contract must provide for the unconditional rescission of the contract by the viator for the longer of the following:

(1) the period ending not more than fifteen (15) days after the receipt of the viatical settlement proceeds by the viator; or

(2) the period ending not more than thirty (30) days after execution of the contract.

(c) A viatical settlement contract is rescinded if the insured dies during the rescission period, subject to repayment to the viatical settlement provider of all proceeds and any premiums, loans, and loan interest that have been paid by the viatical settlement provider.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.22; P.L.223-2005, SEC.6.

IC 27-8-19.8-22
Form for viatical settlement contract

Sec. 22. (a) A person may not use a viatical settlement contract form or a disclosure form in Indiana unless the contract form or disclosure form has been filed with and approved by the department.

(b) A viatical settlement contract form or disclosure form filed with the department is considered approved if the department has not disapproved the form within sixty (60) days after the filing.

(c) The department shall disapprove a viatical settlement contract form or disclosure form if the department finds that the contract form, disclosure form, or the provisions of the contract are:

(1) misleading or unfair to the viator;

(2) not in compliance with this chapter; or

(3) otherwise contrary to the public interest.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.23.

IC 27-8-19.8-23
Required disclosures to viator; information to insured

Sec. 23. (a) A viatical settlement provider or viatical settlement broker shall, not later than the date of application, provide to a viator a brochure approved by the commissioner and describing the viatical settlement process. If a brochure describes only a viatical settlement contract in which the insured does not have a catastrophic or life threatening illness or condition, the brochure may use the term "life settlement" in place of the term "viatical settlement".

(b) A viatical settlement provider or viatical settlement broker shall, in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker, disclose the following information to the viator not later than the date of application:

(1) Possible alternatives to viatical settlement contracts, including accelerated benefits or policy loans offered by the issuer of the life insurance policy.

(2) Federal and state tax consequences that may result from entering into a viatical settlement contract, and that the viator should seek assistance from a professional tax advisor.

(3) Possible:

(A) adverse effect on eligibility for; or

(B) interruption of assistance provided by;

medical or public assistance programs as a consequence of entering into a viatical settlement contract, and that the viator should seek advice from the appropriate government agencies.

(4) The viator's right to rescind a viatical settlement contract as provided in section 21 of this chapter.

(5) The amount of any fees paid by a viatical settlement provider to a viatical settlement broker.

(6) A statement that proceeds of the viatical settlement could be

subject to claims of creditors.

(7) A statement that:

(A) entering into a viatical settlement contract may cause other rights or benefits under the policy, including conversion rights, waiver of premium benefits, family riders, or coverage of a life other than the insured, to be forfeited by the viator; and

(B) the viator should seek advice from a financial advisor.

(8) The procedure for contacts with the insured.

(9) That the proceeds of the viatical settlement will be transferred to the viator as provided in section 24.2 of this chapter.

(10) A statement containing the following language:

"All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years.".

(11) That the insured may be contacted by the viatical settlement provider or viatical settlement broker to determine the health status of the insured in accordance with section 24.9 of this chapter.

(c) The viatical settlement provider shall disclose the following information to the viator, conspicuously displayed in the viatical settlement contract or in a separate document signed by the viatical settlement provider and the viator, before a viatical settlement contract is signed:

(1) Any affiliation between the viatical settlement provider and the insurer that issued the life insurance policy or certificate that is the subject of the viatical settlement contract.

(2) The name, address, and telephone number of the viatical settlement provider.

(3) If the life insurance policy or certificate that is the subject of the viatical settlement contract was issued as a joint policy or includes family riders or any coverage of an individual other than the insured:

(A) the possible loss of coverage of the other individuals under the policy or certificate; and

(B) that the viator should consult with the viator's insurance producer or the insurer that issued the policy or certificate for advice concerning the proposed viatical settlement

contract.

(4) The:

(A) dollar amount of the current death benefit payable to the viatical settlement provider; and

(B) if known, the:

(i) availability of any additional guaranteed insurance benefits;

(ii) dollar amount of any accidental death and dismemberment benefits; and

(iii) viatical settlement provider's interest in the benefits described in items (i) and (ii);

under the policy or certificate.

(5) The:

(A) name, business address, and telephone number of the trustee or escrow agent described in section 24.2 of this chapter; and

(B) right of the viator or insured to inspect or receive copies of the relevant escrow or trust agreements or documents.

(d) A viatical settlement broker shall disclose to the viator, conspicuously displayed in the viatical settlement contract or in a separate document signed by the viatical settlement broker and the viator before a viatical settlement contract is signed, the amount and method of calculation of the viatical settlement broker's compensation.

(e) If a viatical settlement provider transfers ownership or changes the beneficiary of a viaticated policy, the viatical settlement provider shall, not more than twenty (20) days after the transfer or change occurs, inform the insured of the transfer or change.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.24; P.L.223-2005, SEC.7.

IC 27-8-19.8-24

Prerequisites to viatical settlement contract

Sec. 24. A viatical settlement provider shall obtain the following before entering into a viatical settlement contract:

(1) If the viator is the insured, a written statement from a licensed attending physician that the insured is of sound mind and under no constraint or undue influence.

(2) A document signed by the viator and witnessed by two (2) disinterested witnesses in which the viator does the following:

(A) Consents to the viatical settlement contract.

(B) If the insured has a catastrophic or life threatening illness or condition, acknowledges the catastrophic or life threatening illness or condition.

(C) Represents that the viator has a full and complete understanding of the viatical settlement contract.

(D) Represents that the viator has a full and complete understanding of the benefits of the life insurance policy.

(E) Acknowledges that the viator has entered into the viatical settlement contract freely and voluntarily.

(F) Discloses the identity of any person that served as a viatical settlement broker in connection with the viatical settlement contract.

(3) A document in which the insured consents to the release of the insured's medical records.

As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.25; P.L.223-2005, SEC.8.

IC 27-8-19.8-24.2

Payment of proceeds of settlement to trust or escrow account; transfer of proceeds of settlement to viator

Sec. 24.2. (a) Immediately upon a viatical settlement provider's receipt of a signed viatical settlement contract, the viatical settlement provider shall pay the proceeds of the viatical settlement to a trust or escrow account in a state or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation. The account shall be managed by a trustee or escrow agent independent of the parties to the contract.

(b) Within two (2) business days after the viatical settlement provider's receipt of the insurer's or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated according to the viatical settlement contract, the trustee or escrow agent shall transfer the proceeds to the viator.

As added by P.L.32-1998, SEC.26.

IC 27-8-19.8-24.7

Disclosure of identity of viator

Sec. 24.7. Except as otherwise provided by law, a person with actual knowledge of a viator's identity may not disclose that identity to another person unless the disclosure is:

(1) necessary to effect a viatical settlement contract and the viator has provided written consent to the disclosure;

(2) provided in response to an investigation by the commissioner or other governmental officer or agency; or

(3) in connection with a transfer of a viatical settlement contract or viaticated policy to another licensed viatical settlement provider or to an entity that provides financing to effect the viatical settlement contract under a written agreement with a licensed viatical settlement provider.

As added by P.L.32-1998, SEC.27.

IC 27-8-19.8-24.8

Applicability of IC 16-39 to release of insured's medical records

Sec. 24.8. IC 16-39 applies to the release of an insured's medical records under this chapter.

As added by P.L.32-1998, SEC.29.

IC 27-8-19.8-24.9
Contacts with insured for purpose of determining health status

Sec. 24.9. (a) The viatical settlement provider or viatical settlement broker may contact the insured for the purpose of determining the health status of the insured not more than:

(1) one (1) time every three (3) months for an insured with a life expectancy of more than one (1) year; or

(2) one (1) time every month for an insured with a life expectancy of not more than one (1) year.

(b) Contacts made with an insured under subsection (a) must be made by mail unless the parties agree to another method of contact.
As added by P.L.32-1998, SEC.28.

IC 27-8-19.8-25
Standards for evaluation of reasonableness of payments under viatical settlement contract

Sec. 25. The department may adopt rules under IC 4-22-2 to establish standards for evaluating the reasonableness of payments under viatical settlement contracts, including regulation of discount rates used to determine the amount paid in exchange for an assignment, a bequest, a devise, a sale, or a transfer of a benefit under a life insurance policy.
As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70. Amended by P.L.32-1998, SEC.30.

IC 27-8-19.8-26
Adoption of rules

Sec. 26. The department may adopt rules under IC 4-22-2 that the department considers necessary to implement this chapter.
As added by P.L.130-1994, SEC.47 and P.L.116-1994, SEC.70.

IC 27-8-20

Chapter 20. Reimbursement for Off Label Drug Treatment

IC 27-8-20-0.1

Application of chapter

Sec. 0.1. The addition of this chapter by P.L.277-1993(ss) applies to insurance policies or health maintenance contracts that:

(1) are entered into or renewed with employers or individuals; and

(2) become effective after June 30, 1993.

As added by P.L.220-2011, SEC.448.

IC 27-8-20-1

"Commissioner" defined

Sec. 1. As used in this chapter, "commissioner" refers to the commissioner of the department of insurance.

As added by P.L.277-1993(ss), SEC.120.

IC 27-8-20-2

"Drug" defined

Sec. 2. As used in this chapter, "drug" means a drug or biologic that is used in an anticancer chemotherapeutic regimen.

As added by P.L.277-1993(ss), SEC.120.

IC 27-8-20-3

"Insurance policy" defined

Sec. 3. As used in this chapter, "insurance policy" means an accident and sickness policy (as defined in IC 27-8-5-1).

As added by P.L.277-1993(ss), SEC.120.

IC 27-8-20-4

"Off label use" defined

Sec. 4. As used in this chapter, "off label use" means the use of a drug for indications other than those stated in the labeling approved by the federal Food and Drug Administration.

As added by P.L.277-1993(ss), SEC.120.

IC 27-8-20-5

"Health maintenance organization" defined

Sec. 5. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

As added by P.L.277-1993(ss), SEC.120. Amended by P.L.26-1994, SEC.19.

IC 27-8-20-6

"Standard reference compendium" defined

Sec. 6. As used in this chapter, "standard reference compendium" means any of the following:

(1) The United States Pharmacopeia Drug Information.
(2) The American Medical Association Drug Evaluations.
(3) The American Hospital Formulary Service Drug Information.

As added by P.L.277-1993(ss), SEC.120.

IC 27-8-20-7
Exclusion of coverage for drugs not approved by the FDA; limitations

Sec. 7. An insurance policy or a health maintenance organization that provides coverage for drugs may not exclude coverage of a covered drug for a particular indication on the grounds that the drug has not been approved by the federal Food and Drug Administration for the particular indication if any of the following conditions are met:

(1) The drug is recognized for treatment of the indication in at least one (1) standard reference compendium.
(2) The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

As added by P.L.277-1993(ss), SEC.120. Amended by P.L.26-1994, SEC.20.

IC 27-8-20-8
Enforcement of chapter

Sec. 8. The commissioner has the authority to enforce this chapter under the provisions of IC 27-1-3-19, IC 27-9, and IC 27-13.

As added by P.L.277-1993(ss), SEC.120. Amended by P.L.26-1994, SEC.21.

IC 27-8-20-9
Drugs not requiring coverage; drug's use contraindicated; experimental drugs; alteration of laws limiting coverage on drugs not approved by the FDA

Sec. 9. This chapter does not do any of the following:

(1) Require coverage for any drug when the federal Food and Drug Administration has determined the drug's use to be contraindicated.
(2) Require coverage for an experimental drug not approved for any indication by the federal Food and Drug Administration.
(3) Alter any other law limiting the coverage of drugs that have not been approved by the federal Food and Drug Administration.

As added by P.L.277-1993(ss), SEC.120.

IC 27-8-21

Chapter 21. Advertisements Concerning Interest Rate Guarantees

IC 27-8-21-1

Applicability of chapter

Sec. 1. This chapter applies to an advertisement that is broadcast, published, or otherwise presented to the general public in Indiana.
As added by P.L.1-1994, SEC.138.

IC 27-8-21-2

Statement of period of interest rate guarantee required

Sec. 2. An advertisement that refers to an interest rate guarantee applying to a life insurance product or to an annuity contract must state the period for which the interest rate is guaranteed.
As added by P.L.1-1994, SEC.138.

IC 27-8-21-3

Violation an unfair or deceptive act or practice

Sec. 3. The presentation to the general public of an advertisement that violates section 2 of this chapter is an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4.
As added by P.L.1-1994, SEC.138.

IC 27-8-22

Chapter 22. Patient Billing

IC 27-8-22-1

"Health care provider" defined

Sec. 1. As used in this chapter, "health care provider" has the meaning set forth in IC 34-18-2-14.

As added by P.L.1-1994, SEC.139. Amended by P.L.1-1998, SEC.152; P.L.1-2010, SEC.112.

IC 27-8-22-2

"Claim information" defined

Sec. 2. As used in this chapter, "claim information" means the following:

(1) A notice that a claim has been filed with a patient's third party payor.

(2) A copy of an itemized bill for services when submitted to the third party payor.

As added by P.L.1-1994, SEC.139.

IC 27-8-22-3

"Representative" defined

Sec. 3. As used in this chapter, "representative" has the meaning set forth in IC 16-36-1-2.

As added by P.L.1-1994, SEC.139.

IC 27-8-22-4

Providing copy of claim information to patient

Sec. 4. (a) A health care provider shall routinely provide to a patient or the patient's representative, upon request, a copy of the claim information for health care services to the patient that the health care provider submits to the patient's insurance company, Medicare, or other third party payor except Medicaid.

(b) A health care provider is not required by this section to provide the patient with more than one (1) copy of a patient's claim information.

As added by P.L.1-1994, SEC.139.

IC 27-8-22.1

Chapter 22.1. Claims

IC 27-8-22.1-1

"Accident and sickness insurance policy" defined

Sec. 1. As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b), 2(a), 2(b), 2(e), 2(f), and 2(h).

As added by P.L.161-2001, SEC.4.

IC 27-8-22.1-2

"Insurer" defined

Sec. 2. As used in this chapter, "insurer" means:

(1) an insurer that issues:

(A) an accident and sickness insurance policy; or

(B) a worker's compensation policy; or

(2) an employer who has received a certificate from the worker's compensation board to carry the employer's worker's compensation risk without insurance under IC 22-3-2-5.

As added by P.L.161-2001, SEC.4.

IC 27-8-22.1-3

"Provider" defined

Sec. 3. As used in this chapter, "provider" has the meaning set forth in IC 27-8-11-1.

As added by P.L.161-2001, SEC.4.

IC 27-8-22.1-4

"Worker's compensation policy" defined

Sec. 4. As used in this chapter, "worker's compensation policy" means a policy of insurance issued to an employer under IC 22-3-2-5.

As added by P.L.161-2001, SEC.4.

IC 27-8-22.1-5

Use of diagnostic or procedure codes

Sec. 5. (a) Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:

(1) an insurer shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the insurer pays claims for services provided

under an accident and sickness insurance policy or a worker's compensation policy; and

(2) a provider shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the provider submits claims for payment for services provided under an accident and sickness insurance policy or a worker's compensation policy.

(b) If a provider provides services that are covered under an accident and sickness insurance policy or a worker's compensation policy:

(1) after the effective date of the most current version of a diagnostic or procedure code described in subsection (a); and

(2) before the insurer begins using the most current version of the diagnostic or procedure code;

the insurer shall reimburse the provider under the version of the diagnostic or procedure code that was in effect on the date that the services were provided.

As added by P.L.161-2001, SEC.4. Amended by P.L.66-2002, SEC.16.

IC 27-8-23

Chapter 23. Medical Child Support Provisions of Title XIX of the Federal Social Security Act

IC 27-8-23-1

Applicable provisions

Sec. 1. IC 12-15-29-9 and IC 12-15-29-10 apply to this chapter.

As added by P.L.46-1995, SEC.68 and P.L.133-1995, SEC.20.

IC 27-8-23-2

Applicability of chapter

Sec. 2. Notwithstanding any other law, this chapter applies to the duty of an insurer to provide family health coverage to a child in accordance with this chapter.

As added by P.L.46-1995, SEC.68 and P.L.133-1995, SEC.20.

IC 27-8-23-3

"Child" defined

Sec. 3. As used in this chapter, "child" refers to a child who is less than eighteen (18) years of age.

As added by P.L.46-1995, SEC.68 and P.L.133-1995, SEC.20.

IC 27-8-23-4

"Insurer" defined

Sec. 4. As used in this chapter, "insurer" has the meaning set forth in IC 12-7-2-120.

As added by P.L.46-1995, SEC.68 and P.L.133-1995, SEC.20.

IC 27-8-23-5

Prohibited grounds for denial of coverage

Sec. 5. An insurer may not deny enrollment of a child under the health coverage of the child's parent on any of the following grounds:

(1) That the child was born out of wedlock.

(2) That the child is not claimed as a dependent on the parent's federal income tax return.

(3) That the child does not reside:

(A) with the parent; or

(B) in the insurer's service area.

As added by P.L.46-1995, SEC.68 and P.L.133-1995, SEC.20.

IC 27-8-23-6

Duties of insurer to noncustodial parent

Sec. 6. Whenever a child has health coverage through an insurer of a noncustodial parent, the insurer shall:

(1) provide any information to the custodial parent that is necessary for the child to obtain benefits through the coverage;

(2) permit the custodial parent, or the provider of medical assistance services with the custodial parent's approval, to

submit claims for covered services without the approval of the noncustodial parent; and

(3) make payments on insurance claims submitted under subdivision (2) directly to the:

(A) custodial parent;

(B) provider of the medical assistance services; or

(C) office of Medicaid policy and planning.

As added by P.L.46-1995, SEC.68 and P.L.133-1995, SEC.20.

IC 27-8-23-7

Duties of insurer when parent is ordered to provide coverage for child

Sec. 7. Whenever a parent is required by a court or an administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an insurer, the insurer:

(1) shall permit the parent to enroll under the family coverage a child who is otherwise eligible for the coverage, without regard to any enrollment season restrictions;

(2) shall enroll a child under the family coverage upon application by:

(A) the child's custodial parent;

(B) the office of Medicaid policy and planning; or

(C) a Title IV-D agency;

whenever a noncustodial parent who is enrolled fails to apply for coverage of the child; and

(3) may not disenroll or eliminate coverage of a child who is otherwise eligible for coverage unless the insurer is provided satisfactory written evidence that:

(A) the court order or an administrative order is no longer in effect; or

(B) the child is or will be enrolled in comparable health coverage through another insurer that is to take effect not later than the effective date of the disenrollment.

As added by P.L.46-1995, SEC.68 and P.L.133-1995, SEC.20.

IC 27-8-23-8

Requirements imposed by insurer

Sec. 8. An insurer may not impose requirements on a state agency that has been assigned the rights of a person:

(1) eligible for assistance under Medicaid; and

(2) covered for health benefits from the insurer;

that are different from requirements applicable to an agency or assignee of any other person who is covered.

As added by P.L.46-1995, SEC.68 and P.L.133-1995, SEC.20.

IC 27-8-23-9

Delivery of policy

Sec. 9. A policy of health care coverage shall not be delivered or issued for delivery to any person in Indiana unless the policy complies with this chapter.

As added by P.L.46-1995, SEC.68 and P.L.133-1995, SEC.20.

IC 27-8-24
Chapter 24. Minimum Maternity Benefits

IC 27-8-24-1
Applicability of chapter

Sec. 1. This chapter applies to:

(1) every policy of accident and sickness insurance (as defined in IC 27-8-5-1), whether written on an individual basis, a group basis, a franchise basis, or a blanket basis; and

(2) every group contract (as defined in IC 27-13-1-16) or individual contract (as defined in IC 27-13-1-21) through which a health maintenance organization furnishes health care services;

that is issued, delivered, executed, or renewed in Indiana and that provides maternity benefits.

As added by P.L.194-1996, SEC.1.

IC 27-8-24-2
"At-home postdelivery care" defined

Sec. 2. As used in this chapter, "at-home postdelivery care" refers to health care provided to a woman at her residence by a physician licensed under IC 25-22.5 or a registered nurse or an advanced practice nurse licensed under IC 25-23 whose scope of practice includes providing postpartum care in the area of maternal and child health care. The health care services provided must include, at a minimum:

(1) parent education;

(2) assistance and training in breast or bottle feeding; and

(3) performance of any maternal and neonatal tests routinely performed during the usual course of inpatient care for the woman or her newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

As added by P.L.194-1996, SEC.1.

IC 27-8-24-3
"Maternity benefits" defined

Sec. 3. As used in this chapter, "maternity benefits" refers to the provision of health care to a woman before, during, and after delivery of a child, including physician, hospital, laboratory, and ultrasound services.

As added by P.L.194-1996, SEC.1.

IC 27-8-24-4
Postpartum hospital stay; HIV testing of newborns; payment

Sec. 4. (a) Except as provided in section 5 of this chapter, every policy or group contract that provides maternity benefits must provide minimum benefits to a mother and her newborn child that

cover:

(1) a minimum length of postpartum stay at a hospital licensed under IC 16-21 that is consistent with the minimum postpartum hospital stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care;

(2) the examinations to the newborn child required under IC 16-41-17-2; and

(3) the testing of the newborn child required under IC 16-41-6-4.

(b) Payment to a hospital for a test required under IC 16-41-6-4 must be in an amount equal to the hospital's actual cost of performing the test.

As added by P.L.194-1996, SEC.1. Amended by P.L.91-1999, SEC.5; P.L.237-2003, SEC.17.

IC 27-8-24-5

Conditions warranting shorter period of inpatient care; at-home postdelivery care visit

Sec. 5. (a) If the patients' attending physician determines further inpatient care is not necessary for the mother or newborn child, a policy or group contract that provides maternity benefits under this chapter may provide under the policy or group contract a shorter length of postpartum hospital stay than the period under section 4 of this chapter if all the following conditions are met:

(1) in the patients' attending physician's opinion the newborn meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

(A) the antepartum, intrapartum, and postpartum course of the mother and infant;

(B) the gestational stage, birth weight, and clinical condition of the infant;

(C) the demonstrated ability of the mother to care for the infant after discharge; and

(D) the availability of postdischarge follow-up to verify the condition of the infant after discharge; and

(2) the policy or contract authorizes for the mother and the newborn one (1) at-home postdelivery care visit described in subsection (b).

(b) The at-home postdelivery care visit shall be conducted not later than forty-eight (48) hours following the discharge of the woman and her newborn child from a licensed hospital. However, at the mother's discretion, the visit may occur at the facility of the provider subject to the terms of the policy or group contract.

(c) The provider of the policy or group contract described in this

chapter shall provide notice to each enrollee under the policy or group contract regarding the coverage provided under this chapter.
As added by P.L.194-1996, SEC.1. Amended by P.L.2-1997, SEC.66.

IC 27-8-24.1

Chapter 24.1. Coverage for Treatment of Inherited Metabolic Disease

IC 27-8-24.1-0.1

Application of chapter

Sec. 0.1. The addition of this chapter by P.L.166-2003 applies to an accident and sickness insurance policy that is issued, delivered, amended, or renewed after December 31, 2003.

As added by P.L.220-2011, SEC.449.

IC 27-8-24.1-1

"Accident and sickness insurance policy"

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

As added by P.L.166-2003, SEC.2. Amended by P.L.173-2007, SEC.41.

IC 27-8-24.1-2

"Covered individual"

Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to coverage under an accident and sickness

insurance policy.
As added by P.L.166-2003, SEC.2.

IC 27-8-24.1-3
"Inherited metabolic disease"

Sec. 3. As used in this chapter, "inherited metabolic disease" means a disease:

(1) caused by inborn errors of amino acid, organic acid, or urea cycle metabolism; and

(2) treatable by the dietary restriction of one (1) or more amino acids.

As added by P.L.166-2003, SEC.2.

IC 27-8-24.1-4
"Medical food"

Sec. 4. As used in this chapter, "medical food" means a formula that is:

(1) intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and

(2) formulated to be consumed or administered enterally under the direction of a physician.

As added by P.L.166-2003, SEC.2.

IC 27-8-24.1-5
Coverage for medical food

Sec. 5. An accident and sickness insurance policy must provide coverage for medical food that is:

(1) medically necessary; and

(2) prescribed by a covered individual's treating physician for treatment of the covered individual's inherited metabolic disease.

As added by P.L.166-2003, SEC.2.

IC 27-8-24.1-6
Dollar limits, out-of-pocket expenses

Sec. 6. The coverage that must be provided under this chapter shall not be subject to dollar limits, coinsurance, or deductibles that are less favorable to a covered individual than the dollar limits, coinsurance, or deductibles that apply to coverage for:

(1) prescription drugs generally under the accident and sickness insurance policy, if prescription drugs are covered under the accident and sickness insurance policy; or

(2) physical illness generally under the accident and sickness insurance policy, if prescription drugs are not covered under the accident and sickness insurance policy.

As added by P.L.166-2003, SEC.2.

IC 27-8-24.2

Chapter 24.2. Coverage for Prosthetic Devices

IC 27-8-24.2-0.1

Application of chapter

Sec. 0.1. The addition of this chapter by P.L.109-2008 applies to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2008.

As added by P.L.220-2011, SEC.450.

IC 27-8-24.2-1

"Insured"

Sec. 1. As used in this chapter, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

As added by P.L.109-2008, SEC.2.

IC 27-8-24.2-2

"Orthotic device"

Sec. 2. As used in this chapter, "orthotic device" means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

As added by P.L.109-2008, SEC.2.

IC 27-8-24.2-3

"Policy of accident and sickness insurance"

Sec. 3. (a) As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A limited benefit health insurance policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

(9) A student health insurance policy.

As added by P.L.109-2008, SEC.2.

IC 27-8-24.2-4

"Prosthetic device"

Sec. 4. As used in this chapter, "prosthetic device" means an

artificial leg or arm.
As added by P.L.109-2008, SEC.2.

IC 27-8-24.2-5
Coverage required

Sec. 5. A policy of accident and sickness insurance must provide coverage for orthotic devices and prosthetic devices, including repairs or replacements, that:

(1) are provided or performed by a person that is:
(A) accredited as required under 42 U.S.C. 1395m(a)(20); or
(B) a qualified practitioner (as defined in 42 U.S.C. 1395m(h)(1)(F)(iii));
(2) are determined by the insured's physician to be medically necessary to restore or maintain the insured's ability to perform activities of daily living or essential job related activities; and
(3) are not solely for comfort or convenience.

As added by P.L.109-2008, SEC.2.

IC 27-8-24.2-6
Coverage and reimbursement

Sec. 6. The:

(1) coverage required under section 5 of this chapter must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program (42 U.S.C. 1395 et seq.); and
(2) reimbursement under the coverage required under section 5 of this chapter must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

This section does not require a deductible under a policy of accident and sickness insurance to be equal to a deductible under the federal Medicare program.
As added by P.L.109-2008, SEC.2.

IC 27-8-24.2-7
Comparison to other benefits

Sec. 7. Except as provided in sections 8 and 9 of this chapter, the coverage required under section 5 of this chapter:

(1) may be subject to; and
(2) may not be more restrictive than;

the provisions that apply to other benefits under the policy of accident and sickness insurance.
As added by P.L.109-2008, SEC.2.

IC 27-8-24.2-8
Continued medical necessity review

Sec. 8. The coverage required under section 5 of this chapter may

be subject to utilization review, including periodic review, of the continued medical necessity of the benefit.
As added by P.L.109-2008, SEC.2.

IC 27-8-24.2-9
Lifetime maximum coverage limitation

Sec. 9. Any lifetime maximum coverage limitation that applies to prosthetic devices and orthotic devices:

(1) must not be included in; and
(2) must be equal to;

the lifetime maximum coverage limitation that applies to all other items and services generally under the policy of accident and sickness insurance.
As added by P.L.109-2008, SEC.2.

IC 27-8-24.2-10
Deductible, copayment, or coinsurance requirements

Sec. 10. For purposes of this section, "items and services" does not include preventive services for which coverage is provided under a high deductible health plan (as defined in 26 U.S.C. 220(c)(2) or 26 U.S.C. 223(c)(2)). The coverage required under section 5 of this chapter may not be subject to a deductible, copayment, or coinsurance provision that is less favorable to an insured than the deductible, copayment, or coinsurance provisions that apply to other items and services generally under the policy of accident and sickness insurance.
As added by P.L.109-2008, SEC.2.

IC 27-8-24.3

Chapter 24.3. Insurance and Health Plan Coverage for Victims of Abuse

IC 27-8-24.3-0.1

Application of chapter

Sec. 0.1. The addition of this chapter by P.L.188-1996 applies only to an insurance policy or a health plan issued, renewed, or entered into after June 30, 1996.

As added by P.L.220-2011, SEC.451.

IC 27-8-24.3-1

Applicability of chapter

Sec. 1. This chapter applies to every:

(1) policy of accident and sickness insurance (as described in IC 27-8-5-1), whether written on an individual basis, a group basis, a franchise basis, a blanket basis, or under a preferred provider plan (as defined in IC 27-8-11-1);

(2) group contract (as defined in IC 27-13-1-16) or individual contract (as defined in IC 27-13-1-21) through which a health maintenance organization furnishes health care services; and

(3) policy of life insurance or disability insurance described under Class 1 of IC 27-1-5-1.

As added by P.L.188-1996, SEC.2.

IC 27-8-24.3-2

"Abuse" defined

Sec. 2. As used in this chapter, "abuse" refers to the occurrence of one (1) or more of the following acts between family members or current or former household members:

(1) Attempting to cause or intentionally, knowingly, or recklessly causing bodily injury to, physical harm to, sexual assault on, involuntary sexual intercourse with, or rape of another individual.

(2) Knowingly engaging in a course of conduct or repeatedly committing acts, including stalking (as defined in IC 35-45-10-1) or impermissible contact (as defined in IC 35-45-10-3), under circumstances that place the individual toward whom such acts are directed in reasonable fear of bodily injury or physical harm.

(3) Subjecting another individual to false imprisonment.

(4) Attempting to cause or intentionally, knowingly, or recklessly causing damage to property in order to intimidate or attempt to control the behavior of another individual.

As added by P.L.188-1996, SEC.2.

IC 27-8-24.3-3

"Individual" defined

Sec. 3. As used in this chapter, "individual" means a natural person whether adult or minor.
As added by P.L.188-1996, SEC.2.

IC 27-8-24.3-4
"An insurance policy or a health plan" defined

Sec. 4. As used in this chapter, "an insurance policy or a health plan" refers to an insurance policy or a health maintenance organization contract described in section 1 of this chapter.
As added by P.L.188-1996, SEC.2.

IC 27-8-24.3-5
"Insurer" defined

Sec. 5. As used in this chapter, "insurer" means a company, a firm, a partnership, an association, an order, a society, or a system:

(1) making any of the kinds of insurance; or

(2) entering into any of the kinds of contracts;

described in section 1 of this chapter.
As added by P.L.188-1996, SEC.2.

IC 27-8-24.3-6
Prohibited acts by insurer

Sec. 6. Except as provided in sections 7 and 8 of this chapter, an insurer may not do any of the following:

(1) Deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage on an individual under an insurance policy or a health plan because the individual:

(A) has been, is, or has the potential to be a victim of abuse; or

(B) seeks, has sought, or should have sought protection from abuse, shelter from abuse, or medical or psychological treatment for abuse.

(2) Add any surcharge or rating factor to a premium of an insurance policy or a health plan because an individual:

(A) has a history of being;

(B) is; or

(C) has the potential to be;

a victim of abuse.

(3) Exclude or limit coverage for losses or deny a claim incurred by a person covered by an insurance policy or a health plan as a result of abuse or the potential for abuse.

(4) Designate that if an individual:

(A) has a history of being a victim of abuse; or

(B) is a victim of abuse;

the abuse is a preexisting condition that causes coverage to be denied for a specified period.

(5) Ask an individual covered by or applying for an insurance

policy or a health plan if the individual:

(A) is, has been, or may be a victim of abuse; or

(B) seeks, has sought, or should have sought protection from abuse, shelter from abuse, or medical or psychological treatment for abuse.

As added by P.L.188-1996, SEC.2.

IC 27-8-24.3-7

Insurer may adjust premiums

Sec. 7. This chapter does not prohibit an insurer from adjusting premiums of an individual applying for or covered by an insurance policy described in Class 1(a) of IC 27-1-5-1 on the basis that the individual has a physical or mental condition or medical claims history.

As added by P.L.188-1996, SEC.2.

IC 27-8-24.3-8

Underwriting or rating risk on basis of physical or mental condition caused by abuse

Sec. 8. This chapter does not prohibit an insurer from inquiring about, underwriting, or rating a risk on the basis of a physical or mental condition, even if that condition has been caused by abuse if:

(1) the insurer routinely underwrites or charges a different rate for that condition in the same manner with respect to all individuals who apply for or are covered by an insurance policy or a health plan regardless of whether the individual has been the victim of abuse;

(2) the individual's status as being, having been, or having the potential to be the subject of abuse is not considered to be a physical or mental condition;

(3) the insurer does not:

(A) refuse to insure or refuse to contract with;

(B) refuse to continue to insure or refuse to continue to contract with;

(C) limit the amount, extent, or coverage available; or

(D) charge a different rate for the same coverage;

solely because of a physical or mental condition, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actuarial or reasonably anticipated experience; and

(4) the underwriting or rating is not used to evade the intent of this chapter.

As added by P.L.188-1996, SEC.2.

IC 27-8-24.3-9

Violations

Sec. 9. A violation of this chapter is an unfair and deceptive act and practice in the business of insurance under IC 27-4-1-4.

As added by P.L.188-1996, SEC.2.

IC 27-8-24.3-10
Immunity from liability

Sec. 10. An insurer is immune from civil and criminal liability for any damages caused as a result of the insurer's compliance with this chapter.

As added by P.L.188-1996, SEC.2.

IC 27-8-24.7

Chapter 24.7. Referrals to Women's Health Care Providers

IC 27-8-24.7-1

"Health insurance policy" defined

Sec. 1. As used in this chapter, "health insurance policy" means any individual or group accident and sickness policy, contract, subscriber agreement, rider, endorsement, or any contract providing for the delivery of health care benefits, delivered or issued for delivery in Indiana after June 30, 1996, by any of the following:

(1) An insurer.

(2) A fraternal benefit society.

(3) A nonprofit corporation.

(4) A health maintenance organization (as defined in IC 27-13-1-19).

(5) A preferred provider arrangement under IC 27-8-11.

As added by P.L.192-1996, SEC.2.

IC 27-8-24.7-2

"Health insurer" defined

Sec. 2. As used in this chapter, "health insurer" means an entity referred to in section 1 of this chapter that issues, delivers, or renews a health insurance policy.

As added by P.L.192-1996, SEC.2.

IC 27-8-24.7-3

"Insured" defined

Sec. 3. As used in this chapter, "insured" means an individual who is entitled to the benefits provided by a health insurance policy. The term includes the following:

(1) A policyholder of an individual health insurance policy.

(2) A member of the group covered by a group health insurance policy.

(3) A female who is entitled to coverage under a health insurance policy as a spouse or dependent of an individual referred to in subdivision (1) or (2).

As added by P.L.192-1996, SEC.2.

IC 27-8-24.7-4

"Women's health care provider" defined

Sec. 4. As used in this chapter, "women's health care provider" means a physician licensed under IC 25-22.5 who specializes in the provision of obstetric or gynecological services.

As added by P.L.192-1996, SEC.2.

IC 27-8-24.7-5

Designation of women's health care provider as primary care provider

Sec. 5. Under a health insurance policy that is issued, delivered, issued for delivery, or renewed in Indiana, an organization or arrangement described in section 1(1) through 1(5) of this chapter may not refuse to designate a women's health care provider as an insured's primary care provider if the women's health care provider meets the terms and conditions for participation established by an organization or arrangement described in section 1(1) through 1(5) of this chapter under an insurance policy as a primary care physician solely because the individual physician specializes in the provision of obstetric or gynecological services.
As added by P.L.192-1996, SEC.2.

IC 27-8-25

Chapter 25. Coverage for Care Related to Clinical Trials

IC 27-8-25-1

"Care method"

Sec. 1. As used in this chapter, "care method" means the use of a particular drug or device in a particular manner.

As added by P.L.109-2009, SEC.3.

IC 27-8-25-2

"Clinical trial"

Sec. 2. As used in this chapter, "clinical trial" means a Phase I, II, III, or IV research study:

(1) that is conducted:

(A) using a particular care method to prevent, diagnose, or treat a cancer for which:

(i) there is no clearly superior, noninvestigational alternative care method; and

(ii) available clinical or preclinical data provides a reasonable basis from which to believe that the care method used in the research study is at least as effective as any noninvestigational alternative care method;

(B) in a facility where personnel providing the care method to be followed in the research study have:

(i) received training in providing the care method;

(ii) expertise in providing the type of care required for the research study; and

(iii) experience providing the type of care required for the research study to a sufficient volume of patients to maintain expertise; and

(C) to scientifically determine the best care method to prevent, diagnose, or treat the cancer; and

(2) that is approved or funded by one (1) of the following:

(A) A National Institutes of Health institute.

(B) A cooperative group of research facilities that has an established peer review program that is approved by a National Institutes of Health institute or center.

(C) The federal Food and Drug Administration.

(D) The United States Department of Veterans Affairs.

(E) The United States Department of Defense.

(F) The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103.

(G) A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

As added by P.L.109-2009, SEC.3.

IC 27-8-25-3
"Contracted provider"

Sec. 3. As used in this chapter, "contracted provider" means a health care provider that has entered into an agreement under IC 27-8-11-3 with an insurer that issues a policy of accident and sickness insurance.

As added by P.L.109-2009, SEC.3.

IC 27-8-25-4
"Covered individual"

Sec. 4. As used in this chapter, "covered individual" means an individual entitled to coverage under a policy of accident and sickness insurance.

As added by P.L.109-2009, SEC.3.

IC 27-8-25-5
"Noncontracted provider"

Sec. 5. As used in this chapter, "noncontracted provider" means a health care provider that has not entered into an agreement to serve as a contracted provider.

As added by P.L.109-2009, SEC.3.

IC 27-8-25-6
"Policy of accident and sickness insurance"

Sec. 6. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

As added by P.L.109-2009, SEC.3.

IC 27-8-25-7
"Routine care cost"

Sec. 7. As used in this chapter, "routine care cost" means the cost of medically necessary services related to the care method that is under evaluation in a clinical trial. The term does not include the following:

(1) The health care service, item, or investigational drug that is the subject of the clinical trial.

(2) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial.

(3) Any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.

(4) An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.

(5) Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility where a clinical trial

is conducted.

(6) A service, item, or drug that is provided by a clinical trial sponsor free of charge for any new patient.

(7) A service, item, or drug that is eligible for reimbursement from a source other than a covered individual's policy of accident and sickness insurance, including the sponsor of the clinical trial.

As added by P.L.109-2009, SEC.3.

IC 27-8-25-8

Coverage for routine care costs

Sec. 8. (a) A policy of accident and sickness insurance must provide coverage for routine care costs that are incurred in the course of a clinical trial if the policy of accident and sickness insurance would provide coverage for the same routine care costs not incurred in a clinical trial.

(b) The coverage that must be provided under this section is subject to the terms, conditions, restrictions, exclusions, and limitations that apply generally under the policy of accident and sickness insurance, including terms, conditions, restrictions, exclusions, or limitations that apply to health care services rendered by contracted providers and noncontracted providers.

(c) This section does not do any of the following:

(1) Require an insurer that issues a policy of accident and sickness insurance to provide coverage for clinical trial services rendered by a contracted provider.

(2) Prohibit an insurer that issues a policy of accident and sickness insurance from providing coverage for clinical trial services rendered by a contracted provider.

(3) Require reimbursement under a policy of accident and sickness insurance for services that are rendered in a clinical trial by a noncontracted provider at the same rate of reimbursement that would apply to the same services rendered by a contracted provider.

As added by P.L.109-2009, SEC.3.

IC 27-8-25-9

No cause of action created by chapter

Sec. 9. This chapter does not create a cause of action against a person for any harm to a covered individual resulting from a clinical trial.

As added by P.L.109-2009, SEC.3.

IC 27-8-26

Chapter 26. Genetic Screening or Testing

IC 27-8-26-0.1

Application of chapter

Sec. 0.1. The addition of this chapter by P.L.150-1997 applies to all applications and policies for accident and sickness insurance delivered, issued for delivery, renewed, or executed after December 31, 1997.

As added by P.L.220-2011, SEC.452.

IC 27-8-26-1

Applicability of chapter

Sec. 1. (a) This chapter applies to the following:

(1) Every policy of accident and sickness insurance (as defined in IC 27-8-5-1), whether written on an individual basis, a group basis, a franchise basis, or a blanket basis that is issued, delivered, or renewed in Indiana.

(2) Every group contract (as defined in IC 27-13-1-16) or individual contract (as defined in IC 27-13-1-21) through which a health maintenance organization furnishes health care services that is delivered, executed, or renewed in Indiana.

(3) Every health care plan of a state or local governmental entity that provides coverage for health care services on a self-insurance basis in Indiana.

(4) Every employee welfare benefit plan (as defined in 29 U.S.C. 1002) that is self-funded.

(b) This chapter does not apply to the following:

(1) Accident-only insurance, credit insurance, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) Life insurance.

As added by P.L.150-1997, SEC.4.

IC 27-8-26-2

"Genetic screening or testing" defined

Sec. 2. (a) As used in this chapter, "genetic screening or testing" means a laboratory test:

(1) of an individual's genes or chromosomes for abnormalities, defects, or deficiencies, including changes in the number, structure, or integrity of an individual's chromosomes or carrier status, that:

(A) are linked to physical or mental disorders or impairments;

(B) indicate a susceptibility to illness, disease, or other disorders, whether physical or mental; or

(C) demonstrate genetic or chromosomal damage due to environmental factors; and

(2) that is a direct test for abnormalities, defects, or deficiencies in an individual's genes or chromosomes.

(b) The term does not include the detection of a genetic disorder through the manifestation of the genetic disorder.

As added by P.L.150-1997, SEC.4.

IC 27-8-26-3

"Health care services coverage" defined

Sec. 3. As used in this chapter, "health care services coverage" refers to an insurance policy, a health maintenance organization contract, or a governmental health care plan described in section 1 of this chapter.

As added by P.L.150-1997, SEC.4.

IC 27-8-26-4

"Insurer" defined

Sec. 4. As used in this chapter, "insurer" means a company, a firm, a partnership, an entity, an association, an order, a society, or a system:

(1) making any of the kinds of insurance;

(2) entering into any of the kinds of contracts; or

(3) providing any of the coverage;

described in section 1 of this chapter.

As added by P.L.150-1997, SEC.4.

IC 27-8-26-5

Determination of eligibility for health care services coverage by insurer; prohibitions

Sec. 5. In processing an application for health care services coverage or in determining insurability for health care services coverage, an insurer may not do any of the following:

(1) Require an individual or any member of an individual's family seeking health care services coverage to submit to genetic screening or testing.

(2) Consider any information obtained from genetic screening or testing in a manner adverse to:

(A) an applicant or a member of an applicant's family for; or

(B) an individual or a member of an individual's family covered by;

health care services coverage.

(3) Inquire, directly or indirectly, into the results of genetic screening or testing, or use such information to cancel, refuse to issue or renew, or limit benefits under health care services coverage.

(4) Make a decision adverse to an applicant or a member of an applicant's family based on entries related to the results of

genetic testing or screening in medical records or other reports of genetic screening or testing.

As added by P.L.150-1997, SEC.4.

IC 27-8-26-6

Questions by insurer regarding genetic screening or testing results prohibited

Sec. 6. In developing and asking questions regarding the medical history of an applicant for health care services coverage, an insurer may not ask:

(1) for the results of; or

(2) questions designed to ascertain the results of;

genetic screening or testing.

As added by P.L.150-1997, SEC.4.

IC 27-8-26-7

Refusal of health care services coverage based on genetic screening or testing results prohibited

Sec. 7. An insurer may not cancel, refuse to issue, refuse to renew, or refuse to enter into a contract for health care services coverage based on the results of genetic screening or testing.

As added by P.L.150-1997, SEC.4.

IC 27-8-26-8

Limitation of benefits or establishment of premiums based on genetic screening or testing results prohibited

Sec. 8. An insurer may not deliver, issue for delivery, renew, or execute a contract for health care services coverage in Indiana that:

(1) limits benefits; or

(2) establishes premiums;

based on the results of genetic screening or testing.

As added by P.L.150-1997, SEC.4.

IC 27-8-26-9

Consideration of genetic screening or testing results by insurer

Sec. 9. An insurer may consider the results of genetic screening or testing if:

(1) the results are voluntarily submitted by:

(A) an applicant for; or

(B) an individual seeking renewal of;

health care services coverage; and

(2) the results are favorable to the applicant or the individual.

As added by P.L.150-1997, SEC.4.

IC 27-8-26-10

Enforcement of chapter; rules

Sec. 10. (a) The commissioner shall enforce this chapter.

(b) The commissioner may adopt rules under IC 4-22-2 to carry

out this chapter.
As added by P.L.150-1997, SEC.4.

IC 27-8-26-11
Violation unfair and deceptive act or practice

Sec. 11. A violation of this chapter is an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4.
As added by P.L.150-1997, SEC.4.

IC 27-8-27

Chapter 27. Coverage for Services to Infants and Toddlers With Disabilities

IC 27-8-27-1

"Early intervention services" defined

Sec. 1. For purposes of this chapter, "early intervention services" means services provided to a first steps child under IC 12-12.7-2 and 20 U.S.C. 1432(4).

As added by P.L.121-1999, SEC.13. Amended by P.L.93-2006, SEC.17.

IC 27-8-27-2

"First steps child" defined

Sec. 2. For purposes of this chapter, "first steps child" means an infant or toddler from birth through two (2) years of age who is enrolled in the Indiana first steps program and is an insured.

As added by P.L.121-1999, SEC.13.

IC 27-8-27-3

"First steps program" defined

Sec. 3. As used in this chapter, "first steps program" means the program established under IC 12-12.7-2 and 20 U.S.C. 1431 et seq. to meet the needs of:

(1) children who are eligible for early intervention services; and

(2) their families.

The term includes the coordination of all available federal, state, local, and private resources available to provide early intervention services within Indiana.

As added by P.L.121-1999, SEC.13. Amended by P.L.93-2006, SEC.18.

IC 27-8-27-4

"Health insurance plan" defined

Sec. 4. (a) For purposes of this chapter, "health insurance plan" means any:

(1) hospital or medical expense incurred policy or certificate;

(2) hospital or medical service plan contract; or

(3) health maintenance organization subscriber contract;

provided to an insured.

(b) The term does not include the following:

(1) Accident-only, credit, dental, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy issued as an individual policy.

(6) A limited benefit health insurance plan issued as an

individual policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

As added by P.L.121-1999, SEC.13.

IC 27-8-27-5

"Insured" defined

Sec. 5. As used in this chapter, "insured" means an individual covered by a health insurance plan.

As added by P.L.121-1999, SEC.13.

IC 27-8-27-6

Reimbursement of first steps program for early intervention services payments

Sec. 6. A health insurance plan that provides coverage for early intervention services shall reimburse the first steps program a monthly fee established by the division of disability and rehabilitative services. The monthly fee shall be provided instead of claims processing of individual claims.

As added by P.L.121-1999, SEC.13. Amended by P.L.229-2011, SEC.254.

IC 27-8-27-7

Repealed

(As added by P.L.121-1999, SEC.13. Repealed by P.L.246-2005, SEC.231.)

IC 27-8-27-8

Reimbursement not to be applied to lifetime coverage limit

Sec. 8. The reimbursement required under section 6 of this chapter may not be applied to any annual or aggregate lifetime limit on the first steps child's coverage under the health insurance plan.

As added by P.L.121-1999, SEC.13.

IC 27-8-27-9

Payment of deductibles, copayments, or other expenses

Sec. 9. The first steps program may pay required deductibles, copayments, or other out-of-pocket expenses for a first steps child directly to a provider. An insurer (as defined in IC 27-8-14.5-3) shall apply any payments made by the first steps program to the health insurance plan's deductibles, copayments, or other out-of-pocket expenses according to the terms and conditions of the health insurance plan.

As added by P.L.121-1999, SEC.13.

IC 27-8-28

Chapter 28. Internal Grievance Procedures

IC 27-8-28-1

"Accident and sickness insurance policy"

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one (1) or more of the kinds of insurance described in Class 1(b) and 2(a) of IC 27-1-5-1.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy issued as an individual policy.

(5) A limited benefit health insurance policy issued as an individual policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13.

IC 27-8-28-2

"Commissioner"

Sec. 2. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13. Amended by P.L.1-2002, SEC.113.

IC 27-8-28-3

"Covered individual"

Sec. 3. As used in this chapter, "covered individual" means an individual who is covered under an accident and sickness insurance policy.

As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13.

IC 27-8-28-4

"Department"

Sec. 4. As used in this chapter, "department" refers to the department of insurance.

As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13.

IC 27-8-28-5

"External grievance"

Sec. 5. As used in this chapter, "external grievance" means the independent review under IC 27-8-29 of a grievance filed under this chapter.
As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13.

IC 27-8-28-6
"Grievance"
Sec. 6. As used in this chapter, "grievance" means any dissatisfaction expressed by or on behalf of a covered individual regarding:
(1) a determination that a service or proposed service is not appropriate or medically necessary;
(2) a determination that a service or proposed service is experimental or investigational;
(3) the availability of participating providers;
(4) the handling or payment of claims for health care services;
(5) matters pertaining to the contractual relationship between:
(A) a covered individual and an insurer; or
(B) a group policyholder and an insurer; or
(6) an insurer's decision to rescind an accident and sickness insurance policy;
and for which the covered individual has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.
As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13. Amended by P.L.1-2002, SEC.114; P.L.160-2011, SEC.22.

IC 27-8-28-7
"Grievance procedure"
Sec. 7. As used in this chapter, "grievance procedure" means a written procedure established and maintained by an insurer for filing, investigating, and resolving grievances and appeals.
As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13.

IC 27-8-28-8
"Insured"
Sec. 8. As used in this chapter, "insured" means:
(1) an individual whose employment status or other status except family dependency is the basis for coverage under a group accident and sickness insurance policy; or
(2) in the case of an individual accident and sickness insurance policy, the individual in whose name the policy is issued.
As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13.

IC 27-8-28-9
"Insurer"
Sec. 9. As used in this chapter, "insurer" means any person who delivers or issues for delivery an accident and sickness insurance

policy or certificate in Indiana.
As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13.

IC 27-8-28-10
Grievance procedure to comply with chapter requirements

Sec. 10. An insurer shall establish and maintain a grievance procedure that complies with the requirements of this chapter for the resolution of grievances initiated by a covered individual.
As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13.

IC 27-8-28-11
Commissioner may examine procedure

Sec. 11. The commissioner may examine the grievance procedure of any insurer.
As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13.

IC 27-8-28-12
Grievance records

Sec. 12. An insurer shall maintain all grievance records received by the insurer after the most recent examination of the insurer's grievance procedure by the commissioner.
As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13.

IC 27-8-28-13
Notice of grievance related information

Sec. 13. (a) An insurer shall provide, at the request of the insured, covered individual, or legal representative of the insured or covered individual, and upon policy issuance, at each policy renewal, and with any notice of denial of a claim, timely, adequate, and appropriate notice to each insured, covered individual, or legal representative, of:

(1) the grievance procedure required under this chapter;
(2) the external grievance procedure required under IC 27-8-29;
(3) information on how to file:
  (A) a grievance under this chapter; and
  (B) a request for an external grievance review under IC 27-8-29;
(4) a toll free telephone number through which a covered individual may contact the insurer at no cost to the covered individual to obtain information and to file grievances; and
(5) the address for the Internet web site established by the department under IC 27-1-3-33.

(b) An insurer shall prominently display on all notices to covered individuals the toll free telephone number and the address at which a grievance or request for external grievance review may be filed.
As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13. Amended by P.L.18-2016, SEC.2.

IC 27-8-28-14
Filing grievance; toll free number

Sec. 14. (a) A covered individual may file a grievance orally or in writing.

(b) An insurer shall make available to covered individuals a toll free telephone number through which a grievance may be filed. The toll free telephone number must:

(1) be staffed by a qualified representative of the insurer;

(2) be available for at least forty (40) hours per week during normal business hours; and

(3) accept grievances in the languages of the major population groups served by the insurer.

(c) A grievance is considered to be filed on the first date it is received, either by telephone or in writing.

As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13.

IC 27-8-28-15
Assistance in filing grievance; designation of representative

Sec. 15. (a) An insurer shall establish procedures to assist covered individuals in filing grievances.

(b) A covered individual may designate a representative to file a grievance for the covered individual and to represent the covered individual in a grievance under this chapter.

As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13.

IC 27-8-28-16
Policies and procedures for timely resolution of grievances

Sec. 16. (a) An insurer shall establish written policies and procedures for the timely resolution of grievances filed under this chapter. The policies and procedures must include the following:

(1) An acknowledgment of the grievance, given orally or in writing, to the covered individual within five (5) business days after receipt of the grievance.

(2) Documentation of the substance of the grievance and any actions taken.

(3) An investigation of the substance of the grievance, including any aspects involving clinical care.

(4) Notification to the covered individual of the disposition of the grievance and the right to appeal.

(5) Standards for timeliness in:

(A) responding to grievances; and

(B) providing notice to covered individuals of:

(i) the disposition of the grievance; and

(ii) the right to appeal;

that accommodate the clinical urgency of the situation.

(b) An insurer shall appoint at least one (1) individual to resolve a grievance.

(c) A grievance must be resolved as expeditiously as possible, but

not more than twenty (20) business days after the insurer receives all information reasonably necessary to complete the review. If an insurer is unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond the insurer's control, the insurer shall:

(1) before the twentieth business day, notify the covered individual in writing of the reason for the delay; and

(2) issue a written decision regarding the grievance within an additional ten (10) business days.

(d) An insurer shall notify a covered individual in writing of the resolution of a grievance within five (5) business days after completing an investigation. The grievance resolution notice must include the following:

(1) A statement of the decision reached by the insurer.

(2) A statement of the reasons, policies, and procedures that are the basis of the decision.

(3) Notice of the covered individual's right to appeal the decision.

(4) The department, address, and telephone number through which a covered individual may contact a qualified representative to obtain additional information about the decision or the right to appeal.

As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13. Amended by P.L.1-2002, SEC.115.

IC 27-8-28-17

Policies and procedures for timely resolution of appeals of grievance decisions; filing of report for violation

Sec. 17. (a) An insurer shall establish written policies and procedures for the timely resolution of appeals of grievance decisions. The procedures for registering and responding to oral and written appeals of grievance decisions must include the following:

(1) Written or oral acknowledgment of the appeal not more than five (5) business days after the appeal is filed.

(2) Documentation of the substance of the appeal and the actions taken.

(3) Investigation of the substance of the appeal, including any aspects of clinical care involved.

(4) Notification to the covered individual:

(A) of the disposition of an appeal; and

(B) that the covered individual may have the right to further remedies allowed by law.

(5) Standards for timeliness in:

(A) responding to an appeal; and

(B) providing notice to covered individuals of:

(i) the disposition of an appeal; and

(ii) the right to initiate an external grievance review under IC 27-8-29;

that accommodate the clinical urgency of the situation.

(b) In the case of an appeal of a grievance decision described in section 6(1) or 6(2) of this chapter, an insurer shall appoint a panel of one (1) or more qualified individuals to resolve an appeal. The panel must include one (1) or more individuals who:

(1) have knowledge of the medical condition, procedure, or treatment at issue;

(2) are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;

(3) are not involved in the matter giving rise to the appeal or in the initial investigation of the grievance; and

(4) do not have a direct business relationship with the covered individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.

(c) An appeal of a grievance decision must be resolved:

(1) as expeditiously as possible, reflecting the clinical urgency of the situation; and

(2) not later than forty-five (45) days after the appeal is filed.

An insurer that violates this subsection commits an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4.

(d) If an insurer violates subsection (c), the insurer shall file a report with the department during the quarter in which the violation occurred concerning the insurer's compliance with subsection (c). The report must include the following:

(1) The number of appealed grievance decisions that were not resolved as required under subsection (c).

(2) The reason each appeal described in subdivision (1) was not resolved.

(e) An insurer shall allow a covered individual the opportunity to:

(1) appear in person before; or

(2) if unable to appear in person, otherwise appropriately communicate with;

the panel appointed under subsection (b).

(f) An insurer shall notify a covered individual in writing of the resolution of an appeal of a grievance decision within five (5) business days after completing the investigation. The appeal resolution notice must include the following:

(1) A statement of the decision reached by the insurer.

(2) A statement of the reasons, policies, and procedures that are the basis of the decision.

(3) Notice of the covered individual's right to further remedies allowed by law, including the right to external grievance review by an independent review organization under IC 27-8-29.

(4) The department, address, and telephone number through which a covered individual may contact a qualified

representative to obtain more information about the decision or the right to an external grievance review.

As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13. Amended by P.L.1-2002, SEC.116; P.L.178-2003, SEC.72.

IC 27-8-28-18

Insurer prohibited from taking action

Sec. 18. An insurer may not take action against a provider solely on the basis that the provider represents a covered individual in a grievance filed under this chapter.

As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13.

IC 27-8-28-19

Grievance procedure filing; complaint analysis and reporting

Sec. 19. (a) An insurer shall each year file with the commissioner a description of the grievance procedure of the insurer established under this chapter, including:

(1) the total number of grievances handled through the procedure during the preceding calendar year;

(2) a compilation of the causes underlying those grievances; and

(3) a summary of the final disposition of those grievances.

(b) The information required by subsection (a) must be filed with the commissioner on or before March 1 of each year. The commissioner shall:

(1) make the information required to be filed under this section available to the public; and

(2) prepare an annual compilation of the data required under subsection (a) that allows for comparative analysis.

(c) The commissioner may require any additional reports as are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

(d) The commissioner shall do the following:

(1) Compile and analyze complaints received by the department concerning a denial of coverage under an accident and sickness insurance policy for:

(A) an investigational or experimental treatment; or

(B) a treatment not considered to be medically necessary for a covered individual.

(2) If the commissioner determines that a pattern of denials of coverage is evident through the analysis performed under subdivision (1), report the pattern to the legislative council in an electronic format under IC 5-14-6.

(3) Remove from a report made under subdivision (2) any information that could be used to identify an individual.

As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13. Amended by P.L.18-2016, SEC.3.

IC 27-8-28-20

Adoption of rules

Sec. 20. The department may adopt rules under IC 4-22-2 to implement this chapter.

As added by P.L.66-2001, SEC.2 and P.L.203-2001, SEC.13.

IC 27-8-29

Chapter 29. External Review of Grievances

IC 27-8-29-1

"Accident and sickness insurance policy" defined

Sec. 1. As used in this chapter, "accident and sickness insurance policy" has the meaning set forth in IC 27-8-28-1.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

IC 27-8-29-2

"Appeal" defined

Sec. 2. As used in this chapter, "appeal" means the procedure described in IC 27-8-28-17.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

IC 27-8-29-3

"Commissioner" defined

Sec. 3. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14. Amended by P.L.1-2002, SEC.117.

IC 27-8-29-4

"Covered individual" defined

Sec. 4. As used in this chapter, "covered individual" has the meaning set forth in IC 27-8-28-3.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

IC 27-8-29-5

"Department" defined

Sec. 5. As used in this chapter, "department" refers to the department of insurance.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

IC 27-8-29-6

"External grievance" defined

Sec. 6. As used in this chapter, "external grievance" means the independent review under this chapter of a:

(1) grievance filed under IC 27-8-28; or

(2) denial of coverage based on a waiver described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14. Amended by P.L.211-2003, SEC.6; P.L.3-2008, SEC.215.

IC 27-8-29-7

"Grievance" defined

Sec. 7. As used in this chapter, "grievance" has the meaning set

forth in IC 27-8-28-6.
As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

IC 27-8-29-8
"Grievance procedure" defined
Sec. 8. As used in this chapter, "grievance procedure" has the meaning set forth in IC 27-8-28-7.
As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

IC 27-8-29-9
"Health care provider" defined
Sec. 9. As used in this chapter, "health care provider" means a person:
(1) that provides physician services (as defined in IC 12-15-11-1(a)); or
(2) who is licensed under IC 25-33.
As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

IC 27-8-29-10
"Insured" defined
Sec. 10. As used in this chapter, "insured" has the meaning set forth in IC 27-8-28-8.
As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

IC 27-8-29-11
"Insurer" defined
Sec. 11. As used in this chapter, "insurer" has the meaning set forth in IC 27-8-28-9.
As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

IC 27-8-29-12
Insurer to establish external grievance procedures
Sec. 12. An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding the following:
(1) The following determinations made by the insurer or an agent of the insurer regarding a service proposed by the treating health care provider:
(A) An adverse determination of appropriateness.
(B) An adverse determination of medical necessity.
(C) A determination that a proposed service is experimental or investigational.
(D) A denial of coverage based on a waiver described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).
(2) The insurer's decision to rescind an accident and sickness insurance policy.
As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

Amended by P.L.211-2003, SEC.7; P.L.3-2008, SEC.216; P.L.160-2011, SEC.23.

IC 27-8-29-13

Requirements for external grievance procedure; independent review organizations

Sec. 13. (a) An external grievance procedure established under section 12 of this chapter must:

(1) allow a covered individual, or a covered individual's representative, to file a written request with the insurer for an external grievance review of the insurer's

(A) appeal resolution under IC 27-8-28-17 or

(B) denial of coverage based on a waiver described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed);

not more than one hundred twenty (120) days after the covered individual is notified of the resolution; and

(2) provide for:

(A) an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:

(i) life or health; or

(ii) ability to reach and maintain maximum function; or

(B) a standard external grievance review for a grievance not described in clause (A).

A covered individual may file not more than one (1) external grievance of an insurer's appeal resolution under this chapter.

(b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:

(1) select a different independent review organization for each external grievance filed under this chapter from the list of independent review organizations that are certified by the department under section 19 of this chapter; and

(2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

(c) The independent review organization chosen under subsection (b) shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance.

(d) The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:

(1) The insurer.

(2) Any officer, director, or management employee of the insurer.

(3) The health care provider or the health care provider's

medical group that is proposing the service.

(4) The facility at which the service would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider.

(6) The covered individual requesting the external grievance review.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

(e) A covered individual shall not pay any of the costs associated with the services of an independent review organization under this chapter. All costs must be paid by the insurer.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14. Amended by P.L.1-2002, SEC.118; P.L.211-2003, SEC.8; P.L.3-2008, SEC.217; P.L.160-2011, SEC.24.

IC 27-8-29-14

Rights of individuals who file grievances

Sec. 14. (a) A covered individual who files an external grievance under this chapter:

(1) shall not be subject to retaliation for exercising the covered individual's right to an external grievance under this chapter;

(2) shall be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;

(3) shall be permitted to submit additional information relating to the proposed service throughout the review process; and

(4) shall cooperate with the independent review organization by:

(A) providing any requested medical information; or

(B) authorizing the release of necessary medical information.

(b) An insurer shall cooperate with an independent review organization selected under section 13(b) of this chapter by promptly providing any information requested by the independent review organization.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14. Amended by P.L.1-2002, SEC.119.

IC 27-8-29-15

Independent review organizations; determinations

Sec. 15. (a) An independent review organization shall:

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within seventy-two (72) hours after

the external grievance is filed; or

(2) for a standard external grievance filed under section 13(a)(2)(B) of this chapter, within fifteen (15) business days after the external grievance is filed;

make a determination to uphold or reverse the insurer's appeal resolution under IC 27-8-28-17 based on information gathered from the covered individual or the covered individual's designee, the insurer, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.

(b) When making the determination under this section, the independent review organization shall apply:

(1) standards of decision making that are based on objective clinical evidence; and

(2) the terms of the covered individual's accident and sickness insurance policy.

(c) In an external grievance described in section 12(1)(D) of this chapter, the insurer bears the burden of proving that the insurer properly denied coverage for a condition, complication, service, or treatment because the condition, complication, service, or treatment is directly related to a condition for which coverage has been waived under IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).

(d) The independent review organization shall notify the insurer and the covered individual of the determination made under this section:

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within seventy-two (72) hours after the external grievance is filed; and

(2) for a standard external grievance filed under section 13(a)(2)(B) of this chapter, within seventy-two (72) hours after making the determination.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14. Amended by P.L.211-2003, SEC.9; P.L.3-2008, SEC.218; P.L.81-2012, SEC.37; P.L.72-2016, SEC.21.

IC 27-8-29-15.5

Information from independent review organization

Sec. 15.5. Upon the request of a covered individual who is notified under section 15(d) of this chapter that the independent review organization has made a determination, the independent review organization shall provide to the covered individual all information reasonably necessary to enable the covered individual to understand the:

(1) effect of the determination on the covered individual; and

(2) manner in which the insurer may be expected to respond to the determination.

As added by P.L.173-2007, SEC.42.

IC 27-8-29-16
Binding determinations

Sec. 16. A determination made under section 15 of this chapter is binding on the insurer.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

IC 27-8-29-17
Reconsideration of resolution by insurer

Sec. 17. (a) If, at any time during an external review performed under this chapter, the covered individual submits information to the insurer that is relevant to the insurer's resolution of the covered individual's appeal of a grievance decision under IC 27-8-28-17 and that was not considered by the insurer under IC 27-8-28:

(1) the insurer may reconsider the resolution under IC 27-8-28-17; and

(2) if the insurer chooses to reconsider, the independent review organization shall cease the external review process until the reconsideration under subsection (b) is completed.

(b) An insurer reconsidering the resolution of an appeal of a grievance decision due to the submission of information under subsection (a) shall reconsider the resolution under IC 27-8-28-17 based on the information and notify the covered individual of the insurer's decision:

(1) within seventy-two (72) hours after the information is submitted, for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the covered individual's:

(A) life or health; or

(B) ability to reach and maintain maximum function; or

(2) within fifteen (15) days after the information is submitted, for a reconsideration not described in subdivision (1).

(c) If the decision reached under subsection (b) is adverse to the covered individual, the covered individual may request that the independent review organization resume the external review under this chapter.

(d) If an insurer to which information is submitted under subsection (a) chooses not to reconsider the insurer's resolution under IC 27-8-28-17, the insurer shall forward the submitted information to the independent review organization not more than two (2) business days after the insurer's receipt of the information.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14. Amended by P.L.1-2002, SEC.120.

IC 27-8-29-18
Applicability of chapter

Sec. 18. This chapter does not add to or otherwise change the terms of coverage included in a policy, certificate, or contract under which a covered individual receives health care benefits under

IC 27-8.
As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

IC 27-8-29-19
Annual certifications of independent review organizations

Sec. 19. (a) The department shall establish and maintain a process for annual certification of independent review organizations.

(b) The department shall certify a number of independent review organizations determined by the department to be sufficient to fulfill the purposes of this chapter.

(c) An independent review organization must meet the following minimum requirements for certification by the department:

(1) Medical review professionals assigned by the independent review organization to perform external grievance reviews under this chapter:

(A) must be board certified in the specialty in which a covered individual's proposed service would be provided;

(B) must be knowledgeable about a proposed service through actual clinical experience;

(C) must hold an unlimited license to practice in a state of the United States; and

(D) must not have any history of disciplinary actions or sanctions, including:

(i) loss of staff privileges; or

(ii) restriction on participation;

taken or pending by any hospital, government, or regulatory body.

(2) The independent review organization must have a quality assurance mechanism to ensure:

(A) the timeliness and quality of reviews;

(B) the qualifications and independence of medical review professionals;

(C) the confidentiality of medical records and other review materials; and

(D) the satisfaction of covered individuals with the procedures utilized by the independent review organization, including the use of covered individual satisfaction surveys.

(3) The independent review organization must file with the department the following information on or before March 1 of each year:

(A) The number and percentage of determinations made in favor of covered individuals.

(B) The number and percentage of determinations made in favor of insurers.

(C) The average time to process a determination.

(D) The number of external grievance reviews terminated due to reconsideration of the insurer before a determination was made.

(E) Any other information required by the department.

The information required under this subdivision must be specified for each insurer for which the independent review organization performed reviews during the reporting year.

(4) The independent review organization must retain all records related to an external grievance review for at least three (3) years after a determination is made under section 15 of this chapter.

(5) Any additional requirements established by the department.

(d) The department may not certify an independent review organization that is one (1) of the following:

(1) A professional or trade association of health care providers or a subsidiary or an affiliate of a professional or trade association of health care providers.

(2) An insurer, a health maintenance organization, or a health plan association, or a subsidiary or an affiliate of an insurer, health maintenance organization, or health plan association.

(e) The department may suspend or revoke an independent review organization's certification if the department finds that the independent review organization is not in substantial compliance with the certification requirements under this section.

(f) The department shall make available to insurers a list of all certified independent review organizations.

(g) The department shall make the information provided to the department under subsection (c)(3) available to the public in a format that does not identify individual covered individuals.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14. Amended by P.L.1-2002, SEC.121; P.L.160-2011, SEC.25.

IC 27-8-29-20

Documents of review organizations

Sec. 20. Except as provided in section 19(g) of this chapter, documents and other information created or received by the independent review organization or the medical review professional in connection with an external grievance review under this chapter:

(1) are not public records;

(2) may not be disclosed under IC 5-14-3; and

(3) must be treated in accordance with confidentiality requirements of state and federal law.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

IC 27-8-29-21

Filing description of grievance procedure

Sec. 21. (a) An insurer shall each year file with the commissioner a description of the grievance procedure established by the insurer under this chapter, including:

(1) the total number of external grievances handled through the procedure during the preceding calendar year;

(2) a compilation of the causes underlying those grievances; and

(3) a summary of the final disposition of those grievances;

for each independent review organization used by the insurer during the reporting year.

(b) The information required by subsection (a) must be filed with the commissioner on or before March 1 of each year. The commissioner shall:

(1) make the information required to be filed under this section available to the public; and

(2) prepare an annual compilation of the data required under subsection (a) that allows for comparative analysis.

(c) The commissioner may require any additional reports that are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14. Amended by P.L.1-2002, SEC.122.

IC 27-8-29-22

Immunity from civil liability; work product or determination

Sec. 22. (a) An independent review organization is immune from civil liability for actions taken in good faith in connection with an external review under this chapter.

(b) The work product or determination, or both, of an independent review organization under this chapter are admissible in a judicial or administrative proceeding. However, the work product or determination, or both, do not, without other supporting evidence, satisfy a party's burden of proof or persuasion concerning any material issue of fact or law.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

IC 27-8-29-23

Medicare

Sec. 23. If a covered individual has the right to an external review of a grievance under Medicare, the covered individual may not request an external review of the same grievance under this chapter.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

IC 27-8-29-24

Rules

Sec. 24. The department may adopt rules under IC 4-22-2 to implement this chapter.

As added by P.L.66-2001, SEC.3 and P.L.203-2001, SEC.14.

IC 27-8-30

Chapter 30. Specific Accident and Sickness Insurance Reporting Requirements

IC 27-8-30-1

"Accident and sickness insurance policy" defined

Sec. 1. As used in this chapter, "accident and sickness insurance policy" means a policy that:

(1) provides the kinds of coverage described in Class 1(b) or Class 2(a) of IC 27-1-5-1; and

(2) includes a prescription drug benefit.

As added by P.L.107-2002, SEC.29.

IC 27-8-30-2

"Covered individual" defined

Sec. 2. As used in this chapter, "covered individual" means an individual who is covered under an accident and sickness insurance policy.

As added by P.L.107-2002, SEC.29.

IC 27-8-30-3

Allowing an insurer to report the number of covered children who are prescribed a stimulant medication for the treatment of certain disorders

Sec. 3. An insurer that issues an accident and sickness insurance policy may report to the drug utilization review board established by IC 12-15-35-19 the number of covered individuals who are:

(1) less than eighteen (18) years of age; and

(2) prescribed a stimulant medication approved by the federal Food and Drug Administration for the treatment of attention deficit disorder or attention deficit hyperactivity disorder.

As added by P.L.107-2002, SEC.29.

IC 27-8-31

Chapter 31. Interstate Insurance Product Regulation Compact

IC 27-8-31-1

Purpose

Sec. 1. The purposes of this compact are, through means of joint and cooperative action among the compacting states, to:

(1) promote and protect the interest of consumers of individual and group annuity, life insurance, disability income, and long term care insurance products;

(2) develop uniform standards for insurance products covered under the compact;

(3) establish a central clearinghouse to receive and provide prompt review of insurance products covered under the compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one (1) or more compacting states;

(4) give appropriate regulatory approval to product filings and advertisements satisfying the applicable uniform standard;

(5) improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the compact;

(6) create the interstate insurance product regulation commission; and

(7) perform these and any other related functions as may be consistent with the state regulation of the business of insurance.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-2

Definitions

Sec. 2. (a) The definitions in this section apply throughout this chapter.

(b) "Advertisement" means material designed to create public interest in a product or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace, or retain a policy, as more specifically defined in the rules and operating procedures of the commission.

(c) "Bylaws" means bylaws established by the commission for the governance, direction, or control of the commission.

(d) "Commission" refers to the interstate insurance product regulation commission established by section 3 of this chapter.

(e) "Commissioner" means the chief insurance regulatory official of a state, including a commissioner, a superintendent, a director, or an administrator.

(f) "Compacting state" means a state that:

(1) has enacted this compact; and

(2) has not:

(A) withdrawn as provided in section 15 of this chapter; or

(B) been terminated as provided in section 16 of this chapter.

(g) "Domiciliary state" means the state in which an insurer is incorporated or organized, or the state of entry of an alien insurer.

(h) "Insurer" means an entity licensed by a state to issue contracts of insurance for the lines of insurance covered by this chapter.

(i) "Member" means the commissioner or the commissioner's designee.

(j) "NAIC" refers to the National Association of Insurance Commissioners.

(k) "Noncompacting state" means a state that is not a compacting state.

(l) "Operating procedures" mean procedures adopted by the commission to implement a rule, a uniform standard, or a provision of this compact.

(m) "Opt out" means any action by a compacting state to decline to adopt or participate in a promulgated uniform standard.

(n) "Product" means the form of a policy or contract, including an application, an endorsement, or a related form that is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or a group annuity, life insurance, disability income, or long term care insurance product that an insurer is authorized to issue in Indiana or another compacting state.

(o) "Rule" means a statement of general or particular applicability and future effect adopted by the commission, including a uniform standard developed under section 8 of this chapter, that has the full force and effect of law in the compacting states and:

(1) is designed to implement or interpret law or prescribe policy; or

(2) describes the organization, procedure, or practice requirements of the commission.

(p) "State" means a state, district, or territory of the United States.

(q) "Third party filer" means an entity that submits a product filing to the commission on behalf of an insurer.

(r) "Uniform standard" means a standard adopted by the commission for a product line under section 8 of this chapter. The term includes all the product requirements. However:

(1) each uniform standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading, or ambiguous provisions in a product; and

(2) the form of the product made available to the public shall not be unfair, inequitable, or against public policy as determined by the commission.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-3

Interstate insurance product regulation commission

Sec. 3. (a) The compacting states hereby establish a joint public agency known as the interstate insurance product regulation commission. Under section 4 of this chapter, the commission may:

(1) develop uniform standards for product lines;

(2) receive and provide prompt review of products filed with the commission; and

(3) give approval to product filings satisfying applicable uniform standards.

However, it is not intended for the commission to be the exclusive entity for receipt and review of insurance product filings. This chapter does not prohibit an insurer from filing the insurer's product in a state where the insurer is licensed to conduct the business of insurance and any such filing is subject to the laws of the state where filed.

(b) The commission is a body corporate and politic, and an instrumentality of the compacting states.

(c) The commission is solely responsible for the commission's liabilities except as otherwise specifically provided in this compact.

(d) Venue is proper, and judicial proceedings by or against the commission shall be brought solely and exclusively, in a court with jurisdiction where the principal office of the commission is located.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-4

Commission powers

Sec. 4. The commission has the following powers:

(1) To adopt rules under section 8 of this chapter, which shall have the force and effect of law and are binding in the compacting states to the extent and in the manner provided in this compact.

(2) To exercise the commission's rulemaking authority and establish reasonable uniform standards for products covered under the compact and advertisement related to the products, which shall have the force and effect of law and are binding in the compacting states, but only for those products filed with the commission. However, a compacting state has the right to opt out of the uniform standard under section 8(d) of this chapter, to the extent and in the manner provided in this compact, and any uniform standard established by the commission for long term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the NAIC's long term care insurance model act and long term care insurance model regulation, respectively, adopted as of 2001. The commission shall consider whether any subsequent amendments to the NAIC long term care insurance model act or long term care insurance model regulation adopted by the NAIC require

amending the uniform standards established by the commission for long term care insurance products.
(3) To receive and review in an expeditious manner products filed with the commission and rate filings for disability income and long term care insurance products, and give approval of those products and rate filings that satisfy the applicable uniform standard, where the approval shall have the force and effect of law and is binding on the compacting states to the extent and in the manner provided in the compact.
(4) To receive and review in an expeditious manner advertisement relating to long term care insurance products for which uniform standards have been adopted by the commission, and give approval to all advertisement that satisfies the applicable uniform standard. For any product covered under this compact, other than long term care insurance products, the commission has authority to require an insurer to submit all or any part of the insurer's advertisement with respect to that product for review or approval before use, if the commission determines that the nature of the product is such that an advertisement of the product could have the capacity or tendency to mislead the public. The actions of the commission as provided in this section shall have the force and effect of law and are binding in the compacting states to the extent and in the manner provided in the compact.
(5) To exercise the commission's rulemaking authority and designate products and advertisement that may be subject to a self-certification process without the need for prior approval by the commission.
(6) To adopt operating procedures under section 8 of this chapter, which shall have the force and effect of law and are binding in the compacting states to the extent and in the manner provided in this compact.
(7) To bring and prosecute legal proceedings or actions in the commission's name as the commission, provided that the standing of any state insurance department to sue or be sued under applicable law shall not be affected.
(8) To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence.
(9) To establish and maintain offices.
(10) To purchase and maintain insurance and bonds.
(11) To borrow, accept, or contract for services of personnel, including employees of a compacting state.
(12) To hire employees, professionals, or specialists, elect or appoint officers, and fix their compensation, define their duties, give them appropriate authority to carry out the purposes of the compact, determine their qualifications, and establish the commission's personnel policies and programs relating to,

among other things, conflicts of interest, rates of compensation, and qualifications of personnel.

(13) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services, and to receive, use, and dispose of the same. At all times the commission shall strive to avoid any appearance of impropriety.

(14) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use any property, real, personal, or mixed. At all times the commission shall strive to avoid any appearance of impropriety.

(15) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed.

(16) To remit filing fees to compacting states as may be set forth in the bylaws, rules, or operating procedures.

(17) To enforce compliance by compacting states with rules, uniform standards, operating procedures, and bylaws.

(18) To provide for dispute resolution among compacting states.

(19) To advise compacting states on issues relating to insurers domiciled or doing business in noncompacting jurisdictions, consistent with the purposes of this compact.

(20) To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments.

(21) To establish a budget and make expenditures.

(22) To borrow money.

(23) To appoint committees, including advisory committees, comprising members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and any other interested persons as may be designated in the bylaws.

(24) To provide and receive information from and to cooperate with law enforcement agencies.

(25) To adopt and use a corporate seal.

(26) To perform any other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of the business of insurance.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-5

Commission members; action; bylaws

Sec. 5. (a) Each compacting state shall have and be limited to one (1) member. Each member shall be qualified to serve in that capacity under applicable law of the compacting state. Any member may be removed or suspended from office as provided by the law of the state from which the member is appointed. Any vacancy occurring in the commission shall be filled in accordance with the laws of the compacting state where the vacancy exists. Nothing in this section

shall be construed to affect the manner in which a compacting state determines the election or appointment and qualification of the compacting state's commissioner.

(b) Each member is entitled to one (1) vote and is entitled to an opportunity to participate in the governance of the commission in accordance with the bylaws. Notwithstanding any provision in this chapter to the contrary, no action of the commission with respect to the promulgation of a uniform standard is effective unless two-thirds (2/3) of the members vote in favor of adoption.

(c) The commission shall, by a majority of the members, prescribe bylaws to govern the commission's conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the compact, including the following:

(1) Establishing the fiscal year of the commission.

(2) Providing reasonable procedures for appointing and electing members and holding meetings of the management committee.

(3) Providing reasonable standards and procedures:

(A) for the establishment and meetings of other committees; and

(B) governing any general or specific delegation of any authority or function of the commission.

(4) Providing reasonable procedures for calling and conducting meetings of the commission and ensuring reasonable advance notice of each meeting, including:

(A) requiring a majority of commission members to attend a meeting;

(B) providing for the right of citizens to attend the meetings with enumerated exceptions designed to:

(i) protect the public interest;

(ii) protect the privacy of individuals; and

(iii) insure proprietary information, including trade secrets;

(C) allowing a meeting in camera only after a majority of the members of the commission votes to close a meeting en toto or in part, with no proxy voting; and

(D) providing for the commission, as soon as practicable after a vote to close a meeting as described in clause (C), to make public:

(i) a copy of the vote to close the meeting revealing the vote of each member; and

(ii) votes taken during the meeting.

(5) Establishing the titles, duties, authority, and reasonable procedures for the election of the officers of the commission.

(6) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or other similar laws of any compacting state, the bylaws shall exclusively

govern the personnel policies and programs of the commission.

(7) Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees.

(8) Providing a mechanism for winding up the operations of the commission and the equitable disposition of any surplus funds that may exist after the termination of the compact after the payment and reserving of all the commission's debts and obligations.

(d) The commission shall publish bylaws in a convenient form and file a copy of the bylaws and amendments to the bylaws with the appropriate agency or officer in each compacting state.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-6

Management committee; legislative committee; liability

Sec. 6. (a) A management committee comprising not more than fourteen (14) members shall be established as follows:

(1) One (1) member from each of the six (6) compacting states with the largest premium volume for individual and group annuities, life, disability income, and long term care insurance products, determined from the records of the NAIC for the prior year.

(2) Four (4) members from those compacting states with at least two percent (2%) of the market based on the premium volume described in subdivision (1), other than the six (6) compacting states with the largest premium volume, selected on a rotating basis as provided in the bylaws.

(3) Four (4) members from those compacting states with less than two percent (2%) of the market, based on the premium volume described in subdivision (1), with one (1) selected from each of the four (4) zone regions of the NAIC as provided in the bylaws.

(b) The management committee has the authority and duties as may be set forth in the bylaws, including the following:

(1) Managing the affairs of the commission in a manner consistent with the bylaws and purposes of the commission.

(2) Establishing and overseeing an organizational structure within, and appropriate procedures for, the commission to provide for the creation of uniform standards and other rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a compacting state to opt out of a uniform standard. However, a uniform standard shall not be submitted to the compacting states for adoption unless approved by two-thirds (2/3) of the members of the management committee.

(3) Overseeing the offices of the commission.

(4) Planning, implementing, and coordinating communications

and activities with other state, federal, and local government organizations to advance the goals of the commission.

(c) The commission shall annually elect officers from the management committee, with each having the authority and duties as may be specified in the bylaws.

(d) The management committee may, subject to the approval of the commission, appoint or retain an executive director for the period, upon the terms and conditions and for the compensation as the commission considers appropriate. The executive director shall serve as secretary to the commission but may not be a member of the commission. The executive director shall hire and supervise any other staff as may be authorized by the commission.

(e) A legislative committee comprised of state legislators or state legislators' designees shall be established to monitor the operations of and make recommendations to the commission, including the management committee. However, the manner of selection and term of any legislative committee member shall be as set forth in the bylaws. Before the commission adopts any uniform standard, revision to the bylaws, annual budget, or other significant matter as may be provided in the bylaws, the management committee shall consult with and report to the legislative committee. The commission shall establish two (2) advisory committees, one (1) of which shall comprise consumer representatives independent of the insurance industry and the other of which shall comprise insurance industry representatives. The commission may establish additional advisory committees as the commission's bylaws may provide for the carrying out of the commission's functions.

(f) The commission shall maintain its corporate books and records in accordance with the bylaws.

(g) The members, officers, executive director, employees, and representatives of the commission are immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities. However, nothing in this subsection shall be construed to protect any person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of the person.

(h) The commission shall defend any member, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing

occurred within the scope of commission employment, duties, or responsibilities. However:

(1) nothing in this subsection shall be construed to prohibit that person from retaining the person's own counsel; and

(2) this subsection applies only if the actual or alleged act, error, or omission did not result from the person's intentional or willful and wanton misconduct.

(i) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against the person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities. However, this subsection applies only if the actual or alleged act, error, or omission did not result from the intentional or willful and wanton misconduct of that person.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-7

Commission action

Sec. 7. (a) The commission shall meet and take any actions that are consistent with this compact and the bylaws.

(b) Each member of the commission is entitled to cast a vote to which that compacting state is entitled and to participate in the business and affairs of the commission. A member shall vote in person or by other means as provided in the bylaws. The bylaws may provide for members' participation in meetings by telephone or other means of communication.

(c) The commission shall meet at least one (1) time during each calendar year. Additional meetings shall be held as set forth in the bylaws.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-8

Rules; uniform standards; opting out; judicial review

Sec. 8. (a) The commission shall adopt reasonable rules, including uniform standards, and operating procedures in order to effectively and efficiently achieve the purposes of this compact. However, if the commission exercises the commission's rulemaking authority in a manner that is beyond the scope of the purposes of this chapter or the powers granted in this chapter, the action by the commission is invalid and has no force and effect.

(b) Rules and operating procedures shall be made according to a rulemaking process that substantially conforms to the principles of the model state administrative procedure act of 1981, as amended, as may be appropriate to the operations of the commission. Before the

commission adopts a uniform standard, the commission shall give written notice to the relevant state legislative committees in each compacting state responsible for insurance issues of the commission's intention to adopt the uniform standard. The commission, in adopting a uniform standard, shall fully consider all submitted materials and issue a concise explanation of the commission's decision.

(c) A uniform standard becomes effective ninety (90) days after the uniform standard's adoption by the commission or on a later date as the commission may determine. However, a compacting state may opt out of a uniform standard as provided in subsection (d). All other rules and operating procedures and amendments to the other rules and operating procedures become effective as of the date specified in each rule, operating procedure, or amendment.

(d) A compacting state may opt out of a uniform standard, either by legislation or by rule adopted by the insurance department under the compacting state's administrative procedure act. If a compacting state elects to opt out of a uniform standard by rule, the compacting state must:

(1) give written notice to the commission not later than ten (10) business days after the uniform standard is adopted or at the time the state becomes a compacting state; and

(2) find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions in the state. The commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the state that warrant a departure from the uniform standard and determining that the uniform standard would not reasonably protect the citizens of the state. The commissioner must balance, consider, and find that the conditions in the state and needs of the citizens of the state outweigh the following factors:

(A) The intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this chapter.

(B) The presumption that a uniform standard adopted by the commission provides reasonable protections to consumers of the relevant product.

However, a compacting state may, at the time of the compacting state's enactment of this compact, prospectively opt out of all uniform standards involving long term care insurance products by expressly providing for an opt out in the enacted compact, and the opt out shall not be treated as a material variance in the offer or acceptance of any state to participate in this compact. The opt out is effective at the time of enactment of this compact by the compacting state and shall apply to all existing uniform standards involving long

term care insurance products and those subsequently adopted.

(e) If a compacting state elects to opt out of a uniform standard, the uniform standard remains applicable in the compacting state electing to opt out until the time the opt out legislation is enacted or the regulation opting out becomes effective. Once the opt out of a uniform standard by a compacting state becomes effective as provided under the laws of the state, the uniform standard shall have no further force and effect in the state unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the state. If a compacting state opts out of a uniform standard after the uniform standard has been made effective in the state, the opt out shall have the same prospective effect as provided under section 15 of this chapter for withdrawals.

(f) If a compacting state has formally initiated the process of opting out of a uniform standard by rule while the regulatory opt out is pending, the compacting state may petition the commission, not less than fifteen (15) days before the effective date of the uniform standard, to stay the effectiveness of the uniform standard in the compacting state. The commission may grant a stay if the commission determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the commission, the stay or extension may postpone the effective date by not more than ninety (90) days, unless the stay is extended by the commission. However, a stay may not be permitted to remain in effect for more than one (1) year unless the compacting state can show extraordinary circumstances that warrant a continuance of the stay, including the existence of a legal challenge that prevents the compacting state from opting out. A stay may be terminated by the commission on notice that the rulemaking process has been terminated.

(g) Not later than thirty (30) days after a rule or operating procedure is adopted, any person may file a petition for judicial review of the rule or operating procedure. However, the filing of a petition shall not stay or otherwise prevent the rule or operating procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the commission consistent with applicable law and shall not find the rule or operating procedure to be unlawful if the rule or operating procedure represents a reasonable exercise of the commission's authority.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-9

Commission information and records; disclosure; confidentiality; compacting state compliance and oversight

Sec. 9. (a) The commission shall adopt rules establishing conditions and procedures for public inspection and copying of the

commission's information and official records, except information and records involving the privacy of individuals and trade secrets of insurers. The commission may adopt additional rules under which the commission may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with these agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

(b) Except as to privileged records, data, and information, the laws of any compacting state pertaining to confidentiality or nondisclosure shall not relieve any compacting state commissioner of the duty to disclose any relevant records, data, or information to the commission. However, disclosure to the commission shall not be considered to waive or otherwise affect any confidentiality requirement, and, except as otherwise expressly provided in this chapter, the commission shall not be subject to the compacting state's laws pertaining to confidentiality and nondisclosure with respect to records, data, and information in the commission's possession. Confidential information of the commission remains confidential after the information is provided to any commissioner.

(c) The commission shall monitor compacting states for compliance with duly adopted bylaws, rules, including uniform standards, and operating procedures. The commission shall notify any noncomplying compacting state in writing of the noncomplying compacting state's noncompliance with commission bylaws, rules, or operating procedures. If a noncomplying compacting state fails to remedy the noncomplying compacting state's noncompliance within the time specified in the notice of noncompliance, the compacting state is considered to be in default as set forth in section 16 of this chapter.

(d) The commissioner of any state in which an insurer is authorized to do business or is conducting the business of insurance shall continue to exercise the commissioner's authority to oversee the market regulation of the activities of the insurer in accordance with the provisions of the state's law. The commissioner's enforcement of compliance with the compact is governed by the following:

(1) With respect to the commissioner's market regulation of a product or an advertisement that is approved or certified to the commission, the content of the product or advertisement does not constitute a violation of the provisions, standards, or requirements of the compact except upon a final order of the commission, issued at the request of a commissioner after prior notice to the insurer and an opportunity for hearing before the commission.

(2) Before a commissioner may bring an action for violation of a provision, standard, or requirement of the compact related to the content of an advertisement not approved or certified to the

commission, the commission or an authorized commission officer or employee must authorize the action. However, authorization under this subdivision does not require:

(A) notice to the insurer;

(B) opportunity for hearing; or

(C) disclosure of:

(i) requests for authorization; or

(ii) records of the commission's action on a request described in item (i).

As added by P.L.138-2005, SEC.3.

IC 27-8-31-10

Dispute resolution

Sec. 10. The commission shall attempt, upon the request of a member, to resolve any disputes or other issues that are subject to this compact and that may arise between two (2) or more compacting states, or between compacting states and noncompacting states, and the commission shall adopt an operating procedure providing for resolution of any disputes.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-11

Product filing and approval

Sec. 11. (a) Insurers and third party filers seeking to have a product approved by the commission shall file the product with and pay applicable filing fees to the commission. Nothing in this chapter restricts or otherwise prevents an insurer from filing the insurer's product with the insurance department in any state where the insurer is licensed to conduct the business of insurance, and the filing is subject to the laws of the states where filed.

(b) The commission shall establish appropriate filing and review processes and procedures under commission rules and operating procedures. Notwithstanding any provision in this chapter to the contrary, the commission shall adopt rules to establish conditions and procedures under which the commission will provide public access to product filing information. In establishing any rules, the commission shall consider the interests of the public in having access to the information as well as protection of personal medical and financial information and trade secrets that may be contained in a product filing or supporting information.

(c) Any product approved by the commission may be sold or otherwise issued in the compacting states in which the insurer is legally authorized to do business.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-12

Disapproval; appeal; monitoring

Sec. 12. (a) Not later than thirty (30) days after the commission

has given notice of a disapproved product or advertisement filed with the commission, the insurer or third party filer whose filing was disapproved may appeal the determination to a review panel appointed by the commission. The commission shall adopt rules to establish procedures for appointing the review panels and provide for notice and hearing. An allegation that the commission, in disapproving a product or an advertisement filed with the commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with section 3(e) of this chapter.

(b) The commission shall monitor, review, and reconsider products and advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant uniform standard. If appropriate, the commission may withdraw or modify the commission's approval after proper notice and hearing, subject to the appeal process in subsection (a).

As added by P.L.138-2005, SEC.3.

IC 27-8-31-13

Commission finances

Sec. 13. (a) The commission shall pay or provide for the payment of the reasonable expenses of the commission's establishment and organization. To fund the cost of the commission's initial operations, the commission may accept contributions and other forms of funding from the NAIC, compacting states, and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the commission concerning the performance of the commission's duties is not compromised.

(b) The commission shall collect a filing fee from each insurer and third party filer filing a product with the commission to cover the cost of the operations and activities of the commission and the commission's staff in an amount sufficient to cover the commission's annual budget.

(c) The commission's budget for a fiscal year may not be approved until the commission's budget has been subject to notice and comment as set forth in section 8(b) of this chapter.

(d) The commission is exempt from all taxation in and by the compacting states.

(e) The commission shall not pledge the credit of any compacting state, except by and with the appropriate legal authority of that compacting state.

(f) The commission shall keep complete and accurate accounts of all the commission's internal receipts, including grants and donations, and disbursements of all funds under the commission's control. The internal financial accounts of the commission are subject to the accounting procedures established under the commission's bylaws. The financial accounts and reports, including the system of internal

controls and procedures of the commission, shall be audited annually by an independent certified public accountant. Upon the determination of the commission, but not less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the commission. The commission shall make an annual report, to the governor and legislature of the compacting states, including a report of the independent audit. The commission's internal accounts are not confidential and such internal account materials may be shared with the commissioner of any compacting state upon request. However, work papers related to internal or independent audit and information regarding the privacy of individuals and proprietary information of insurers, including trade secrets, is confidential.

(g) No compacting state shall have any claim to or ownership of any property held by or vested in the commission or to any commission funds held under the provisions of this compact.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-14

Effectiveness of compact; amendments

Sec. 14. (a) Any state is eligible to become a compacting state. The compact becomes effective and binding upon legislative enactment of the compact into law by two (2) compacting states. However, the commission shall become effective for purposes of adopting uniform standards for, reviewing, and giving approval or disapproval of products filed with the commission that satisfy applicable uniform standards only after twenty-six (26) states are compacting states or, alternatively, by states representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income, and long term care insurance products, based on records of the NAIC for the prior year. Thereafter, it becomes effective and binding as to any other compacting state upon enactment of the compact into law by that state.

(b) Amendments to the compact may be proposed by the commission for enactment by the compacting states. An amendment does not become effective and binding upon the commission and the compacting states unless and until all compacting states enact the amendment into law.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-15

Withdrawal of compacting state; reinstatement

Sec. 15. (a) Once effective, the compact continues in force and remains binding upon each compacting state. However, a compacting state may withdraw from the compact by enacting a statute specifically repealing the statute that enacted the compact into law.

(b) The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal does not apply to any

product filings approved or self-certified, or any advertisement of products, on the date the repealing statute becomes effective, except by mutual agreement of the commission and the withdrawing state, unless the approval is rescinded by the withdrawing state as provided in subsection (e).

(c) The commissioner of the withdrawing state shall immediately notify the management committee in writing upon the introduction of legislation repealing this compact in the withdrawing state.

(d) The commission shall notify the other compacting states of the introduction of the legislation within ten (10) days after the commission's receipt of notice of the introduction of the legislation.

(e) The withdrawing state is responsible for all obligations, duties, and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the commission and the withdrawing state. The commission's approval of products and advertisement before the effective date of withdrawal shall continue to be effective and be given full force and effect in the withdrawing state, unless formally rescinded by the withdrawing state in the same manner as provided by the laws of the withdrawing state for the prospective disapproval of products or advertisement previously approved under state law.

(f) Reinstatement following withdrawal of any compacting state occurs on the effective date of the withdrawing state reenacting the compact.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-16

Default of compacting state; reinstatement

Sec. 16. (a) If the commission determines that any compacting state has at any time defaulted in the performance of any of the compacting state's obligations or responsibilities under this compact, the bylaws, or adopted rules or operating procedures, after notice and hearing as set forth in the bylaws, all rights, privileges, and benefits conferred by this compact on the defaulting state shall be suspended from the effective date of default as fixed by the commission. The grounds for default include:

(1) failure of a compacting state to perform its obligations or responsibilities; or

(2) any other grounds designated in commission rules.

The commission shall immediately notify the defaulting state in writing of the defaulting state's suspension pending a cure of the default. The commission shall stipulate the conditions and the period within which the defaulting state must cure the defaulting state's default. If the defaulting state fails to cure the default within the period specified by the commission, the defaulting state shall be terminated and the compact and all rights, privileges, and benefits

conferred by this compact shall be terminated on the effective date of termination.

(b) Product approvals by the commission, product self-certifications, or any advertisement in connection with the product that is in force on the effective date of termination shall remain in force in the defaulting state in the same manner as if the defaulting state had withdrawn voluntarily under section 15 of this chapter.

(c) Reinstatement following termination of any compacting state requires a reenactment of the compact.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-17
Dissolution of compact

Sec. 17. The compact dissolves effective on the date of the withdrawal or default of the compacting state that reduces membership in the compact to one (1) compacting state. Upon the dissolution of this compact, the compact is null and void and is of no further force or effect, and the business and affairs of the commission shall be wound up and any surplus funds shall be distributed in accordance with the bylaws.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-18
Severability

Sec. 18. The provisions of this compact are severable and if any phrase, clause, sentence, or provision is considered unenforceable, the remaining provisions of the compact are enforceable. The provisions of this compact shall be liberally construed to effectuate the compact's purposes.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-19
Effect on state law

Sec. 19. (a) Nothing in this chapter prevents the enforcement of any other law of a compacting state, except as provided in subsection (b).

(b) For a product approved or certified to the commission, the rules, uniform standards, and any other requirements of the commission constitute the exclusive provisions applicable to the content, approval, and certification of the products. For an advertisement that is subject to the commission's authority, any rule, uniform standard, or other requirement of the commission that governs the content of the advertisement constitutes the exclusive provision that a commissioner may apply to the content of the advertisement. However, no action taken by the commission shall abrogate or restrict:

(1) the access of any person to state courts;

(2) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the product;

(3) state law relating to the construction of insurance contracts; or

(4) the authority of the attorney general of the state, including maintaining actions or proceedings, as authorized by law.

(c) All insurance products filed with individual states are subject to the laws of those states.

As added by P.L.138-2005, SEC.3.

IC 27-8-31-20

Commission actions and agreements; effect on compacting states; constitutional violation

Sec. 20. (a) All lawful actions of the commission, including all rules and operating procedures adopted by the commission, are binding upon the compacting states.

(b) All agreements between the commission and the compacting states are binding in accordance with the terms of the agreements.

(c) Upon the request of a party to a conflict over the meaning or interpretation of commission actions and upon a majority vote of the compacting states, the commission may issue advisory opinions regarding the meaning or interpretation in dispute.

(d) Any provision of this compact that violates the Constitution of the State of Indiana is ineffective in Indiana.

As added by P.L.138-2005, SEC.3.

IC 27-8-31.2

Chapter 31.2. Mail Order and Internet Pharmacy Designation

IC 27-8-31.2-0.1

Application of chapter

Sec. 0.1. The addition of this chapter by P.L.251-2003 applies to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2003.

As added by P.L.220-2011, SEC.453.

IC 27-8-31.2-1

"Insurer"

Sec. 1. As used in this chapter, "insurer" refers to an insurer (as defined in IC 27-1-2-3) that issues a policy of accident and sickness insurance.

As added by P.L.251-2003, SEC.4.

IC 27-8-31.2-2

"Insured"

Sec. 2. As used in this chapter, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

As added by P.L.251-2003, SEC.4.

IC 27-8-31.2-3

"Mail order or Internet based pharmacy"

Sec. 3. As used in this chapter, "mail order or Internet based pharmacy" has the meaning set forth in IC 25-26-18-1.

As added by P.L.251-2003, SEC.4.

IC 27-8-31.2-4

"Policy of accident and sickness insurance"

Sec. 4. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

As added by P.L.251-2003, SEC.4.

IC 27-8-31.2-5

Designation of mail order or Internet based pharmacy

Sec. 5. (a) An insurer that provides coverage for prescription drugs may designate a mail order or an Internet based pharmacy to provide prescription drugs to an insured.

(b) An insurer may not require an insured to obtain a prescription drug from a pharmacy designated under subsection (a) as a condition of coverage.

As added by P.L.251-2003, SEC.4.

IC 27-8-32

Chapter 32. Coverage for Chemotherapy

IC 27-8-32-1

Application of chapter

Sec. 1. This chapter applies to a policy of accident and sickness insurance that provides coverage for both of the following:

(1) Orally administered cancer chemotherapy.

(2) Cancer chemotherapy that is administered intravenously or by injection.

As added by P.L.46-2009, SEC.1.

IC 27-8-32-2

"Cancer chemotherapy"

Sec. 2. As used in this chapter, "cancer chemotherapy" means medication that is prescribed by a physician to kill or slow the growth of cancer cells.

As added by P.L.46-2009, SEC.1.

IC 27-8-32-3

"Insured"

Sec. 3. As used in this chapter, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

As added by P.L.46-2009, SEC.1.

IC 27-8-32-4

"Policy of accident and sickness insurance"

Sec. 4. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

As added by P.L.46-2009, SEC.1.

IC 27-8-32-5

Prohibition on coverage limitations

Sec. 5. Coverage for orally administered cancer chemotherapy under a policy of accident and sickness insurance must not be subject to dollar limits, copayments, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, copayments, deductibles, or coinsurance provisions that apply to coverage for cancer chemotherapy that is administered intravenously or by injection under the policy of accident and sickness insurance.

As added by P.L.46-2009, SEC.1.

IC 27-8-32.1

Chapter 32.1. Coverage for Prescription Eye Drops

IC 27-8-32.1-1

Application

Sec. 1. This chapter applies to a policy of accident and sickness insurance that provides coverage for prescription eye drops.

As added by P.L.43-2015, SEC.2.

IC 27-8-32.1-2

"Insured"

Sec. 2. As used in this chapter, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

As added by P.L.43-2015, SEC.2.

IC 27-8-32.1-3

"Policy of accident and sickness insurance"

Sec. 3. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

As added by P.L.43-2015, SEC.2.

IC 27-8-32.1-4

Policy of accident and sickness insurance; coverage for refill of prescription eye drops; requirements

Sec. 4. (a) A policy of accident and sickness insurance must provide coverage for a refill of prescription eye drops if the following are met:

(1) For a thirty (30) day supply, the insured requests the refill not earlier than twenty-five (25) days after the date the prescription eye drops were last dispensed to the insured.

(2) For a ninety (90) day supply, the insured requests the refill not earlier than seventy-five (75) days after the date the prescription eye drops were last dispensed to the insured.

(3) The prescribing practitioner has indicated on the prescription that the prescription eye drops are refillable and the refill requested by the insured does not exceed the refillable amount remaining on the prescription.

(b) The coverage required by subsection (a) must not be subject to dollar limits, copayments, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, copayments, deductibles, or coinsurance provisions that apply to coverage for prescription drugs generally under the policy of accident and sickness insurance.

(c) This section applies to a policy of accident and sickness insurance issued, delivered, amended, or renewed after December 31, 2015.

As added by P.L.43-2015, SEC.2.

IC 27-8-32.4

Chapter 32.4. Coverage for Methadone

IC 27-8-32.4-1

Application

Sec. 1. This chapter applies to a policy of accident and sickness insurance that is issued, amended, or renewed after June 30, 2015.

As added by P.L.209-2015, SEC.19.

IC 27-8-32.4-2

Repealed

(As added by P.L.209-2015, SEC.19. Repealed by P.L.149-2016, SEC.78.)

IC 27-8-32.4-3

"Policy of accident and sickness insurance"

Sec. 3. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

As added by P.L.209-2015, SEC.19.

IC 27-8-32.4-4

Coverage of methadone when prescribed for pain

Sec. 4. A policy of accident and sickness insurance may provide coverage for methadone if the drug is prescribed for the treatment of pain or pain management only as follows:

(1) If the daily dosage is not more than sixty (60) milligrams.

(2) If the daily dosage is more than sixty (60) milligrams, only if:

(A) prior authorization is obtained; and

(B) a determination of medical necessity has been shown by the provider.

As added by P.L.209-2015, SEC.19.

IC 27-8-33

Chapter 33. Health Care Exchanges and Abortion

IC 27-8-33-1

"Abortion"

Sec. 1. As used in this chapter, "abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.

As added by P.L.193-2011, SEC.16.

IC 27-8-33-2

"Federal Patient Protection and Affordable Care Act"

Sec. 2. As used in this chapter, "federal Patient Protection and Affordable Care Act" includes amendments made by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

As added by P.L.193-2011, SEC.16.

IC 27-8-33-3

"Qualified health plan"

Sec. 3. As used in this chapter, "qualified health plan" has the meaning set forth in Section 1301 of the federal Patient Protection and Affordable Care Act (P.L. 111-148).

As added by P.L.193-2011, SEC.16.

IC 27-8-33-4

Prohibition on coverage for abortion; exceptions

Sec. 4. A qualified health plan offered under Subtitle D of Title 1 of the federal Patient Protection and Affordable Care Act may not provide coverage for abortion, except in the following cases:

(1) The pregnant woman became pregnant through an act of rape or incest.

(2) An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

As added by P.L.193-2011, SEC.16.

IC 27-8-34

Chapter 34. Coverage for Telemedicine Services

IC 27-8-34-1

"Covered individual"

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

As added by P.L.185-2015, SEC.25.

IC 27-8-34-2

"Health care services"

Sec. 2. As used in this chapter, "health care services" has the meaning set forth in IC 27-8-11-1.

As added by P.L.185-2015, SEC.25.

IC 27-8-34-3

"Policy"

Sec. 3. As used in this chapter, "policy" means a policy of accident and sickness insurance (as defined in IC 27-8-5-1). The term does not include dental insurance or vision insurance.

As added by P.L.185-2015, SEC.25.

IC 27-8-34-4

"Provider"

Sec. 4. As used in this chapter, "provider" has the meaning set forth in IC 27-8-11-1.

As added by P.L.185-2015, SEC.25.

IC 27-8-34-5

"Telemedicine services"

Sec. 5. (a) As used in this chapter, "telemedicine services" means health care services delivered by use of interactive audio, video, or other electronic media, including the following:

(1) Medical exams and consultations.

(2) Behavioral health, including substance abuse evaluations and treatment.

(b) The term does not include the delivery of health care services by use of the following:

(1) A telephone transmitter for transtelephonic monitoring.

(2) A telephone or any other means of communication for the consultation from one (1) provider to another provider.

As added by P.L.185-2015, SEC.25.

IC 27-8-34-6

Coverage of telemedicine services; limits; separate consent prohibited

Sec. 6. (a) A policy must provide coverage for telemedicine

services in accordance with the same clinical criteria as the policy provides coverage for the same health care services delivered in person.

(b) Coverage for telemedicine services required by subsection (a) may not be subject to a dollar limit, deductible, or coinsurance requirement that is less favorable to a covered individual than the dollar limit, deductible, or coinsurance requirement that applies to the same health care services delivered to a covered individual in person.

(c) Any annual or lifetime dollar limit that applies to telemedicine services must be the same annual or lifetime dollar limit that applies in the aggregate to all items and services covered under the policy.

(d) A separate consent for telemedicine services may not be required.

As added by P.L.185-2015, SEC.25.

IC 27-8-34-7

Application limitations

Sec. 7. This chapter does not do any of the following:

(1) Require a policy to provide coverage for a telemedicine service that is not a covered health care service under the policy.

(2) Require the use of telemedicine services when the treating provider has determined that telemedicine services are inappropriate.

(3) Prevent the use of utilization review concerning coverage for telemedicine services in the same manner as utilization review is used concerning coverage for the same health care services delivered to a covered individual in person.

As added by P.L.185-2015, SEC.25.

IC 27-9

ARTICLE 9. SUPERVISION; REHABILITATION; LIQUIDATION

IC 27-9-1

Chapter 1. General Provisions

IC 27-9-1-1

Applicability of article

Sec. 1. Proceedings under this article apply to the following:

(1) All insurers who are doing, or who have done, insurance business in Indiana, and against whom claims arising from that business may exist.

(2) All insurers who purport to do insurance business in Indiana.

(3) All insurers who have insureds resident in Indiana.

(4) All other persons organized or in the process of organizing with the intent to do an insurance business in Indiana.

(5) All nonprofit service plans, fraternal benefit societies, and beneficial societies.

(6) All title insurance companies.

(7) All health maintenance organizations under IC 27-13.

(8) All multiple employer welfare arrangements under IC 27-1-34.

(9) All limited service health maintenance organizations under IC 27-13-34.

(10) All mutual insurance holding companies under IC 27-14.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.274-1987, SEC.16; P.L.192-1991, SEC.4; P.L.1-1992, SEC.155; P.L.26-1994, SEC.22; P.L.5-2000, SEC.1.

IC 27-9-1-2

Definitions

Sec. 2. As used in IC 27-9:

(a) "Ancillary state" means any state other than a domiciliary state.

(b) "Collateral", for purposes of IC 27-9-3-34.5, means cash, a letter of credit, a surety bond, or another form of security posted by an insured, a captive insurer, or reinsurer, to secure the insured's obligation to:

(1) pay deductible claims or to reimburse the insurer for deductible claim payments under a large deductible policy; or

(2) reimburse or pay the insurer as required for other secured obligations.

(c) "Commercially reasonable" means:

(1) acting in good faith according to prevailing industry practices; and

(2) making all reasonable efforts considering the facts and circumstances of a matter.

(d) "Commissioner" refers to the insurance commissioner.

(e) "Creditor" means a person having a claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed or contingent.

(f) "Deductible claim" means a claim under a large deductible policy that does not exceed the deductible. The term includes a claim for loss, defense, and (unless excluded) cost containment expense.

(g) "Delinquency proceeding" means:

(1) any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving that insurer; and

(2) any summary proceeding under IC 27-9-2-1 or IC 27-9-2-2.

(h) "Doing business" includes the following acts, whether effected by mail or otherwise:

(1) The issuance or delivery of contracts of insurance to persons resident in Indiana.

(2) The solicitation of applications for contracts or other negotiations preliminary to the execution of contracts.

(3) The collection of premiums, membership fees, assessments, or other consideration for contracts.

(4) The transaction of matters subsequent to execution of contracts and arising out of them.

(5) Operating under a license or certificate of authority, as an insurer, issued by the insurance department.

(i) "Domiciliary state" means the state in which an insurer is incorporated or organized, or, in the case of an alien insurer, its state of entry.

(j) "Fair consideration" is given for property or obligation:

(1) when in exchange for that property or obligation, as a fair equivalent for it, and in good faith, property is conveyed or services are provided or an obligation is incurred or an antecedent debt is satisfied; or

(2) when that property or obligation is received in good faith to secure a present advance or antecedent debt in amount not disproportionately small as compared to the value of the property or obligation obtained.

(k) "Foreign guaranty association" refers to a guaranty association similar to those listed in subsection (n) established in any state.

(l) "Formal delinquency hearing" means any liquidation or rehabilitation proceeding.

(m) "General assets" means all property not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, "general assets" includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured by that property. Assets held in

trust and on deposit for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as general assets.

(n) "Guaranty association" includes an association established under:

(1) IC 27-6-8, the insurance guaranty association law; or

(2) IC 27-8-8, the life and health guaranty association law.

(o) "Insolvency" or "insolvent" means:

(1) for an insurer issuing only assessable fire insurance policies:

(A) the inability of the insurer to pay any obligation within thirty (30) days after it becomes payable; or

(B) if an assessment be made within thirty (30) days after the date an obligation becomes payable, the inability of the insurer to pay that obligation thirty (30) days following the date specified in the first assessment notice issued after the date of loss; and

(2) for all other insurers when:

(A) the insurer is unable to pay its obligations when they are due; or

(B) the insurer's admitted assets do not exceed its liabilities, plus the greater of:

(i) any capital and surplus required by law for its organization; or

(ii) the total par or stated value of its authorized and issued capital stock.

For purposes of this subsection, "liabilities" include reserves required by law or by regulation.

(p) "Insurer" means any person who:

(1) has done, purports to do, is doing, or is licensed to do insurance business; and

(2) is subject to the authority of any insurance commissioner as to liquidation, rehabilitation, reorganization, supervision, or conservation.

For purposes of IC 27-9, other persons included under section 1 of this chapter shall be considered to be insurers.

(q) "Large deductible policy" means a combination of worker's compensation policies or endorsements, or both, issued to an insured and contracts or security agreements entered into between the insured and insurer in which the insured has agreed to pay directly, or reimburse the insurer for the insurer's payment of, the:

(1) initial part of a claim under the policy; or

(2) expenses related to a claim;

up to a specified dollar amount. The term includes a policy that contains, in addition to a per claim limit, an aggregate limit on the insured's liability for all deductible claims. The term also includes a policy with a deductible of at least fifty thousand dollars ($50,000). The term does not include a policy, an endorsement, or an agreement under which the initial part of a claim is self-insured and the insurer

is not obligated to pay any part of the self-insured retention. The term also does not include a policy that provides for retrospectively rated premium payments or a reinsurance agreement, except to the extent that a reinsurance agreement assumes, secures, or pays the insured's large deductible obligations.

(r) "Other secured obligations", for purposes of IC 27-9-3-34.5, means obligations of an insured to an insurer other than obligations under a large deductible policy. The term includes obligations under a reinsurance agreement or another agreement that involves retrospective premium obligations the performance of which is secured by collateral that also secures an insured's obligations under a large deductible policy.

(s) "Preferred claim" means any claim with respect to which the terms of IC 27-9 accord priority of payment from the general assets of the insurer.

(t) "Receiver" includes liquidator, rehabilitator, or conservator.

(u) "Reciprocal state" means any state other than Indiana in which:

(1) in substance and effect IC 27-9-3-7(a), IC 27-9-4-3, IC 27-9-4-4, and IC 27-9-4-6 through IC 27-9-4-8 are in force;
(2) provisions are in force requiring that the commissioner (or equivalent official) be the receiver of a delinquent insurer; and
(3) some provision exists for the avoidance of fraudulent conveyances and preferential transfers.

(v) "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise, but not including special deposit claims or claims against general assets. The term also includes claims which have become liens upon specific assets by reason of judicial process.

(w) "Special deposit claim" means any claim secured by a deposit made under law for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

(x) "State" includes the District of Columbia and all other territories of the United States.

(y) "Transfer" includes all methods of disposing with any interest in property or with the possession of that property, or of fixing a lien upon property, or upon an interest in property, absolutely or conditionally, voluntarily, by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be considered a transfer made by the debtor.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.72-2016, SEC.22.

IC 27-9-1-3

Jurisdiction of court and commissioner; actions by receivers; place of action

Sec. 3. (a) A delinquency proceeding under this chapter may only

be commenced by the commissioner. A court may not entertain, hear, or determine a proceeding commenced by any other person.

(b) A court may not entertain, hear, or determine any complaint requesting:

(1) the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of any insurer; or

(2) an injunction, restraining order, or other relief preliminary to, incidental to, or relating to those proceedings other than in accordance with this article.

(c) In addition to other grounds for jurisdiction provided by the law, an Indiana court having jurisdiction of the subject matter has jurisdiction over a person served under the Indiana rules of court or other applicable law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in Indiana if the person served is:

(1) obligated to the insurer in any way as an incident to any agency or brokerage arrangement that may exist or has existed between the insurer and the insurance producer or broker, in any action on or incident to the obligation;

(2) a reinsurer who:

(A) has at any time written a policy of reinsurance for an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced; or

(B) is an insurance producer or broker of, or for, the reinsurer in any action on or incident to the reinsurance contract; or

(3) or has been an officer, manager, trustee, organizer, promoter, or person in a position of comparable authority or influence in an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced in any action resulting from such a relationship with the insurer.

(d) If it appears to a receiver appointed in a proceeding under this article that there has been criminal or tortious conduct, breach of any contractual or fiduciary obligation, or other unlawful conduct detrimental to the insurer by any director, officer, manager, insurance producer, broker, employee, or other person or entity, the receiver may pursue all appropriate legal remedies on behalf of the insurer.

(e) If the court on motion of any party finds that any action should as a matter of substantial justice be tried in a forum outside Indiana, the court may enter an order to stay further proceedings on the action in Indiana.

(f) All action authorized by this section must be brought in the Marion County circuit court.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.167-1986, SEC.1; P.L.178-2003, SEC.73.

IC 27-9-1-3.5

Change of judge or venue from Marion County Circuit Court in

actions against receiver

Sec. 3.5. Notwithstanding the Indiana rules of trial procedure or other law to the contrary, an automatic change of judge or change of venue from the Marion County circuit court may not be granted in any action brought by or against a receiver appointed in a proceeding under this article. A change of judge or change of venue from the Marion County circuit court in such an action shall be granted only upon the filing of a verified application alleging and demonstrating one (1) or more of the specific grounds for a change of judge set forth in the Indiana rules of trial procedure or for a change of venue set forth in IC 34-35-1-1.

As added by P.L.167-1986, SEC.2. Amended by P.L.1-1998, SEC.153.

IC 27-9-1-4

Restraining orders and injunctions

Sec. 4. (a) A receiver appointed in a proceeding under IC 27-9 may at any time apply for, and any court with general jurisdiction may grant, restraining orders, preliminary and permanent injunctions, and other orders as considered necessary and proper to prevent any of the following:

(1) The transaction of further business.

(2) The transfer of property.

(3) Interference with the receiver or with a proceeding under IC 27-9.

(4) Waste of the insurer's assets.

(5) Dissipation and transfer of bank accounts.

(6) The institution or further prosecution of any actions or precedings.

(7) The obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets or its policyholders.

(8) The levying of execution against the insurer, its assets, or its policyholders.

(9) The making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer.

(10) The withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer.

(11) Any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors, or shareholders, or the administration of any proceeding under IC 27-9.

(b) The receiver may apply to any court outside of Indiana for the relief described in subsection (a).

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-1-5
Cooperation of insurer with commissioner

Sec. 5. (a) An officer, manager, director, trustee, owner, employee, or insurance producer of any insurer, or any other persons with authority over or in charge of any segment of the insurer's affairs, shall cooperate with the commissioner in any proceeding under IC 27-9 or any investigation preliminary to the proceeding. The term "person", as used in this section, includes any person who exercises control, directly or indirectly, over activities of an insurer through any holding company or other affiliate of the insurer. "To cooperate" includes:

(1) replying promptly in writing to any inquiry from the commissioner requesting such a reply; and

(2) making available to the commissioner all books, accounts, documents, or other records, information, or property of or pertaining to the insurer and in the insurer's possession, custody, or control.

(b) A person may not obstruct or interfere with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary to or incidental to an investigation.

(c) This section does not abridge existing legal rights, including the right to resist a petition for liquidation, other delinquency proceedings, or other orders.

(d) A person who:

(1) is included within subsection (a) and who fails to cooperate with the commissioner;

(2) obstructs or interferes with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental to a delinquency proceeding; or

(3) violates any order of the commissioner under IC 27-9;

commits a Class A infraction.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.178-2003, SEC.74.

IC 27-9-1-6
Bonds of commissioner and deputies

Sec. 6. In any proceeding under IC 27-9, the commissioner and his deputies are responsible on their official bonds for the faithful performance of their duties. If the court considers it desirable for the protection of the insurer's assets, the court may at any time require an additional bond from the commissioner or his deputies. Those bonds shall be paid for out of the assets of the insurer as a cost of administration.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-2

Chapter 2. Summary Proceedings

IC 27-9-2-1

Practices or condition of domestic insurers requiring control or supervision

Sec. 1. (a) Whenever the commissioner has reasonable cause to believe, and determines, after a hearing held under IC 4-21.5-3, that any domestic insurer has committed or engaged in, or is about to commit or engage in, any act, practice, or transaction that would subject it to a delinquency proceeding under IC 27-9-3-1 or IC 27-9-3-6, the commissioner may make and serve upon the insurer and any other persons involved, any orders reasonably necessary to correct, eliminate, or remedy that conduct, condition, or ground.

(b) If the commissioner has reasonable cause to believe that any domestic insurer is in such condition as to render the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance, or if that domestic insurer gives its consent, the commissioner shall upon his determination issue an order:

(1) notifying the insurer of his determination; and

(2) providing the insurer with a written list of the commissioner's requirements to correct its business practices.

(c) If the commissioner makes a determination to supervise an insurer subject to an order under subsection (a) or (b), the commissioner shall notify the insurer that it is under the supervision of the commissioner. If the insurer is a reorganized insurer under IC 27-14, the commissioner may also determine to supervise the mutual insurance holding company that is affiliated with the reorganized insurer, regardless of whether another basis exists for supervising the mutual insurance holding company. If the commissioner makes a determination to supervise a mutual insurance holding company, the commissioner shall notify the mutual insurance holding company that it is under the supervision of the commissioner.

(d) During the period of supervision, the commissioner may appoint a supervisor to supervise the insurer. The order appointing a supervisor must direct the supervisor to enforce orders issued under subsection (a) or (b). The order may also provide that the insurer may not do any of the following things, during the period of supervision, without the prior approval of the commissioner or his supervisor:

(1) Dispose of, convey, or encumber any of its assets or its business in force.

(2) Withdraw funds from any of its bank accounts.

(3) Lend any of its funds.

(4) Invest any of its funds.

(5) Transfer any of its property.

(6) Incur any debt, obligation, or liability.

(7) Merge or consolidate with another company.

(8) Enter into any new reinsurance contract or agreement.

(9) Restrict the writing of new business on the renewal of existing business.

(e) Any insurer subject to an order under this section must comply with the lawful requirements of the commissioner and, if placed under supervision, has sixty (60) days from the date the supervision order is served within which to comply with the requirements of the commissioner. In the event of the insurer's failure to comply within those time requirements, the commissioner may institute proceedings under IC 27-9-3-1 or IC 27-9-3-6 to have a rehabilitator or liquidator appointed, or extend the period of supervision.

(f) During the period of supervision, the insurer may request the commissioner to review any action taken or proposed to be taken by the supervisor, specifying the reason the action complained of is believed not to be in the best interest of the insurer.

(g) If a person violates a supervision order issued under this section, he is civilly liable up to ten thousand dollars ($10,000).

(h) The commissioner may apply for and the Marion County circuit court may grant, under IC 4-21.5-6, orders as are necessary and proper to enforce a supervision order.

(i) In the event that a person subject to this article knowingly violates any valid order of the commissioner issued under this section and, as a result of that violation, the net worth of the insurer is reduced or the insurer suffers loss it would not otherwise have suffered, that person is personally liable to the insurer for the amount of that reduction or loss. The commissioner or supervisor is authorized to bring an action on behalf of the insurer in the Marion County circuit court to recover the amount of the reduction or loss together with any costs.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.7-1987, SEC.155; P.L.5-2000, SEC.2.

IC 27-9-2-2

Petition; orders

Sec. 2. (a) The commissioner may file in the Marion County circuit court a petition alleging, with respect to a domestic insurer:

(1) that there exist grounds that justify a court order for a formal delinquency proceeding against the insurer under IC 27-9;

(2) that the interests of policyholders, creditors, or the public will be endangered by delay; and

(3) other matters the commissioner considers necessary.

(b) Upon a filing under subsection (a), the Marion County circuit court may issue, ex parte, and without a hearing, the requested order that must:

(1) Direct the commissioner to take possession and control any part of the property, books, accounts, documents, and other records of an insurer.

(2) Direct the commissioner to take possession of the premises

occupied by the insurer for transaction of its business.

(3) Until further order of the Marion County circuit court, enjoin the insurer and its officers, managers, agents, and employees from disposition of its property and from transaction of its business except with the written consent of the commissioner.

(c) The Marion County circuit court shall specify the order's duration, which shall be such time as the court considers necessary for the commissioner to determine the condition of the insurer. On motion of either party or on its own motion, the Marion County circuit court may hold hearings as it considers desirable after giving notice as it considers appropriate, and may extend, shorten, or modify the terms of the seizure order. The Marion County circuit court shall vacate the seizure order if the commissioner fails to commence a formal proceeding under IC 27-9 after having had a reasonable opportunity to do so. An order of the Marion County circuit court under a formal proceeding under IC 27-9 shall ipso facto vacate the seizure order.

(d) Entry of a seizure order under this section does not constitute an anticipatory breach of any contract of the insurer.

(e) An insurer subject to an ex parte order under this section may petition the Marion County circuit court at any time after the issuance of the order for a hearing and review of the order. The Marion County circuit court shall hold a hearing and review not more than fifteen (15) days after the request. A hearing under this subsection may be held privately in chambers, and the hearing must be held in chambers if the petitioning insurer requests it.

(f) If, at any time after the issuance of an order, it appears to the Marion County circuit court that any person whose interest is or will be substantially affected by the order did not appear at the hearing and has not been served, the Marion County circuit court may order notice to be given to that person. An order that notice be given does not stay the effect of any order previously issued by the court.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-2-3

Confidential nature of records and documents

Sec. 3. In all proceedings and judicial reviews of those proceedings under sections 1 and 2 of this chapter, all records of the insurer, other documents, and all insurance department files, and court records and papers, so far as they concern or are a part of the record of the proceedings, shall remain confidential except as is necessary to obtain compliance with those proceedings or judicial reviews, unless and until the Marion County circuit court, after hearing arguments from the parties in chambers, shall order otherwise, or unless the insurer requests that the matter be made public. Until the Marion County circuit court issues an order, all papers filed with the clerk of the Marion County circuit court must

be held by him in a confidential file.
As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3

Chapter 3. Formal Proceedings

IC 27-9-3-0.1

Application of certain amendments to chapter

Sec. 0.1. The amendments made to section 40 of this chapter by P.L.185-1996 apply to and govern the priority of the distribution of assets in any proceeding to liquidate an insurer pending on, commenced on, or commenced after March 21, 1996.

As added by P.L.220-2011, SEC.454.

IC 27-9-3-1

Petition to rehabilitate insurer

Sec. 1. The commissioner may apply by petition to the Marion County circuit court for an order authorizing him to rehabilitate a domestic insurer or an alien insurer domiciled in Indiana on any one (1) of the following grounds:

(1) The insurer is in a condition that the further transaction of business would be hazardous, financially, to its policyholders, creditors, or the public.

(2) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

(3) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee, or other person, if the person has been found after notice and hearing by the commissioner under IC 4-21.5-3 to be dishonest or untrustworthy in a way affecting the insurer's business.

(4) Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person found after notice and hearing under IC 4-21.5-3 to be untrustworthy.

(5) Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director or trustee, employee, or other person, has refused to be examined under oath by the commissioner concerning its affairs, whether in Indiana or elsewhere, and after reasonable notice of the fact the insurer has failed promptly and effectively to terminate the employment and status of the person and all his influence on management.

(6) After demand by the commissioner under this article or IC 27-1-3, the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records, or those of any subsidiary or related company within the control of the insurer, or those of

any person having executive authority in the insurer so far as they concern the insurer.

(7) Without first obtaining the written consent of the commissioner, the insurer has transferred, or attempted to transfer, in a manner contrary to IC 27-1-23 or IC 27-6, substantially all of its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person.

(8) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator, or sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized under this title, and the appointment has been made or is imminent, and the appointment might:

(A) remove the insurer from the jurisdiction of the Indiana courts; or

(B) prejudice orderly delinquency proceedings under this article.

(9) Within the previous four (4) years the insurer has willfully violated its charter or articles of incorporation, its bylaws, this title, or any valid order of the commissioner under IC 27-9-2-1.

(10) The insurer has failed to pay within sixty (60) days after the due date any obligation to any state or any political subdivision of any state or any judgment entered in any state, if the court in which the judgment was entered had jurisdiction over the subject matter. However, nonpayment shall not be a ground until sixty (60) days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the commissioner or in the courts, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full.

(11) The insurer has failed to file its annual report or other financial report required by law and, after written demand by the commissioner, has failed to immediately give an adequate explanation.

(12) The board of directors or the holders of a majority of the shares entitled to vote, or a majority of those individuals entitled to the control of those entities, request or consent to rehabilitation under this article.

(13) The insurer is a mutual insurance holding company under IC 27-14 and a reorganized insurance company that is affiliated with the mutual insurance holding company and is or has been the subject of a petition for an order authorizing the commissioner to rehabilitate the reorganized insurance company under this section or to liquidate the reorganized insurance company under section 6 of this chapter, regardless

of whether another basis exists for petitioning for rehabilitation of the mutual insurance holding company.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.7-1987, SEC.156; P.L.5-2000, SEC.3.

IC 27-9-3-2

Order to rehabilitate insurer

Sec. 2. (a) An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in Indiana, must:

(1) Appoint the commissioner and his successors in office as the rehabilitator.

(2) Direct the rehabilitator to take possession of the assets of the insurer as soon as possible, and to administer them under the general supervision of the Marion County circuit court.

(b) The filing or recording of the order with the clerk of the Marion County circuit court or recorder of deeds of the county in which the principal business of the company is conducted, or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted. The order to rehabilitate the insurer shall by operation of law vest title to all assets of the insurer in the rehabilitator.

(c) An order issued under this section must require accounting by the rehabilitator to the Marion County circuit court. Accountings shall be at intervals as the Marion County circuit court specifies in its order.

(d) Entry of an order of rehabilitation does not constitute an anticipatory breach of any contracts of the insurer.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-3

Rehabilitator; personnel; term; compensation; powers; plan

Sec. 3. (a) The commissioner, as rehabilitator, may appoint one (1) or more special deputies, who shall have all the powers and responsibilities of the rehabilitator granted under this section. Also, the commissioner may employ such counsel, clerks, and assistants as he considers necessary.

(b) With the approval of the court, the compensation of the special deputy, counsel, clerks, and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be:

(1) fixed by the commissioner; and

(2) paid out of the funds or assets of the insurer.

(c) The persons appointed under this section shall serve at the pleasure of the commissioner.

(d) In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner may advance the costs so incurred out of any appropriation for the maintenance of the insurance department. Any

amounts so advanced for expenses of administration shall be repaid to the commissioner for the use of the insurance department out of the first available money of the insurer.

(e) The rehabilitator may take such action as he considers necessary or appropriate to reform and revitalize the insurer. The commissioner:

(1) has all the powers of the directors, officers, and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator;

(2) may direct, manage, hire, and discharge employees subject to any contract rights they may have; and

(3) may deal with the property and business of the insurer.

(f) The rehabilitator may prosecute any action that exists in behalf of the creditors, members, policyholders, or shareholders of the insurer against any director or officer of the insurer or any other person or entity.

(g) The rehabilitator may pursue insurance proceeds for the negligent, reckless, or fraudulent actions or omissions of the officers and directors of the insurer. An act or omission of an officer or director of the insurer during the eighteen (18) months immediately preceding the date on which an order of rehabilitation is entered may not be used to avoid coverage or other duties under a policy of insurance covering directors' and officers' liability.

(h) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, he shall prepare a plan to effect those changes.

(i) Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the Marion County circuit court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section must be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan.

(j) In the case of the life insurer, the plan proposed may include the imposition of liens upon the policies of company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.167-1986, SEC.3; P.L.72-2016, SEC.23.

IC 27-9-3-4

Pending actions; protection of insurer after rehabilitation order

Sec. 4. (a) Any court in Indiana before which any action or proceeding in which the insurer is a party or is obligated to defend a party is pending when a rehabilitation order against the insurer is

entered shall stay the action or proceeding for ninety (90) days and for any additional time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take action respecting the pending litigation as he considers necessary in the interests of justice and for the protection of creditors, policyholders, and the public. The rehabilitator shall immediately consider all litigation pending outside Indiana and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

(b) The statute of limitations or the defense of laches shall not run with respect to any action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. Any action by or against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty (60) days after the order of rehabilitation is entered or the petition is denied.

(c) Any guaranty association or foreign guaranty association covering life or health insurance or annuities has standing to appear in any court proceeding concerning the rehabilitation of a life or health insurer if that association is or may become liable to act as a result of the rehabilitation.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-5

Petition for liquidation; termination of rehabilitation

Sec. 5. (a) Whenever the commissioner believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders, or the public, or would be futile, the commissioner may petition the Marion County circuit court for an order of liquidation. A petition under this subsection has the same effect as a petition under section 6 of this chapter. The Marion County circuit court shall permit the directors of the insurer to take actions that are reasonably necessary to defend against the petition and may order payment from the estate of the insurer of such costs and other expenses of defense as justice may require.

(b) The rehabilitator may at any time petition the Marion County circuit court for an order terminating rehabilitation of an insurer. The Marion County circuit court shall also permit the directors of the insurer to petition the court for an order terminating rehabilitation of the insurer and may order payment from the estate of the insurer of such costs and other expenses of the petition as justice may require. If the Marion County circuit court finds that rehabilitation has been accomplished and that grounds for rehabilitation under section 1 of this chapter no longer exist, the court shall order that the insurer be restored to possession of its property and the control of its business. The Marion County circuit court may also make that finding and issue that order at any time upon its own motion.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-6
Basis for liquidation

Sec. 6. The commissioner may petition the Marion County circuit court for an order directing him to liquidate a domestic insurer or an alien insurer domiciled in Indiana on the basis:

(1) of any ground for an order of rehabilitation as specified in section 1 of this chapter, whether or not there has been a prior order directing the rehabilitation of the insurer;

(2) that the insurer is insolvent; or

(3) that the insurer is in such a condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors, or the public.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-7
Order to liquidate; content; effect; declaration of insolvency; accounting

Sec. 7. (a) An order to liquidate the business of a domestic insurer must:

(1) Appoint the commissioner and his successors in office liquidator.

(2) Direct the liquidator as soon as possible to take possession of the assets of the insurer and to administer them under the general supervision of the Marion County circuit court.

(b) The liquidator shall be vested by operation of law with the title to all of the property, contracts, and rights of action and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation. The filing or recording of the order with the clerk of the circuit court and the recorder of deeds of the county in which its principal office or place or business is located, or in the case of real estate with the recorder of deeds of the county where the property is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(c) Upon issuance of the order, the rights and liabilities of any insurer and of its creditors, policyholders, shareholders, members and all other persons interested in its estate become fixed as of the date of entry of the order of liquidation, except as provided in sections 8 and 35 of this chapter.

(d) An order to liquidate the business of an alien insurer domiciled in Indiana must be in the same terms and have the same legal effect as an order to liquidate a domestic insurer, except that the assets and the business in the United States shall be the only assets and business included in the liquidation.

(e) At the time of petitioning for an order of liquidation, or at any time after petitioning for an order of liquidation, the commissioner, after making appropriate findings of an insurer's insolvency, may petition the Marion County circuit court for a judicial declaration of

that insolvency. After providing for a notice and hearing as the Marion County circuit court considers proper, the court may make the declaration.

(f) An order issued under this section shall require accounting by the liquidator to the Marion County circuit court. Accountings shall be at intervals as the court specifies in its order.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-8

Termination of insurance coverage

Sec. 8. (a) All policies, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force only for the lesser of:

(1) a period of thirty (30) days from the date of entry of the liquidation order;

(2) the expiration of the policy coverage;

(3) the date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy; or

(4) the date when the liquidator has effected a transfer of the policy obligation under section 9(b)(8) of this chapter.

(b) An order of liquidation under section 7 of this chapter shall terminate coverages at the time specified in subsection (a) for purposes of any other law.

(c) Policies of life or health insurance or annuities shall continue in force for periods and under terms as is provided for by any applicable guaranty association or foreign guaranty association.

(d) Policies of life or health insurance or annuities or any period or coverage of those policies not covered by a guaranty association or foreign guaranty association terminate under subsections (a) and (b).

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-9

Dissolution of corporate existence; authorized acts of liquidator

Sec. 9. (a) The commissioner may petition for an order dissolving the corporate existence of a domestic insurer, or the United States branch of an alien insurer domiciled in Indiana, at the time the commissioner applies for a liquidation order. The Marion County circuit court shall order dissolution of the corporation upon petition by the commissioner upon or after the granting of a liquidation order. If the dissolution has not previously been ordered, the dissolution shall be effected by operation of law upon the discharge of the liquidator if the insurer is insolvent but may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason.

(b) The liquidator may do all acts necessary or appropriate for the accomplishment of the liquidation, including the following:

(1) Appoint a special deputy to act for the liquidator under this article, and determine a reasonable compensation for that special deputy.
(2) Employ employees and insurance producers, legal counsel, actuaries, accountants, appraisers, consultants, and other personnel as the liquidator considers necessary to assist in the liquidation.
(3) Fix the reasonable compensation of employees and insurance producers, legal counsel, actuaries, accountants, appraisers, and consultants with the approval of the court.
(4) Pay reasonable compensation to persons appointed and defray from the funds or assets of the insurer all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer.
(5) Hold hearings, subpoena witnesses to compel their attendance, administer oaths, examine any person under oath, and compel any person to subscribe to the person's testimony after it has been correctly reduced to writing, and in connection with hearings and the examination of witnesses require the production of any books, papers, records, or other documents which the liquidator deems relevant to the inquiry.
(6) Collect all debts and moneys due and claims belonging to the insurer, wherever located, and for this purpose:
(A) institute timely action in other jurisdictions, in order to forestall garnishment and attachment proceedings against those debts;
(B) do other acts necessary or expedient to collect, conserve, or protect its assets or property, including the power to sell, compound, compromise, or assign debts for purposes of collection upon terms and conditions as the liquidator considers best; and
(C) pursue any creditor's remedies available to enforce the liquidator's claims.
(7) Conduct public and private sales of the property of the insurer.
(8) Use assets of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under section 40 of this chapter.
(9) Acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with, any property of the insurer at its market value or upon such terms and conditions as are fair and reasonable.
(10) Borrow money on the security of the insurer's assets or without security and execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation.

(11) Enter into contracts that are necessary to carry out the order to liquidate, and affirm or disavow any contracts to which the insurer is a party.
(12) Continue to prosecute and to institute in the name of the insurer, or in the liquidator's own name, all suits and other legal proceedings, in Indiana or elsewhere, and abandon the prosecution of claims the liquidator considers unprofitable to pursue further.
(13) Prosecute any action that may exist in behalf of the creditors, members, policyholders, or shareholders of the insurer against any director or officer of the insurer, or any other person.
(14) Pursue insurance proceeds for the negligent, reckless, or fraudulent actions or omissions of the officers and directors of the insurer. An act or omission of an officer or director of the insurer during the eighteen (18) months immediately preceding the date on which petition for liquidation is filed may not be used to avoid coverage or other duties under a policy of insurance covering directors' and officers' liability.
(15) Remove all records and property of the insurer to the offices of the commissioner or to some other place as may be convenient for the purposes of efficient and orderly execution of the liquidation.
(16) Deposit in one (1) or more banks in Indiana sums required for meeting current administration expenses and dividend distributions.
(17) Invest all sums not currently needed, unless the court orders otherwise.
(18) File any necessary documents for record in the office of any recorder of deeds or record office in Indiana or elsewhere where property of the insurer is located.
(19) Assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds, and the defense of usury.
(20) Exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder, or member, including any power to avoid any transfer or lien that may be given by the general law and that is not included in sections 14 through 16 of this chapter.
(21) Intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee, and act as the receiver or trustee whenever the appointment is offered.
(22) Enter into agreements with any receiver or commissioner of any other state relating to the rehabilitation, liquidation, conservation, or dissolution of an insurer doing business in both states.
(23) Exercise all powers conferred upon receivers by the laws of Indiana not inconsistent with this article.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.167-1986, SEC.4; P.L.178-2003, SEC.75; P.L.72-2016, SEC.24.

IC 27-9-3-10
Notice of liquidation by liquidator

Sec. 10. (a) Unless the Marion County circuit court otherwise directs, the liquidator shall give notice of the liquidation order as soon as possible by:

(1) first-class mail and either by telegram or telephone to the insurance commissioner of each jurisdiction in which the insurer is doing business;

(2) first-class mail to any guaranty association or foreign guaranty association that is or may become obligated as a result of the liquidation;

(3) first-class mail to all insurance producers of the insurer;

(4) first-class mail to all persons known or reasonably expected to have claims against the insurer, including all policyholders, at their last known address as indicated by the records of the insurer;

(5) first-class mail to the secretary of state's office; and

(6) publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in all other locations the liquidator considers appropriate.

(b) Notice to potential claimants under subsection (a) must require claimants to file with the liquidator their claims, together with proper proof of those claims under section 34 of this chapter, before a date the liquidator specifies in the notice. The liquidator need not require persons claiming cash surrender values or other investment values in life insurance and annuities to file a claim. All claimants must keep the liquidator informed of any changes of address.

(c) If notice is given in accordance with this section, the distribution of assets of the insurer under this chapter shall be conclusive with respect to all claimants, whether or not they received notice.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.178-2003, SEC.76.

IC 27-9-3-11
Notice of liquidation by insurance producers to policyholders

Sec. 11. (a) Every person who receives notice in the form prescribed in section 10 of this chapter that an insurer whom the person represents as an insurance producer is the subject of a liquidation order must, within fifteen (15) days of that notice, give notice of the liquidation order to each policyholder as provided by subsection (b).

(b) The notice must be sent by first class mail to the last address contained in the insurance producer's records to each policyholder or other person named in any policy issued through that insurance

producer by the insurer, if the insurance producer has a record of the address of the policyholder or other person.

(c) A policy shall be treated as though it were issued through an insurance producer if the insurance producer has a property interest in the expiration of the policy, or if the insurance producer has had in the insurance producer's possession a copy of the declarations of the policy at any time during the life of the policy, except where the ownership of the expiration of the policy has been transferred to another.

(d) The written notice must include:

(1) the name and address of the insurer;

(2) the name and address of the insurance producer; and

(3) identification of the policy impaired and the nature of the impairment, including termination of coverage as described in section 8 of this chapter.

(e) Notice by a general agent satisfies the notice requirement for any insurance producers under contract to the general agent. Each insurance producer obligated to give notice under this section shall file a report of compliance with the liquidator.

(f) After a hearing under IC 4-21.5-3, an insurance producer failing to give notice or file a report of compliance as required by subsection (e) may be subject to payment of a penalty of not more than one thousand dollars ($1,000) and may have the insurance producer's license suspended.

(g) The liquidator may waive the duties imposed by this section if the liquidator determines that other notice to the policyholders of the insurer under liquidation is adequate.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.7-1987, SEC.157; P.L.178-2003, SEC.77.

IC 27-9-3-12

Actions after liquidation orders

Sec. 12. (a) Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in Indiana, an action at law or equity may not be brought against the insurer or liquidator, whether in Indiana or elsewhere, nor shall any existing actions be maintained or further presented after issuance of an order.

(b) The courts of Indiana shall give full faith and credit to injunctions against the liquidator or the company or the continuation of existing actions against the liquidator or the company, when those injunctions are included in an order to liquidate an insurer issued under similar provisions in other states.

(c) Whenever in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside Indiana, the liquidator may intervene in the action. The liquidator may defend any action in which he intervenes under this section at the expense of the estate of the insurer.

(d) Within two (2) years after an order for liquidation (or a time in addition to two (2) years as applicable law may permit) the liquidator may institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which the order is entered.

(e) Where, by any agreement, a period of limitation is fixed for instituting a suit or proceeding upon any claim, or for filing any claim, proof of claim, proof of loss, demand, notice, or the like, or where in any proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for taking any action, filing any claim or pleading, or doing any act, and where in any such case the period had not expired at the date of the filing of the petition. The liquidator may, for the benefit of the estate, take any such action or do any such act, required of or permitted to the insurer, within a period of one hundred eighty (180) days after the entry of an order for liquidation, or within such further period as is shown to the satisfaction of the Marion County circuit court not to be unfairly prejudicial to the other party.

(f) A statute of limitations or defense of laches shall not run with respect to any action against an insurer between the filing of a petition for liquidation against an insurer and the denial of the petition. Any action against the insurer that might have been commenced when the petition was filed may not be commenced for at least sixty (60) days after the petition is denied.

(g) Any guaranty association or foreign guaranty association has standing to appear in any court proceeding concerning the liquidation of an insurer if that association is or may become liable to act as a result of the liquidation.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-13

Listing of assets

Sec. 13. (a) As soon as practicable after the liquidation order, but not later than one hundred twenty (120) days after that order, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended or supplemented as the liquidator determines necessary. One (1) copy shall be filed in the office of the clerk of the Marion County circuit court and one (1) copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

(b) The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation.

(c) A submission to the Marion County circuit court for disbursement of assets in accordance with section 32 of this chapter fulfills the requirements of subsection (a).

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-14

Transfers made or obligations incurred as fraudulent

Sec. 14. (a) Every transfer made, or suffered, and every obligation incurred by an insurer within one (1) year before the filing of a successful petition for rehabilitation or liquidation under IC 27-9 is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay, or defraud either existing or future creditors.

(b) A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under IC 27-9, which is fraudulent under this section, may be avoided by the receiver, except:

(1) as to a person who in good faith is a purchaser, lienor, or obligee for a present fair equivalent value; and

(2) that any purchaser, lienor, or obligee, who in good faith has given a consideration less than fair for such transfer, lien, or obligation, may retain the property, lien, or obligation as security for repayment.

The court may, on due notice, order any transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver shall succeed to and may enforce the rights of the purchaser, lienor, or obligee.

(c) A transfer of property, other than real property, is made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee under section 18 of this chapter.

(d) A transfer of real property is made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(e) A transfer that creates an equitable lien is not perfected if there are available means by which a legal lien could be created.

(f) Any transfer not perfected before the filing of a petition for liquidation shall be treated as if it were made immediately before the filing of the successful petition.

(g) The provisions of subsections (b) through (f) apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

(h) Any transaction of the insurer with a reinsurer is fraudulent and may be avoided by the receiver under section 13 of this chapter if:

(1) the transaction consists of the termination, adjustment, or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred before the time of the transaction, unless the reinsurer gives a present fair equivalent value for the release; and

(2) any part of the transaction took place within one (1) year

before the date of filing of the petition through which the receivership was commenced.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-15

Transfers after petition; validity

Sec. 15. (a) After a petition for rehabilitation or liquidation has been filed, a transfer of any of the real property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid for that real property, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the recorder of deeds in the county where any real property in question is located. The exercise by a court of the United States or any state with jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state shall not be impaired by the pendency of a proceeding, unless the copy is recorded in the county before the consummation of the judicial sale.

(b) After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(1) a transfer of any of the property of the insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid for that real property, for which amount the transferee shall have a lien on the property so transferred;

(2) a person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property, or any part of the property, to the insurer or upon his order, with the same effect as if the petition were not pending;

(3) a person having actual knowledge of the pending rehabilitation or liquidation shall be considered not to act in good faith; and

(4) a person asserting the validity of a transfer under this section has the burden of proof.

Except as elsewhere provided in this section, a transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator is not valid against the liquidator.

(c) Nothing in IC 27-9 shall be considered to impair the negotiability of currency or negotiable instruments.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-16
Preferences

Sec. 16. (a) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one (1) year before the filing of a successful petition for liquidation under IC 27-9, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then that transfer shall be considered a preference if made or suffered within one (1) year before the filing of the successful petition for rehabilitation, or within two (2) years before the filing of the successful petition for liquidation, whichever time is shorter.

(b) A preference may be avoided by the liquidator if:

(1) the insurer was insolvent at the time of the transfer;

(2) the transfer was made within four (4) months before the filing of the petition;

(3) the creditor receiving it or to be benefited by it or his agent acting with reference to it had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or

(4) the creditor receiving it was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not he held such a position, or any shareholder holding directly or indirectly more than five percent (5%) of any class of any equity security issued by the insurer, or any other person, firm, limited liability company, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(c) Where the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property, except where a bona fide purchaser or lienor has given less than fair equivalent value, he shall have a lien upon the property to the extent of the consideration actually given by him. Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.8-1993, SEC.433.

IC 27-9-3-17
Transfers; time perfected

Sec. 17. (a) A transfer of property other than real property shall

be considered to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(b) A transfer of real property shall be considered to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(c) A transfer that creates an equitable lien shall not be considered to be perfected if there are available means by which a legal lien could be created.

(d) A transfer not perfected before the filing of a petition for liquidation shall be considered to be made immediately before the filing of the successful petition.

(e) This section applies whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-18

Liens

Sec. 18. (a) A lien obtainable by legal or equitable proceedings upon a simple contract is one arising in the ordinary course of those proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens that under applicable law are given a special priority over other liens that are prior in time.

(b) A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee within the meaning of section 17 of this chapter, if those consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. A lien could not, however, become superior and a purchase could not create superior rights for the purpose of section 17 of this chapter through any acts after obtaining a lien or after a purchase that requires the agreement or concurrence of any third party or which requires any further judicial action or ruling.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-19

Transfers on account of new and contemporaneous consideration

Sec. 19. A transfer of property for or on account of a new and contemporaneous consideration that is considered under section 17 of this chapter to be made or suffered after the transfer because of delay in perfecting it does not become a transfer for or on account of

an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within twenty-one (21) days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan or a transfer that becomes security for a future loan, has the same effect as a transfer for or on account of a new and contemporaneous consideration.
As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-20
Liens dissolved by furnishing bond; effect of voidable lien

Sec. 20. If any lien that is voidable under section 16(b) of this chapter has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition under IC 27-9 that results in a liquidation order, the indemnifying transfer or lien shall also be considered voidable.
As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-21
Discharge from voidable lien

Sec. 21. The property affected by any lien considered voidable under sections 16 and 20 of this chapter shall be discharged from that lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator, except that the court may on due notice order any lien to be preserved for the benefit of the estate and the court may direct that the conveyance be executed as may be proper or adequate to evidence the title of the liquidator.
As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-22
Jurisdiction of Marion County circuit court under this chapter

Sec. 22. The Marion County circuit court has summary jurisdiction of any proceeding by the liquidator to hear and determine the rights of any parties under this chapter. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. Where an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien, and if the value is less than the amount for which the property is indemnity or than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the court, to the liquidator, within reasonable times as the court shall fix.
As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-23
Discharge of surety under releasing bond

Sec. 23. The liability of a surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the liquidator, or where the property is retained under section 22 of this chapter to the extent of the amount paid to the liquidator.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-24
Extension of unsecured credit by preferred creditor

Sec. 24. If a creditor has been preferred, and afterward in good faith gives the insurer further credit without security of any kind for property that becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition may be set off against the preference that would otherwise be recoverable from him.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-25
Payment to attorney for services

Sec. 25. If an insurer shall, directly or indirectly:

(1) within four (4) months before the filing of a successful petition for liquidation under IC 27-9; or

(2) at any time in contemplation of a proceeding to liquidate it;

pay money or transfer property to an attorney for services, the transaction may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court. The excess may be recovered by the liquidator for the benefit of the estate. However, where the attorney is in a position of influence in the insurer or an affiliate of the insurer payment of any money or the transfer of any property to the attorney for services is governed by section 16(b)(4) of this chapter.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-26
Personal liability relating to improper preferences

Sec. 26. (a) Every officer, manager, employee, shareholder, member, subscriber, attorney, or any other person acting on behalf of the insurer who knowingly participates in giving any preference when he has reasonable cause to believe the insurer is or is about to become insolvent at the time of the preference is personally liable to the liquidator for the amount of the preference. If the transfer was made within four (4) months before the date of filing a successful petition for liquidation it may be presumed that the person knew of the pending insolvency.

(b) Every person receiving any property from the insurer (or the

benefit of any property) as a preference voidable under section 16(a) of this chapter is personally liable for that property and is bound to account to the liquidator.

(c) Nothing in this section shall prejudice any other claim by the liquidator against any person.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.1-1991, SEC.168.

IC 27-9-3-27

Claims by creditors holding voidable preferences

Sec. 27. (a) Claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment, or encumbrance, voidable under IC 27-9, shall not be allowed unless he surrenders the preference, lien, conveyance, transfer, assignment, or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within thirty (30) days from the date of entering of the final judgment, except that the Marion County circuit court may allow further time if there is an appeal or other continuation of the proceeding.

(b) A claim allowable under subsection (a) by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment, or encumbrance, may be filed as an excused late filing under section 33 of this chapter if filed within thirty (30) days from the date of the avoidance (or within the further time allowed by the court under subsection (a)).

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-28

Setoff of mutual debts or credits

Sec. 28. (a) Mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this article shall be set off and only the balance shall be allowed or paid, except as provided in section 31(a) of this chapter.

(b) A setoff or counterclaim shall not be allowed in favor of any person where:

(1) the obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer;

(2) the obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff; or

(3) the obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, or is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.29-1987, SEC.3; P.L.255-1995, SEC.10.

IC 27-9-3-29

Liquidator's report; assessment of members

Sec. 29. (a) As soon as practicable but not more than two (2) years from the date of an order of liquidation under section 7 of this chapter of an insurer issuing assessable policies, the liquidator shall make a report to the Marion County circuit court stating:

(1) The reasonable value of the assets of the insurer.

(2) The insurer's probable total liabilities.

(3) The probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment.

(4) A recommendation as to whether or not an assessment should be made and in what amount.

(b) Upon the basis of the report required by subsection (a), including any supplements and amendments to that report, the Marion County circuit court may levy one (1) or more assessments against all members of the insurer who are subject to assessment.

(c) Subject to any applicable legal limits on assessability, the aggregate assessment must be the amount that:

(1) the sum of the probable liabilities;

(2) the expenses of administration; and

(3) the estimated cost of collection of the assessment;

exceed the value of existing assets, with due regard being given to assessments that cannot be collected economically.

(d) After the levy of assessment under subsections (b) and (c), the liquidator shall issue an order directing each member who has not paid the assessment under the order to show cause why the liquidator should not pursue a judgment for that amount.

(e) The liquidator shall give notice of the order to show cause by publication and by first-class mail to each member liable under the order mailed to his last known address as it appears on the insurer's records, at least twenty (20) days before the return day of the order to show cause.

(f) If a member does not appear and serve duly verified objections upon the liquidator on or before the return day of the order to show cause under subsection (d), the Marion County circuit court shall issue an order adjudging the member liable for the amount of the assessment against him, under subsection (d) together with costs. The liquidator shall have a judgment against the member for that amount.

(g) If on or before the return day, the member appears and serves duly verified objections upon the liquidator, the commissioner may hear and determine the matter or may appoint a referee to hear it and make an order as the facts warrant. In the event that the commissioner determines that the objections do not warrant relief from assessment, the member may request the Marion County circuit court to review the matter and vacate the order to show cause.

(h) The liquidator may enforce any order or collect any judgment

under subsection (f) by any lawful means.
As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-30
Repealed
(As added by Acts 1979, P.L.255, SEC.1. Repealed by P.L.233-1999, SEC.16.)

IC 27-9-3-30.1
Reinsurance; method of payment upon liquidation
Sec. 30.1. (a) Reinsurance must be payable under a contract reinsured by an assuming insurer on the basis of reported claims allowed in the liquidation proceedings, subject to court approval, without diminution because of the insolvency of the ceding insurer. Payments must be made directly to the ceding insurer or to the ceding insurer's domiciliary liquidator except when:

(1) the contract or other written agreement specifically provides another payee of the reinsurance in the event of the insolvency of the ceding insurer; or

(2) before the initiation of the insolvency proceedings, the assuming insurer, with the consent of the direct insured, has assumed the policy obligations of the ceding insurer as direct obligations of the assuming insurer to policy payees and in substitution for the obligations of the ceding insurer to the payees.

(b) During the pendency of a receivership proceeding, an assuming insurer, with the consent of the direct insured and the receiver, subject to court approval, may assume policy obligations of the ceding insurer as direct obligations of the assuming insurer to the policy payees and in substitution for the obligations of the ceding insurer to the payees.
As added by P.L.233-1999, SEC.12.

IC 27-9-3-31
Liability for payment of premiums by insured and person other than insured; penalties
Sec. 31. (a) An insurance producer, a broker, an agency, a premium finance company, an insured, or any other person responsible for the payment of a premium shall be obligated to pay any earned but unpaid premium for any policy that is due the insurer for coverage provided before the declaration of insolvency. However, an insurance producer, a broker, an agency, a premium finance company, an insured, or any other person responsible for the payment of a premium shall not be responsible for any unpaid premium unearned as of the time of the declaration of insolvency.

(b) In addition to the obligation owed under subsection (a), an insurance producer, broker, agency, premium finance company, or any other person, other than the insured, responsible for the payment

of a premium to the insurance company or any holding company shall pay any unearned premium collected from the insured before the declaration of insolvency. The commissioner may also recover from that person any part of an unearned premium that represents a commission of that person.

(c) Credits or setoffs or both may not be allowed to an insurance producer, broker, or premium finance company for any amounts advanced to the insurer by the insurance producer, broker, or premium finance company on behalf of, but in the absence of a payment by, the insured.

(d) Upon satisfactory evidence of a violation of this section, the commissioner may pursue the following courses of action against those parties licensed by the department of insurance:

(1) Suspend, revoke, or refuse to renew the licenses of the offending party.

(2) Impose a penalty of not more than one thousand dollars ($1,000) for each and every act in violation of this article by the party.

These penalties are in addition to and not in lieu of the obligations owed under subsections (a) and (b).

(e) Before the commissioner may take any action as provided in subsection (d), the commissioner shall give written notice to the person accused of violating the law, stating specifically the nature of the alleged violation, and fixing a time (at least ten (10) days after the notice is sent) and place when a hearing on the matter is to be held. After the hearing, if the commissioner finds a violation, or upon failure of the accused to appear at the hearing, the commissioner shall impose whatever penalties allowed under subsection (d) as the commissioner considers advisable.

(f) Subsection (a) does not relieve an insured of any obligation that may exist to reimburse any agency, insurance producer, broker, premium finance company, or other person for amounts advanced to the insurer on behalf of the insured.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.29-1987, SEC.4; P.L.255-1995, SEC.11; P.L.178-2003, SEC.78.

IC 27-9-3-32

Proposal to disburse assets

Sec. 32. (a) Within one hundred twenty (120) days of a final determination of insolvency of an insurer by the Marion County circuit court, the liquidator shall make application to that court for approval of a proposal to disburse assets out of marshalled assets, from time to time as those assets become available, to a guaranty association or foreign guaranty association having obligations because of the insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by this section shall be considered satisfied by the liquidator filing a statement setting forth the reasons for this determination.

(b) The proposal to disburse assets must include:

(1) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and claims falling within the priorities established in section 40 of this chapter (Classes 1 and 2).

(2) Disbursement of the assets marshalled to date and subsequent disbursement of assets as they become available.

(3) Equitable allocation of disbursements to each of the guaranty associations and foreign guaranty associations entitled to disbursements.

(4) The securing by the liquidator from each of the associations entitled to disbursements under this section of an agreement to return to the liquidator those assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in section 40 of this chapter in accordance with those priorities. A bond may not be required of any guaranty association or foreign guaranty association.

(5) A full report to be made by each association to the liquidator accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on those assets and any other matter as the court may direct.

(c) The liquidator's proposal must provide:

(1) for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made by disbursements for which those associations could assert a claim against the liquidator; and

(2) that if the assets available for disbursement from time to time do not equal or exceed the amount of the claim payments made or to be made by the association then disbursements shall be in the amount of available assets.

(d) With respect to an insolvent insurer writing life or health insurance or annuities, the liquidator's proposal must provide for disbursements of assets to any guaranty association or any foreign guaranty association covering life or health insurance or annuities or to any other entity or organization reinsuring, assuming, or guaranteeing policies or contracts of insurance under the laws creating those associations.

(e) Notice of application must be given to the association in and to the commissioners of insurance of each of the states. The notice shall be considered to have been given when deposited in the United States certified mails, first-class postage prepaid, at least thirty (30) days before submission of the application to the Marion County circuit court. Action on the application may be taken by the Marion County circuit court provided that:

(1) the required notice has been given; and

(2) the liquidator's proposal complies with subsections (b)(1) and (b)(2).

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-33

Filing proof of claims

Sec. 33. (a) Proof of all claims must be filed with the liquidator in the form required by section 34 of this chapter on or before the last day for filing specified in the notice required by section 10 of this chapter, except that proof of claims for cash surrender values or other investment values in life insurance and annuities need not be filed unless the liquidator expressly requires it.

(b) The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if he were not late, to the extent that any late payment will not prejudice the orderly administration of the liquidation, when:

(1) the existence of the claim was not known to the claimant but that after learning of it he filed his claim as promptly as is reasonably possible;

(2) a transfer to a creditor was avoided under sections 14 through 16 of this chapter, or was voluntarily surrendered under section 27 of this chapter and that the filing satisfies the conditions of section 27 of this chapter; and

(3) the valuation under section 39 of this chapter, of security held by a secured creditor shows a deficiency, which is filed within thirty (30) days after the valuation.

(c) The liquidator shall permit late filing claims to share in distributions, whether past or future, as if they were not late, if those claims are claims of a guaranty association or foreign guaranty association for reimbursement of covered claims paid or expenses after the last day for filing where the payments were made and expenses incurred as provided by law.

(d) The liquidator may consider any claim filed late that is not covered by subsection (b), and permit it to receive distributions that are subsequently declared on any claims of the same or lower priority if the payment does not prejudice the orderly administration of the liquidation. The late-filing claimant shall receive, at each distribution, the same percentage of the amount allowed on his claim as is then being paid to claimants of any lower priority. This shall continue until his claim has been paid in full.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-34

Content of proof of claim

Sec. 34. (a) Proof of a claim shall consist of a statement signed by the claimant that includes all of the following that are applicable:

(1) The particulars of the claim including the consideration given for it.

(2) The identity and amount of the security on the claim.
(3) The payments made on the debt, if any.
(4) That the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to the claim.
(5) Any right of priority of payment or other specific right asserted by the claimants.
(6) A copy of written instrument that is the foundation of the claim.
(7) The name and address of the claimant and the attorney who represents him, if any.

(b) A claim need not be considered or allowed if it does not contain all the information in subsection (a) that is applicable. The liquidator may require that a prescribed form be used, and may require that other information and documents be included.

(c) At any time, the liquidator may:
(1) request the claimant to present information or evidence supplementary to that required by subsection (a);
(2) take testimony under oath;
(3) require production of affidavits or depositions; or
(4) obtain additional information or evidence necessary.

(d) The following do not need to be considered as evidence of liability or the measure of damages:
(1) A judgment or order against an insured or the insurer entered after the date of filing a successful petition for liquidation.
(2) A judgment or order against an insured or the insurer entered at any time by default or by collusion.
(3) A judgment or order against an insured or the insurer entered not more than four (4) months before the filing of the petition.

(e) All claims of a guaranty association or foreign guaranty association must be in a form and contain substantiation as may be agreed to by the association and the liquidator.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-34.5

Administration of large deductible worker's compensation policy

Sec. 34.5. (a) This section:
(1) applies to a worker's compensation large deductible policy issued by an insurer that is subject to this chapter; and
(2) does not apply to first party claims or claims funded by the guaranty association net of the deductible.

(b) To the extent that the terms of a large deductible policy conflict with this section, the policy must be administered in accordance with this section.

(c) Unless otherwise agreed by the guaranty association, all deductible claims that are covered claims (as defined in IC 27-6-8-4), including claims funded by an insured before liquidation, must be

referred to the guaranty association for processing. To the extent an insured funds or pays a deductible claim under an agreement with the guaranty association or otherwise, the insured's funding or payment of the deductible claim extinguishes any obligation of the receiver or the guaranty association to pay the claim. A charge may not be made against the receiver or the guaranty association on the basis of an insured's funding or payment of a deductible claim.

(d) The following apply when the guaranty association pays a deductible claim:

(1) If the guaranty association pays a deductible claim for which the insurer would have been entitled to reimbursement from the insured, the guaranty association is entitled to the full amount of the reimbursement and available collateral to the extent necessary to reimburse the guaranty association. Reimbursements paid to the guaranty association under this subsection are not early access payments under section 32 of this chapter or distributions under section 40 of this chapter.

(2) If the guaranty association pays:

(A) a deductible claim that is not reimbursed:

(i) from collateral; or

(ii) by payment by the insured; or

(B) an incurred expense in connection with a large deductible policy that is not reimbursed;

the guaranty association is entitled to assert a claim for the payments in the delinquency proceeding.

(e) Subsection (d) does not limit the receiver's or guaranty association's rights under other applicable law to obtain reimbursement from an insured for claim payments made by the guaranty association:

(1) under the policies of the insurer; or

(2) for the guaranty association's related expenses;

including payments described in IC 27-6-8-11.5 or under another state's similar law.

(f) A receiver shall do the following:

(1) Upon receipt by the receiver of notice from the guaranty association of reimbursable payments for which the guaranty association has not been reimbursed, bill an insured for reimbursement of deductible claims:

(A) paid by the insurer before the commencement of delinquency proceedings;

(B) paid by the guaranty association; or

(C) paid or allowed by the receiver.

(2) If an insured that is billed under subdivision (1) does not make payment within:

(A) the time specified in the large deductible policy; or

(B) if no time is specified in the large deductible policy, sixty (60) days after the date of billing;

the receiver shall pursue all commercially reasonable actions to

collect the payment.

(g) The following do not relieve an insured from the insured's reimbursement obligation under a large deductible policy and this chapter:

(1) An insurer's insolvency.

(2) An insurer's inability to perform the insurer's obligations.

(3) An allegation of improper processing or payment of a deductible claim, except for gross negligence, by the:

(A) insurer;

(B) receiver; or

(C) guaranty association.

(h) With respect to collateral, the following apply:

(1) A receiver shall use available collateral to secure:

(A) an insured's obligation to fund or reimburse deductible claims; and

(B) other secured obligations or payment obligations.

The guaranty association is entitled to collateral to the extent needed to reimburse the guaranty association for the guaranty association's payment of a deductible claim. A distribution to the guaranty association under this subdivision is not an early access payment under section 32 of this chapter or a distribution under section 40 of this chapter.

(2) A receiver shall pay all claims against collateral in the order received, and a claim of the receiver, including claims described in this subsection, does not supersede any other claim against the collateral as described in subdivision (4).

(3) A receiver shall draw down collateral to the extent necessary if the insured fails to do any of the following:

(A) Perform the insured's funding or payment obligations under the large deductible policy.

(B) Pay a deductible claim reimbursement within the time specified in subsection (f)(2).

(C) Pay amounts due to the insurer estate for pre-liquidation obligations.

(D) Fund any other secured obligation within:

(i) the time specified in the large deductible policy; or

(ii) another reasonable period.

(E) Pay expenses within the time specified in subsection (f)(2).

(4) A receiver shall pay all claims that are validly asserted against the collateral in the order in which the claims are received by the receiver.

(5) A receiver shall return to an insured any excess collateral, as determined by the receiver after a periodic review of claims paid, outstanding case reserves, and a factor for incurred but not reported claims.

As added by P.L.72-2016, SEC.25.

IC 27-9-3-35
Claims subject to contingencies

Sec. 35. (a) The claim of a third party that is contingent only on his first obtaining a judgment against the insured must be considered and allowed as if there were no contingency.

(b) If a claim is filed in accordance with section 33 of this chapter, it may be allowed even if contingent. A contingent claim may be allowed and may participate in all distributions declared after it is filed to the extent that it does not prejudice the orderly administration of the liquidation.

(c) Claims that are due except for the passage of time must be treated as absolute claims are treated, except that the claims may be discounted at the legal rate of interest.

(d) Claims made under employment contracts by directors or principal officers (or persons performing similar functions or having similar powers) are limited to payment for services provided before the issuance of any order of rehabilitation or liquidation under sections 2 or 7 of this chapter.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-36
Claims by insured or by third party

Sec. 36. (a) Whenever a third party asserts a cause of action against an insured of an insurer in liquidation, the third party may file a claim with the liquidator.

(b) Whether or not the third party files a claim, the insured may file a claim on his own behalf in the liquidation. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation, or within sixty (60) days after mailing of the notice required by section 10 of this chapter, whichever is later, the insured is an unexcused late filer.

(c) The liquidator shall make his recommendations to the Marion County circuit court under section 40 of this chapter, for the allowance of an insured's claim under subsection (b), after consideration of:

(1) the probable outcome of any pending action against the insured on which the claim is based;
(2) the probable damages recoverable in the action; and
(3) the probable costs and expenses of defense.

(d) After allowance by the court, the liquidator shall withhold any dividends payable on the claim, pending the outcome of litigation and negotiation with the insured. Whenever it seems appropriate, the liquidator shall reconsider the claim on the basis of additional information and amend his recommendations to the Marion County circuit court. The insured shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination. The Marion County circuit court may amend its allowance as it thinks appropriate.

(e) As claims against the insured are settled or barred, the insured shall be paid from the amount withheld the same percentage dividend as was paid on other claims of like property, based on the lesser of:

(1) the amount actually recovered from the insured by action or paid by agreement, plus the reasonable costs and expenses of defense; or

(2) the amount allowed on the claims by the court.

(f) After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection is not a ground for unreasonable delay of final distribution and discharge of the liquidator.

(g) If several claims founded upon one (1) policy are filed, whether by third parties or as claims by the insured under this section, and the aggregate allowed amount of the claims to which the same limit of liability in the policy is applicable exceeds that limit, each claim as allowed shall be reduced in the same proportion so that the total equals the policy limit. Claims by the insured shall be evaluated as required in subsections (c) through (f). If any insured's claim is subsequently reduced under subsections (c) through (f) the amount freed shall be apportioned ratably among the claims that have been reduced under this subsection.

(h) A claim may not be presented under this section if it is or may be covered by any guaranty association or foreign guaranty association.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-37

Denial of claim; objections; hearing

Sec. 37. (a) When a claim is denied in whole or in part by the liquidator, written notice of the determination must be given to the claimant or his attorney by first-class mail at the address shown in the proof of claim. Within sixty (60) days from the mailing of the notice, the claimant may file his objections with the liquidator. If no filing is made, the claimant may not further object to the determination.

(b) Whenever objections are filed with the liquidator and the liquidator does not alter his denial of the claim as a result of the objections, the liquidator shall ask the Marion County circuit court for a hearing as soon as practicable and give notice of the hearing by first-class mail to the claimant or his attorney and to any other persons directly affected, not less than ten (10) nor more then thirty (30) days before the date of the hearing. The matter may be heard by the court or by a court appointed referee who shall submit findings of fact along with his recommendation.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-38

Claims in name of secured creditors

Sec. 38. Whenever a creditor whose claim against an insurer is secured, in whole or in part, by the undertaking of another person, fails to prove and file that claim, the other person may do so in the creditor's name, and shall be subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that he discharges the undertaking. However, in the absence of an agreement with the creditor to the contrary, the other person is not entitled to any distribution until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor shall be held by him in trust for the other person. As used in this section, the term "other person" is not intended to apply to a guaranty association or foreign guaranty association.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-39

Valuation of security held by secured creditor

Sec. 39. (a) The value of any security held by a secured creditor shall be determined in one (1) of the following ways, as the Marion County circuit court may direct:

(1) By converting the security into money according to the terms of the agreement under which the security was delivered to the creditors.

(2) By agreement, arbitration, compromise, or litigation between the creditor and the liquidator.

(b) The valuation determination shall be under the supervision and control of the Marion County circuit court with due regard for the recommendation of the liquidator. The amount determined shall be credited upon the secured claim, and any deficiency shall be treated as an unsecured claim. If the claimant surrenders his security to the liquidator, the entire claim shall be allowed as if unsecured.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-40

Priority of distribution of claims

Sec. 40. (a) The priority of distribution of claims from the insurer's estate must be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class must be paid in full (or adequate funds retained for payment) before the members of the next class receive any payment. Subclasses may not be established within any class. The order of distribution of claims shall be:

(1) Class 1. The costs and expenses of administration, including:

(A) The actual and necessary costs of preserving or

recovering the assets of the insurer.

(B) Compensation for all services rendered in the liquidation.

(C) Any necessary filing fees.

(D) The fees and mileage payable to witnesses.

(E) Reasonable attorney's fees.

(F) The reasonable expenses of a guaranty association or foreign guaranty association in handling claims.

(2) Class 2. All claims under policies for losses incurred, including third party claims, all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property which are not under policies, and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. Payment by an employer to his employee may not be treated as gratuity.

(3) Class 3. Claims of the federal government.

(4) Class 4. Debts owed to employees for services performed, to the extent that they do not exceed one thousand dollars ($1,000) and represent payment for services performed within one (1) year before the filing of the petition for liquidation. Officers and directors are not entitled to the benefit of this priority. This priority is in place of any other similar priority that may be authorized by law as to wages or compensation of employees.

(5) Class 5. Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors.

(6) Class 6. Claims of any state or local government. Claims, including those of any governmental body for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of these claims shall be postponed to the class of claims under subdivision (9).

(7) Class 7. Claims filed late or any other claims other than claims under subdivisions (8) and (9).

(8) Class 8. Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.

(9) Class 9. The claims of shareholders or other owners.

(b) This section is severable in the manner provided in IC 1-1-1-8(b). If:

(1) any provision of this section; or

(2) the application of any provision of this section to any person or circumstance;

is held invalid, the invalidity does not affect the other provisions or applications of this section.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.185-1996, SEC.15.

IC 27-9-3-40.5

Segregated investment accounts

Sec. 40.5. (a) A claim under a contract that is funded by an account established under IC 27-1-5-1 as a segregated investment account must be satisfied from the assets maintained in the account. The segregated investment account is not chargeable with a liability arising out of other business that the insurer conducts that has no specific relation to or dependence on the account.

(b) Surplus remaining in a segregated investment account by virtue of a guarantee by the insurer as described in IC 27-1-5-1 must be included in the assets of the insurer's estate.

(c) A deficit in a segregated investment account by virtue of a guarantee by an insurer as described in IC 27-1-5-1 must be treated as a Class 2 claim under section 40 of this chapter.

As added by P.L.130-2002, SEC.4.

IC 27-9-3-41

Settlement of claims; report of unresolved claims; action of court on report

Sec. 41. (a) The liquidator shall review all claims duly filed in the liquidation and shall make further investigation as he considers necessary. He may compound, compromise, or in any other manner negotiate the amount for which claims will be recommended to the Marion County circuit court except where the liquidator is required by law to accept claims as settled by any person or organization, including any guaranty association or foreign guaranty association. Unresolved disputes shall be determined under section 37 of this chapter. As soon as practicable, the liquidator shall present to the Marion County circuit court a report of the claims against the insurer with his recommendations. The report must include the name and address of each claimant and the amount of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the liquidator shall report the persons to whom, according to the records of the insurer, amounts are owed as cash surrender values or other investment value and the amounts owed.

(b) The Marion County circuit court may approve, disapprove, or modify the report on claims by the liquidator. Reports that are not modified by the court within a period of sixty (60) days following

submission by the liquidator shall be treated by the liquidator as allowed claims, subject to later modification or to rulings made by the court under to section 37 of this chapter. A claim under a policy of insurance may not be allowed for an amount in excess of the applicable policy limits.
As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-42
Payment of distributions

Sec. 42. Under the direction of the Marion County circuit court, the liquidator shall pay distributions in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third party claims. Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the Marion County circuit court.
As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-43
Deposit of unclaimed funds

Sec. 43. (a) All unclaimed funds subject to distribution remaining in the liquidator's hands when the liquidator is ready to apply to the Marion County circuit court for discharge, including the amount distributable to any creditor, shareholder, member, or other person who is unknown or cannot be found, shall be deposited with the treasurer of state, and shall be paid without interest except in accordance with section 40 of this chapter to the person entitled to it or his legal representative upon proof satisfactory to the treasurer of state of his right to it. Any amount on deposit that is not claimed within six (6) years from the discharge of the liquidator shall be treated as if abandoned and shall be escheated without formal escheat proceedings and be deposited in the state general fund.

(b) All funds withheld under section 35 of this chapter and not distributed shall upon discharge of the liquidator be deposited with the treasurer of state and paid by him as required by section 40 of this chapter. Any sums remaining, which under section 40 of this chapter would revert to the undistributed assets of the insurer, shall be transferred to the treasurer of state and become the property of the state as provided by subsection (a), unless the commissioner in his discretion petitions the Marion County circuit court to reopen the liquidation under section 45 of this chapter.
As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-44
Discharge of liquidator

Sec. 44. (a) When all assets justifying the expense of collection and distribution have been collected and distributed under IC 27-9,

the liquidator shall apply to the Marion County circuit court for discharge. The court may grant the discharge and make any other orders, including an order to transfer any remaining funds that are uneconomic to distribute, as may be considered appropriate.

(b) Any other person may apply to the Marion County circuit court at any time for an order under subsection (a). If the application is denied, the applicant shall pay the costs and expenses of the liquidator in resisting the application, including a reasonable attorney's fee.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-45

Reopening of proceedings

Sec. 45. After the liquidation proceeding has been terminated and the liquidator discharged, the commissioner or other interested party may at any time petition the Marion County circuit court to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, the court shall order it.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-46

Destruction of records

Sec. 46. Whenever it appears to the commissioner that the records of any insurer in process of liquidation or completely liquidated are no longer useful, he may recommend to the Marion County circuit court that certain records be destroyed. The court shall direct what records should be retained for future reference and what should be destroyed.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3-47

Audit of books of commissioner relating to receivership

Sec. 47. The Marion County circuit court may, as the court considers desirable, cause audits to be made of the books of the commissioner relating to any receivership established under IC 27-9, and a report of each audit must be filed with the commissioner and with the court. The books, records, and other documents of the receivership must be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of the administration of the receivership.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-3.1

Chapter 3.1. Treatment of Certain Agreements

IC 27-9-3.1-1

"Actual direct compensatory damages"

Sec. 1. (a) As used in this chapter, "actual direct compensatory damages" includes:

(1) normal and reasonable costs of cover; and

(2) other reasonable measures of damages used in the derivatives market, the securities market, or another market for contract claims.

(b) The term does not include:

(1) punitive or exemplary damages;

(2) damages for lost profit or lost opportunity; or

(3) damages for pain and suffering.

As added by P.L.11-2011, SEC.36. Amended by P.L.13-2013, SEC.70.

IC 27-9-3.1-2

"Business day"

Sec. 2. As used in this chapter, "business day" means a day other than:

(1) Saturday;

(2) Sunday; or

(3) a day on which either the New York Stock Exchange or the Federal Reserve Bank of New York is closed.

As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-3

"Commodity contract"

Sec. 3. As used in this chapter, "commodity contract" means any of the following:

(1) A contract for the purchase or sale of a commodity:

(A) for future delivery on; or

(B) subject to the rules of;

a board of trade or contract market under the federal Commodity Exchange Act (7 U.S.C. 1 et seq.) or a board of trade outside the United States.

(2) An agreement that is:

(A) subject to regulation under Section 19 of the federal Commodity Exchange Act (7 U.S.C. 1 et seq.); and

(B) commonly known to the commodities trade as a margin account, margin contract, leverage account, or leverage contract.

(3) An agreement or transaction that is:

(A) subject to regulation under Section 4c(b) of the federal Commodity Exchange Act (7 U.S.C. 1 et seq.); and

(B) commonly known to the commodities trade as a

commodity option.

(4) A combination of the contracts, agreements, or transactions described in subdivisions (1) through (3).

(5) An option to enter into:

(A) a contract;

(B) an agreement;

(C) a transaction; or

(D) a combination of contracts, agreements, or transactions; described in subdivisions (1) through (4).

As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-4
"Contractual right"

Sec. 4. As used in this chapter, "contractual right" includes the following:

(1) A right set forth in a rule, bylaw, or resolution of the governing board of any of the following:

(A) A derivatives clearing organization (as defined in the federal Commodity Exchange Act (7 U.S.C. 1 et seq.)).

(B) A multilateral clearing organization (as defined in the Federal Deposit Insurance Corporation Improvement Act (12 U.S.C. 1821)).

(C) A national securities exchange, national securities association, or securities clearing agency.

(D) A contract market designated under the federal Commodity Exchange Act (7 U.S.C. 1 et seq.).

(E) A derivatives transaction execution facility registered under the federal Commodity Exchange Act (7 U.S.C. 1 et seq.).

(F) A board of trade (as defined in the federal Commodity Exchange Act (7 U.S.C. 1 et seq.)).

(2) A right, regardless of whether evidenced in writing, arising:

(A) under statutory or common law;

(B) under the law merchant; or

(C) by reason of normal business practice.

As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-5
"Forward contract"

Sec. 5. As used in this chapter, "forward contract" has the meaning set forth in the Federal Deposit Insurance Act (12 U.S.C. 1821).

As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-6
"Netting agreement"

Sec. 6. (a) As used in this chapter, "netting agreement" means a new agreement that:

(1) allows the parties to a previous agreement to aggregate the amounts owing by each party under all transactions that are outstanding under the previous agreement; and
(2) replaces the amounts owing under the previous agreement with a single net amount:
(A) resulting from the aggregation under subdivision (1); and
(B) owing:
(i) by one (1) party; and
(ii) to the other party;
to the previous agreement.

(b) The single net amount described in subsection (a)(2) may be determined as follows:
(1) In the event of a relevant default (including counterparty bankruptcy) as specified in the previous agreement, all transactions of a certain type are netted at:
(A) market value; or
(B) if:
(i) otherwise specified in the contract; or
(ii) market value is impossible to obtain;
an amount equal to the loss suffered by the nondefaulting party as a result of the default.
(2) Under the new agreement, the parties agree that legal obligations of the parties to make required payments under at least one (1) series of related transactions under the previous agreement are:
(A) canceled; and
(B) replaced by a new legal obligation to make payments on only the single net amount under the new agreement.
(3) In the event of a cash settled trade, the parties agree that legal obligations of:
(A) the parties; or
(B) a party and parents or affiliates of a party;
under related or unrelated transactions are canceled and replaced by the cash settled trade.

As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-7
"Qualified financial contract"

Sec. 7. As used in this chapter, "qualified financial contract" means a commodity contract, forward contract, repurchase agreement, securities contract, swap agreement, or a similar agreement, as determined by the commissioner.

As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-8
"Repurchase agreement"

Sec. 8. As used in this chapter, "repurchase agreement" has the

meaning set forth in the Federal Deposit Insurance Act (12 U.S.C. 1821).
As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-9
"Securities contract"
Sec. 9. As used in this chapter, "securities contract" has the meaning set forth in the Federal Deposit Insurance Act (12 U.S.C. 1821).
As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-10
"Swap agreement"
Sec. 10. As used in this chapter, "swap agreement" has the meaning set forth in the Federal Deposit Insurance Act (12 U.S.C. 1821).
As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-11
"Walkaway clause"
Sec. 11. As used in this chapter, "walkaway clause" means a provision in a netting agreement or qualified financial contract that, after calculation of the value of a party's position or an amount due to or from a party under the netting agreement or qualified financial contract upon termination, liquidation, or acceleration of the netting agreement or qualified financial contract, either:
(1) does not create a payment obligation of a party; or
(2) voids any part of a payment obligation of a party;
solely because of the party's status as a nondefaulting party.
As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-12
Rights
Sec. 12. Notwithstanding a provision of IC 27-9-3 or this chapter to the contrary, a person may exercise any of the following:
(1) A contractual right to cause the termination, liquidation, acceleration, or close-out of obligations in connection with a netting agreement or qualified financial contract with an insurer due to:
(A) the insolvency, financial condition, or default of the insurer if the right is enforceable under applicable law other than this chapter; or
(B) the commencement of a formal delinquency proceeding under IC 27-9-3.
(2) A right under:
(A) a pledge, security, collateral, reimbursement, guarantee agreement, or similar security agreement; or
(B) an arrangement or credit enhancement relating to at least

one (1) netting agreement or qualified financial contract.

(3) A right to set off or net out a termination value, payment amount, or other transfer obligation arising in connection with at least one (1) qualified financial contract in which the counterparty or the counterparty's guarantor is organized under the laws of:

(A) the United States; or

(B) a state or foreign jurisdiction approved as eligible for netting by the Securities Valuation Office of the NAIC.

As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-13
Damages

Sec. 13. (a) If a counterparty to a netting agreement or qualified financial contract with an insurer that is subject to a proceeding under IC 27-9-3 terminates, liquidates, closes out, or accelerates the netting agreement or qualified financial contract, damages must be measured as of the date of termination, liquidation, close-out, or acceleration.

(b) The amount of a claim for damages under subsection (a) is equal to the actual direct compensatory damages calculated in accordance with section 19 of this chapter.

As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-14
Transfer of amounts with receiver

Sec. 14. (a) Notwithstanding a walkaway clause in a netting agreement or qualified financial contract, upon termination of the netting agreement or qualified financial contract, any net or settlement amount owed by a nondefaulting party to an insurer against which an application or petition has been filed under IC 27-9-3 must be transferred:

(1) to; or

(2) according to the order of;

the receiver for the insurer, regardless of whether the insurer is the defaulting party.

(b) For purposes of subsection (a), a limited two-way payment or first method provision in a netting agreement or qualified financial contract with an insurer that has defaulted is considered to be a full two-way payment or second method provision as against the defaulting insurer.

As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-15
Transfers by receiver

Sec. 15. In making a transfer of a netting agreement or qualified financial contract of an insurer that is subject to a proceeding under IC 27-9-3, the receiver shall either:

(1) transfer to one (1) party, other than an insurer subject to a proceeding under IC 27-9-3, all netting agreements and qualified financial contracts between a counterparty or an affiliate of a counterparty and the insurer that is the subject of the proceeding, including:

(A) all rights and obligations of each party; and

(B) all property, including guarantees or credit enhancements, that secures claims of each party;

under each netting agreement and qualified financial contract; or

(2) transfer none of the netting agreements, qualified financial contracts, rights, obligations, or property referred to in subdivision (1) with respect to a counterparty or an affiliate of a counterparty.

As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-16

Notice to parties of transfer

Sec. 16. If an insurer's receiver makes a transfer of at least one (1) netting agreement or qualified financial contract under section 14 of this chapter, the receiver shall use the receiver's best efforts to notify any person that is a party to the netting agreement or qualified financial contract before noon, local time of the receiver, on the business day following the transfer.

As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-17

Avoidance of transfer by receiver

Sec. 17. Notwithstanding IC 27-9-3 and this chapter, a receiver may not avoid a transfer of money or other property arising in connection with:

(1) a netting agreement or qualified financial contract;

(2) a pledge, security, collateral, reimbursement, guarantee agreement, or similar security agreement; or

(3) an arrangement or credit enhancement relating to a netting agreement or qualified financial contract;

made before the commencement of a formal delinquency proceeding under IC 27-9-3. However, a receiver may avoid a transfer made with actual intent to hinder, delay, or defraud the insurer, the insurer's receiver, or creditors.

As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-18

Receiver's right of disaffirmance or repudiation

Sec. 18. In exercising a receiver's right of disaffirmance or repudiation with respect to a netting agreement or qualified financial contract to which an insurer is a party, the receiver for the insurer shall either:

(1) disaffirm or repudiate all netting agreements and qualified financial contracts between a counterparty or an affiliate of a counterparty and the insurer that is the subject of the proceeding; or

(2) disaffirm or repudiate none of the netting agreements and qualified financial contracts referred to in subdivision (1) with respect to a counterparty or an affiliate of a counterparty.

As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-19

Claim arising from disaffirmance or repudiation

Sec. 19. (a) Notwithstanding IC 27-9-3 and this chapter, a claim of a counterparty against an estate arising from an insurer's receiver's disaffirmance or repudiation of a netting agreement or qualified financial contract that has not been previously affirmed in the liquidation or immediately preceding conservation or rehabilitation case must be determined and allowed or disallowed:

(1) as if the claim had arisen before the date of the filing of the petition for liquidation; or

(2) if a conservation or rehabilitation proceeding is converted to a liquidation proceeding, as if the claim had arisen before the date of the filing of the petition for conservation or rehabilitation.

(b) The amount of a claim described in subsection (a) is the actual direct compensatory damages determined as of the date of the disaffirmance or repudiation of the netting agreement or qualified financial contract.

As added by P.L.11-2011, SEC.36.

IC 27-9-3.1-20

Application of counterparty rights

Sec. 20. All rights of counterparties under this chapter apply to netting agreements and qualified financial contracts entered into on behalf of the general account or separate accounts if the assets of each separate account are:

(1) available only to counterparties to netting agreements and qualified financial contracts; and

(2) entered into on behalf of the separate account.

As added by P.L.11-2011, SEC.36.

IC 27-9-4

Chapter 4. Interstate Relations

IC 27-9-4-1

Conservators for alien or foreign insurers; grounds for appointment; procedure; order; termination

Sec. 1. (a) If a domiciliary liquidator has not been appointed, the commissioner may apply to the Marion County circuit court by verified petition for an order directing him to act as conservator to conserve the property of an alien insurer not domiciled in Indiana or a foreign insurer on any one (1) or more of the following grounds:

(1) Any of the grounds stated in IC 27-9-3-1.

(2) That any part of its property has been sequestered by official action in any other state.

(3) That enough of its property has been sequestered in a foreign country to give reasonable cause to fear that the insurer is or may become insolvent.

(4) That its certificate of authority to do business in Indiana has been revoked or that none was ever issued.

(5) That there are residents of Indiana with outstanding claims or outstanding policies.

(b) When an order is sought under subsection (a), the Marion County circuit court shall cause the insurer to be given a notice and a time within which to respond to the request as is reasonable under the circumstances.

(c) The Marion County circuit court may issue the order in whatever terms the court considers appropriate. The filing or recording of the order with the clerk of the Marion County circuit court or the recorder of deeds of the county in which the principal business of the company is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(d) The conservator may at any time petition for and the Marion County circuit court may grant an order under section 2 of this chapter to liquidate assets of a foreign or alien insurer under conservation, or, if appropriate, for an order under section 4 of this chapter to be appointed ancillary receiver.

(e) The conservator may at any time petition the Marion County circuit court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, the court shall order the insurer be restored to possession of its property and the control of its business. The court may also make such finding and issue such order at any time upon motion of any interested party, but if that motion is denied all costs shall be assessed against such party.
As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-4-2

Liquidation of assets of foreign or alien insurer; grounds;

procedure; order; domiciliary proceedings; federal court proceedings; payment of claims

Sec. 2. (a) If no domiciliary receiver has been appointed, the commissioner may apply to the Marion County circuit court by verified petition for an order directing him to liquidate the assets found in Indiana of a foreign insurer or an alien insurer not domiciled in Indiana, on any of the grounds:

(1) specified in IC 27-9-3-1 or IC 27-9-3-6; or

(2) specified in section 1(a)(2) through 1(a)(4).

(b) When an order is sought under subsection (a), the Marion County circuit court shall cause the insurer to be given a notice and a time to respond to the request as is reasonable under the circumstances.

(c) If it appears to the court that the best interests of creditors, policyholders, and the public require, the Marion County circuit court may issue an order to liquidate in whatever terms the court considers appropriate. The filing or recording of the order with the clerk of the Marion County circuit court or the recorder of deeds of the county in which the principal business of the company is located or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(d) If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under this section, the liquidator under this section shall act as ancillary receiver under section 4 of this chapter. If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under this section, the liquidator under this section may petition the Marion County circuit court for permission to act as ancillary receiver under section 4 of this chapter.

(e) On the same grounds as are specified in subsection (a), the commissioner may petition any appropriate federal district court to be appointed receiver to liquidate that part of the insurer's assets and business over which the court will exercise jurisdiction, or any lesser part of the assets that the commissioner considers desirable for the protection of the policyholders and creditors in Indiana.

(f) The district court may order the commissioner, when he has liquidated the assets of a foreign or alien insurer under this section, to pay claims of residents of Indiana against the insurer under such rules as to the liquidation of insurers under IC 27-9 as are otherwise compatible with this section.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-4-3

Insurers domiciled in reciprocal states; title to property in Indiana; filing of claims by Indiana residents

Sec. 3. (a) The domiciliary liquidator of an insurer domiciled in

a reciprocal state shall, except as to special deposits and security on secured claims under section 4(c) of this chapter, be vested by operation of law with the title to all of the assets, property, contracts, and rights of action, insurance producers' balances, and all of the books, accounts, and other records of the insurer located in Indiana. The date of vesting shall be the date of the filing of the petition, if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from insurance producers and to obtain possession of the books, accounts, and other records of the insurer located in Indiana. The domiciliary liquidator also shall have the right to recover all other assets of the insurer located in Indiana, subject to section 4 of this chapter.

(b) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the commissioner shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books, accounts, and other records of the insurer located in Indiana, at the same time that the domiciliary liquidator is vested with title in the domicile. The Indiana insurance commissioner may petition for a conservation or liquidation order under section 1 or 2 of this chapter, or for an ancillary receivership under section 4 of this chapter, or after approval by the Marion County circuit court may transfer title to the domiciliary liquidator, as the interests of justice and the equitable distribution of the assets require.

(c) Claimants residing in Indiana may file claims with the liquidator or ancillary receiver, if any, in Indiana or with the domiciliary liquidator, if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

As added by Acts 1979, P.L.255, SEC.1. Amended by P.L.178-2003, SEC.79.

IC 27-9-4-4

Ancillary state receivers

Sec. 4. (a) If a domiciliary liquidator has been appointed for an insurer not domiciled in Indiana, the commissioner may file a petition with the Marion County circuit court requesting appointment as ancillary receiver in Indiana if:

(1) he finds that there are sufficient assets of the insurer located in Indiana to justify the appointment of an ancillary receiver; and

(2) the protection of creditors or policyholders in Indiana requires it.

(b) The Marion County circuit court may issue an order appointing an ancillary receiver in whatever terms it considers

appropriate. The filing or recording of the order with the recorder of deeds in Indiana imparts the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds.

(c) When a domiciliary liquidator has been appointed in a reciprocal state, then the ancillary receiver appointed in Indiana may, whenever necessary, aid and assist the domiciliary liquidator in recovering assets of the insurer located in Indiana. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in Indiana, and shall pay the necessary expenses of the proceedings. He shall promptly transfer all remaining assets, books, accounts and records to the domiciliary liquidator. Subject to this section, the ancillary receiver and his deputies shall have the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in Indiana.

(d) When a domiciliary liquidator has been appointed in Indiana, ancillary receivers appointed in reciprocal states shall have, as to assets and books, accounts, and other records in their respective states, corresponding rights, duties and powers to those provided in subsection (c) for ancillary receivers appointed in Indiana.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-4-5

Summary proceedings at request of officials of domiciliary states

Sec. 5. The commissioner in his sole discretion may institute proceedings under IC 27-9-2 at the request of the commissioner or other appropriate insurance official of the domiciliary state of any foreign or alien insurer having property located in Indiana.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-4-6

Claims by residents of other states

Sec. 6. (a) In a liquidation proceeding begun in Indiana against an insurer domiciled in Indiana, claimants residing in foreign countries or in states not reciprocal states must file claims in Indiana, and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary liquidator. Claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

(b) Claims belonging to claimants residing in reciprocal states may be proved either in the liquidation proceeding in Indiana as provided in IC 27-9, or in ancillary proceedings, if any, in the reciprocal states. If notice of the claims and opportunity to appear and be heard is afforded the domiciliary liquidator of Indiana as provided in section 7(b) of this chapter with respect to ancillary

proceedings, the final allowance of claims by the courts in ancillary proceedings in reciprocal states shall be conclusive as to amount and as to priority against special deposits or other security located in ancillary states, but shall not be conclusive with respect to priorities against general assets under IC 27-9-3-40.
As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-4-7
Claims by residents in proceeding in other states or in ancillary proceedings in Indiana

Sec. 7. (a) In a liquidation proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within Indiana may file claims either with the ancillary receiver, if any, in Indiana, or with the domiciliary liquidator. Claims must be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

(b) Claims belonging to claimants residing in Indiana may be proved either in the domiciliary state under the law of that state, or in ancillary proceedings, if any, in Indiana. If a claimant elects to prove his claim in Indiana, he shall file his claim with the liquidator in the manner provided in IC 27-9-3-33 and IC 27-9-3-34. The ancillary receiver shall make his recommendation to the court as under IC 27-9-3-41. He shall also arrange a date for hearing if necessary under IC 27-9-3-37 and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service at least forty (40) days prior to the date set for hearing. If the domiciliary liquidator, within thirty (30) days after the giving of such notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or by personal service, of his intention to contest the claim, he may appear or be represented in any proceeding in Indiana involving the adjudication of the claim.

(c) The final allowance of the claim by the courts of Indiana shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in Indiana.
As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-4-8
Attachment, garnishment, or levy of execution

Sec. 8. During the pendency in this or any other state of a liquidation proceeding, whether called by that name or not, no action or proceeding in the nature of an attachment, garnishment, or levy of execution shall be commenced or maintained in Indiana against the delinquent insurer or its assets.
As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-4-9
Proceedings involving reciprocal states, orders of distribution, and priority of claims; special deposit claims; secured claims

Sec. 9. (a) In a liquidation proceeding in Indiana involving one (1) or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and reciprocal states. All claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where those assets are located.

(b) The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit, so that the claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(c) The owner of a secured claim against an insurer for which a liquidator has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security in accordance with IC 27-9-3-39, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors.

As added by Acts 1979, P.L.255, SEC.1.

IC 27-9-4-10

Failure by ancillary receiver to transfer assets

Sec. 10. If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in Indiana any assets within his control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under IC 27-9-3-40(7).

As added by Acts 1979, P.L.255, SEC.1.

IC 27-10

ARTICLE 10. INDIANA BAIL LAW

IC 27-10-1

Chapter 1. Definitions

IC 27-10-1-0.3

Validity of licenses issued before September 1, 1985; renewal

Sec. 0.3. Licenses issued before September 1, 1985, under IC 35-4-5 (before its repeal) remain valid and may be renewed under this article, subject to this article.

As added by P.L.220-2011, SEC.455.

IC 27-10-1-1

Application of definitions

Sec. 1. The definitions in this chapter apply throughout this article.

As added by P.L.261-1985, SEC.1.

IC 27-10-1-2

"All lines fire and casualty insurance producer"

Sec. 2. "All lines fire and casualty insurance producer" means an insurance producer who holds a valid license issued by the department of insurance to engage in the writing and transacting of all of the following lines and kinds of insurance:

(1) Property insurance.
(2) Casualty insurance.
(3) Surety insurance.
(4) Disability insurance.
(5) Inland marine insurance.

As added by P.L.261-1985, SEC.1. Amended by P.L.178-2003, SEC.80.

IC 27-10-1-3

Repealed

(Repealed by P.L.305-1987, SEC.38.)

IC 27-10-1-4

"Bail agent"

Sec. 4. "Bail agent" means a person who has been:

(1) approved by the commissioner; and
(2) appointed by an insurer by power of attorney;

to execute or countersign bail bonds for the insurer in connection with judicial proceedings for which the person receives a premium.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.2.

IC 27-10-1-4.3

"Bureau"

Sec. 4.3. "Bureau" refers to the child support bureau established by IC 31-25-3-1.

As added by P.L.23-1996, SEC.25. Amended by P.L.145-2006, SEC.166.

IC 27-10-1-5

"Commissioner"

Sec. 5. "Commissioner" means the insurance commissioner.

As added by P.L.261-1985, SEC.1.

IC 27-10-1-5.5

"Delinquent"

Sec. 5.5. "Delinquent" means at least:

(1) two thousand dollars ($2,000); or

(2) three (3) months;

past due on payment of court ordered child support.

As added by P.L.23-1996, SEC.26.

IC 27-10-1-6

"Disqualifying offense"

Sec. 6. "Disqualifying offense" means:

(1) a felony; or

(2) a misdemeanor if an element of the offense involves dishonesty, violence, or a deadly weapon.

As added by P.L.261-1985, SEC.1.

IC 27-10-1-7

"Insurer"

Sec. 7. "Insurer" means any domestic, foreign, or alien surety company which has qualified generally to transact surety business under the requirements of this title and specifically to transact bail bond business in this state.

As added by P.L.261-1985, SEC.1. Amended by P.L.149-1986, SEC.60.

IC 27-10-1-7.5

"License"

Sec. 7.5. "License" has the meaning set forth in IC 25-1-2-6.

As added by P.L.23-1996, SEC.27.

IC 27-10-1-8

"Premium"

Sec. 8. "Premium" means:

(1) currency issued by the United States of America paid to a bail agent prior to the execution of a bail bond;

(2) a check delivered to a bail agent prior to the execution of the bail bond that must be:

(A) properly payable when delivered; and
(B) deposited in the bail agent's bank account; or
(3) a credit card transaction if the bail agent:
(A) accepts the credit card; and
(B) obtains:
(i) authorization from the credit card issuer for the amount due; and
(ii) an approval number from the credit card issuer for the credit card transaction;
before the execution of the bail bond.
As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.3; P.L.348-1995, SEC.1.

IC 27-10-1-9
"Recovery agent"
Sec. 9. "Recovery agent" means a person who is offered or given any compensation by a bail agent or surety in exchange for assisting the bail agent or surety in apprehending or surrendering any defendant or keeping a defendant under necessary surveillance. This does not affect the right of bail agents or sureties to hire counsel or to ask assistance of law enforcement officers.
As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.4.

IC 27-10-1-10
"Surety"
Sec. 10. "Surety" means any person who satisfies the qualifications of IC 27-10-2-4 and who agrees to pay the bond in the event the defendant fails to appear in court at the scheduled date and time.
As added by P.L.261-1985, SEC.1.

IC 27-10-1-11
"Transfer fee"
Sec. 11. "Transfer fee" means a service charge made by an insurer, in addition to the premium, when a bond is executed by an agent of the insurer for another agent in a different jurisdiction.
As added by P.L.261-1985, SEC.1.

IC 27-10-2
Chapter 2. General Provisions

IC 27-10-2-1
Administration of article; rules; employees

Sec. 1. (a) The commissioner:

(1) shall administer this article, which regulates bail agents, recovery agents, and sureties; and

(2) may adopt rules to enforce this article.

(b) The commissioner may employ and discharge employees, examiners, counsel, and other assistants as necessary and shall prescribe their duties and their compensation.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.5.

IC 27-10-2-2
Prima facie evidence

Sec. 2. Any written instrument purporting to be a copy of any action, proceeding, or finding of fact by the commissioner, or any record of the commissioner authenticated under the hand of the commissioner by the seal of the commissioner's office shall be accepted by all the courts of this state as prima facie evidence of the contents thereof.

As added by P.L.261-1985, SEC.1.

IC 27-10-2-3
Undertakings; validity; defect of form or other irregularity; expiration

Sec. 3. (a) An undertaking is valid if it states:

(1) the court where the defendant is to appear;

(2) the amount of the bail; and

(3) that it was made before an official legally authorized to take the bond.

(b) A surety remains liable on an undertaking despite:

(1) any lack of the surety's qualifications as required by section 4 of this chapter;

(2) any other agreement that is expressed in the undertaking;

(3) any failure of the defendant to join in the undertaking; or

(4) any other defect of form or record, or any other irregularity, except as to matters covered by subsection (a).

(c) Any undertaking written after August 31, 1985, shall expire thirty-six (36) months after it is posted for the release of a defendant from custody. This section does not apply to cases in which a bond has been declared to be forfeited and the surety and bail agent have been notified as described in section 12 of this chapter.

As added by P.L.261-1985, SEC.1. Amended by P.L.355-1989(ss), SEC.1; P.L.105-2010, SEC.6.

IC 27-10-2-4
Qualifications of surety

Sec. 4. Every surety for the release of a person on bail shall be qualified as:

(1) an insurer as defined and meeting the qualifications prescribed in IC 27-1-5-1, and represented by a bail agent as defined in and meeting the qualifications prescribed in this article; or

(2) a person who:

(A) has reached the age of eighteen (18) years;

(B) is a citizen of the United States;

(C) has been a bona fide resident of Indiana for at least one (1) year immediately preceding the execution of the bond;

(D) is related to the person for whom release on bail is sought within the third degree of affinity; and

(E) owns real or tangible personal property in Indiana with a net asset value that is acceptable to the proper authority approving the bond.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.6.

IC 27-10-2-5
Surrender of defendants

Sec. 5. (a) Any time before there has been a breach of the undertaking in any type of bail and cash bond, the surety may surrender a defendant, or the defendant may surrender, to the official to whose custody the defendant was committed at the time bail was taken or to the official into whose custody the defendant would have been given if committed.

(b) A defendant shall be surrendered without the return of premium for the bond if the defendant has been guilty of:

(1) changing address without notifying the defendant's bail agent or surety;

(2) concealing one's self;

(3) leaving the jurisdiction of the court without the permission of the defendant's bail agent or surety or the court; or

(4) violating the defendant's contract with the bail agent or surety in a way that does harm to the bail agent or the surety or violates the defendant's obligation to the court.

As added by P.L.261-1985, SEC.1. Amended by P.L.355-1989(ss), SEC.2; P.L.224-1993, SEC.7.

IC 27-10-2-6
Surrender of defendants; detention; exoneration of sureties

Sec. 6. (a) The person desiring to make a surrender of the defendant shall be provided a certified copy of the undertakings and a certified copy of the arrest warrant forthwith by the clerk of the court having jurisdiction and shall deliver them together with the

defendant to the official in whose custody the defendant was at the time bail was taken or to the official into whose custody the defendant would have been given if committed, who shall detain the defendant in the official's custody thereon, as upon a commitment, and shall acknowledge the surrender in a written certificate.

(b) The court having jurisdiction of the offense shall order that a surety be exonerated from liability for an undertaking and that any money or bonds deposited as bail be refunded when the person surrendering the defendant has:

(1) presented to the court both of the documents described in subsection (a); and

(2) given to the prosecuting attorney:

(A) three (3) days notice; and

(B) copies of both of the documents described in subsection (a).

As added by P.L.261-1985, SEC.1. Amended by P.L.348-1995, SEC.2.

IC 27-10-2-7

Apprehension of defendant; time; fees

Sec. 7. For the purpose of surrendering the defendant, the surety may apprehend the defendant before or after the forfeiture of the undertaking or may empower any law enforcement officer to make apprehension by providing written authority endorsed on a certified copy of the undertaking and paying the lawful fees therefor.

As added by P.L.261-1985, SEC.1.

IC 27-10-2-8

Notice of trial or hearing; breach of undertaking; record

Sec. 8. (a) The court shall give the bail agent or insurer legal written notice of the defendant's trial or hearing for purposes of entering a plea at least seventy-two (72) hours before the defendant's appearance is required unless the appearance is scheduled within seventy-two (72) hours from the execution of the bond.

(b) The defendant's failure to appear constitutes a breach of the undertaking. The court before which the cause is pending shall make a record of the breach at which time section 12 of this chapter then applies.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.8; P.L.105-2010, SEC.7.

IC 27-10-2-9

Property bonds; recordings; liens

Sec. 9. (a) If the undertaking is a property bond, the clerk shall record the same in the proper records of the county. If the undertaking describes property in another county, the clerk of the trial court shall transmit the undertaking to the clerk of such other county, who shall likewise record it and return it to the first

mentioned clerk.

(b) The undertaking shall be a lien on any real property described in it, until released in accordance with IC 35-33-8.5.

As added by P.L.261-1985, SEC.1. Amended by P.L.5-1988, SEC.150.

IC 27-10-2-10

Recognizances; affidavits; forms

Sec. 10. (a) Recognizances for the appearance of prisoners shall in all cases and in all courts be in writing, be taken with at least one (1) resident freehold surety or be secured by a surety company, and be substantially in the following form:

STATE OF INDIANA)
) SS:
COUNTY OF _____)

State of Indiana.

vs.

John Doe

We, A B and C D, jointly and severally acknowledge ourselves bound to the state of Indiana in _____ dollars. If A B (the prisoner) shall appear on the ____ day of _____, 20___, in the _____ court, to answer a charge of (here state the offense) and from day to day and from term to term thereof, and abide the order of the court until the cause is determined and not depart therefrom without leave, then this recognizance shall be void, else to remain in full force.

If the above named defendant does not appear at any time fixed in this bond, the court shall order CD (the surety) to produce the defendant. The court shall mail notice of this order to CD, the surety at _____ and _____ in _____ county and state of Indiana. If the surety does not produce the defendant, and does not pay all costs and late surrender fees in compliance with IC 27-10-2-12, the court shall, three hundred sixty-five (365) days after the mailing of the above notice to the surety, declare the bond forfeited, enter judgment forthwith against the surety, and certify the judgment to the clerk for record. Such forfeiture shall be without pleadings and without change of judge or change of venue. The obligors on such bond may appeal to the ruling of the court and appeal to the court of appeals as in other civil cases, and on appeal the evidence may be reviewed. Execution shall issue forthwith to the sheriff against the properties of each of us to be levied as other executions are levied.

Witness our hand and seals this ___ day of _____, 20___.

A B _____ (SEAL)

C D _____ (SEAL)

taken and approved this ___ day of _____, 20___.

_____

(Officer taking surety)

Affidavits shall be taken from each personal surety substantially as follows:

State of Indiana)

County of _____)

I, C D, being duly sworn, on oath say, that I am worth in my personal rights and name, over and above all debts and liabilities of any and every kind, not less than _____ dollars, and that I possess real estate in my own name, located in the above-named county, which is worth over and above all encumbrances and liens, more than _____ dollars; that I am surety on the following recognizance bonds and none other, aggregating the total amount of _____ to-wit: (Here name bonds and amounts, if any) _____, And that I am not surety on any recognizance bond of any kind in any court which bond has been forfeited which judgment remains unpaid.

C D _____ (SEAL)

Subscribed and sworn to before me, this ___ day of _____, 20___.

_____

(Officer administering oath)

(b) Printed forms of the above bonds shall be kept by all clerks of court that are authorized by law to admit prisoners to bail and shall be supplied by the clerks to sheriffs.

(c) For the purposes of this article, a cause is determined when a:

(1) judgment of conviction or acquittal is entered for a misdemeanor;

(2) judgment is withheld in a misdemeanor case;

(3) judgment of acquittal is entered in a felony case;

(4) sentence is imposed in a felony case; or

(5) defendant has been ordered or admitted to a diversion program.

As added by P.L.261-1985, SEC.1. Amended by P.L.355-1989(ss), SEC.3; P.L.2-2005, SEC.73.

IC 27-10-2-11

Transcript of proceedings; docketing; liens

Sec. 11. Such recognizance, together with a transcript of the proceedings and all papers in the case, shall be filed forthwith with the clerk of the proper court, who shall docket the cause and record such recognizance forthwith and enter it on the judgment docket, all as provided in IC 35-33-8.5. From the date of the entries in the records of the respective counties as provided in IC 35-33-8.5, it shall be a lien upon all lands in the counties where recorded owned by any of the obligors, and any judgment afterward had upon it shall relate back to the date of entry in such county, or counties, where any such lands are situated.

As added by P.L.261-1985, SEC.1. Amended by P.L.5-1988, SEC.151.

IC 27-10-2-12

Failure of defendant to appear; notice; late surrender fees; forfeiture proceedings; satisfaction of judgment; revocation of license

Sec. 12. (a) Only if a defendant does not appear as provided in the bond:

(1) the court shall:

(A) issue a warrant for the defendant's arrest; and

(B) order the bail agent and the surety to surrender the defendant to the court immediately;

(2) the clerk shall, less than thirty (30) days after the defendant's failure to appear, mail notice of the order to both:

(A) the bail agent; and

(B) the surety;

at each of the addresses indicated in the bonds; and

(3) if the defendant later is arrested or otherwise appears:

(A) the court shall order that the surety be released from the bond; and

(B) after the court issues an order under clause (A), the surety's original undertaking shall be reinstated if the surety files a written request for the reinstatement of the undertaking with the court.

This subsection may not be construed to prevent a court from revoking or resetting bail.

(b) The bail agent or surety must:

(1) produce the defendant; or

(2) prove within three hundred sixty-five (365) days:

(A) that the appearance of the defendant was prevented:

(i) by the defendant's illness or death;

(ii) because the defendant was at the scheduled time of appearance or currently is in the custody of the United States, a state, or a political subdivision of the United States or a state;

(iii) because the required notice was not given; or

(iv) because authorities have refused to extradite the defendant, by a preponderance of the evidence; and

(B) the defendant's absence was not with the consent or connivance of the sureties.

(c) If the bail agent or surety does not comply with the terms of subsection (b) within one hundred twenty (120) days after the mailing of the notice required under subsection (a)(2), a late surrender fee shall be assessed against the bail agent or surety as follows:

(1) If compliance occurs more than one hundred twenty (120) days but not more than one hundred eighty (180) days after the mailing of notice, the late surrender fee is twenty percent (20%) of the face value of the bond.

(2) If compliance occurs more than one hundred eighty (180)

days but not more than two hundred ten (210) days after the mailing of notice, the late surrender fee is thirty percent (30%) of the face value of the bond.

(3) If compliance occurs more than two hundred ten (210) days but not more than two hundred forty (240) days after the mailing of notice, the late surrender fee is fifty percent (50%) of the face value of the bond.

(4) If compliance occurs more than two hundred forty (240) days but not more than three hundred sixty-five (365) days after the mailing of notice, the late surrender fee is eighty percent (80%) of the face value of the bond.

(5) If the bail agent or surety does not comply with the terms of subsection (b) within three hundred sixty-five (365) days of the mailing of notice required under subsection (a)(2), the late surrender fee is eighty percent (80%) of the face value of the bond.

All late surrender fees are due as of the date of compliance with subsection (b) or three hundred sixty-five (365) days after the mailing of notice required under subsection (a)(2), whichever is earlier, and shall be paid by the surety when due. If the surety fails to pay, then the late surrender fees shall be paid by the commissioner as provided in subsection (f).

(d) If the bail agent or surety does not comply with the terms of subsection (b) within three hundred sixty-five (365) days of the mailing of notice required by subsection (a)(2), the court shall declare forfeited an amount equal to twenty percent (20%) of the face value of the bond. The court shall immediately enter judgment on the forfeiture, without pleadings and without change of judge or change of venue, and assess against the bail agent or surety all actual costs resulting from the defendant's failure to appear. These costs include jury fees, witness fees, and any other documented costs incurred by the court.

(e) Proceedings relative to the bond, forfeiture of a bond, judgment on the forfeiture, execution of judgment, or stay of proceedings shall be in the court in which the bond was posted. Costs and late surrender fee assessed against a bail agent or surety under subsection (c) shall be satisfied without further order of the court as provided in subsection (f). The court may waive the late surrender fee or extend the period for payment beyond the statutorily permitted period, or both, if the following conditions are met:

(1) A written request is filed with the court and the prosecutor.

(2) The surety or bail agent provides evidence satisfactory to the court that diligent efforts were made to locate the defendant.

(f) In the case of an insurer, if the fees, costs, or judgment is not paid, then the clerk shall mail the notice to the commissioner. The commissioner shall:

(1) within ten (10) days of receipt of the notice forward a copy by certified mail to the insurer;

(2) forty-five (45) days after receipt of the notice from the clerk, if the commissioner has not been notified by the clerk that the fees or judgment or both have been paid, pay the late surrender fee assessment, costs, and any judgment of forfeiture ordered by the court from funds the insurer has on deposit with the department of insurance;

(3) upon paying the assessment, costs, and judgment, if any, from funds on deposit, immediately revoke the license of the insurer, if the satisfaction causes the deposit remaining to be less than the amount required by this article; and

(4) within ten (10) days after revoking a license, notify the insurer and the insurer's agents and the clerk of each county in Indiana of the revocation and the insurer shall be prohibited from conducting a bail bond business in Indiana until the deposit has been replenished.

(g) The notice mailed by the clerk to the commissioner pursuant to the terms of subsection (f) shall include:

(1) the date on which the defendant originally failed to appear as provided in the bond;

(2) the date of compliance with subsection (b), if compliance was achieved within three hundred sixty-five (365) days after the mailing of the notice required by subsection (a)(2);

(3) the amount of the bond;

(4) the dollar amount of the late surrender fee due;

(5) the amount of costs resulting from the defendant's failure to appear; and

(6) if applicable, the dollar amount of the judgment of forfeiture entered by the court.

(h) Any surety on a bond may appeal to the court of appeals as in other civil cases without moving for a new trial, and on the appeal the evidence, if any, shall be reviewed.

(i) Fifty percent (50%) of the late surrender fees collected under this chapter shall be deposited in the police pension trust fund established under IC 36-8-10-12 and the remaining fifty percent (50%) shall be deposited in the county extradition and sheriff's assistance fund established under IC 35-33-14.

As added by P.L.261-1985, SEC.1. Amended by P.L.355-1989(ss), SEC.4; P.L.224-1993, SEC.9; P.L.348-1995, SEC.3; P.L.105-2010, SEC.8; P.L.42-2013, SEC.1.

IC 27-10-2-13

Liability of bail agent or surety

Sec. 13. All liability of the bail agent or surety may be enforced on motion without necessity of an independent action if conformance with sections 1 through 12 of this chapter is shown.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.10.

IC 27-10-2-14
Collateral securities; receipts; records

Sec. 14. (a) When a bail agent or insurer accepts collateral, the bail agent or insurer shall give a written receipt for the collateral. The receipt shall give in detail a full description of the collateral received and the terms of redemption. The collateral shall be considered to have been taken in a fiduciary capacity. The bail agent or insurer shall keep copies of all receipts at the bail agent's or insurer's place of business to be available to the commissioner for the commissioner's review.

(b) A bail agent or an insurer shall maintain in the bail agent's or insurer's office records of bail bonds executed or countersigned by the bail agent or insurer for at least one (1) year after the liability of the surety has been terminated. Salient details of the bonds shall be a part of the records required by this subsection.

(c) At the time a bail agent's license issued under IC 27-10-3 is renewed, the bail agent or a firm or an agency that the bail agent is employed by, associated with, or a member of shall file with the commissioner a sworn statement on a form furnished by the commissioner. The statement must include:

(1) a list of every outstanding or unpaid late surrender fee and judgment;

(2) the name of the court in which each outstanding or unpaid late surrender fee and judgment is recorded; and

(3) all other information determined by the commissioner to be pertinent.

(d) The commissioner may:

(1) deny;

(2) suspend;

(3) revoke; or

(4) refuse to renew;

a license issued under this article for failure of the licensee to comply with subsection (c).

(e) The commissioner may impose a civil penalty of not more than ten thousand dollars ($10,000) against:

(1) an insurer;

(2) a bail agent; or

(3) a firm or an agency;

for failure to comply with subsection (c).

(f) A civil penalty imposed under subsection (e) may be enforced in the same manner as a civil judgment.

As added by P.L.261-1985, SEC.1. Amended by P.L.355-1989(ss), SEC.5; P.L.224-1993, SEC.11; P.L.86-2011, SEC.1.

IC 27-10-2-15
Bail instead of money or bonds; refund

Sec. 15. If money or bonds have been deposited, bail by sureties may be substituted therefor at any time before a breach of the

undertaking, and the official taking the new bail shall make an order that the money or bonds be refunded to the person depositing the same and they shall be refunded accordingly and the original undertakings shall be cancelled.
As added by P.L.261-1985, SEC.1.

IC 27-10-2-16
Deposits instead of bond

Sec. 16. (a) When the defendant has been admitted to bail, the defendant, or another in the defendant's behalf, may deposit with an official authorized to take bail, a sum of money, or nonregistered bonds of the United States, of the state, or of any county, city, or town within the state, equal in market value to the amount of such bail, together with the defendant's personal undertaking, and an undertaking of such other person, if the money or bonds are deposited by another. Upon delivery to the official in whose custody the defendant is of a certificate of such deposit, the defendant shall be discharged from custody in the cause.

(b) When bail other than a deposit of money or bonds has been given, the defendant or the surety may, at any time before a breach of the undertaking, deposit the sum mentioned in the undertaking, and upon such deposit being made, accompanied by a new undertaking, the original undertaking shall be cancelled.
As added by P.L.261-1985, SEC.1.

IC 27-10-3

Chapter 3. Licensure and Registration

IC 27-10-3-1

Bail agent and recovery agent; licenses; qualifications

Sec. 1. (a) A person may not act in the capacity of a bail agent or recovery agent or perform any of the functions, duties, or powers prescribed for bail agents or recovery agents under this article unless the person is qualified and licensed as provided in this article. However, none of the terms of this section shall prohibit any individual or individuals from:

(1) pledging real or other property as security for a bail bond in judicial proceedings and where the individual does not receive, or is not promised, money or other things of value; or

(2) executing any bail bond for an insurer, pursuant to a bail bond service agreement entered into between the insurer and any automobile club or association, financing institution, insurance company, or other organization or association, and on behalf of a person required to furnish bail in connection with any violation of law arising out of the use of a motor vehicle.

(b) A license:

(1) may not be issued except in compliance with this article; and

(2) may only be issued to an individual.

However, upon an affirmative showing to the commissioner in writing by an individual that the individual is an all lines fire and casualty insurance producer, a surety bail agent license shall be issued to the individual without further qualification or fee to represent an insurer the individual is licensed to represent. The individual shall be subject to and governed by laws and rules relating to bail agents when engaged in the activities of a bail agent.

(c) A firm, a partnership, an association, a limited liability company, or a corporation may not be licensed.

(d) The applicant must apply in writing, on forms prepared and supplied by the commissioner, and the commissioner may propound any reasonable interrogatories to an applicant for a license under this article or on any renewal of a license relating to the applicant's qualifications, residence, prospective place of business, and any other matters which, in the opinion of the commissioner, are deemed necessary or expedient in order to protect the public and ascertain the qualifications of the applicant. The commissioner may also conduct any reasonable inquiry or investigation the commissioner sees fit, relative to the determination of the applicant's fitness to be licensed or to continue to be licensed.

(e) The failure of the applicant to secure approval of the commissioner shall not preclude the applicant from applying as many times as the applicant desires. However, an applicant's application may not be considered by the commissioner within one (1) year

subsequent to the date upon which the commissioner denied the applicant's last application.

As added by P.L.261-1985, SEC.1. Amended by P.L.8-1993, SEC.434; P.L.224-1993, SEC.12; P.L.1-1994, SEC.140; P.L.178-2003, SEC.81.

IC 27-10-3-2

Expiration of license; reinstatement

Sec. 2. (a) All licenses issued expire two (2) years after the end of the month of issue.

(b) A license that has expired may be reinstated if:

(1) the licensee:

(A) applies for reinstatement not more than ninety (90) days after the expiration date;

(B) is not on probation;

(C) has not previously been denied a license;

(D) pays:

(i) the license fee required under section 7 of this chapter; plus

(ii) to the commissioner a license reinstatement fee of one hundred dollars ($100); and

(E) meets all other requirements for licensure; and

(2) the license was not revoked or suspended at the time that the license expired.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.13; P.L.1-1994, SEC.141; P.L.102-2005, SEC.1; P.L.81-2012, SEC.38.

IC 27-10-3-3

Applications; qualifications

Sec. 3. (a) The application for license, in addition to the matters set out in section 1 of this chapter, to serve as a bail agent must affirmatively show that:

(1) the applicant is at least eighteen (18) years of age and is of good moral character;

(2) the applicant has never been convicted of a disqualifying offense, notwithstanding IC 25-1-1.1, or:

(A) in the case of a felony conviction, at least ten (10) years have passed since the date of the applicant's conviction or release from imprisonment, parole, or probation, whichever is later; or

(B) in the case of a misdemeanor disqualifying offense, at least five (5) years have passed since the date of the applicant's conviction or release from imprisonment, parole, or probation, whichever is later;

(3) the applicant has knowledge or experience in the bail bond business, or has held a valid all lines fire and casualty insurance producer's license for one (1) year within the last five (5) years,

or has been employed by a company engaged in writing bail bonds in which field the applicant has actively engaged for at least one (1) year of the last five (5) years; and

(4) the applicant has completed at least twelve (12) hours of instruction in courses approved by the commissioner under section 7.1 of this chapter that pertain to the duties and responsibilities of a bail agent or recovery agent, including instruction in the laws that relate to the conduct of a bail agent or recovery agent.

(b) The application must affirmatively show that the applicant has been a bona fide resident of Indiana for one (1) year immediately preceding the date of application. However, the commissioner may waive this requirement.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.14; P.L.178-2003, SEC.82; P.L.102-2005, SEC.2.

IC 27-10-3-4

Examination; fees; fingerprints and photographs

Sec. 4. (a) A license fee of six hundred fifty dollars ($650) and an examination fee of one hundred dollars ($100) must be submitted to the commissioner with each application for the issuance of a bail agent's license.

(b) An applicant for a bail agent's license must also furnish with the application a complete set of the applicant's fingerprints and a recent credential-size full face photograph of the applicant. The applicant's fingerprints must be certified by an authorized law enforcement officer.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.15.

IC 27-10-3-5

Recovery agent; additional licensing requirements; fees; fingerprints and photographs

Sec. 5. In addition to the requirements prescribed in section 1 of this chapter, an applicant for a license to serve as a recovery agent must affirmatively show that:

(1) the applicant is at least eighteen (18) years of age;

(2) the applicant is a citizen of the United States and has been a bona fide resident of this state for more than six (6) months immediately preceding the date of application;

(3) the applicant has never been convicted of a disqualifying offense, notwithstanding IC 25-1-1.1, or:

(A) in the case of a felony conviction, at least ten (10) years have passed since the date of the applicant's conviction or release from imprisonment, parole, or probation, whichever is later; or

(B) in the case of a misdemeanor disqualifying offense, at least five (5) years have passed since the date of the

applicant's conviction or release from imprisonment, parole, or probation, whichever is later; and

(4) the applicant has completed at least twelve (12) hours of instruction in courses approved by the commissioner under section 7.1 of this chapter that pertain to the duties and responsibilities of a bail agent or recovery agent, including instruction in the laws that relate to the conduct of a bail agent or recovery agent.

A license fee of three hundred dollars ($300) and an examination fee of one hundred dollars ($100) shall be submitted to the commissioner with each application, together with the applicant's fingerprints and photograph.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.16; P.L.102-2005, SEC.3.

IC 27-10-3-6

Examination; application

Sec. 6. (a) The applicant for a bail agent's or recovery agent's license shall be required to appear in person and take a written examination prepared by the commissioner testing the applicant's ability and qualifications to be a bail agent or recovery agent.

(b) An applicant is eligible for examination after the date the application is received by the commissioner, if the commissioner is satisfied as to the applicant's fitness to take the examination. Examinations shall be held at times and places designated by the commissioner, and an applicant shall be given notice of a time and place not less than fifteen (15) days prior to taking the examination.

(c) The failure of an applicant to pass an examination may not preclude the applicant from taking subsequent examinations.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.17; P.L.348-1995, SEC.4.

IC 27-10-3-7

Renewal; fees; continuing education

Sec. 7. (a) A renewal license shall be issued by the commissioner to a licensee who:

(1) has continuously maintained a license in effect;

(2) pays a renewal fee of:

(A) six hundred dollars ($600) for bail agents; and

(B) three hundred dollars ($300) for recovery agents;

(3) has fulfilled the continuing education requirement as required under subsection (b);

(4) satisfactorily completes a renewal examination if required by the commissioner; and

(5) has in all other respects complied with and been subject to this article.

(b) A licensee shall complete at least six (6) hours of continuing education courses that:

(1) are approved under section 7.1 of this chapter; and
(2) apply to the licensee's particular license, including instruction in the laws that relate to the conduct of a bail agent or recovery agent;

during each license period. A continuing education course that is used to fulfill the continuing education requirements for an insurance producer license under IC 27-1-15.7 may not be used to satisfy the continuing education requirement set forth in this section.

(c) After the receipt of the licensee's application for renewal, the current license continues in effect until the renewal license is issued, suspended, or denied for cause.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.18; P.L.102-2005, SEC.4; P.L.81-2012, SEC.39.

IC 27-10-3-7.1

Continuing education course approval; fees; criteria

Sec. 7.1. (a) A provider of courses required for licensure under sections 3 and 5 of this chapter or license renewal under section 7 of this chapter:

(1) shall obtain from the commissioner approval of the courses and instructors before the courses are conducted;
(2) shall annually pay to the commissioner a reasonable fee, as determined by the commissioner;
(3) must have been:
(A) a full-time resident of Indiana and licensed as a bail agent under this chapter for at least five (5) of the immediately preceding ten (10) years; or
(B) a bail agent association operating in Indiana and approved by the commissioner; and
(4) shall comply with any other requirements established by the commissioner.

However, the commissioner may waive the full-time residency requirement specified in subdivision (3)(A).

(b) A provider described in subsection (a) may charge a reasonable fee for attendance at an approved course.

(c) A fee paid under subsection (a)(2) must be:
(1) deposited in the bail bond enforcement and administration fund created under IC 27-10-5-1; and
(2) used to implement this article.

(d) The commissioner shall:
(1) establish criteria for approval or disapproval of instructors and courses required for:
(A) licensure under sections 3 and 5 of this chapter; and
(B) license renewal under section 7 of this chapter; and
(2) approve or disapprove instructors and courses specified in subdivision (1);

that pertain to the duties and responsibilities of a bail agent and recovery agent, including instruction concerning the laws that relate

to the conduct of a bail agent and recovery agent.
As added by P.L.102-2005, SEC.5. Amended by P.L.86-2011, SEC.2; P.L.81-2012, SEC.40.

IC 27-10-3-8
Denial, suspension, or revocation of licenses; refusal to renew

Sec. 8. (a) The commissioner shall deny, suspend, revoke, or refuse to renew any license issued under this article for any of the following causes:

(1) Any cause for which issuance of the license could have been refused had it then existed and been known to the commissioner.

(2) Violation of any laws of this state in the course of dealings under any license issued the licensee by the commissioner.

(3) Material misstatement, misrepresentation, or fraud in obtaining the license.

(4) Misappropriation, conversion, or unlawful withholding of money belonging to insurers or others and received in the conduct of business under any license issued to the licensee by the commissioner.

(5) Fraudulent or dishonest practices in the conduct of business under any license issued to the licensee by the commissioner.

(6) Willful failure to comply with or willful violation of any proper order or rule of the commissioner.

(7) When, in the judgment of the commissioner, the licensee has, in the conduct of affairs under the license, demonstrated:

(A) incompetency or untrustworthiness;

(B) conduct or practices rendering the licensee unfit to carry on the bail bond business or making the licensee's continuance in such business detrimental to the public interest;

(C) that the licensee is no longer in good faith carrying on the bail bond business; or

(D) that the licensee is guilty of rebating, or offering to rebate, or unlawfully dividing, or offering to divide, the licensee's commissions in the case of limited surety agents;

and for such reasons is found by the commissioner to be a source of detriment, injury, or loss to the public.

(8) The listing of the name of the applicant or licensee on the most recent tax warrant list supplied to the commissioner by the department of state revenue.

(b) The commissioner shall refuse to:

(1) issue a license; or

(2) renew a license issued;

under this chapter to a person who is the subject of an order issued by a court under IC 31-16-12-10 (or IC 31-1-11.5-13(m), IC 31-6-6.1-16(m), or IC 31-14-12-7 before their repeal).

(c) The commissioner may also levy a civil penalty of not more

than ten thousand dollars ($10,000) for any of the causes listed in subsection (a). Any civil penalty levied under this subsection may be enforced in the same manner as a civil judgment.

(d) When a person who holds a license under this chapter enters a plea of guilty to a disqualifying offense, the commissioner, immediately upon the court's acceptance of the plea, shall revoke the person's license. The commissioner shall revoke the license of any person who is convicted of a disqualifying offense immediately upon conviction. The pending of sentencing or the pending of an appeal of a conviction of a disqualifying offense does not stay the revocation of a license under this subsection. A person convicted of a felony is not eligible to reapply for a license until ten (10) years from the date of conviction or release from imprisonment, parole, or probation, whichever is later. A person convicted of a misdemeanor disqualifying offense is not eligible to reapply for a license until five (5) years from the date of conviction or release from imprisonment, parole, or probation, whichever is later.

As added by P.L.261-1985, SEC.1. Amended by P.L.29-1987, SEC.5; P.L.185-1996, SEC.16; P.L.23-1996, SEC.28; P.L.1-1997, SEC.114; P.L.207-2013, SEC.14.

IC 27-10-3-9

Suspension or revocation of licenses; hearings; witnesses; attorneys; penalty

Sec. 9. (a) If, after investigation, the commissioner determines that a licensed bail agent or recovery agent has been guilty of violating any of the laws of this state relating to bail bonds or has committed any disqualifying offense, the commissioner shall, upon ten (10) days notice in writing to:

(1) the bail agent or recovery agent; and

(2) the insurer represented by the bail agent if a surety bail agent;

accompanied by a copy of the charges of the unlawful conduct of the bail agent or the recovery agent, suspend the license of the bail agent or the recovery agent, unless on or before the expiration of the ten (10) days the bail agent or the recovery agent makes a written response to the commissioner concerning the charges.

(b) If, after the expiration of ten (10) days and within twenty (20) days after the expiration of the ten (10) days, the bail agent or the recovery agent fails to make a written response to the charges, the commissioner shall suspend or revoke the license of the bail agent or the recovery agent. If, however, the bail agent or the recovery agent files a written response denying the charges within the time specified, the commissioner shall call a hearing within a reasonable time for the purpose of taking testimony and evidence on any issue of facts made by the charges and answer.

(c) The commissioner shall give notice to:

(1) the bail agent or the recovery agent; and

(2) the insurer represented by the bail agent if a surety bail agent;

of the time and place of the hearing. The parties may produce witnesses and appear personally with or without representation by counsel.

(d) If, following the hearing, the commissioner determines by a preponderance of the evidence that the bail agent or the recovery agent is guilty as alleged in the charges, whether or not convicted in court, the commissioner shall publish the determination not later than thirty (30) days after the conclusion of the hearing and shall:

(1) revoke the license of the bail agent or the recovery agent; or

(2) suspend the bail agent for a definite period of time to be fixed in the order of suspension.

The commissioner may also levy a civil penalty against the bail agent or the recovery agent that is not more than ten thousand dollars ($10,000).

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.19; P.L.102-2005, SEC.6.

IC 27-10-3-10

Suspension or revocation of licenses; appeals

Sec. 10. An applicant for license as a bail agent or recovery agent whose:

(1) application has been denied; or

(2) license has been suspended, revoked, or denied renewal by the commissioner;

may appeal to the circuit court, superior court, or probate court of the county from which the bail agent or recovery agent applied for the license. The appeal shall be heard de novo.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.20; P.L.84-2016, SEC.119.

IC 27-10-3-11

Surety bail agents; terminating appointment; premiums owed; remedies

Sec. 11. (a) An insurer who appoints a surety bail agent in Indiana shall give notice of the appointment to the commissioner along with a written application for license for the bail agent. All appointments are subject to the issuance of a license to the surety bail agent.

(b) If an insurer appoints a surety bail agent under subsection (a), not later than sixty (60) days after the appointment, the appointee shall submit to the commissioner an affidavit:

(1) on a form prescribed by the commissioner;

(2) signed by the appointee; and

(3) that states:

(A) whether the appointee owes premiums to a former insurer or an agency to which the appointee reported on behalf of a former insurer;

(B) to whom the appointee owes a premium;
(C) the amount of the premium owed; and
(D) whether there is a dispute concerning the premium.

(c) An appointee shall provide a copy of an affidavit submitted under subsection (b) by certified mail to each of the appointee's former insurers or agents to which the appointee reported on behalf of a former insurer in the six (6) years immediately preceding the appointee's appointment under subsection (a).

(d) Not more than one hundred eighty (180) days after receiving a copy of an appointee's affidavit provided under subsection (c), a former insurer or agent that has knowledge that the affidavit is untrue may file a petition with the commissioner stating that the appointee still owes a premium to the insurer or agent in violation of IC 27-10-4-7 and requesting relief. At the same time that the insurer or agent files the petition with the commissioner, the insurer or agent shall mail a copy of the petition to the appointee by certified mail. The appointee may file a response with the commissioner not later than ten (10) days after the appointee receives the petition.

(e) Upon receipt of the petition and response, if filed, under subsection (d), the commissioner may conduct an investigation and institute proceedings in accordance with section 9 of this chapter.

(f) The remedies provided in this section are not the exclusive remedies available to an insurer or agent. The election of an insurer or agent to seek a remedy under this section does not preclude the insurer or agent from seeking other remedies available at law or in equity, and is not a prerequisite for an insurer or agent to seek other remedies available at law or in equity.

(g) An insurer that terminates the appointment of a surety bail agent shall file written notice of the termination with the commissioner together with a statement that the insurer has given or mailed notice to the surety bail agent. The notice filed with the commissioner must state the reasons, if any, for the termination. Information furnished to the commissioner is confidential and may not be used as evidence in or a basis for any action against the insurer or any of the insurer's representatives.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.21; P.L.348-1995, SEC.5; P.L.102-2005, SEC.7.

IC 27-10-3-12

Deposits in accounts of insurers or agents; reports

Sec. 12. All insurers or general agents requiring bail bond agents to post deposits pursuant to their bail bond writing authority must maintain those deposits in a bank, savings association, or credit union in this state. Each insurer or general agent shall report to the commissioner the location of each agent's account at the time of the agent's license issuance or renewal. Any change in the location of an agent's account shall be reported by the insurer or general agent to the commissioner within thirty (30) days of the change of location.

As added by P.L.261-1985, SEC.1. Amended by P.L.79-1998, SEC.33.

IC 27-10-3-13
Discontinuing business; return of license

Sec. 13. A bail agent who discontinues writing bail bonds during the period for which the bail agent is licensed shall:

(1) notify the clerks of the circuit court and the sheriffs with whom the bail agent is registered; and

(2) return the bail agent's license to the commissioner for cancellation;

within thirty (30) days after the discontinuance.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.22.

IC 27-10-3-14
Recovery agent; use of licensed persons; list

Sec. 14. A person who is licensed as a bail agent may use as a recovery agent any person who holds a valid recovery agent's license. A bail agent must, at the time the bail agent's license is renewed under this chapter, furnish to the commissioner, on a form supplied by the commissioner, a list of all recovery agents used by the bail agent during the preceding year.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.23; P.L.86-2011, SEC.3.

IC 27-10-3-15
Insurers; deposits; engaging in bail bond business

Sec. 15. All insurers must deposit with the commissioner cash, United States treasury notes, or bonds in bearer form with coupons attached having a par value of at least seventy-five thousand dollars ($75,000) in order to obtain a license to engage in the bail bond business, out of which the commissioner shall satisfy judgment on all forfeitures which have not been paid. Such deposit shall be subject to all laws and rules as are deposits by domestic insurance companies.

As added by P.L.261-1985, SEC.1. Amended by P.L.255-1995, SEC.12.

IC 27-10-3-16
Repealed

(Repealed by P.L.224-1993, SEC.32.)

IC 27-10-3-17
Registration of licenses; power of attorney

Sec. 17. (a) A bail agent may not become a surety on an undertaking unless the bail agent has registered the bail agent's license in the office of the sheriff and with the clerk of the circuit

court in the county in which the bail agent resides. The bail agent may then become a surety on an undertaking in any other county upon filing a copy of the bail agent's license in the office of the sheriff and with the clerk of the circuit court in the other county. A surety bail agent must also file an original qualifying power of attorney signed by the bail agent and attached to a specimen bail bond with the clerk of the circuit court and file a copy of the qualifying power of attorney with the office of the sheriff. The clerk of the circuit court and the sheriff may not permit the registration of a bail agent unless the bail agent is currently licensed by the commissioner under this article.

(b) A recovery agent may not perform the recovery agent's duties unless the recovery agent has registered the recovery agent's license within fifteen (15) days of issuance or any renewal in the office of the sheriff and with the clerk of the circuit court in the county where the recovery agent resides. The clerk of the circuit court and the sheriff may not permit a registration unless the recovery agent is properly licensed by the commissioner under this article.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.24; P.L.348-1995, SEC.6.

IC 27-10-3-18

Access to jails

Sec. 18. A person who holds a valid bail agent's license issued by the insurance commissioner and registered as required in section 17 of this chapter may have equal access to the jails of this state for the purpose of making bond, subject to this article and rules adopted under this article.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.25.

IC 27-10-3-19

Duty of commissioner upon receipt of support order; reinstatement

Sec. 19. (a) Upon receiving an order of a court issued under IC 31-16-12-10 (or IC 31-1-11.5-13(m), IC 31-6-6.1-16(m), or IC 31-14-12-7 before their repeal), the commissioner shall:

(1) suspend a license issued under this chapter to any person who is the subject of the order; and

(2) promptly mail a notice to the last known address of the person who is the subject of the order, stating the following:

(A) That the person's license is suspended beginning five (5) business days after the date the notice is mailed, and that the suspension will terminate not earlier than ten (10) business days after the commissioner receives an order allowing reinstatement from the court that issued the suspension order.

(B) That the person has the right to petition for reinstatement of a license issued under this chapter to the court that issued

the order for suspension.

(b) The commissioner shall not reinstate a license suspended under subsection (a) until the commissioner receives an order allowing reinstatement from the court that issued the order for suspension.

As added by P.L.23-1996, SEC.29. Amended by P.L.1-1997, SEC.115; P.L.207-2013, SEC.15.

IC 27-10-3-20

Notice; probationary status; appeal; reinstatement

Sec. 20. (a) Upon receiving an order from the bureau (Title IV-D agency) under IC 31-25-4-32(i), the commissioner shall send to the person who is the subject of the order a notice that does the following:

(1) States that the person is delinquent and is subject to an order placing the person on probationary status.

(2) Explains that unless the person contacts the bureau and:

(A) pays the person's child support arrearage in full;

(B) establishes a payment plan with the bureau to pay the arrearage, which must include an income withholding order under IC 31-16-15-2 or IC 31-16-15-2.5; or

(C) requests a hearing under IC 31-25-4-33;

within twenty (20) days after the date the notice is mailed, the commissioner shall place the person on probationary status with respect to any license issued to the person under this chapter.

(3) Explains that the person may contest the bureau's determination that the person is delinquent and subject to an order placing the person on probationary status by making written application to the bureau within twenty (20) days after the date the notice is mailed.

(4) Explains that the only basis for contesting the bureau's determination that the person is delinquent and subject to an order placing the person on probationary status is a mistake of fact.

(5) Explains the procedures to:

(A) pay the person's child support arrearage in full;

(B) establish a payment plan with the bureau to pay the arrearage, which must include an income withholding order under IC 31-16-15-2 or IC 31-16-15-2.5; and

(C) request a hearing under IC 31-25-4-33.

(6) Explains that the probation will terminate ten (10) business days after the commissioner receives a notice from the bureau that the person has:

(A) paid the person's child support arrearage in full; or

(B) established a payment plan with the bureau to pay the arrearage, which includes an income withholding order under IC 31-16-15-2 or IC 31-16-15-2.5.

(b) Upon receiving an order from the bureau (Title IV-D agency)

under IC 31-25-4-34(d), the commissioner shall send to the person who is the subject of the order a notice that states the following:

(1) That a license issued to the person under this chapter has been placed on probationary status, beginning five (5) business days after the date the notice is mailed, and that the probation will terminate ten (10) business days after the commissioner receives a notice from the bureau that the person has:

(A) paid the person's child support arrearage in full; or

(B) established a payment plan with the bureau to pay the arrearage, which includes an income withholding order under IC 31-16-15-2 or IC 31-16-15-2.5.

(2) That if the commissioner is advised by the bureau that the person whose license has been placed on probationary status has failed to:

(A) pay the person's child support arrearage in full; or

(B) establish a payment plan with the bureau to pay the arrearage, which includes an income withholding order under IC 31-16-15-2 or IC 31-16-15-2.5;

within twenty (20) days after the date the notice is mailed, the commissioner shall suspend the person's license.

(c) If the commissioner receives a notice from the bureau (Title IV-D agency) under IC 31-25-4-32(i) that the person whose license has been placed on probationary status has failed to:

(1) pay the person's child support arrearage in full; or

(2) establish a payment plan with the bureau to pay the arrearage, which includes an income withholding order under IC 31-16-15-2 or IC 31-16-15-2.5;

within twenty (20) days after the notice required under subsection (b) is mailed, the commissioner shall suspend the person's license.

(d) The commissioner may not reinstate any license placed on probation or suspended under this section until the commissioner receives a notice from the bureau that the person has:

(1) paid the person's child support arrearage in full; or

(2) established a payment plan with the bureau to pay the arrearage, which includes an income withholding order under IC 31-16-15-2 or IC 31-16-15-2.5.

As added by P.L.23-1996, SEC.30. Amended by P.L.1-1997, SEC.116; P.L.145-2006, SEC.167; P.L.103-2007, SEC.9.

IC 27-10-3-21

Rules

Sec. 21. The department may adopt rules under IC 4-22-2 to implement this chapter.

As added by P.L.102-2005, SEC.8.

IC 27-10-4
Chapter 4. Prohibited Activities

IC 27-10-4-1
Financial interest in agencies; services during period of license suspension or revocation

Sec. 1. (a) No person may possess a financial interest in, be employed by, have an agency relationship with, or perform any services for a bail bond agency or insurer during the period of license suspension or revocation. No licensee under this article may accept any services from a person during the period of that person's license suspension or revocation.

(b) The commissioner shall immediately suspend under IC 27-10-3-8(a) an agent, agency, or insurer who violates this section.

(c) A person who knowingly or intentionally violates this section commits a Class B misdemeanor.

As added by P.L.261-1985, SEC.1. Amended by P.L.29-1987, SEC.6; P.L.355-1989(ss), SEC.6.

IC 27-10-4-2
Advising employment of attorney; paying fees or rebates; acting as attorney; accepting property; soliciting business

Sec. 2. (a) A bail agent or recovery agent may not do any of the following:

(1) Suggest or advise the employment of or name for employment any particular attorney to represent the bail agent's principal.

(2) Pay a fee or rebate or give any property to an attorney in bail bond matters, except in defense of any action on a bond.

(3) Pay a fee or rebate or give or promise any property to the principal or anyone in the bail agent's behalf.

(4) Participate in the capacity of an attorney at a trial or hearing of one on whose bond the bail agent is surety.

(5) Accept any property from a principal except the premium, bail bond filing fee (when applicable), and transfer fee (when applicable), except that the bail agent or surety may accept collateral security or other indemnity from the principal that must be returned upon final termination of liability on the bond. The collateral security or other indemnity required by the bail agent or surety must be reasonable in relation to the amount of the bond.

(6) Solicit business in or about any place where prisoners are confined or in or near any courtroom.

(b) A person who recklessly violates this section or who operates as a bail agent or recovery agent without a valid license commits a Class A misdemeanor.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993,

SEC.26.

IC 27-10-4-3
Persons excluded as bail agent

Sec. 3. (a) The following persons may not be bail agents or receive any benefits from the execution of any bail bond:

(1) Jailers.
(2) Law enforcement officers.
(3) Judges.
(4) Persons having anything to do with the control of federal, state, county, or municipal prisoners.

(b) A person who recklessly violates this section commits a Class B misdemeanor.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.27.

IC 27-10-4-4
Blank bond; signature

Sec. 4. (a) A bail agent may not:

(1) sign or countersign in blank any bond; or
(2) give a power of attorney to or otherwise authorize anyone to countersign the bail agent's name to bonds unless the person who is authorized is a licensed bail agent directly employed by the bail agent giving the power of attorney.

(b) A person who recklessly violates this section commits a Class B misdemeanor.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.28.

IC 27-10-4-5
Failure of bail agent to collect full premium; penalty

Sec. 5. A bail agent who knowingly or intentionally executes a bail bond without collecting in full a premium for the bail bond, at the premium rate as filed with and approved by the commissioner, commits a Level 6 felony.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.29; P.L.158-2013, SEC.298.

IC 27-10-4-6
Payments for apprehension or surrender of defendants

Sec. 6. (a) A person may not give or receive anything of value in exchange for the apprehension or surrender of a defendant unless the payment is made:

(1) to a law enforcement agency for actual expenses incurred in the apprehension or surrender, or both, of the defendant, or other lawful fees; or
(2) to a bail agent or recovery agent properly licensed under this article.

(b) A bail agent or recovery agent who knowingly or intentionally gives or offers to give anything of value to any law enforcement officer, officer of the court, or other public servant, except as permitted by subsection (a), commits a Level 6 felony.

(c) A person who recklessly violates this section, except as provided in subsection (b), commits a Class B misdemeanor.

As added by P.L.261-1985, SEC.1. Amended by P.L.224-1993, SEC.30; P.L.158-2013, SEC.299.

IC 27-10-4-7

Surety bail agent; payment of premium owed

Sec. 7. (a) Notwithstanding any other law, not later than thirty (30) days after the termination of a surety bail agent's appointment, the surety bail agent shall pay to the former insurer or agent of the insurer to whom the surety bail agent reported on behalf of the former insurer any premium owed.

(b) The commissioner may enforce this section in accordance with IC 27-10-3-9.

As added by P.L.102-2005, SEC.9.

IC 27-10-5
Chapter 5. Enforcement and Administration

IC 27-10-5-1
Bail bond enforcement and administration fund; creation; deposit and use of funds

Sec. 1. (a) The bail bond enforcement and administration fund is created. All fees and penalties collected by the commissioner under this article shall be paid into the fund to be utilized for the enforcement and administration of this article. The fund shall be administered by the commissioner.

(b) Any balance remaining in the fund at the end of a state fiscal year does not revert to the state general fund. The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested.

As added by P.L.261-1985, SEC.1. Amended by P.L.102-2005, SEC.10.

IC 27-10-5-2
Bail bond enforcement and administration fund; use of money

Sec. 2. The money in the fund created by this chapter shall be used for the following purposes and no other:

(1) The employment of a qualified investigator and investigation staff.
(2) The expense of examination.
(3) Licensing.
(4) Forms.
(5) Other related expenses necessitated by this article.

As added by P.L.261-1985, SEC.1.

IC 27-10-5-3
Investigator; qualifications; staff; duties

Sec. 3. (a) The commissioner shall appoint a qualified investigator who shall serve at the pleasure of the commissioner. The investigator shall be of good moral character, have had at least five (5) years of experience as an insurance or private investigator or equivalent experience as a law enforcement or judicial officer, and be thoroughly familiar and conversant with Indiana criminal law, including the court procedure and structure.

(b) The investigator, with the approval of the commissioner, may select such staff as is necessary to enable the investigator to properly perform the investigator's duties. The primary duty of the investigator and the investigator's staff is to administer this article and to investigate all violations of this article and to report and recommend to the commissioner all findings made on the investigation.

As added by P.L.261-1985, SEC.1.

IC 27-11

ARTICLE 11. FRATERNAL BENEFIT SOCIETIES

IC 27-11-1

Chapter 1. Applicability and Definitions

IC 27-11-1-0.3

Society authorized to transact business under prior law not required to reincorporate; renewal of licenses

Sec. 0.3. (a) Any incorporated society authorized to transact business in Indiana under IC 27-1-14 (before its repeal) on December 31, 1985, is not required to reincorporate under this article.

(b) Societies described in subsection (a) may continue to transact business until April 30, 1986, and their licenses may be renewed annually under this article.

As added by P.L.220-2011, SEC.456.

IC 27-11-1-1

Application of article

Sec. 1. This article applies to any incorporated society, order, or supreme lodge without capital stock, whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not-for-profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and that provides benefits in accordance with this article.

As added by P.L.262-1985, SEC.1.

IC 27-11-1-2

Application of definitions

Sec. 2. The definitions in this chapter apply throughout this article.

As added by P.L.262-1985, SEC.1.

IC 27-11-1-3

"Benefit contract" defined

Sec. 3. "Benefit contract" means the agreement for provision of benefits authorized by IC 27-11-6-1, as that agreement is described in IC 27-11-6-4.

As added by P.L.262-1985, SEC.1.

IC 27-11-1-4

"Benefit member" defined

Sec. 4. "Benefit member" means an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.

As added by P.L.262-1985, SEC.1.

IC 27-11-1-5

"Certificate" defined

Sec. 5. "Certificate" means the document issued as written evidence of the benefit contract.

As added by P.L.262-1985, SEC.1.

IC 27-11-1-6

"Commissioner" defined

Sec. 6. "Commissioner" refers to the insurance commissioner of this state.

As added by P.L.262-1985, SEC.1.

IC 27-11-1-7

"Laws" defined

Sec. 7. "Laws" means the society's articles of incorporation, constitution, and bylaws, however designated.

As added by P.L.262-1985, SEC.1.

IC 27-11-1-8

"Lodge" defined

Sec. 8. "Lodge" means a subordinate member unit of the society, whether known as a camp, court, council, branch, or by any other designation.

As added by P.L.262-1985, SEC.1.

IC 27-11-1-9

"Premiums" defined

Sec. 9. "Premiums" includes rates, dues, or other required contributions by whatever name known that are payable under the certificate.

As added by P.L.262-1985, SEC.1.

IC 27-11-1-10

"Rules" defined

Sec. 10. "Rules" means all rules, regulations, or resolutions adopted by the supreme governing body or board of directors that are intended to have general application to the members of the society.

As added by P.L.262-1985, SEC.1.

IC 27-11-1-11

"Society" defined

Sec. 11. "Society" refers to a fraternal benefit society to which this article applies, according to section 1 of this chapter.

As added by P.L.262-1985, SEC.1.

IC 27-11-2
Chapter 2. Structure and Purpose

IC 27-11-2-1
"Lodge system" defined; organization and operation of lodges for children

Sec. 1. (a) A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated, or admitted in accordance with its laws, rules, and ritual. Subordinate lodges shall be required by the laws of the society to hold periodic meetings in furtherance of the purposes of the society.

(b) A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of children, nor shall they have a voice or vote in the management of the society.

As added by P.L.262-1985, SEC.1.

IC 27-11-2-2
Representative form of government

Sec. 2. A society has a representative form of government if it meets all of the following conditions:

(1) It has a supreme governing body constituted in one (1) of the following ways:

(A) The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than a majority of the votes and not less than the number of votes required to amend the society's laws. The assembly shall meet at least once every four (4) years and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws.

(B) The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member may not exceed four (4) years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board constitute a majority in number and not less than the number of votes required to amend the society's laws. A

person filling the unexpired term of an elected board member is considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society.

(2) The officers of the society are elected either by the supreme governing body or by the board of directors.

(3) Only benefit members are eligible for election to the supreme governing body, the board of directors, or any intermediate assembly.

(4) Each voting member shall have one (1) vote and no vote may be cast by proxy.

As added by P.L.262-1985, SEC.1.

IC 27-11-2-3

Operation for benefit of members and beneficiaries

Sec. 3. A society shall operate for the benefit of members and their beneficiaries by:

(1) providing benefits as specified in IC 27-11-6-1; and

(2) operating for one (1) or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic, or religious purposes for the benefit of its members that may also be extended to others. These purposes may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

As added by P.L.262-1985, SEC.1.

IC 27-11-2-4

Laws and rules; necessary and incidental powers

Sec. 4. Every society may adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It may change, alter, add to, or amend such laws and rules. It shall have such other powers as are necessary and incidental to effect the objectives and purposes of the society.

As added by P.L.262-1985, SEC.1.

IC 27-11-3
Chapter 3. Membership

IC 27-11-3-1
Eligibility standards; admission process; rights and privileges of members; social members

Sec. 1. (a) A society shall specify in its laws or rules:

(1) eligibility standards for each and every class of membership, provided that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age fifteen (15) and not greater than age twenty-one (21);

(2) the process for admission to each membership class; and

(3) the rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(b) A society may also admit social members who have no voice or vote in the management of the insurance affairs of the society.

(c) Membership rights in the society are personal to the member and are not assignable.

As added by P.L.262-1985, SEC.1.

IC 27-11-3-2
Location of principal office; meetings; official publication; synopsis of annual statement; grievance procedures

Sec. 2. (a) The principal office of any domestic society shall be located in this state. The meetings of its supreme governing body may be held in any state, district, province, or territory where the society has at least one (1) subordinate lodge, or in another location as determined by the supreme governing body, and all business transacted at the meetings shall be as valid in all respects as if the meetings were held in this state. The minutes of the proceedings of the supreme governing body and of the board of directors must be in the English language.

(b) A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. Such required reports, notices, and statements shall be printed conspicuously in the publication. If the records of a society show that two (2) or more members have the same mailing address, an official publication mailed to one (1) member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

(c) Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society shall be printed and mailed to each benefit member of the society or, instead, the synopsis may be published in the society's official publication.

(d) A society may provide in its laws or rules for grievance or

complaint procedures for members.
As added by P.L.262-1985, SEC.1.

IC 27-11-3-3
Personal liability of officers and members; indemnification and reimbursement of certain persons; maintenance of insurance on certain persons

Sec. 3. (a) The officers and members of the supreme governing body or any subordinate body of a society are not personally liable for any benefits provided by a society.

(b) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by and liabilities imposed upon the person in connection with or arising out of any action, suit, or proceeding, whether civil, criminal, administrative, or investigative, or threat thereof, in which the person may be involved by reason of the fact that the person is or was a director, officer, employee, or agent of the society or of any firm, limited liability company, corporation, or organization that the person served in any capacity at the request of the society. A person shall not be indemnified or reimbursed:

(1) in relation to any matter in such action, suit, or proceeding as to which the person is adjudged to be or has been guilty of breach of a duty as a director, officer, employee, or agent of the society; or

(2) in relation to any matter in an action, suit, proceeding, or threat that has been made the subject of a compromise settlement;

unless in either case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, had no reasonable cause to believe that this conduct was unlawful.

(c) The determination whether the conduct of such person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in subsection (b)(1) or (b)(2) may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to the action, suit, or proceeding or by a court of competent jurisdiction. The termination of any action, suit, or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest does not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement.

(d) The right of indemnification and reimbursement provided in this section is not exclusive of other rights to which the person may be entitled as a matter of law and shall inure to the benefit of that person's heirs, executors, and administrators.

(e) A society may purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of

the society or who is or was serving at the request of the society as a director, officer, employee, or agent of any other firm, corporation, limited liability company, or organization against any liability asserted against the person and incurred by the person in any such capacity or arising out of the person's status, whether or not the society would have the power to indemnify the person against such liability under this section.
As added by P.L.262-1985, SEC.1. Amended by P.L.8-1993, SEC.435.

IC 27-11-3-4
Waiver of provisions of laws of the society

Sec. 4. The laws of the society may provide that no subordinate body nor any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the laws of the society. The provision shall be binding on the society and every member and beneficiary of a member.
As added by P.L.262-1985, SEC.1.

IC 27-11-4
Chapter 4. Organization

IC 27-11-4-1
Application of chapter

Sec. 1. A domestic society organized after December 31, 1985, shall be formed under this chapter.

As added by P.L.262-1985, SEC.1.

IC 27-11-4-2
Organization of fraternal benefit society; articles of incorporation

Sec. 2. Seven (7) or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society, may make, sign, and acknowledge before some officer competent to take acknowledgment of deeds and articles of incorporation. The article of incorporation must state the following:

(1) The proposed corporate name of the society, which must not resemble the name of any society or insurance company as to be misleading or confusing.

(2) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes may not include more liberal powers than are granted by this article.

(3) The names and residences of the incorporators and the names, residences, and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one (1) year from the date of issuance of the permanent certificate of authority.

As added by P.L.262-1985, SEC.1.

IC 27-11-4-3
Filing of articles of incorporation, bylaws and rules, forms of certificates, circulars, and bond

Sec. 3. Articles of incorporation, certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, circulars to be issued by the society, and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one (1) year shall be filed with the commissioner, who may require further information as the commissioner considers necessary. The bond with sureties approved by the commissioner shall be not less than three hundred thousand dollars ($300,000) nor more than one million five hundred thousand dollars ($1,500,000), as required by the commissioner. All documents filed are to be in the English language.

If the purposes of the society conform to the requirements of this article and all provisions of the law have been complied with, the commissioner shall certify, retain, and file the articles of incorporation and furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as provided in this chapter.
As added by P.L.262-1985, SEC.1.

IC 27-11-4-4
Preliminary certificate of authority; expiration; extension

Sec. 4. No preliminary certificate of authority granted under this section shall be valid after one (1) year from its date or after a further period, not exceeding one (1) year, as may be authorized by the commissioner upon cause shown, unless the five hundred (500) applicants required in this chapter have been secured and the organization has been completed as provided. The articles of incorporation and all other proceedings thereunder shall become null and void in one (1) year from the date of the preliminary certificate of authority or at the expiration of the extended period, unless the society has completed its organization and received a certificate of authority to do business in Indiana.
As added by P.L.262-1985, SEC.1.

IC 27-11-4-5
Solicitation of members; liabilities incurred upon receipt of preliminary certificate

Sec. 5. Upon receipt of a preliminary certificate of authority from the commissioner, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one (1) regular monthly premium in accordance with its table of rates, and shall issue to each applicant a receipt for the amount collected. No society shall incur any liability other than for the return of the advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow any benefit to any person until:

(1) actual bona fide applications for benefits have been secured on not less than five hundred (500) applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

(2) at least ten (10) subordinate lodges have been established into which the five hundred (500) applicants have been admitted;

(3) there has been submitted to the commissioner, under oath of the president or secretary, or corresponding officer of the society, a list of the applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted, and premiums therefor; and

(4) it shall have been shown to the commissioner, by sworn statement of the treasurer, or corresponding officer of such society, that at least five hundred (500) applicants have each paid in cash at least one (1) regular monthly premium, which premiums in the aggregate amount to at least one hundred fifty thousand dollars ($150,000). The advance premiums shall be held in trust during the period of organization and, if the society has not qualified for a certificate of authority within one (1) year as provided in this chapter, the premiums shall be returned to the applicants.

As added by P.L.262-1985, SEC.1.

IC 27-11-4-6
Certificate of authority

Sec. 6. The commissioner may make an examination and require any further information as the commissioner considers advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the commissioner shall issue to the society a certificate of authority authorizing the society to transact business under this article. The certificate of authority is prima facie evidence of the existence of the society at the date of the certificate. The commissioner shall cause a record of the certificate of authority to be made. A certified copy of the record may be given in evidence with like effect as the original certificate of authority.

As added by P.L.262-1985, SEC.1.

IC 27-11-5

Chapter 5. Governance

IC 27-11-5-1

Amendment of laws of domestic society

Sec. 1. (a) A domestic society may amend its laws in accordance with the provisions of the domestic society by action of its supreme governing body at any regular or special meeting of the domestic society or, if its laws provide, by referendum. The referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members, or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six (6) months from the date of submission of the amendment, a majority of the members voting shall have signified their consent to the amendment.

(b) No amendment to the laws of any domestic society shall take effect unless approved by the commissioner, who shall approve the amendment if the commissioner finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this state or with the character, objects, and purposes of the society. Unless the commissioner disapproves any amendment within sixty (60) days after the filing of the amendment, the amendment shall be considered approved. The approval or disapproval of the commissioner shall be in writing and mailed to the secretary or corresponding officer of the society at its principal office. In case the commissioner disapproves the amendment, the reasons for the disapproval shall be stated in the written notice.

(c) Within ninety (90) days from the approval of an amendment by the commissioner, all such amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis of the amendments stating facts that show that the amendments have been duly addressed and mailed, is prima facie evidence that the amendments or synopsis of the amendments have been furnished the addressee.

(d) Every foreign or alien society authorized to do business in this state shall file with the commissioner a duly certified copy of all amendments of, or additions to, its laws within ninety (90) days after the enactment of same.

(e) Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society, shall be prima facie evidence of the legal adoption thereof.

As added by P.L.262-1985, SEC.1.

IC 27-11-5-2

Operation of not-for-profit institutions

Sec. 2. A society may create, maintain, and operate or may establish organizations to operate not-for-profit institutions to further the purposes permitted by IC 27-11-2-3. Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held, or leased by the society for this purpose shall be reported in every annual statement.

As added by P.L.262-1985, SEC.1.

IC 27-11-5-3

Reinsurance agreements

Sec. 3. (a) A domestic society may by a reinsurance agreement cede any individual risk or risks in whole or in part to an insurer (other than another fraternal benefit society) having the power to make the reinsurance and authorized to do business in this state or, if not so authorized, one that is approved by the commissioner, but no society may reinsure substantially all of its insurance in force without the written permission of the commissioner. It may take credit for the reserves on the ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after December 31, 1985, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

(b) Notwithstanding the limitation in subsection (a), a society may reinsure the risks of another society in a consolidation or merger approved by the commissioner under section 4 of this chapter.

As added by P.L.262-1985, SEC.1.

IC 27-11-5-4

Consolidation or merger

Sec. 4. (a) A domestic society may consolidate or merge with any other society by complying with this section. It shall file with the commissioner:

(1) a certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

(2) a sworn statement by the president and secretary or corresponding officers of each society showing the financial condition of the society on a date fixed by the commissioner, but not earlier than December 31 next preceding the date of the contract;

(3) a certificate of the officers, verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds (2/3) vote of the supreme governing body of each society, the vote being conducted at a regular or special meeting of each body, or, if the society's laws permit, by mail; and

(4) evidence that, at least sixty (60) days before the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

(b) If the commissioner finds that:

(1) the contract is in conformity with this section;

(2) the financial statements are correct; and

(3) the consolidation or merger is just and equitable to the members of each society;

the commissioner shall approve the contract and issue a certificate to that effect. Upon approval, the contract shall be in full force and effect unless any society that is a party to the contract is incorporated under the laws of any other state or territory. In that event, the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of the state or territory and a certificate of approval has been filed with the commissioner or, if the laws of the state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the commissioner of that state or territory and a certificate of approval has been filed with the commissioner of this state.

(c) Upon the consolidation or merger becoming effective, all the rights, franchises, and interests of the consolidated or merged societies in and to every species of property, real, personal, or mixed, and things in action thereunto belonging shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this state in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after the consolidation or merger.

(d) The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that the notice or document has been duly addressed and mailed, is prima facie evidence that the notice or document has been furnished the addressees.

As added by P.L.262-1985, SEC.1.

IC 27-11-5-5

Conversion and licensing as mutual life insurance company

Sec. 5. Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the requirements of the insurance law for mutual life insurance companies. A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of

conversion. The affirmative vote of two-thirds (2/3) of all members of the supreme governing body at a regular or special meeting shall be necessary for the approval of the plan. No conversion shall take effect unless and until approved by the commissioner, who may give the approval if the commissioner finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society.
As added by P.L.262-1985, SEC.1.

IC 27-11-6
Chapter 6. Contractual Benefits

IC 27-11-6-1
Contractual benefits

Sec. 1. (a) A society may provide the following contractual benefits in any form:

(1) Death benefits.
(2) Endowment benefits.
(3) Annuity benefits.
(4) Temporary or permanent disability benefits.
(5) Hospital, medical, or nursing benefits.
(6) Monument or tombstone benefits to the memory of deceased members.
(7) Such other benefits as authorized for life insurers and that are not inconsistent with this chapter.

(b) A society shall specify in its rules those persons who may be issued or covered by the contractual benefits in subsection (a), consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

As added by P.L.262-1985, SEC.1.

IC 27-11-6-2
Beneficiaries of benefit contracts; funeral benefits; failure to designate lawful beneficiary

Sec. 2. (a) The owner of a benefit contract is entitled to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(b) A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member.

(c) If at the death of any person insured under a benefit contract there is no lawful beneficiary to whom the proceeds shall be payable, the amount of the benefit, except to the extent that funeral benefits may be paid, shall be payable to the personal representative of the deceased insured, provided that if the owner of the certificate is other than the insured, the proceeds shall be payable to such owner.

As added by P.L.262-1985, SEC.1.

IC 27-11-6-3
Limitation on use of benefits to pay debts or liabilities of members, beneficiaries, or other persons

Sec. 3. No money or other benefit, charity, relief, or aid to be paid, provided, or rendered by any society shall be liable to attachment, garnishment, or other process or to be seized, taken, appropriated, or applied by any legal or equitable process or operation of law to pay any debt or liability of a member, beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.
As added by P.L.262-1985, SEC.1.

IC 27-11-6-4
Issuance of certificate to owner of benefit contract

Sec. 4. Every society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided. The certificate, together with any riders or endorsements attached to the certificate, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each constitutes the benefit contract as of the date of issuance between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.
As added by P.L.262-1985, SEC.1.

IC 27-11-6-5
Effect of changes, additions, or amendments to laws of society upon owner and beneficiaries of benefit contract

Sec. 5. Any changes, additions, or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate shall bind the owner and the beneficiaries and shall govern and control the benefit contract in all respects as though the changes, additions, or amendments had been made before and were in force at the time of the application for insurance, except that no change, addition, or amendment shall destroy or diminish benefits that the society contracted to give the owner as of the date of issuance.
As added by P.L.262-1985, SEC.1.

IC 27-11-6-6
Issuance of benefit contract upon life of a minor

Sec. 6. Any person upon whose life a benefit contract is issued before attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

As added by P.L.262-1985, SEC.1.

IC 27-11-6-7
Payment of owner's equitable proportion of deficiency where society's reserves are impaired

Sec. 7. A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and that, if the payment is not made, either:

(1) it shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or

(2) instead of or in combination with subdivision (1), the owner may accept a proportionate reduction in benefits under the certificate.

The society may specify the manner of the election and which alternative is to be presumed if no election is made.
As added by P.L.262-1985, SEC.1.

IC 27-11-6-8
Copies of documents as evidence of terms and conditions

Sec. 8. Copies of any of the documents mentioned in this chapter, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.
As added by P.L.262-1985, SEC.1.

IC 27-11-6-9
Filing of copy of certificate with commissioner; contents of certificate

Sec. 9. A certificate shall not be delivered or issued for delivery in Indiana unless a copy of the form has been filed with the commissioner in the manner provided for like policies issued by life insurers in Indiana. Every life, accident, health, or disability insurance certificate and every annuity certificate issued after December 31, 1986, shall meet the standard contract provision requirements not inconsistent with this chapter for like policies issued by life insurers in this state, except that a society may provide for a grace period for payment of premiums of one (1) full month in its certificate. The certificate shall also contain a provision stating the amount of premiums that are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate that, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended,

except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.
As added by P.L.262-1985, SEC.1. Amended by P.L.2-1995, SEC.110.

IC 27-11-6-10
Benefit contract issued on life of a minor; transfer of control of ownership to the insured

Sec. 10. Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer and may provide in all other respects for the regulation, government, and control of certificates and all rights, obligations, and liabilities incident to a benefit contract. Ownership rights before a transfer shall be specified in the certificate.
As added by P.L.262-1985, SEC.1.

IC 27-11-6-11
Assignment of benefit contracts

Sec. 11. A society may specify the terms and conditions on which benefit contracts may be assigned.
As added by P.L.262-1985, SEC.1.

IC 27-11-6-12
Cash surrender value, loans, or other options

Sec. 12. (a) For certificates issued before January 1, 1987, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall comply with the provisions of law applicable on December 31, 1985.

(b) For certificates issued after December 31, 1986, for which reserves are computed on the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Table, the Commissioner's 1958 Standard Ordinary Mortality Table, the Commissioner's 1980 Standard Mortality Table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits based upon the tables.
As added by P.L.262-1985, SEC.1.

IC 27-11-7
Chapter 7. Financial Matters

IC 27-11-7-1
Investments

Sec. 1. A society shall invest its funds only in such investments as are authorized by the laws of this state for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this state that invests its funds in accordance with the laws of the state, district, territory, country, or province in which it is incorporated shall be held to meet the requirements of this section for the investment of funds.

As added by P.L.262-1985, SEC.1.

IC 27-11-7-2
Financial affairs of fraternal benefit societies

Sec. 2. (a) All assets shall be held, invested, and disbursed for the use and benefit of the society, and no member or beneficiary shall have or acquire individual rights in the assets or become entitled to any apportionment on the surrender of any part of the assets, except as provided in the benefit contract.

(b) A society may create, maintain, invest, disburse, and apply any special fund or funds necessary to carry out any purpose permitted by the laws of the society.

(c) A society may, pursuant to resolution of its supreme governing body, establish and operate one (1) or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing accounts and issuing contracts. To the extent the society considers it necessary in order to comply with any applicable federal or state laws or any rules issued thereunder, the society may:

(1) adopt special procedures for the conduct of the business and affairs of a separate account;

(2) for persons having beneficial interest therein, provide special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account; and

(3) issue contracts on a variable basis to which IC 27-11-6-5 and IC 27-11-6-7 shall not apply.

As added by P.L.262-1985, SEC.1.

IC 27-11-7-3
Law governing financial matters

Sec. 3. Except as provided in this article, societies shall be governed by this article and by IC 27-1-2, IC 27-1-3, and IC 27-9,

and shall be exempt from all other provisions of this title unless they be expressly designated therein, or unless it is specifically made applicable by this article.
As added by P.L.262-1985, SEC.1.

IC 27-11-7-4
Designation as charitable or benevolent institution

Sec. 4. Every society organized or licensed under this article is declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all and every state, county, district, municipal, and school tax other than taxes on real estate not occupied by a society in carrying on its business.
As added by P.L.262-1985, SEC.1.

IC 27-11-8
Chapter 8. Regulation

IC 27-11-8-1
Standards for valuation of certificates; maintenance of excess reserves on certificates

Sec. 1. (a) Standards of valuation for certificates issued before January 1, 1987, shall be those provided by the laws applicable on December 31, 1985.

(b) The minimum standards of valuation for certificates issued after December 31, 1986, shall be based on the following tables:

(1) For certificates of life insurance–the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Mortality Table, the Commissioner's 1958 Standard Ordinary Mortality Table, the Commissioner's 1980 Standard Ordinary Mortality Table, or any more recent table made applicable to life insurers.

(2) For annuity and pure endowment certificates, total and permanent disability benefits, accidental death benefits, and noncancellable accident and health benefits–such tables as are authorized for use by life insurers in this state.

(c) All of the above shall be under valuation methods and standards (including interest assumptions) in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits.

(d) The commissioner may accept other standards for valuation if the commissioner finds that the reserves produced will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard prescribed in this section. The commissioner may vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by any society authorized to do business in this state.

(e) Any society, with the consent of the commissioner of the state of domicile of the society and under the conditions, if any, that the commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

As added by P.L.262-1985, SEC.1.

IC 27-11-8-2
Annual financial statement

Sec. 2. (a) Reports shall be filed in accordance with this section.

(b) Every society transacting business in this state shall annually, before March 1, unless for cause shown the time has been extended by the commissioner, file with the commissioner a true statement of its financial condition, transactions, and affairs for the preceding calendar year and pay a fee of twenty-five dollars ($25) for filing the

statement. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner.

(c) As part of the annual statement required in this section, each society shall, before March 1, file with the commissioner a valuation of its certificates in force on December 31 last preceding, provided the commissioner may for cause shown, extend the time for filing the valuation for not more than two (2) calendar months. The valuation shall be done in accordance with the standards specified in section 1 of this chapter. The valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

(d) A society neglecting to file the annual statement in the form and within the time provided by this section shall forfeit one hundred dollars ($100) for each day during which the neglect continues, and, upon notice by the commissioner to that effect, its authority to do business in Indiana shall cease while the default continues.

As added by P.L.262-1985, SEC.1. Amended by P.L.31-1988, SEC.24.

IC 27-11-8-3

Renewal of license; fee

Sec. 3. The authority of all societies licensed may be renewed annually, but in all cases to terminate on April 30. However, a license shall continue in full force and effect until the new license is issued or specifically refused. For each license or renewal, the society shall pay the commissioner a fee of twenty-five dollars ($25). A duly certified copy or duplicate of the license is prima facie evidence that the licensee is a fraternal benefit society within the meaning of this article.

As added by P.L.262-1985, SEC.1. Amended by P.L.31-1988, SEC.25.

IC 27-11-8-4

Examination of societies transacting or applying for admission to transact business in Indiana; expenses

Sec. 4. (a) The commissioner or any person the commissioner may appoint may examine any domestic, foreign, or alien society transacting or applying for admission to transact business in Indiana in the same manner as authorized for examination of domestic, foreign, or alien insurers. Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

(b) The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be

paid by the society examined or whose certificates are valued, upon statements furnished by the commissioner.
As added by P.L.262-1985, SEC.1.

IC 27-11-8-5
Requirements for issuance of license to transact business in Indiana

Sec. 5. No foreign or alien society shall transact business in Indiana without a license issued by the commissioner. Any society desiring admission to Indiana shall comply substantially with the requirements and limitations of this article applicable to domestic societies. Any society may be licensed to transact business in Indiana upon filing with the commissioner:

(1) a certified copy of its articles of incorporation;
(2) a copy of its bylaws, certified by its secretary or corresponding officer;
(3) a power of attorney to the commissioner as prescribed in IC 27-11-9-1;
(4) a statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the commissioner, verified by an examination made by the supervising insurance official of its home state or other state, territory, province, or country and satisfactory to the commissioner;
(5) certification from the proper official of its home state, territory, province, or country that the society is legally incorporated and licensed to transact business therein;
(6) copies of its certificate forms; and
(7) such other information as the commissioner considers necessary;

and upon a showing that its assets are invested in accordance with this chapter.
As added by P.L.262-1985, SEC.1.

IC 27-11-8-6
Noncompliance with limitations on transaction of business; injunction; hearing; liquidation of society; receivership; voluntary determination to discontinue business

Sec. 6. (a) When the commissioner upon investigation finds that a domestic society:

(1) has exceeded its powers;
(2) has failed to comply with this chapter;
(3) is not fulfilling its contracts in good faith;
(4) has a membership of less than four hundred (400) after an existence of one (1) year or more; or
(5) is conducting business fraudulently or in a manner hazardous to its members, creditors, the public, or the business;

the commissioner shall in writing notify the society of the deficiency

or deficiencies, state the reasons for the commissioner's dissatisfaction, and require that the deficiency or deficiencies that exist be corrected. After notice, the society shall have thirty (30) days in which to comply with the commissioner's request for correction, and, if the society fails to comply, the commissioner shall notify the society of the findings of noncompliance and require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of shall have been corrected, or why an action in quo warranto should not be commenced against the society.

(b) If on that date the society does not present good and sufficient reasons why it should not be enjoined or why action should not be commenced, the commissioner may present the facts relating thereto to the attorney general who shall, if the attorney general considers the circumstances warrant, commence an action to enjoin the society from transacting business or in quo warranto.

(c) The court shall notify the officers of the society of a hearing. If after a full hearing it appears that the society should be enjoined or liquidated or a receiver appointed, the court shall enter the necessary order. No society so enjoined shall have the authority to do business until:

(1) the commissioner finds that the violation complained of has been corrected;

(2) the costs of the action have been paid by the society if the court finds that the society was in default as charged;

(3) the court has dissolved its injunction; and

(4) the commissioner has reinstated the certificate of authority.

(d) If the court orders the society liquidated, it shall be enjoined from carrying on any further business, whereupon the receiver of the society shall proceed at once to take possession of the books, papers, money, and other assets of the society and, under the direction of the court, proceed to close the affairs of the society and to distribute its funds to those entitled to the funds.

(e) No action under this section shall be recognized in any court of this state unless brought by the attorney general upon request of the commissioner. Whenever a receiver is to be appointed for a domestic society, the court shall appoint the commissioner as the receiver.

(f) The provisions of this section relating to hearing by the commissioner, action by the attorney general at the request of the commissioner, hearing by the court, injunction, and receivership shall be applicable to a society that shall voluntarily determine to discontinue business.

As added by P.L.262-1985, SEC.1.

IC 27-11-8-7

Noncompliance by foreign or alien society; suspension, revocation, or refusal of license

Sec. 7. (a) When the commissioner upon investigation finds that a foreign or alien society transacting or applying to transact business in Indiana:

(1) has exceeded its powers;

(2) has failed to comply with any of the provisions of this chapter;

(3) is not fulfilling its contracts in good faith; or

(4) is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public;

the commissioner shall in writing notify the society of the deficiency or deficiencies, state the reasons for the commissioner's dissatisfaction, and require that the deficiency or deficiencies that exist be corrected.

(b) After the notice, the society shall have thirty (30) days in which to comply with the commissioner's request for correction, and, if the society fails to comply, the commissioner shall notify the society of the findings of noncompliance and require the society to show cause on a date named why its license should not be suspended, revoked, or refused. If on that date the society does not present good and sufficient reason why its authority to do business in Indiana should not be suspended, revoked, or refused, the commissioner may suspend or refuse the license of the society to do business in Indiana until satisfactory evidence is furnished to the commissioner that the suspension or refusal should be withdrawn, or the commissioner may revoke the authority of the society to do business in Indiana.

(c) Nothing contained in this section shall be taken or construed as preventing any society from continuing in good faith all contracts made in Indiana during the time the society was legally authorized to transact business in Indiana.

As added by P.L.262-1985, SEC.1.

IC 27-11-8-8

Application or petition for injunction

Sec. 8. No application or petition for injunction against any domestic, foreign, or alien society, or lodge shall be recognized in any court of Indiana unless made by the attorney general upon request of the commissioner.

As added by P.L.262-1985, SEC.1.

IC 27-11-8-9

Licensing of insurance producers of societies

Sec. 9. (a) Insurance producers of societies shall be licensed in accordance with the laws regulating the licensing and the revocation, suspension, or termination of license of resident and nonresident insurance producers.

(b) No examination or license shall be required of any regular salaried officer, employee, or member of a licensed society who devotes substantially all of the officer's, employee's or member's

services to activities other than the solicitation of fraternal insurance contracts from the public and who receives for the solicitation of those contracts no commission or other compensation directly dependent upon the amount of business obtained.
As added by P.L.262-1985, SEC.1. Amended by P.L.178-2003, SEC.83.

IC 27-11-8-10
Unfair competition; unfair or deceptive acts or practices

Sec. 10. Every society authorized to do business in Indiana shall be subject to IC 27-4-1 relating to unfair methods of competition and unfair or deceptive acts or practices, provided that nothing in those provisions shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.
As added by P.L.262-1985, SEC.1.

IC 27-11-9
Chapter 9. Miscellaneous Provisions

IC 27-11-9-1
Appointment of attorney for service of process; method of serving process

Sec. 1. (a) Every society authorized to do business in Indiana shall appoint in writing an individual resident of Indiana, a corporate resident of Indiana, or an authorized Indiana insurer to be its true and lawful attorney upon whom all lawful process in any action or proceeding against it shall be served and shall agree in such writing that:

(1) any lawful process against it that is served on the attorney shall be of the same legal force and validity as if served upon the society; and

(2) the authority shall continue in force so long as any liability remains outstanding in this state.

Copies of the appointment, certified by the commissioner, shall be considered sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original might be admitted.

(b) Service shall only be made upon the attorney or, if absent, upon the person in charge of the attorney's office. It shall be made in duplicate and shall constitute sufficient service upon the society. When legal process against a society is served upon the attorney, the attorney shall immediately forward one (1) of the duplicate copies by registered mail, prepaid, directed to the secretary or corresponding officer. No service shall require a society to file its answer, pleading, or defense in less than thirty (30) days from the date of mailing the copy of the service to a society. Legal process shall not be served upon a society except in the manner provided in this section.

As added by P.L.262-1985, SEC.1. Amended by P.L.130-1994, SEC.48; P.L.116-1994, SEC.71; P.L.268-1999, SEC.21.

IC 27-11-9-2
Judicial review of decisions and findings of commissioner

Sec. 2. All decisions and findings of the commissioner made under this article shall be subject to review by proper proceedings in any court of competent jurisdiction in this state.

As added by P.L.262-1985, SEC.1.

IC 27-11-9-3
Violations

Sec. 3. (a) A person who knowingly makes any false or fraudulent statement or representation in or with reference to any application for membership or for the purpose of obtaining money from or benefits in any society transacting business under this chapter, commits a Class A misdemeanor.

(b) A person who solicits membership for any fraternal beneficiary association not licensed to do business in Indiana, or for any society not authorized to do business in Indiana, commits a Class C infraction.

(c) Any person who knowingly violates, neglects, or refuses to comply with a provision of this article for which a penalty is not otherwise prescribed commits a Class B misdemeanor.

As added by P.L.262-1985, SEC.1.

IC 27-11-9-4

Construction of article

Sec. 4. (a) Nothing contained in this article shall be so construed as to affect or apply to:

(1) grand or subordinate lodges of societies, orders, or associations doing business in Indiana that provide benefits exclusively through local or subordinate lodges;

(2) orders, societies, or associations that admit to membership only persons engaged in one (1) or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families, and the ladies' societies or ladies' auxiliaries to these orders, societies, or associations;

(3) domestic societies that limit their membership to employees of a particular city or town, designated firm, business house, or corporation that provide for a death benefit of not more than four hundred dollars ($400) or disability benefits of not more than three hundred fifty dollars ($350) to any person in any one (1) year, or both; or

(4) domestic societies or associations of a purely religious, charitable, or benevolent description that provide for a death benefit of not more than four hundred dollars ($400) or for disability benefits of not more than three hundred fifty dollars ($350) to any one (1) person in any one (1) year, or both.

(b) Any society or association described in subsection (a)(3) or (a)(4) that provides for death or disability benefits for which benefit certificates are issued, and any society or association included in subsection (a)(4) that has more than one thousand (1,000) members, shall not be exempted from this article but shall comply with all requirements of this article.

(c) A society that under this section is exempt from the requirements of this article, except any society described in subsection (a)(2), shall not give or allow or promise to give or allow to any person any compensation for procuring new members.

(d) Every society that provides for benefits in case of death or disability resulting solely from accident and that does not obligate itself to pay natural death or sick benefits shall have all of the privileges and be subject to all the applicable provisions and rules of this article, except that the provisions relating to medical

examination, valuations of benefit certificates, and incontestability shall not apply to the society.

(e) The commissioner may require from any society or association, by examination or otherwise, such information as will enable the commissioner to determine whether the society or association is exempt from this article.

(f) Societies exempted under this section shall also be exempt from all other provisions of this title.

As added by P.L.262-1985, SEC.1.

IC 27-12

ARTICLE 12. REPEALED

(Repealed by P.L.1-1998, SEC.221.)

IC 27-13

ARTICLE 13. HEALTH MAINTENANCE ORGANIZATIONS

IC 27-13-1

Chapter 1. Definitions

IC 27-13-1-1

Applicability of definitions

Sec. 1. The definitions in this chapter apply throughout this article.

As added by P.L.26-1994, SEC.25.

IC 27-13-1-2

"Admitted asset"

Sec. 2. "Admitted asset" means an asset that may be included in a health maintenance organization's total assets for the purpose of computing the net worth of the health maintenance organization.

As added by P.L.26-1994, SEC.25.

IC 27-13-1-3

Repealed

(As added by P.L.26-1994, SEC.25. Amended by P.L.132-2001, SEC.15; P.L.178-2003, SEC.84. Repealed by P.L.97-2004, SEC.133.)

IC 27-13-1-4

"Basic health care services"

Sec. 4. (a) "Basic health care services" means the following medically necessary services:

(1) Preventive care.
(2) Inpatient and outpatient hospital and physician care.
(3) Diagnostic laboratory care.
(4) Diagnostic and therapeutic radiological services.
(5) Emergency care.

(b) The term does not include the following:

(1) Mental health services.
(2) Services for alcohol and drug abuse.
(3) Dental services.
(4) Vision services.
(5) Long term rehabilitation treatment.

As added by P.L.26-1994, SEC.25.

IC 27-13-1-5

"Capitated basis"

Sec. 5. "Capitated basis" means fixed per member per month payment or percentage of premium payment under which the provider assumes the full risk for the cost of contracted services without regard to type, value, or frequency of services provided. For

purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.
As added by P.L.26-1994, SEC.25.

IC 27-13-1-6
"Carrier"
Sec. 6. "Carrier" refers to any of the following:
(1) A health maintenance organization.
(2) An insurer licensed in Indiana to write Class 1(B) or Class 2(A) lines of insurance.
(3) Any other entity responsible for the payment of benefits or provision of services under a group contract.
As added by P.L.26-1994, SEC.25.

IC 27-13-1-7
"Commissioner"
Sec. 7. "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.
As added by P.L.26-1994, SEC.25.

IC 27-13-1-8
"Copayment"
Sec. 8. "Copayment" means an amount, or a percentage of the charge, that an enrollee must pay to receive a specific service that is not fully prepaid.
As added by P.L.26-1994, SEC.25.

IC 27-13-1-9
"Coverage"
Sec. 9. "Coverage" means the health care services to which a person is contractually entitled, either directly or indirectly, under a contract with a carrier.
As added by P.L.26-1994, SEC.25.

IC 27-13-1-10
"Covered by a health maintenance organization"
Sec. 10. "Covered by a health maintenance organization" means that a person is contractually entitled, either directly or indirectly, to health care services from the health maintenance organization.
As added by P.L.26-1994, SEC.25.

IC 27-13-1-10.5
"Credentialing"
Sec. 10.5. "Credentialing" means a process through which a health maintenance organization makes a determination:
(1) based on criteria established by the health maintenance organization; and
(2) concerning whether a provider may serve as a participating

provider.
As added by P.L.26-2005, SEC.3.

IC 27-13-1-11
"Deductible"
Sec. 11. "Deductible" means the amount that an enrollee is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with the health care services.
As added by P.L.26-1994, SEC.25.

IC 27-13-1-11.3
"Department"
Sec. 11.3. "Department" refers to the department of insurance.
As added by P.L.69-1998, SEC.1.

IC 27-13-1-11.5
"Dialysis facility"
Sec. 11.5. "Dialysis facility" means an outpatient facility in Indiana at which a dialysis treatment provider provides dialysis treatment.
As added by P.L.111-2008, SEC.5.

IC 27-13-1-11.7
"Emergency"
Sec. 11.7. "Emergency" means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:
(1) place an individual's health in serious jeopardy;
(2) result in serious impairment to the individual's bodily functions; or
(3) result in serious dysfunction of a bodily organ or part of the individual.
As added by P.L.69-1998, SEC.2.

IC 27-13-1-12
"Enrollee"
Sec. 12. "Enrollee" means a subscriber or a subscriber's dependent who is covered by a health maintenance organization.
As added by P.L.26-1994, SEC.25. Amended by P.L.191-1997, SEC.1.

IC 27-13-1-13
"Evidence of coverage"
Sec. 13. "Evidence of coverage" means a statement of the

essential features and services of the coverage provided by a health maintenance organization.
As added by P.L.26-1994, SEC.25.

IC 27-13-1-13.5
"Experimental treatment"

Sec. 13.5. "Experimental treatment" means medical technology or a new application of existing medical technology, including medical procedures, drugs, and devices for treating a medical condition, illness, or diagnosis that:

(1) is not generally accepted by informed health care professionals in the United States as effective; or

(2) has not been proven by scientific testing or evidence to be effective;

in treating the medical condition, illness, or diagnosis for which its use is proposed.
As added by P.L.69-1998, SEC.3.

IC 27-13-1-14
"Extension of benefits"

Sec. 14. "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following the termination of an enrollee with a total disability on the date of termination.
As added by P.L.26-1994, SEC.25. Amended by P.L.99-2007, SEC.194.

IC 27-13-1-15
"Grievance"

Sec. 15. "Grievance" means a written complaint submitted in accordance with the formal grievance procedure of a health maintenance organization by or on behalf of:

(1) the enrollee or subscriber regarding any aspect of the health maintenance organization relative to the enrollee or subscriber; or

(2) an individual who would be an enrollee or a subscriber under an individual contract or a group contract regarding the health maintenance organization's decision to rescind the individual contract or group contract.

As added by P.L.26-1994, SEC.25. Amended by P.L.160-2011, SEC.26.

IC 27-13-1-16
"Group contract"

Sec. 16. "Group contract" means a contract for health care services which by the contract's terms limits eligibility to members of a specified group. A group contract may include coverage for dependents.

As added by P.L.26-1994, SEC.25.

IC 27-13-1-17
"Group contract holder"

Sec. 17. "Group contract holder" means the person to whom a group contract has been issued.

As added by P.L.26-1994, SEC.25.

IC 27-13-1-18
"Health care services"

Sec. 18. (a) "Health care services" means:

(1) any services provided by individuals licensed under IC 25-5.1, IC 25-10, IC 25-13, IC 25-14, IC 25-22.5, IC 25-23, IC 25-24, IC 25-26, IC 25-27, IC 25-29, IC 25-33, or IC 25-35.6;

(2) services provided as a result of hospitalization;

(3) services incidental to the furnishing of services described in subdivision (1) or (2); or

(4) any other services or goods furnished for the purpose of preventing, alleviating, curing, or healing human illness, physical disability, or injury.

(b) The term does not include any service provided by, from, or through a licensed health care facility in connection with any life care, founder's fee, or other type of prepaid fee contract for residency and health care in a retirement home, community, or facility for elderly persons.

As added by P.L.26-1994, SEC.25. Amended by P.L.133-2011, SEC.2.

IC 27-13-1-19
"Health maintenance organization"

Sec. 19. "Health maintenance organization" means a person that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles.

As added by P.L.26-1994, SEC.25.

IC 27-13-1-20
"In-plan covered services"

Sec. 20. "In-plan covered services" means the following:

(1) Covered health care services that are obtained from a provider who:

(A) is employed by;

(B) is under contract with;

(C) provides health care services to an enrollee referred by; or

(D) is otherwise affiliated with;

the health maintenance organization.

(2) Emergency services.
As added by P.L.26-1994, SEC.25.

IC 27-13-1-21
"Individual contract"
Sec. 21. (a) "Individual contract" means a contract for health care services that:
(1) is issued to; and
(2) covers;
an individual.
(b) An individual contract may include coverage for a dependent of the subscriber.
As added by P.L.26-1994, SEC.25.

IC 27-13-1-21.3
"Insurance producer"
Sec. 21.3. "Insurance producer" means a person who is a licensed insurance producer under IC 27-1-15.6 and who:
(1) solicits, negotiates, effects, procures, delivers, renews, or continues a policy or contract for membership in a health maintenance organization or a prepaid limited health service organization;
(2) takes or transmits a membership fee or premium for the policy or contract other than for the insurance producer; or
(3) causes the insurance producer to be held out to the public, through advertising or otherwise, as a producer for a health maintenance organization or a prepaid limited health service organization.
As added by P.L.97-2004, SEC.102.

IC 27-13-1-21.5
"Managed hospital payment basis"
Sec. 21.5. "Managed hospital payment basis" means agreements in which the financial risk is primarily related to the degree of utilization rather than to cost of services.
As added by P.L.255-1995, SEC.13.

IC 27-13-1-22
"Net worth"
Sec. 22. (a) "Net worth" means the excess of total admitted assets over total liabilities.
(b) For the purposes of subsection (a), "liabilities" does not include fully subordinated debt.
As added by P.L.26-1994, SEC.25.

IC 27-13-1-23
"Out-of-plan covered services"
Sec. 23. (a) "Out-of-plan covered services" means nonemergency,

self-referred covered health care services that:

(1) are obtained from a provider who is:

(A) not otherwise employed by;

(B) not under contract with; and

(C) not otherwise affiliated with;

the health maintenance organization; or

(2) are obtained from a participating provider without a referral.

(b) The term does not include uncovered services.

As added by P.L.26-1994, SEC.25.

IC 27-13-1-24

"Participating provider"

Sec. 24. "Participating provider" means a provider who, under an express or implied contract with:

(1) the health maintenance organization; or

(2) a contractor of the health maintenance organization or any subcontractor of a contractor of the health maintenance organization;

has agreed to provide health care services to enrollees with an expectation of directly or indirectly receiving payment, other than copayment or deductible, from the health maintenance organization.

As added by P.L.26-1994, SEC.25. Amended by P.L.195-1996, SEC.1.

IC 27-13-1-25

"Person"

Sec. 25. "Person" includes the following:

(1) An individual.

(2) A partnership.

(3) An association.

(4) A trust.

(5) A limited liability company.

(6) A corporation.

As added by P.L.26-1994, SEC.25.

IC 27-13-1-26

"Point-of-service product"

Sec. 26. "Point-of-service product" means a product that covers both:

(1) in-plan covered services; and

(2) out-of-plan covered services.

As added by P.L.26-1994, SEC.25.

IC 27-13-1-27

"Limited service health maintenance organization"

Sec. 27. "Limited service health maintenance organization" has the meaning set forth in IC 27-13-34-4.

As added by P.L.26-1994, SEC.25. Amended by P.L.2-1998, SEC.70.

IC 27-13-1-27.5
"Primary care provider"

Sec. 27.5. "Primary care provider" means a provider under contract with a health maintenance organization who is designated by the health maintenance organization to coordinate, supervise, or provide ongoing care to an enrollee.

As added by P.L.69-1998, SEC.4.

IC 27-13-1-28
"Provider"

Sec. 28. (a) "Provider" means a physician, a hospital, or any other person licensed or authorized to furnish health care services.

(b) The term includes an entity that:

(1) is owned in whole or in part by one (1) or more physicians, hospitals, or other persons licensed or authorized to furnish health care services; and

(2) was established for purposes of furnishing health care services through:

(A) contracts; or

(B) employment agreements;

with one (1) or more physicians, hospitals, or other persons licensed or authorized to furnish health care services.

As added by P.L.26-1994, SEC.25. Amended by P.L.195-1996, SEC.2.

IC 27-13-1-28.5
"Quality assurance"

Sec. 28.5. "Quality assurance" means the ongoing evaluation of the quality of health care services provided to enrollees.

As added by P.L.69-1998, SEC.5.

IC 27-13-1-29
"Receivership"

Sec. 29. "Receivership" means that the health maintenance organization has been placed in receivership under an order of rehabilitation or liquidation by a court with jurisdiction.

As added by P.L.26-1994, SEC.25.

IC 27-13-1-30
"Replacement coverage"

Sec. 30. "Replacement coverage" means the coverage provided to a person whose last preceding carrier has ceased providing coverage to that person.

As added by P.L.26-1994, SEC.25.

IC 27-13-1-31
"Service area"

Sec. 31. "Service area" means the geographic area within which

a health maintenance organization licensed under this article provides or arranges for the delivery of health care services to enrollees.
As added by P.L.26-1994, SEC.25.

IC 27-13-1-32
"Subscriber"
Sec. 32. "Subscriber" means:
(1) an individual whose employment status or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization; or
(2) in the case of an individual contract, the person in whose name the contract is issued.
As added by P.L.26-1994, SEC.25.

IC 27-13-1-33
"Subscriber premiums"
Sec. 33. "Subscriber premiums" means money or any other thing of value paid or given in consideration to a health maintenance organization, agent, or solicitor on account of or in connection with a contract under which a health maintenance organization provides or arranges for the delivery of health care benefits to enrollees.
As added by P.L.26-1994, SEC.25.

IC 27-13-1-34
"Telemedicine services"
Sec. 34. (a) "Telemedicine services" means health care services delivered by use of interactive audio, video, or other electronic media, including the following:
(1) Medical exams and consultations.
(2) Behavioral health, including substance abuse evaluations and treatment.
(b) The term does not include the delivery of health care services by use of the following:
(1) A telephone transmitter for transtelephonic monitoring.
(2) A telephone or any other means of communication for the consultation from one (1) provider to another provider.
As added by P.L.185-2015, SEC.26.

IC 27-13-2

Chapter 2. Establishment of Health Maintenance Organizations

IC 27-13-2-1

Persons applying for certificate of authority

Sec. 1. Notwithstanding any other law, any person may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization under this article.

As added by P.L.26-1994, SEC.25.

IC 27-13-2-2

Certificate of authority required

Sec. 2. (a) A person may not establish or operate a health maintenance organization without obtaining a certificate of authority under this article.

(b) If a participating provider contracts with another provider under a contract that complies with IC 27-13-15 to provide health services on a prepaid basis to enrollees of a health maintenance organization that holds a certificate of authority, neither provider, with respect to the contract is:

(1) considered to be engaged in the business of insurance; or

(2) required to obtain a certificate of authority under this article.

As added by P.L.26-1994, SEC.25. Amended by P.L.195-1996, SEC.3.

IC 27-13-2-3

Foreign entities obtaining certificate of authority

Sec. 3. (a) A foreign corporation, other than a foreign corporation defined under IC 27-1-2-3, may obtain a certificate of authority if the foreign corporation:

(1) is authorized to do business in Indiana under IC 23-1-49 or IC 23-17-26; and

(2) complies with this article.

(b) A foreign corporation (as defined in IC 27-1-2-3) may obtain a certificate of authority if the foreign corporation complies with this article.

(c) A foreign or alien health maintenance organization granted a certificate of authority under this section has the same but no greater rights and privileges than a domestic health maintenance organization.

As added by P.L.26-1994, SEC.25. Amended by P.L.203-2001, SEC.15.

IC 27-13-2-4

Certificate of authority application; verification; form

Sec. 4. An application for a certificate of authority to operate a health maintenance organization must be:

(1) verified by an officer or authorized representative of the applicant; and

(2) submitted on a form prescribed by the commissioner.

As added by P.L.26-1994, SEC.25.

IC 27-13-2-5

Certificate of authority application; requirements

Sec. 5. An application for a certificate of authority to operate a health maintenance organization must set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant, such as the articles of incorporation, partnership agreement, trust agreement, articles of organization, or any other applicable documents, and all amendments to those documents.

(2) A copy of the bylaws, rules and regulations, or similar document regulating the conduct of the internal affairs of the applicant.

(3) A list, on a form acceptable to the commissioner, of the names, addresses, official positions, and biographical information of the persons who are to be responsible for the conduct of the affairs and daily operations of the applicant, including the following:

(A) All members of the board of directors, board of trustees, executive committee, or other governing board or committee of the applicant.

(B) The principal officers, if the applicant is a corporation.

(C) The partners or members, if the applicant is a partnership or an association.

(D) The manager or, if there is no manager, all members of a limited liability company.

(4) A copy of any contract form that has been made or is to be made between any class of providers and the health maintenance organization.

(5) A copy of any contract that has been made or is to be made between:

(A) third party administrators, agents, or persons identified under subdivision (3); and

(B) the health maintenance organization.

(6) A copy of the form of evidence of coverage that is to be issued by the health maintenance organization to an enrollee.

(7) A copy of the form of a group contract, if any, that is to be issued by the health maintenance organization to an employer, a union, a trustee, or another entity.

(8) Financial statements showing the assets, liabilities, and sources of financial support of the applicant, including:

(A) a copy of the most recent certified financial statement of the applicant; and

(B) an unaudited current financial statement.

(9) A financial feasibility plan that includes the following:
(A) Detailed enrollment projections.
(B) The methodology for determining premium rates to be charged during the first twelve (12) months of operations, certified by an actuary or other qualified person acceptable to the commissioner.
(C) A projection of:
(i) balance sheets;
(ii) cash flow statements showing any capital expenditures, purchase and sale of investments, and deposits with the state; and
(iii) income and expense statements;
anticipated from the start of operations until the organization has had net income for at least one (1) year.
(D) A statement of the sources of working capital as well as any other sources of funding.
(10) If the applicant is not domiciled in Indiana, an executed power of attorney appointing the commissioner, the commissioner's successors in office, and authorized deputies of the commissioner as the true and lawful attorney of the applicant in and for Indiana upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in Indiana may be served.
(11) A statement or map reasonably indicating, on a county-by-county basis, the service area to be served by the health maintenance organization.
(12) A description of the internal procedures to be used by the health maintenance organization for the investigation and resolution of the complaints and grievances of enrollees.
(13) A description of the proposed quality management program of the applicant, including the following:
(A) The formal organizational structure.
(B) Methods for developing criteria.
(C) Procedures for comprehensive evaluation of the quality of care rendered to enrollees.
(D) Processes to initiate corrective action and reevaluation when deficiencies in provider performance or organizational performance are identified.
(14) A description of the procedures to be implemented to meet the requirements set forth in IC 27-13-12 through IC 27-13-17.
(15) A list of the names, addresses, and license numbers of any providers with whom the health maintenance organization has agreements.
(16) Any other information required by the commissioner to make the determination required under IC 27-13-3.
As added by P.L.26-1994, SEC.25.

IC 27-13-2-6
Certificate of authority application; modifications or amendments

Sec. 6. (a) An applicant shall submit to the commissioner any modifications or amendments to the items of information required in an application under section 5 of this chapter.

(b) The commissioner may adopt rules under this section that provide that any modifications or amendments to the items of information in the application required of a health maintenance organization:

(1) must be submitted to the commissioner before the modification or amendment takes effect:

(A) for the approval of the commissioner; or

(B) for the information of the commissioner only; or

(2) must be indicated by the health maintenance organization to the commissioner at the time of the next succeeding site visit or examination of the organization by the department of insurance.

(c) A health maintenance organization shall file any assumed corporate name with the department at least thirty (30) days before assuming the name.

As added by P.L.26-1994, SEC.25. Amended by P.L.203-2001, SEC.16.

IC 27-13-2-7
Certificate of authority application; approval of modifications or amendments

Sec. 7. Any modification or amendment requiring the approval of the commissioner under rules adopted under section 6 of this chapter is considered approved unless the commissioner disapproves the modification or amendment not more than thirty (30) days after the modification or amendment is submitted. However, the commissioner may postpone the action, if necessary for proper consideration, and if the commissioner gives written notice of the postponement to the applicant before the expiration of the thirty (30) day period.

As added by P.L.26-1994, SEC.25.

IC 27-13-2-8
Waiver of rights under bankruptcy laws

Sec. 8. The commissioner may not issue a certificate of authority to operate a health maintenance organization unless the applicant has submitted to the commissioner a written waiver of the health maintenance organization's rights under the federal bankruptcy laws.

As added by P.L.26-1994, SEC.25.

IC 27-13-2-9
Prohibited names

Sec. 9. (a) A health maintenance organization established under this article may not:

(1) use as a part of its corporate name the words "United States", "Federal", "government", "official", or any word that would imply that the company is an administrative agency of the state of Indiana or of the United States, or that it is subject to supervision of any department other than the department of insurance; or

(2) take or assume a corporate name the same as, or confusingly similar to, an existing name of any other insurance company or other entity licensed or regulated under IC 27, unless at the same time:

(A) the other company changes its corporate name or withdraws from transacting business in Indiana; and

(B) the written consent of the other company, signed and verified under oath by its secretary, is filed with the department.

(b) This section does not affect the right of any health maintenance organization that:

(1) exists under the laws of Indiana as of July 1, 2001;

(2) exists under the laws of Indiana as of July 1, 2001, and thereafter reorganizes or reincorporates under this article; or

(3) is authorized to transact business in Indiana as of July 1, 2001;

to continue the use of its corporate name.

As added by P.L.203-2001, SEC.17.

IC 27-13-2-10

Application of other laws to domestic health maintenance organizations

Sec. 10. (a) A domestic health maintenance organization that is admitted to transact business in Indiana shall do the following:

(1) If the health maintenance organization is a domestic health maintenance organization admitted to transact business in Indiana after June 30, 2011, comply with IC 27-1-6-21.

(2) If the health maintenance organization changes the physical location of its home office, provide written notice to the department and all subscribers at least thirty (30) days before the location is changed, including the address and telephone number of the new location.

(b) A domestic health maintenance organization operating under this article is subject to IC 27-1-7-11.

As added by P.L.11-2011, SEC.37.

IC 27-13-3
Chapter 3. Issuance of Certificates of Authority

IC 27-13-3-1
Satisfaction of requirements

Sec. 1. After receiving a completed application, the commissioner shall issue a certificate of authority to operate a health maintenance organization to the applicant if:

(1) the application fee is received by the commissioner; and

(2) the commissioner is satisfied that the following requirements are met:

(A) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and have good reputations.

(B) The health maintenance organization will effectively provide or arrange for the provision of the health care services covered in the health maintenance organization's individual and group contracts on a prepaid basis, through insurance or other means, except to the extent of reasonable requirements for copayments and deductibles.

(C) The health maintenance organization complies with IC 27-13-12 through IC 27-13-19.

As added by P.L.26-1994, SEC.25.

IC 27-13-3-1.5
Approval of certificate of authority

Sec. 1.5. (a) Except as provided in subsection (b), a completed application for a certificate of authority is considered approved one hundred twenty (120) days after the completed application is submitted to the commissioner.

(b) If the commissioner issues an order under IC 27-13-24-3(b) within one hundred twenty (120) days after a completed application is submitted under subsection (a), the review and processing of the application are subject to IC 27-13-24-3 and IC 27-13-24-4.

As added by P.L.195-1996, SEC.4.

IC 27-13-3-2
Denial of application

Sec. 2. An application for a certificate of authority may be denied only after the commissioner complies with the requirements set forth in IC 27-13-24.

As added by P.L.26-1994, SEC.25.

IC 27-13-4
Chapter 4. Powers of Health Maintenance Organizations

IC 27-13-4-1
General powers

Sec. 1. (a) Subject to section 3 of this chapter, the powers of a health maintenance organization include the following:

(1) The purchase, lease, construction, renovation, operation, or maintenance of:

(A) hospitals and medical facilities;

(B) equipment for hospitals and medical facilities; and

(C) other property reasonably required for the principal office of the health maintenance organization or for purposes necessary in the transaction of the business of the organization.

(2) Engaging in transactions between affiliated entities, including loans and the transfer of responsibility under any or all contracts:

(A) between affiliates; or

(B) between the health maintenance organization and the parent organization of the health maintenance organization.

(3) The furnishing of health care services through:

(A) providers;

(B) provider associations; and

(C) agents for providers;

who are under contract with or are employed by the health maintenance organization. The contracts with providers, provider associations, or agents of providers may include fee for service, cost plus, capitation, or other payment or risk-sharing arrangements.

(4) Contracting with any person for the performance on behalf of the health maintenance organization of certain functions, including:

(A) marketing;

(B) enrollment; and

(C) administration.

(5) Contracting with:

(A) an insurance company licensed in Indiana;

(B) an authorized reinsurer; or

(C) a hospital authorized to conduct business in Indiana;

for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization.

(6) The offering of point-of-service products.

(7) The joint marketing of products with:

(A) an insurance company that is licensed in Indiana; or

(B) a hospital that is authorized to conduct business in Indiana;

if the company that is offering each product is clearly identified.

(8) Administration of the provision of health care services at the expense of a self-funded plan.

(b) A health maintenance organization may offer any of the following:

(1) Plans that include only basic health care services.

(2) Plans that include basic health care services and other health care services.

(3) Plans that include health care services other than basic health care services so long as at least one (1) of the plans offered by the health maintenance organization includes basic health care services.

(c) Notwithstanding subsection (a)(5), a health maintenance organization may not take credit for reinsurance unless the risk is ceded to a reinsurer qualified under IC 27-6-10.

As added by P.L.26-1994, SEC.25. Amended by P.L.2-1995, SEC.111; P.L.203-2001, SEC.18.

IC 27-13-4-2

Asset of health maintenance organization as an admitted asset

Sec. 2. Nothing in this chapter qualifies an asset of a health maintenance organization as an admitted asset.

As added by P.L.26-1994, SEC.25.

IC 27-13-4-3

Filing notice with commissioner before exercising power; disapproval of exercise of power; exemptions from filing requirement

Sec. 3. (a) A domestic health maintenance organization must file notice with the commissioner, with supporting information that the commissioner deems adequate, before exercising any power granted in:

(1) section 1(a)(1); or

(2) section 1(a)(4);

of this chapter if the proposed transaction is equal to or greater than ten percent (10%) of the health maintenance organization's admitted assets.

(b) A domestic health maintenance organization must file notice with the commissioner, with the supporting information that the commissioner deems adequate, before exercising any power granted in section 1(a)(2), if the proposed transaction is equal to or greater than three percent (3%) of the health maintenance organization's admitted assets.

(c) The commissioner may disapprove an exercise of power referred to in a notice received under subsection (a) or (b) only if, in the opinion of the commissioner, the exercise of the power would:

(1) substantially and adversely affect the financial soundness of the health maintenance organization; and

(2) endanger the ability of the health maintenance organization to meet its obligations.

(d) If the commissioner does not disapprove an exercise of power referred to in a notice received under subsection (a) or (b) within thirty (30) days after the notice is filed with the commissioner, the exercise of power is considered approved.

(e) The commissioner may adopt rules under IC 4-22-2 exempting from the filing requirement of this section certain activities that have a minimal effect on:

(1) the financial soundness of the health maintenance organization; and

(2) the ability of the health maintenance organization to meet its obligations.

As added by P.L.26-1994, SEC.25. Amended by P.L.203-2001, SEC.19.

IC 27-13-5

Chapter 5. Fiduciary Responsibilities

IC 27-13-5-1

Persons having fiduciary responsibilities

Sec. 1. Any:

(1) director;
(2) officer;
(3) employee; or
(4) partner;

of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the organization has a fiduciary responsibility to the organization for the funds.

As added by P.L.26-1994, SEC.25.

IC 27-13-5-2

Fidelity bond or fidelity insurance

Sec. 2. A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on the directors, officers, employees, and partners referred to in section 1 of this chapter:

(1) in an amount:
  (A) not less than two hundred and fifty thousand dollars ($250,000) for each health maintenance organization; or
  (B) not more than five million dollars ($5,000,000) in the aggregate on behalf of all health maintenance organizations owned by a common parent organization; or
(2) in an amount prescribed by the commissioner.

As added by P.L.26-1994, SEC.25.

IC 27-13-6

Chapter 6. Quality Management Programs

IC 27-13-6-1

Procedures; establishment

Sec. 1. (a) A health maintenance organization shall establish procedures based on professionally recognized standards to assess and monitor the health care services provided to enrollees of the organization.

(b) The procedures established under this section must include mechanisms to implement corrective action when necessary and to assess the availability, accessibility, and continuity of care.

As added by P.L.26-1994, SEC.25.

IC 27-13-6-2

Internal quality management program required

Sec. 2. A health maintenance organization shall have an ongoing internal quality management program to monitor and evaluate the health care services it provides, including:

(1) primary and specialist physician services; and

(2) ancillary and preventive health care services;

across all institutional and noninstitutional settings.

As added by P.L.26-1994, SEC.25.

IC 27-13-6-3

Quality management program requirements

Sec. 3. The quality management program required by section 2 of this chapter must include at least the following:

(1) A written statement of the scope and purpose of the health maintenance organization's quality management program, including a written statement of goals and objectives that emphasizes improved health status in evaluating the quality of care rendered to enrollees.

(2) The organizational structure responsible for quality management activities.

(3) Any contractual arrangements, when appropriate, for delegation of quality management activities.

(4) Confidentiality of policies and procedures.

(5) A system of ongoing evaluation activities.

(6) A system of focused evaluation activities.

(7) A system for credentialing providers and performing peer review activities.

(8) Duties and responsibilities of the designated physician responsible for the quality management activities.

As added by P.L.26-1994, SEC.25.

IC 27-13-6-4

Written statement of quality management activities

Sec. 4. The quality management program required by section 2 of this chapter must contain a written statement describing the system of ongoing quality management activities, including the following:

(1) Problem assessment, identification, selection, and study.

(2) Corrective action, monitoring, evaluation, and reassessment.

(3) Interpretation and analysis of patterns of care rendered to individual patients by individual providers.

(4) Comparison between patterns of care, including outcomes, rendered to patients by providers and the cost to the health maintenance organization of that care.

(5) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies method of topic selection, study, data collection, analysis, interpretation, and report format.

As added by P.L.26-1994, SEC.25.

IC 27-13-6-5

Written plans for correcting insufficient service

Sec. 5. The quality management program required by section 2 of this chapter must contain written plans for taking appropriate corrective action whenever the quality management program determines that:

(1) inappropriate or substandard services have been provided; or

(2) services that should have been provided were not provided.

As added by P.L.26-1994, SEC.25.

IC 27-13-6-6

Patient record system

Sec. 6. A health maintenance organization shall ensure the use and maintenance of an adequate patient record system that will facilitate:

(1) documentation and retrieval of clinical information to enable the health maintenance organization to evaluate continuity and coordination of patient care; and

(2) the assessment of the quality of health and medical care provided to enrollees.

As added by P.L.26-1994, SEC.25.

IC 27-13-6-7

Reporting quality management program activities

Sec. 7. A health maintenance organization shall establish a mechanism for periodic reporting of quality management program activities to the governing body, providers, and appropriate staff of the organization.

As added by P.L.26-1994, SEC.25.

IC 27-13-6-8

Records of proceedings; confidentiality

Sec. 8. A health maintenance organization shall:

(1) record the proceedings of formal quality management program activities; and

(2) maintain its documentation of the quality management program in a confidential manner.

As added by P.L.26-1994, SEC.25.

IC 27-13-6-9

Inspection of records by commissioner

Sec. 9. The commissioner may inspect the records of a health maintenance organization's quality management program. The health maintenance organization shall cooperate with the inspections by making available to the commissioner the records requested by the commissioner, while protecting the confidentiality of enrollee medical records.

As added by P.L.26-1994, SEC.25.

IC 27-13-6-10

Hospital accreditation

Sec. 10. (a) A health maintenance organization may not refuse to enter into an agreement with a hospital solely because the hospital has not obtained accreditation from an accreditation organization that:

(1) establishes standards for the organization and operation of hospitals;

(2) requires the hospital to undergo a survey process for a fee paid by the hospital; and

(3) was organized and formed in 1951.

(b) This section does not prohibit a health maintenance organization from using performance indicators or quality standards that:

(1) are developed by private organizations; and

(2) do not rely upon a survey process for a fee charged to the hospital to evaluate performance.

As added by P.L.259-1995, SEC.3.

IC 27-13-7

Chapter 7. Requirements for Group Contracts, Individual Contracts, and Evidence of Coverage

IC 27-13-7-0.1

Application of certain amendments to chapter

Sec. 0.1. The following amendments to this chapter apply as follows:

(1) The addition of sections 15.3 and 16 of this chapter by P.L.170-1999 applies to health maintenance organization contracts that are issued, delivered, or renewed after June 30, 1999.

(2) The addition of section 18 of this chapter by P.L.166-2003 applies to a health maintenance organization contract that is entered into, delivered, amended, or renewed after December 31, 2003.

(3) The amendments made to section 14 of this chapter by P.L.204-2003 apply to an individual contract or a group contract that is entered into, delivered, amended, or renewed after June 30, 2003.

(4) The amendments made to section 14.8 of this chapter by P.L.226-2003 apply to a group or an individual contract with a health maintenance organization that is entered into, delivered, amended, or renewed after June 30, 2003.

(5) The amendments made to section 14.5 of this chapter by P.L.196-2005 apply to a health maintenance organization contract that is entered into, delivered, amended, or renewed after June 30, 2005.

(6) The amendments made to section 3 of this chapter by P.L.218-2007 apply to a health maintenance organization contract that is entered into, delivered, amended, or renewed after June 30, 2007.

(7) The addition of section 19 of this chapter by P.L.109-2008 applies to an individual contract or a group contract that is entered into, delivered, amended, or renewed after June 30, 2008.

As added by P.L.220-2011, SEC.457.

IC 27-13-7-1

Persons entitled to copies of contracts

Sec. 1. Any holder of a group or an individual contract with a health maintenance organization is entitled to a copy of the group or individual contract.

As added by P.L.26-1994, SEC.25.

IC 27-13-7-2

Deceptive contract provisions prohibited

Sec. 2. A contract or an evidence of coverage referred to in

section 1 or section 5 of this chapter may not contain provisions or statements that are unjust, unfair, inequitable, misleading, or deceptive or that encourage misrepresentation prohibited by IC 27-1-15.6-12 or IC 27-4-1-4.
As added by P.L.26-1994, SEC.25. Amended by P.L.132-2001, SEC.16.

IC 27-13-7-3
Contract provisions

Sec. 3. (a) A contract referred to in section 1 of this chapter must clearly state the following:

(1) The name and address of the health maintenance organization.
(2) Eligibility requirements.
(3) Benefits and services within the service area.
(4) Emergency care benefits and services.
(5) Any out-of-area benefits and services.
(6) Copayments, deductibles, and other out-of-pocket costs.
(7) Limitations and exclusions.
(8) Enrollee termination provisions.
(9) Any enrollee reinstatement provisions.
(10) Claims procedures.
(11) Enrollee grievance procedures.
(12) Continuation of coverage provisions.
(13) Conversion provisions.
(14) Extension of benefit provisions.
(15) Coordination of benefit provisions.
(16) Any subrogation provisions.
(17) A description of the service area.
(18) The entire contract provisions.
(19) The term of the coverage provided by the contract.
(20) Any right of cancellation of the group or individual contract holder.
(21) Right of renewal provisions.
(22) Provisions regarding reinstatement of a group or an individual contract holder.
(23) Grace period provisions.
(24) A provision on conformity with state law.
(25) A provision or provisions that comply with the:
(A) guaranteed renewability; and
(B) group portability;
requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).
(26) That the contract provides, upon request of the subscriber, coverage for a child of the subscriber until the date the child becomes twenty-six (26) years of age.

(b) For purposes of subsection (a), an evidence of coverage which is filed with a contract may be considered part of the contract.

As added by P.L.26-1994, SEC.25. Amended by P.L.91-1998, SEC.22; P.L.218-2007, SEC.50; P.L.160-2011, SEC.27.

IC 27-13-7-4
Compliance with requirements; ten day grace period

Sec. 4. (a) An individual contract must comply with all provisions of section 3(a) of this chapter and provide for a period of ten (10) days during which the individual entering into the contract with the health maintenance organization may:

(1) examine the contract; and

(2) if the individual decides, return the contract to the health maintenance organization and obtain a refund of the premium paid.

(b) If:

(1) services were received during the ten (10) day period referred to in subsection (a); and

(2) the individual returns the contract to receive a refund of the premium paid;

the individual must pay for the services received during the ten (10) day period.

As added by P.L.26-1994, SEC.25.

IC 27-13-7-5
Evidence of coverage

Sec. 5. (a) A subscriber under a group contract must receive an evidence of coverage from:

(1) the group contract holder; or

(2) the health maintenance organization.

(b) A group contract holder or health maintenance organization may provide the evidence of coverage required under subsection (a) in electronic or paper form. The group contract holder or health maintenance organization shall provide the evidence of coverage in paper form upon the request of the subscriber.

(c) A health maintenance organization shall include in the health maintenance organization's enrollment materials information concerning the manner in which a subscriber may:

(1) obtain an evidence of coverage; and

(2) request the evidence of coverage in paper form.

As added by P.L.26-1994, SEC.25. Amended by P.L.125-2005, SEC.6.

IC 27-13-7-6
Evidence of coverage; prohibited provisions

Sec. 6. The evidence of coverage required by section 5 of this chapter may not contain provisions or statements:

(1) that are unfair, unjust, inequitable, misleading, or deceptive; or

(2) that encourage misrepresentation prohibited by

IC 27-1-15.6-12 or IC 27-4-1-4.
As added by P.L.26-1994, SEC.25. Amended by P.L.132-2001, SEC.17.

IC 27-13-7-7
Evidence of coverage; required statement
Sec. 7. The evidence of coverage required by section 5 of this chapter must contain a clear statement of the matters set forth in section 3(a) of this chapter.
As added by P.L.26-1994, SEC.25.

IC 27-13-7-7.5
Prohibition on coverage of abortion; exceptions; coverage through rider or endorsement
Sec. 7.5. (a) A health maintenance organization that provides coverage for basic health care services and that is entered into, delivered, amended, or renewed after December 31, 2014, under a group contract or an individual contract may not provide coverage for abortion, except in the following cases:
(1) The pregnant woman became pregnant through an act of rape or incest.
(2) An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.
(b) A health maintenance organization that enters into a group contract or an individual contract described in subsection (a) may offer coverage for abortion through a rider or an endorsement.
As added by P.L.124-2014, SEC.2.

IC 27-13-7-8
Readability standards
Sec. 8. The commissioner may adopt rules under IC 4-22-2 establishing readability standards for individual contracts and evidence of coverage forms.
As added by P.L.26-1994, SEC.25.

IC 27-13-7-9
Approval of forms by commissioner
Sec. 9. Subject to sections 10 and 11 of this chapter:
(1) a group or an individual contract;
(2) an evidence of coverage; or
(3) an amendment to:
(A) a group or an individual contract; or
(B) an evidence of coverage;
may not be delivered or issued for delivery in Indiana unless the form has been filed with and approved by the commissioner.
As added by P.L.26-1994, SEC.25.

IC 27-13-7-10
Coverage outside Indiana; commissioner's approval not required

Sec. 10. If:

(1) an evidence of coverage that is issued under and incorporated into a contract issued in Indiana is intended for delivery in another state;

(2) the evidence of coverage has been approved for use in the state in which it is to be delivered; and

(3) the evidence of coverage is not delivered in Indiana;

the evidence of coverage need not be submitted to the commissioner in Indiana for approval.

As added by P.L.26-1994, SEC.25.

IC 27-13-7-11
Filing of form with commissioner; review period; approval; withdrawal of approval; hearing

Sec. 11. (a) A form required by this chapter must be filed with the commissioner at least thirty (30) days before the form is:

(1) delivered; or

(2) issued for delivery;

in Indiana.

(b) At any time during the thirty (30) day period referred to in subsection (a), the commissioner may extend the period for review for an additional thirty (30) days.

(c) The commissioner must give notice in writing of an extension of a review period under subsection (b).

(d) If the commissioner does not take action on a form submitted to the commissioner within the thirty (30) day period and any period of extension, the form is considered approved.

(e) At any time after notice and for cause shown, the commissioner may withdraw approval of any form, effective thirty (30) days after notice of the withdrawal of the approval is issued.

(f) When the commissioner:

(1) disapproves a filing; or

(2) withdraws approval of a form;

under this section, the commissioner shall give the health maintenance organization written notice of the reasons for the disapproval or withdrawal of approval. The notice must inform the health maintenance organization that it may, not more than thirty (30) days after it receives the notice, request a hearing concerning the disapproval or withdrawal of approval. If the health maintenance organization requests a hearing not more than thirty (30) days after it receives the notice, the commissioner shall hold a hearing upon not less than ten (10) days notice to the health maintenance organization.

As added by P.L.26-1994, SEC.25.

IC 27-13-7-12
Additional information required by commissioner

Sec. 12. The commissioner may require the submission of any information the commissioner considers necessary to determine whether to approve or disapprove a filing under this chapter.
As added by P.L.26-1994, SEC.25.

IC 27-13-7-13
Continuation of coverage statement

Sec. 13. (a) A health maintenance organization must include in each contract a written statement that if the contract is terminated by the health maintenance organization, an enrollee who is hospitalized for a medical or surgical condition on the date of termination will have continuation of coverage for inpatient covered services.

(b) The continuation of coverage referred to in subsection (a) is not required after one (1) of the following occurs:

(1) The discharge of the enrollee from the hospital.

(2) Sixty (60) days pass after the contract is terminated by the health maintenance organization.

(3) The hospitalized enrollee obtains from another carrier coverage that includes the coverage provided by the terminating health maintenance organization.

(4) A contract holder terminates the contract with the health maintenance organization, as determined by:

(A) the effective date specified in written communication sent by the contract holder to the health maintenance organization, which effective date shall be at least fifteen (15) days after the date the written communication is placed in the United States mail or sent by facsimile transmission; or

(B) the failure to pay a premium within the grace period permitted under the contract.

(5) Termination of an enrollee by a health maintenance organization due to:

(A) the enrollee knowingly providing false information to the health maintenance organization;

(B) the enrollee's failure to comply with the rules of the health maintenance organization stated in the contract; or

(C) the enrollee's failure to pay a premium within the grace period permitted under contract.

(c) In order to satisfy the requirements of subsection (a), a health maintenance organization may provide benefits that exceed the continuation of coverage required by this section, either in the types or time period of health care services covered, or both.

(d) If an enrollee terminates the enrollee's coverage, the health maintenance organization is not required to provide continuation of coverage to that enrollee under this section after the termination.

(e) This section does not apply to a termination of coverage as the result of the receivership of a health maintenance organization.
As added by P.L.26-1994, SEC.25.

IC 27-13-7-14
Post-mastectomy coverage

Sec. 14. (a) As used in this section, "mastectomy" means the removal of all or part of the breast for reasons that are determined by a licensed physician to be medically necessary.

(b) A contract with a health maintenance organization that provides coverage for a mastectomy must provide coverage as required under 29 U.S.C. 1185b, including coverage for:

(1) prosthetic devices; and

(2) reconstructive surgery incident to a mastectomy including:

(A) all stages of reconstruction of the breast on which the mastectomy has been performed; and

(B) surgery and reconstruction of the other breast to produce symmetry;

in the manner determined by the attending physician and the patient to be appropriate.

(c) Coverage required under this section is subject to:

(1) the deductible and coinsurance provisions applicable to a mastectomy; and

(2) all other terms and conditions applicable to other services under the contract.

(d) A health maintenance organization shall provide to an enrollee, at the time that an individual contract or a group contract is entered into and annually thereafter, written notice of the coverage required under this section. Notice that is sent by the health maintenance organization that meets the requirements set forth in 29 U.S.C. 1185b constitutes compliance with this subsection.

(e) The coverage required under this section applies to a contract with a health maintenance organization that provides coverage for a mastectomy, regardless of whether an individual who:

(1) underwent a mastectomy; and

(2) is covered under the contract;

was covered under the contract at the time of the mastectomy.

(f) This section does not require a health maintenance organization to provide coverage related to post mastectomy care that exceeds the coverage required for post mastectomy care under federal law.

As added by P.L.150-1997, SEC.5. Amended by P.L.2-1998, SEC.71; P.L.96-2002, SEC.3; P.L.204-2003, SEC.2.

IC 27-13-7-14.5
Coverage for nonexperimental, surgical treatment of morbid obesity

Sec. 14.5. (a) As used in this section, "health care provider" means a:

(1) physician licensed under IC 25-22.5; or

(2) hospital licensed under IC 16-21;

that provides health care services for surgical treatment of morbid

obesity.

(b) As used in this section, "morbid obesity" means:

(1) a body mass index of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or

(2) a body mass index of at least forty (40) kilograms per meter squared without comorbidity.

For purposes of this subsection, body mass index equals weight in kilograms divided by height in meters squared.

(c) Except as provided in subsection (d), a health maintenance organization that provides coverage for basic health care services under a group contract shall offer coverage for nonexperimental, surgical treatment by a health care provider of morbid obesity:

(1) that has persisted for at least five (5) years; and

(2) for which nonsurgical treatment that is supervised by a physician has been unsuccessful for at least six (6) consecutive months.

(d) A health maintenance organization that provides coverage for basic health care services may not provide coverage for surgical treatment of morbid obesity for an enrollee who is less than twenty-one (21) years of age unless two (2) physicians licensed under IC 25-22.5 determine that the surgery is necessary to:

(1) save the life of the enrollee; or

(2) restore the enrollee's ability to maintain a major life activity (as defined in IC 4-23-29-6);

and each physician documents in the enrollee's medical record the reason for the physician's determination.

As added by P.L.78-2000, SEC.3. Amended by P.L.196-2005, SEC.6; P.L.102-2006, SEC.5.

IC 27-13-7-14.7

Coverage for autism spectrum disorders

Sec. 14.7. (a) As used in this section, "autism spectrum disorder" means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(b) A group contract with a health maintenance organization that provides basic health care services must provide services for the treatment of an autism spectrum disorder of an enrollee. Services provided to an enrollee under this subsection are limited to services that are prescribed by the enrollee's treating physician in accordance with a treatment plan. A health maintenance organization may not deny or refuse to provide services to, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under a group contract to services to an individual solely because the individual is diagnosed with an autism spectrum disorder.

(c) The services required under subsection (b) may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to an enrollee than the dollar limits, deductibles, copayments, or coinsurance provisions that apply to physical illness generally under the contract with the health maintenance organization.

(d) A health maintenance organization that enters into an individual contract that provides basic health care services must offer to provide services for the treatment of an autism spectrum disorder of an enrollee. Services provided to an enrollee under this subsection are limited to services that are prescribed by the enrollee's treating physician in accordance with a treatment plan. A health maintenance organization may not deny or refuse to provide services to, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under an individual contract to services to an individual solely because the individual is diagnosed with an autism spectrum disorder.

(e) The services that must be offered under subsection (d) may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to an enrollee than the dollar limits, deductibles, copayments, or coinsurance provisions that apply to physical illness generally under the contract with the health maintenance organization.

As added by P.L.148-2001, SEC.3. Amended by P.L.188-2013, SEC.24.

IC 27-13-7-14.8

Treatment limitations or financial requirements on coverage of services for mental illness

Sec. 14.8. (a) As used in this section, "coverage of services for a mental illness" includes the services defined under the contract with the health maintenance organization. However, the term does not include services for the treatment of substance abuse or chemical dependency.

(b) This section applies to a group or individual contract with a health maintenance organization that:

(1) is issued, entered into, or renewed after December 31, 1999; and

(2) is issued to an employer that employs more than fifty (50) full-time employees.

(c) This section does not apply to a legal business entity that has obtained an exemption under IC 27-8-5-15.7.

(d) A group or individual contract with a health maintenance organization may not permit treatment limitations or financial requirements on the coverage of services for a mental illness if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(e) A health maintenance organization that enters into an

individual contract or a group contract that provides coverage of services for the treatment of substance abuse and chemical dependency when the services are required in the treatment of a mental illness shall offer to provide the coverage without treatment limitations or financial requirements if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(f) This section does not require a group or individual contract with a health maintenance organization to offer mental health benefits.

As added by P.L.42-1997, SEC.3. Amended by P.L.81-1999, SEC.5; P.L.226-2003, SEC.2.

IC 27-13-7-15

Dental care provisions required

Sec. 15. (a) As used in this section, "child" means an individual who is less than nineteen (19) years of age.

(b) As used in this section, "enrollee" means an enrollee who is a child or an individual:

(1) with a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual; and

(2) who:

(A) has a record of; or

(B) is regarded as;

having an impairment described in subdivision (1).

(c) A health maintenance organization that provides basic health care services shall include coverage under the terms and conditions of the benefits contract for anesthesia and hospital charges for an enrollee for dental care if the mental or physical condition of the enrollee requires dental treatment to be rendered in a hospital or an ambulatory outpatient surgical center. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the utilization standards for determining whether performing dental procedures necessary to treat the enrollee's condition under general anesthesia constitutes appropriate treatment.

(d) A health maintenance organization may:

(1) require prior authorization for hospitalization or treatment in an ambulatory outpatient surgical center for dental care procedures in the same manner that prior authorization is required for hospitalization or treatment of other covered medical conditions; and

(2) restrict coverage to include only procedures performed by a licensed dentist who has privileges at the hospital or ambulatory outpatient surgical center.

(e) This section does not apply to treatment rendered for temporal mandibular joint disorders (TMJ).

As added by P.L.189-1999, SEC.3.

IC 27-13-7-15.3
Breast cancer screening mammography

Sec. 15.3. (a) As used in this section, "breast cancer screening mammography" has the meaning set forth in IC 27-8-14-2.

(b) As used in this section, "woman at risk" has the meaning set forth in IC 27-8-14-5.

(c) Except as provided in subsection (g), a health maintenance organization issued a certificate of authority in Indiana shall provide breast cancer screening mammography as a covered service under every group contract that provides coverage for basic health care services.

(d) Except as provided in subsection (g), the coverage that a health maintenance organization must provide under this section must include the following:

(1) If the enrollee is at least thirty-five (35) years of age but less than forty (40) years of age and a female, coverage for at least one (1) baseline breast cancer screening mammography performed upon the enrollee before the enrollee becomes forty (40) years of age.

(2) If the enrollee is less than forty (40) years of age and a woman at risk, one (1) breast cancer screening mammography performed upon the enrollee every year.

(3) If the enrollee is at least forty (40) years of age and a female, one (1) breast cancer screening mammography performed upon the enrollee every year.

(4) Any additional mammography views that are required for proper evaluation.

(5) Ultrasound services, if determined medically necessary by the physician treating the enrollee.

(e) Except as provided in subsection (g), the coverage that a health maintenance organization must provide under this section may not be subject to a contract provision that is less favorable to an enrollee or a subscriber than contract provisions applying to physical illness generally under the health maintenance organization contract.

(f) Except as provided in subsection (g), the coverage that a health maintenance organization must provide under this section is in addition to services specifically provided for x-rays, laboratory testing, or wellness examinations.

(g) In the case of coverage that is not employer based, the health maintenance organization must offer to provide the coverage described in subsections (c) through (f).

As added by P.L.170-1999, SEC.5.

IC 27-13-7-16
Prostate specific antigen test

Sec. 16. (a) As used in this section, "prostate specific antigen test"

means a standard blood test performed to determine the level of prostate specific antigen in the blood.

(b) Except as provided in subsection (f), a health maintenance organization issued a certificate of authority in Indiana shall provide prostate specific antigen testing as a covered service under every group contract that provides coverage for basic health care services.

(c) Except as provided in subsection (f), the coverage required under subsection (b) must include the following:

(1) At least one (1) prostate specific antigen test annually for a male enrollee who is at least fifty (50) years of age.

(2) At least one (1) prostate specific antigen test annually for a male enrollee who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

(d) Except as provided in subsection (f), the coverage that a health maintenance organization must provide under this section may not be subject to a contract provision that is less favorable to an enrollee than a contract provision applying to physical illness generally under the health maintenance organization contract.

(e) Except as provided in subsection (f), the coverage that a health maintenance organization must provide under this section is in addition to services specifically provided for x-rays, laboratory testing, or wellness examinations.

(f) In the case of coverage that is not employer based, the health maintenance organization must offer to provide the coverage described in subsections (b) through (e).

As added by P.L.170-1999, SEC.6.

IC 27-13-7-17

Colorectal cancer testing coverage

Sec. 17. (a) As used in this section, "colorectal cancer testing" means examinations and laboratory tests for cancer for any nonsymptomatic enrollee, in accordance with the current American Cancer Society guidelines.

(b) Except as provided in subsection (e), a health maintenance organization issued a certificate of authority in Indiana shall provide colorectal cancer testing as a covered service under every group contract that provides coverage for basic health care services.

(c) For an enrollee who is:

(1) at least fifty (50) years of age; or

(2) less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society;

the colorectal cancer testing required under this section must meet the requirements set forth in subsection (d).

(d) An enrollee may not be required to pay a copayment for the colorectal cancer examination and laboratory testing benefit that is greater than a copayment established for similar benefits under a

group contract. If the group contract does not cover a similar covered service, the copayment may not be set at a level that materially diminishes the value of the colorectal cancer examination and laboratory testing benefit required under this section.

(e) In the case of coverage that is not employer based, the health maintenance organization is required only to offer to provide the colorectal cancer testing described in subsections (b) through (d) as a covered service under a proposed group contract providing coverage for basic health care services.

As added by P.L.54-2000, SEC.3. Amended by P.L.1-2001, SEC.34.

IC 27-13-7-18

Inherited metabolic disease coverage

Sec. 18. (a) As used in this section, "inherited metabolic disease" means a disease:

(1) caused by inborn errors of amino acid, organic acid, or urea cycle metabolism; and

(2) treatable by the dietary restriction of one (1) or more amino acids.

(b) As used in this section, "medical food" means a formula that is:

(1) intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and

(2) formulated to be consumed or administered enterally under the direction of a physician.

(c) A group health maintenance organization contract that provides coverage for basic health care services must provide coverage for medical food that is:

(1) medically necessary; and

(2) prescribed for an enrollee by the enrollee's treating physician for treatment of the enrollee's inherited metabolic disease.

(d) The coverage that must be provided under this section shall not be subject to dollar limits, copayments, or deductibles that are less favorable to an enrollee than the dollar limits, copayments, or deductibles that apply to coverage for:

(1) prescription drugs generally under the group contract, if prescription drugs are covered under the group contract; or

(2) physical illness generally under the group contract, if prescription drugs are not covered under the group contract.

As added by P.L.166-2003, SEC.3.

IC 27-13-7-19

Coverage for orthotic devices and prosthetic devices

Sec. 19. (a) As used in this section, "orthotic device" means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

(b) As used in this section, "prosthetic device" means an artificial leg or arm.

(c) An individual contract or a group contract that provides coverage for basic health care services must provide coverage for orthotic devices and prosthetic devices, including repairs or replacements, that:

(1) are provided or performed by a person that is:

(A) accredited as required under 42 U.S.C. 1395m(a)(20); or

(B) a qualified practitioner (as defined in 42 U.S.C. 1395m(h)(1)(F)(iii));

(2) are determined by the enrollee's physician to be medically necessary to restore or maintain the enrollee's ability to perform activities of daily living or essential job related activities; and

(3) are not solely for comfort or convenience.

(d) The:

(1) coverage required under subsection (c) must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program (42 U.S.C. 1395 et seq.); and

(2) reimbursement under the coverage required under subsection (c) must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

This subsection does not require a deductible under an individual contract or a group contract to be equal to a deductible under the federal Medicare program.

(e) Except as provided in subsections (f) and (g), the coverage required under subsection (c):

(1) may be subject to; and

(2) may not be more restrictive than;

the provisions that apply to other benefits under the individual contract or group contract.

(f) The coverage required under subsection (c) may be subject to utilization review, including periodic review, of the continued medical necessity of the benefit.

(g) Any lifetime maximum coverage limitation that applies to prosthetic devices and orthotic devices:

(1) must not be included in; and

(2) must be equal to;

the lifetime maximum coverage limitation that applies to all other items and services generally under the individual contract or group contract.

(h) For purposes of this subsection, "items and services" does not include preventive services for which coverage is provided under a high deductible health plan (as defined in 26 U.S.C. 220(c)(2) or 26 U.S.C. 223(c)(2)). The coverage required under subsection (c) may not be subject to a deductible, copayment, or coinsurance provision

that is less favorable to an enrollee than the deductible, copayment, or coinsurance provisions that apply to other items and services generally under the individual contract or group contract.
As added by P.L.109-2008, SEC.3.

IC 27-13-7-20
Prohibition on chemotherapy coverage limitations

Sec. 20. (a) This section applies to an individual contract or a group contract that provides coverage for both of the following:

(1) Orally administered cancer chemotherapy.

(2) Cancer chemotherapy that is administered intravenously or by injection.

(b) As used in this section, "cancer chemotherapy" means medication that is prescribed by a physician to kill or slow the growth of cancer cells.

(c) Coverage for orally administered cancer chemotherapy under an individual contract or a group contract must not be subject to dollar limits, copayments, deductibles, or coinsurance provisions that are less favorable to an enrollee than the dollar limits, copayments, deductibles, or coinsurance provisions that apply to coverage for cancer chemotherapy that is administered intravenously or by injection under the individual contract or group contract.
As added by P.L.46-2009, SEC.2.

IC 27-13-7-20.1
Individual or group contract providing coverage for prescription eye drops; refill of prescription eye drops; requirements

Sec. 20.1. (a) This section applies to an individual contract or a group contract that provides coverage for prescription eye drops.

(b) An individual contract or a group contract must provide coverage for a refill of prescription eye drops if the following are met:

(1) For a thirty (30) day supply, the enrollee requests the refill not earlier than twenty-five (25) days from the date the prescription eye drops were last dispensed to the enrollee.

(2) For a ninety (90) day supply, the enrollee requests the refill not earlier than seventy-five (75) days from the date the prescription eye drops were last dispensed to the enrollee.

(3) The prescribing practitioner has indicated on the prescription that the prescription eye drops are refillable and the refill requested by the enrollee does not exceed the refillable amount remaining on the prescription.

(c) The coverage required by subsection (b) must not be subject to dollar limits, copayments, deductibles, or coinsurance provisions that are less favorable to an enrollee than the dollar limits, copayments, deductibles, or coinsurance provisions that apply to coverage for prescription drugs generally under the individual contract or group contract.

(d) This section applies to an individual contract or a group contract issued, delivered, amended, or renewed after December 31, 2015.
As added by P.L.43-2015, SEC.3.

IC 27-13-7-20.2
Coverage for care related to cancer clinical trials

Sec. 20.2. (a) As used in this section, "care method" means the use of a particular drug or device in a particular manner.

(b) As used in this section, "clinical trial" means a Phase I, II, III, or IV research study:

(1) that is conducted:

(A) using a particular care method to prevent, diagnose, or treat a cancer for which:

(i) there is no clearly superior, noninvestigational alternative care method; and

(ii) available clinical or preclinical data provides a reasonable basis from which to believe that the care method used in the research study is at least as effective as any noninvestigational alternative care method;

(B) in a facility where personnel providing the care method to be followed in the research study have:

(i) received training in providing the care method;

(ii) expertise in providing the type of care required for the research study; and

(iii) experience providing the type of care required for the research study to a sufficient volume of patients to maintain expertise; and

(C) to scientifically determine the best care method to prevent, diagnose, or treat the cancer; and

(2) that is approved or funded by one (1) of the following:

(A) A National Institutes of Health institute.

(B) A cooperative group of research facilities that has an established peer review program that is approved by a National Institutes of Health institute or center.

(C) The federal Food and Drug Administration.

(D) The United States Department of Veterans Affairs.

(E) The United States Department of Defense.

(F) The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103.

(G) A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

(c) As used in this section, "nonparticipating provider" means a health care provider that has not entered into an agreement described in IC 27-13-1-24.

(d) As used in this section, "routine care cost" means the cost of medically necessary services related to the care method that is under evaluation in a clinical trial. The term does not include the following:

(1) The health care service, item, or investigational drug that is the subject of the clinical trial.

(2) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial.

(3) Any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.

(4) An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.

(5) Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility where a clinical trial is conducted.

(6) A service, item, or drug that is provided by a clinical trial sponsor free of charge for any new patient.

(7) A service, item, or drug that is eligible for reimbursement from a source other than an enrollee's individual contract or group contract, including the sponsor of the clinical trial.

(e) An individual contract or a group contract must provide coverage for routine care costs that are incurred in the course of a clinical trial if the individual contract or group contract would provide coverage for the same routine care costs not incurred in a clinical trial.

(f) The coverage that must be provided under this section is subject to the terms, conditions, restrictions, exclusions, and limitations that apply generally under the individual contract or group contract, including terms, conditions, restrictions, exclusions, or limitations that apply to health care services rendered by participating providers and nonparticipating providers.

(g) This section does not do any of the following:

(1) Require a health maintenance organization to provide coverage for clinical trial services rendered by a participating provider.

(2) Prohibit a health maintenance organization from providing coverage for clinical trial services rendered by a participating provider.

(3) Require reimbursement under an individual contract or a group contract for services that are rendered in a clinical trial by a nonparticipating provider at the same rate of reimbursement that would apply to the same services rendered by a participating provider.

(h) This section does not create a cause of action against a person for any harm to an enrollee resulting from a clinical trial.

As added by P.L.109-2009, SEC.4.

IC 27-13-7-20.4
Applicability; coverage for methadone for treatment of pain

Sec. 20.4. (a) This section applies to an individual contract or a group contract that is entered into, amended, or renewed after June 30, 2015.

(b) An individual contract or a group contract may provide coverage for methadone if the drug is prescribed for the treatment of pain or pain management only as follows:

(1) If the daily dosage is not more than sixty (60) milligrams.

(2) If the daily dosage is more than sixty (60) milligrams, only if:

(A) prior authorization is obtained; and

(B) a determination of medical necessity has been shown by the provider.

As added by P.L.209-2015, SEC.20.

IC 27-13-7-21
High breast density

Sec. 21. (a) As used in this section, "high breast density" means a condition in which there is a greater amount of breast and connective tissue in comparison to fat in the breast.

(b) An individual contract or a group contract that provides coverage for basic health care services must provide coverage for an appropriate medical screening, test, or examination for a female enrollee who is at least forty (40) years of age and who has been determined to have high breast density.

As added by P.L.126-2013, SEC.5.

IC 27-13-7-22
Coverage for telemedicine services; limitations; application; separate consent prohibited

Sec. 22. (a) An individual contract or a group contract must provide coverage for telemedicine services in accordance with the same clinical criteria as the individual contract or the group contract provides coverage for the same health care services delivered to an enrollee in person.

(b) Coverage for telemedicine services required by subsection (a) may not be subject to a dollar limit, copayment, or coinsurance requirement that is less favorable to an enrollee than the dollar limit, copayment, or coinsurance requirement that applies to the same health care services delivered to an enrollee in person.

(c) Any annual or lifetime dollar limit that applies to telemedicine services must be the same annual or lifetime dollar limit that applies in the aggregate to all items and services covered under the individual contract or the group contract.

(d) This section does not do any of the following:

(1) Require an individual contract or a group contract to provide coverage for a telemedicine service that is not a covered health care service under the individual contract or group contract.

(2) Require the use of telemedicine services when the treating provider has determined that telemedicine services are inappropriate.

(3) Prevent the use of utilization review concerning coverage for telemedicine services in the same manner as utilization review is used concerning coverage for the same health care services delivered to an enrollee in person.

(e) A separate consent for telemedicine services may not be required.

As added by P.L.185-2015, SEC.27.

IC 27-13-7-23

Step therapy protocol

Sec. 23. (a) As used in this section, "group contract" refers to a group contract that provides coverage for prescription drugs.

(b) As used in this section, "health maintenance organization" refers to a health maintenance organization that provides coverage for prescription drugs. The term includes the following:

(1) A limited service health maintenance organization.

(2) A person that administers prescription drug benefits on behalf of a health maintenance organization or a limited service health maintenance organization.

(c) As used in this section, "individual contract" refers to an individual contract that provides coverage for prescription drugs.

(d) As used in this section, "preceding prescription drug" means a prescription drug that, according to a step therapy protocol, must be:

(1) first used to treat an enrollee's condition; and

(2) as a result of the treatment under subdivision (1), determined to be inappropriate to treat the enrollee's condition;

as a condition of coverage under an individual contract or a group contract for succeeding treatment with another prescription drug.

(e) As used in this section, "protocol exception" means a determination by a health maintenance organization that, based on a review of a request for the determination and any supporting documentation:

(1) a step therapy protocol is not medically appropriate for treatment of a particular enrollee's condition; and

(2) the health maintenance organization will:

(A) not require the enrollee's use of a preceding prescription drug under the step therapy protocol; and

(B) provide immediate coverage for another prescription drug that is prescribed for the enrollee.

(f) As used in this section, "step therapy protocol" means a protocol that specifies, as a condition of coverage under an

individual contract or a group contract, the order in which certain prescription drugs must be used to treat an enrollee's condition.

(g) As used in this section, "urgent care situation" means an enrollee's injury or condition about which the following apply:

(1) If medical care or treatment is not provided earlier than the time frame generally considered by the medical profession to be reasonable for a nonurgent situation, the injury or condition could seriously jeopardize the enrollee's:

(A) life or health; or

(B) ability to regain maximum function;

based on a prudent layperson's judgment.

(2) If medical care or treatment is not provided earlier than the time frame generally considered by the medical profession to be reasonable for a nonurgent situation, the injury or condition could subject the enrollee to severe pain that cannot be adequately managed, based on the enrollee's treating health care provider's judgment.

(h) A health maintenance organization shall publish on the health maintenance organization's Internet web site, and provide to an enrollee in writing, a procedure for the enrollee's use in requesting a protocol exception. The procedure must include the following provisions:

(1) A description of the manner in which an enrollee may request a protocol exception.

(2) That the health maintenance organization shall make a determination concerning a protocol exception request, or an appeal of a denial of a protocol exception request, not more than:

(A) in an urgent care situation, one (1) business day after receiving the request or appeal; or

(B) in a nonurgent care situation, three (3) business days after receiving the request or appeal.

(3) That a protocol exception will be granted if any of the following apply:

(A) A preceding prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the enrollee.

(B) A preceding prescription drug is expected to be ineffective, based on both of the following:

(i) The known clinical characteristics of the enrollee.

(ii) Known characteristics of the preceding prescription drug, as found in sound clinical evidence.

(C) The enrollee has previously received:

(i) a preceding prescription drug; or

(ii) another prescription drug that is in the same pharmacologic class or has the same mechanism of action as a preceding prescription drug;

and the prescription drug was discontinued due to lack of

efficacy or effectiveness, diminished effect, or an adverse event.

(D) Based on clinical appropriateness, a preceding prescription drug is not in the best interest of the enrollee because the enrollee's use of the preceding prescription drug is expected to:

(i) cause a significant barrier to the enrollee's adherence to or compliance with the enrollee's plan of care;

(ii) worsen a comorbid condition of the enrollee; or

(iii) decrease the enrollee's ability to achieve or maintain reasonable functional ability in performing daily activities.

(4) That when a protocol exception is granted, the health maintenance organization shall notify the enrollee and the enrollee's health care provider of the authorization for coverage of the prescription drug that is the subject of the protocol exception.

(5) That if:

(A) a protocol exception request; or

(B) an appeal of a denied protocol exception request;

results in a denial of the protocol exception, the health maintenance organization shall provide to the enrollee and the treating health care provider notice of the denial, including a detailed, written explanation of the reason for the denial and the clinical rationale that supports the denial.

(6) That the insurer may request a copy of relevant documentation from the insured's medical record in support of a protocol exception.

As added by P.L.19-2016, SEC.5.

IC 27-13-8

Chapter 8. Annual Report

IC 27-13-8-0.1

Application of certain amendments to chapter

Sec. 0.1. The amendments made to section 2 of this chapter by P.L.133-1999 apply to external grievances filed by enrollees after January 1, 2000.

As added by P.L.220-2011, SEC.458.

IC 27-13-8-1

Filing

Sec. 1. On or before March 1 of each year, a health maintenance organization must file with the commissioner a report that covers the preceding calendar year. The report must be:

(1) made on forms prescribed by the commissioner; and

(2) verified by at least two (2) principal officers of the health maintenance organization.

As added by P.L.26-1994, SEC.25.

IC 27-13-8-1.5

Preparation of annual statement

Sec. 1.5. (a) Each health maintenance organization authorized to conduct business in Indiana and required to file an annual statement with the department under this chapter shall prepare the health maintenance organization's statement:

(1) on the National Association of Insurance Commissioners (NAIC) Annual Statement Blank;

(2) in accordance with NAIC Annual Statement Instructions; and

(3) following practices and procedures prescribed by the most recent NAIC Accounting Practices and Procedures Manual.

(b) To the extent that the NAIC Annual Statement Instructions require disclosure under subsection (a) of compensation paid to or on behalf of a health maintenance organization's officers, directors, or employees, the information may be filed with the department as an exhibit separate from the annual statement blank. The compensation information described under this subsection shall be maintained by the department as confidential and may not be disclosed to the public under IC 5-14-3.

As added by P.L.203-2001, SEC.20.

IC 27-13-8-2

Filings with commissioner; complaint analysis and reporting

Sec. 2. (a) In addition to the report required by section 1 of this chapter, a health maintenance organization shall each year file with the commissioner the following:

(1) Audited financial statements of the health maintenance

organization for the preceding calendar year prepared in conformity with statutory accounting practices prescribed or otherwise permitted by the department.

(2) A list of participating providers who provide health care services to enrollees or subscribers of the health maintenance organization.

(3) A description of the grievance procedure of the health maintenance organization:

(A) established under IC 27-13-10, including:

(i) the total number of grievances handled through the procedure during the preceding calendar year;

(ii) a compilation of the causes underlying those grievances; and

(iii) a summary of the final disposition of those grievances; and

(B) established under IC 27-13-10.1, including:

(i) the total number of external grievances handled through the procedure during the preceding calendar year;

(ii) a compilation of the causes underlying those grievances; and

(iii) a summary of the final disposition of those grievances;

for each independent review organization used by the health maintenance organization during the reporting year.

(4) The percentage of providers credentialed by the health maintenance organization according to the most current standards or guidelines, if any, developed by the National Committee on Quality Assurance or a successor organization.

(5) The RBC report required under IC 27-1-36-25.

(6) The health maintenance organization's Health Plan Employer Data and Information Set (HEDIS) data.

(b) The information required by subsection (a)(2) through (a)(5) must be filed with the commissioner on or before March 1 of each year. The audited financial statements required by subsection (a)(1) must be filed with the commissioner on or before June 1 of each year. The health maintenance organization's HEDIS data required by subsection (a)(6) must be filed with the commissioner on or before July 1 of each year. The commissioner shall:

(1) make the information required to be filed under this section available to the public; and

(2) prepare an annual compilation of the data required under subsection (a)(3), (a)(4), and (a)(6) that allows for comparative analysis.

(c) Upon a determination by a health maintenance organization's auditor that the health maintenance organization:

(1) does not meet the requirements of IC 27-13-12-3; or

(2) is in the condition described in IC 27-13-24-1(a)(5);

the health maintenance organization shall notify the commissioner

within five (5) business days after the auditor's determination.

(d) The commissioner may require any additional reports as are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

(e) The commissioner shall do the following:

(1) Compile and analyze complaints received by the department concerning a denial of coverage under an individual contract or a group contract for:

(A) an investigational or experimental treatment; or

(B) a treatment not considered to be medically necessary for an enrollee.

(2) If the commissioner determines that a pattern of denials of coverage is evident through the analysis performed under subdivision (1), report the pattern to the legislative council in an electronic format under IC 5-14-6.

(3) Remove from a report made under subdivision (2) any information that could be used to identify an individual.

As added by P.L.26-1994, SEC.25. Amended by P.L.195-1996, SEC.5; P.L.191-1997, SEC.2; P.L.133-1999, SEC.1; P.L.133-1999, SEC.2; P.L.203-2001, SEC.21; P.L.51-2002, SEC.10; P.L.18-2016, SEC.4.

IC 27-13-8-3

Annual statement convention blank; quarterly reports

Sec. 3. (a) This section applies to a domestic health maintenance organization that is authorized to transact business in Indiana.

(b) As used in this section, "NAIC" refers to the National Association of Insurance Commissioners.

(c) On or before March 1 of each year, a health maintenance organization shall file with the National Association of Insurance Commissioners and with the department a copy of the health maintenance organization's annual statement convention blank and additional filings prescribed by the commissioner for the preceding year. A health maintenance organization shall also file quarterly statements with the NAIC and with the department, on or before May 15, August 15, and November 15 of each year, in a form prescribed by the commissioner. The information filed with the NAIC under this subsection:

(1) must be:

(A) in the same format; and

(B) of the same scope;

as is required by the commissioner under section 1 of this chapter;

(2) to the extent required by the NAIC, must include the signed jurat page and the actuarial certification; and

(3) must be filed electronically in accordance with NAIC electronic filing specifications.

The commissioner may, for good cause shown, grant an exemption

from the requirement of this section to domestic health maintenance organizations that operate only in Indiana. If a health maintenance organization files any amendment or addendum to the health maintenance organization's annual statement convention blank or quarterly statement with the commissioner, the health maintenance organization shall also file a copy of the amendment or addendum with the NAIC. Annual and quarterly financial statements are considered filed with the NAIC when delivered to the address designated by the NAIC for the filings, regardless of whether the filing is accompanied by any applicable fee.

(d) The commissioner may, for good cause shown, grant a health maintenance organization an extension of time for the filing required by subsection (c).

(e) In the absence of actual malice:

(1) members of the NAIC;

(2) duly authorized committees, subcommittees, and task forces of members of the NAIC;

(3) delegates of members of the NAIC;

(4) employees of the NAIC; and

(5) other persons responsible for collecting, reviewing, analyzing, and disseminating information developed from the filing of annual statement convention blanks under this section;

shall be considered to be acting as agents of the commissioner under the authority of this section and are not subject to civil liability for libel, slander, or any other cause of action by virtue of the collection, review, analysis, or dissemination of the data and information collected from the filings required by this section.

(f) The commissioner may suspend, revoke, or refuse to renew the certificate of authority of a health maintenance organization that fails to file the health maintenance organization's annual statement convention blank or quarterly statements with the NAIC or with the department within the time allowed by subsection (c) or (d).

As added by P.L.203-2001, SEC.22.

IC 27-13-8-4

Civil penalties

Sec. 4. (a) The commissioner may impose a civil penalty of five hundred dollars ($500), after notice and hearing under IC 4-21.5-3, on a health maintenance organization that fails to file an annual statement under this chapter.

(b) A domestic health maintenance organization that fails to file an audited annual financial statement under section 2(a)(1) of this chapter before June 1 of each year without obtaining an extension is subject to a civil penalty of fifty dollars ($50) per day until the report is received by the commissioner.

As added by P.L.203-2001, SEC.23.

IC 27-13-9

Chapter 9. Information to Enrollees or Subscribers

IC 27-13-9-1

List of providers

Sec. 1. (a) Upon:

(1) the enrollment; and

(2) each reenrollment;

of a subscriber, a health maintenance organization must provide to the subscriber in electronic or paper form a list of providers who provide health care services through the health maintenance organization. The health maintenance organization must also provide the list of providers in electronic or paper form to a potential enrollee upon request.

(b) A health maintenance organization shall:

(1) inform a subscriber or potential enrollee that the subscriber or potential enrollee may request a list described in subsection (a) in paper form; and

(2) provide the list in paper form upon the request of the subscriber or potential enrollee.

As added by P.L.26-1994, SEC.25. Amended by P.L.69-1998, SEC.7; P.L.125-2005, SEC.7.

IC 27-13-9-2

Notice of change in operation of health maintenance organization

Sec. 2. Not more than thirty (30) days after any material change in the operation of a health maintenance organization that will directly affect the subscribers or enrollees of the organization, the health maintenance organization shall provide notice of the change to the subscribers or enrollees affected by the change.

As added by P.L.26-1994, SEC.25.

IC 27-13-9-3

Termination of provider

Sec. 3. (a) A health maintenance organization shall notify an enrollee in writing of the termination of:

(1) the provider who currently provides primary health care services to that enrollee;

(2) any other participating provider seen by the enrollee during the previous year; and

(3) a hospital.

(b) After the termination of the provider who provided primary health care services to an enrollee, the health maintenance organization shall assist the enrollee in transferring to another participating primary care provider.

(c) If a health maintenance organization notifies an enrollee of the termination of a hospital, the notice must include the names of all participating providers employed by the hospital.

As added by P.L.26-1994, SEC.25. Amended by P.L.133-1999, SEC.3; P.L.196-2001, SEC.2.

IC 27-13-9-4
Information on services and filing grievances; telephone number

Sec. 4. A health maintenance organization shall provide to each enrollee and subscriber:

(1) information on:

(A) how services can be obtained;

(B) where additional information on access to services can be obtained;

(C) how to file a grievance under IC 27-13-10 and IC 27-13-10.1;

(D) the health maintenance organization's:

(i) structure;

(ii) health care benefits and exclusions; and

(iii) criteria for denying coverage; and

(E) costs for which the enrollee or subscriber is responsible; and

(2) a toll free telephone number through which the enrollee can contact the health maintenance organization at no cost to the enrollee to obtain information and to file grievances.

The information under this section must be provided to a potential enrollee of the health maintenance organization upon request.

As added by P.L.26-1994, SEC.25. Amended by P.L.191-1997, SEC.3; P.L.69-1998, SEC.8; P.L.133-1999, SEC.4.

IC 27-13-9-5
Prescription drug information card

Sec. 5. (a) This section applies to a health maintenance organization that provides coverage for prescription drugs or devices and issues a card or other technology for claims processing.

(b) The card or other technology issued by a health maintenance organization must contain uniform prescription drug information that complies with the requirements established under subsection (c).

(c) Prescription drug information cards or other technology must meet either of the following criteria:

(1) Be in a format and contain information fields approved by the National Council for Prescription Drug Programs (NCPDP) as contained in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide in effect on the October 1 most immediately preceding the issuance of the card.

(2) Contain the following information:

(A) The health benefit plan's name.

(B) The enrollee's name, group number, and identification number.

(C) A telephone number to inquire about pharmacy related

issues.

(D) The issuer's international identification number or ANSI BIN number, labeled as RxBIN.

(E) The processor control number, labeled as RxPCN.

(F) The insured's pharmacy benefits group number if different than medical group number, labeled as RxGRP.

Only those fields listed in clauses (A) through (F) that are required for proper adjudication of the claim must appear on the card. If the card is used to adjudicate non-pharmacy claims, then the designation "Rx" listed in clauses (D) through (F) is not required to be used by the issuer.

(d) A health maintenance organization may not be required to issue a prescription drug information card or other technology to a person more than one (1) time during a twelve (12) month period.

(e) The prescription drug information cards or other technology issued under this section may be used for health care service coverage other than the coverage to which this chapter applies.

As added by P.L.230-2001, SEC.3. Amended by P.L.1-2002, SEC.123.

IC 27-13-10

Chapter 10. Grievance Procedures

IC 27-13-10-1

Establishment of procedures

Sec. 1. A health maintenance organization or limited service health maintenance organization shall establish and maintain a grievance procedure for the resolution of grievances initiated by enrollees and subscribers of the organization. The grievance procedure of a health maintenance organization or limited service health maintenance organization must be approved by the commissioner.

As added by P.L.26-1994, SEC.25. Amended by P.L.191-1997, SEC.4.

IC 27-13-10-2

Examination by commissioner

Sec. 2. The commissioner may examine the grievance procedures of health maintenance organizations and limited service health maintenance organizations.

As added by P.L.26-1994, SEC.25.

IC 27-13-10-3

Records of grievances

Sec. 3. A health maintenance organization or limited service health maintenance organization shall maintain records regarding all grievances of enrollees that the organization has received since the examination by the commissioner of the grievance procedure of the organization that immediately preceded the receipt of the grievances.

As added by P.L.26-1994, SEC.25. Amended by P.L.191-1997, SEC.5.

IC 27-13-10-4

Notice of grievance related information

Sec. 4. (a) A health maintenance organization shall provide, at the request of the enrollee, subscriber, or legal representative of the enrollee or subscriber, and upon contract issuance, at each contract renewal, and with any notice of denial of a claim, timely, adequate, and appropriate notice to each enrollee, subscriber, or legal representative, of:

(1) the grievance procedure under this chapter and IC 27-13-10.1;

(2) information on how to file:

(A) a grievance under this chapter; and

(B) a request for an external grievance review under IC 27-13-10.1; and

(3) the address for the Internet web site established by the department under IC 27-1-3-33.

(b) A health maintenance organization shall prominently display on all notices to enrollees and subscribers the telephone number and address at which a grievance may be filed.

(c) A written description of the enrollee's or subscriber's right to file a grievance must be posted by the provider in a conspicuous public location in each facility that offers services on behalf of a health maintenance organization.

As added by P.L.191-1997, SEC.6. Amended by P.L.133-1999, SEC.5; P.L.18-2016, SEC.5.

IC 27-13-10-5

Filing; oral or written grievance; telephone number; date

Sec. 5. (a) An enrollee or a subscriber may file a grievance orally or in writing.

(b) A health maintenance organization shall make available to enrollees and subscribers a toll free telephone number through which grievances may be filed. The toll free number must:

(1) be staffed by a qualified representative of the health maintenance organization;

(2) be available for at least forty (40) normal business hours per week; and

(3) accept grievances in the languages of the major population groups served.

(c) A grievance is considered to be filed on the first date it is received, either by telephone or in writing.

As added by P.L.191-1997, SEC.7.

IC 27-13-10-6

Filing; procedures; representative

Sec. 6. (a) A health maintenance organization shall establish procedures to assist enrollees and subscribers in filing grievances.

(b) An enrollee or subscriber may designate a representative to file a grievance for the enrollee or subscriber and to represent the enrollee or subscriber in a grievance under this chapter.

As added by P.L.191-1997, SEC.8.

IC 27-13-10-7

Resolution of grievances

Sec. 7. (a) A health maintenance organization shall establish written policies and procedures for the timely resolution of grievances filed under this chapter. The policies and procedures must include the following:

(1) An acknowledgment of the grievance, orally or in writing, to the enrollee or subscriber within three (3) business days.

(2) Documentation of the substance of the grievance and any actions taken.

(3) An investigation of the substance of the grievance, including any aspects involving clinical care.

(4) Notification to the enrollee or subscriber of the disposition of the grievance and the right to appeal.

(5) Standards for timeliness in responding to complaints and providing notice to enrollees and subscribers of the disposition of the complaint and the right to appeal that accommodate the clinical urgency of the situation.

(b) The health maintenance organization shall appoint at least one (1) individual to resolve the complaint.

(c) A grievance must be resolved as expeditiously as possible, but not more than twenty (20) business days after the grievance is filed. If a health maintenance organization is unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond the health maintenance organization's control, the health maintenance organization shall:

(1) notify the enrollee or subscriber in writing of the reason for the delay before the twentieth business day; and

(2) issue a written decision regarding the complaint within an additional ten (10) business days.

(d) A health maintenance organization shall notify the enrollee or subscriber in writing of the resolution of the grievance within five (5) business days after completing the investigation. The grievance resolution notice must contain the following:

(1) The decision reached by the health maintenance organization.

(2) The reasons, policies, and procedures that are the basis of the decision.

(3) Notice of the enrollee's or subscriber's right to appeal the decision.

(4) The department, address, and telephone number through which an enrollee may contact a qualified representative to obtain more information about the decision or the right to appeal.

As added by P.L.191-1997, SEC.9.

IC 27-13-10-8

Appeals of grievance decisions; filing of report for violation

Sec. 8. (a) A health maintenance organization shall establish written policies and procedures for the timely resolution of appeals of grievance decisions. The procedures for registering and responding to oral and written appeals of grievance decisions must include the following:

(1) Acknowledgment of the appeal, orally or in writing, within three (3) business days after receipt of the appeal being filed.

(2) Documentation of the substance of the appeal and the actions taken.

(3) Investigation of the substance of the appeal, including any aspects of clinical care involved.

(4) Notification to enrollees or subscribers of the disposition of

the appeal and that the enrollee or subscriber may have the right to further remedies allowed by law.

(5) Standards for timeliness in responding to appeals and providing notice to enrollees or subscribers of the disposition of the appeal and the right to initiate an external appeals process that accommodate the clinical urgency of the situation.

(b) The health maintenance organization shall appoint a panel of qualified individuals to resolve an appeal. An individual may not be appointed to the panel who has been involved in the matter giving rise to the complaint or in the initial investigation of the complaint. Except for grievances that have previously been appealed under IC 27-8-17, in the case of an appeal from the proposal, refusal, or delivery of a health care procedure, treatment, or service, the health maintenance organization shall appoint one (1) or more individuals to the panel to resolve the appeal. The panel must include one (1) or more individuals who:

(1) have knowledge in the medical condition, procedure, or treatment at issue;

(2) are in the same licensed profession as the provider who proposed, refused, or delivered the health care procedure, treatment, or service;

(3) are not involved in the matter giving rise to the appeal or the previous grievance process; and

(4) do not have a direct business relationship with the enrollee or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.

(c) An appeal of a grievance decision must be resolved as expeditiously as possible and with regard to the clinical urgency of the appeal. However, an appeal must be resolved not later than forty-five (45) days after the appeal is filed. A health maintenance organization that violates this subsection commits an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4.

(d) If a health maintenance organization violates subsection (c), the health maintenance organization shall file a report with the department during the quarter in which the violation occurred concerning the insurer's compliance with subsection (c). The report must include the following:

(1) The number of appealed grievance decisions that were not resolved as required under subsection (c).

(2) The reason each appeal described in subdivision (1) was not resolved.

(e) A health maintenance organization shall allow enrollees and subscribers the opportunity to appear in person at the panel or to communicate with the panel through appropriate other means if the enrollee or subscriber is unable to appear in person.

(f) A health maintenance organization shall notify the enrollee or

subscriber in writing of the resolution of the appeal of a grievance within five (5) business days after completing the investigation. The grievance resolution notice must contain the following:

(1) The decision reached by the health maintenance organization.

(2) The reasons, policies, or procedures that are the basis of the decision.

(3) Notice of the enrollee's or subscriber's right to further remedies allowed by law, including the right to review by an independent review organization under IC 27-13-10.1.

(4) The department, address, and telephone number through which an enrollee may contact a qualified representative to obtain more information about the decision or the right to an appeal.

As added by P.L.191-1997, SEC.10. Amended by P.L.133-1999, SEC.6; P.L.178-2003, SEC.85.

IC 27-13-10-11

Action against provider representing enrollee or subscriber

Sec. 11. A health maintenance organization may not take action against a provider solely on the basis that the provider represents an enrollee or subscriber in a grievance filed under this chapter.

As added by P.L.191-1997, SEC.11.

IC 27-13-10-12

Approval of grievance and appeals procedures

Sec. 12. (a) Notwithstanding IC 27-13, the department shall approve the grievance and appeals procedures of a health maintenance organization if:

(1) the health maintenance organization certifies in writing to the department of the health maintenance organization's compliance with grievance and appeals procedures established by the federal Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services; and

(2) the department certifies that the grievance and appeals procedures established by the federal Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services are substantially similar to the grievance and appeals process in IC 27-13.

(b) Subsection (a) does not:

(1) limit the authority of the department;

(2) limit the responsibility of a health maintenance organization;

(3) release a health maintenance organization from the prohibitions established under section 11 of this chapter; or

(4) require a health maintenance organization to use a grievance and appeals procedure established by the federal Centers for

Medicare and Medicaid Services of the United States Department of Health and Human Services.

As added by P.L.191-1997, SEC.12. Amended by P.L.66-2002, SEC.17.

IC 27-13-10-13

Adoption of rules

Sec. 13. The department may adopt rules under IC 4-22-2 to implement this chapter.

As added by P.L.191-1997, SEC.13.

IC 27-13-10.1

Chapter 10.1. External Review of Grievances

IC 27-13-10.1-0.1

Application of chapter

Sec. 0.1. The addition of this chapter by P.L.133-1999 applies to grievances filed under IC 27-13-10-5 after January 1, 2000.

As added by P.L.220-2011, SEC.459.

IC 27-13-10.1-1

External grievance procedure established

Sec. 1. A health maintenance organization shall establish and maintain an external grievance procedure for the resolution of grievances regarding the following:

(1) The following determinations made by the health maintenance organization or an agent of the health maintenance organization regarding a service proposed by the treating physician:

(A) An adverse utilization review determination (as defined in IC 27-8-17-8).

(B) An adverse determination of medical necessity.

(C) A determination that a proposed service is experimental or investigational.

(2) The health maintenance organization's decision to rescind an individual contract or a group contract.

As added by P.L.133-1999, SEC.7. Amended by P.L.160-2011, SEC.28.

IC 27-13-10.1-2

Requirements of procedure

Sec. 2. (a) An external grievance procedure established under section 1 of this chapter must:

(1) allow an enrollee or the enrollee's representative to file a written request with the health maintenance organization for an appeal of the health maintenance organization's grievance resolution under IC 27-13-10-8 not later than one hundred twenty (120) days after the enrollee is notified of the resolution under IC 27-13-10-8; and

(2) provide for:

(A) an expedited appeal for a grievance related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the enrollee's:

(i) life or health; or

(ii) ability to reach and maintain maximum function; or

(B) a standard appeal for a grievance not described in clause (A).

An enrollee may file not more than one (1) appeal of a health maintenance organization's grievance resolution under this chapter.

(b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the health maintenance organization shall:

(1) select a different independent review organization for each appeal filed under this chapter from the list of independent review organizations that are certified by the department under section 8 of this chapter; and

(2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

(c) The independent review organizations shall assign a medical review professional who is board certified in the applicable specialty for resolution of an appeal.

(d) The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:

(1) The health maintenance organization.

(2) Any officer, director, or management employee of the health maintenance organization.

(3) The physician or the physician's medical group that is proposing the service.

(4) The facility at which the service would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating physician.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to enrollees of the health maintenance organization and may have an affiliation that is limited to staff privileges at the health facility if the affiliation is disclosed to the enrollee and the health maintenance organization before commencing the review and neither the enrollee nor the health maintenance organization objects.

(e) The enrollee shall not pay any of the costs associated with the services of an independent review organization under this chapter. All costs must be paid by the health maintenance organization.

As added by P.L.133-1999, SEC.7. Amended by P.L.160-2011, SEC.29; P.L.81-2012, SEC.41.

IC 27-13-10.1-3

Cooperation with review organization; requirements of enrollee

Sec. 3. (a) An enrollee who files an appeal under this chapter shall:

(1) not be subject to retaliation for exercising the enrollee's right to an appeal under this chapter;

(2) be permitted to utilize the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the review process;

(3) be permitted to submit additional information relating to the proposed service throughout the review process; and
(4) cooperate with the independent review organization by:
(A) providing any requested medical information; or
(B) authorizing the release of necessary medical information.

(b) A health maintenance organization shall cooperate with an independent review organization selected under section 2 of this chapter by promptly providing any information requested by the independent review organization.

As added by P.L.133-1999, SEC.7.

IC 27-13-10.1-4
Requirements of independent review organization

Sec. 4. (a) An independent review organization shall:
(1) for an expedited appeal filed under section 2(a)(2)(A) of this chapter, within seventy-two (72) hours after the appeal is filed; or
(2) for a standard appeal filed under section 2(a)(2)(B) of this chapter, within fifteen (15) business days after the appeal is filed;

make a determination to uphold or reverse the health maintenance organization's grievance resolution under IC 27-13-10-8 based on information gathered from the enrollee or the enrollee's designee, the health maintenance organization, and the treating physician, and any additional information that the independent review organization considers necessary and appropriate.

(b) When making the determination under this section, the independent review organization shall apply:
(1) standards of decision making that are based on objective clinical evidence; and
(2) the terms of the enrollee's benefit contract.

(c) The independent review organization shall notify the health maintenance organization and the enrollee of the determination made under this section:
(1) for an expedited appeal filed under section 2(a)(2)(A) of this chapter, within seventy-two (72) hours after the appeal is filed; or
(2) for a standard appeal filed under section 2(a)(2)(B) of this chapter, within seventy-two (72) hours after making the determination.

As added by P.L.133-1999, SEC.7. Amended by P.L.72-2016, SEC.26.

IC 27-13-10.1-4.5
Information from independent review organization

Sec. 4.5. Upon the request of an enrollee who is notified under section 4(c) of this chapter that the independent review organization has made a determination, the independent review organization shall

provide to the enrollee all information reasonably necessary to enable the enrollee to understand the:

(1) effect of the determination on the enrollee; and

(2) manner in which the health maintenance organization may be expected to respond to the determination.

As added by P.L.173-2007, SEC.43.

IC 27-13-10.1-5

Determination binding on health maintenance organization

Sec. 5. A determination made under section 4 of this chapter is binding on the health maintenance organization.

As added by P.L.133-1999, SEC.7.

IC 27-13-10.1-6

Reconsideration of resolution

Sec. 6. (a) If at any time during an external review performed under this chapter, the enrollee submits information to the health maintenance organization that is relevant to the health maintenance organization's resolution under IC 27-13-10-8 and was not considered by the health maintenance organization under IC 27-13-10:

(1) the health maintenance organization shall reconsider the health maintenance organization's resolution under IC 27-13-10-8; and

(2) the independent review organization shall cease the external review process until the reconsideration under subsection (b) is completed.

(b) A health maintenance organization to which information is submitted under subsection (a) shall reconsider the resolution under IC 27-13-10-8 based on the information and notify the enrollee of the health maintenance organization's decision:

(1) within seventy-two (72) hours after the information is submitted for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the enrollee's:

(A) life or health; or

(B) ability to reach and maintain maximum function; or

(2) within fifteen (15) days after the information is submitted for a reconsideration not described in subdivision (1).

(c) If the decision reached under subsection (b) is adverse to the enrollee, the enrollee may request that the independent review organization resume the external review under this chapter.

As added by P.L.133-1999, SEC.7.

IC 27-13-10.1-7

Terms of coverage unchanged

Sec. 7. This chapter does not add to or otherwise change the terms of coverage included in a contract under which an enrollee receives health care benefits under IC 27-13.

As added by P.L.133-1999, SEC.7.

IC 27-13-10.1-8
Certification of independent review organizations

Sec. 8. (a) The department shall establish and maintain a process for annual certification of independent review organizations.

(b) The department shall certify a number of independent review organizations determined by the department to be sufficient to fulfill the purposes of this chapter.

(c) An independent review organization shall meet the following minimum requirements for certification by the department:

(1) Medical review professionals assigned by the independent review organization to perform external grievance reviews under this chapter:

(A) must be board certified in the specialty in which an enrollee's proposed service would be provided;

(B) must be knowledgeable about a proposed service through actual clinical experience;

(C) must hold an unlimited license to practice in a state of the United States; and

(D) must have no history of disciplinary actions or sanctions including:

(i) loss of staff privileges; or

(ii) restriction on participation;

taken or pending by any hospital, government, or regulatory body.

(2) The independent review organization must have a quality assurance mechanism to ensure the:

(A) timeliness and quality of reviews;

(B) qualifications and independence of medical review professionals;

(C) confidentiality of medical records and other review materials; and

(D) satisfaction of enrollees with the procedures utilized by the independent review organization, including the use of enrollee satisfaction surveys.

(3) The independent review organization must file with the department the following information before March 1 of each year:

(A) The number and percentage of determinations made in favor of enrollees.

(B) The number and percentage of determinations made in favor of health maintenance organizations.

(C) The average time to process a determination.

(D) The number of external grievance reviews terminated due to reconsideration of the health maintenance organization before a determination was made.

(E) Any other information required by the department.

The information required under this subdivision must be specified for each health maintenance organization for which the independent review organization performed reviews during the reporting year.

(4) The independent review organization must retain all records related to an external grievance review for at least three (3) years after a determination is made under section 4 of this chapter.

(5) Any additional requirements established by the department.

(d) The department may not certify an independent review organization that is one (1) of the following:

(1) A professional or trade association of health care providers or a subsidiary or an affiliate of a professional or trade association of health care providers.

(2) A health insurer, health maintenance organization, or health plan association or a subsidiary or an affiliate of a health insurer, health maintenance organization, or health plan association.

(e) The department may suspend or revoke an independent review organization's certification if the department finds that the independent review organization is not in substantial compliance with the certification requirements under this section.

(f) The department shall make available to health maintenance organizations a list of all certified independent review organizations.

(g) The department shall make the information provided to the department under subsection (c)(3) available to the public in a format that does not identify individual enrollees.

As added by P.L.133-1999, SEC.7. Amended by P.L.14-2000, SEC.60; P.L.160-2011, SEC.30.

IC 27-13-10.1-9
Confidentiality

Sec. 9. Except as provided in section 8(g) of this chapter, documents and other information created or received by the independent review organization or the medical review professional in connection with an external review under this chapter:

(1) are not public records;

(2) may not be disclosed under IC 5-14-3; and

(3) must be treated in accordance with confidentiality requirements of state and federal law.

As added by P.L.133-1999, SEC.7.

IC 27-13-10.1-10
Immunity from civil liability

Sec. 10. (a) An independent review organization is immune from civil liability for actions taken in good faith in connection with an external review under this chapter.

(b) The work product or determination, or both, of an independent

review organization under this chapter are admissible in a judicial or administrative proceeding. However, the work product or determination, or both, do not, without other supporting evidence, satisfy any party's burden of proof or persuasion concerning any material issue of fact or law.
As added by P.L.133-1999, SEC.7.

IC 27-13-10.1-11
Medicare review

Sec. 11. If an enrollee has the right to an external review under Medicare (42 U.S.C. 1395 et seq.) the enrollee may not request an external review under this chapter.
As added by P.L.133-1999, SEC.7.

IC 27-13-10.1-12
Adoption of rules

Sec. 12. The department may adopt rules under IC 4-22-2 to implement this chapter.
As added by P.L.133-1999, SEC.7.

IC 27-13-11

Chapter 11. Investments

IC 27-13-11-1

Permitted investments

Sec. 1. Except for investments under IC 27-13-4-1(a)(1), the funds of a health maintenance organization or limited service health maintenance organization may be invested only as follows:

(1) The funds of a health maintenance organization or limited service health maintenance organization that is domiciled in Indiana may be invested only in the types of securities and other investments in which investment is authorized under IC 27-1-13-3.

(2) The funds of a foreign corporation (as defined in IC 27-1-2-3) that obtains a certificate of authority to operate a health maintenance organization under IC 27-13-2-3 or a limited service health maintenance organization under IC 27-13-34-9 may be invested only in the types of securities and other investments in which investment is authorized:

(A) under the law of the state in which the foreign corporation is domiciled, if that law is acceptable to the commissioner; or

(B) under IC 27-1-13-3, if the law of the state in which the foreign corporation is domiciled is silent or if the law of that state is not acceptable to the commissioner.

As added by P.L.26-1994, SEC.25.

IC 27-13-12

Chapter 12. Protection Against Insolvency; Net Worth Requirements

IC 27-13-12-1

"Net worth" defined; computation

Sec. 1. (a) As used in this chapter, "net worth" means the excess of total assets over total liabilities, excluding liabilities that have been subordinated in a manner acceptable to the commissioner.

(b) For the purposes of computing net worth, the total assets must be reduced by the value assigned to the following intangible assets:

(1) Goodwill.

(2) Going concern value.

(3) Organizational expense.

(4) Start-up costs.

(5) Long term prepayments of deferred charges.

(6) Nonreturnable deposits.

(7) Obligations of officers, directors, owners, or affiliates, except short term obligations of affiliates for goods or services that:

(A) arise in the normal course of business;

(B) are payable on the same terms as equivalent transactions with nonaffiliates; and

(C) are not past due.

(c) For purposes of computing net worth, the health maintenance organization may include in its assets the value assigned to the following:

(1) Medical equipment that:

(A) is owned by the health maintenance organization and is not subject to any lien, claim, or encumbrance;

(B) is used in the treatment, diagnosis, or care of enrollees of the health maintenance organization;

(C) has an initial cost of at least three thousand dollars ($3,000) for each piece of equipment; and

(D) has a useful life of at least two (2) years.

(2) Data processing equipment that is:

(A) owned by the health maintenance organization and is not subject to any lien, claim, or encumbrance; and

(B) used in the operation of the health maintenance organization.

(d) The value assigned to the assets described in subsection (c) must equal the lesser of:

(1) the fair market value; or

(2) the cost of the equipment, minus its accumulated depreciation, calculated in accordance with generally accepted accounting principles.

(e) The aggregate value of the medical equipment described in subsection (c)(1) may not exceed thirty percent (30%) of the total

assets permitted to be included in the computation of net worth.
As added by P.L.26-1994, SEC.25. Amended by P.L.195-1996, SEC.6.

IC 27-13-12-2
Initial minimum net worth

Sec. 2. Before issuing a certificate of authority to a health maintenance organization, the commissioner shall require that the health maintenance organization:

(1) have an initial net worth of at least one million five hundred thousand dollars ($1,500,000); and

(2) maintain, after issuance of the certificate, at least the minimum net worth required under section 3 of this chapter.

As added by P.L.26-1994, SEC.25.

IC 27-13-12-3
Maintenance of minimum net worth

Sec. 3. Except as provided in sections 4 and 5 of this chapter, a health maintenance organization shall maintain a minimum net worth equal to the greater of:

(1) one million dollars ($1,000,000);

(2) based on annual premium revenues as reported on the most recent annual financial statement filed with the commissioner, the total of two percent (2%) of annual premium revenues on the first one hundred fifty million dollars ($150,000,000) of premium and one percent (1%) of annual premium on the premium in excess of one hundred fifty million dollars ($150,000,000);

(3) an amount equal to the sum of three (3) months of uncovered health care expenditures, as reported on the most recent financial statement of the health maintenance organization filed with the commissioner under IC 27-13-8-2(a)(1); or

(4) an amount equal to the sum of:

(A) eight percent (8%) of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and

(B) four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.

As added by P.L.26-1994, SEC.25.

IC 27-13-12-4
Net worth schedule

Sec. 4. A health maintenance organization licensed before July 1, 1994, must maintain a net worth equal to the following:

(1) Twenty-five percent (25%) of the amount required under

section 3 of this chapter by December 31, 1994.

(2) Fifty percent (50%) of the amount required under section 3 of this chapter by December 31, 1995.

(3) Seventy-five percent (75%) of the amount required under section 3 of this chapter by December 31, 1996.

(4) One hundred percent (100%) of the amount required under section 3 of this chapter by December 31, 1997.

As added by P.L.26-1994, SEC.25.

IC 27-13-12-5

Consideration of debts

Sec. 5. (a) In determining net worth under this chapter, a debt may not be considered fully subordinated unless:

(1) the subordination clause is in a form acceptable to the commissioner; and

(2) any interest obligation relating to the repayment of the subordinated debt is subordinated under a clause that is in a form acceptable to the commissioner.

(b) The interest expense relating to the repayment of any fully subordinated debt is considered a covered expense.

(c) Any debt that:

(1) is incurred through a note that meets the requirements of this chapter; and

(2) is otherwise acceptable to the commissioner;

may not be considered liability and must be recorded as equity.

As added by P.L.26-1994, SEC.25.

IC 27-13-12-6

Adoption of rules

Sec. 6. The commissioner may adopt rules to further define whether and to what extent the assets of a health maintenance organization may be considered admitted assets for purposes of complying with the requirements of this chapter.

As added by P.L.26-1994, SEC.25.

IC 27-13-13

Chapter 13. Protection Against Insolvency; Deposit Requirements

IC 27-13-13-1

Items deposited; minimum value

Sec. 1. Except as provided in this chapter, a health maintenance organization shall deposit with the commissioner or, at the discretion of the commissioner, with any bank or bank and trust company or other trustee acceptable to the commissioner through which a custodial or controlled account is used:

(1) cash;

(2) certificates of deposit;

(3) United States government obligations acceptable to the commissioner;

(4) any other securities acceptable to the commissioner; or

(5) a combination of items described in subdivisions (1) through (4);

which at all times must have a value of at least five hundred thousand dollars ($500,000).

As added by P.L.26-1994, SEC.25.

IC 27-13-13-2

Deposit schedule

Sec. 2. A health maintenance organization that is in operation on July 1, 1994, shall make:

(1) a deposit with the commissioner equal to two hundred fifty thousand dollars ($250,000) on July 1, 1994; and

(2) an additional deposit with the commissioner equal to two hundred fifty thousand dollars ($250,000) by December 31, 1995.

As added by P.L.26-1994, SEC.25.

IC 27-13-13-3

Deposits considered admitted asset

Sec. 3. Deposits made under this chapter shall be considered an admitted asset of the health maintenance organization in the determination of the net worth of the organization.

As added by P.L.26-1994, SEC.25.

IC 27-13-13-4

Income from deposits; replacing deposits

Sec. 4. (a) All income from deposits made under this chapter is an asset of the organization that made the deposits.

(b) A health maintenance organization that has made a deposit under this chapter may replace the deposit or any part of the deposit with an equal amount and value of:

(1) cash;

(2) certificates of deposit;
(3) United States government obligations acceptable to the commissioner;
(4) any other securities acceptable to the commissioner; or
(5) any combination of subdivisions (1) through (4).

(c) Any obligations of the United States government must be approved by the commissioner before being deposited or substituted under this chapter.

As added by P.L.26-1994, SEC.25.

IC 27-13-13-5
Use of deposit

Sec. 5. (a) A deposit made by a health maintenance organization under this chapter must be used:
(1) to protect the interest of the enrollees of the health maintenance organization; and
(2) to ensure continuation of health care services to enrollees of the health maintenance organization, if the health maintenance organization is in supervision, rehabilitation, or liquidation.

(b) The commissioner may use the deposit for administrative costs that are attributable to a receivership of the health maintenance organization.

(c) If the health maintenance organization is placed in receivership, the deposit made by the organization must be treated as an asset of the organization subject to IC 27-9.

As added by P.L.26-1994, SEC.25.

IC 27-13-13-6
Reduction or elimination of deposit requirements for foreign corporations

Sec. 6. The commissioner may reduce or eliminate the requirement of a deposit under this chapter for a health maintenance organization that is a foreign corporation as defined in IC 27-1-2-3 if:
(1) the organization makes a deposit that meets the requirements of section 1 of this chapter with the treasurer of state, insurance commissioner, or other official body of the state or jurisdiction in which the organization is domiciled for the protection of all subscribers and enrollees of the health maintenance organization; and
(2) the organization delivers to the commissioner a certificate, duly authenticated by the appropriate state official holding the deposit, that the requirements of this section have been met.

As added by P.L.26-1994, SEC.25.

IC 27-13-13-7
Return of deposit

Sec. 7. If:

(1) a health maintenance organization ceases operation for reasons other than:
(A) insolvency; or
(B) receivership;
(2) the organization is not a debtor in any pending bankruptcy proceeding;
(3) the health maintenance organization submits a request in writing to the commissioner for the return of the deposit made by the organization; and
(4) the health maintenance organization has furnished the commissioner with written proof that all claims liabilities of the health maintenance organization have been paid;

the commissioner shall return all or a part of the deposit to the health maintenance organization not more than thirty (30) days after the commissioner receives written proof from the organization under subdivision (4).

As added by P.L.26-1994, SEC.25.

IC 27-13-13-8

Additional financial requirements

Sec. 8. (a) In addition to meeting all other financial requirements imposed by IC 27-13-12 and this chapter, a health maintenance organization that offers a point of service product shall maintain either of the following:

(1) A reinsurance agreement, which must be satisfactory to the commissioner, that cedes one hundred percent (100%) of the liability for out-of-plan services.
(2) A ratio of the revenues of the health maintenance organization from the point of service product to the net worth of the organization of not more than three (3) to one (1).

(b) The reinsurance to which subsection (a)(1) refers may be used to:

(1) directly make payments for out-of-plan services; or
(2) reinsure coverage for out-of-plan services.

(c) To achieve the ratio referred to in subsection (a)(2), a health maintenance organization may use reinsurance to cede part or all of the liability for out-of-plan services.

As added by P.L.26-1994, SEC.25.

IC 27-13-13-9

Deposit of cash or securities for noncovered health care expenditures

Sec. 9. (a) As used in this section, "noncovered health care expenditures" means the costs to a health maintenance organization for health care services:

(1) that are the obligation of the health maintenance organization;
(2) for which the enrollee may be liable in the event of the

health maintenance organization's insolvency; and

(3) for which:

(A) no alternative arrangements have been made that are acceptable to the commissioner; or

(B) statutory deposits and net worth of the health maintenance organization are determined by the commissioner to be inadequate.

(b) If noncovered health care expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall deposit cash or securities that are acceptable to the commissioner with:

(1) the commissioner; or

(2) an organization or trustee approved by the commissioner through which a custodial or controlled account is maintained.

(c) The deposit made under subsection (b) must have a fair market value:

(1) calculated on the first day of each month; and

(2) maintained for the remainder of the month;

of not less than one hundred twenty percent (120%) of the health maintenance organization's outstanding liability for noncovered health care expenditures for enrollees in Indiana, including incurred but not reported claims.

(d) The commissioner may require a health maintenance organization to file periodic reports, including reports on liability for noncovered health care expenditures and audit opinions, that the commissioner considers necessary to monitor compliance with this section.

As added by P.L.203-2001, SEC.24.

IC 27-13-14
Chapter 14. Protection Against Insolvency; Liabilities

IC 27-13-14-1
Determination of liabilities

Sec. 1. When determining its liabilities, a health maintenance organization shall include an amount estimated in the aggregate to provide:

(1) for any unearned premium;

(2) for the payment of all claims for health care expenditures, whether reported or unreported:

(A) that have been incurred;

(B) that are unpaid; and

(C) for which the organization is or may be liable; and

(3) for the expense of adjustment or settlement of claims described in subdivision (2).

As added by P.L.26-1994, SEC.25.

IC 27-13-14-2
Computation of liabilities

Sec. 2. The liabilities of a health maintenance organization must be computed:

(1) in accordance with rules adopted by the commissioner; and

(2) upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

As added by P.L.26-1994, SEC.25.

IC 27-13-15

Chapter 15. Participating Providers; Contracts and Legal Actions

IC 27-13-15-0.1

Application of certain amendments to chapter

Sec. 0.1. The addition of section 4 of this chapter by P.L.74-2007 applies to a contract between a health maintenance organization and a participating provider that is entered into, amended, or renewed on or after April 26, 2007.

As added by P.L.220-2011, SEC.460.

IC 27-13-15-1

Contract requirements; enrollee coverage; payment of provider; application

Sec. 1. (a) A contract between a health maintenance organization and a participating provider of health care services:

(1) must be in writing;

(2) may not prohibit the participating provider from disclosing:

(A) the terms of the contract as it relates to financial or other incentives to limit medical services by the participating provider; or

(B) all treatment options available to an insured, including those not covered by the insured's policy;

(3) may not provide for a financial or other penalty to a provider for making a disclosure permitted under subdivision (2); and

(4) must provide that in the event the health maintenance organization fails to pay for health care services as specified by the contract, the subscriber or enrollee is not liable to the participating provider for any sums owed by the health maintenance organization.

(b) An enrollee is not entitled to coverage of a health care service under a group or an individual contract unless that health care service is included in the enrollee's contract.

(c) A provider is not entitled to payment under a contract for health care services provided to an enrollee unless the provider has a contract or an agreement with the carrier.

(d) This section applies to a contract entered, renewed, or modified after June 30, 1996.

As added by P.L.26-1994, SEC.25. Amended by P.L.195-1996, SEC.7; P.L.192-1996, SEC.3.

IC 27-13-15-2

Contract requirements not met; collection of money owed by health maintenance organization prohibited

Sec. 2. If:

(1) the contract between a health maintenance organization and a participating provider has not been reduced to writing as

required by this chapter; or

(2) the contract fails to contain the provision required by section 1(a)(4) of this chapter;

the participating provider may not collect or attempt to collect from the subscriber or enrollee any sums that are owed by the health maintenance organization.

As added by P.L.26-1994, SEC.25. Amended by P.L.203-2001, SEC.25.

IC 27-13-15-3

Actions against subscribers; costs and attorney's fees

Sec. 3. (a) A:

(1) participating provider; or

(2) trustee, an agent, a representative, or an assignee of a participating provider;

may not bring or maintain any legal action against a subscriber or an enrollee of a health maintenance organization to collect sums owed by the health maintenance organization.

(b) Except as provided in subsection (c), if a participating provider of a health maintenance organization brings or maintains a legal action against a subscriber or enrollee for an amount owed to the participating provider by the health maintenance organization, the participating provider is liable to the subscriber or enrollee for costs and attorney's fees incurred by the subscriber or enrollee in defending the legal action.

(c) A participating provider shall not be liable to the subscriber or enrollee for costs and attorney's fees described in subsection (b) if the participating provider can demonstrate a reasonable basis for believing at the time the legal action was brought and while the legal action was maintained that the health maintenance organization did not owe the sums the participating provider sought to collect from the subscriber or enrollee.

As added by P.L.26-1994, SEC.25. Amended by P.L.203-2001, SEC.26.

IC 27-13-15-4

Participating provider agreement prohibitions

Sec. 4. (a) As used in this section, "health maintenance organization" includes the following:

(1) A limited service health maintenance organization.

(2) A person that pays or administers claims on behalf of a health maintenance organization or a limited service health maintenance organization.

(b) An agreement between a health maintenance organization and a participating provider under this chapter may not contain a provision that:

(1) prohibits, or grants the health maintenance organization an option to prohibit, the participating provider from contracting

with another health maintenance organization to accept lower payment for health care services than the payment specified in the agreement;

(2) requires, or grants the health maintenance organization an option to require, the participating provider to accept a lower payment from the health maintenance organization if the participating provider agrees with another health maintenance organization to accept lower payment for health care services;

(3) requires, or grants the health maintenance organization an option of, termination or renegotiation of the agreement if the participating provider agrees with another health maintenance organization to accept lower payment for health care services; or

(4) requires the participating provider to disclose the participating provider's reimbursement rates under contracts with other health maintenance organizations.

(c) A contract provision that violates this section is void.

As added by P.L.74-2007, SEC.2.

IC 27-13-15-5

Coverage for dialysis treatment

Sec. 5. (a) Notwithstanding IC 27-13-1-12, as used in this section, "enrollee" refers only to an enrollee who requires dialysis treatment.

(b) As used in this section, "health maintenance organization" includes the following:

(1) A limited service health maintenance organization.

(2) An agent of a health maintenance organization or a limited service health maintenance organization.

(c) A health maintenance organization shall not require an enrollee, as a condition of coverage or reimbursement, to:

(1) if the nearest dialysis facility is located within thirty (30) miles of the enrollee's home, travel more than thirty (30) miles from the enrollee's home to obtain dialysis treatment; or

(2) if the nearest dialysis facility is located more than thirty (30) miles from the enrollee's home, travel a greater distance than the distance to the nearest dialysis facility to obtain dialysis treatment;

regardless of whether the enrollee chooses to receive dialysis treatment at a dialysis facility that is a participating provider or a dialysis facility that is not a participating provider.

As added by P.L.111-2008, SEC.6.

IC 27-13-16

Chapter 16. Protection Against Receivership; Continuation of Benefits

IC 27-13-16-1

Plan for receivership

Sec. 1. The commissioner shall require a health maintenance organization to have a plan for handling receivership that allows for the continuation of benefits after the date of receivership:

(1) for the duration of the contract period for which premiums have been paid; or

(2) if an enrollee is hospitalized on the date of receivership for the longer of:

(A) the period ending when the enrollee is discharged from hospitalization; or

(B) the duration of the contract period for which premiums have been paid.

As added by P.L.26-1994, SEC.25. Amended by P.L.83-2003, SEC.1.

IC 27-13-16-2

Requirements of commissioner to ensure continuation of benefits

Sec. 2. (a) In considering the plan prepared by a health maintenance organization under section 1 of this chapter, the commissioner may require one (1) or more of the following:

(1) Insurance to cover the expenses to be paid for continued benefits after receivership.

(2) Receivership reserves.

(3) Any other arrangements to ensure that benefits are continued as required by section 1 of this chapter.

(b) However, the commissioner may not require provisions in contracts between the health maintenance organization and participating providers that obligate a provider to provide services after the organization enters receivership.

As added by P.L.26-1994, SEC.25.

IC 27-13-16-3

Termination of continuation of benefits

Sec. 3. The continuation of benefits required under section 1 of this chapter shall terminate on the date that an enrollee obtains coverage under IC 27-13-18.

As added by P.L.26-1994, SEC.25.

IC 27-13-16-4

Eligibility for Indiana comprehensive health insurance policy

Sec. 4. If an enrollee is hospitalized continuously from the date of receivership through the last date of the enrollee's continuation of benefits under section 1 of this chapter, the enrollee shall be eligible for an Indiana comprehensive health insurance policy under

IC 27-8-10. Notwithstanding any provision of IC 27-8-10, the policy may not contain preexisting condition exclusions with respect to the condition for which the enrollee was hospitalized. The enrollee shall become eligible for coverage effective on the first day after the enrollee's continuation of benefits ends.
As added by P.L.26-1994, SEC.25.

IC 27-13-16-5
Rules for governing plan

Sec. 5. The commissioner may adopt rules governing a health maintenance organization's plan for covering all outstanding claims during the first sixty (60) days that the health maintenance organization enters receivership. These rules may govern at least the following:

(1) Letters of guarantee from a parent company.
(2) Conversion policies.
(3) Insolvency insurance policies.
(4) Additional deposits.

As added by P.L.26-1994, SEC.25.

IC 27-13-17

Chapter 17. Protection Against Insolvency; Notice of Termination

IC 27-13-17-1

Notice requirements before termination of agreement by provider

Sec. 1. An agreement between a provider and a health maintenance organization under which the provider agrees to provide health care services must require the provider to give the organization at least sixty (60) days advance notice before terminating the agreement unless the provider or the group of providers provide thirty percent (30%) or more of the health maintenance organization services, in which case the provider must give at least one hundred twenty (120) days advance notice.

As added by P.L.26-1994, SEC.25.

IC 27-13-18
Chapter 18. Enrollment Period in Event of Receivership

IC 27-13-18-1
Offer of coverage required; allocation of contracts

Sec. 1. (a) In the event of receivership of a health maintenance organization, the commissioner may order all other carriers that participated in the enrollment process of the group covered by the organization in receivership at the last regular enrollment period of the group to offer the enrollees of the organization in receivership an enrollment period of thirty (30) days beginning on the date of receivership.

(b) Each carrier referred to in subsection (a) shall offer the enrollees of the health maintenance organization in receivership:

(1) the same coverage;

(2) under the same terms; and

(3) at the same rates;

as the carrier had offered at the last regular enrollment period of the group. The coverage required under this chapter shall begin on the date of receivership and end on the date the contract period would have ended had the health maintenance organization not gone into receivership.

(c) If there is no carrier referred to in subsection (a), or the commissioner determines that there is no carrier referred to in subsection (a) that has adequate or accessible resources, the commissioner shall equitably allocate the:

(1) group contracts of the health maintenance organization in receivership; and

(2) individual contracts of the health maintenance organization in receivership belonging to enrollees who are unable to obtain other coverage;

among all health maintenance organizations operating within a portion of the service area of the health maintenance organization in receivership. The commissioner shall not allocate individual contracts to a health maintenance organization that does not offer direct individual enrollment.

(d) A health maintenance organization to which the commissioner allocates a group contract under subsection (c)(1) shall offer to the group existing coverage that is most similar to the group's coverage with the health maintenance organization in receivership, at rates consistent with the successor health maintenance organization's existing rating methodology.

(e) A health maintenance organization to which the commissioner allocates individual contracts under subsection (c)(2) shall offer to the enrollee existing individual or conversion coverage that is most similar to the enrollee's coverage with the health maintenance organization in receivership, at rates consistent with the successor health maintenance organization's existing rating methodology.

As added by P.L.26-1994, SEC.25. Amended by P.L.203-2001, SEC.27.

IC 27-13-18-2

Failing to provide for continuation of benefits; assessments of health maintenance organizations; tax credits or premium adjustments

Sec. 2. (a) If for any reason the plan of the health maintenance organization under IC 27-13-16 does not provide for continuation of benefits as required by IC 27-13-16-1, the liquidator shall assess, or cause to be assessed, each licensed health maintenance organization doing business in Indiana. The amount that each licensed health maintenance organization is assessed must be based on the ratio of the amount of all subscriber premiums received by the health maintenance organization for contracts issued in Indiana for the previous calendar year to the amount of the total subscriber premiums received by all licensed health maintenance organizations for contracts issued in Indiana for the previous calendar year.

(b) The total assessments of health maintenance organizations under subsection (a) must equal an amount sufficient to provide for continuation of benefits as required by IC 27-13-16-1 to enrollees covered under contracts issued by the health maintenance organization to subscribers located in Indiana, and to pay administrative expenses.

(c) The total amount of all assessments to be paid by a health maintenance organization in any one (1) calendar year may not exceed one percent (1%) of the premiums received by the health maintenance organization from business in Indiana during the calendar year preceding the assessment.

(d) If the total amount of all assessments in any one (1) calendar year does not provide an amount sufficient to meet the requirements of subsection (a), additional funds must be assessed in succeeding calendar years.

(e) Health maintenance organizations that, during any preceding calendar year, have paid one (1) or more assessments levied under this section may either:

(1) take as a credit against adjusted gross income taxes or similar taxes upon revenue or income of health maintenance organizations that may be imposed by Indiana up to twenty percent (20%) of any assessment described in this section for each calendar year following the year in which those assessments were paid until the aggregate of those assessments have been offset; or

(2) include in the premiums charged for coverage to which this article applies amounts sufficient to recoup a sum equal to the amounts paid in assessments as long as the premiums are not excessive by virtue of including an amount reasonably calculated to recoup assessments paid by the health

maintenance organization.

As added by P.L.26-1994, SEC.25. Amended by P.L.192-2002(ss), SEC.170.

IC 27-13-19
Chapter 19. Replacement Coverage in Event of Receivership

IC 27-13-19-1
"Discontinuance" defined

Sec. 1. As used in this chapter, "discontinuance" means the termination of the contract between a group contract holder and a health maintenance organization due to the receivership of the health maintenance organization. The term does not refer to the termination of an individual contract.

As added by P.L.26-1994, SEC.25.

IC 27-13-19-2
Replacement coverage; challenge of enrollee

Sec. 2. (a) A carrier that provides replacement coverage with respect to group health care services after the discontinuance of the prior health maintenance organization contract or policy providing health care services must, immediately upon beginning to provide the replacement coverage, cover all enrollees who were covered under the previous health maintenance organization contract or policy on the date of discontinuance.

(b) A carrier that provides replacement coverage under this section may challenge whether an individual designated as an enrollee under the previous health maintenance organization contract qualified as an enrollee under the previous health maintenance organization contract.

As added by P.L.26-1994, SEC.25.

IC 27-13-19-3
Provisions reducing or excluding benefits

Sec. 3. (a) Except as provided in subsection (b), a provision in a succeeding carrier's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to the benefits preexisted the effective date of the succeeding carrier's contract may not be applied with respect to those enrollees who were covered under the prior carrier's contract or policy on the date of discontinuance.

(b) A provision in a succeeding carrier's contract of replacement coverage may operate to reduce or exclude benefits on the basis of a preexisting condition to the extent that the prior carrier's contract or policy would have required that benefits for the condition be reduced or excluded.

As added by P.L.26-1994, SEC.25.

IC 27-13-20
Chapter 20. Filing Requirements

IC 27-13-20-1
Rates; approval

Sec. 1. The rates to be used by a health maintenance organization, including the actuarial assumptions underlying those rates, must be filed with the commissioner for approval and:

(1) must be established in accordance with actuarial principles for various categories of enrollees and, in the case of a group contract, shall not be individually determined based on the status of an enrollee's health;

(2) must be developed by an actuary or other qualified person acceptable to the commissioner; and

(3) may not be excessive, inadequate, or unfairly discriminatory.

As added by P.L.26-1994, SEC.25.

IC 27-13-20-2
Approval of documents by commissioner

Sec. 2. (a) Except as provided in subsection (b), a document submitted to the commissioner under this chapter is deemed approved when one (1) of the following conditions is met:

(1) The health maintenance organization receives a written communication of approval from the commissioner.

(2) Thirty (30) days pass after the commissioner receives the document.

(b) A document is not deemed approved under subsection (a)(2) if, within thirty (30) days after the commissioner receives the document, or within any period of extension granted by the commissioner, the commissioner deposits in the United States mail addressed to the health maintenance organization a written communication to the contrary. Not more than thirty (30) days after receiving the written communication from the commissioner, the health maintenance organization may request a hearing. If, not more than thirty (30) days after receiving the communication from the commissioner, the health maintenance organization requests a hearing, the commissioner shall hold a hearing upon not less than ten (10) days notice to the health maintenance organization.

As added by P.L.26-1994, SEC.25.

IC 27-13-21

Chapter 21. Insurance Producers of Health Maintenance Organizations and Limited Service Health Maintenance Organizations

IC 27-13-21-1

Licensing of insurance producer

Sec. 1. To qualify to represent a health maintenance organization or a limited service health maintenance organization, an insurance producer shall be licensed with an accident and health or sickness qualification under IC 27-1-15.6-7.

As added by P.L.26-1994, SEC.25. Amended by P.L.132-2001, SEC.18; P.L.178-2003, SEC.86.

IC 27-13-22
Chapter 22. Powers of Insurers and Hospital Corporations

IC 27-13-22-1
Operation of health maintenance organization by insurer or hospital

Sec. 1. (a) A licensed insurer or a hospital authorized to conduct business in Indiana may, through a subsidiary or an affiliate, organize and operate a health maintenance organization under this article.

(b) This section does not apply to a health maintenance organization granted a certificate of authority under this article before July 1, 2001.

As added by P.L.26-1994, SEC.25. Amended by P.L.203-2001, SEC.28.

IC 27-13-22-2
Joint organization or operation as health maintenance organization

Sec. 2. Notwithstanding any other law:

(1) insurers;

(2) hospitals; or

(3) subsidiaries or affiliates of entities referred to in subdivisions (1) and (2);

may jointly organize and operate a health maintenance organization.

As added by P.L.26-1994, SEC.25.

IC 27-13-22-3
Business of insurance including health care maintenance organizations

Sec. 3. For the purposes of IC 27-1-2-2, the business of insurance includes the providing of health care services by a health care maintenance organization owned or operated by an insurer or a subsidiary of an insurer.

As added by P.L.26-1994, SEC.25.

IC 27-13-22-4
Contracting with health maintenance organizations to provide insurance coverage

Sec. 4. An insurer or a hospital may contract with a health maintenance organization to provide to the health maintenance organization:

(1) insurance coverage or similar protection against the cost of health care services provided through the health maintenance organization; or

(2) insurance coverage in the event of the failure of the health maintenance organization to meet its obligations to enrollees or providers.

As added by P.L.26-1994, SEC.25.

IC 27-13-22-5

Benefit payments to health maintenance organization; contract provisions

Sec. 5. Under a contract between an insurer or a hospital and a health maintenance organization under section 4 of this chapter, the insurer or hospital may make benefit payments to the health maintenance organization for health care services for which the health maintenance organization is liable.

As added by P.L.26-1994, SEC.25.

IC 27-13-23

Chapter 23. Examinations

IC 27-13-23-1

Health maintenance organization examination

Sec. 1. The commissioner may make an examination of a health maintenance organization whenever necessary for the protection of the interests of the citizens of Indiana. However, an examination of a health maintenance organization domiciled in Indiana must be conducted at least once every three (3) years.

As added by P.L.26-1994, SEC.25.

IC 27-13-23-2

Quality management program examination

Sec. 2. The commissioner may make an examination concerning the quality management program of a health maintenance organization whenever necessary for the protection of the citizens of Indiana. However, an examination of the quality management program of a health maintenance organization domiciled in Indiana must be conducted at least once every three (3) years.

As added by P.L.26-1994, SEC.25.

IC 27-13-23-3

Availability of books and records

Sec. 3. Each health maintenance organization that is subject to an examination under this chapter shall make its books and records, and the books and records in its custody or control, available for examination and otherwise facilitate the completion of the examination.

As added by P.L.26-1994, SEC.25.

IC 27-13-23-4

Officers and agents; oaths and examination by commissioner

Sec. 4. When conducting an examination of a health maintenance organization, the commissioner:

(1) may administer oaths to; and

(2) examine;

the officers and agents of the health maintenance organization concerning the business of the organization.

As added by P.L.26-1994, SEC.25.

IC 27-13-23-5

Expenses of examination

Sec. 5. The expenses incurred by the commissioner in conducting an examination under this chapter must be paid by the health maintenance organization being examined.

As added by P.L.26-1994, SEC.25.

IC 27-13-23-6

Health maintenance organizations outside Indiana; reports of other insurance commissioners

Sec. 6. Instead of conducting an examination of a health maintenance organization that is not domiciled in Indiana, the commissioner may accept the report of an examination made by the insurance commissioner of another state if the other state is accredited by the National Association of Insurance Commissioners.
As added by P.L.26-1994, SEC.25.

IC 27-13-23-7

Annual review of HEDIS data

Sec. 7. (a) Beginning July 1, 1999, the commissioner shall review each health maintenance organization's Health Plan Employer Data and Information Set (HEDIS) data on an annual basis.

(b) The commissioner may contract with an appropriate entity to conduct the reviews required under this section.
As added by P.L.69-1998, SEC.9.

IC 27-13-23-8

Filing examination reports of other states

Sec. 8. A health maintenance organization shall file a copy of any examination report filed by the insurance commissioner of another state during the preceding calendar year with the annual statement required under IC 27-13-8-1.
As added by P.L.203-2001, SEC.29.

IC 27-13-24

Chapter 24. Suspension, Revocation, or Denial of Certificate of Authority

IC 27-13-24-1

Grounds for suspension or revocation

Sec. 1. (a) The commissioner may suspend or revoke a certificate of authority issued under this article or deny an application submitted under this article if the commissioner finds that any of the following conditions exists:

(1) The health maintenance organization is operating:

(A) significantly in contravention of its basic organizational document; or

(B) in a manner contrary to that described in any other information submitted under IC 27-13-2;

unless amendments to the basic organizational document or other submissions that are consistent with the operations of the organization have been filed with and approved by the commissioner.

(2) The health maintenance organization:

(A) issues an evidence of coverage;

(B) enters into a contract with a participating provider; or

(C) uses a schedule of charges for health care services;

that does not comply with the requirements of IC 27-13-7, IC 27-13-15, and IC 27-13-20.

(3) The health maintenance organization does not provide or arrange for basic health care services.

(4) The commissioner determines that the health maintenance organization is unable to fulfill its obligations to furnish health care coverage.

(5) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(6) The health maintenance organization has failed to correct, within the time prescribed by section 2 of this chapter, any deficiency occurring due to the impairment of the prescribed minimum net worth of the health maintenance organization.

(7) The health maintenance organization has failed to implement the grievance procedures required by IC 27-13-10 in a reasonable manner to resolve valid complaints.

(8) The health maintenance organization or any person acting on behalf of the organization has intentionally advertised or merchandised the services of the organization in an untrue, a misrepresentative, a misleading, a deceptive, or an unfair manner.

(9) The continued operation of the health maintenance organization would be hazardous to the enrollees of the organization.

(10) The health maintenance organization fails to comply with the requirements provided under IC 27-13-36 through IC 27-13-40.

(11) The health maintenance organization has otherwise failed substantially to comply with this article.

(b) The commissioner, in a proceeding under IC 4-21.5-3-8, may impose a civil penalty of not more than twenty-five thousand dollars ($25,000) against a health maintenance organization for each cause listed in subsection (a). The civil penalties may not exceed one hundred thousand dollars ($100,000) for any one (1) health maintenance organization in one (1) calendar year. The penalty may be imposed in addition to or instead of a suspension or revocation of the certificate of authority of the health maintenance organization.

As added by P.L.26-1994, SEC.25. Amended by P.L.69-1998, SEC.10.

IC 27-13-24-2

Deficient net worth

Sec. 2. (a) If the commissioner finds that the net worth maintained by a health maintenance organization subject to this article is less than the minimum net worth required by IC 27-13-12, the commissioner shall:

(1) give written notice to the health maintenance organization of the amount of the deficiency; and

(2) require the health maintenance organization to:

(A) file with the commissioner a plan for correction of the deficiency that is acceptable to the commissioner; and

(B) correct the deficiency within a reasonable time, not to exceed sixty (60) days, unless an extension of time, not to exceed an additional sixty (60) days, is granted by the commissioner.

(b) A deficiency described in subsection (a) is an impairment, and the failure of a health maintenance organization to correct the impairment in the time prescribed by the commissioner under subsection (a) is grounds for:

(1) the suspension or revocation of the certificate of authority of the organization; or

(2) placing the health maintenance organization in rehabilitation or liquidation.

As added by P.L.26-1994, SEC.25.

IC 27-13-24-3

Procedures; written order; revised application; hearing

Sec. 3. (a) The commissioner may:

(1) suspend or revoke a certificate of authority;

(2) deny an application for a certificate of authority; or

(3) impose an administrative penalty;

under this article only after complying with this section.

(b) The commissioner may:

(1) suspend or revoke a certificate of authority;

(2) deny an application for a certificate of authority; or

(3) impose an administrative penalty;

under this section by written order that shall be sent to the health maintenance organization or applicant by certified or registered mail. In the case of an application for a certificate of authority, the written order must be sent within one hundred twenty (120) days after the submission of a completed application. Failure by the commissioner to issue an order within the one hundred twenty (120) day period constitutes approval of the application for a certificate of authority. The written order must state the grounds, charges, or conduct on which the suspension, revocation, denial, or administrative penalty is based. The health maintenance organization or applicant may in writing request a hearing within thirty (30) days after the date of the mailing of the order. If a written request is not made, the order is final upon expiration of the thirty (30) days.

(c) If an order is issued under subsection (b) denying an application for a certificate of authority, the applicant may initiate the following procedure:

(1) The applicant may submit to the commissioner a revised application or any other information or material addressing the reasons the commissioner denied the application. A revised application and other information submitted to the commissioner under this subdivision must be submitted within thirty (30) days after receiving the order, unless the applicant requests an extension of time from the commissioner, who may not unreasonably deny the request.

(2) Upon receiving an applicant's revised application or other information or materials as described in subdivision (1), the commissioner shall promptly review the materials regardless of whether the applicant has requested a hearing under subsection (b).

(3) An applicant's submission of a revised application or other information or materials is considered to correct and resolve the reasons for denying the original application for a certificate of authority. The application or revised application is considered to be approved unless the commissioner notifies the applicant in writing by certified or registered mail, within fifteen (15) business days after the date the submission under subdivision (1) is made, that the application or revised application is not approved. A written notification under this subdivision must state in detail the reasons for continuing to deny the application or the revised application.

(d) If the health maintenance organization or applicant requests a hearing under this chapter, the commissioner shall issue a written notice of hearing and send the notice to the health maintenance

organization or applicant by certified or registered mail. The notice must contain a specific date and time for the hearing, which may not be less than twenty (20) days or more than sixty (60) days after the mailing of the notice of hearing.
As added by P.L.26-1994, SEC.25. Amended by P.L.195-1996, SEC.8.

IC 27-13-24-4
Action by commissioner after hearing

Sec. 4. (a) After a hearing, or upon failure of the health maintenance organization or applicant to appear at the hearing, the commissioner shall:

(1) take whatever action the commissioner finds necessary and appropriate based on written findings; and

(2) mail the decision to the health maintenance organization or applicant.

(b) The action of the commissioner under this chapter is subject to review under IC 4-21.5.
As added by P.L.26-1994, SEC.25.

IC 27-13-24-5
Application of IC 4-21.5

Sec. 5. IC 4-21.5 applies to proceedings under this chapter to the extent IC 4-21.5 does not conflict with any section of this chapter.
As added by P.L.26-1994, SEC.25.

IC 27-13-24-6
Prohibited activity during suspension

Sec. 6. A health maintenance organization whose certificate of authority is suspended may not, during the period of suspension:

(1) enroll any additional enrollees, except newborn children or other newly acquired dependents of existing enrollees; or

(2) engage in any advertising or solicitation.

As added by P.L.26-1994, SEC.25.

IC 27-13-24-7
Conclusion of affairs following revocation of certificate of authority

Sec. 7. (a) A health maintenance organization whose certificate of authority is revoked:

(1) shall proceed, immediately following the effective date of the order of revocation, to wind up the affairs of the organization; and

(2) may not conduct further business, except as essential to the orderly conclusion of the affairs of the organization.

(b) After the certificate of authority of a health maintenance organization is revoked, the health maintenance organization may not engage in further advertising or solicitation.

(c) Notwithstanding subsection (a), the commissioner may, by written order, permit further operation of a health maintenance organization after the certificate of authority of the organization is revoked if the commissioner finds the further operation of the organization to be in the best interest of enrollees.
As added by P.L.26-1994, SEC.25.

IC 27-13-24-8
Prohibited activities before hearing

Sec. 8. If the commissioner issues an order under section 3(b)(1) of this chapter and the health maintenance organization requests a hearing under section 3(d) of this chapter within the time period specified, the health maintenance organization may not:

(1) enroll any additional enrollees, except newborn children or other newly acquired dependents of existing enrollees; or
(2) engage in any advertising or solicitation;

until the commissioner takes action under section 4 of this chapter.
As added by P.L.26-1994, SEC.25. Amended by P.L.195-1996, SEC.9.

IC 27-13-25

Chapter 25. Rehabilitation or Liquidation of Health Maintenance Organizations

IC 27-13-25-1

Rehabilitation or liquidation as an insurance company; applicability of IC 27-9

Sec. 1. The rehabilitation or liquidation of a health maintenance organization:

(1) shall be considered to be the rehabilitation or liquidation of an insurance company; and

(2) shall be conducted under IC 27-9.

As added by P.L.26-1994, SEC.25.

IC 27-13-25-2

Appointment of commissioner as rehabilitator or liquidator; grounds

Sec. 2. The commissioner may apply for an order appointing the commissioner as rehabilitator or liquidator to rehabilitate or liquidate a health maintenance organization:

(1) upon at least one (1) of the grounds set forth in IC 27-9-3-1 or IC 27-9-3-6; or

(2) when, in the commissioner's opinion, the continued operation of the health maintenance organization would be hazardous to the enrollees of the organization or the people of Indiana.

As added by P.L.26-1994, SEC.25.

IC 27-13-25-3

Claims against health maintenance organization

Sec. 3. (a) In the liquidation of a health maintenance organization, the claims against the health maintenance organization by enrollees, beneficiaries, and providers qualify as class 3 claims under IC 27-9-3-40(3).

(b) If an enrollee is liable to a provider for services provided under and covered by a health maintenance organization, that liability has the status of an enrollee claim in the liquidation of a health maintenance organization. If the health maintenance organization in liquidation pays the provider the amount of a claim under this subsection, then the claim of the enrollee is extinguished.

As added by P.L.26-1994, SEC.25.

IC 27-13-26

Chapter 26. Summary of Orders and Supervision

IC 27-13-26-1

Hazardous financial condition; corrective action ordered by commissioner

Sec. 1. (a) If the commissioner determines that:

(1) the financial condition of a health maintenance organization is such that the continued operation of the organization might be hazardous to:

(A) the subscribers, enrollees, or creditors of the organization; or

(B) the general public; or

(2) the organization has violated any provision of this article;

the commissioner may, after notice and hearing, order the health maintenance organization to take action reasonably necessary to rectify the condition or violation.

(b) An order of the commissioner under subsection (a) may require a health maintenance organization to do one (1) or more of the following:

(1) Reduce the total amount of present and potential liability for benefits by reinsurance or another method acceptable to the commissioner.

(2) Reduce the volume of new business being accepted.

(3) Reduce expenses by specified methods.

(4) Suspend or limit the writing of new business for a period of time.

(5) Increase the capital and surplus of the health maintenance organization by contribution.

(6) Take other steps the commissioner considers appropriate under the circumstances.

(c) The commissioner's order under this section may require items in addition to those set forth in subsection (b).

As added by P.L.26-1994, SEC.25.

IC 27-13-26-2

Violation of article

Sec. 2. For purposes of section 1(a)(2) of this chapter, the violation by a health maintenance organization of any Indiana law to which the health maintenance organization is subject is considered a violation of this article.

As added by P.L.26-1994, SEC.25.

IC 27-13-26-3

Adoption of rules; uniform standards set by commissioner

Sec. 3. (a) The commissioner may adopt rules under IC 4-22-2 to do the following:

(1) Set uniform standards and criteria to produce an early

warning that the continued operation of a health maintenance organization might be hazardous to the subscribers, enrollees, or creditors of the organization or to the general public.

(2) Set standards for evaluating the financial condition of a health maintenance organization.

(b) The standards set under subsection (a)(2) must be consistent with the purposes expressed in section 1 of this chapter.

As added by P.L.26-1994, SEC.25.

IC 27-13-26-4

Remedies and measures

Sec. 4. The remedies and measures available to the commissioner under this chapter are in addition to and not in place of the remedies and measures available to the commissioner under IC 27-9.

As added by P.L.26-1994, SEC.25.

IC 27-13-27

Chapter 27. Fees

IC 27-13-27-1

Filing fees

Sec. 1. Each health maintenance organization subject to this article shall pay to the commissioner for deposit into the department of insurance fund established by IC 27-1-3-28 the following fees:

(1) Three hundred fifty dollars ($350) for filing:

(A) an application for a certificate of authority; or

(B) an application for an amendment to a certificate of authority.

(2) Fifty dollars ($50) for filing each annual report.

As added by P.L.26-1994, SEC.25. Amended by P.L.173-2007, SEC.44; P.L.234-2007, SEC.198.

IC 27-13-27-2

Fees required by IC 27-1-3-15

Sec. 2. In addition to the fees required by section 1 of this chapter, a health maintenance organization subject to this article must pay the fees required by IC 27-1-3-15. For purposes of IC 27-1-3-15, a contract between a health maintenance organization and a subscriber or enrollee and an evidence of coverage shall constitute a single policy.

As added by P.L.26-1994, SEC.25.

IC 27-13-28

Chapter 28. Penalties and Enforcement

IC 27-13-28-1

Augmentation of penalty; damages suffered by enrollees or other members of the public

Sec. 1. The commissioner may augment a penalty imposed under IC 27-13-24-1(b) by an amount equal to the sum that the commissioner calculates to be the damages suffered by enrollees or other members of the public. The commissioner may direct that any penalty imposed under this section be paid to the enrollees or other members of the public damaged by the health maintenance organization.

As added by P.L.26-1994, SEC.25.

IC 27-13-28-2

Conference to determine violations

Sec. 2. If the commissioner has cause to believe that a violation of this article by a health maintenance organization has occurred or is threatened, the commissioner may give notice to:

(1) the health maintenance organization; and

(2) the other persons who appear to be involved in the suspected violation;

to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to determine the facts relating to the suspected violation and, if a violation has occurred or is threatened, to determine an adequate and effective means of correcting or preventing the violation.

As added by P.L.26-1994, SEC.25.

IC 27-13-28-3

Procedural requirements

Sec. 3. Proceedings under section 2 of this chapter are not governed by any formal procedural requirements and may be conducted in a manner the commissioner considers appropriate under the circumstances. However, a conference under section 2 of this chapter may not result in a rule or an order until the requirements of section 2 of this chapter are satisfied, unless the health maintenance organization consents to the rule or order.

As added by P.L.26-1994, SEC.25.

IC 27-13-28-4

Cease and desist orders

Sec. 4. (a) The commissioner may issue an order directing:

(1) a health maintenance organization; or

(2) a representative of a health maintenance organization;

to cease and desist from engaging in any act or practice that violates this article.

(b) Within ten (10) days after a cease and desist order is served under subsection (a), the health maintenance organization or its representative may request a hearing on the question of whether acts or practices in violation of this article have occurred. The hearing must be conducted under IC 4-21.5.
As added by P.L.26-1994, SEC.25.

IC 27-13-28-5
Injunctive or other relief
Sec. 5. In the case of a violation of this article, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued under section 4 of this chapter, the commissioner may institute a proceeding to obtain injunctive relief or other appropriate relief in the Marion County circuit court.
As added by P.L.26-1994, SEC.25.

IC 27-13-28-6
Failure to comply with net worth requirements; continued operation
Sec. 6. Notwithstanding any other provision of this article, if a health maintenance organization fails to comply with the net worth requirement of this article, the commissioner may take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to the enrollees of the organization.
As added by P.L.26-1994, SEC.25.

IC 27-13-28-7
Investigations on behalf of enrollees or providers not precluded
Sec. 7. This article does not preclude the department from investigating complaints, grievances, or appeals on behalf of enrollees or providers.
As added by P.L.69-1998, SEC.11.

IC 27-13-29

Chapter 29. Statutory Construction and Relationship to Other Laws

IC 27-13-29-1

Applicability of provisions

Sec. 1. (a) Except as provided in subsection (b) or as otherwise provided in this article or IC 27:

(1) IC 27; and

(2) the provisions of IC 16 regulating hospitals;

do not apply to any health maintenance organization or limited service health maintenance organization (as defined in IC 27-13-34-4) that is granted a certificate of authority under this article. However, this section does not apply to an insurer or a hospital that is licensed under Indiana law, except with respect to the health maintenance organization activities of the hospital or insurer that are authorized and regulated under this article.

(b) Every:

(1) health maintenance organization; and

(2) limited service health maintenance organization (as defined in IC 27-13-34-4);

authorized to do business in Indiana is subject to IC 27-4-1 relating to unfair methods of competition and unfair or deceptive acts or practices to the extent that IC 27-4-1 does not conflict with this article. If a provision in IC 27-4-1 conflicts with this article, this article governs and controls.

As added by P.L.26-1994, SEC.25. Amended by P.L.255-1995, SEC.14; P.L.91-1998, SEC.23.

IC 27-13-29-2

Solicitation of enrollees

Sec. 2. Provided that the solicitation otherwise complies with IC 27-13-21, the solicitation of enrollees by:

(1) a health maintenance organization or limited service health maintenance organization that is granted a certificate of authority; or

(2) a representative of an organization described in subdivision (1);

may not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

As added by P.L.26-1994, SEC.25.

IC 27-13-29-3

Repealed

(Repealed by P.L.227-1995, SEC.2.)

IC 27-13-29-4

Risk based capital requirements

Sec. 4. A:

(1) health maintenance organization; or

(2) limited service health maintenance organization;

that is domiciled in Indiana is subject to the risk based capital requirements of IC 27-1-36, unless exempted by the commissioner under IC 27-1-36-1.

As added by P.L.51-2002, SEC.11.

IC 27-13-30

Chapter 30. Filings and Reports as Public Documents

IC 27-13-30-1

Public records; exemptions; annual financial statement

Sec. 1. (a) All applications, filings, and reports required under this article shall be treated as public records under IC 5-14-3, except those that are:

(1) trade secrets; or

(2) privileged or confidential:

(A) quality management information; or

(B) commercial or financial information.

(b) An annual financial statement required under IC 27-13-8 is not exempt from treatment as a public document under subsection (a)(2)(B).

As added by P.L.26-1994, SEC.25.

IC 27-13-31

Chapter 31. Confidentiality of Medical Information and Limitation of Liability

IC 27-13-31-1

Information treated as confidential; exceptions; privilege against disclosure

Sec. 1. (a) Notwithstanding IC 27-13-30, any information:

(1) that pertains to the diagnosis, treatment, or health of any enrollee of a health maintenance organization or limited service health maintenance organization; and

(2) that is obtained from:

(A) the enrollee; or

(B) any provider;

by any health maintenance organization or limited service health maintenance organization;

is confidential and may not be disclosed to any person, except under the circumstances set forth in subsection (b).

(b) Information described in subsection (a) may be disclosed:

(1) to the extent necessary to carry out this article;

(2) upon the express consent of the enrollee;

(3) under a statute or court order for the production of evidence or the discovery of evidence; or

(4) in the event of a claim or litigation between:

(A) the enrollee; and

(B) the health maintenance organization or limited service health maintenance organization;

in which the data or information is pertinent.

(c) A health maintenance organization or limited service health maintenance organization is entitled to claim any statutory privilege against the disclosure of information described in subsection (a) that the provider who furnished the information to the health maintenance organization or limited service health maintenance organization is entitled to claim.

As added by P.L.26-1994, SEC.25.

IC 27-13-31-2

Liability limitations

Sec. 2. (a) As used in this section, "in good faith and without malice" when used to describe an action taken or a decision or recommendation made means that:

(1) a reasonable effort has been taken to obtain the facts of the matter;

(2) a reasonable belief exists that the action, decision, or recommendation is warranted by the facts known; and

(3) if the action is described in IC 34-30-15-7, the action is made in compliance with IC 34-30-15-7.

(b) As used in this section, "health care review committee" means

a peer review committee under IC 34-6-2-99 (or IC 34-4-12.6-1(c) before its repeal).

(c) In all actions to which this section applies, good faith shall be presumed and malice shall be required to be proven by the person aggrieved.

(d) A person who, in good faith and without malice:

(1) takes any action or makes a decision or recommendation as a member, an agent, or an employee of a health care review committee; or

(2) furnishes any record, information, or assistance to a health care review committee;

is not subject to liability for damages in any legal action in consequence of that action.

(e) Neither:

(1) the health maintenance organization or limited service health maintenance organization that established the health care review committee; or

(2) the officers, directors, employees, or agents of the health maintenance organization or limited service health maintenance organization;

are liable for damages in any civil action for the activities of a person who, in good faith and without malice, takes any action or makes a decision or recommendation as a member, an agent, or an employee of a health care review committee, or furnishes any record, information, or assistance to a health care review committee.

(f) This section does not relieve any person of liability arising from treatment of a patient or an enrollee, or from a determination of the reimbursement to be provided under the terms of an insurance policy, a health maintenance organization contract, or another benefit program providing payment, reimbursement, or indemnification for health care costs based on the appropriateness of health care services delivered to an enrollee.

(g) A health care review committee shall comply with IC 34-6-2-99.

As added by P.L.26-1994, SEC.25. Amended by P.L.261-1995, SEC.1; P.L.1-1998, SEC.155.

IC 27-13-31-3

Information and records subject to subpoena or discovery

Sec. 3. (a) Notwithstanding IC 27-13-30, the information considered by a health care review committee and the record of the actions and proceedings of the committee are confidential for purposes of IC 5-14-3-4 and not subject to subpoena or order to produce, except:

(1) in proceedings before the appropriate state licensing or certifying agency; and

(2) in an appeal, if permitted, from the finding or recommendation of the health care review committee.

(b) If information considered by a health care review committee or records of the actions and proceedings of a health care review committee are used under subsection (a) by a state licensing or certifying agency or in an appeal, the information or records:

(1) shall be kept confidential; and

(2) are subject to the same provisions concerning discovery and use in legal actions as are the original information and records in the possession and control of a health care review committee.

As added by P.L.26-1994, SEC.25.

IC 27-13-31-4

Quality management program; access to records

Sec. 4. To fulfill its obligations under IC 27-13-6 concerning the quality management program of the organization, a health maintenance organization is entitled to access to treatment records and other information pertaining to the diagnosis, treatment, and health status of any enrollee during the period of time the enrollee is covered by the health maintenance organization.

As added by P.L.26-1994, SEC.25.

IC 27-13-32

Chapter 32. Transfers of Ownership

IC 27-13-32-1

Acquisition of control of health maintenance organization or limited service health maintenance organization

Sec. 1. (a) This section does not apply to a health maintenance organization or a limited service health maintenance organization that is a foreign corporation.

(b) As used in this section, "foreign corporation" means a corporation organized or reorganized under the law of a state or jurisdiction other than Indiana.

(c) A person may not acquire control, as that term is defined in IC 27-1-23-1, of a health maintenance organization or a limited service health maintenance organization unless:

(1) that person complies with the requirements of IC 27-1-23-2; and

(2) the acquisition is approved by the commissioner under the procedure set forth in IC 27-1-23-2.

As added by P.L.26-1994, SEC.25. Amended by P.L.185-1996, SEC.17; P.L.203-2001, SEC.30.

IC 27-13-32.5

Chapter 32.5. Voluntary Dissolution

IC 27-13-32.5-1

Notice; filing articles of dissolution

Sec. 1. Upon authorization of voluntary dissolution by the board of directors and any shareholders entitled to vote in respect of the voluntary dissolution, the board of directors shall:

(1) cause a notice that the health maintenance organization is about to be dissolved to be published at least once in a newspaper of general circulation, printed and published in the English language, in the county in which the principal office of the health maintenance organization is located, and at least once in a newspaper of general circulation, printed and published in the English language in the city of Indianapolis, Marion County, Indiana;

(2) cause a copy of the publication under subdivision (1) to be mailed to each subscriber;

(3) file a copy of the publication under subdivision (1) with the department;

(4) file a certified copy of the articles of dissolution with the department; and

(5) present to the department the certificate of authority issued or renewed under IC 27-13-3-1 for cancellation.

The department shall file the certified copy of the articles of dissolution, cancel the certificate of authority, endorse the cancellation on the certificate, and return the canceled certificate of authority to the health maintenance organization or its representatives.

As added by P.L.203-2001, SEC.31.

IC 27-13-32.5-2

Effect on rights of enrollees

Sec. 2. The dissolution of a health maintenance organization under this chapter does not alter the rights of an enrollee under IC 27-13-7-13.

As added by P.L.203-2001, SEC.31.

IC 27-13-33

Chapter 33. Coordination of Benefits

IC 27-13-33-1

Coordination of benefits provision; purpose

Sec. 1. Health maintenance organizations may adopt a coordination of benefits provision to:

(1) avoid overinsurance; and

(2) provide for the orderly payment of a claim when a person is covered by two (2) or more group health insurance or health care plans.

As added by P.L.26-1994, SEC.25.

IC 27-13-33-2

Provision consistent with 760 IAC 1-38.1

Sec. 2. If a health maintenance organization adopts a coordination of benefits provision, the provision must be consistent with the coordination of benefits provisions of 760 IAC 1-38.1 as it may be amended or replaced from time to time.

As added by P.L.26-1994, SEC.25.

IC 27-13-34

Chapter 34. Limited Service Health Maintenance Organizations

IC 27-13-34-0.1

Application of certain amendments to chapter

Sec. 0.1. The amendments made to section 12 of this chapter by P.L.69-1998 apply to contracts that are entered into, renewed, or modified after June 30, 1998.

As added by P.L.220-2011, SEC.461.

IC 27-13-34-1

"Enrollee" defined

Sec. 1. (a) As used in this chapter, "enrollee" means an individual who is entitled to limited health services under a contract with an entity authorized to provide or arrange for limited health services under this chapter.

(b) The term includes the dependent of an individual described in subsection (a).

As added by P.L.26-1994, SEC.25.

IC 27-13-34-2

"Evidence of coverage" defined

Sec. 2. As used in this chapter, "evidence of coverage" means the certificate, agreement, or contract issued under section 13 of this chapter setting forth the coverage to which an enrollee is entitled.

As added by P.L.26-1994, SEC.25.

IC 27-13-34-3

"Limited health services" defined

Sec. 3. (a) As used in this chapter, "limited health services" refers to:

(1) dental care services;
(2) vision care services;
(3) mental health services;
(4) substance abuse services;
(5) pharmaceutical services;
(6) podiatric care services; and
(7) other services that the commissioner determines to be limited health services.

(b) The term does not include hospital or emergency services, except as those services are provided incident to a limited health service.

As added by P.L.26-1994, SEC.25.

IC 27-13-34-4

"Limited service health maintenance organization" defined

Sec. 4. (a) As used in this chapter, "limited service health

maintenance organization" means a corporation, partnership, limited liability company, or other entity that undertakes to provide or arrange a limited health service on a prepayment basis or other basis.

(b) The term does not include a provider or an entity when providing or arranging for the provision of limited health services under a contract with a limited service health maintenance organization.

As added by P.L.26-1994, SEC.25.

IC 27-13-34-5

"Provider" defined

Sec. 5. As used in this chapter, "provider" means a physician, a dentist, an optometrist, a health facility, or other person or institution that is licensed or otherwise authorized to deliver or furnish limited health service.

As added by P.L.26-1994, SEC.25.

IC 27-13-34-6

"Subscriber" defined

Sec. 6. As used in this chapter, "subscriber" means a person whose employment status or other status, except for family dependency, is the basis for eligibility for limited health services under a contract with an entity authorized to provide or arrange for limited health services under this chapter.

As added by P.L.26-1994, SEC.25.

IC 27-13-34-7

Certificate of authority required; foreign entities

Sec. 7. (a) After December 31, 1994, a person, corporation, partnership, limited liability company, or other entity may not operate a limited service health maintenance organization in Indiana without obtaining and maintaining a certificate of authority from the commissioner under this chapter.

(b) A for-profit or nonprofit corporation organized under the laws of another state, other than a foreign corporation defined under IC 27-1-2-3, may obtain a certificate of authority to operate a limited service health maintenance organization in Indiana if the foreign corporation is authorized to do business in Indiana under IC 23-1-49 or IC 23-17-26 and complies with this chapter.

(c) A foreign corporation (as defined in IC 27-1-2-3) may obtain a certificate of authority to operate a limited service health maintenance organization in Indiana if the foreign corporation complies with this chapter.

(d) A foreign or alien limited service health maintenance organization granted a certificate of authority under this chapter has the same but not greater rights and privileges than a domestic limited service health maintenance organization.

As added by P.L.26-1994, SEC.25. Amended by P.L.203-2001,

SEC.32.

IC 27-13-34-8
Application for certificate of authority; requirements

Sec. 8. (a) An application for a certificate of authority to operate a limited service health maintenance organization must be filed with the commissioner on a form prescribed by the commissioner. An application must be verified by an officer or authorized representative of the applicant and must set forth, or be accompanied by, the following:

(1) A copy of the applicant's basic organizational document, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, articles of organization, or other applicable documents, and all amendments to those documents.

(2) A copy of all bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant.

(3) A list of the names, addresses, official positions, and biographical information of the individuals who are to be responsible for conducting the affairs and daily operations of the applicant, including the following:

(A) All members of the board of directors, board of trustees, executive committee, or other governing board or committee.

(B) The principal officers.

(C) Any person or entity owning or having the right to acquire at least ten percent (10%) of the voting securities of the applicant.

(D) In the case of a partnership or an association, the partners or members of the partnership or association.

(E) In the case of a limited liability company, the managers or members of the limited liability company.

(4) A statement generally describing the applicant, the facilities and personnel of the applicant, and the limited health service or services that the applicant will offer.

(5) A copy of the form of any contract that has been made or is to be made between the applicant and any providers regarding the provision of limited health services to enrollees.

(6) A copy of the form of any contract that has been made or is to be made between the applicant and any person referred to in subdivision (3).

(7) A copy of the form of any contract that has been made or is to be made between the applicant and any person, corporation, partnership, or other entity for the performance of any functions on behalf of the applicant, including the following:

(A) Marketing.

(B) Administration.

(C) Enrollment.
(D) Investment management.
(E) Subcontracting for the provision of limited health services to enrollees.

(8) A copy of the form of any contract that is to be issued to employers, unions, trustees, or other organizations or individuals, and a copy of any form of evidence of coverage to be issued to subscribers.

(9) Subject to subsection (b), a copy of the most recent financial statements of the applicant, audited by an independent certified public accountant.

(10) A copy of the financial plan of the applicant, including:
(A) a projection of anticipated operating results for at least three (3) years; and
(B) a statement of the sources of working capital and any other sources of funding and provisions for contingencies.

(11) A description of the proposed method of marketing.

(12) A statement acknowledging that all lawful process in any legal action or proceeding against the applicant on a cause of action arising in Indiana is valid if served in accordance with the Indiana Rules of Trial Procedure.

(13) A description of the complaint procedures to be established and maintained under IC 27-13-10.

(14) A description of the quality assessment and utilization review procedures to be used by the applicant.

(15) A description of how the applicant will comply with sections 16 and 17 of this chapter.

(16) The fee for the issuance of a certificate of authority required by section 23 of this chapter.

(17) A written waiver of the applicant's rights under federal bankruptcy laws.

(18) Other information that the commissioner reasonably requires to make the determinations required by this chapter.

(19) If the applicant is not domiciled in Indiana, an executed power of attorney appointing the commissioner, the commissioner's successors in office, and authorized deputies of the commissioner as the true and lawful attorney of the applicant in and for Indiana upon whom all lawful process in any legal action or proceeding against the limited service health maintenance organization on a cause of action arising in Indiana may be served.

(b) If the financial affairs of the parent company of the applicant are audited by independent certified public accountants but those of the applicant are not, an applicant may satisfy the requirement set forth in subsection (a)(9) by including with the application the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the applicant,

unless the commissioner determines that additional or more recent financial information is required for the proper administration of this chapter.
As added by P.L.26-1994, SEC.25.

IC 27-13-34-9
Issuance of certificate of authority; application deficiencies; denial of application

Sec. 9. (a) After receiving an application filed under section 8 of this chapter, the commissioner shall review the application and notify the applicant of any deficiencies in the application.

(b) The commissioner shall issue a certificate of authority to an applicant if the following conditions are met:

(1) The requirements of section 8 of this chapter have been fulfilled.

(2) The individuals responsible for conducting the affairs of the applicant are competent, trustworthy, possess good reputations, and have had appropriate experience, training, or education.

(3) The applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the commissioner may consider:

(A) the financial soundness of the arrangements of the applicant for limited health services;

(B) the adequacy of the applicant's working capital, other sources of funding, and provisions for contingencies;

(C) any agreement for paying the cost of the limited health services or for alternative coverage in the event of insolvency of the limited service health maintenance organization; and

(D) the manner in which the requirements of sections 16 and 17 of this chapter have been fulfilled.

(4) The agreements with providers for the provision of limited health services contain the provisions required by section 15 of this chapter.

(5) Any deficiencies identified by the commissioner have been corrected.

(c) If an application for a certificate of authority is denied, the commissioner shall notify the applicant and shall specify in the notice the reasons for the denial of the application. Within thirty (30) days after receiving the notice, the applicant may request a hearing before the commissioner under IC 4-21.5.
As added by P.L.26-1994, SEC.25.

IC 27-13-34-10
Powers of limited service health maintenance organization

Sec. 10. (a) Subject to subsection (b), the powers of a limited service health maintenance organization include the following:

(1) The purchase, lease, construction, renovation, operation, or maintenance of:

(A) medical facilities that will provide limited health services;

(B) equipment for medical facilities providing limited health services; and

(C) other property reasonably required for the principal office of the limited service health maintenance organization or for purposes necessary in the transaction of the business of the organization.

(2) Engaging in transactions between affiliated entities, including loans and the transfer of responsibility under any or all contracts:

(A) between affiliates; or

(B) between the limited service health maintenance organization and the parent organization of the limited service health maintenance organization.

(3) The furnishing of limited health services through the following:

(A) Providers.

(B) Provider associations.

(C) Agents for providers who are under contract with or are employed by the limited service health maintenance organization. The contracts with providers, provider associations, or agents for providers may include fee for service, cost plus, capitation, or other payment or risk-sharing agreements.

(4) Contracting with any person for the performance on behalf of the limited service health maintenance organization of certain functions, including:

(A) marketing;

(B) enrollment; and

(C) administration.

(5) Contracting with:

(A) an insurance company licensed in Indiana; or

(B) an authorized reinsurer for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the limited service health maintenance organization.

(6) The offering of point-of-service products for the limited health services for which the limited service health maintenance organization is licensed so long as the limited service health maintenance organization complies with the reinsurance or ratio requirements of IC 27-13-13-8.

(7) The joint marketing of products with:

(A) an insurance company that is licensed in Indiana; or

(B) a health maintenance organization that is authorized to conduct business in Indiana;

if the company that is offering each product is clearly identified.

(8) Providing limited health services at the expense of a self-funded plan.

(b) Nothing in this section qualifies an asset of a prepaid limited health service organization as an admitted asset.

As added by P.L.26-1994, SEC.25.

IC 27-13-34-11

Modification of documents; filing; disapproval

Sec. 11. (a) Before making any material modification of any matter or document furnished under section 8 of this chapter, a limited service health maintenance organization shall file with the commissioner:

(1) a notice of the modification; and

(2) supporting documents that are necessary to fully explain the modification.

(b) If a limited service health maintenance organization desires to add one (1) or more limited health services, it must:

(1) file a notice with the commissioner;

(2) submit the information required by section 8 of this chapter concerning each limited health service to be added, if that information is different from the information filed with the application of the limited service health maintenance organization; and

(3) demonstrate compliance with sections 16, 17, 18, and 23 of this chapter with respect to each limited health service to be added by the organization.

(c) If the commissioner does not disapprove a filing under subsection (a) or (b) within thirty (30) days after the commissioner receives the filing, or within any period of extension granted by the commissioner, the filing shall be deemed approved.

(d) If a filing under subsection (a) or (b) is disapproved, the commissioner shall:

(1) notify the limited service health maintenance organization of the disapproval of the filing in writing deposited in the United States mail addressed to the limited service health maintenance organization; and

(2) specify the reasons for disapproval of the filing in the notice.

(e) Within thirty (30) days after it receives a notice of disapproval under subsection (d), the limited service health maintenance organization may request a hearing before the commissioner under IC 4-21.5 concerning the disapproval of the filing. If, not more than thirty (30) days after receiving the notice from the commissioner, the limited service health maintenance organization requests a hearing, the commissioner shall hold a hearing upon not less than ten (10) days notice to the limited service health maintenance organization.

As added by P.L.26-1994, SEC.25.

IC 27-13-34-12
Applicable statutes

Sec. 12. A limited service health maintenance organization operated under this chapter is subject to the following:

(1) IC 27-1-36 concerning risk based capital, unless exempted by the commissioner under IC 27-1-36-1.

(2) IC 27-13-2-10, concerning physical presence in Indiana.

(3) IC 27-13-8, except for IC 27-13-8-2(a)(6) concerning reports.

(4) IC 27-13-9-3 concerning termination of providers.

(5) IC 27-13-10-1 through IC 27-13-10-3 concerning grievance procedures.

(6) IC 27-13-11 concerning investments.

(7) IC 27-13-15-1(a)(2) through IC 27-13-15-1(a)(3) concerning gag clauses in contracts.

(8) IC 27-13-21 concerning producers.

(9) IC 27-13-29 concerning statutory construction and relationship to other laws.

(10) IC 27-13-30 concerning public records.

(11) IC 27-13-31 concerning confidentiality of medical information and limitation of liability.

(12) IC 27-13-36-5 and IC 27-13-36-6 concerning referrals to out of network providers and continuation of care.

(13) IC 27-13-40 concerning comparison sheets of services provided by the limited service health maintenance organization.

As added by P.L.26-1994, SEC.25. Amended by P.L.191-1997, SEC.14; P.L.69-1998, SEC.12; P.L.133-1999, SEC.8; P.L.51-2002, SEC.12; P.L.11-2011, SEC.38.

IC 27-13-34-13
Evidence of coverage; required information

Sec. 13. (a) Every subscriber of a limited service health maintenance organization shall be issued an evidence of coverage in electronic or paper form, which must contain a clear and complete statement of the following:

(1) The limited health services to which each enrollee is entitled.

(2) Any limitation of the services, kinds of services, or benefits to be provided.

(3) Any exclusions, including any copayment or other charges.

(4) Where and in what manner information is available as to where and how services may be obtained.

(5) The method for resolving complaints.

(b) Any amendment to the evidence of coverage may be provided to the subscriber in a separate document in electronic or paper form.

(c) A limited service health maintenance organization shall issue the evidence of coverage described in subsection (a) and an

amendment described in subsection (b) in paper form upon the request of the subscriber.

(d) A limited service health maintenance organization shall include in the limited service health maintenance organization's enrollment materials information concerning the manner in which a subscriber may:

(1) obtain an evidence of coverage; and

(2) request the evidence of coverage in paper form.

As added by P.L.26-1994, SEC.25. Amended by P.L.125-2005, SEC.8.

IC 27-13-34-14

Examinations by commissioner

Sec. 14. (a) The commissioner may examine a limited service health maintenance organization as often as is reasonably necessary to protect the interests of Indiana citizens. However, an examination of a limited service health maintenance organization domiciled in Indiana must be conducted at least one (1) time every three (3) years.

(b) A limited service health maintenance organization:

(1) shall make its relevant books and records, and the books and records in its custody and control, available for examination under this section; and

(2) in every way cooperate with the commissioner to facilitate the examination.

(c) The expenses of an examination under this section shall be paid by the organization being examined.

(d) Instead of conducting an examination of a limited service health maintenance organization that is not domiciled in Indiana, the commissioner may accept the report of an examination made by the chief administrative officer who regulates insurance in another state, if the other state is accredited by the National Association of Insurance Commissioners.

As added by P.L.26-1994, SEC.25.

IC 27-13-34-15

Required contract terms and conditions; exemptions

Sec. 15. All contracts with providers or with entities subcontracting for the provision of limited health services to enrollees on a prepayment basis or other basis must contain, or shall be construed to contain, the following terms and conditions:

(1) If the limited service health maintenance organization fails to pay for limited health services for any reason whatsoever, including insolvency or breach of this contract, the enrollees shall not be liable to the provider for any sums owed to the provider under this contract.

(2) No provider or agent, trustee, representative, or assignee of a provider may maintain an action at law or attempt to collect from the enrollee sums that the limited service health

maintenance organization owes to the provider.

(3) These provisions do not prohibit the collection of:

(A) uncovered charges consented to by enrollees; or

(B) copayments;

from enrollees.

(4) The contract may not provide for a financial or other penalty to a primary care provider for making a referral permitted under IC 27-13-36-5(a), but may provide for reasonable cost sharing between the primary care provider and the limited service health maintenance organization for the additional costs incurred as a result of services provided by an out of network provider.

(5) These provisions survive the termination of this contract, regardless of the reason for the termination.

(6) For not more than ninety (90) days after the termination of this contract, the provider must complete procedures in progress on an enrollee receiving treatment for a specific condition, at the same schedule of copayment or other applicable charge that is in effect on the effective date of termination of the contract.

(7) An amendment to the provisions of this contract set forth in subdivisions (1) through (6) must be:

(A) submitted to; and

(B) approved by;

the commissioner before it becomes effective.

As added by P.L.26-1994, SEC.25. Amended by P.L.69-1998, SEC.13.

IC 27-13-34-16

"Net worth" and "uncovered expense" defined; computation of net worth; minimum net worth

Sec. 16. (a) As used in this section, "net worth" means the excess of total assets over total liabilities, excluding liabilities that have been subordinated in a manner acceptable to the commissioner.

(b) For the purposes of computing net worth, the total assets must be reduced by the value assigned to the following intangible assets:

(1) Goodwill.

(2) Going concern value.

(3) Organizational expense.

(4) Start-up costs.

(5) Long term prepayments of deferred charges.

(6) Nonreturnable deposits.

(7) Obligations of officers, directors, owners, or affiliates, except short term obligations of affiliates for goods or services that:

(A) arise in the normal course of business;

(B) are payable on the same terms as equivalent transactions with nonaffiliates; and

(C) are not past due.

(c) As used in this section, "uncovered expense" means the cost of health care services:

(1) that are the obligation of a limited service health maintenance organization;

(2) for which an enrollee may be liable in the event of the insolvency of the organization; and

(3) for which alternative arrangements acceptable to the commissioner have not been made to cover the costs.

(d) For purposes of the definition of "uncovered expense" set forth in subsection (c), costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, shall be considered a covered expense.

(e) Each limited service health maintenance organization must, at all times, have and maintain net worth equal to the greater of:

(1) fifty thousand dollars ($50,000); or

(2) two and one-half percent (2.5%) of the annual gross subscription income of the organization, up to a maximum of two hundred fifty thousand dollars ($250,000).

(f) A limited service health maintenance organization shall maintain as a claim or loss reserve, in cash or obligations of the United States government, assets sufficient to discharge all liabilities on all uncovered expenses arising under policies issued.

(g) The commissioner may adopt rules under IC 4-22-2 to further define whether and to what extent the assets of a limited service health maintenance organization may be considered to be admitted assets for the purposes of complying with the requirements of this chapter.

As added by P.L.26-1994, SEC.25.

IC 27-13-34-17

Required deposit

Sec. 17. (a) Each limited service health maintenance organization shall deposit in a joint-name account with:

(1) the commissioner; or

(2) any bank or bank and trust company or other financial institution acceptable to the commissioner through which a custodial or controlled account is used;

cash, securities acceptable to the commissioner, or any combination of these, in an amount equal to fifty thousand dollars ($50,000).

(b) For the purposes of section 16 of this chapter:

(1) a deposit made by an organization under this section shall be treated as an admitted asset of the organization in the determination of net worth; and

(2) all income from deposits of an organization under this section shall be an asset of the organization.

(c) An organization may withdraw:

(1) a deposit made under this section; or

(2) any part of the deposit;

after making a substitute deposit of equal amount and value.

(d) Any obligations of the United States government deposited with the commissioner under this section must be approved by the commissioner before being substituted under subsection (c).

(e) The deposit made by a limited service health maintenance organization under this section shall be used to protect the interest of the enrollees of the organization and to assure continuation of limited health care services to enrollees of a limited service health maintenance organization that is in rehabilitation or conservation.

(f) If a limited service health maintenance organization is placed in rehabilitation or liquidation, the deposit made by the organization under this section shall be an asset subject to IC 27-9.

(g) The commissioner is not required to but may reduce or eliminate the deposit requirement of this section for a limited service health maintenance organization if the organization:

(1) has made an acceptable deposit with the state or jurisdiction in which the organization is domiciled for the protection of all enrollees, wherever located; and

(2) delivers to the commissioner a certificate to that effect, authenticated by the appropriate state official holding the deposit.

As added by P.L.26-1994, SEC.25.

IC 27-13-34-18

Fidelity bonds; deposit in place of bond

Sec. 18. (a) Except as provided in subsection (c), a limited service health maintenance organization shall maintain in force a fidelity bond in its own name on its officers and employees:

(1) in an amount not less than fifty thousand dollars ($50,000); or

(2) in any other amount prescribed by the commissioner.

(b) The fidelity bond required by this section must be issued by an insurance company not affiliated in any way with the limited service health maintenance organization, that is licensed to do business in Indiana. However, if a fidelity bond is not available from an insurance company that holds a certificate of authority in Indiana, a limited service health maintenance organization may satisfy the requirement of this section by maintaining a fidelity bond procured by a surplus lines insurance producer not affiliated in any way with the limited service health maintenance organization who holds a license issued under IC 27-1-15.8.

(c) Instead of maintaining a fidelity bond under subsection (a), a limited service health maintenance organization may deposit with the commissioner:

(1) cash;

(2) certificates of deposit;

(3) United States government obligations acceptable to the commissioner;

(4) any other securities acceptable to the commissioner of the types referred to in IC 27-13-11-1; or

(5) a combination of the items described in subdivisions (1) through (4).

A deposit made under this subsection is in addition to any other required deposit, and must also be maintained in joint custody with the commissioner in the amount and subject to the same conditions required for a fidelity bond under this section.

As added by P.L.26-1994, SEC.25. Amended by P.L.132-2001, SEC.19; P.L.178-2003, SEC.87.

IC 27-13-34-19

Annual reports; additional reports

Sec. 19. (a) On or before March 1 of each year, a limited service health maintenance organization shall file with the commissioner a report that covers the preceding calendar year. The report must be:

(1) made on forms prescribed by the commissioner; and

(2) verified by at least two (2) principal officers of the limited service health maintenance organization.

(b) In addition to the report required by subsection (a), a limited service health maintenance organization shall file with the commissioner on or before June 1 of each year an audited financial statement of the limited service health maintenance organization for the preceding calendar year.

(c) The commissioner may require any additional reports necessary to enable the commissioner to carry out the duties of the commissioner under this chapter.

As added by P.L.26-1994, SEC.25.

IC 27-13-34-20

Suspension or revocation of certificate of authority

Sec. 20. (a) The commissioner may suspend or revoke the certificate of authority issued to a limited service health maintenance organization under this chapter or deny an application submitted under this chapter upon determining that any of the following conditions exist:

(1) The limited service health maintenance organization is operating:

(A) significantly in contravention of the basic organizational document of the organization; or

(B) in a manner contrary to that described in and reasonably inferred from any other information submitted under section 8 of this chapter;

unless amendments to the organization's submissions have been filed and authorized under section 11 of this chapter.

(2) The limited service health maintenance organization issues an evidence of coverage that does not comply with the requirements of section 13 of this chapter.

(3) The limited service health maintenance organization is unable to fulfill its obligations to furnish limited health services.

(4) The limited service health maintenance organization is not financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(5) The net worth of the limited service health maintenance organization is less than that required by section 16 of this chapter, or the limited service health maintenance organization has failed to correct any deficiency in its net worth as required by the commissioner.

(6) The limited service health maintenance organization has failed to implement in a reasonable manner the grievance system required by IC 27-13-10.

(7) The continued operation of the limited service health maintenance organization would be hazardous to the enrollees of the organization.

(8) The limited service health maintenance organization has otherwise failed to comply with this chapter.

(b) The commissioner may suspend or revoke a certificate of authority or deny an application for a certificate of authority by written order sent to the limited service health maintenance organization by certified mail or registered mail. The written order shall state the grounds for the suspension, revocation, or denial. A limited service health maintenance organization may request in writing a hearing within thirty (30) days after mailing of the order. If the limited service health maintenance organization requests a hearing within the time specified, the commissioner shall hold a hearing, which may not be less than twenty (20) days or more than sixty (60) days after the date of the notice for a hearing on the matter under IC 4-21.5.

(c) Immediately after the certificate of authority of a limited service health maintenance organization is revoked, the organization shall proceed to wind up its affairs. An organization whose certificate is revoked:

(1) shall not conduct further business except as may be essential to the orderly conclusion of the affairs of the organization; and

(2) shall not engage in further advertising or solicitation.

However, the commissioner may, by written order, permit the further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

As added by P.L.26-1994, SEC.25.

IC 27-13-34-21
Chapter violations; fines and penalties

Sec. 21. (a) In place of any other penalty specified in this chapter, or when no penalty is specifically provided, whenever any limited service health maintenance organization or other person, corporation, partnership, limited liability company, or entity subject to this chapter has been found to have violated any provision of this chapter, the commissioner may:

(1) issue and cause to be served upon the organization, person, or entity charged with the violation a copy of the findings and an order requiring the organization, person, or entity to cease and desist from engaging in the act or practice that constitutes the violation; and

(2) impose a monetary penalty of not more than two thousand five hundred dollars ($2,500) for each violation, but not to exceed an aggregate penalty of twenty-five thousand dollars ($25,000).

(b) A limited service health maintenance organization may appeal any action taken by the commissioner under this section within thirty (30) days after receiving notice of the action by requesting a hearing before the commissioner under IC 4-21.5.

As added by P.L.26-1994, SEC.25.

IC 27-13-34-22

Supervision, rehabilitation, or liquidation; remedies and measures

Sec. 22. (a) Any supervision, rehabilitation, or liquidation of a limited service health maintenance organization shall be considered to be the supervision, rehabilitation, or liquidation of an insurance company and shall be conducted under IC 27-9.

(b) A limited service health maintenance organization is not subject to IC 27-6-8 or IC 27-8-8.

(c) The remedies and measures available to the commissioner under this chapter are in addition to and not in the place of the remedies and measures available to the commissioner under IC 27-9.

As added by P.L.26-1994, SEC.25.

IC 27-13-34-23

Fees

Sec. 23. (a) A limited service health maintenance organization subject to this chapter shall pay to the commissioner for deposit into the department of insurance fund established by IC 27-1-3-28 the following fees:

(1) For filing an application for a certificate of authority or an amendment to an application, three hundred fifty dollars ($350).

(2) For filing each annual report, fifty dollars ($50).

(b) In addition to the fees required by subsection (a), a limited service health maintenance organization subject to this chapter must pay the fees required by IC 27-1-3-15.

As added by P.L.26-1994, SEC.25. Amended by P.L.173-2007, SEC.45; P.L.234-2007, SEC.199.

IC 27-13-34-24

Dental care services and director; review of adverse decisions; complaints

Sec. 24. (a) A limited service health maintenance organization that provides dental care services shall appoint a dental director who has an unlimited license to practice dentistry under IC 25-14 or an equivalent license issued by another state.

(b) The dental director appointed under subsection (a) is responsible for oversight of treatment policies, protocols, quality assurance activities, credentialing of participating providers, and utilization management decisions of the limited service health maintenance organization.

(c) A limited service health maintenance organization that provides dental care services shall contract with or employ at least one (1) individual who holds an unlimited license to practice dentistry under IC 25-14 or an equivalent license issued by another state to do the following:

(1) Develop, in consultation with a group of appropriate providers, the limited service health maintenance organization's treatment policies, protocols, and quality assurance activities.

(2) Respond when a treating provider requests in writing that a dentist reconsider an adverse utilization review decision.

(d) A limited service health maintenance organization that provides dental care services that receives a written request for reconsideration of an adverse utilization review decision from a treating provider shall:

(1) review the decision as expeditiously as possible; and

(2) provide a response to the treating provider not more than ten (10) business days after receiving the request.

(e) A limited service health maintenance organization that provides dental care services shall provide participating providers with an opportunity to comment on the following:

(1) Treatment policies.

(2) Protocols.

(3) Quality assurance activities.

(4) Credentialing policies and procedures.

(5) Utilization management policies and procedures.

As added by P.L.91-2000, SEC.1.

IC 27-13-34-26

Complaints; records

Sec. 26. (a) The department shall maintain records concerning complaints filed against a limited service health maintenance organization that provides dental care services.

(b) The department shall classify complaints described in subsection (a) in categories according to the National Association of Insurance Commissioners standardized complaint report procedures.

(c) The department shall classify the disposition of complaints in

each category by:

(1) number of complaints for which corrective action is considered necessary by the department; and

(2) number of complaints classified by National Association of Insurance Commissioners disposition codes.

(d) The department shall make information specified in this section available to the public in a form that does not identify any specific individual.

(e) A limited service health maintenance organization that provides dental care services may not take any retaliatory action, including cancellation or refusal to renew a participating provider contract, individual contract, or group contract, solely because a participating provider, enrollee, or individual or group contract holder files a complaint against the limited service health maintenance organization.

As added by P.L.91-2000, SEC.2.

IC 27-13-35

Chapter 35. General Rulemaking Authority

IC 27-13-35-1

Adoption of rules to carry out article

Sec. 1. The commissioner may adopt reasonable rules under IC 4-22-2 that are necessary or proper to carry out this article.

As added by P.L.26-1994, SEC.25.

IC 27-13-36

Chapter 36. Patient Protection; Clinical Decision Making; Access to Personnel and Facilities

IC 27-13-36-1

Medical director; individual to develop treatment policies and consult with treating providers

Sec. 1. (a) Each health maintenance organization shall appoint a medical director who has an unlimited license to practice medicine under IC 25-22.5 or an equivalent license issued by another state.

(b) The medical director is responsible for oversight of treatment policies, protocols, quality assurance activities, and utilization management decisions of the health maintenance organization.

(c) A health maintenance organization shall contract with or employ at least one (1) individual who holds an unlimited license to practice medicine under IC 25-22.5 to do the following:

(1) Develop, in consultation with a group of appropriate providers, the health maintenance organization's treatment policies, protocols, and quality assurance activities.

(2) Consult with the treating provider before an adverse utilization review decision is made.

(d) Compliance with the most current standards or guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this section.

As added by P.L.69-1998, SEC.14.

IC 27-13-36-2

Sufficient number and type of primary care providers

Sec. 2. Beginning July 1, 1999, each health maintenance organization shall include a sufficient number and type of primary care providers and other appropriate providers throughout the health maintenance organization's service area to:

(1) meet the needs of; and

(2) provide a choice of primary care providers and other appropriate providers to;

enrollees and subscribers of the health maintenance organization. Compliance with the most current standards or guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this section.

As added by P.L.69-1998, SEC.14.

IC 27-13-36-2.5

Discrimination on basis of provider's license or certification prohibited

Sec. 2.5. (a) A health maintenance organization may not discriminate against a provider acting within the scope of the provider's license or certification with respect to:

(1) participation;
(2) reimbursement;
(3) indemnification; or
(4) scope of care;

solely on the basis of the provider's license or certification.

(b) This section does not require a health maintenance organization to enter into a contract with a provider that would allow the provider to enter the health maintenance organization network.

As added by P.L.233-1999, SEC.13.

IC 27-13-36-3

Adequate number of services and providers within reasonable proximity of subscribers

Sec. 3. (a) The provisions of this section do not apply until July 1, 1999.

(b) Each health maintenance organization shall demonstrate to the department that the health maintenance organization offers an adequate number of:

(1) acute care hospital services;
(2) primary care providers; and
(3) other appropriate providers;

that are located within a reasonable proximity of subscribers of the health maintenance organization. Compliance with the most current standards or guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this subsection.

(c) If a health maintenance organization provides coverage for:

(1) specialty medical services, including physical therapy, occupational therapy, and rehabilitation services;
(2) mental and behavioral care services; or
(3) pharmacy services;

the health maintenance organization shall demonstrate to the department that the offered services are located within a reasonable proximity of subscribers of the health maintenance organization. Compliance with the most current standards or guidelines developed by the National Committee on Quality Assurance or a successor organization is sufficient to meet the requirements of this subsection.

As added by P.L.69-1998, SEC.14.

IC 27-13-36-4

Specialty areas of primary care providers

Sec. 4. Beginning July 1, 1999, primary care providers shall include licensed physicians who practice in one (1) or more of the following areas:

(1) Family practice.
(2) General practice.
(3) Internal medicine.
(4) As a woman's health care provider, in compliance with

IC 27-8-24.7.

(5) Pediatrics.

As added by P.L.69-1998, SEC.14.

IC 27-13-36-5

Referrals to out of network providers

Sec. 5. (a) The provisions of the section do not apply until July 1, 1999.

(b) When an enrollee's primary care provider determines that the enrollee needs a particular health care service and the health maintenance organization determines that the type of health care service needed by the enrollee to treat a specific condition:

(1) is a covered service; and

(2) is not available from the health maintenance organization's network of participating providers;

the primary care provider and the health maintenance organization shall refer the enrollee to an appropriate provider who is not a participating provider within a reasonable amount of time and within a reasonable proximity of the enrollee.

(c) When an enrollee receives health care services from a provider to whom the enrollee was referred as described in subsection (b), the health maintenance organization shall pay the out of network provider the lesser of the following:

(1) The usual, customary, and reasonable charge in the health maintenance organization's service area for the health care services provided by the out of network provider.

(2) An amount agreed to between the health maintenance organization and the out of network provider.

The enrollee's treating provider may collect from the enrollee only the deductible or copayment, if any, that the enrollee would be responsible to pay if the health care services had been provided by a participating provider. The enrollee may not be billed by the health maintenance organization or by the out of network provider for any difference between the out of network provider's charge and the amount paid by the health maintenance organization to the out of network provider as provided in this subsection.

(d) A contract between a health maintenance organization and a primary care provider may not provide for a financial or other penalty to the primary care provider for making a determination allowed under subsection (b).

As added by P.L.69-1998, SEC.14.

IC 27-13-36-6

Continuation of care provisions

Sec. 6. (a) A health maintenance organization shall include provisions in the health maintenance organization's contracts with providers to provide for continuation of care in the event that a provider's contract with the health maintenance organization is

terminated, provided that the termination is not due to a quality of care issue.

(b) The contract provisions under subsection (a) shall require that the provider, upon the request of the enrollee, continue to treat the enrollee for up to sixty (60) days following the termination of the provider's contract with the health maintenance organization or, in the case of a pregnant enrollee in the third trimester of pregnancy, throughout the term of the enrollee's pregnancy. If the provider is a hospital, the contract shall provide for continuation of treatment until the earlier of the following:

(1) Sixty (60) days following the termination of the provider's contract with the health maintenance organization.

(2) The enrollee is released from inpatient status at the hospital.

(c) During a continuation period under this section, the provider:

(1) shall agree to continue accepting the contract terms and conditions, together with applicable deductibles and copayments, as payment in full; and

(2) is prohibited from billing the enrollee for any amounts in excess of the enrollee's applicable deductible or copayment.

As added by P.L.69-1998, SEC.14.

IC 27-13-36-7

Telephone access for authorization of care

Sec. 7. Each health maintenance organization shall provide the following:

(1) Telephone access to the health maintenance organization during business hours to ensure enrollee access for routine care.

(2) Twenty-four (24) hour telephone access to either:

(A) a representative of the health maintenance organization; or

(B) a participating provider;

for authorization for care.

As added by P.L.69-1998, SEC.14.

IC 27-13-36-8

Guidelines for establishing reasonable periods for appointments

Sec. 8. (a) Each health maintenance organization shall establish guidelines for establishing reasonable periods of time within which an enrollee must be given an appointment with a participating provider, except as provided in section 9 of this chapter regarding emergency services.

(b) The guidelines described in subsection (a) must include appointment scheduling guidelines based on the type of health care services most often requested, including the following:

(1) Prenatal care appointments.

(2) Well-child visits and immunizations.

(3) Routine physicals.

(4) Adult preventive services.

(5) Urgent visits.

As added by P.L.69-1998, SEC.14.

IC 27-13-36-9

Coverage and reimbursement for expenses for care obtained in an emergency

Sec. 9. (a) As used in this section, "care obtained in an emergency" means, with respect to an enrollee, covered services that are:

(1) furnished by a provider within the scope of the provider's license and as otherwise authorized under law; and

(2) needed to evaluate or stabilize an individual in an emergency.

(b) As used in this section, "stabilize" means to provide medical treatment to an individual in an emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of the individual's condition is not likely to result from or during any of the following:

(1) The discharge of the individual from an emergency department or other care setting where emergency services are provided to the individual.

(2) The transfer of the individual from an emergency department or other care setting where emergency services are provided to the individual to another health care facility.

(3) The transfer of the individual from a hospital emergency department or other hospital care setting where emergency services are provided to the individual to the hospital's inpatient setting.

(c) As described in subsection (d), each health maintenance organization shall cover and reimburse expenses for care obtained in an emergency by an enrollee without:

(1) prior authorization; or

(2) regard to the contractual relationship between:

(A) the provider who provided health care services to the enrollee in an emergency; and

(B) the health maintenance organization;

in a situation where a prudent lay person could reasonably believe that the enrollee's condition required immediate medical attention. The emergency care obtained by an enrollee under this section includes care for the alleviation of severe pain, which is a symptom of an emergency as provided in IC 27-13-1-11.7.

(d) Each health maintenance organization shall cover and reimburse expenses for emergency services at a rate equal to the lesser of the following:

(1) The usual, customary, and reasonable charge in the health maintenance organization's service area for health care services provided during the emergency.

(2) An amount agreed to between the health maintenance

organization and the out of network provider.

A provider that provides emergency services to an enrollee under this section may not charge the enrollee except for an applicable copayment or deductible. Care and treatment provided to an enrollee once the enrollee is stabilized is not care obtained in an emergency.

As added by P.L.69-1998, SEC.14.

IC 27-13-36-10

Access plan to meet needs of vulnerable, underserved, and non-English speaking enrollees

Sec. 10. Each health maintenance organization shall demonstrate to the commissioner that the health maintenance organization has developed an access plan to meet the needs of the health maintenance organization's enrollees, including vulnerable and underserved enrollees and enrollees from major population groups who speak a primary language other than English.

As added by P.L.69-1998, SEC.14.

IC 27-13-36-11

Standards for continuity of care

Sec. 11. The health maintenance organization shall develop standards for continuity of care following enrollment, including sufficient information on how to access care within the health maintenance organization.

As added by P.L.69-1998, SEC.14.

IC 27-13-36-12

Payment to enrollee for service rendered by nonparticipating provider; requirements

Sec. 12. (a) As used in this section, "nonparticipating provider" means a provider that has not entered into an agreement with a health maintenance organization to serve as a participating provider.

(b) After September 30, 2009, if a health maintenance organization makes a payment to an enrollee for a health care service rendered by a nonparticipating provider, the health maintenance organization shall include with the payment instrument written notice to the enrollee that includes the following:

(1) A statement specifying the claims covered by the payment instrument.

(2) The name and address of the provider submitting each claim.

(3) The amount paid by the health maintenance organization for each claim.

(4) Any amount of a claim that is the enrollee's responsibility.

(5) A statement in at least 24 point bold type that:

(A) instructs the enrollee to use the payment to pay the nonparticipating provider if the enrollee has not paid the nonparticipating provider in full;

(B) specifies that paying the nonparticipating provider is the enrollee's responsibility; and

(C) states that the failure to make the payment violates the law and may result in collection proceedings or criminal penalties.

As added by P.L.144-2009, SEC.3.

IC 27-13-36.2

Chapter 36.2. Provider Payment

IC 27-13-36.2-1

"Clean claim" defined

Sec. 1. As used in this chapter, "clean claim" means a claim submitted by a provider for payment for health care services provided to an enrollee that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

As added by P.L.162-2001, SEC.6.

IC 27-13-36.2-2

"Health maintenance organization" defined

Sec. 2. As used in this chapter, "health maintenance organization" includes:

(1) an insurance administrator that:

(A) collects charges or premiums; and

(B) adjusts or settles claims;

in connection with coverage under a contract with a health maintenance organization; and

(2) a limited service health maintenance organization.

As added by P.L.162-2001, SEC.6.

IC 27-13-36.2-3

Notice of deficiencies in claims

Sec. 3. (a) A health maintenance organization shall pay or deny each clean claim in accordance with section 4 of this chapter.

(b) A health maintenance organization shall notify a provider of any deficiencies in a submitted claim not more than:

(1) thirty (30) days for a claim that is filed electronically; or

(2) forty-five (45) days for a claim that is filed on paper;

and describe any remedy necessary to establish a clean claim.

(c) Failure of a health maintenance organization to notify a provider as required under subsection (b) establishes the submitted claim as a clean claim.

As added by P.L.162-2001, SEC.6. Amended by P.L.137-2002, SEC.3.

IC 27-13-36.2-4

Payment or denial of claims; interest

Sec. 4. (a) A health maintenance organization shall pay or deny each clean claim as follows:

(1) If the claim is filed electronically, not more than thirty (30) days after the date the claim is received by the health maintenance organization.

(2) If the claim is filed on paper, not more than forty-five (45) days after the date the claim is received by the health maintenance organization.

(b) If:

(1) a health maintenance organization fails to pay or deny a clean claim in the time required under subsection (a); and

(2) the health maintenance organization subsequently pays the claim;

the health maintenance organization shall pay the provider that submitted the claim interest on the lesser of the usual, customary, and reasonable charge for the health care services provided to the enrollee or an amount agreed to between the health maintenance organization and the provider paid under this section.

(c) Interest paid under subsection (b):

(1) accrues beginning:

(A) thirty-one (31) days after the date the claim is filed under subsection (a)(1); or

(B) forty-six (46) days after the date the claim is filed under subsection (a)(2); and

(2) stops accruing on the date the claim is paid.

(d) In paying interest under subsection (b), a health maintenance organization shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

As added by P.L.162-2001, SEC.6. Amended by P.L.137-2002, SEC.4.

IC 27-13-36.2-5
Permitted forms

Sec. 5. A provider shall submit only the following forms for payment by a health maintenance organization:

(1) HCFA-1500.

(2) HCFA-1450 (UB-92).

(3) American Dental Association (ADA) claim form.

As added by P.L.162-2001, SEC.6.

IC 27-13-36.2-6
Civil penalties

Sec. 6. (a) If the commissioner finds that a health maintenance organization has failed during any calendar year to process and pay clean claims in compliance with this chapter, the commissioner may assess an aggregate civil penalty against the health maintenance organization according to the following schedule:

(1) If the health maintenance organization has paid at least eighty-five percent (85%) but less than ninety-five percent (95%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of up to ten thousand dollars ($10,000).

(2) If the health maintenance organization has paid at least sixty percent (60%) but less than eighty-five percent (85%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of at least

ten thousand dollars ($10,000) but not more than one hundred thousand dollars ($100,000).

(3) If the health maintenance organization has paid less than sixty percent (60%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of at least one hundred thousand dollars ($100,000) but not more than two hundred thousand dollars ($200,000).

(b) In determining the amount of a civil penalty under this section, the commissioner shall consider whether the health maintenance organization's failure to achieve the standards established by this chapter is due to circumstances beyond the health maintenance organization's control.

(c) A health maintenance organization may contest a civil penalty imposed under this section by requesting an administrative hearing under IC 4-21.5 not more than thirty (30) days after the health maintenance organization receives notice of the assessment of the fine.

(d) If the commissioner imposes a civil penalty under this section, the commissioner may not impose a penalty against the health maintenance organization under IC 27-4-1 for the same activity.

(e) Civil penalties collected under this section shall be deposited in the state general fund.

As added by P.L.162-2001, SEC.6.

IC 27-13-36.2-7
Repealed

(As added by P.L.178-2003, SEC.88. Repealed by P.L.1-2007, SEC.248.)

IC 27-13-36.2-8
Claim payment errors

Sec. 8. (a) A health maintenance organization may not, more than two (2) years after the date on which an overpayment on a provider claim was made to the provider by the health maintenance organization:

(1) request that the provider repay the overpayment; or

(2) adjust a subsequent claim filed by the provider as a method of obtaining reimbursement of the overpayment from the provider.

(b) A health maintenance organization may not be required to correct a payment error to a provider more than two (2) years after the date on which a payment on a provider claim was made to the provider by the health maintenance organization.

(c) This section does not apply in cases of fraud by the provider, the enrollee, or the health maintenance organization with respect to the claim on which the overpayment or underpayment was made.

As added by P.L.55-2006, SEC.3.

IC 27-13-36.2-9
Claim overpayment adjustment

Sec. 9. Every subsequent claim that is adjusted by a health maintenance organization for reimbursement on an overpayment of a previous provider claim made to the provider must be accompanied by an explanation of the reason for the adjustment, including:

(1) an identification of:

(A) the claim on which the overpayment was made; and

(B) if ascertainable, the party financially responsible for the amount overpaid; and

(2) the amount of the overpayment that is being reimbursed to the health maintenance organization through the adjusted subsequent claim.

As added by P.L.55-2006, SEC.4.

IC 27-13-37

Chapter 37. Patient Protection; Choice of Health Care Professional

IC 27-13-37-1

Enrollees allowed to choose primary care provider from list

Sec. 1. (a) A health maintenance organization shall allow each enrollee of the health maintenance organization to choose the enrollee's own primary care provider from a list of participating primary care providers within the health maintenance organization.

(b) The list described in subsection (a) shall be updated semiannually and must include a sufficient number of primary care providers that accept new enrollees. The list must be:

(1) provided to each enrollee annually; and

(2) sent to an enrollee at the enrollee's request.

As added by P.L.69-1998, SEC.15.

IC 27-13-37-2

Use of participating provider other than primary care provider

Sec. 2. (a) Each health maintenance organization shall develop a system to allow an enrollee to use an appropriate participating provider to manage the enrollee's medical condition when the enrollee's primary care provider determines that the use of another appropriate participating provider is warranted by the enrollee's medical condition.

(b) A primary care provider who makes the required determination under subsection (a) shall refer the enrollee to a participating provider whom the primary care provider determines is appropriate.

(c) A health maintenance organization shall provide coverage under this section for treatment received by an enrollee from an appropriate participating provider when the enrollee is referred to the participating provider as provided in this section for as long as the treatment is appropriate for the medical condition, subject to the terms and conditions of the enrollee's contract with the health maintenance organization.

(d) A contract between a health maintenance organization and a primary care provider may not provide for a financial or other penalty to the primary care provider for making a referral allowed under this section.

As added by P.L.69-1998, SEC.15.

IC 27-13-37-3

Continuity of care and referrals when specialty care warranted

Sec. 3. Beginning July 1, 1999, each health maintenance organization shall provide continuity of care and referral to appropriate participating providers when specialty care is warranted, including the following:

(1) Enrollees have access to appropriate participating providers on a timely basis.

(2) Enrollees have a choice of appropriate participating providers when a referral is made.

As added by P.L.69-1998, SEC.15.

IC 27-13-37-4

Point-of-service products; dental care services

Sec. 4. (a) Each health maintenance organization shall offer to each purchaser of a group contract or individual contract a point-of-service product to the extent permitted by IC 27-13-13-8.

(b) Beginning July 1, 2001, a limited service health maintenance organization that provides dental care services shall offer to each purchaser of a group contract or individual contract:

(1) a point-of-service product to the extent permitted by IC 27-13-34-10(a)(6);

(2) a preferred provider plan (as defined in IC 27-8-11-1); or

(3) a policy of accident and sickness insurance (as defined in IC 27-8-5-1);

that provides dental care services.

As added by P.L.69-1998, SEC.15. Amended by P.L.91-2000, SEC.3.

IC 27-13-37-5

Second medical opinions

Sec. 5. Each health maintenance organization shall allow an enrollee who has received a medical opinion from a participating provider to obtain a second medical opinion from an appropriate participating provider concerning the enrollee's medical condition at the enrollee's request.

As added by P.L.69-1998, SEC.15.

IC 27-13-37.5

Chapter 37.5. Mail Order and Internet Pharmacy Designation

IC 27-13-37.5-0.1

Application of chapter

Sec. 0.1. This chapter applies to an individual contract or a group contract that is entered into, delivered, amended, or renewed after June 30, 2003.

As added by P.L.220-2011, SEC.462.

IC 27-13-37.5-1

"Mail order or Internet based pharmacy"

Sec. 1. As used in this chapter, "mail order or Internet based pharmacy" has the meaning set forth in IC 25-26-18-1.

As added by P.L.251-2003, SEC.5.

IC 27-13-37.5-2

Designation of mail order or Internet based pharmacy

Sec. 2. (a) A health maintenance organization may designate, under an individual contract or a group contract that provides coverage for prescription drugs, a mail order or an Internet based pharmacy to provide prescription drugs to an enrollee.

(b) A health maintenance organization may not require an enrollee to obtain a prescription drug from a pharmacy designated under subsection (a) as a condition of coverage.

As added by P.L.251-2003, SEC.5.

IC 27-13-38

Chapter 38. Patient Protection; Drugs and Devices; Drug Utilization Review Program

IC 27-13-38-1

Drug and devices formularies

Sec. 1. (a) A health maintenance organization may apply a formulary to the prescription drug and devices benefits provided by the health maintenance organization if the formulary is developed, reviewed, and updated:

(1) in consultation with; and

(2) with the approval of;

a pharmacy and therapeutics committee, a majority of whose members are licensed physicians.

(b) If a health maintenance organization maintains one (1) or more drug and devices formularies, the health maintenance organization shall do the following:

(1) Disseminate to participating providers and pharmacists the complete drug and devices formulary or formularies maintained by the health maintenance organization, including a list of the devices and prescription drugs on the formulary by major therapeutic category that specifies whether a particular drug or device is preferred over other drugs or devices.

(2) Establish and maintain an expeditious process or procedure that allows an enrollee to obtain, without penalty or additional cost sharing beyond that provided for in the enrollee's covered benefits with the health maintenance organization, coverage for a specific, medically necessary and appropriate nonformulary drug or device without prior approval from the health maintenance organization.

(c) A health maintenance organization may not:

(1) void a contract; or

(2) refuse to renew a contract;

between the health maintenance organization and a prescribing provider because the prescribing provider has prescribed a medically necessary and appropriate nonformulary drug or device as provided in subsection (b)(2).

As added by P.L.69-1998, SEC.16.

IC 27-13-38-2

Substitution of brand name drugs

Sec. 2. Subject to IC 16-42-22:

(1) a pharmacist shall not substitute; and

(2) a health maintenance organization shall not require the substitution of;

a different single source brand name drug for a single source brand name drug written on a prescription form or electronically transmitted to a pharmacy unless the substitution is approved by the

prescribing provider.
As added by P.L.69-1998, SEC.16. Amended by P.L.204-2005, SEC.20.

IC 27-13-38-3
Drug utilization review programs; contents

Sec. 3. Each health maintenance organization that has a prescription drug benefit shall establish and operate, or cause to be established and operated, a drug utilization review program that includes the following:

(1) Retrospective review of prescription drugs furnished to enrollees.

(2) Education of physicians, enrollees, and pharmacists regarding the appropriate use of prescription drugs.

(3) Ongoing periodic examination of data on outpatient prescription drugs to ensure quality therapeutic outcomes for enrollees.

(4) Clinically relevant criteria and standards for drug therapy.

(5) Nonproprietary criteria and standards, developed and revised through an open, professional consensus process.

(6) Interventions that focus on improving therapeutic outcomes, including prospective drug utilization review programs that monitor for possible prescription drug problems or complications, including drug to disease interactions, drug to drug interactions, or therapeutic duplication.

As added by P.L.69-1998, SEC.16.

IC 27-13-38-4
Drug utilization review programs; primary emphasis

Sec. 4. The primary emphasis of the drug utilization review program established under section 3 of this chapter is to enhance quality of care for enrollees by assuring appropriate drug therapy.
As added by P.L.69-1998, SEC.16.

IC 27-13-38-5
Drug utilization review programs; confidentiality of enrollees

Sec. 5. The name of an enrollee that is discovered in the course of the drug utilization review program shall remain confidential.
As added by P.L.69-1998, SEC.16.

IC 27-13-38-6
Adoption of rules

Sec. 6. The commissioner, with input and assistance from the state health commissioner, may adopt rules under IC 4-22-2 to implement this chapter.
As added by P.L.69-1998, SEC.16.

IC 27-13-38-7

Prescription drug coverage

Sec. 7. (a) The definitions in IC 27-13-7-23 apply throughout this section.

(b) A health maintenance organization shall not remove a prescription drug from the health maintenance organization's formulary, change the cost sharing requirements that apply to a prescription drug, or change the utilization review program requirements that apply to a prescription drug unless that health maintenance organization does at least one (1) of the following:

(1) At least sixty (60) days before the removal or change is effective, send written notice of the removal or change to each enrollee for whom the prescription drug has been prescribed during the preceding twelve (12) month period.

(2) At the time an enrollee for whom the prescription drug has been prescribed during the preceding twelve (12) month period requests a refill of the prescription drug, provide to the enrollee:

(A) written notice of the removal or change; and

(B) a sixty (60) day supply of the prescription drug under the terms that applied before the removal or change.

As added by P.L.19-2016, SEC.6.

IC 27-13-39

Chapter 39. Patient Protection; Experimental Treatments

IC 27-13-39-1

Procedures regarding experimental treatments

Sec. 1. (a) A health maintenance organization shall develop and implement a procedure to evaluate whether to provide coverage for new medical technologies and new applications of existing medical technologies, including medical treatments, procedures, drugs, and devices.

(b) A health maintenance organization shall maintain the procedure required under subsection (a) in writing. The written procedure shall describe the process used to determine whether the health maintenance organization will provide coverage for new medical technologies and new uses of existing medical technologies.

(c) The procedure required under this section shall include a review of information from appropriate governmental regulatory bodies and published scientific literature about new medical technologies and new uses of existing medical technologies.

(d) A health maintenance organization shall include appropriate professionals in the decision making process to determine whether new medical technologies and new uses of existing medical technologies qualify for coverage.

As added by P.L.69-1998, SEC.17.

IC 27-13-39-2

Disclosure of coverage limitations

Sec. 2. (a) A health maintenance organization that limits coverage for experimental treatments, procedures, drugs, or devices must clearly state the limitations in any contract, policy, agreement, or certificate of coverage.

(b) The disclosure required under subsection (a) must include the following:

(1) A description of the process used to make the determination regarding a limitation under subsection (a).

(2) A description of the criteria the health maintenance organization uses to determine whether a treatment, procedure, drug, or device is experimental, as provided in section 1 of this chapter.

As added by P.L.69-1998, SEC.17.

IC 27-13-39-3

Written explanation of denial of coverage of experimental treatment; review

Sec. 3. (a) If a health maintenance organization denies coverage for a treatment, procedure, drug, or device on the grounds that the treatment, procedure, drug, or device is experimental, the health maintenance organization shall provide the enrollee with a written

explanation that includes the following:

(1) The basis for the denial.

(2) The enrollee's right to appeal the health maintenance organization's decision as provided in IC 27-8-16-8, IC 27-8-17-12, and IC 27-13-10.

(3) The telephone number of:

(A) an individual employed by the health maintenance organization whom; or

(B) a department of the health maintenance organization that;

the enrollee may contact for assistance in initiating an appeal of the health maintenance organization's decision.

(b) An enrollee is entitled to a review that takes not more than seventy-two (72) hours if the enrollee's health situation is life threatening or is an emergency.

As added by P.L.69-1998, SEC.17.

IC 27-13-40

Chapter 40. Patient Protection; Health Maintenance Organization Comparison Sheets

IC 27-13-40-1

Availability of comparison sheets

Sec. 1. Beginning January 1, 2000, each health maintenance organization shall make available a health maintenance organization comparison sheet for each policy or contract that either covers or is marketed to an Indiana resident or the resident's employer.

As added by P.L.69-1998, SEC.18.

IC 27-13-40-2

Requirements for comparison sheets

Sec. 2. (a) The comparison sheet required under section 1 of this chapter must include information of general interest to:

(1) purchasers of group contracts and individual contracts; and

(2) individuals covered by each group contract or individual contract.

(b) The comparison sheet must be designed to facilitate comparison of different health maintenance organizations.

As added by P.L.69-1998, SEC.18.

IC 27-13-40-3

Persons to be provided comparison sheets

Sec. 3. A health maintenance organization shall provide a completed health maintenance organization comparison sheet to the following:

(1) Upon request, to an enrollee or subscriber or to the enrollee's or subscriber's employer.

(2) As part of the health maintenance organization's marketing materials, to a person or an employer that may be interested in purchasing or obtaining coverage under a group contract or individual contract offered by the health maintenance organization.

As added by P.L.69-1998, SEC.18.

IC 27-13-41
Chapter 41. Claims

IC 27-13-41-1
Use of diagnostic or procedure codes

Sec. 1. Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this section:

(1) a health maintenance organization and a limited service health maintenance organization shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the health maintenance organization and limited service health maintenance organization pay claims for health care services covered under an individual contract or a group contract; and

(2) a provider shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the provider submits claims for payment for health care services covered under an individual contract or a group contract.

As added by P.L.161-2001, SEC.5. Amended by P.L.66-2002, SEC.18.

IC 27-13-41-2
Reimbursement

Sec. 2. If a provider provides health care services that are covered under an individual contract or a group contract:

(1) after the effective date of the most current version of a diagnostic or procedure code described in section 1 of this chapter; and

(2) before the health maintenance organization or limited service health maintenance organization begins using the most current version of the diagnostic or procedure code;

the health maintenance organization or limited service health

maintenance organization shall reimburse the provider under the version of the diagnostic or procedure code that was in effect on the date that the health care services were provided.
As added by P.L.161-2001, SEC.5.

IC 27-13-42

Chapter 42. Specific Reporting Requirements

IC 27-13-42-1

Allowing a health maintenance organization to report the number of children enrollees who are prescribed stimulant medication for the treatment of certain disorders

Sec. 1. A health maintenance organization that enters into an individual contract or a group contract that provides a prescription drug benefit may report to the drug utilization review board established by IC 12-15-35-19, not later than October 1 of each calendar year, the number of enrollees who are:

(1) less than eighteen (18) years of age; and

(2) prescribed a stimulant medication approved by the federal Food and Drug Administration for the treatment of attention deficit disorder or attention deficit hyperactivity disorder.

As added by P.L.107-2002, SEC.30.

IC 27-13-43

Chapter 43. Credentialing

IC 27-13-43-1

Application of chapter

Sec. 1. (a) Except as provided in subsection (b), this chapter applies to a health maintenance organization that provides basic health care services.

(b) This chapter does not apply to the credentialing of a provider by a health maintenance organization if the provider's application for credentialing is only for purposes of providing health care services to the following:

(1) A Medicaid recipient under a Medicaid risk based managed care program described in IC 12-15-12.

(2) An individual who is covered under the children's health insurance program established under IC 12-17.6-2.

As added by P.L.26-2005, SEC.4.

IC 27-13-43-2

Provider credentialing

Sec. 2. (a) The department shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format. The form must be used by:

(1) a provider who applies for credentialing by a health maintenance organization; and

(2) a health maintenance organization that performs credentialing activities.

(b) A health maintenance organization shall notify a provider concerning a deficiency on a completed credentialing application form submitted by the provider not later than thirty (30) business days after the health maintenance organization receives the completed credentialing application form.

(c) A health maintenance organization shall notify a provider concerning the status of the provider's completed credentialing application not later than:

(1) sixty (60) days after the health maintenance organization receives the completed credentialing application form; and

(2) every thirty (30) days after the notice is provided under subdivision (1), until the health maintenance organization makes a final credentialing determination concerning the provider.

As added by P.L.26-2005, SEC.4. Amended by P.L.1-2006, SEC.489.

IC 27-14

ARTICLE 14. MUTUAL INSURANCE HOLDING COMPANY LAW

IC 27-14-1

Chapter 1. General Provisions and Definitions

IC 27-14-1-1

Short title

Sec. 1. This article may be referred to as the Indiana mutual insurance holding company law.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-1.1

Intent of article; alternative organizational structure

Sec. 1.1. (a) This article is intended to enable mutual insurance companies to seek additional capital more effectively to:

(1) enhance their financial strength and flexibility;

(2) support long term growth internally and through mergers and acquisitions; and

(3) expand and enhance the domestic insurance companies of this state.

(b) This article provides an alternative organizational structure to help strengthen the Indiana mutual insurance industry by permitting mutual insurance companies to:

(1) reorganize into a mutual insurance holding company structure; and

(2) raise capital through the sale of capital stock.

As added by P.L.220-2011, SEC.463.

IC 27-14-1-2

"Members' surplus protection principle"

Sec. 2. (a) The requirements of this section constitute the "members' surplus protection principle" for purposes of this article.

(b) The MIHC must at all times have the voting power and economic interests required by IC 27-14-5-1.

(c) The aggregate value of the members' interests in an MIHC shall be protected from dilution as a result of sales of stock of a reorganized insurer or stock holding company to persons other than the MIHC through compliance with the requirements of IC 27-14-5-6, IC 27-14-5-7, IC 27-14-5-8, and IC 27-14-6-5.

(d) Dividends paid on participating policies shall be protected as provided by IC 27-14-3-11.

(e) An MIHC, stock holding company, and reorganized insurer must have outside directors as required by IC 27-14-3-5.

(f) The officers and directors of the MIHC and any subsidiary of the MIHC are subject to the restrictions on stock ownership set forth in IC 27-14-5-2, IC 27-14-5-3, and IC 27-14-5-9.

(g) Dividends paid on the equity securities of a stock holding company or reorganized insurer may be paid only in accordance with IC 27-14-3-11.

(h) Compensation payable to directors and executive officers of an MIHC, stock holding company, or reorganized insurer may be paid only in accordance with IC 27-14-3-12.

(i) Operations outside the ordinary course of the insurance business may be conducted only as provided in IC 27-14-3-13.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-3

Applicability of definitions

Sec. 3. The definitions set forth in this chapter apply throughout this article.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-4

"Acting in concert"

Sec. 4. (a) Subject to subsection (b), "acting in concert" means:

(1) a knowing participation in a joint activity whether or not under an express agreement;

(2) interdependent conscious parallel action toward a common goal under an express agreement or otherwise; or

(3) a combination or pooling of voting interests or other interests in the securities of any person for a common purpose under any contract, understanding, relationship, agreement, or other arrangement, written or otherwise.

(b) An employee benefit plan is acting in concert with:

(1) its trustee; or

(2) a person who serves in a capacity similar to a trustee;

solely for the purpose of determining whether capital stock held by the trustee or the person in a similar capacity and capital stock held by the plan will be aggregated.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-5

"Adoption date"

Sec. 5. "Adoption date" means, with respect to a plan, the date on which the board of directors approves a plan of reorganization or a plan to issue stock.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-6

"Affiliate"

Sec. 6. "Affiliate" means a person who, directly or indirectly:

(1) controls;

(2) is controlled by; or

(3) is under common control with;

another person.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-7
"Applicant"

Sec. 7. "Applicant" means, with respect to a plan, a person that has submitted a plan to the commissioner under this article.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-8
"Associate"

Sec. 8. (a) Subject to subsection (b), "associate" means any of the following:

(1) With respect to a particular person, corporation, business entity, or other organization (other than the applicant or an affiliate of the applicant) for which the person is:

(A) an officer;

(B) a partner; or

(C) directly or indirectly the beneficial owner of at least ten percent (10%) of any class of equity securities.

(2) With respect to an individual who is a director or an officer of the applicant or of any of the applicant's affiliates, a:

(A) spouse; or

(B) member of the immediate family sharing the same household.

(3) With respect to a particular person, a trust or other estate in which the person has a substantial beneficial interest or for which the person serves as trustee or in a similar fiduciary capacity.

(b) The term does not apply to a person that:

(1) has a beneficial interest in; or

(2) serves as a trustee or in a similar fiduciary capacity for;

an employee benefit plan.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-9
"Board"

Sec. 9. "Board" means:

(1) the board of directors of an MIHC, an MIC, a stock holding company, or a reorganized insurer; or

(2) another board or committee that is responsible under the articles or bylaws of the company for decisions involving the structure or management of an MIHC, MIC, stock holding company, or reorganized insurer.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-10
"Commissioner"

Sec. 10. "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-11
"Company"
Sec. 11. "Company" means any of the following:
(1) An MIC.
(2) An MIHC.
(3) A stock holding company.
(4) A reorganized insurer.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-12
"Disinterested director"
Sec. 12. "Disinterested director" means a director of an MIHC who does not hold, directly or indirectly, a material ownership interest in any subsidiary.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-13
"Effective date"
Sec. 13. "Effective date" means, with respect to a plan, the date on which the plan becomes effective under this article.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-14
"Eligible member"
Sec. 14. "Eligible member" means, with respect to a plan, a person who is a member of an MIC or MIHC, as applicable, on the adoption date of a plan and:
(1) solely for purposes of receipt of notice of and voting at a meeting of members on a plan of reorganization, continues to be a member of the MIC on the record date for the meeting of members; or
(2) solely for purposes of eligibility to receive stock subscription rights under a plan to issue stock, continues to be a member of the MIC or MIHC, as applicable, on the date the commissioner approves the plan to issue stock.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-15
"Employee benefit plan"
Sec. 15. "Employee benefit plan" means an employee benefit plan established by an MIHC or by one (1) or more of the subsidiaries of an MIHC for the sole benefit of its:
(1) employees; or
(2) sales agents.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-16
"Financial services businesses"

Sec. 16. "Financial services businesses" includes investment banking, commercial banking, industrial banking, savings and loan associations, credit unions, trust companies, other lending and loan brokerage services, services related to the extension of credit (including but not limited to real estate and personal property appraisal; arranging equity financing; check-guaranty services; collection agency services; asset management, servicing, and collection activities; real estate settlement services; and lease financing transactions), securities broker-dealer and trading services, private placement services, acting as a futures commission merchant, securities underwriting, transactions in bullion, precious metals, and foreign currency, investment advisory services, financial planning services, third party administration of insurance policy claims and accounts receivable, the advance or loan of funds using accounts receivable as collateral, organization and operation of investment companies and mutual funds, employee benefit planning and consultation services, actuarial services, issuance of money orders, savings bonds, and traveler's checks, and other operations and services either closely related to or a proper incident to the foregoing.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-17
"Immediate family"

Sec. 17. "Immediate family" means any child, stepchild, grandchild, parent, stepparent, grandparent, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law, and includes adoptive relationships.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-18
"Internal Revenue Code"

Sec. 18. "Internal Revenue Code" refers to the Internal Revenue Code of 1986, as amended.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-19
"Material ownership interest"

Sec. 19. "Material ownership interest" means an ownership interest equal to more than one-half of one percent (0.5%) of the voting securities of the issuer, or a larger percentage as the commissioner may approve.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-20

"Member"

Sec. 20. "Member" means a person that, according to the:

(1) records; and

(2) articles of incorporation and bylaws;

of an MIC or MIHC, as applicable, is a member of the MIC or MIHC, as applicable.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-21

"Member's interest"

Sec. 21. "Member's interest" means:

(1) the voting rights of a member provided by law and by the MIC's or MIHC's articles of incorporation and bylaws; and

(2) the right to receive cash, stock, or other consideration in the event of a conversion to a stock company under IC 27-1 through IC 27-13 or a dissolution under IC 27-1-10, as provided by those laws and by the MIC's or MIHC's articles of incorporation or bylaws.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-22

"MIC"

Sec. 22. "MIC" refers to a mutual insurance company.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-23

"MIHC"

Sec. 23. "MIHC" refers to a mutual insurance holding company.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-24

"Mutual insurance company" or "MIC"

Sec. 24. "Mutual insurance company" or "MIC" means a mutual insurer that is:

(1) submitting; or

(2) subject to;

a plan of reorganization or plan to issue stock under this article.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-25

"Mutual insurance holding company" or "MIHC"

Sec. 25. "Mutual insurance holding company" or "MIHC" means a mutual insurance holding company established under IC 27-14-2.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-26

"Net income"

Sec. 26. "Net income" means an amount equal to the consolidated

net income of the company for which the determination is being made, determined in accordance with generally accepted accounting principles on a basis consistent with prior periods, less net realized investment gains (reduced by capital gains tax, if any) on the sale of investments (including real estate) that were held as of the effective date of the plan of reorganization by a former MIC. For purposes of this section, "net realized investment gains" means an amount equal to realized investment gains less realized investment losses (reduced by capital gains tax, if any) for the same accounting period for all investments (including real estate) held as of the effective date of the plan of reorganization as determined in accordance with generally accepted accounting principles on a basis consistent with prior periods. The cumulative total of net realized investment gains after the effective date of the plan of reorganization that are applied to reduce one (1) or more years of net income for the purposes of this section and IC 27-14-3-11(e) shall not exceed the net unrealized investment gains as of the effective date of the plan of reorganization. For purposes of this section, "net unrealized investment gains" mean unrealized investment gains less unrealized investment losses (as adjusted for deferred income taxes) as of the effective date of the plan of reorganization.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-27
"Ordinary course of the insurance business"

Sec. 27. "Ordinary course of the insurance business" includes but is not limited to the following actions and activities of the MIHC and its subsidiaries:

(1) Operations, practices, and procedures of the company in effect prior to the effective date of the plan of reorganization.

(2) Operations, practices, and procedures that are consistent with industry practices and standards used or in effect at any relevant time.

(3) The payment of obligations due under any surplus note issued by the company with the approval of the commissioner.

(4) Expanding the business of any company into other insurance, insurance-related, and financial services businesses.

Any expansion in the ordinary course of the insurance business may be accomplished through acquisition, merger, consolidation, strategic alliance, joint venture, or other business combination.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-28
"Outside director"

Sec. 28. (a) "Outside director" means an individual who:

(1) is a member of a board of:

(A) an MIHC;

(B) a stock holding company; or

(C) a reorganized insurer;

(2) is not and has not been within the last three (3) years an officer of, an employee of, or a consultant to the entity or any affiliate of the entity referred to in subdivision (1), of whose board the individual is a member;

(3) with respect to a director of an MIHC that does not, directly or indirectly, own all of the stock of each of its reorganized insurers, is not and has not been within the last three (3) years a director of a stock holding company or a reorganized insurer that is affiliated with the MIHC; and

(4) is not a spouse of or a member of the immediate family who shares the same household with an officer of, an employee of, or a consultant to the entity or any affiliate of the entity referred to in subdivision (1), of whose board the individual is a member.

(b) For purposes of this section, a consultant is an individual who directly derives more than thirty-three percent (33%) of the consultant's income in any calendar year from the MIHC or an affiliate of the MIHC or an associate of a person who derives more than thirty-three percent (33%) of its income in any calendar year from the MIHC or any affiliate of the MIHC.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-29

"Participating policy"

Sec. 29. "Participating policy" means a policy providing for the distribution of policy dividends.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-30

"Person"

Sec. 30. "Person" means any of the following:

(1) An individual.

(2) A group of individuals acting in concert.

(3) A trust.

(4) An association.

(5) A partnership.

(6) A limited liability company.

(7) A corporation.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-31

"Plan"

Sec. 31. "Plan" means a plan:

(1) of reorganization; or

(2) to issue stock.

As added by P.L.5-2000, SEC.4.

IC 27-14-1-32
"Plan of reorganization"
Sec. 32. "Plan of reorganization" means a plan adopted under IC 27-14-2.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-33
"Plan to issue stock"
Sec. 33. "Plan to issue stock" means a plan to issue shares of a stock holding company or a reorganized insurer adopted under IC 27-14-4.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-34
"Policy"
Sec. 34. "Policy" means a contract providing one (1) or more of the kinds of insurance described in IC 27-1-5-1.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-35
"Reorganized insurer"
Sec. 35. "Reorganized insurer" means an entity:
(1) that is a domestic stock insurance company that is owned entirely or in part by an MIHC or a stock holding company; and
(2) the policyholders of which may be or are entitled to become members of the MIHC.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-36
"Stock holding company"
Sec. 36. "Stock holding company" means an entity other than a reorganized insurer and its subsidiaries that:
(1) is owned entirely or in part, directly or indirectly, by an MIHC; and
(2) directly or indirectly owns all or part of the capital stock of a reorganized insurer.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-37
"Subsidiary"
Sec. 37. "Subsidiary" means, with respect to a particular person, an affiliate of the person that is controlled by the person, either:
(1) directly; or
(2) indirectly through one (1) or more intermediaries.
As added by P.L.5-2000, SEC.4.

IC 27-14-1-38
"Voting capital stock"

Sec. 38. "Voting capital stock" means capital stock whose holder has the right to vote in the election of directors.
As added by P.L.5-2000, SEC.4.

IC 27-14-2

Chapter 2. Mutual Insurance Company Reorganization

IC 27-14-2-1

Prerequisites to reorganization

Sec. 1. (a) A mutual insurance company (MIC) may reorganize under this chapter as a mutual insurance holding company (MIHC) with one (1) or more subsidiaries after the following have occurred:

(1) The favorable vote of its board of directors to reorganize.

(2) The filing of an application with the commissioner.

(3) A notice of a public hearing made to its members and the public.

(4) At least one (1) public hearing conducted by the commissioner.

(5) The approval of the plan by the commissioner.

(6) A favorable vote of the eligible members of the MIC.

(7) The issuance of an order of completion by the commissioner.

(b) The subsidiaries of an MIHC:

(1) must include at least one (1) reorganized insurer;

(2) may include one (1) or more stock holding companies; and

(3) may include one (1) or more stock insurance companies, the policyholders of which are not and do not become members of the MIHC.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-2

Methods of reorganization

Sec. 2. The reorganization of an MIC or two (2) or more MICs into an MIHC structure under this chapter may be accomplished by any means approved by the commissioner, including the following:

(1) The establishment of at least one (1) company.

(2) The amendment or restatement of the articles and bylaws of any company.

(3) The transfer or acquisition of any or all of the assets and liabilities or of the stock of any company.

(4) The merger or consolidation of two (2) or more MICs.

(5) The merger or consolidation of two (2) or more stock holding companies as part of the merger of two (2) or more MIHCs.

(6) The merger or consolidation of two (2) or more stock insurance companies.

(7) The merger of an MIC's membership interests into any existing MIHC, with the continued corporate existence of the reorganized MIC as a reorganized insurer.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-3

Adoption of plan of reorganization by directors

Sec. 3. (a) A plan of reorganization must be adopted by the board of directors of the MIC.

(b) For a plan of reorganization to be adopted by the board of directors of an MIC, at least seventy-five percent (75%) of the members of the board of directors must vote in favor of the adoption.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-4

Application for reorganization

Sec. 4. Within ninety (90) days after the adoption of a plan of reorganization and before a vote on the plan by the members, the company adopting the plan must file with the commissioner an application containing the following:

(1) A plan of reorganization.

(2) The form of the notices to be sent to members under sections 8 and 12(b) of this chapter.

(3) A copy of the:

(A) proposed articles of incorporation; and

(B) bylaws;

of each company to be formed under the plan, including the reorganized insurer in compliance with the requirements of IC 27-1-6.

(4) If it is necessary to amend the current articles of incorporation or bylaws of any company that is affected by the plan, a copy of:

(A) the proposed articles of amendment or amended and restated articles of incorporation; and

(B) amended or restated bylaws;

of the company, which in the case of each domestic insurance company must comply with the requirements of IC 27-1-8.

(5) With respect to participating policies and contracts of the reorganized insurer, a description of:

(A) the current dividend practices of the MIC; and

(B) the dividend practices to be followed by the reorganized insurer following the effective date of reorganization.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-5

Requirements for plan of reorganization

Sec. 5. A plan of reorganization filed with the commissioner under this chapter must meet the following requirements:

(1) It must describe all significant terms of the proposed reorganization.

(2) It must describe in a narrative form any plan to issue stock that may be proposed in connection with the plan of reorganization.

(3) It must:

(A) describe the reasons for and purposes of the proposed reorganization;

(B) describe the manner in which the reorganization is expected to benefit and serve the best interests of the members; and

(C) include an analysis of the risks and benefits to the MIC and its members of the proposed reorganization, and compare those risks and benefits with the risks and benefits of reasonable alternatives (including demutualization of the MIC) to the reorganization.

(4) It must provide that:

(A) a member's interest in the MIC becomes a member's interest in the MIHC;

(B) the members' surplus protection principle will govern the actions of the MIHC and its subsidiaries;

(C) a member's interest in the MIHC may not be transferred, assigned, pledged, or alienated in any manner except in connection with a transfer, assignment, pledge, or alienation of the policy from which the member's interest is derived; and

(D) any member's interest in an MIHC will automatically terminate upon the lapse or other termination of the policy from which the member's interest is derived.

(5) It must describe how the plan of reorganization is to be effected, including a description of a contemplated transfer, acquisition, or assumption of assets, rights, franchises, interests, debts, liabilities, or other obligations of the applicant and any other company affected by the plan or reorganization.

(6) It must describe the:

(A) establishment of companies;

(B) amendment or restatement of the articles of incorporation and bylaws of a company; and

(C) merger of companies;

that will take place under the plan of reorganization.

(7) It must provide a list of:

(A) all individuals who are or have been selected to become directors or officers of the MIHC or any company that is a subsidiary of the MIHC; and

(B) other individuals who perform or will perform duties customarily performed by a director or officer.

(8) The list prepared under subdivision (7) must include, for each individual on the list:

(A) the individual's principal occupation;

(B) all offices and positions the individual has held in the preceding five (5) years;

(C) any crime of which the individual has been convicted (other than traffic violations) in the preceding ten (10) years;

(D) information concerning any personal bankruptcy of the individual or the individual's spouse during the previous seven (7) years;

(E) information concerning the bankruptcy of any corporation of which the individual was an officer or director during the previous seven (7) years;

(F) information concerning any state or federal securities law allegations against the individual that within the previous ten (10) years resulted in a:

(i) determination that the individual violated the state or federal securities law;

(ii) plea of nolo contendere; or

(iii) consent decree;

(G) information concerning the revocation during the previous ten (10) years of any state or federal license issued to the individual; and

(H) information as to whether the individual was refused a performance or other bond during the previous ten (10) years.

(9) It must provide that any policy of any reorganized insurer that goes into force after the effective date of the reorganization, will provide that:

(A) the owner of the policy; or

(B) another person or persons specified in the:

(i) policy; or

(ii) MIHC's articles of incorporation or bylaws;

becomes a member of the MIHC. However, a plan of reorganization may provide that any person who becomes an owner of a policy or who would otherwise become a member under a policy issued during a particular period of not more than three (3) years immediately after the effective date of the plan of reorganization will not become a member until after the expiration of that period.

(10) It must provide that, with regard to a policy of the MIC in force on the effective date of the plan of reorganization:

(A) the policy continues to remain in force under the policy's terms as the policy of a reorganized insurer;

(B) the holder of a participating policy continues to have the right to receive policy dividends as provided for in the policy; and

(C) the policyholder's right to benefits, values, guarantees, and other contractual obligations of the MIC continues after the effective date of the plan of reorganization as obligations of the reorganized insurer.

(11) It must describe the nature and content of the report and financial statement to be sent annually to each member following the reorganization.

(12) It must provide that, in the event of proceedings under IC 27-9 involving a reorganized insurer, the assets of the MIHC that is affiliated with the reorganized insurer are available to satisfy the policyholder obligations of the reorganized insurer.
(13) It must provide that the name of the reorganized insurer does not include the term "mutual", except as approved by the commissioner as not being misleading to the policyholders or the public.
(14) It must provide any additional information that the commissioner may request.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-6
Amendment or termination of plan of reorganization

Sec. 6. (a) A plan of reorganization that is adopted by the board of directors of the applicant may be:
(1) amended by the board of directors of the applicant:
(A) in response to the comments or recommendations of the commissioner, or any other state or federal agency or entity, before any solicitation of proxies from the members to vote on the plan of reorganization; and
(B) otherwise, with the consent of the commissioner; or
(2) terminated by the board of directors of the applicant:
(A) before notice is sent to the members under section 8 of this chapter; or
(B) with the consent of the commissioner.

(b) For a plan of reorganization to be:
(1) amended; or
(2) terminated;

by the board of directors of an MIC, at least seventy-five percent (75%) of the members of the board of directors must vote in favor of the amendment or termination.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-7
Public hearing

Sec. 7. (a) The commissioner shall, as soon as practicable after a plan of reorganization is filed with the commissioner but not more than ninety (90) days (or a longer period after the plan is filed as the commissioner determines for good cause), conduct a public hearing under IC 4-22-2-26 to afford interested persons an opportunity to present information, views, arguments, or comments about the plan.

(b) At least thirty (30) days before a hearing held under this section, the commissioner shall publish notice of the hearing in a newspaper of general circulation in:
(1) the city of Indianapolis;
(2) the city in which the principal office of the applicant is located; and

(3) other cities or towns that the commissioner considers appropriate.

The commissioner may provide written notice of the hearing by other means and to other persons that the commissioner considers appropriate.

(c) The notice provided under this section must:

(1) refer to the applicable statutory provisions;

(2) state the date, time, and location of the hearing; and

(3) include a brief statement of the subject of the hearing.

(d) At the discretion of the commissioner or the commissioner's appointee, testimony may be taken under oath or by affirmation at a public hearing under this article.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-8

Notice of hearing to members and policyholders

Sec. 8. The applicant shall, at least thirty (30) days before the public hearing required under this chapter, mail notice of the public hearing to the last known address of each member and policyholder of the MIC as shown on the books of the MIC. The notice must achieve a minimum score of forty (40) on the Flesch reading ease test or an equivalent score on a comparable test approved by the commissioner. The notice must include the following:

(1) Reference to the applicable statutory provisions.

(2) A statement of the date, time, and location of the hearing.

(3) A brief statement of the subject of the hearing, including specific notice to the member that the member's interest in the MIC will be affected by the reorganization.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-9

Prerequisites to approval of plan of reorganization

Sec. 9. The commissioner may not approve a plan of reorganization submitted under this article unless the applicant has shown, by a preponderance of the evidence, that the plan of reorganization:

(1) complies with the law;

(2) includes the disclosures and notices required under this article;

(3) is fair, reasonable, and equitable to the members and policyholders of the MIC; and

(4) complies with the members' surplus protection principle.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-10

Approval or disapproval of plan of reorganization by commissioner

Sec. 10. (a) Not more than one hundred eighty (180) days after the

filing of the application and submission of all other information requested by the commissioner relative to the plan, or a longer period if extended by the commissioner for good cause, the commissioner shall approve or disapprove the plan of reorganization. The commissioner's approval of the plan must be conditioned upon:

(1) the approval of the plan by the eligible members under this chapter; and

(2) the requirements of sections 16 and 17 of this chapter.

(b) The commissioner shall fully consider any comments received at the public hearing under IC 4-22-2-27 before issuing an order under subsection (a).

As added by P.L.5-2000, SEC.4.

IC 27-14-2-11

Notice of approval or disapproval

Sec. 11. The commissioner shall notify the applicant upon reaching a decision on a plan of reorganization.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-12

Submitting plan of reorganization to members

Sec. 12. (a) A plan of reorganization of an MIC must be submitted for approval by the eligible members of the MIC after approval of the application by the commissioner under section 10 of this chapter. A vote by the eligible members to approve the plan must be made at a special or annual meeting held under IC 27-1-7-7 and this chapter.

(b) The eligible members must be sent notice of the meeting at which a plan of reorganization will be submitted for approval by eligible members. The notice must:

(1) be mailed at least thirty (30) days before the meeting;

(2) refer to the applicable statutory provisions;

(3) state the date, time, and location of the meeting;

(4) include or be accompanied by a brief statement of the subject of the meeting, including specific notice to the member that the member's interest in the MIC will be affected by the reorganization;

(5) include or be accompanied by a copy of the plan or a summary of the plan; and

(6) describe the member's right to attend and participate in the meeting.

(c) The notice sent under this section must achieve a minimum score of forty (40) on the Flesch reading ease test or an equivalent score on a comparable test approved by the commissioner.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-13

Voting on plan of reorganization

Sec. 13. Notwithstanding IC 27-1-7-9, with respect to a vote under

section 12 of this chapter, an eligible member:

(1) may vote in person or by proxy if the proxy soliciting material:

(A) includes reference to the applicable statutory provisions;

(B) states the date, time, and location of the meeting;

(C) contains a brief statement of the subject of the meeting, including specific notice that the member's interest in the MIC will be affected by the reorganization;

(D) was solicited and obtained from the member after the commissioner has approved the plan of reorganization under this article; and

(E) was found to be sufficient in the reasonable determination of the commissioner for the eligible members to make an informed decision about the plan of reorganization; and

(2) is entitled to cast only one (1) vote on the proposed plan of reorganization, regardless of the number of policies or the amount of insurance that the member has with the MIC or any affiliate of the MIC.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-14

Approval of plan of reorganization by members

Sec. 14. For a plan of reorganization to be approved by the members of an MIC:

(1) the plan of reorganization must be approved at a meeting at which at least ten percent (10%) of the eligible members are represented in person or by proxy; and

(2) at least two-thirds (2/3) of the eligible members voting in person or by proxy must vote in favor of the plan.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-15

Filing minutes of meeting at which plan approved

Sec. 15. Not later than thirty (30) days after members have approved a plan of reorganization at a special or annual meeting of members under this chapter, an applicant must file with the commissioner the minutes of the meeting at which the plan of reorganization was approved.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-16

Issuance of permit for completion of organization

Sec. 16. (a) Before the commissioner issues a permit for completion of organization under subsection (b):

(1) a public hearing must have been conducted under this chapter;

(2) the commissioner must have issued notice to the applicant

that the commissioner has approved the plan of reorganization of the applicant under section 10 of this chapter; and

(3) the commissioner must have received the minutes of the meeting of the members at which the plan was approved reflecting that the plan of reorganization was on the agenda and the plan was approved.

(b) After the events referred to in subsection (a), the commissioner shall issue:

(1) a permit for completion of organization of the MIHC; and

(2) in the case of:

(A) a newly organized domestic insurance company, a permit for completion of organization as provided in IC 27-1-6-11; or

(B) amended articles of incorporation of a domestic insurance company, an amended certificate of authority as provided in IC 27-1-8-9.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-17

Effectiveness of plan of reorganization

Sec. 17. A plan of reorganization is effective when each reorganized insurer and MIHC affected by the plan has filed:

(1) its articles of incorporation or, if appropriate, its articles of amendment; and

(2) the certificate of authority and any amended certificate of authority issued to the company by the commissioner under this chapter;

in the office of the county recorder of the county in which the principal office of the company is located, or at any later date specified in the plan of reorganization.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-18

Organization of insurer under plan of reorganization

Sec. 18. The organization of a domestic insurance company under a plan of reorganization under this article must be conducted under IC 27-1-6 concerning the formation of domestic insurance companies.

As added by P.L.5-2000, SEC.4.

IC 27-14-2-19

Amendment of articles of incorporation of insurer under plan of reorganization

Sec. 19. The amendment of the articles of incorporation of a domestic insurance company under a plan of reorganization under this article must be conducted in compliance with IC 27-1-8.

As added by P.L.5-2000, SEC.4.

IC 27-14-3

Chapter 3. Mutual Insurance Holding Companies

IC 27-14-3-1

Requirement to comply with IC 27-14-2

Sec. 1. An MIHC organized under this article must meet the requirements of IC 27-14-2.

As added by P.L.5-2000, SEC.4.

IC 27-14-3-2

Contents of articles of incorporation

Sec. 2. The articles of incorporation of an MIHC must contain the following, or provisions at least substantially equivalent to the following:

(1) The name of the MIHC, which must include the term "mutual" or the abbreviation "MIHC".

(2) A provision specifying that the MIHC does not have the power to engage in the business of issuing insurance policies or contracts.

(3) A provision specifying that the MIHC is not authorized to issue voting or any other capital stock.

(4) A provision setting forth the rights of members of the MIHC in the equity of the MIHC in the event of a conversion to a stock company under Indiana law or a dissolution under IC 27-1-10, including the rights of the members to the assets of the MIHC.

(5) A provision specifying that:

(A) a member of the MIHC is not, as a member, personally liable for the acts, debts, liabilities, or obligations of the MIHC; and

(B) no assessment may be imposed upon the members of the MIHC by any person, including:

(i) the board of directors, members, or creditors of the MIHC; and

(ii) any governmental office or official, including the commissioner;

because of any liability of any company or because of any act, debt, or liability of the MIHC.

As added by P.L.5-2000, SEC.4.

IC 27-14-3-3

Rights and obligations of members

Sec. 3. Members of an MIHC have rights and obligations specified in:

(1) this article; and

(2) the articles of incorporation and bylaws of the MIHC.

As added by P.L.5-2000, SEC.4.

IC 27-14-3-4
Direct payments to members

Sec. 4. The MIHC may not make any direct payment of income, dividends, or other distribution of profits to a member of an MIHC with respect to any membership interest in the MIHC, other than as directed or approved by the commissioner.

As added by P.L.5-2000, SEC.4.

IC 27-14-3-5
Outside directors

Sec. 5. (a) At least a majority of the following must be made up of outside directors:

(1) The board of directors of an MIHC.

(2) The board of directors of a stock holding company that is not a wholly-owned subsidiary of an MIHC.

(3) The board of directors of a reorganized insurer that is not a wholly-owned subsidiary of an MIHC.

(4) Any audit committee or executive committee of the board of directors of:

(A) an MIHC;

(B) a stock holding company that is not a wholly-owned subsidiary of an MIHC; or

(C) a reorganized insurer that is not a wholly-owned subsidiary of an MIHC.

(b) All of the directors who are members of any management compensation committee of the following entities must be outside directors:

(1) An MIHC.

(2) A stock holding company that is not a wholly-owned subsidiary of an MIHC.

(3) A reorganized insurer that is not a wholly-owned subsidiary of an MIHC.

(c) All of the directors who are members of any pricing committee of the following entities with responsibility for approving the price of stock sold in any offering under this article must be outside directors:

(1) A stock holding company.

(2) A reorganized insurer.

(d) The commissioner may determine, after furnishing the affected company and director with notice and opportunity to be heard, that an individual does not qualify as an outside director or otherwise should not be considered an outside director. Such an individual may continue to serve as a director, but from the date the commissioner notifies the affected company in writing of the determination and the basis for the determination, the individual may not be considered an outside director.

(e) A director's failure to qualify as or be considered an outside director does not affect the validity of any action taken by the

company, the board of directors, or any committee of the board of directors.

(f) Concurrent with the initial public offering of any securities of a stock holding company or a reorganized insurer, the majority of the members of the board of directors of the MIHC must be disinterested directors.

As added by P.L.5-2000, SEC.4.

IC 27-14-3-6

Rights and obligations of an MIHC

Sec. 6. (a) Except as provided in subsection (b), an MIHC:

(1) has and may exercise all the rights and privileges of insurance companies formed under this title; and

(2) is subject to all the requirements and regulations imposed upon insurance companies formed under this title.

(b) The exceptions referred to in subsection (a) are as follows:

(1) An MIHC does not have the right or privilege to write insurance (except through an insurance company subsidiary) and is not subject to any requirement or rule adopted under IC 4-22-2 relating to the writing of insurance.

(2) An MIHC is not subject to the deposit requirement in IC 27-1-6-15(d).

(3) An MIHC is not subject to any statute or rule adopted under IC 4-22-2 that is imposed upon insurance companies formed under this title to the extent that the statute or rule is in conflict with this article.

(4) An MIHC is not subject to the investment requirements under IC 27-1-12 or IC 27-1-13 that limit or restrict investments in subsidiaries.

(5) An MIHC is not subject to risk-based capital requirements under IC 27-1-36.

(6) An MIHC is not subject to a requirement under IC 27 if the commissioner determines by order or rule adopted by the commissioner under IC 4-22-2 that the requirement does not apply to the MIHC.

As added by P.L.5-2000, SEC.4.

IC 27-14-3-7

Annual statement; certifications

Sec. 7. (a) Not later than July 1 of each year, an MIHC shall file with the commissioner an annual statement containing the following information:

(1) Audited financial statements, including:

(A) an income statement;

(B) a balance sheet;

(C) a statement of cash flows; and

(D) footnotes.

(2) Complete information on the status of any condition

imposed in connection with the approval of a plan of reorganization.

(3) An investment plan covering all assets of the MIHC.

(4) A statement that the MIHC and its affiliates have complied with section 8 of this chapter.

(5) A statement that describes any changes in the members' interests and the reason for any change in the members' interests.

(b) Not later than July 1 of the first, second, and third years after completion of a reorganization under IC 27-14-2, a reorganized insurer shall file with the commissioner:

(1) a certificate of an actuary stating that the methodology used by the reorganized insurer for any payment of policyholder dividends in the previous year complied with the methodology stated in the plan submitted under IC 27-14-2-4(5) or other methodology approved by the commissioner; and

(2) a certificate of an independent auditor of the reorganized insurer that the calculation of any participating policy dividends paid during the previous year complied with the methodology stated in the plan submitted under IC 27-14-2-4(5) and was accurate.

(c) If the certification of the actuary or auditor required in subsection (b) has not been filed or if the commissioner has other reasonable cause, the commissioner may employ at the expense of the reorganized insurer an independent actuary or auditor, or both, to issue the certifications required in subsection (b).

(d) The requirement to submit the certifications under subsection (b) may be extended by the commissioner beyond the third year after completion of a reorganization under IC 27-14-2:

(1) by order applicable to a particular recognized insurer if the commissioner determines that further certifications are necessary for the protection of the interests of the policyholders of the reorganized insurer; and

(2) by rule adopted under IC 4-22-2 if the commissioner determines that further certifications are necessary for the protection of the interests of the policyholders of all reorganized insurers or a particular class of reorganized insurers.

As added by P.L.5-2000, SEC.4.

IC 27-14-3-8
Material transactions

Sec. 8. (a) For the purposes of IC 27-1-23:

(1) an MIHC and its affiliates constitute an insurance holding company system; and

(2) an MIHC is considered to be an "insurer".

However, a separate filing or approval is not required under IC 27-1-23 for an acquisition or a reorganization that is included in

a plan approved under this article.

(b) For the purpose of this section, a "material transaction" means:

(1) a transaction described in IC 27-1-23-4(b):

(A) between an MIHC and any affiliate; or

(B) between any affiliates of an MIHC if the transaction equals or exceeds the percentages of admitted assets or surplus set forth in IC 27-1-23-4(b) of any reorganized insurer of the MIHC; or

(2) a transaction described in IC 27-1-23-4(b) between an MIHC and any person as specified in a rule adopted by the commissioner under IC 4-22-2 or an order issued by the commissioner.

(c) An MIHC may not enter into a material transaction unless the MIHC has notified the commissioner in writing of its intention to enter into a material transaction at least thirty (30) days before the transaction, or a shorter period as the commissioner may permit, and the commissioner has not disapproved the transaction within that period.

(d) In addition to the requirements of IC 27-1-23-4(a) and IC 27-1-23-4(d), a material transaction must:

(1) be fair and reasonable to the members of the MIHC; and

(2) not violate the members' surplus protection principle.

(e) An MIHC and its affiliates may not enter into transactions that are part of a plan or series of like transactions if the purpose of those separate transactions is to circumvent any rules of the commissioner prohibiting a material transaction or this section.

As added by P.L.5-2000, SEC.4.

IC 27-14-3-9

Interest of member not considered a security

Sec. 9. The interest of a member in an MIHC does not constitute a security under Indiana law.

As added by P.L.5-2000, SEC.4.

IC 27-14-3-10

Fiduciary responsibilities and liability of officers and directors

Sec. 10. (a) After the effective date of a plan of reorganization, the officers and directors of the MIHC:

(1) owe the same fiduciary responsibilities to members of the MIHC as the officers and directors of the former MIC owed to members of the former MIC; and

(2) are subject to potential liability to members of the MIHC to the same extent as the officers and directors of the former MIC were to members of the former MIC before the effective date of the plan of reorganization.

(b) An action may be brought to recover for the violation of fiduciary responsibilities under this article under IC 34-11-2-4, or, in the case of fraud, under IC 34-11-2-7.

As added by P.L.5-2000, SEC.4.

IC 27-14-3-11
Dividends and distributions

Sec. 11. (a) The reorganized insurer must obtain commissioner approval of the dividend practices with respect to participating policies and contracts in force as of the effective date of the reorganization to be followed by the reorganized insurer as set forth in IC 27-14-2-4(5) if the dividend practices of the reorganized insurer will be different from the dividend practices of the MIC.

(b) The commissioner may require the establishment of a closed block or other mechanism that the commissioner finds to be fair for the protection of MIC policyholder dividends.

(c) The dividend practices of the reorganized insurer, the requirement to establish a closed block or other mechanism, or the terms of the closed block, may be modified after approval under subsection (a) or subsequent to a reorganization under IC 27-14-2 only with the prior approval of the commissioner on application of the reorganized insurer.

(d) Neither a stock holding company nor a reorganized insurer may pay dividends or make other distributions with respect to its stock to its shareholders if the reorganized insurer has failed to pay policyholder dividends in compliance with the dividend practices approved by the commissioner in accordance with this section.

(e) A reorganized insurer or stock holding company of the MIHC that has any shareholder other than the MIHC or a direct or indirect wholly owned subsidiary of the MIHC may not declare or pay any dividend or other distribution on its capital stock except to the extent of:

(1) one (1) or more years of net income attributable to the year of or years after the effective date of the plan of reorganization; and

(2) proceeds from the issuance of capital stock (which as of any date shall be that amount equal to the net proceeds received by the issuer less amounts previously paid out of the net proceeds to stockholders in the form of dividends or other distributions).

As added by P.L.5-2000, SEC.4.

IC 27-14-3-12
Compensation of directors and executive officers

Sec. 12. (a) For purposes of this section, "executive officer" has the same meaning as the term is defined by the Securities and Exchange Commission in 17 CFR 240.3b-7.

(b) After the effective date of a reorganization under this article, the compensation of directors or executive officers of a company shall include only those amounts that satisfy any one (1) of the following criteria:

(1) Amounts that are payable with respect to services rendered

before the effective date of the plan of reorganization.

(2) Amounts that would be deemed to be reasonable compensation by the Internal Revenue Service and therefore allowed as proper expense deductions for federal income tax purposes.

(3) Amounts that are disclosed to the policyholders in proxy solicitation materials or other written materials approved by the commissioner as part of the notice of the meeting of the members called to approve a plan of reorganization, are approved by the commissioner in principle and concept as part of the approval of the plan of reorganization, and are approved by the commissioner as to specific amount prior to payments after the effective date of the plan of reorganization.

(4) Amounts that the commissioner deems necessary to preserve the safety and soundness of the stock insurance company subsidiary by enabling it to engage and retain capable employees.

(5) Amounts payable solely out of net income of the company after the effective date of the plan of reorganization.

As added by P.L.5-2000, SEC.4.

IC 27-14-3-13

Investment and operations in businesses outside insurance business

Sec. 13. A company may invest and conduct operations in businesses outside the ordinary course of the insurance business only from funds separately raised and net income earned, after the effective date of a plan of reorganization.

As added by P.L.5-2000, SEC.4.

IC 27-14-4

Chapter 4. Issuance of Capital Stock

IC 27-14-4-1

Applicability of chapter; issuance of stock

Sec. 1. (a) This chapter applies only to the initial public offering of voting capital stock by a reorganized insurer or stock holding company.

(b) A reorganized insurer or a stock holding company may issue any type of stock permitted by the law under which it is organized. However, a reorganized insurer and a stock holding company may issue shares of stock to a person or entity other than:

(1) the MIHC of which it is a subsidiary; or

(2) a stock holding company or reorganized insurer that is a direct or indirect subsidiary of the MIHC referred to in subdivision (1);

only in compliance with this article.

As added by P.L.5-2000, SEC.4.

IC 27-14-4-2

Adoption of plan to issue stock

Sec. 2. A plan to issue stock under this chapter must be adopted:

(1) in the case of a plan to issue stock that is concurrent with the formation of the MIHC, by the board of directors of the MIC; or

(2) in the case of a plan to issue shares of stock that is not concurrent with the formation of the MIHC, by the board of directors of the MIHC and reorganized insurer or stock holding company proposing to issue the stock.

As added by P.L.5-2000, SEC.4.

IC 27-14-4-3

Amendment or withdrawal of plan

Sec. 3. A board of directors that adopts a plan to issue stock under this chapter may amend or withdraw that plan at any time before the effective date. However, after the commissioner has approved a plan to issue stock, the plan may not be amended unless the commissioner approves the amendment.

As added by P.L.5-2000, SEC.4.

IC 27-14-4-4

Application to issue stock

Sec. 4. Within ninety (90) days after the adoption of a plan to issue stock, the reorganized insurer or stock holding company adopting the plan must file with the commissioner an application that contains the following:

(1) A proposed plan to issue stock.

(2) A description of the reasons for and purpose of the proposed

plan and the manner in which the issuance will benefit the members of the MIHC.

(3) If it is necessary to amend the current articles of incorporation or bylaws of a company that is affected by the plan, a copy of the proposed articles of amendment and amended bylaws of the company, which in the case of each domestic insurance company must comply with IC 27-1-8.

(4) A list of the officers and directors of a company that is affected by the plan.

(5) A description of:

(A) the stock intended to be offered by the applicant;

(B) all shareholder rights applicable to the stock intended to be offered by the applicant;

(C) the total number of shares authorized to be issued;

(D) the estimated number of shares the applicant intends to offer; and

(E) the intended date or range of dates for the offering.

(6) A list of:

(A) the name of any underwriter, syndicate member, or placement agent involved;

(B) if known by the applicant, the name of each person or group of persons who will control five percent (5%) or more of the total outstanding shares of the class of stock to be offered; and

(C) if any of the persons listed under clause (A) or (B) is a corporation or other business organization, the name of each member of its board of directors or equivalent management body.

(7) A description of all expenses expected to be incurred in connection with the offering.

(8) Any other information requested by the commissioner.

As added by P.L.5-2000, SEC.4.

IC 27-14-4-5

Mandatory provisions of plan to issue stock

Sec. 5. A plan to issue stock in a public offering (other than an offering solely in connection with a consolidation, merger, share exchange, or other business combination or an offering of stock under a stock option or other employee benefit plan) must do the following:

(1) Provide for each eligible member to receive, without payment, nontransferable subscription rights to purchase a portion of the stock of the applicant.

(2) Specify how subscription rights are to be allocated in whole shares of stock among the eligible members.

(3) Provide a fair and equitable means for allocating shares of stock in the event of an over-subscription to the shares by eligible members exercising subscription rights received under

this chapter.

(4) Provide that any shares of stock not subscribed to by eligible members exercising subscription rights received under this chapter, or not subscribed to by an employee benefit plan or by directors, officers, and employees exercising subscription rights, will be sold:

(A) in a public offering through an underwriter;

(B) through private placement; or

(C) by any other method approved by the commissioner that is fair and equitable to members.

(5) Provide that the MIHC will adopt articles of incorporation or articles of amendment that include a provision prohibiting the MIHC from waiving any dividends from its subsidiaries except after approval of the waiver by the board of directors of the MIHC and by the commissioner.

(6) Establish a pricing committee within the board of directors of the entity making the offering of stock, consisting exclusively of outside directors.

(7) Require that the shares not be issued without the favorable written opinion of the independent financial advisor as required by IC 27-14-6-4.

As added by P.L.5-2000, SEC.4.

IC 27-14-4-6

Permitted provisions of plan to issue stock

Sec. 6. Subject to the limitations of IC 27-14-5, a plan to issue stock may do the following:

(1) Provide an allocation without payment of nontransferable subscription rights to purchase not more than ten percent (10%) of the total amount of outstanding stock to one (1) or more employee benefit plans that satisfy the requirements of Section 401(a), 403(b), 404(c), 408, 423, or 501(c)(9) of the Internal Revenue Code, limited to the extent that unsubscribed shares of stock remain after the members have exercised their subscription rights.

(2) Provide for:

(A) the establishment of; and

(B) the allocation of not more than four percent (4%) of the total amount of outstanding stock to;

an employee benefit plan that provides benefits that are subject to taxation under Section 83 of the Internal Revenue Code or that complies with the requirements of Section 422 of the Internal Revenue Code, for the purpose of granting stock or stock options.

(3) Provide that the articles of incorporation of a subsidiary of the MIHC may, subject to specified exceptions, prohibit a:

(A) person; or

(B) group of persons acting in concert;

acting directly or through associates, from acquiring more than a specified percentage of any class of the issued and outstanding shares of capital stock of the issuing subsidiary.

(4) Provide that the aggregate number of shares of outstanding stock purchased by an eligible member that exercises subscription rights may not exceed:

(A) a specified number of shares equal to at least one percent (1%) of the total number of outstanding shares; or

(B) a specified percentage of not less than one percent (1%) of the total number of outstanding shares.

(5) Provide that subscription rights need not be granted to an eligible member who resides in a foreign country or other jurisdiction for which the commissioner determines that all of the following apply:

(A) A small number of eligible members reside in the jurisdiction.

(B) The granting of subscription rights or the offer or sale of stock to eligible members in the jurisdiction would require the issuer or its officers or directors to:

(i) register, under the security laws of the jurisdiction, as a broker, dealer, salesman, or agent; or

(ii) register, or otherwise qualify, the stock for sale in the jurisdiction.

(C) The registration, qualification, or filing in the judgment of the commissioner would be impracticable or unduly burdensome for reasons of cost or otherwise.

(6) Provide that an eligible member that exercises subscription rights must subscribe for at least a minimum number of shares of stock or a minimum dollar amount of stock unless the commissioner has determined that either minimum is unreasonable based on the respective interests of the issuer of stock and the eligible members.

As added by P.L.5-2000, SEC.4.

IC 27-14-4-7

Stock option as compensation of officer or director prohibited

Sec. 7. Notwithstanding any provision of this article, an MIHC or an affiliate of an MIHC may not use any form of a stock option or other preference with respect to the sale or purchase of any stock or other equity instrument of the MIHC or an affiliate of the MIHC to compensate an officer or director of the MIHC or an affiliate of the MIHC for services in connection with a plan to issue stock.

As added by P.L.5-2000, SEC.4.

IC 27-14-4-8

Restrictions on dividends and distributions

Sec. 8. Neither a stock holding company nor a reorganized insurer may pay dividends or make other distributions with respect to its

stock to its shareholders if the reorganized insurer has failed to pay policyholder dividends under IC 27-14-3-11.
As added by P.L.5-2000, SEC.4.

IC 27-14-5

Chapter 5. Restrictions on Capital and Other Stock

IC 27-14-5-1

MIHC to retain majority of voting stock

Sec. 1. After the effective date of the plan of reorganization, the MIHC must at all times have the direct or indirect:

(1) power to cast at least fifty-one percent (51%) of the votes on all matters submitted to a vote of the holders of common stock (or any other class of stock entitled to vote generally on matters submitted to security holders for a vote, including the election of directors) of each reorganized insurer and any stock holding company of the MIHC; and

(2) ownership of shares of stock entitled to:

(A) receipt of at least fifty-one percent (51%) of all dividends declared on common stock of each reorganized insurer and any stock holding company of the MIHC; and

(B) receipt of at least fifty-one percent (51%) of the net proceeds to common stockholders upon any dissolution of each reorganized insurer and any stock holding company of the MIHC.

As added by P.L.5-2000, SEC.4.

IC 27-14-5-2

Limits on aggregate number of shares owned by directors and officers

Sec. 2. (a) As used in this section, "CPI adjustment" means the percentage increase or decrease in the Consumer Price Index for Urban Wage Earners and Clerical Workers published monthly by the United States Bureau of Labor Statistics or any successor index published by the United States, as of the end of each calendar year, commencing January 1, 1999.

(b) The CPI adjustment referred to under subsection (c) shall be made by the commissioner as of January 1, 2000, and each year thereafter, based on the CPI adjustment for the preceding year.

(c) The aggregate number of shares of equity securities owned by all of the directors and officers of the MIHC and its affiliates and associates, excluding any shares acquired by or held for the benefit of the officers and directors and their associates through an employee benefit plan as permitted by IC 27-14-4-6(1) and section 5 of this chapter, may not exceed the following:

(1) Fifteen percent (15%) of the total number of outstanding shares of equity securities of each reorganized insurer and any stock holding company if the total surplus of the MIHC and all of its reorganized insurers is greater than one billion five hundred million dollars ($1,500,000,000), as adjusted annually by the CPI.

(2) Twenty percent (20%) of the total number of outstanding

shares of equity securities of each reorganized insurer and any stock holding company if the total surplus of the MIHC and all of its reorganized insurers is greater than seven hundred fifty million dollars ($750,000,000), as adjusted annually by the CPI, and less than or equal to one billion five hundred million dollars ($1,500,000,000), as adjusted annually by the CPI.

(3) Twenty-five percent (25%) of the total number of outstanding shares of equity securities of each reorganized insurer and any stock holding company if the total surplus of the MIHC and all of this reorganized insurers is greater than two hundred fifty million dollars ($250,000,000), as adjusted annually by the CPI, and less than or equal to seven hundred fifty million dollars ($750,000,000), as adjusted annually by the CPI.

(4) Thirty percent (30%) of the total number of outstanding shares of equity securities of each reorganized insurer and all of its reorganized insurers is less than or equal to two hundred fifty million dollars ($250,000,000), as adjusted annually by the CPI.

As added by P.L.5-2000, SEC.4.

IC 27-14-5-3

Limit on aggregate number of shares owned by single director or officer

Sec. 3. The aggregate number of shares of equity securities owned by:

(1) a single director or officer of the MIHC or any subsidiary of the MIHC;

(2) associates of the person referred to in subdivision (1); and

(3) persons acting in concert with the person referred to in subdivision (1) or (2);

may not exceed five percent (5%) of the total number of outstanding shares of equity securities of each reorganized insurer and any stock holding company excluding any equity securities acquired by or held for the benefit of the officers and directors and their associates through employee benefit plans as permitted by IC 27-14-4-6(1) and section 5 of this chapter, but including any equity securities beneficially owned by officers and directors and their associates under employee benefit plans as provided in IC 27-14-4-6(2).

As added by P.L.5-2000, SEC.4.

IC 27-14-5-4

Fees or commissions for issuance of stock prohibited

Sec. 4. A director, officer, agent, or employee of the MIHC or its subsidiaries, or an associate of a director, an officer, an agent, or employee, may not receive a fee, commission, or other valuable consideration for aiding, promoting, or assisting in the issuance of stock under this section, except for:

(1) compensation as provided for in the plan and approved by the commissioner;
(2) the person's usual, regular salary or compensation; or
(3) reasonable fees and compensation paid to an individual who is an attorney, accountant, actuary, or financial adviser for services performed in the individual's independent practice, even if the individual is also a director, an officer, an agent, or an employee of the MIHC or its subsidiaries.

As added by P.L.5-2000, SEC.4.

IC 27-14-5-5
Limit on aggregate number of shares owned by employee benefit plan

Sec. 5. The aggregate number of shares of stock that may be purchased or held by an employee benefit plan may not exceed ten percent (10%) of the total number of outstanding shares of a reorganized insurer or any stock holding company.

As added by P.L.5-2000, SEC.4.

IC 27-14-5-6
Only publicly traded stock to be issued to directors or officers

Sec. 6. A reorganized insurer or stock holding company may not issue stock to directors or officers, or both, except stock of a class that is publicly traded.

As added by P.L.5-2000, SEC.4.

IC 27-14-5-7
Stock option or sale of stock below fair market value as compensation of officer or director prohibited

Sec. 7. A reorganized insurer or stock holding company may not:
(1) grant stock purchase options or warrants, or otherwise use securities to provide compensation to directors or officers, or both, at a price less than the fair market value of the security on the date of the grant; or
(2) sell securities to directors or officers, or both, at a price less than the fair market value of the security (except under the exercise of authorized stock options consistent with subdivision (1) and section 8 of this chapter).

As added by P.L.5-2000, SEC.4.

IC 27-14-5-8
Stock purchase options for directors or officers prohibited until six months after public trading begins

Sec. 8. A reorganized insurer or stock holding company may not grant stock purchase options to directors or officers, or both, until at least six (6) months after public trading for the stock has begun.

As added by P.L.5-2000, SEC.4.

IC 27-14-5-9

Factors in determining compliance with ownership restrictions

Sec. 9. (a) For purposes of determining compliance with ownership restrictions in this chapter, a person to whom a stock purchase option or warrant has been granted under this chapter is not considered to own the underlying securities until the stock purchase option or warrant is exercised and the securities have been issued.

(b) An increase in a person's percentage ownership of securities does not constitute a violation of the securities ownership restrictions in this chapter if the increase in percentage ownership results solely from a decrease in the aggregate number of securities outstanding.

(c) An inadvertent ownership of securities that exceeds the securities ownership limitations in this chapter does not violate this chapter if:

(1) a sufficient number of securities are divested within thirty (30) days after the limitation was first known to be exceeded so that the limitation is no longer exceeded; and

(2) during the period when the limitation is known to have been exceeded, the owner of the securities:

(A) does not vote any securities in excess of the limitation; and

(B) does not accept a dividend in respect of any securities that exceed the limitations.

As added by P.L.5-2000, SEC.4.

IC 27-14-6

Chapter 6. Public Hearing, Commissioner Approval, and Effective Date of Plan to Issue Stock

IC 27-14-6-1

Public hearing

Sec. 1. Not more than:

(1) sixty (60) days after the acceptance of an application filed with respect to a plan to issue stock under IC 27-14-4; or

(2) a longer period after the application is filed, as determined by the commissioner upon a showing of good cause;

the commissioner may conduct a public hearing under IC 4-22-2-26 to afford interested persons an opportunity to present information, views, arguments, or comments about the plan.

As added by P.L.5-2000, SEC.4.

IC 27-14-6-2

Notice of hearing

Sec. 2. (a) At least thirty (30) days before a hearing held under this chapter, the commissioner shall publish notice of the hearing in a newspaper of general circulation in:

(1) the city of Indianapolis;

(2) the city in which the principal office of the applicant is located; and

(3) another city or cities that the commissioner considers appropriate;

and may provide written notice of the hearing by other means and to other persons that the commissioner considers appropriate.

(b) The notice provided under this section must:

(1) refer to the applicable statutory provisions;

(2) state the date, time, and location of the hearing; and

(3) include a brief statement of the subject of the hearing.

As added by P.L.5-2000, SEC.4.

IC 27-14-6-3

Issuance of order of approval or disapproval

Sec. 3. (a) On or before the later of:

(1) sixty (60) days after a public hearing held under this chapter; or

(2) one hundred twenty (120) days after the commissioner accepts the application relating to the plan;

or a longer period if extended by the commissioner for good cause, the commissioner shall issue an order to approve or disapprove the plan under IC 27-14-4 to issue stock.

(b) The commissioner shall fully consider any comments received at a public hearing under IC 4-22-2-27 before issuing an order under subsection (a).

As added by P.L.5-2000, SEC.4.

IC 27-14-6-4
Financial adviser

Sec. 4. (a) The commissioner shall retain an independent financial adviser who shall, on behalf of members, review the offering price and issue a written opinion as to whether the offering price is fair from a financial point of view to the members as a group.

(b) The commissioner's approval of a plan under section 6 of this chapter is subject to the condition that a favorable opinion of the financial advisor is delivered to the commissioner before the stock is issued.

(c) The fees and expenses of the financial adviser shall be paid by the issuer of the stock.

As added by P.L.5-2000, SEC.4.

IC 27-14-6-5
Findings requiring disapproval

Sec. 5. The commissioner shall approve a plan to issue stock submitted under IC 27-14-4 unless the commissioner makes at least one (1) of the following findings with respect to the plan:

(1) Disapproval of the plan is necessary to prevent practices that will cause financial impairment to the applicant or its subsidiaries.

(2) The financial or management resources of the applicant or its subsidiaries or affiliates warrant disapproval.

(3) The plan does not comply with this article.

(4) The proposed plan is unfair, unreasonable or inequitable to members or policyholders.

(5) The plan does not comply with the members' surplus protection principle.

As added by P.L.5-2000, SEC.4.

IC 27-14-6-6
Copy of order; written statement of reasons for disapproval

Sec. 6. (a) The commissioner shall transmit to the applicant a copy of any order approving or disapproving a plan.

(b) If the commissioner disapproves a plan, the commissioner shall provide the applicant with a written statement detailing the reasons for the disapproval.

As added by P.L.5-2000, SEC.4.

IC 27-14-6-7
Expiration of commissioner's approval

Sec. 7. The approval by the commissioner of a plan to issue stock expires one hundred eighty (180) days after the date of approval, except as otherwise provided by an order of the commissioner.

As added by P.L.5-2000, SEC.4.

IC 27-14-6-8

Amendment of articles of incorporation

Sec. 8. The amendment of the articles of incorporation of a domestic insurance company under a plan under this article must be conducted in compliance with IC 27-1-8, except as provided in this chapter.

As added by P.L.5-2000, SEC.4.

IC 27-14-7
Chapter 7. Miscellaneous Provisions

IC 27-14-7-1
Supplemental nature of article; applicability of other insurance statutes

Sec. 1. (a) This article, while independent of any other law, is supplemental to IC 27-1-2 through IC 27-1-20.

(b) Except as provided in this article, all provisions of IC 27-1-2 through IC 27-1-20 are fully and completely applicable to this article in the same manner as if the provisions of this article had been an original part of IC 27-1-2 through IC 27-1-20. If any conflict exists between this article and IC 27-1-2 through IC 27-1-20, this article is controlling.

As added by P.L.5-2000, SEC.4.

IC 27-14-7-2
Limitation of actions

Sec. 2. A civil action:

(1) challenging the validity of; or

(2) arising out of;

action that is taken or proposed to be taken under this article must commence not later than sixty (60) days after the approval by the commissioner of the plan under which or in respect of which the action is taken or proposed to be taken.

As added by P.L.5-2000, SEC.4.

IC 27-14-7-3
Severability of provisions

Sec. 3. The provisions of this article are severable in the manner provided in IC 1-1-1-8(b).

As added by P.L.5-2000, SEC.4.

IC 27-14-7-4
Judicial review of action of commissioner; mandamus

Sec. 4. (a) A person who is aggrieved by an action of the commissioner under this article may petition for judicial review of the action under IC 4-21.5-5.

(b) A person who is aggrieved by a failure of the commissioner to act or make a determination required by this article may bring an action for mandate in the circuit court of Marion County to compel the commissioner to act or make the determination.

As added by P.L.5-2000, SEC.4.

IC 27-14-7-5
Treatment of confidential information

Sec. 5. (a) Except as provided in this section, IC 5-14 applies to all filings made under this article.

(b) Filings made under this article may include information that might be damaging to an applicant or its affiliate if made available to competitors. Subject to subsection (c), all information, documents, and copies of the filings containing trade secrets of an applicant or its affiliate are declared:

(1) confidential for the purposes of IC 5-14-3-4; and

(2) not subject to inspection and copying by the public under person, except to insurance departments of other states which agree to such confidential treatment;

without the written consent of the person to which they pertain.

(c) If the commissioner, after giving notice to the person seeking such confidential treatment and any other person requesting disclosure, after giving them an opportunity to respond at a departmental hearing in camera, and after giving due consideration to any legitimate interest in preserving trade secrets, determines that the members or policyholders have a compelling interest that would be served by disclosure, then the commissioner, after five (5) business days have elapsed from notification to the applicant, may disclose all or any part thereof in a manner and subject to the limitations as the commissioner determines appropriate.

(d) If within the five (5) business days period referred to in subsection (c), the applicant notifies the commissioner that the applicant or other interested party has filed an action seeking a protective order from a circuit or superior court to prevent or to limit disclosure, the commissioner shall not disclose the information, documents, or copies thereof during the pendency of the action and any appeal or after any final court decision prohibiting disclosure.

As added by P.L.5-2000, SEC.4.

IC 27-14-7-6

Prohibited acts

Sec. 6. An MIHC and its subsidiaries and affiliates may not do any of the following:

(1) Lend funds to a person to finance the purchase of stock in a stock offering by an MIHC or any of its subsidiaries other than policyholder loans granted under the terms of an insurance policy of a subsidiary.

(2) Pay commissions, special fees, or other special or extraordinary compensation to officers, directors, interested persons, or affiliates for arranging, promoting, aiding, assisting, or participating in the structure or placement of a stock offering by the MIHC or any of its subsidiaries, except to the extent permitted under IC 27-14-4.

(3) Enter into an understanding or agreement transferring legal or beneficial ownership of stock to another person in avoidance of this article.

As added by P.L.5-2000, SEC.4.

IC 27-14-7-7
Reorganized insurer or MIHC having all rights and obligations of MIC

Sec. 7. (a) Except as provided in subsection (b), a reorganized insurer to which insurance policies, contracts, and other assets and obligations are transferred in connection with a plan of reorganization under this article has, with respect to the insurance policies, contracts, and other assets and obligations, all rights, liabilities, and authority of the MIC that is the subject of the plan of reorganization.

(b) An MIHC resulting from a plan of reorganization of a MIC under this article, has all obligations and liabilities of the MIC for any claim, asserted or otherwise, that existed at the effective date of the reorganization and that:

(1) seeks the imposition of a constructive or charitable trust on assets of the MIC for the benefit of policyholders, members, or other persons;

(2) seeks distribution or return of assets, or other form of compensation, from the MIC to policy holders or members; or

(3) otherwise arises out of, or relates to, the ownership interest of policyholders or members of the MIC, or to the value of their ownership interests, including any claim that challenges a statutory transaction engaged in by the MIC before the effective date of the reorganization.

As added by P.L.5-2000, SEC.4.

IC 27-14-7-8
Effect of reorganization on pending actions

Sec. 8. If a proceeding is pending against an MIC that is the subject of a plan of reorganization under this article:

(1) the proceeding may be continued after the effective date as if the reorganization had not occurred; or

(2) the reorganized insurer that is the successor to the MIC's business may be substituted in the proceeding for the MIC;

except that the MIHC resulting from the plan of reorganization shall be substituted for the MIC and any subsidiaries of the MIC in all proceedings involving any claim described in section 7(b) of this chapter.

As added by P.L.5-2000, SEC.4.

IC 27-14-7-9
Conversion of MIHC to stock company

Sec. 9. An MIHC may convert to a stock company under IC 27-15 as though the MIHC were an MIC.

As added by P.L.5-2000, SEC.4. Amended by P.L.1-2010, SEC.113; P.L.11-2011, SEC.39.

IC 27-14-7-10

Experts hired by commissioner

Sec. 10. The commissioner shall, at the applicant's expense, hire attorneys, actuaries, accountants, investment bankers, and other experts as may be necessary to assist the commissioner in reviewing all matters under this article that are associated with a plan of reorganization or a plan to issue stock. The commissioner may at any time require an applicant to deposit an amount of money with the department of insurance in anticipation of expenses to be incurred by the commissioner under this article.

As added by P.L.5-2000, SEC.4.

IC 27-14-7-11

Adoption of rules

Sec. 11. The commissioner may adopt rules under IC 4-22-2 to carry out the purposes of this article.

As added by P.L.5-2000, SEC.4.

IC 27-14-7-12

Reorganization of domestic MIC with foreign mutual holding company

Sec. 12. (a) A domestic MIC may reorganize with a foreign mutual holding company by complying with IC 27-14-2. The commissioner may waive any provision of IC 27-14-2 if the commissioner determines the provision to be unnecessary for the protection of policyholders and members.

(b) A plan of reorganization under subsection (a) is effective when the reorganized domestic stock insurance company subsidiary has filed its articles of amendment and amended certificate of authority in the office of the county recorder of the county in which the principal office of the company is located or at a later date specified in the plan of reorganization.

(c) A domestic MIC seeking to reorganize under subsection (a) may at the same time redomesticate to another state by complying with IC 27-1-6.5 and the applicable requirements of the state to which it seeks to transfer domicile.

As added by P.L.5-2000, SEC.4.

IC 27-14-7-13

Acquisition of foreign MIC by existing MIHC; granting membership interests

Sec. 13. (a) An existing MIHC may, with the prior approval of the commissioner:

(1) acquire direct or indirect ownership of a converting foreign MIC that becomes a stock insurer in compliance with the laws of its state of domicile; and

(2) grant membership interests and equity rights to the members or policyholders of a foreign mutual insurer that merges with a direct or indirect domestic or foreign subsidiary of the MIHC or

is otherwise acquired by the MIHC.

(b) The commissioner shall consider the fairness of the terms and conditions of the transaction, whether the interests of the members of each MIHC that is a party to the transaction are protected, and whether the proposed transaction is in the public interest when determining whether to approve a transaction under subsection (a).

As added by P.L.5-2000, SEC.4.

IC 27-14-7-14

Concurrent reorganization of multiple MICs into single MIHC

Sec. 14. The concurrent reorganization of two (2) or more MICs into a single MIHC structure under IC 27-14-2 may be accomplished by a joint application and a joint plan of reorganization and may be approved by the commissioner following a combined hearing. The commissioner may allow such other procedures as may be necessary or desirable to avoid unnecessary or duplicative costs and efforts in satisfying the requirements of this article and in effectuating the reorganization.

As added by P.L.5-2000, SEC.4.

IC 27-14-7-15

Reorganization of MIHC with foreign mutual insurance holding company

Sec. 15. An MIHC may reorganize with a foreign mutual insurance holding company, subject to the approval of the commissioner, under IC 27-1-23. If the MIHC is not the surviving entity in any reorganization transaction, then the commissioner must consider the effect of the transaction on the protections afforded policyholders under the members' surplus protection principle in determining whether the transaction is in the best interests of the policyholders. If the commissioner waives any or all of the provisions of the members' surplus protection principle in approving a transaction, then the commissioner must explain the basis for waiving the provisions in writing in the order approving the transaction.

As added by P.L.5-2000, SEC.4.

IC 27-15

ARTICLE 15. DEMUTUALIZATION OF MUTUAL INSURANCE COMPANIES

IC 27-15-1

Chapter 1. General Provisions and Definitions

IC 27-15-1-1

Short title

Sec. 1. This article may be referred to as the Indiana demutualization law.

As added by P.L.94-1999, SEC.3.

IC 27-15-1-2

Conversion generally

Sec. 2. (a) Any domestic mutual insurance company that:

(1) maintains its executive offices in Indiana; and

(2) employs at least five hundred (500) persons or a substantial percentage of its workforce in Indiana;

may, by amendment to its articles of incorporation, convert to a stock insurance company by means of a plan of conversion described in IC 27-15-2-2 or a simple plan of conversion described in IC 27-15-2-3 and IC 27-1-8.

(b) The commissioner shall determine whether a mutual insurance company meets the requirements of subsection (a)(2).

As added by P.L.94-1999, SEC.3. Amended by P.L.14-2000, SEC.61.

IC 27-15-1-3

Applicability of definitions

Sec. 3. The definitions set forth in this chapter and IC 27-1-2-3 apply throughout this article.

As added by P.L.94-1999, SEC.3.

IC 27-15-1-4

"Closed block"

Sec. 4. "Closed block" means an allocation of assets for a defined group of in force policies which, together with the premiums of those policies and related investment earnings, are expected to be sufficient to maintain the payments of guaranteed benefits, certain expenses, and continuation of the current dividend scale on the closed block, if experience does not change.

As added by P.L.94-1999, SEC.3.

IC 27-15-1-5

"Company action level RBC"

Sec. 5. "Company action level RBC" has the meaning set forth in IC 27-1-36-6.

As added by P.L.94-1999, SEC.3.

IC 27-15-1-6
"Converting mutual"

Sec. 6. "Converting mutual" means a domestic mutual insurance company that has adopted a plan of conversion and an amendment to its articles of incorporation under this article that will, upon consummation, result in the domestic mutual insurance company converting into a domestic stock insurance company.

As added by P.L.94-1999, SEC.3.

IC 27-15-1-7
"Eligible member"

Sec. 7. "Eligible member" means a person who:

(1) is a member of the converting mutual on the date the converting mutual's board of directors adopts a resolution proposing a plan of conversion and an amendment to the articles of incorporation; and

(2) continues to be a member of the converting mutual on the effective date of the conversion.

As added by P.L.94-1999, SEC.3.

IC 27-15-1-8
"Former mutual"

Sec. 8. "Former mutual" means the domestic stock insurance company resulting from the conversion of a converting mutual to a stock insurance company under a plan of conversion and an amendment to its articles of incorporation under this article.

As added by P.L.94-1999, SEC.3.

IC 27-15-1-9
"Member"

Sec. 9. "Member" means a person that, according to the:

(1) records;

(2) articles of incorporation; and

(3) bylaws;

of a converting mutual, is a member of the converting mutual.

As added by P.L.94-1999, SEC.3.

IC 27-15-1-10
"Membership interests"

Sec. 10. "Membership interests" means:

(1) the voting rights of members of a domestic mutual insurance company as provided by law and by the company's articles of incorporation and bylaws; and

(2) the rights of members of a domestic mutual insurance company to receive cash, stock, or other consideration in the event of a conversion to a stock insurance company under this article or a dissolution under IC 27-1-10, as provided by those laws and by the company's articles of incorporation and bylaws.

As added by P.L.94-1999, SEC.3.

IC 27-15-1-11
"Parent company"

Sec. 11. "Parent company" means a corporation that, upon the effective date of a conversion, owns all of the stock of the former mutual.

As added by P.L.94-1999, SEC.3.

IC 27-15-1-12
"Plan of conversion"

Sec. 12. "Plan of conversion" means the plan of conversion described in either IC 27-15-2-2 or IC 27-15-2-3.

As added by P.L.94-1999, SEC.3.

IC 27-15-1-13
"RBC level"

Sec. 13. "RBC level" has the meaning set forth in IC 27-1-36-18.

As added by P.L.94-1999, SEC.3.

IC 27-15-1-14
"Simple plan of conversion"

Sec. 14. "Simple plan of conversion" means the plan of conversion described in IC 27-15-2-3.

As added by P.L.94-1999, SEC.3.

IC 27-15-2

Chapter 2. Plan of Conversion

IC 27-15-2-1

Commencement of demutualization

Sec. 1. The board of directors of the converting mutual shall commence the demutualization process by adopting a resolution that proposes:

(1) the amendment of its articles of incorporation under IC 27-1-8-2; and

(2) a plan of conversion.

As added by P.L.94-1999, SEC.3.

IC 27-15-2-2

Required provisions

Sec. 2. The plan of conversion, other than a simple plan of conversion, must do the following in accordance with this article:

(1) Describe the manner in which the proposed conversion will occur and the insurance and any other companies that will result from or be directly affected by the conversion, including the former mutual and any parent company.

(2) Provide that the membership interests in the converting mutual will be extinguished as of the effective date of the conversion.

(3) Require the distribution to the eligible members, upon the extinguishing of their membership interests, of aggregate consideration equal to the fair value of the converting mutual.

(4) Describe the manner in which the fair value of the converting mutual has been or will be determined.

(5) Describe the form or forms and amount, if known, of consideration to be distributed to the eligible members.

(6) Specify relevant classes, categories, or groups of eligible members, and describe and explain any differences in the form or forms and amount of consideration to be distributed to or among the eligible members.

(7) Require and describe the method or formula for the fair and equitable allocation of the consideration among the eligible members.

(8) Provide for the determination and preservation of the reasonable dividend expectations of eligible members and other policyholders with policies that provide for the distribution of policy dividends, through establishment of a closed block or other method acceptable to the commissioner.

(9) Provide that each member and other policyholder of the converting mutual will receive notification of the address and telephone number of the converting mutual and the former mutual, if different, along with the notice of hearing outlined in IC 27-15-4-4.

(10) Include other provisions as the converting mutual determines to be necessary.

As added by P.L.94-1999, SEC.3.

IC 27-15-2-3

Adoption of simple plan of conversion

Sec. 3. (a) The board of directors of the converting mutual may adopt a simple plan of conversion under this section. The simple plan of conversion must include the following:

(1) The distribution to the eligible members, upon the extinguishing of their membership interests, of all of the initial issue of the voting common stock of the former mutual or any parent company. The initial issue of the voting common stock may include only one (1) class of stock, and may not include more than one (1) series of stock.

(2) Describe the manner in which the proposed conversion will occur and the insurance and any other companies that will result from or be directly affected by the conversion, including the former mutual and any parent company.

(3) Provide that the membership interests in the converting mutual will be extinguished as of the effective date of the conversion.

(4) Provide for the registration of that distribution of stock under section 5 of the federal Securities Act of 1933, as amended.

(5) Specify each separate class, category, or group of eligible members, and describe and explain any differences in the amount of stock to be distributed to or among the eligible members of each separate class, category, or group of eligible members.

(6) Require and describe the method or formula for the fair and equitable allocation of the stock among the eligible members.

(7) Provide for the determination and preservation of the reasonable dividend expectations of eligible members and other policyholders with policies that provide for the distribution of policy dividends, through the establishment of a closed block or other method acceptable to the commissioner.

(b) The plan may include other provisions:

(1) that the converting mutual determines to be necessary; and

(2) consistent with this title.

As added by P.L.94-1999, SEC.3.

IC 27-15-3
Chapter 3. Application for Conversion

IC 27-15-3-1
Filing with commissioner

Sec. 1. After the adoption by the board of directors of the resolution proposing the plan of conversion under IC 27-15-2 and the amendment to its articles of incorporation, the converting mutual shall file with the commissioner an application for approval of the plan and amendment.

As added by P.L.94-1999, SEC.3.

IC 27-15-3-2
Content of application

Sec. 2. The application must contain the following information, together with such additional information as the commissioner may require:

(1) The plan of conversion and a certificate of the secretary of the converting mutual certifying the adoption of the plan by the board of directors.

(2) A statement of the reasons for the proposed conversion and why the conversion is in the best interests of the converting mutual, the eligible members, and the other policyholders. The statement must include an analysis of the risks and benefits to the converting mutual and its members of the proposed conversion and a comparison of the risks and benefits of the conversion with the risks and benefits of reasonable alternatives to a conversion.

(3) A five (5) year business plan and at least two (2) years of financial projections of the former mutual and any parent company.

(4) Any plans that the former mutual or any parent company may have to:

(A) raise additional capital through the issuance of stock or otherwise;

(B) sell or issue stock to any person, including any compensation or benefit plan for directors, officers, or employees under which stock may be issued;

(C) liquidate or dissolve any company or sell any material assets;

(D) merge or consolidate or pursue any other form of reorganization with any person; or

(E) make any other material change in investment policy, business, corporate structure, or management.

(5) Any plans for a delayed distribution of consideration to eligible members or restrictions on sale or transfer of stock or other securities.

(6) A copy of the form of trust agreement, if a distribution of

consideration is to be delayed by more than six (6) months after the effective date of the conversion.

(7) A plan of operation for a closed block, if a closed block is used for the preservation of the reasonable dividend expectations of eligible members and other policyholders with policies that provide for the distribution of policy dividends.

(8) Copies of the amendment to the articles of incorporation proposed by the board of directors and the proposed bylaws of the former mutual and copies of the existing and any proposed articles of incorporation and bylaws of any parent company.

(9) A list of all individuals who are or have been selected to become directors or officers of the former mutual and any parent company, or the individuals who perform or will perform duties customarily performed by a director or officer, and the following information concerning each individual on the list unless the information is already on file with the commissioner:

(A) The individual's principal occupation.

(B) All offices and positions the individual has held in the preceding five (5) years.

(C) Any crime of which the individual has been convicted (other than traffic violations) in the preceding ten (10) years.

(D) Information concerning any personal bankruptcy of the individual or the individual's spouse during the previous seven (7) years.

(E) Information concerning the bankruptcy of any corporation or other entity of which the individual was an officer or director during the previous seven (7) years.

(F) Information concerning allegations of state or federal securities law violations made against the individual that within the previous ten (10) years resulted in:

(i) a determination that the individual violated state or federal securities law;

(ii) a plea of nolo contendere; or

(iii) a consent decree.

(G) Information concerning the suspension, revocation, or other disciplinary action during the previous ten (10) years of any state or federal license issued to the individual.

(H) Information as to whether the individual was refused a bond during the previous ten (10) years.

(10) A fairness opinion addressed to the board of directors of the converting mutual from a qualified, independent financial adviser, asserting:

(A) that the provision of stock, cash, policy benefits, or other forms of consideration upon the extinguishing of the converting mutual's membership interests under the plan of conversion and the amendment to the articles of incorporation is fair to the eligible members, as a group, from a financial point of view; and

(B) whether the total consideration under clause (A) is equal to or greater than the surplus of the converting mutual.

(11) An actuarial opinion as to the following:

(A) The reasonableness and appropriateness of the methodology or formulas used to allocate consideration among eligible members, consistent with this article.

(B) The reasonableness of the plan of operation and the sufficiency of the assets allocated to the closed block, if a closed block is used for the preservation of the reasonable dividend expectations of eligible members and other policyholders with policies that provide for the distribution of policy dividends.

(12) If any of the consideration to be distributed to eligible members consists of stock or other securities, a description of the plans made by the former mutual or its parent company to assure that an active public trading market for the stock or other securities will develop within a reasonable amount of time after the effective date of the plan of conversion and that eligible members who receive stock or other securities will be able to sell their stock or other securities, subject to any delayed distribution or transfer restrictions under this article, at reasonable cost and effort. The plans may consist of the following:

(A) Appointing a registrar and transfer agent for the stock or other securities.

(B) Making filings, applications, or registrations for the stock or other securities with the federal Securities and Exchange Commission and state securities commissioners.

(C) Listing the stock or other securities on a national or other securities exchange.

(D) Facilitating coverage of the stock or other securities by research analysts and securing the commitment of at least one (1) market maker to make a market in the stock or other securities.

(E) Conducting an underwritten public offering of the same class of stock or other securities, promptly following the effectiveness of the plan of conversion, in order to facilitate the development of a public market.

(F) Making available a procedure for eligible members holding small numbers or amounts of stock or other securities to sell their stock or other securities to the former mutual or a parent company at market value without the payment of brokerage commissions or similar fees, or to sell their stock or other securities in the market through a broker with discounted brokerage commissions or fees.

(13) Any additional information, documents, or materials that the converting mutual determines to be necessary.

(14) Any other additional information, documents, or materials

that the commissioner requests in writing.
As added by P.L.94-1999, SEC.3.

IC 27-15-3-3
Content excepted from simple plan of conversion

Sec. 3. Notwithstanding section 2 of this chapter, the opinion described in section 2(10) of this chapter is not required under this chapter if the converting mutual utilizes a simple plan of conversion.
As added by P.L.94-1999, SEC.3.

IC 27-15-3-4
Actuarial opinion requirements

Sec. 4. The actuarial opinion required by this chapter shall be:

(1) provided and signed by a qualified and independent actuary who is a member of the American Academy of Actuaries;

(2) given in accordance with professional standards and practices generally accepted by the actuarial profession and those other factors as the actuary believes are reasonable and appropriate in the exercise of professional judgment at the time the opinion is given;

(3) supported by a memorandum of the actuary, describing the calculations made in support of the opinion and the assumptions used in the calculations; and

(4) submitted to the commissioner.

As added by P.L.94-1999, SEC.3.

IC 27-15-4

Chapter 4. Public Hearing and Commissioner's Determination

IC 27-15-4-1

Commissioner's determination of application completeness; designation of date for public hearing

Sec. 1. (a) The commissioner shall determine, within forty-five (45) days after the later of:

(1) the submission of an application for approval of a plan of conversion; or

(2) the submission of any amendment to the application;

whether the application is complete.

(b) Upon determining that the application is complete, the commissioner shall designate a date for a public hearing on the plan of conversion and the amendment to the articles of incorporation.

(c) No public hearing by the commissioner under this chapter is required for a simple plan of conversion.

As added by P.L.94-1999, SEC.3.

IC 27-15-4-2

Purpose of public hearing

Sec. 2. The commissioner shall hold a public hearing upon the plan of conversion and the amendment to the articles of incorporation. The purpose of the public hearing shall be to receive comments and information to aid the commissioner in considering and approving or disapproving the application for approval of the plan of conversion and the amendment to the articles of incorporation. Persons wishing to make comments and submit information may submit written statements before or at the public hearing and may also appear and be heard at the public hearing.

As added by P.L.94-1999, SEC.3.

IC 27-15-4-3

Commencement of hearing; postponement

Sec. 3. The public hearing shall commence within sixty (60) days after the date on which the commissioner determines the application is complete, unless the converting mutual requests, and the commissioner agrees to, a longer period. In the event that an amendment to the plan of conversion or the application for approval is filed with the commissioner after the commissioner has determined the application is complete, the hearing may be postponed for a period not to exceed sixty (60) days after the filing of the amendment.

As added by P.L.94-1999, SEC.3.

IC 27-15-4-4

Notice of hearing

Sec. 4. (a) The converting mutual shall provide at least thirty (30) days prior written notice of the hearing to its members and other policyholders as of the date its board of directors adopted the resolution proposing the plan of conversion.

(b) The notice must include the following:

(1) A brief statement of the subject of the hearing, the date, time, and location of the hearing.

(2) A description of members eligible to vote on the plan of conversion and the amendment to the articles of incorporation.

(3) A statement that the members and policyholders may examine, at the department, the public record portion of the application submitted to the commissioner.

(4) The address and telephone number of the converting mutual and, if different, the former mutual.

(c) The converting mutual shall provide the commissioner with the proposed form and content of the notice not less than fifteen (15) days before notice is to be provided to the members and policyholders, and the commissioner shall approve or disapprove the form and content of the notice within ten (10) days after its submission to the commissioner. The notice to members and other policyholders shall, after approval by the commissioner, be provided by mail or other means approved by the commissioner.

As added by P.L.94-1999, SEC.3.

IC 27-15-4-5

Publication of notice

Sec. 5. (a) The converting mutual shall cause notice of the public hearing to be published in a newspaper of general circulation in the city where the principal office of the converting mutual is located, in Indianapolis, and in any other city specified by the commissioner at the time the commissioner determines that the application is complete.

(b) The notice shall be published at least two (2) times at intervals of not less than two (2) weeks, the first publication to be not more than forty-five (45) days and the last publication not less than fifteen (15) days before the public hearing. The notice of the public hearing shall state the purpose of the hearing and the date, time, and place where the hearing will occur.

(c) The converting mutual shall provide the commissioner with the proposed form and content of the notice not less than fifteen (15) days before it is to be first published, and the commissioner shall approve or disapprove the form and content of the notice within ten (10) days after its submission to the commissioner.

As added by P.L.94-1999, SEC.3.

IC 27-15-4-6

Hearing procedures

Sec. 6. The hearing shall be conducted by the commissioner or by

the commissioner's designee, consistent with the procedures described in IC 4-22-2-26.
As added by P.L.94-1999, SEC.3.

IC 27-15-4-7
Issuance of commissioner's determination

Sec. 7. (a) The commissioner shall fully consider any comments received at a required hearing consistent with IC 4-22-2-27 before issuing an order approving or disapproving the application, plan of conversion, and amendment to the articles of incorporation.

(b) The commissioner's order or determination shall:

(1) be issued within thirty (30) days after the last day of the public hearing or, for a simple plan of conversion, within ninety (90) days after the filing of an application for approval of the plan;

(2) be in writing; and

(3) detail the reasons why the converting mutual's application is approved or disapproved.

As added by P.L.94-1999, SEC.3.

IC 27-15-4-8
Findings required for application approval

Sec. 8. The commissioner shall approve the application and permit the conversion under the plan of conversion and the amendment to the articles of incorporation if the commissioner finds, following the public hearing, if required:

(1) that the amount and form of consideration is fair in the aggregate and to each member class;

(2) that the plan of conversion and the amendment to the articles of incorporation:

(A) comply with this article and other applicable laws;

(B) are fair, reasonable, and equitable to the eligible members; and

(C) will not prejudice the interests of the other policyholders of the converting mutual; and

(3) except for a simple plan of conversion, that the total consideration provided to eligible members upon the extinguishing of the converting mutual's membership interests is equal to or greater than the surplus of the converting mutual.

As added by P.L.94-1999, SEC.3.

IC 27-15-4-9
Waiver of findings for application approval

Sec. 9. The commissioner may waive the requirement of section 8(3) of this chapter upon a showing of good cause.
As added by P.L.94-1999, SEC.3.

IC 27-15-5

Chapter 5. Voting on the Plan by Members

IC 27-15-5-1

Submission of plan to vote

Sec. 1. The proposed plan of conversion and amendment to the articles of incorporation of the converting mutual shall be submitted to a vote of the members of the converting mutual, as provided in IC 27-1-8-3 and in this chapter.

As added by P.L.94-1999, SEC.3.

IC 27-15-5-2

Time of meeting

Sec. 2. The meeting of members shall be held not later than ninety (90) days after the later of:

(1) the issuance of the commissioner's order approving the conversion; or

(2) the final resolution of an appeal of that decision under this article.

As added by P.L.94-1999, SEC.3.

IC 27-15-5-3

Notice of opportunity to vote; form and content

Sec. 3. (a) The members of the converting mutual entitled to vote on the plan of conversion and the amendment to the articles of incorporation shall be given written notice of their opportunity to vote. The notice shall be accompanied by explanatory information concerning the conversion and may be accompanied by proxy solicitation materials.

(b) The form and content of the notice, explanatory information, and any proxy solicitation materials must be provided to the commissioner not less than twenty (20) business days before they are mailed to the members, and the commissioner shall approve or disapprove the form and content of the notice, explanatory materials, and any proxy solicitation materials within fifteen (15) business days after their submission to the commissioner.

(c) The notice and explanatory materials must include the following:

(1) Reference to the applicable statutory provisions.

(2) The date, time, and location of the meeting.

(3) A brief statement of the subject of the meeting.

(4) A copy of the plan of conversion and a summary of the plan.

(5) A copy of the amendment to the articles of incorporation and a summary of the amendment.

(6) A description of the member's right to attend and participate in the meeting.

(7) The definition of the term "eligible member".

(8) A statement that no member will receive consideration as a

result of the conversion unless the member continues to be a member of the converting mutual on the effective date of the conversion.

(9) For each form of consideration, a description of the nature and amount of consideration that will be provided to the eligible members upon completion of the conversion and, if reasonably ascertainable by the converting mutual, a description of the nature and amount or approximate amount of consideration to be provided to the particular member to whom the notice is addressed.

As added by P.L.94-1999, SEC.3.

IC 27-15-5-4

Notice of opportunity to vote; Flesch reading ease score; mailing

Sec. 4. The notice described in section 3 of this chapter:

(1) must achieve a minimum score of forty (40) on the Flesch reading ease test or an equivalent score on a comparable test approved by the commissioner;

(2) shall be mailed, or provided by some other method or methods as may be approved by the commissioner, not less than thirty (30) days before the date of the meeting of members to vote on the plan of conversion and amendment to the articles of incorporation; and

(3) may be combined with any other notices, materials, or information.

As added by P.L.94-1999, SEC.3.

IC 27-15-5-5

Members entitled to vote

Sec. 5. (a) Only members of the converting mutual as of both:

(1) the date the converting mutual's board of directors adopted the resolution proposing the plan of conversion and the amendment to the articles of incorporation; and

(2) the record date for the members' meeting established by the board of directors;

are entitled to vote on the proposed plan of conversion and the amendment to the articles of incorporation of the converting mutual.

(b) Each member is entitled to cast only one (1) vote, irrespective of the number or value of policies held, unless the converting mutual's articles of incorporation provide otherwise.

As added by P.L.94-1999, SEC.3.

IC 27-15-5-6

Proxy voting

Sec. 6. Notwithstanding IC 27-1-7-9, a member may vote by proxy only if:

(1) the proxy was solicited and obtained from the member for the express purpose of voting on the plan of conversion and the

amendment to the articles of incorporation; and

(2) the proxy solicitation materials were provided to and approved by the commissioner before they were mailed or provided to the member.

As added by P.L.94-1999, SEC.3.

IC 27-15-5-7

Vote required for approval

Sec. 7. The proposed plan of conversion and amendment to the converting mutual's articles of incorporation shall be approved by the members upon receiving the affirmative votes of:

(1) at least two-thirds (2/3) of the members voting at the meeting; and

(2) if the plan provides for different classes, categories, or groups of eligible members to receive different forms of consideration, other than as permitted by IC 27-15-8-4(b)(2) or IC 27-15-12, at least two-thirds (2/3) of the members voting at the meeting who would receive each different form of consideration, voting as a class.

As added by P.L.94-1999, SEC.3.

IC 27-15-6

Chapter 6. Implementation of Approved Plan of Conversion

IC 27-15-6-1

Consummation of plan

Sec. 1. After the proposed plan of conversion and amendment to the converting mutual's articles of incorporation are approved by the commissioner and approved by the members under this article, the converting mutual may proceed to consummate the plan and comply with IC 27-1-8.

As added by P.L.94-1999, SEC.3.

IC 27-15-6-2

Effective date

Sec. 2. The plan of conversion and the amendment to the articles of incorporation of the converting mutual become effective upon the date and time of approval of the articles of amendment by the secretary of state as provided in IC 27-1-8-8, unless a later date and time are specified in the articles of amendment, in which event the plan of conversion and amendment become effective and take place at the later date and time.

As added by P.L.94-1999, SEC.3.

IC 27-15-6-3

Effect of plan and amendment

Sec. 3. When the plan of conversion and the amendment to the articles of incorporation of the converting mutual become effective:

(1) the converting mutual shall:

(A) be converted from a domestic mutual insurance company to a domestic stock insurance company; and

(B) have all the rights, privileges, immunities, and powers and be subject to all the duties and liabilities of a stock insurance company existing under this title;

(2) the membership interests of every member and policyholder of the converting mutual are extinguished and cease; and

(3) the rights of every member and policyholder of the converting mutual under any contract of insurance continue in force under the terms of the contract, including rights, if any, to policyholder dividends.

As added by P.L.94-1999, SEC.3.

IC 27-15-6-4

Continuation of former mutual

Sec. 4. The former mutual shall be a continuation of the original converting mutual in all of the following respects:

(1) The former mutual shall be recognized as an insurance company formed under the laws of this state as of the date of the company's original organization.

(2) The conversion does not in any way annul, modify, or change any of the original converting mutual's existing suits, claims, demands, rights, contracts, or other assets, or absolute or contingent liabilities.

(3) The former mutual shall be vested in all of the rights, franchises, and interests of the converting mutual in and to every species of property without any deed or transfer.

(4) The former mutual shall succeed to all the obligations and liabilities of the converting mutual and retain all rights and contracts existing before the effectiveness of the conversion.

As added by P.L.94-1999, SEC.3.

IC 27-15-6-5

Compliance with capital and surplus requirements

Sec. 5. The former mutual shall comply with the minimum capital and surplus requirements applicable to domestic stock insurance companies as though the former mutual was organized as a stock insurance company on its original date of organization.

As added by P.L.94-1999, SEC.3.

IC 27-15-7

Chapter 7. Confidential Records

IC 27-15-7-1

Applicability of chapter

Sec. 1. Except as otherwise specifically provided in this chapter, IC 5-14 applies to all filings made under this article.

As added by P.L.94-1999, SEC.3.

IC 27-15-7-2

Purpose; effect of confidentiality

Sec. 2. Filings, information, and documents made with or provided to the commissioner under this article may include information that might be damaging to a converting mutual or its affiliates if made available to competitors. Subject to section 3 of this chapter, all documents containing trade secrets of a converting mutual or its affiliates and marked "confidential" by the converting mutual:

(1) are declared confidential for purposes of IC 5-14-3-4;

(2) are not subject to inspection and copying by the public under IC 5-14-3-3;

(3) may be disclosed by the commissioner to the department of insurance of another state if that department of insurance agrees to keep the information confidential; and

(4) may not be disclosed by the commissioner to any person other than a department of insurance under subdivision (3) without the written consent of the converting mutual.

As added by P.L.94-1999, SEC.3.

IC 27-15-7-3

Disclosure of confidential information

Sec. 3. (a) Subject to subsection (c), the commissioner may disclose to any person all or part of any document marked "confidential" in the commissioner's possession as the result of being filed under this article if the following conditions are met:

(1) The commissioner must give written notice of the proposed disclosure to the converting mutual and any other person requesting disclosure.

(2) The converting mutual must be given an opportunity in private to respond to the proposed disclosure.

(3) The commissioner must give consideration to any legitimate interest in preserving trade secrets.

(4) The commissioner must determine that the eligible members or other policyholders have a compelling interest which would be served by disclosure.

(5) At least five (5) business days have elapsed from the converting mutual's receipt of written notice.

(b) The commissioner may disclose information under subsection

(a) in a manner and subject to limitations as the commissioner considers appropriate.

(c) If:

(1) not more than six (6) business days have elapsed since the converting mutual received notice of a proposed disclosure; and

(2) the converting mutual has notified the commissioner that it or another interested party has filed an action seeking a protective order from a circuit or superior court to prevent or to limit disclosure;

the commissioner may not disclose the documents or copies of documents during the pendency of the action and any appeal or after any final court decision prohibiting disclosure.

As added by P.L.94-1999, SEC.3.

IC 27-15-8
Chapter 8. Distribution of Consideration to Members

IC 27-15-8-1
Forms of consideration

Sec. 1. The consideration to be distributed to the eligible members shall be:

(1) cash;

(2) stock or other securities of the former mutual or of the parent company;

(3) additional paid up insurance or annuity benefits;

(4) any combination of the forms of consideration listed in this section; or

(5) other forms of consideration described in the plan of conversion and approved by the commissioner.

As added by P.L.94-1999, SEC.3.

IC 27-15-8-2
Factors in determination of forms and amount

Sec. 2. The amount and the form or forms of consideration to be distributed to a class, category, or group of eligible members may differ from the amount and form or forms of consideration to be distributed to another class, category, or group of eligible members. The choice of the amount and form or forms of consideration to be distributed to a class or category of eligible members may take into account such factors as the type of policies with respect to which the consideration is being distributed, the country or state of residence or tax status of the eligible members, the length of time the eligible members have been members of the converting mutual, or other appropriate factors or circumstances described in the plan of conversion.

As added by P.L.94-1999, SEC.3.

IC 27-15-8-3
Delay in distribution; time limitation

Sec. 3. Distribution of all or part of the consideration to some or all of the eligible members may be delayed, or restrictions on sale or transfer of any stock or other securities to be distributed to eligible members may be required, for a reasonable period of time following the effective date of the conversion. However, the period of time may not exceed six (6) months except as permitted under IC 27-15-12.

As added by P.L.94-1999, SEC.3.

IC 27-15-8-4
Distribution of initial stock

Sec. 4. (a) A converting mutual using IC 27-15-2-2 or a converting mutual using a simple plan of conversion under IC 27-15-2-3 may satisfy the requirement to distribute the fair value

of the converting company to the eligible members by providing for the distribution to the eligible members of all of the initial stock without the payment by or to the eligible members of any additional consideration.

(b) For purposes of this section, all of the initial issue of the only class of voting common stock of the former mutual or a parent company shall be considered distributed to the eligible members even if the plan of conversion or the application for approval provides for:

(1) the offer or sale, promptly following the effective date of the plan of conversion, to the public or to other persons of additional shares of the same class of voting common stock of the former mutual or a parent company at a price not less than the fair market value of that stock, with the proposed terms of the transaction disclosed to the commissioner in the application for approval;

(2) the distribution to or for the benefit of certain classes, categories, or groups of eligible members of cash, additional paid up insurance or annuity benefits, or other consideration in lieu of initial stock of the former mutual or a parent company, if:

(A) other consideration is required or appropriate as a result of tax considerations, the country or state of residence of the eligible members, the nominal value of the stock that those eligible members otherwise would be entitled to receive, or other factors or circumstances approved by the commissioner;

(B) the value of the other consideration to be distributed to those eligible members is substantially equal, as of the effective date of the conversion, to the value of the stock those eligible members otherwise would be entitled to receive;

(C) the eligible members who receive any consideration other than stock constitute not more than ten percent (10%) of the total number of eligible members; and

(D) the classes, categories, or groups of those eligible members, and the consideration they are to receive in lieu of stock, are described in the plan of conversion, with all additional material terms and conditions disclosed in the application for approval; or

(3) a delayed distribution of consideration that is approved under section 3 of this chapter or IC 27-15-12.

As added by P.L.94-1999, SEC.3.

IC 27-15-9

Chapter 9. Formula for Allocation of Consideration Among Members

IC 27-15-9-1

Value, amount, or proportion of consideration received

Sec. 1. The method or formula for allocating consideration among the eligible members shall provide for each eligible member to receive:

(1) a fixed value, amount, or proportion of consideration;

(2) a variable value, amount, or proportion of consideration; or

(3) a combination of fixed and variable values, amounts, or proportions of consideration.

As added by P.L.94-1999, SEC.3.

IC 27-15-9-2

Applicable actuarial principles

Sec. 2. Any method used or formula developed for the fair and equitable allocation of stock among eligible members under this article must utilize generally accepted actuarial principles.

As added by P.L.94-1999, SEC.3.

IC 27-15-10
Chapter 10. Dividend Preservation

IC 27-15-10-1
Purpose of provisions; prohibitions

Sec. 1. (a) The sole purpose of any dividend preservation provision shall be to provide for reasonable policyholder dividend expectations on policies that provide for the distribution of policy dividends.

(b) No dividend preservation provision in a plan under this article shall be permitted:

(1) to be a substitute for the distribution of consideration to eligible members upon extinguishing their membership interests as required by this article; or

(2) to diminish any contractual rights to a dividend that a member or policyholder may have.

As added by P.L.94-1999, SEC.3.

IC 27-15-10-2
Limitations on provisions

Sec. 2. Any dividend preservation provision may be limited to participating individual life insurance policies and participating individual annuity contracts in force or considered to be in force by the plan of conversion on the effective date of the plan of conversion for which the mutual insurer has an experience based dividend scale due, paid, or accrued by action of the board of directors of the converting mutual in the year in which the plan of reorganization is adopted. However:

(1) policies that would be included but for the fact that their recent issuance results in no dividends for an initial period may be included;

(2) policies that are in force as extended term insurance may be included; and

(3) other categories of policies and benefits not described in this subsection may be included or excluded, subject to the approval of the commissioner.

As added by P.L.94-1999, SEC.3.

IC 27-15-11

Chapter 11. Use of a Closed Block

IC 27-15-11-1

Applicability of chapter

Sec. 1. This chapter applies if a closed block is used for the preservation of the reasonable dividend expectations of eligible members and other policyholders.

As added by P.L.94-1999, SEC.3.

IC 27-15-11-2

Preparation of written plan of operation

Sec. 2. The converting mutual shall prepare a written plan of operation for the closed block, consistent with the requirements of this article.

As added by P.L.94-1999, SEC.3.

IC 27-15-11-3

Operation of closed block; nonreversion of assets

Sec. 3. The closed block shall be operated for the exclusive benefit of policies and contracts included in it. No costs or expenses incurred in connection with the conversion shall be charged to the closed block. Subject to termination of the closed block under section 7 of this chapter, none of the assets allocated to the closed block or the revenue derived from those assets may revert to the benefit of the stockholders of the former mutual or any parent company.

As added by P.L.94-1999, SEC.3.

IC 27-15-11-4

Sufficiency of assets

Sec. 4. The assets allocated to the closed block, together with the revenue from the closed block, must be reasonably sufficient to:

(1) support the business in the closed block until the time the last policy in the closed block has terminated, including payment of claims and those expenses and taxes as are specified in the plan of conversion; and

(2) provide for:

(A) continuation of dividend scales in effect on the date the board of directors adopted the resolution proposing the plan of conversion, if the experience underlying those scales continues; and

(B) appropriate adjustments in the scales if the experience changes.

As added by P.L.94-1999, SEC.3.

IC 27-15-11-5

Designation of assets

Sec. 5. The assets assigned to a closed block shall be specified in the plan of operation and must consist of:

(1) a list of designated assets of the converting mutual's general account or specified segments of the converting mutual's general account, which list shall change periodically to reflect the acquisition and disposition of assets;

(2) a designated portion of each and every asset of the converting mutual's general account or specified segments of the converting mutual's general account, which portion shall change periodically to reflect the cash flows of the closed block; or

(3) assets designated by a combination of the methods described in this section.

As added by P.L.94-1999, SEC.3.

IC 27-15-11-6

Methods for assignment or designation of assets

Sec. 6. The plan of operation must specify the following:

(1) The method of assignment of closed block assets referred to in section 5 of this chapter that is being used.

(2) The methods by which the designations of assets or portions of assets are changed during the course of closed block operations.

As added by P.L.94-1999, SEC.3.

IC 27-15-11-7

Conditions for ceasing maintenance of closed block

Sec. 7. The plan of operation must provide for the conditions under which the former mutual, with the approval of the commissioner, may cease to maintain the closed block.

As added by P.L.94-1999, SEC.3.

IC 27-15-11-8

Annual reports and reviews of former mutual

Sec. 8. The former mutual shall:

(1) submit to the commissioner annual reports, in a form acceptable to the commissioner, that account for and describe the operations of the closed block; and

(2) as specified in the plan of operation, provide at least every three (3) years for reviews of, and reports and opinions on, the closed block by an independent actuary, unless otherwise directed by the commissioner.

As added by P.L.94-1999, SEC.3.

IC 27-15-12

Chapter 12. Effect of Pending Claims on the Distribution of Consideration to Members

IC 27-15-12-1

Delay of distribution

Sec. 1. All or part of the consideration to be distributed to some or all of the eligible members may be delayed by more than six (6) months following the effective date of the plan of conversion if:

(1) the plan of conversion includes a provision for the establishment of a trust for that purpose; and

(2) one (1) or more of the following claims have been asserted against a converting mutual and remain unresolved at the effective date of the plan of conversion:

(A) A claim seeking the imposition of a constructive or charitable trust on assets of the converting mutual for the benefit of policyholders, members, or other identified or unidentified persons.

(B) A claim seeking distribution or return of assets, or other form of compensation, from the converting mutual to policyholders, members, or other identified or unidentified persons.

(C) A claim that arises out of or relates to the ownership interest of members of the converting mutual, or to the value of their ownership interests, including any claim that challenges a statutory transaction engaged in by the converting mutual before the effective date of the plan of conversion.

As added by P.L.94-1999, SEC.3.

IC 27-15-12-2

Formation of trust under trust agreement; beneficiaries; satisfaction of claims; reports

Sec. 2. (a) At the effective date of the plan of conversion, assets adequate to satisfy a claim described in section 1 of this chapter, consisting of the consideration that otherwise would be distributed directly to eligible members, must be placed in trust under a trust agreement in a form approved by the commissioner. The trustee or trustees of the trust shall:

(1) be appointed by the board of directors of the converting mutual, subject to disapproval of any trustee by the commissioner; and

(2) consist of one (1) or more institutions authorized by Indiana law to act as corporate trustees.

(b) The beneficiaries of the trust:

(1) are the eligible members who, in the absence of the claims, would have been entitled to the consideration placed in the trust; and

(2) may consist of all of the eligible members or specified classes or groups of eligible members.

(c) Assets of the trust shall be made available to pay or otherwise satisfy the claims for which the trust has been established, the expenses of the trust in contesting or resolving those claims, and any other reasonable expenses of the trust. Upon final resolution of the claims, by judgment, settlement or otherwise, or at such other times as may be provided for in the trust agreement, the remaining assets of the trust shall be distributed to the beneficiaries in accordance with their respective interests in the trust.

(d) Until the trust has been terminated, the trustee or trustees shall prepare reports not less frequently than annually, upon termination of the trust, and at such other times as may be requested by the commissioner or the former mutual. The reports must contain information regarding the financial condition of the trust and the status of any resolved and pending claims. The reports shall be provided to the commissioner and the former mutual and the reports or summary reports shall be mailed at least annually to the beneficiaries of the trust at the expense of the trust.

(e) An interest in a trust established under this section does not constitute a security under Indiana law.

(f) The establishment of a trust or pendency of any claim described in this chapter shall not delay or affect the effectiveness of a plan of conversion or an amendment to the articles of incorporation.

As added by P.L.94-1999, SEC.3.

IC 27-15-13
Chapter 13. Initial Limits on Ownership of Shares

IC 27-15-13-1
Acquisition of beneficial ownership; limitations

Sec. 1. (a) Except as specifically provided in a plan of conversion, for five (5) years following the effective date of the conversion no person or persons acting in concert (other than the former mutual, any parent company, or any employee benefit plans or trusts sponsored by the former mutual or a parent company) shall directly or indirectly acquire, or agree or offer to acquire, in any manner the beneficial ownership of five percent (5%) or more of the outstanding shares of any class of a voting security of the former mutual or any parent company without the prior approval by the commissioner of a statement filed by that person with the commissioner.

(b) The statement described in subsection (a) must contain the information required by IC 27-1-23-2(b) and any other information required by the commissioner.

As added by P.L.94-1999, SEC.3.

IC 27-15-13-2
Acquisition of beneficial ownership; factors for approval procedure

Sec. 2. (a) The commissioner may not approve an acquisition under section 1(a) of this chapter unless the commissioner finds that:

(1) the requirements of IC 27-1-23-2(e) will be satisfied;

(2) the acquisition will not frustrate the plan of conversion or the amendment to the articles of incorporation as approved by the members and the commissioner;

(3) the boards of directors of the former mutual and any parent company have approved the acquisition; and

(4) the acquisition would be in the best interest of the present and future policyholders of the former mutual without regard to any interest of policyholders as shareholders of the former mutual or any parent company.

(b) The commissioner shall adopt rules under IC 4-22-2 to establish a procedure under which an institutional investor that is not affiliated with the former mutual or a parent company may be considered to have been approved by the commissioner under this section to acquire beneficial ownership of at least five percent (5%) or less than ten percent (10%) of the outstanding shares of any class of a voting security of the former mutual or any parent company upon the filing with the commissioner of:

(1) a certificate executed by appropriate officers of the former mutual and any parent company certifying that:

(A) the acquisition has been approved by the boards of directors of the former mutual and any parent company; and

(B) the institutional investor is not an affiliate of the former

mutual or any parent company; and

(2) a certificate executed by appropriate officers of the institutional investor:

(A) certifying that the institutional investor will acquire the shares in the ordinary course of its business and not with the purpose nor with the effect of changing or influencing the control, management, or policies of the former mutual or the parent company;

(B) certifying that the institutional investor is not an affiliate of the former mutual or any parent company; and

(C) undertaking to notify the commissioner and the former mutual and any parent company in writing not less than twenty (20) business days before any change in the matters certified.

The commissioner may require the filing of any other information the commissioner considers necessary and may provide in the rules for remedies or consequences upon receipt of a notice under subdivision (2)(C), including divestiture and denial of voting rights.

As added by P.L.94-1999, SEC.3.

IC 27-15-13-3

Voting of securities subject to acquisition

Sec. 3. A security that is:

(1) the subject of any agreement or arrangement regarding acquisition; or

(2) held, acquired, or is to be acquired;

in contravention of this chapter or of an order of the commissioner, may not be voted at any shareholders' meeting. Any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding. However, no action taken at a meeting shall be invalidated by the voting of those securities unless the action would materially affect control of the former mutual or a person that owns or controls a majority or all of the voting securities of the former mutual or unless the courts of this state have so ordered.

As added by P.L.94-1999, SEC.3.

IC 27-15-13-4

Supplemental nature of provisions

Sec. 4. The requirements of this chapter are in addition to any other filings or approvals required by IC 27-1-23 or otherwise by law.

As added by P.L.94-1999, SEC.3.

IC 27-15-14

Chapter 14. Modified Conversion Requirements for Companies in Hazardous Financial Condition

IC 27-15-14-1

Qualifications for modified conversion; waivers or modifications of notice requirements

Sec. 1. (a) If a domestic mutual insurance company:

(1) is insolvent, as defined in IC 27-9-1-2(o);

(2) does not meet the minimum surplus requirements of IC 27-1-6-15; or

(3) in the judgment of the commissioner, is in a hazardous financial condition;

its board of directors may adopt, and the commissioner may approve, any plan of conversion and amendment to the articles of incorporation that, on the effective date of the conversion, would provide for the former mutual to have paid-in capital stock and surplus in an amount not less than the minimum requirements of IC 27-1-6-14(c) and IC 27-1-6-14(e) and an RBC level greater than its company action RBC level.

(b) The commissioner may allow waivers or material modifications of the requirement to give any notices to members and policyholders, to obtain member approval of the proposed plan of conversion or amendment to the articles of incorporation of the converting mutual, or to distribute consideration to members if the value of a converting mutual described in subsection (a) does not in the judgment of the commissioner warrant any such notices, approvals, or distribution under the circumstances, including the expenses involved in a distribution of consideration.

As added by P.L.94-1999, SEC.3. Amended by P.L.72-2016, SEC.27.

IC 27-15-14-2

Application for approval; required descriptions

Sec. 2. The application for approval of a plan of conversion and an amendment to the articles of incorporation described in section 1 of this chapter must include a description of how the converting mutual will meet the statutory surplus and capital requirements on the date the plan of conversion is completed, which may involve the issuance and sale directly to one (1) or more purchasers of the capital stock of the former mutual or of a parent company.

As added by P.L.94-1999, SEC.3.

IC 27-15-14-3

Approval of application; public hearing

Sec. 3. The commissioner shall approve the application and permit the conversion under a plan of conversion and an amendment to the articles of incorporation described in this chapter if the commissioner finds, following a public hearing, that the plan of

conversion and the amendment to the articles of incorporation are in the best interests of the members and policyholders of the converting mutual, without regard to their membership interests.
As added by P.L.94-1999, SEC.3.

IC 27-15-14-4
Supplemental requirements for modified conversion

Sec. 4. The requirements of this chapter are in addition to, and may be combined with, any other filings, approvals, or hearings required by IC 27-1-23 or otherwise by law.
As added by P.L.94-1999, SEC.3.

IC 27-15-15
Chapter 15. Judicial Review

IC 27-15-15-1
Petition for review

Sec. 1. A person who is aggrieved by an agency action of the commissioner under this article may petition for judicial review of the action under IC 4-21.5-5.

As added by P.L.94-1999, SEC.3.

IC 27-15-15-2
Time for filing petitions

Sec. 2. All petitions for judicial review of, and any action challenging the validity of or arising out of:

(1) the approval or disapproval of; or

(2) any action proposed to be taken under;

any order or determination of the commissioner in connection with a plan of conversion under this article must be filed not later than thirty (30) days after the order or determination is issued by the commissioner.

As added by P.L.94-1999, SEC.3.

IC 27-15-15-3
Action to compel determination

Sec. 3. A person who is aggrieved by a failure of the commissioner to act or make a determination required by this article may bring an action for mandate in the circuit court of Marion County to compel the commissioner to act or make the determination.

As added by P.L.94-1999, SEC.3.

IC 27-15-16
Chapter 16. Miscellaneous Provisions

IC 27-15-16-1
Parent company
Sec. 1. A parent company under this article:
(1) shall locate its executive offices in Indiana;
(2) shall employ at least five hundred (500) persons or a substantial percentage of its workforce in Indiana;
(3) shall be organized under the laws of Indiana; and
(4) may be:
(A) a corporation organized for the purpose of serving as a holding company for the former mutual or a corporation that, before the conversion, was a subsidiary of the converting mutual; or
(B) any other existing or newly created corporation.
As added by P.L.94-1999, SEC.3.

IC 27-15-16-2
Rules
Sec. 2. The commissioner may adopt rules under IC 4-22-2 necessary for the administration of this article.
As added by P.L.94-1999, SEC.3.

IC 27-15-16-3
Hiring professionals necessary to assist commissioner's review
Sec. 3. (a) The commissioner may, at the expense of a converting mutual that has:
(1) filed an application under this article;
(2) notified the commissioner of its intention to file an application under this article; or
(3) adopted a resolution proposing a simple plan of conversion under this article;
hire accountants, actuaries, attorneys, financial advisors, investment bankers, and other experts that are necessary to assist the commissioner in reviewing all matters under this article.
(b) The commissioner may at any time require the converting mutual to deposit an amount of money with the department in anticipation of expenses to be incurred by the commissioner under this section.
As added by P.L.94-1999, SEC.3.

IC 27-15-16-4
Failure to give notice; good faith exception
Sec. 4. If a converting mutual complies substantially and in good faith with this article with respect to any required notice to members and policyholders, its failure in any case to give the notice to any person entitled to notice does not:

(1) impair the validity of actions taken under this article; or
(2) entitle the person to any injunctive or other relief.
As added by P.L.94-1999, SEC.3.

IC 27-15-16-5
Abandonment of plan of conversion
Sec. 5. At any time before the effective date of the plan of conversion, the plan may be abandoned under provisions included in the plan of conversion filed under this article.
As added by P.L.94-1999, SEC.3.

IC 27-15-16-6
Use of "mutual" prohibited after conversion
Sec. 6. After conversion, the name of the former mutual may not include the term "mutual".
As added by P.L.94-1999, SEC.3.

IC 27-16

ARTICLE 16. PROFESSIONAL EMPLOYER ORGANIZATIONS

IC 27-16-1

Chapter 1. Applicability

IC 27-16-1-1

Applicability of article

Sec. 1. This article applies after December 31, 2005.

As added by P.L.245-2005, SEC.7.

IC 27-16-2
Chapter 2. Definitions

IC 27-16-2-1
Application of definitions
Sec. 1. The definitions in this chapter apply throughout this article.
As added by P.L.245-2005, SEC.7.

IC 27-16-2-2
"Administrative fee"
Sec. 2. (a) "Administrative fee" means the fee charged to a client by a professional employer organization for professional employer services.
(b) The term does not include any amount charged to a client by a professional employer organization for wages and salaries, benefits, worker's compensation, payroll taxes, withholding, or other assessments paid by a professional employer organization to or on behalf of a covered employee.
As added by P.L.245-2005, SEC.7.

IC 27-16-2-3
"Client"
Sec. 3. "Client" means a person that enters into a professional employer agreement with a professional employer organization.
As added by P.L.245-2005, SEC.7.

IC 27-16-2-4
"Co-employed"
Sec. 4. "Co-employed" means that an individual is contemporaneously employed by both a client and a professional employer organization.
As added by P.L.245-2005, SEC.7.

IC 27-16-2-5
"Co-employer"
Sec. 5. "Co-employer" refers to a client or a professional employer organization that has entered into a professional employer agreement and has a relationship with a co-employed individual.
As added by P.L.245-2005, SEC.7.

IC 27-16-2-6
"Co-employment relationship"
Sec. 6. "Co-employment relationship" means a relationship:
(1) between a:
(A) client and a professional employer organization; or
(B) co-employer and a covered employee; and
(2) that results from the client and the professional employer

organization entering into a professional employer agreement.
As added by P.L.245-2005, SEC.7.

IC 27-16-2-7
"Commissioner"
Sec. 7. "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.
As added by P.L.245-2005, SEC.7.

IC 27-16-2-8
"Covered employee"
Sec. 8. (a) "Covered employee" means an individual who is co-employed.
(b) The term includes an individual who is an officer, a director, a shareholder, a partner, or a manager of a client to the extent the professional employer organization and the client expressly agree that the individual:
(1) is described in subsection (a); and
(2) acts as an operational manager or performs day to day operational services for the client;
as reflected in the professional employer agreement.
As added by P.L.245-2005, SEC.7.

IC 27-16-2-9
"Department"
Sec. 9. "Department" refers to the department of insurance created by IC 27-1-1-1.
As added by P.L.245-2005, SEC.7.

IC 27-16-2-10
"PEO group"
Sec. 10. "PEO group" means two (2) or more professional employer organizations that are majority owned or commonly controlled by the same entity, parent, or controlling person.
As added by P.L.245-2005, SEC.7.

IC 27-16-2-11
"Person"
Sec. 11. "Person" means an individual, a partnership, a corporation, a limited liability company, an association, or another legally recognized entity.
As added by P.L.245-2005, SEC.7.

IC 27-16-2-12
"Professional employer agreement"
Sec. 12. "Professional employer agreement" means a written contract between a person and a professional employer organization:
(1) under which all or a majority of the person's employees

become covered employees;

(2) that provides for the allocation of employer rights and obligations between the person and the professional employer organization with respect to the covered employees; and

(3) that specifies the professional employer services that will be provided.

As added by P.L.245-2005, SEC.7.

IC 27-16-2-13
"Professional employer organization" or "PEO"

Sec. 13. (a) "Professional employer organization" or "PEO" means a person engaged in the business of providing professional employer services.

(b) The term does not include the following:

(1) An arrangement through which a person:

(A) whose principal business activity is an activity other than entering into professional employer agreements; and

(B) that does not hold the person out as a professional employer organization;

shares employees with a commonly owned company within the meaning of Section 414(b) and 414(c) of the Internal Revenue Code of 1986, as amended.

(2) An independent contractor arrangement through which a person:

(A) assumes responsibility for a product produced or a service performed by the person or the person's agent; and

(B) retains and exercises primary direction and control over the work performed by an individual whose services are supplied under the independent contractor arrangement.

(3) The provision of temporary help services.

As added by P.L.245-2005, SEC.7.

IC 27-16-2-14
"Professional employer services"

Sec. 14. "Professional employer services" means the services that are provided to a client by a professional employer organization under a professional employer agreement.

As added by P.L.245-2005, SEC.7.

IC 27-16-2-15
"Temporary help service"

Sec. 15. "Temporary help service" means a service consisting of a person that:

(1) recruits and hires the person's own employees, not including an officer, a manager, or a controlling person of a client to which the person's own employee is assigned by the person;

(2) identifies organizations that need the services of employees described in subdivision (1);

(3) assigns employees described in subdivision (1) to:
(A) perform work or services for organizations described in subdivision (2);
(B) support or supplement the workforces of organizations described in subdivision (2); or
(C) provide assistance in special work situations, including employee absences, skill shortages, seasonal workloads, and special assignments or projects; and
(4) customarily attempts to reassign the employees described in subdivision (1) to other organizations when an assignment described in subdivision (3) is completed.

As added by P.L.245-2005, SEC.7.

IC 27-16-2-16
"Working capital"

Sec. 16. "Working capital" means the difference between a person's:
(1) current assets; and
(2) current liabilities;
determined in accordance with generally accepted accounting principles.

As added by P.L.11-2011, SEC.40.

IC 27-16-3

Chapter 3. Effect on Rights, Duties, and Obligations

IC 27-16-3-1

Effect on collective bargaining agreement or federal rights or obligations

Sec. 1. This article and a professional employer agreement do not affect, modify, or amend:

(1) a collective bargaining agreement; or

(2) rights or obligations of a client, PEO, or covered employee under:

(A) the federal National Labor Relations Act (29 U.S.C. 151 et seq.);

(B) the federal Railway Labor Act (45 U.S.C. 151 et seq.); or

(C) IC 22-7.

As added by P.L.245-2005, SEC.7.

IC 27-16-3-2

Effect on duties

Sec. 2. This article and a professional employer agreement do not do the following:

(1) Diminish, abolish, or remove the obligations of a client to a covered employee that exist before the effective date of the professional employer agreement.

(2) Affect, modify, or amend a contractual relationship or restrictive covenant:

(A) between a covered employee and a client that is in effect on the effective date of the professional employer agreement; or

(B) that is entered into between a client and a covered employee after the effective date of the professional employer agreement.

A PEO is not responsible or liable for a dispute in connection with or arising out of a contractual relationship or restrictive covenant described in this subdivision unless the PEO has otherwise specifically agreed in writing.

(3) Create a new or additional enforceable right of a covered employee against a PEO that is not specifically provided by the professional employer agreement or this article.

As added by P.L.245-2005, SEC.7.

IC 27-16-3-3

Effect on federal, state, or local requirements

Sec. 3. (a) This article and a professional employer agreement do not affect, modify, or amend a federal, state, or local:

(1) license;

(2) registration; or

(3) certification;

requirement that applies to a client or covered employee.

(b) The following apply to a federal, state, or local requirement described in subsection (a):

(1) A covered employee who is required to be licensed, registered, or certified is considered solely an employee of the client for purposes of a license, registration, or certification requirement.

(2) A PEO is not considered to engage in an occupation, a trade, a profession, or another activity that is:

(A) subject to a license, registration, or certification requirement; or

(B) otherwise regulated by a governmental entity;

solely because the PEO has entered into and maintained a co-employment relationship with a covered employee who is subject to a requirement or regulation described in clause (A) or (B).

(3) A client has the sole right of direction and control of the professional or licensed activities of a covered employee and of the client's business.

(4) Only a:

(A) covered employee; or

(B) client;

that is subject to a requirement or regulation described in subdivision (2)(A) or (2)(B) is subject to the regulation by a regulatory or governmental entity responsible for licensing, registration, certification, or other regulation of the covered employee or client.

As added by P.L.245-2005, SEC.7.

IC 27-16-3-4

Effect on tax credits and incentives

Sec. 4. (a) For purposes of the determination of tax credits and other economic incentives:

(1) provided by the state or another governmental entity; and

(2) based on employment;

a covered employee is considered an employee solely of the client.

(b) A client is entitled to the benefit of any tax credit, economic incentive, or other benefit arising as the result of the employment of a covered employee of the client.

(c) If the grant or amount of an incentive is based on the number of employees a client employs:

(1) each client must be treated as employing only the covered employees actually working in the client's business operations; and

(2) covered employees working for other clients of the PEO must not be counted.

(d) A PEO shall provide, upon request by a client or an agency or

a department of the state or of another governmental entity, employment information:

(1) reasonably required by an agency or a department of the state or of another governmental entity that is responsible for administration of a tax credit or economic incentive described in this section; and

(2) necessary;

to support a request, a claim, an application, or another action by a client seeking a tax credit or an economic incentive.

As added by P.L.245-2005, SEC.7.

IC 27-16-3-5

Effect on government contracts

Sec. 5. With respect to a bid, a contract, a purchase order, or an agreement entered into with the state or a political subdivision of the state, a client's status or certification as a:

(1) small, minority owned, disadvantaged, or woman owned business enterprise; or

(2) historically underutilized business;

is not affected because the client has entered into the professional employment agreement.

As added by P.L.245-2005, SEC.7.

IC 27-16-4
Chapter 4. Registration

IC 27-16-4-1
Registration requirements

Sec. 1. (a) A person shall not:
(1) provide professional employer services;
(2) advertise that the person:
(A) is a professional employer organization; or
(B) provides professional employer services; or
(3) otherwise hold the person out as a professional employer organization;
in Indiana unless the person is registered under this article.

(b) The registration requirement specified in subsection (a) applies to a person that performs any of the activities specified in subsection (a) regardless of the person's use of any of the following terms:
(1) Professional employer organization.
(2) PEO.
(3) Staff leasing company.
(4) Registered staff leasing company.
(5) Employee leasing company.
(6) Administrative employer.
(7) Any other name.

As added by P.L.245-2005, SEC.7.

IC 27-16-4-2
Application

Sec. 2. (a) This section does not apply to an applicant for limited registration under section 6 of this chapter.

(b) An applicant for registration under this article shall file with the department the following information:
(1) The name or names under which the applicant conducts business.
(2) The address of the principal place of business of the applicant and the address of each office the applicant maintains in Indiana.
(3) The applicant's taxpayer or employer identification number.
(4) A list by jurisdiction of each name under which the applicant has operated in the preceding five (5) years, including any alternative names, names of predecessors, and, if known, successor business entities.
(5) A statement of ownership that includes the name and evidence of the business experience of any person that, individually or acting in concert with one (1) or more other persons, owns or controls, directly or indirectly, twenty-five percent (25%) or more of the equity interests of the applicant.
(6) A statement of management that includes the name and

evidence of the business experience of any individual who serves as president, chief executive officer, or otherwise has the authority to act as senior executive officer of the applicant.

(7) Except as provided in subsections (c) and (d), a financial statement:

(A) setting forth the financial condition of the applicant as of a date not earlier than one hundred eighty (180) days before the date the financial statement is submitted to the department;

(B) prepared in accordance with generally accepted accounting principles; and

(C) audited by an:

(i) independent certified public accountant licensed to practice in the jurisdiction in which the accountant is located; or

(ii) individual who is certified under IC 25-2.1-3 or IC 25-2.1-4;

with a resulting audit report that is issued without qualification as to the status of the applicant as a going concern.

(c) If a PEO has less than twelve (12) months of operating history on which to base an audited financial statement, the PEO shall file a financial statement that has been reviewed by an:

(1) independent certified public accountant licensed to practice in the jurisdiction in which the accountant is located; or

(2) individual who is certified under IC 25-2.1-3 or IC 25-2.1-4.

(d) An applicant may apply to the department for an extension of time in which to file the audited financial statement and audit report required by subsection (b). An application under this subsection must be accompanied by a letter from the auditor described in subsection (b) specifying the reason for the requested extension and the anticipated date by which the audit will be completed.

As added by P.L.245-2005, SEC.7. Amended by P.L.11-2011, SEC.41.

IC 27-16-4-3

Registration deadline

Sec. 3. (a) A PEO that is operating in Indiana on January 1, 2006, shall complete the PEO's initial registration not later than July 1, 2006.

(b) An initial registration under subsection (a) is valid until the end of the PEO's first fiscal year end that occurs after December 31, 2006.

(c) A PEO that is not operating in Indiana on December 31, 2005, shall complete the PEO's initial registration before commencement of operations in Indiana.

As added by P.L.245-2005, SEC.7.

IC 27-16-4-4
Renewal deadline

Sec. 4. A PEO shall, not more than one hundred eighty (180) days after the end of the PEO's fiscal year, renew the PEO's registration by filing a statement notifying the department of any changes in the information provided in the PEO's most recent registration or renewal.

As added by P.L.245-2005, SEC.7.

IC 27-16-4-5
Satisfaction of requirements

Sec. 5. A PEO group may satisfy the reporting and financial requirements of this chapter on a combined or consolidated basis if each member of the PEO group guarantees the obligations under this article of each other member of the PEO group.

As added by P.L.245-2005, SEC.7.

IC 27-16-4-6
Limited registration for foreign PEOs

Sec. 6. (a) A PEO that is not domiciled in Indiana is eligible for a limited registration under this article if the PEO:

(1) submits a properly executed request for limited registration on a form prescribed by the department;

(2) is licensed or registered as a professional employer organization in another state that has licensure or registration requirements that are:

(A) substantially the same as; or

(B) more restrictive than;

the requirements of this article;

(3) does not:

(A) maintain an office; or

(B) directly solicit clients located or domiciled;

in Indiana; and

(4) does not have more than fifty (50) covered employees who are employed or domiciled in Indiana on any day.

(b) A limited registration is valid for one (1) year and may be renewed.

(c) A PEO that seeks limited registration under this section shall provide to the department information and documentation necessary to show that the PEO meets the requirements of this section.

(d) IC 27-16-6 does not apply to a PEO that applies for limited registration under this section.

As added by P.L.245-2005, SEC.7. Amended by P.L.11-2011, SEC.42.

IC 27-16-4-7
Rules

Sec. 7. The department shall adopt rules under IC 4-22-2 to

provide for registration of a PEO without compliance with this chapter and IC 27-16-6 by the commissioner's acceptance of an affidavit or a certification:

(1) provided by a bonded, independent, and qualified assurance organization that has been approved by the commissioner; and

(2) that certifies the qualifications of a professional employer organization.

As added by P.L.245-2005, SEC.7.

IC 27-16-4-8
List of registered PEOs

Sec. 8. The department shall:

(1) maintain; and

(2) publish on the department's Internet site;

a list of PEOs that are registered under this article.

As added by P.L.245-2005, SEC.7. Amended by P.L.11-2011, SEC.43.

IC 27-16-4-9
Forms

Sec. 9. The department may prescribe forms necessary to promote the efficient administration of this chapter.

As added by P.L.245-2005, SEC.7.

IC 27-16-4-10
Confidentiality of records

Sec. 10. All records, reports, and other information obtained from a PEO under this chapter, except to the extent necessary for the proper administration of this chapter by the department, are confidential.

As added by P.L.245-2005, SEC.7.

IC 27-16-5
Chapter 5. Fees

IC 27-16-5-1
Registration fee
Sec. 1. Upon filing an initial registration application under IC 27-16-4-2, a PEO shall pay an initial registration fee not to exceed five hundred dollars ($500).
As added by P.L.245-2005, SEC.7.

IC 27-16-5-2
Renewal fee
Sec. 2. Upon the filing of an annual renewal of a registration under IC 27-16-4-4, a PEO shall pay a renewal fee not to exceed two hundred fifty dollars ($250).
As added by P.L.245-2005, SEC.7.

IC 27-16-5-3
Limited registration or renewal fee
Sec. 3. Upon initial application for limited registration under IC 27-16-4-6 and upon each annual renewal of the limited registration, a PEO shall pay a fee not to exceed two hundred fifty dollars ($250).
As added by P.L.245-2005, SEC.7.

IC 27-16-5-4
Rules for PEO group registration fees
Sec. 4. The department shall adopt rules under IC 4-22-2 to specify any fee to be charged for a PEO group registration.
As added by P.L.245-2005, SEC.7.

IC 27-16-5-5
Fees for registration under IC 27-16-4-7
Sec. 5. A PEO seeking registration under IC 27-16-4-7 shall pay an initial and annual fee not to exceed two hundred fifty dollars ($250).
As added by P.L.245-2005, SEC.7.

IC 27-16-5-6
Rules for other fees
Sec. 6. (a) The department shall adopt rules under IC 4-22-2 to specify any other fee to be charged under this article.
(b) A fee:
(1) for which the amount is not specified in; and
(2) that is charged under;
this article must not exceed the amount reasonably necessary for the administration of this article.
As added by P.L.245-2005, SEC.7.

IC 27-16-5-7
Deposit of fees

Sec. 7. Fees collected under this chapter shall be deposited in the department of insurance fund established by IC 27-1-3-28.

As added by P.L.245-2005, SEC.7.

IC 27-16-6
Chapter 6. Financial Requirements

IC 27-16-6-1
Financial requirements

Sec. 1. (a) A PEO or PEO group shall do one (1) of the following:

(1) Maintain positive working capital, as reflected in the financial statement submitted to the department by the PEO or PEO group under IC 27-16-4.

(2) If the PEO or PEO group does not meet the requirement of subdivision (1), maintain any of the following with a minimum aggregate value in an amount that is at least sufficient to eliminate the PEO's or PEO group's negative working capital plus one hundred thousand dollars ($100,000):

(A) A surety bond.

(B) An irrevocable letter of credit.

(C) Cash.

(D) A combination of items listed in clauses (A) through (C).

(b) An instrument or cash described in subsection (a)(2) must be held by an institution designated by the department, securing payment by the PEO or PEO group of all taxes, wages, benefits, or other entitlement due to or with respect to covered employees in the event that the PEO or PEO group does not make the payments when due.

As added by P.L.245-2005, SEC.7. Amended by P.L.11-2011, SEC.44.

IC 27-16-6-2
Calculation of positive working capital

Sec. 2. An instrument or cash described in section 1(a)(2) of this chapter must not be included in the calculation of the positive working capital described in section 1(a)(1) of this chapter.

As added by P.L.245-2005, SEC.7. Amended by P.L.11-2011, SEC.45.

IC 27-16-7

Chapter 7. General Requirements and Provisions

IC 27-16-7-1

Requirements of co-employment relationships

Sec. 1. Except as provided in a professional employer agreement, the following apply to a co-employment relationship:

(1) The client:

(A) may exercise and enforce all rights; and

(B) is obligated to perform all duties and responsibilities;

that otherwise apply to an employer in an employment relationship, that are allocated to the client by the professional employer agreement and this article, and that are not specifically allocated to the PEO by the professional employer agreement and this article.

(2) The PEO:

(A) may exercise and enforce only the rights; and

(B) is obligated to perform only the duties and responsibilities;

that are required of the PEO or specifically allocated to the PEO by this article and the professional employer agreement.

(3) Unless otherwise expressly agreed by the PEO and the client in the professional employer agreement, the client retains the exclusive right to direct and control the covered employees as necessary to:

(A) conduct the client's business;

(B) discharge the client's fiduciary responsibilities; or

(C) comply with licensure requirements that apply to the client or the covered employees.

As added by P.L.245-2005, SEC.7.

IC 27-16-7-2

Professional employer agreement contents

Sec. 2. (a) Except as provided in this article, the co-employment relationship between a client and a PEO, and between a co-employer and a covered employee, is governed by the professional employer agreement.

(b) A professional employer agreement must specify the following:

(1) The allocation of rights, duties, and responsibilities described in section 1 of this chapter.

(2) Except as provided in subsection (c), that the PEO is responsible for:

(A) payment of wages to covered employees;

(B) withholding, collection, reporting, and remittance of payroll related and unemployment taxes; and

(C) to the extent the PEO has assumed responsibility in the professional employer agreement, making payments for

employee benefits for covered employees.

(3) The allocation, to either the client or the PEO, of the responsibility to obtain worker's compensation coverage for covered employees from a worker's compensation insurer that is authorized under this title to conduct the business of insurance in Indiana.

(4) If the professional employer agreement allocates the responsibility under subdivision (3) to the PEO, a requirement that the PEO maintain and provide to the client, at the client's request at the termination of the professional employer agreement, records regarding loss experience related to the worker's compensation insurance coverage.

(c) A PEO is not responsible for an obligation between a client and a covered employee for payments in addition to the covered employee's salary, draw, or regular rate of pay, including bonuses, commissions, severance pay, deferred compensation, profit sharing, or vacation, sick, or other paid time off, unless the PEO has expressly agreed to assume liability for the payments in the professional employer agreement.

As added by P.L.245-2005, SEC.7.

IC 27-16-7-3

Notice to affected employees

Sec. 3. A PEO shall provide written notice to each covered employee who is affected by a professional employer agreement entered into by the PEO concerning the general nature of the co-employment relationship between and among the PEO, the client, and the covered employee.

As added by P.L.245-2005, SEC.7.

IC 27-16-7-4

Responsibilities of clients, PEOs, and covered employees

Sec. 4. (a) Except as expressly provided by the professional employer agreement:

(1) a client:

(A) is solely responsible for:

(i) the quality, adequacy, or safety of goods or services produced or sold in the client's business;

(ii) directing, supervising, training, and controlling the work of a covered employee with respect to the business activities of the client; and

(iii) the acts, errors, or omissions of a covered employee with respect to activities described in item (ii); and

(B) is not liable for the acts, errors, or omissions of:

(i) the PEO; or

(ii) a covered employee of the client and a PEO when the covered employee is acting under the express direction and control of the PEO.

(2) A PEO is not liable for the acts, errors, or omissions of a client or a covered employee of the client when the covered employee is acting under the express direction and control of the client.

(3) A covered employee is not, solely as the result of being a covered employee of a PEO, an employee of the PEO for purposes of:

(A) general liability insurance;

(B) fidelity bonds;

(C) surety bonds;

(D) employer's liability that is not covered by worker's compensation; or

(E) liquor liability insurance;

carried by the PEO unless the covered employee is specified as an employee of the PEO by specific reference in the professional employer agreement and any applicable prearranged employment contract, insurance contract, or bond.

(b) This section does not limit:

(1) a contractual liability or obligation specified in a professional employer agreement; or

(2) the liabilities and obligations of a PEO or client as specified in this article.

As added by P.L.245-2005, SEC.7.

IC 27-16-7-5

PEO not engaged in business of insurance

Sec. 5. A PEO that offers, markets, sells, administers, or provides professional employer services under a professional employer agreement as provided in this article is not:

(1) engaged in the business of insurance; or

(2) acting as an administrator (as defined in IC 27-1-25-1).

As added by P.L.245-2005, SEC.7.

IC 27-16-7-6

Basis of fees or taxes on PEOs

Sec. 6. (a) A business license fee or another fee that is based upon gross receipts must, in the case of a PEO, be based upon the administrative fee of the PEO.

(b) A tax assessed on a per capita or per employee basis must be assessed against a:

(1) client for covered employees; and

(2) PEO for the PEO's employees who are not covered employees.

(c) In the case of tax imposed or calculated upon the basis of total payroll, a PEO is eligible to apply a small business allowance or exemption available to the client for covered employees for the purpose of computing the tax.

As added by P.L.245-2005, SEC.7.

IC 27-16-8

Chapter 8. Benefit Plans

IC 27-16-8-1

Client and PEO considered employer for purposes of retirement and welfare benefits

Sec. 1. A client and a PEO are each considered to be an employer for purposes of sponsoring retirement and welfare benefit plans for covered employees.

As added by P.L.245-2005, SEC.7.

IC 27-16-8-2

Fully insured welfare benefit plans

Sec. 2. A fully insured welfare benefit plan offered to covered employees of a single PEO is:

(1) considered to be a single employer welfare benefit plan; and

(2) not a multiple employer welfare arrangement (as defined in IC 27-1-34-1(b)) and is not required to comply with IC 27-1-34.

As added by P.L.245-2005, SEC.7.

IC 27-16-8-3

Covered employees considered to participate in single employer plan

Sec. 3. For purposes of IC 27-8-15, all covered employees of a PEO participating in a group health benefit plan sponsored by the PEO are considered to be:

(1) employees of the PEO; and

(2) participating in a single employer plan.

As added by P.L.245-2005, SEC.7.

IC 27-16-8-4

Health benefit plan offered by PEO

Sec. 4. If a PEO offers to the PEO's covered employees a health benefit plan that is not fully insured by an insurer authorized under this title to conduct the business of insurance in Indiana, the health benefit plan must:

(1) be administered by an administrator licensed under IC 27-1-25;

(2) hold all plan assets, including participant contributions, in a trust account;

(3) provide sound reserves for the health benefit plan as determined using generally accepted actuarial standards as set forth in an actuarial opinion filed with the commissioner and prepared and signed by a qualified actuary who:

(A) is a member in good standing of the American Academy of Actuaries; and

(B) meets the requirements established by the commissioner in rules adopted under IC 4-22-2;

(4) annually submit current audited financial statements to the commissioner;

(5) at the discretion of the commissioner, possess a written commitment, binder, or policy for stop-loss insurance:

(A) issued by an insurer authorized to conduct the business of insurance in Indiana; and

(B) that meets any specific and total coverage requirements established by the commissioner in rules adopted under IC 4-22-2;

(6) be subject to audit for compliance with the requirements of this section by the department on a random basis or upon a finding of reasonable need; and

(7) provide written notice to each covered employee participating in the health benefit plan that the health benefit plan is:

(A) self-insured or not fully insured; and

(B) subject to the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

As added by P.L.245-2005, SEC.7.

IC 27-16-9

Chapter 9. Worker's Compensation

IC 27-16-9-1

Clients and PEO considered employer for purposes of worker's compensation

Sec. 1. Subject to the specification required under IC 27-16-7-2(b)(3), a client and a PEO are both considered the employer of a covered employee for purposes of coverage under IC 22-3-2 through IC 22-3-7.

As added by P.L.245-2005, SEC.7.

IC 27-16-9-2

Exclusive remedy provisions apply to PEOs, clients, and employees

Sec. 2. The protection of the exclusive remedy provisions of IC 22-3-2-6 and IC 22-3-7-6 apply to the PEO, the client, and each covered employee and other employee of the client regardless of whether the PEO or the client is responsible to obtain the worker's compensation coverage for the covered employees under the professional employer agreement.

As added by P.L.245-2005, SEC.7.

IC 27-16-10
Repealed
(Repealed by P.L.33-2013, SEC.6.)

IC 27-17

ARTICLE 17. DISCOUNT MEDICAL CARD PROGRAM ORGANIZATIONS

IC 27-17-1

Chapter 1. Definitions

IC 27-17-1-1

Application of definitions

Sec. 1. The definitions in this chapter apply throughout this article.

As added by P.L.73-2006, SEC.3.

IC 27-17-1-2

"Cardholder"

Sec. 2. "Cardholder" means a person that pays consideration for the right to participate in a discount medical card program.

As added by P.L.73-2006, SEC.3.

IC 27-17-1-3

"Commissioner"

Sec. 3. "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

As added by P.L.73-2006, SEC.3.

IC 27-17-1-4

"Department"

Sec. 4. "Department" refers to the department of insurance created by IC 27-1-1-1.

As added by P.L.73-2006, SEC.3.

IC 27-17-1-5

"Discount medical card program"

Sec. 5. "Discount medical card program" means a program through which a discount medical card program organization provides, in exchange for consideration, a cardholder with access to medical services provided by a program provider under a provider agreement. The term does not include:

(1) a policy or contract regulated under this title; or

(2) self-funded coverage regulated under the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

As added by P.L.73-2006, SEC.3.

IC 27-17-1-6

"Discount medical card program organization"

Sec. 6. (a) "Discount medical card program organization" means a person that:

(1) negotiates and enters into provider agreements;
(2) in exchange for consideration, provides cardholders with a right of access to the discounted prices available under the provider agreements entered into under subdivision (1); and
(3) determines the charge to cardholders for the discount prices.

(b) The term does not include the following:
(1) An insurance company, or an affiliate (as defined in IC 27-1-12-2) of an insurance company, that is regulated under this title.
(2) A health maintenance organization, or an affiliate (as defined in IC 27-1-12-2) of a health maintenance organization, that is regulated under this title.
(3) A limited service health maintenance organization, or an affiliate (as defined in IC 27-1-12-2) of a limited service health maintenance organization, that is regulated under this title.

As added by P.L.73-2006, SEC.3.

IC 27-17-1-7
"Marketer"

Sec. 7. "Marketer" means a person that markets, promotes, sells, or distributes a discount medical card program. The term includes a person that markets or distributes a discount medical card program under the person's own name, but does not operate a discount medical card program.

As added by P.L.73-2006, SEC.3.

IC 27-17-1-8
"Medical service"

Sec. 8. (a) "Medical service" means care, service, or treatment related to:
(1) an illness or a dysfunction of; or
(2) injury to;
the human body.

(b) The term includes physician care, inpatient care, hospital services, surgical services, emergency services, ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, laboratory services, radiology services, and medical equipment and supplies.

(c) The term does not include pharmaceutical supplies or prescriptions.

As added by P.L.73-2006, SEC.3.

IC 27-17-1-9
"Person"

Sec. 9. "Person" means an individual or a business entity.

As added by P.L.73-2006, SEC.3.

IC 27-17-1-10
"Program provider"

Sec. 10. "Program provider" means a provider that has, individually or through a provider network, entered into a provider agreement with a discount medical card program organization.

As added by P.L.73-2006, SEC.3.

IC 27-17-1-11
"Provider"

Sec. 11. "Provider" means a person that is licensed under Indiana law to provide medical services.

As added by P.L.73-2006, SEC.3.

IC 27-17-1-12
"Provider agreement"

Sec. 12. "Provider agreement" means a written agreement between a discount medical card program organization and a:

(1) provider; or
(2) provider network;

for the provider or providers that belong to the provider network to render medical services to cardholders at discounted rates.

As added by P.L.73-2006, SEC.3.

IC 27-17-1-13
"Provider network"

Sec. 13. "Provider network" means a group of two (2) or more providers that is represented by a person for purposes of negotiations with third parties.

As added by P.L.73-2006, SEC.3.

IC 27-17-1-14
"Service area"

Sec. 14. "Service area" means a geographic area within a radius of sixty (60) miles from the home or place of business of a cardholder.

As added by P.L.73-2006, SEC.3.

IC 27-17-2

Chapter 2. Registration of Discount Medical Card Program Organizations

IC 27-17-2-1

Requirements to transact business

Sec. 1. A discount medical card program organization may not transact business in Indiana unless the discount medical card program organization is:

(1) authorized to transact business in Indiana; and

(2) registered under this chapter.

As added by P.L.73-2006, SEC.3.

IC 27-17-2-2

Application; requirements

Sec. 2. (a) An application for registration to operate as a discount medical card program organization must be filed with the department on a form prescribed by the department.

(b) An application filed under subsection (a) must be:

(1) sworn to by an officer or authorized representative of the applicant; and

(2) accompanied by the following:

(A) A copy of the applicant's organizational documents, such as articles of incorporation, including all amendments.

(B) A copy of the applicant's bylaws or other enabling documents that establish the organizational structure and governance of the applicant.

(C) A list of the names, addresses, official positions, and biographical information of each individual responsible for conducting the applicant's affairs, including each:

(i) member of the board of directors, board of trustees, executive committee, or other governing board or committee; and

(ii) officer.

(D) A statement generally describing the applicant, the applicant's facilities and personnel, and the medical services for which discounts will be available.

(E) A complete list of all program providers in Indiana available to Indiana cardholders.

(F) A copy of the form of any contract or arrangement between the applicant and a person listed in clause (C).

(G) A copy of the form of any contract between the applicant and a person for the performance on the applicant's behalf of any function, including marketing, administration, enrollment, investment management, and contracting for the provision of medical services to cardholders.

(H) A description of the proposed method of marketing.

(I) A toll free telephone number that program providers and

cardholders can use at least forty (40) hours per week during normal business hours to contact the applicant.

(J) A copy of the applicant's cancellation and refund policy.

(K) A description of program provider and cardholder complaint procedures.

(L) The name and address of the applicant's agent for service of process, notice or demand, or an executed power of attorney appointing the commissioner as the attorney of the applicant in Indiana for service of process for a cause of action arising in Indiana.

(M) Other information the commissioner reasonably requires to make the determinations required under this chapter.

As added by P.L.73-2006, SEC.3. Amended by P.L.1-2007, SEC.187.

IC 27-17-2-3

Registration; fees; duration; renewal

Sec. 3. (a) The fee for issuance of a registration under this chapter is five hundred dollars ($500).

(b) A registration issued or renewed under this chapter expires annually on the last day of the month of issuance or renewal.

(c) The fee for renewal of a registration under this chapter is two hundred fifty dollars ($250).

(d) The department shall renew a registration issued under this chapter if:

(1) the fee specified under subsection (c) is paid; and

(2) the commissioner is satisfied that the discount medical card program organization is in compliance with this article.

(e) Fees collected under this section must be deposited in the department of insurance fund established by IC 27-1-3-28.

As added by P.L.73-2006, SEC.3. Amended by P.L.146-2015, SEC.37.

IC 27-17-2-4

Exception for certain providers providing discounted prices

Sec. 4. This article does not require a provider that provides discounted prices for medical services to the provider's patients to be registered under this chapter.

As added by P.L.73-2006, SEC.3.

IC 27-17-2-5

Exception for certain providers and business entities

Sec. 5. A provider or a business entity owned by at least one (1) provider that contracts with employers or health plans to provide medical services is not required to register under this chapter.

As added by P.L.73-2006, SEC.3.

IC 27-17-3

Chapter 3. Examinations and Investigations

IC 27-17-3-1

Authority to examine and investigate; expenses

Sec. 1. (a) The department may examine or investigate the business and affairs of a discount medical card program organization.

(b) The department may:

(1) order a discount medical card program organization or applicant for registration under IC 27-17-2 to produce records, books, files, advertising and solicitation materials, and other information; and

(2) take statements under oath to determine whether the discount medical card program organization or applicant is in violation of the law or is acting contrary to the public interest.

(c) A discount medical card program organization or applicant that is examined or investigated under this chapter shall pay any expense incurred in conducting the examination or investigation.

As added by P.L.73-2006, SEC.3.

IC 27-17-3-2

Denial or revocation of registration

Sec. 2. A discount medical card program organization's failure to:

(1) comply with an action of the department under section 1 of this chapter; or

(2) pay expenses incurred under section 1 of this chapter;

is grounds for denial or revocation of a registration issued under IC 27-17-2.

As added by P.L.73-2006, SEC.3.

IC 27-17-3-3

Compliance with registration requirements

Sec. 3. A program provider is subject to IC 27-1-3.1.

As added by P.L.73-2006, SEC.3.

IC 27-17-4

Chapter 4. Prohibited Activities

IC 27-17-4-1

Prohibited activities

Sec. 1. A discount medical card program organization may not do the following:

(1) Use the following in the discount medical card program organization's advertisements, marketing materials, brochures, or discount cards:

(A) The term "insurance", except as:

(i) a disclaimer of a relationship between discount medical card program benefits and insurance;

(ii) a description of an insurance product connected with a discount medical card program; or

(iii) otherwise provided in this article.

(B) The terms "health plan", "coverage", "copay", "copayment", "preexisting condition", "guaranteed issue", "portability", "premium", "underwriting", or another term that could reasonably mislead a person to believe that a discount medical card program is health insurance.

(2) Implement restrictions on cardholder access to program providers, including waiting periods and notification periods.

(3) Pay a provider a fee for medical services.

(4) Collect or accept money from a cardholder for payment to a provider for medical services furnished to the cardholder unless the discount medical card program organization is an administrator licensed under IC 27-1-25.

(5) Make misleading, deceptive, or fraudulent representations regarding the discount, range of discounts, or access to the range of discounts offered by the discount medical card program.

(6) List, market, promote, or advertise a physician licensed under IC 25-22.5 as a program provider without the express written consent of the physician.

As added by P.L.73-2006, SEC.3.

IC 27-17-5

Chapter 5. Disclosures

IC 27-17-5-1

Required disclosures

Sec. 1. (a) A discount medical card program organization shall make to a prospective cardholder, and print on the first page of advertisements, marketing materials, and brochures relating to a discount medical card program, the following written disclosures:

(1) That the discount medical card program is not health insurance.

(2) That the discount medical card program provides discounts for medical services rendered by program providers.

(3) That the discount medical card program does not make payments to providers.

(4) That the discount medical card program makes available, before purchase and upon request, a list of program providers, including the:

(A) name;

(B) city;

(C) state; and

(D) specialty;

of each program provider that is located in the prospective cardholder's service area.

(5) That the cardholder:

(A) is obligated to pay for all medical services; and

(B) will receive a discount from a program provider.

(6) The name and the locations of the discount medical card program organization and the corresponding customer service toll free telephone number.

(b) The disclosures made under subsection (a) must be printed in at least 12 point type.

(c) The front of an identification card or other materials designed to identify an individual as a cardholder must include, in boldface, 8 point type, the statement "This is not insurance".

(d) If the initial contact with a prospective cardholder is by telephone, the disclosures made under subsection (a) must be:

(1) made orally; and

(2) included in the initial written materials that describe the terms and conditions of the benefits under the discount medical card program provided to the prospective or new cardholder.

As added by P.L.73-2006, SEC.3.

IC 27-17-5-2

Agreement; requirements

Sec. 2. (a) A person that wishes to be a cardholder of a discount medical card program shall enter into a written agreement with the discount medical card program organization.

(b) A written agreement entered into under subsection (a) must:
(1) specify the cardholder's benefits under the discount medical card program;
(2) specify excluded medical services;
(3) specify that the discount medical card program organization will continuously make available to the cardholder, through a toll free telephone number, the Internet, or in writing upon request, the:
(A) name;
(B) address;
(C) telephone number; and
(D) specialty;
of each program provider in the cardholder's service area; and
(4) comply with the disclosure requirements specified under section 1 of this chapter.

As added by P.L.73-2006, SEC.3.

IC 27-17-5-3
Disclosures by certain marketing organizations

Sec. 3. A marketing organization that is wholly owned by an insurer or a health maintenance organization granted a certificate of authority under this title shall disclose the marketing organization's parent company affiliation in all marketing and membership materials.

As added by P.L.73-2006, SEC.3.

IC 27-17-6
Chapter 6. Filings

IC 27-17-6-1
Filing of advertisement, marketing materials, or brochure

Sec. 1. Before using an advertisement, marketing materials, or a brochure, a discount medical card program organization shall file the advertisement, marketing materials, or brochure with the commissioner and:

(1) obtain the commissioner's approval for use; or

(2) wait at least sixty (60) days after filing and receive no notice of the commissioner's disapproval;

of the advertisement, marketing materials, or brochure.

As added by P.L.73-2006, SEC.3.

IC 27-17-6-2
Notice of approval or disapproval of filing; time

Sec. 2. (a) The commissioner shall:

(1) notify a discount medical card program organization of the commissioner's approval or disapproval of a filing under section 1 of this chapter; and

(2) specify in the notice the reason for a disapproval.

(b) A discount medical card program organization that receives a notice of disapproval under subsection (a) may, not more than twenty-one (21) days after the date the discount medical card program organization receives the notice, request a hearing under IC 4-21.5.

As added by P.L.73-2006, SEC.3.

IC 27-17-7

Chapter 7. Annual Reports

IC 27-17-7-1

Annual report; time

Sec. 1. A discount medical card program organization shall file an annual report with the department not later than three (3) months after the end of the discount medical card program organization's fiscal year.

As added by P.L.73-2006, SEC.3.

IC 27-17-7-2

Annual report; requirements

Sec. 2. A report filed under section 1 of this chapter must be on a form prescribed by the commissioner and must include the following:

(1) If the information is different from the initial application for a registration or from the last annual report, a:

(A) list of the name and residence address of each individual responsible for conducting the discount medical card program organization's affairs, including:

(i) each member of the board of directors, board of trustees, executive committee, or other governing board or committee; and

(ii) each officer; and

(B) disclosure of the extent and nature of any contract or arrangement between each individual listed under clause (A) and the discount medical card program organization, including possible conflicts of interest.

(2) The number of cardholders in Indiana of the discount medical card program organization's discount medical card program.

As added by P.L.73-2006, SEC.3.

IC 27-17-7-3

Noncompliance; notification; payment; suspension of registration

Sec. 3. (a) The department shall notify a discount medical card program organization that is not in compliance with this chapter.

(b) A discount medical card program organization that fails to file an annual report as required under this chapter shall pay to the department for deposit in the department of insurance fund established by IC 27-1-3-28:

(1) five hundred dollars ($500) per day for the first ten (10) days of noncompliance; and

(2) one thousand dollars ($1,000) per day for the eleventh day and each subsequent day of noncompliance.

(c) Upon receiving notice under subsection (a), a discount medical card program organization's registration is suspended until the

commissioner determines that the discount medical card program organization is in compliance with this chapter.
As added by P.L.73-2006, SEC.3.

IC 27-17-8

Chapter 8. Cancellation

IC 27-17-8-1

Cancellation of agreement; time; refund

Sec. 1. (a) A written agreement entered into under IC 27-17-5-2 may be canceled for any reason by the cardholder within:

(1) thirty (30) days after the date the cardholder's identification card is delivered; or

(2) a period that exceeds the period specified in subdivision (1), as provided in the written agreement.

(b) A cardholder that cancels a written agreement under subsection (a) shall receive a full refund of all fees paid by the cardholder, less nominal fees associated with the enrollment cost of the identification card.

As added by P.L.73-2006, SEC.3.

IC 27-17-8-2

Notice of right to cancel; restrictions

Sec. 2. A discount medical card program organization:

(1) shall ensure that a cardholder receives, with the cardholder's identification card, notice that the written agreement may be canceled as provided in section 1 of this chapter; and

(2) may not charge or collect a fee, including a cancellation fee, after a cardholder provides notice to the discount medical card program organization of the cardholder's intention to cancel the written agreement under section 1 of this chapter.

As added by P.L.73-2006, SEC.3.

IC 27-17-8-3

Agreement void

Sec. 3. A written agreement that is:

(1) entered into under IC 27-17-5-2; and

(2) canceled as provided in section 1 of this chapter;

is void from the date the written agreement is entered into.

As added by P.L.73-2006, SEC.3.

IC 27-17-9

Chapter 9. Financial Requirements

IC 27-17-9-1

Application; exemption

Sec. 1. This chapter does not apply to a person that is exempt from registration under IC 27-17-2.

As added by P.L.73-2006, SEC.3.

IC 27-17-9-2

Surety bond requirements

Sec. 2. Except as provided in section 3 of this chapter, a discount medical card program organization shall maintain in force a surety bond issued:

(1) by an insurer granted a certificate of authority under this title;

(2) in the discount medical card organization's name; and

(3) in an amount equal to at least thirty-five thousand dollars ($35,000);

for the commissioner's use in protecting the financial interest of a cardholder who may be adversely affected by the insolvency of the discount medical card program organization.

As added by P.L.73-2006, SEC.3.

IC 27-17-9-3

Option to maintain a deposit; income

Sec. 3. (a) A discount medical card program organization may, instead of maintaining a surety bond under section 2 of this chapter, maintain a deposit with:

(1) the commissioner; or

(2) at the discretion of the commissioner, an organization or a trustee approved by the commissioner and using a custodial or controlled account;

cash, securities, a combination of cash and securities, or another measure approved by the commissioner and having at all times a market value equal to at least thirty-five thousand dollars ($35,000).

(b) Income that results from a deposit made under subsection (a) is an asset of the discount medical card program organization.

As added by P.L.73-2006, SEC.3.

IC 27-17-9-4

Assets or securities not subject to levy

Sec. 4. Assets or securities held in Indiana as a deposit under this chapter are not subject to levy by a judgment creditor or other claimant, except the commissioner, against the discount medical card program organization.

As added by P.L.73-2006, SEC.3.

IC 27-17-10
Chapter 10. Suspension or Revocation of Registration

IC 27-17-10-1
Findings to suspend or revoke a registration

Sec. 1. The department may suspend or revoke a discount medical card program organization's registration or order compliance if the department finds any of the following:

(1) The discount medical card program organization is not in compliance with this article.

(2) The discount medical card program organization is not in compliance with the financial requirements of IC 27-17-9.

(3) The discount medical card program organization has:

(A) advertised, marketed, or attempted to market the discount medical card program organization's services in such a manner as to misrepresent the discount medical card program organization's services or capacity for service; or

(B) engaged in deceptive, misleading, or unfair practices with respect to advertising or marketing.

(4) The discount medical card program organization is not fulfilling the discount medical card program organization's obligations as a discount medical card program organization.

(5) The continued operation of the discount medical card program organization would be hazardous to the discount medical card program organization's cardholders.

As added by P.L.73-2006, SEC.3.

IC 27-17-10-2
Notification; hearing

Sec. 2. If the department has cause to believe that grounds for the suspension or revocation of a registration under this article exist, the department shall:

(1) notify the discount medical card program organization in writing specifically stating the grounds for suspension or revocation; and

(2) pursue a hearing under IC 4-21.5.

As added by P.L.73-2006, SEC.3.

IC 27-17-10-3
Conclude affairs; prohibited activity

Sec. 3. Upon the effective date of the surrender or revocation of a discount medical card program organization's registration, the discount medical card program organization shall conclude the discount medical card program organization's affairs transacted under the registration. The discount medical card program organization may not engage in any further advertising, solicitation, collection of consideration, or renewal of agreements.

As added by P.L.73-2006, SEC.3.

IC 27-17-10-4
Suspension; specifications; rescind or modify; reinstatement

Sec. 4. (a) If the department suspends the registration of a discount medical card program organization, the department must specify in the order of suspension the:

(1) period during which the suspension is in effect; and

(2) conditions that must be met by the discount medical card program organization before the registration is reinstated.

(b) An order of suspension may be rescinded or modified by further order of the department before the expiration of the suspension period specified under subsection (a).

(c) The department may not reinstate a suspended registration unless reinstatement is requested by the discount medical card program organization.

(d) The department may not reinstate a suspended registration if the department determines that the circumstances for which the suspension occurred continue to exist or are likely to recur.

As added by P.L.73-2006, SEC.3.

IC 27-17-10-5
Suspension; requirements

Sec. 5. On the date that a discount medical card program organization receives notice from the department that the discount medical card program organization's registration is suspended, the discount medical card program organization shall:

(1) cease to enroll new cardholders;

(2) honor discounts for existing cardholders for expenses incurred before and on the date of suspension;

(3) discontinue collection of fees from existing cardholders after the date of suspension; and

(4) refund fees collected from existing cardholders after the date of suspension.

As added by P.L.73-2006, SEC.3.

IC 27-17-11
Chapter 11. Notice of Change of Name or Address

IC 27-17-11-1
Notification of change of name or address; time

Sec. 1. A discount medical card program organization shall notify the department of a change of the discount medical card program organization's name, address, principal business address, or mailing address at least thirty (30) days before the change occurs.
As added by P.L.73-2006, SEC.3.

IC 27-17-12
Chapter 12. Marketing of Discount Medical Card Programs

IC 27-17-12-1
Approval of advertisements, marketing materials, brochures, and discount cards

Sec. 1. A discount medical card program organization shall approve in writing all advertisements, marketing materials, brochures, and discount cards before the advertisements, marketing materials, brochures, and discount cards are used by marketers.

As added by P.L.73-2006, SEC.3.

IC 27-17-12-2
Agreement with marketer; liability

Sec. 2. A discount medical card program organization:

(1) shall enter into a written agreement with a marketer before the marketer may begin marketing, promoting, selling, or distributing the discount medical card program; and

(2) is responsible and financially liable for any acts of the discount medical card program organization's marketers that do not comply with this article.

As added by P.L.73-2006, SEC.3.

IC 27-17-13

Chapter 13. Rulemaking

IC 27-17-13-1

Rules

Sec. 1. The department may adopt rules under IC 4-22-2 to implement this article.

As added by P.L.73-2006, SEC.3.

IC 27-17-14
Chapter 14. Violations

IC 27-17-14-1
Civil penalties

Sec. 1. The department may impose a civil penalty of:
(1) at least five hundred dollars ($500); and
(2) not more than fifty thousand dollars ($50,000);
for each violation of this article.
As added by P.L.73-2006, SEC.3.

IC 27-17-14-2
Application of unauthorized insurers act

Sec. 2. IC 27-4-5 applies to a discount medical card program organization that operates without registration under this article as if the discount medical card program organization were an unauthorized insurer.
As added by P.L.73-2006, SEC.3.

IC 27-18

ARTICLE 18. SURPLUS LINES INSURANCE COMPACT

IC 27-18-1

Chapter 1. Definitions

IC 27-18-1-1

Application of definitions

Sec. 1. The definitions in this chapter apply throughout this article.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-2

"Affiliate"

Sec. 2. "Affiliate" means, with respect to an insured, an entity that controls, is controlled by, or is under common control with the insured.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-3

"Affiliated group"

Sec. 3. "Affiliated group" means a group of affiliates.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-4

"Allocation formula"

Sec. 4. "Allocation formula" means the uniform method adopted by the commission by which insured risk exposures are apportioned to each state to calculate premium taxes due.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-5

"Bylaws"

Sec. 5. "Bylaws" refers to the bylaws governing the commission.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-6

"Clearinghouse"

Sec. 6. "Clearinghouse" means the commission's operations involving the acceptance, processing, and dissemination among:

(1) compacting states;
(2) contracting states;
(3) surplus lines licensees;
(4) insureds; and
(5) other persons;

of premium tax and clearinghouse transaction data for nonadmitted insurance of multistate risks under this compact.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-7
"Clearinghouse transaction data"

Sec. 7. (a) "Clearinghouse transaction data" means information regarding nonadmitted insurance of multistate risks that must be reported, accepted, collected, processed, and disseminated by:

(1) surplus lines licensees, for surplus lines insurance; and
(2) insureds, for independently procured insurance;

under this compact.

(b) The term includes information related to single state risks if a state elects to have the clearinghouse collect taxes for the state on single state risks.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-8
"Commission"

Sec. 8. "Commission" refers to the surplus lines insurance multistate compliance compact commission established by this compact.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-9
"Commissioner"

Sec. 9. "Commissioner" refers to the chief insurance regulatory official of a state or the official's designee.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-10
"Compact"

Sec. 10. "Compact" refers to the compact entered into under this article.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-11
"Compacting state"

Sec. 11. "Compacting state" means a state that:

(1) has enacted this compact; and
(2) has not:
    (A) withdrawn; or
    (B) been terminated;

under IC 27-18-14.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-12
"Contracting state"

Sec. 12. "Contracting state" means a state that:

(1) has not enacted this compact; and

(2) has entered into a written contract with the commission to use the services of and fully participate in the clearinghouse.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-13
"Control"

Sec. 13. "Control" means:

(1) ownership or power to vote at least twenty-five percent (25%) of any class of voting securities; or

(2) power to determine the election of a majority of the directors or trustees;

of an entity.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-14
"Home state"

Sec. 14. "Home state" means the following:

(1) With respect to an insured:

(A) the state in which the insured maintains:

(i) the insured's principal place of business; or

(ii) if the insured is an individual, the insured's principal residence; or

(B) if one hundred percent (100%) of the insured risk is located outside the state described in clause (A), the state to which the greatest percentage of the insured's taxable premium for the insurance contract is allocated.

(2) With respect to an affiliated group, if more than one (1) insured from the affiliated group is a named insured on a single nonadmitted insurance contract, the home state determined under subdivision (1) of the member of the affiliated group that has the largest percentage of premium attributed to the member under the insurance contract.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-15
"Independently procured insurance"

Sec. 15. "Independently procured insurance" means insurance procured by an insured directly from a surplus lines insurer or other nonadmitted insurer under the law of the home state.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-16
"Insurer eligibility requirements"

Sec. 16. "Insurer eligibility requirements" means the criteria, forms, and procedures that are:

(1) established to qualify as a surplus lines insurer under the law of the home state; and

(2) consistent with the NRRA.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-17
"Member"

Sec. 17. "Member" means a person chosen by a compacting state as the compacting state's representative to the commission.
As added by P.L.111-2011, SEC.1.

IC 27-18-1-18
"Multistate risk"

Sec. 18. "Multistate risk" means a risk with insured exposures in more than one (1) state.
As added by P.L.111-2011, SEC.1.

IC 27-18-1-19
"Nonadmitted insurance"

Sec. 19. "Nonadmitted insurance" means:
(1) surplus lines insurance; or
(2) independently procured insurance;
procured from a nonadmitted insurer.
As added by P.L.111-2011, SEC.1.

IC 27-18-1-20
"Nonadmitted insurer"

Sec. 20. "Nonadmitted insurer" means an insurer that is not authorized to transact the business of insurance under the law of the home state.
As added by P.L.111-2011, SEC.1.

IC 27-18-1-21
"Noncompacting state"

Sec. 21. "Noncompacting state" means a state that has not adopted this compact.
As added by P.L.111-2011, SEC.1.

IC 27-18-1-22
"NRRA"

Sec. 22. "NRRA" refers to the federal Nonadmitted and Reinsurance Reform Act of 2010 (Subtitle B of Title V of P.L.111-203).
As added by P.L.111-2011, SEC.1.

IC 27-18-1-23
"Policyholder notice"

Sec. 23. "Policyholder notice" means the disclosure notice or stamp that must be furnished to an applicant or a policyholder in connection with a surplus lines insurance placement.
As added by P.L.111-2011, SEC.1.

IC 27-18-1-24
"Premium tax"

Sec. 24. "Premium tax" means, with respect to nonadmitted insurance, a tax, a fee, an assessment, or another charge imposed by a government entity based on a payment made as consideration for the nonadmitted insurance.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-25
"Principal place of business"

Sec. 25. "Principal place of business" means, with respect to determining the home state of an insured, the state where the:

(1) insured maintains the insured's headquarters; and
(2) insured's officers direct, control, and coordinate the business activities of the insured.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-26
"Purchasing group"

Sec. 26. "Purchasing group" means a group that:

(1) is formed under the federal Liability Risk Retention Act of 1986;
(2) has as one (1) of the group's purposes the purchase of liability insurance on a group basis;
(3) purchases liability insurance only:
  (A) for the members of the group; and
  (B) to cover the members' similar or related liability exposure;
(4) is composed of members with similar or related business or activity liability exposure due to the members' related, similar, or common:
  (A) business;
  (B) trade;
  (C) product;
  (D) services;
  (E) premises; or
  (F) operations; and
(5) is domiciled in any state.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-27
"Rule"

Sec. 27. "Rule" refers to a rule adopted by the commission:

(1) to implement, interpret, or prescribe law or policy; or
(2) describing the organization, procedure, or practice requirements of the commission;

that has the force and effect of law in the compacting states.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-28
"Single state risk"

Sec. 28. "Single state risk" means a risk with insured exposures in only one (1) state.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-29
"State"

Sec. 29. "State" means a state, district, or territory of the United States.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-30
"State transaction documentation"

Sec. 30. "State transaction documentation" means information required under the laws of a home state to be filed by:

(1) a surplus lines licensee to:
  (A) report surplus lines insurance; and
  (B) verify compliance with surplus lines laws; and
(2) an insured to report independently procured insurance.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-31
"Surplus lines insurance"

Sec. 31. (a) "Surplus lines insurance" means insurance procured by a surplus lines licensee from a surplus lines insurer or other nonadmitted insurer as permitted under the law of the home state.

(b) The term includes excess lines insurance (as defined by applicable state law).

As added by P.L.111-2011, SEC.1.

IC 27-18-1-32
"Surplus lines insurer"

Sec. 32. (a) "Surplus lines insurer" means a nonadmitted insurer that is eligible under the law of the home state to accept business from a surplus lines licensee.

(b) The term includes an insurer that is permitted to write surplus lines insurance under the law of the state where the insurer is domiciled.

As added by P.L.111-2011, SEC.1.

IC 27-18-1-33
"Surplus lines licensee"

Sec. 33. "Surplus lines licensee" means an individual, firm, or corporation licensed under the law of the home state to place surplus lines insurance.

As added by P.L.111-2011, SEC.1.

IC 27-18-2

Chapter 2. Establishment of the Commission and Venue

IC 27-18-2-1

Creation of surplus lines insurance multistate compliance compact commission

Sec. 1. The compacting states hereby create and establish a joint public agency known as the surplus lines insurance multistate compliance compact commission.

As added by P.L.111-2011, SEC.1.

IC 27-18-2-2

Adoption of rules; home state authority

Sec. 2. The commission may adopt mandatory rules to establish exclusive home state authority regarding nonadmitted insurance of multistate risks, allocation formulas, clearinghouse transaction data, a clearinghouse for receipt and distribution of allocated premium tax and clearinghouse transaction data, and uniform rulemaking procedures and rules to finance, administer, operate, and enforce compliance with this compact and the bylaws and rules.

As added by P.L.111-2011, SEC.1.

IC 27-18-2-3

Adoption of rules; foreign insurer eligibility; policyholder notice

Sec. 3. The commission may adopt mandatory rules establishing foreign insurer eligibility requirements and a concise and objective policyholder notice regarding the nature of a surplus lines insurance placement.

As added by P.L.111-2011, SEC.1.

IC 27-18-2-4

Body corporate and politic

Sec. 4. The commission is a body corporate and politic and an instrumentality of the compacting states.

As added by P.L.111-2011, SEC.1.

IC 27-18-2-5

Responsibility for commission liabilities

Sec. 5. The commission is solely responsible for the commission's liabilities, except as otherwise specifically provided in this compact.

As added by P.L.111-2011, SEC.1.

IC 27-18-2-6

Venue; jurisdiction

Sec. 6. (a) Venue is proper, and judicial proceedings by or against the commission must be brought solely and exclusively, in a court of competent jurisdiction where the principal office of the commission is located.

(b) The commission may waive venue and jurisdictional defenses to the extent the commission adopts or consents to participate in alternative dispute resolution proceedings.

As added by P.L.111-2011, SEC.1.

IC 27-18-3

Chapter 3. Authority of Commission

IC 27-18-3-1

Mandatory rules

Sec. 1. The commission shall adopt mandatory rules to establish the following:

(1) Allocation formulas for each type of nonadmitted insurance coverage, which must be used by each compacting state and contracting state in acquiring premium tax and clearinghouse transaction data from surplus lines licensees and insureds to report to the clearinghouse. The rules described in this subdivision must be adopted with input from surplus lines licensees and must be based on readily available data, with simplicity and uniformity for the surplus lines licensee as a material consideration.

(2) Uniform clearinghouse transaction data reporting requirements for all information reported to the clearinghouse.

(3) Methods by which compacting states and contracting states will require surplus lines licensees and insureds to pay premium tax and report clearinghouse transaction data to the clearinghouse, including processing clearinghouse transaction data through state stamping and service offices, state insurance departments, or other state designated agencies or entities.

(4) That nonadmitted insurance of multistate risks is subject to all regulatory compliance requirements of the home state exclusively. The regulatory compliance requirements that will be applicable to surplus lines insurance under the rules described in this subdivision include the following:

(A) Licensure requirements for persons to sell, solicit, or negotiate surplus lines insurance.

(B) Insurer eligibility requirements or other approved nonadmitted insurer requirements.

(C) Diligent search requirements.

(D) Providing state transaction documentation and clearinghouse transaction data regarding the payment of premium tax under this compact.

The regulatory compliance requirements that will be applicable to independently procured insurance placements under the rules described in this subdivision include providing state transaction documentation and clearinghouse transaction data regarding the payment of premium tax under this compact.

(5) That each compacting state and each contracting state may charge its own rate of taxation on the premium allocated to the compacting state or contracting state based on the applicable allocation formula. However:

(A) the state shall establish a single rate of taxation applicable to all nonadmitted insurance transactions; and

(B) no other tax, fee assessment, or other charge by a governmental or quasi-governmental agency is permitted, except that stamping office fees may be charged as a separate, additional cost unless the fees are incorporated into a state's single rate of taxation.

(6) That a change in the rate of taxation by a compacting state or contracting state is restricted to changes made prospectively with at least ninety (90) days advance notice to the commission.

(7) That each compacting state and each contracting state shall require premium tax payments annually, semiannually, or quarterly, using only one (1) or more of the following dates:

(A) March 1.

(B) June 1.

(C) September 1.

(D) December 1.

(8) That each compacting state and each contracting state shall prohibit any state agency or political subdivision from requiring surplus lines licensees to provide clearinghouse transaction data and state transaction documentation other than to:

(A) the insurance department or tax official; or

(B) a single designated agent of the insurance department or tax official;

of the home state.

(9) The obligation of the home state:

(A) itself; or

(B) through a:

(i) designated agent; or

(ii) surplus lines stamping or service office;

to collect clearinghouse transaction data from surplus lines licensees and from insureds (for independently procured insurance), for reporting to the clearinghouse.

(10) A method for the clearinghouse to periodically report to compacting states, contracting states, surplus lines licensees, and insureds who independently procure insurance:

(A) all premium taxes owed to each of the compacting states and contracting states;

(B) the dates upon which payment of the premium taxes are due; and

(C) a method for paying the premium taxes through the clearinghouse.

(11) That each surplus lines licensee is required to be licensed only in the home state of each insured for whom the licensee has procured surplus lines insurance.

(12) That:

(A) a policy considered to be surplus lines insurance in the insured's home state shall be:

(i) considered to be surplus lines insurance in all compacting states and contracting states; and

(ii) taxed as a surplus lines transaction in all states to which a portion of the risk is allocated;

(B) each compacting state and each contracting state shall require each surplus lines licensee to pay to every other compacting state and contracting state premium taxes on each multistate risk through the clearinghouse at the tax rate charged on surplus lines transactions in the other compacting state or contracting state on the portion of the risk in the compacting state or contracting state, as determined by the applicable uniform allocation formula adopted by the commission;

(C) a policy considered to be independently procured insurance in the insured's home state is considered to be independently procured insurance in all compacting states and contracting states; and

(D) each compacting state and each contracting state shall require the insured to pay every other compacting state and contracting state the independently procured insurance premium tax on each multistate risk through the clearinghouse, as determined by the uniform allocation formula adopted by the commission.

(13) Uniform foreign insurer eligibility requirements, as authorized by the NRRA.

(14) A uniform policyholder notice.

(15) Uniform treatment of purchasing group surplus lines insurance placements.

As added by P.L.111-2011, SEC.1. Amended by P.L.6-2012, SEC.188.

IC 27-18-3-2

Commission powers

Sec. 2. The commission has the following powers:

(1) To adopt rules and operating procedures under IC 27-18-8 that:

(A) have the force and effect of law; and

(B) are binding;

in the compacting states to the extent and in the manner provided in this compact.

(2) To bring and prosecute legal actions in the name of the commission. This subdivision does not affect the standing of a state insurance department to sue or be sued under applicable law.

(3) To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence. This subdivision does not empower the commission to demand or subpoena records or data from nonadmitted insurers.

(4) To establish and maintain offices, including the creation of a clearinghouse for the receipt of premium tax and

clearinghouse transaction data regarding:

(A) nonadmitted insurance of multistate risks;

(B) single state risks for states that elect to require surplus lines licensees to pay premium tax on single state risks through the clearinghouse; and

(C) tax reporting forms.

(5) To purchase and maintain insurance and bonds.

(6) To borrow, accept, or contract for services of personnel, including employees of a compacting state or stamping office, under an open, objective, competitive process and procedure adopted by the commission.

(7) To:

(A) hire employees, professionals, or specialists;

(B) elect or appoint officers;

(C) fix the compensation of individuals described in clauses (A) and (B);

(D) define the duties of individuals described in clauses (A) and (B);

(E) give the individuals described in clauses (A) and (B) appropriate authority to carry out the purposes of this compact; and

(F) determine the qualifications of individuals described in clauses (A) and (B);

under an open, objective, competitive process and procedure adopted by the commission, and to establish the commission's personnel policies and programs relating to conflicts of interest, rates of compensation and qualifications of personnel, and other related personnel matters.

(8) To:

(A) accept;

(B) receive;

(C) use; and

(D) dispose of;

appropriate donations and grants of money, equipment, supplies, materials, and services, avoiding at all times any appearance of impropriety or conflict of interest.

(9) To:

(A) lease;

(B) purchase;

(C) accept appropriate gifts or donations of; or

(D) otherwise own, hold, improve, or use;

real, personal, or real and personal property, avoiding at all times any appearance of impropriety or conflict of interest.

(10) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of real, personal, or real and personal property.

(11) To provide for tax audit rules and procedures for the compacting states with respect to the allocation of premium

taxes, including the following:

(A) Minimum audit standards, including sampling methods.

(B) Review of internal controls.

(C) Cooperation and sharing of audit responsibilities among compacting states.

(D) Handling of refunds or credits due to overpayments or improper allocation of premium taxes.

(E) Taxpayer records to be reviewed, including a minimum retention period.

(F) Authority of compacting states to review, challenge, or re-audit taxpayer records.

(12) To enforce compliance by compacting states and contracting states with rules and bylaws under the authority set forth in IC 27-18-9.

(13) To provide for dispute resolution among compacting states and contracting states.

(14) To advise compacting states and contracting states on tax issues relating to insurers, insureds, surplus lines licensees, agents, or brokers domiciled or doing business in noncompacting states, consistent with the purposes of this compact.

(15) To:

(A) make available advice and training to personnel in state stamping offices, state insurance departments, or other state departments for record keeping, tax compliance, and tax allocations; and

(B) serve as a resource for state insurance departments and other state departments.

(16) To establish a budget and make expenditures.

(17) To borrow money.

(18) To appoint and oversee committees, including advisory committees comprised of members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and other interested persons designated in this compact and the bylaws.

(19) To establish an executive committee under IC 27-18-4-4 that:

(A) is comprised of at least seven (7) and not more than fifteen (15) representatives, including officers elected by the commission and such other representatives as are provided for in this article or determined by the bylaws, who:

(i) serve a one (1) year term; and

(ii) are each entitled to one (1) vote;

(B) has the power to act on behalf of the commission, except for rulemaking, when the commission is not in session;

(C) oversees the day to day activities of the administration of this compact, including the activities of the operations committee established under subdivision (20) and

IC 27-18-4-5, and compliance and enforcement of the provisions of this compact and the bylaws and rules; and

(D) has other duties as provided in this article and as considered necessary.

(20) To establish an operations committee under IC 27-18-4-5 consisting of at least seven (7) and not more than fifteen (15) representatives to provide analysis, advice, determinations, and recommendations regarding:

(A) technology, software, and systems integration to be acquired by the commission; and

(B) the establishment of mandatory rules to be adopted by the commission.

(21) To enter into contracts with contracting states to enable contracting states to use the services of and fully participate in the clearinghouse under the terms and conditions set forth in the contracts.

(22) To adopt and use a corporate seal.

(23) To perform other functions that are necessary or appropriate to the achievement of the purposes of this compact, consistent with state regulation of the business of insurance.

As added by P.L.111-2011, SEC.1. Amended by P.L.6-2012, SEC.189.

IC 27-18-4

Chapter 4. Organization of the Commission

IC 27-18-4-1

Commission membership

Sec. 1. (a) Each compacting state is represented on the commission by only one (1) member. A member shall be:

(1) chosen through a process and according to the qualifications and method of selection determined by the compacting state; or

(2) in the absence of provisions described in subdivision (1), appointed by the governor of the compacting state.

(b) A member may be removed or suspended from office as provided by the law of the compacting state represented by the member.

(c) A vacancy on the commission must be filled in accordance with the law of the compacting state represented by the member whose position has become vacant.

As added by P.L.111-2011, SEC.1.

IC 27-18-4-2

Member participation; voting

Sec. 2. Each member:

(1) is entitled to one (1) vote; and

(2) has an opportunity to participate in the governance of the commission in accordance with the bylaws.

As added by P.L.111-2011, SEC.1.

IC 27-18-4-3

Bylaws

Sec. 3. (a) The commission shall, by a majority vote of the members, prescribe bylaws to govern the commission's conduct as necessary or appropriate to carry out the purposes and exercise the powers of this compact, including bylaws to do the following:

(1) Establish the fiscal year of the commission.

(2) Provide reasonable procedures for the calling and conduct of meetings of the following:

(A) The commission, including the following:

(i) Attendance of a majority of members, including members' participation in meetings by telephone or other means of communication.

(ii) Ensuring reasonable advance notice of the meeting.

(iii) Providing for the right of citizens to attend each meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' and surplus lines licensees' proprietary information, including trade secrets.

(iv) Allowing the commission to meet in camera only after a majority of the entire membership votes to close a

meeting in toto or in part.

(v) Requiring that, as soon as practicable following a meeting described in item (iv), the commission publishes a copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed, and votes taken during the meeting.

(B) The executive committee.

(C) The operations committee.

(3) Provide reasonable standards and procedures:

(A) for the establishment and meetings of committees not described in subdivision (2); and

(B) governing general or specific delegation of authority or a function of the commission.

(4) Establish:

(A) the titles, duties, and authority; and

(B) reasonable procedures for the election;

of the officers of the commission.

(5) Provide reasonable standards and procedures for the establishment of the personnel policies and programs of the commission.

(6) Adopt a code of ethics to address permissible and prohibited activities of members and commission employees.

(7) Provide a mechanism for winding up the operations of the commission and the equitable disposition of surplus funds existing after the:

(A) termination of this compact; and

(B) payment or reservation of the commission's debts and obligations.

(b) Notwithstanding any civil service or other similar laws of a compacting state, the bylaws exclusively govern the personnel policies and programs of the commission.

(c) The commission shall publish the bylaws in a convenient form and file a copy of the bylaws and any amendment to the bylaws with the appropriate agency or officer in each of the compacting states.

As added by P.L.111-2011, SEC.1.

IC 27-18-4-4

Executive committee

Sec. 4. (a) The commission shall establish an executive committee.

(b) All actions of the executive committee, including compliance and enforcement actions, are subject to the review and ratification of the commission as provided in the bylaws.

(c) The executive committee shall consist of not more than fifteen (15) representatives, or one (1) representative for each state if there are less than fifteen (15) compacting states, who are appointed and serve for a term in accordance with the bylaws.

(d) The executive committee has the authority and duties set forth

in the bylaws, which must include the following:

(1) Managing the affairs of the commission in a manner consistent with the bylaws and purposes of the commission.

(2) Establishing and overseeing:

(A) an organizational structure within; and

(B) appropriate procedures for the commission to provide for the creation of;

rules and operating procedures.

(3) Overseeing the offices of the commission.

(4) Planning, implementing, and coordinating communications and activities with other state, federal, and local government organizations to advance the goals of the commission.

(e) The commission shall annually elect officers from the membership of the executive committee. The officers have the authority and duties specified in the bylaws.

(f) The executive committee may:

(1) subject to the approval of the commission; and

(2) according to terms and conditions, and for compensation, that the commission determines to be appropriate;

appoint or retain an executive director.

(g) The executive director:

(1) shall serve as secretary to the commission;

(2) shall not serve as a member of the commission; and

(3) shall hire and supervise other persons as authorized by the commission.

As added by P.L.111-2011, SEC.1.

IC 27-18-4-5

Operations committee

Sec. 5. (a) The commission shall establish an operations committee.

(b) All actions of the operations committee are subject to the review and oversight of the commission and the executive committee, and must be approved by the commission.

(c) The executive committee shall accept the determinations and recommendations of the operations committee unless good cause is shown why those determinations and recommendations should not be approved. Disputes as to whether good cause exists to reject a determination or recommendation of the operations committee must be resolved by a majority vote of the commission.

(d) The operations committee consists of not more than fifteen (15) representatives (or one (1) representative for each state if there are less than fifteen (15) compacting states) who are appointed and serve for a term according to the bylaws.

(e) The operations committee shall have responsibility for the following:

(1) Evaluating technology requirements for the clearinghouse, assessing existing systems used by state regulatory agencies and

state stamping offices:

(A) to maximize the efficiency and successful integration of the clearinghouse technology systems with state and state stamping office technology platforms; and

(B) to minimize costs to the states, the state stamping offices, and the clearinghouse.

(2) Making recommendations to the executive committee based on the operations committee's analysis and determination of the clearinghouse technology requirements and compatibility with existing state and state stamping office systems.

(3) Evaluating the most suitable proposals for adoption as mandatory rules, assessing the proposals for ease of integration by states and likelihood of successful implementation, and reporting to the executive committee the operations committee's determinations and recommendations.

(4) Other duties and responsibilities delegated to the operations committee by the bylaws, the executive committee, or the commission.

(f) All representatives of the operations committee must be individuals who have extensive experience or employment in the surplus lines insurance business, including executives and attorneys employed by:

(1) surplus lines insurers;

(2) surplus lines licensees;

(3) law firms;

(4) state insurance departments; or

(5) state stamping offices.

(g) Operations committee representatives from compacting states that use the services of a state stamping office shall appoint the chief operating officer or a senior manager of the state stamping office to the operations committee.

As added by P.L.111-2011, SEC.1.

IC 27-18-4-6

Legislative committee

Sec. 6. (a) A legislative committee comprised of state legislators or state legislators' designees shall be established to monitor the operations of and make recommendations to the commission, including the executive committee.

(b) The bylaws must determine the manner of selecting the members of the legislative committee and the term of office of the legislative committee members.

(c) Before the commission adopts any:

(1) uniform standard;

(2) revision to the bylaws;

(3) annual budget; or

(4) other significant matter as provided in the bylaws;

the executive committee shall consult with and report to the

legislative committee.
As added by P.L.111-2011, SEC.1.

IC 27-18-4-7
Advisory committees

Sec. 7. The commission may establish additional advisory committees, as the bylaws provide, for carrying out the commission's functions.
As added by P.L.111-2011, SEC.1.

IC 27-18-5

Chapter 5. Corporate Records of the Commission

IC 27-18-5-1

Commission books and records

Sec. 1. The commission shall maintain the commission's corporate books and records in accordance with the bylaws.

As added by P.L.111-2011, SEC.1.

IC 27-18-6
Chapter 6. Qualified Immunity, Defense, and Indemnification

IC 27-18-6-1
Qualified immunity

Sec. 1. (a) The members, officers, executive director, employees, and representatives of the commission, members of the executive committee, and members of any other committee of the commission are, personally and in their official capacity, immune from suit and liability for a claim for damage to or loss of property, personal injury, or other civil liability caused by or arising out of an actual or alleged act, error, or omission:

(1) that occurs; or

(2) that the person against whom the claim is made has a reasonable basis for believing to have occurred;

within the scope of commission employment, duties, or responsibilities.

(b) This section does not protect a person described in subsection (a) from suit or liability for damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of the person.

As added by P.L.111-2011, SEC.1.

IC 27-18-6-2
Defense against liability

Sec. 2. (a) The commission shall defend a member, officer, executive director, employee, or representative of the commission, the executive committee, or any other committee of the commission in a civil action seeking to impose liability arising out of an actual or alleged act, error, or omission:

(1) that occurs; or

(2) that the person against whom the claim is made has a reasonable basis for believing to have occurred;

within the scope of commission employment, duties, or responsibilities if the actual or alleged act, error, or omission did not result from the person's intentional or willful or wanton misconduct.

(b) This section does not prohibit a person described in subsection (a) from retaining the person's own counsel.

As added by P.L.111-2011, SEC.1.

IC 27-18-6-3
Indemnification

Sec. 3. The commission shall indemnify and hold harmless a member, officer, executive director, employee, or representative of the commission, executive committee, or other committee of the commission for the amount of a settlement or judgment obtained against the person arising out of an actual or alleged act, error, or omission:

(1) that occurs; or

(2) that the person against whom the claim is made has a reasonable basis for believing to have occurred;

within the scope of commission employment, duties, or responsibilities if the actual or alleged act, error, or omission did not result from the person's intentional or willful or wanton misconduct.

As added by P.L.111-2011, SEC.1.

IC 27-18-7

Chapter 7. Meetings and Acts of the Commission

IC 27-18-7-1

Meetings; taking action

Sec. 1. The commission shall meet and take action consistent with this compact and the bylaws.

As added by P.L.111-2011, SEC.1.

IC 27-18-7-2

Member voting and participation

Sec. 2. (a) Each member of the commission has the right and power to:

(1) cast a vote to which the compacting state represented by the member is entitled; and

(2) participate in the business and affairs of the commission.

(b) A member shall vote in person or by other means provided in the bylaws.

As added by P.L.111-2011, SEC.1.

IC 27-18-7-3

Schedule of meetings

Sec. 3. The commission:

(1) shall meet at least once during each calendar year; and

(2) shall hold additional meetings according to the bylaws.

As added by P.L.111-2011, SEC.1.

IC 27-18-7-4

Public meeting notice

Sec. 4. Public notice shall be given of all meetings, and all meetings shall be open to the public, except as set forth in the rules or in this compact.

As added by P.L.111-2011, SEC.1.

IC 27-18-7-5

Rules concerning conduct of meetings

Sec. 5. The commission shall adopt rules concerning the commission's meetings consistent with the principles contained in 5 U.S.C. 552b.

As added by P.L.111-2011, SEC.1.

IC 27-18-7-6

Closure of meetings

Sec. 6. The commission and the commission's committees may close a meeting, or a part of a meeting, upon a determination by the commission by majority vote that an open meeting would be likely to do any of the following:

(1) Relate solely to the commission's internal personnel

practices and procedures.

(2) Disclose matters specifically exempted from disclosure by federal or state statute.

(3) Disclose trade secrets or commercial or financial information that is privileged or confidential.

(4) Involve:

(A) the accusation of a person of a crime; or

(B) the formal censure of a person.

(5) Disclose information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy.

(6) Disclose investigative records compiled for law enforcement purposes.

(7) Specifically relate to the commission's issuance of a subpoena or the commission's participation in a civil action or other legal proceeding.

As added by P.L.111-2011, SEC.1. Amended by P.L.6-2012, SEC.190.

IC 27-18-7-7

Certification of appropriateness of closed meeting; documentation

Sec. 7. (a) For a meeting or part of a meeting that is closed under section 6 of this chapter, the commission's legal counsel or the counsel's designee shall certify that the meeting may be closed and shall reference each relevant exemptive provision.

(b) The commission shall keep minutes of each meeting that fully and clearly describe all matters discussed in the meeting and provide a full and accurate summary of actions taken and the reasons for the actions, including a description of the views expressed and the record of any roll call vote.

(c) All documents considered in connection with an action by the commission must be identified in the minutes.

(d) All minutes and documents of a closed meeting must remain under seal, subject to release by a majority vote of the commission.

As added by P.L.111-2011, SEC.1.

IC 27-18-8

Chapter 8. Rules and Operating Procedures

IC 27-18-8-1

Rules

Sec. 1. (a) The commission shall adopt reasonable rules to effectively and efficiently achieve the purposes of this compact.

(b) If the commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this compact, or the powers granted by this compact, the action by the commission is invalid and has no force or effect.

As added by P.L.111-2011, SEC.1.

IC 27-18-8-2

Rules adoption

Sec. 2. Rules adopted under this chapter must be made under a rulemaking process that substantially conforms to the Model State Administrative Procedure Act of 1981, Uniform Laws Annotated, Vol. 15, p.1 (2000), as appropriate for the operations of the commission.

As added by P.L.111-2011, SEC.1.

IC 27-18-8-3

Effective date of rules

Sec. 3. A rule, operating procedure, or amendment to a rule is effective on the date specified in the rule, operating procedure, or amendment.

As added by P.L.111-2011, SEC.1.

IC 27-18-8-4

Judicial review of rules

Sec. 4. (a) Not later than thirty (30) days after a rule is adopted, any person may file a petition for judicial review of the rule.

(b) The filing under subsection (a) of a petition for judicial review of a rule does not stay or otherwise prevent the rule from becoming effective unless the court finds that the petitioner has a substantial likelihood of success.

(c) The court shall give deference to the actions of the commission consistent with applicable law and shall not find a rule that is the subject of a petition under this section to be unlawful if the rule represents a reasonable exercise of the commission's authority.

As added by P.L.111-2011, SEC.1.

IC 27-18-9

Chapter 9. Commission Records and Enforcement

IC 27-18-9-1

Public inspection and copying of commission information

Sec. 1. (a) The commission shall adopt rules establishing conditions and procedures for public inspection and copying of the commission's information and official records, not including information and records involving the privacy of individuals, insurers, or insureds, or surplus lines licensee trade secrets.

(b) State transaction documentation and clearinghouse transaction data collected by the clearinghouse may be used only for purposes expressed in or reasonably implied under the provisions of this compact, and the commission shall afford the state transaction documentation and clearinghouse transaction data the broadest protections as permitted by applicable law for proprietary information, trade secrets, or personal data.

(c) The commission may adopt additional rules under which the commission may:

(1) make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure; and

(2) enter into agreements with agencies described in subdivision (1) to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

As added by P.L.111-2011, SEC.1.

IC 27-18-9-2

Duty to disclose to commission

Sec. 2. (a) Except for privileged records, data, and information, the laws of a compacting state pertaining to confidentiality or nondisclosure do not relieve a compacting state member of the duty to disclose any relevant records, data, or information to the commission.

(b) Disclosure to the commission as described in subsection (a) does not waive or otherwise affect a confidentiality requirement.

(c) Except as otherwise expressly provided in this compact, the commission is not subject to the laws of a compacting state described in subsection (a) with respect to records, data, and information in the commission's possession.

(d) Confidential information of the commission remains confidential after the information is provided to a member.

(e) The commission shall maintain the confidentiality of information provided by a member if that information is confidential under the member's state's law.

As added by P.L.111-2011, SEC.1.

IC 27-18-9-3

Compliance of compacting states; notice of noncompliance

Sec. 3. (a) The commission shall monitor compacting states for compliance with the bylaws and rules.

(b) The commission shall provide written notice of noncompliance to a compacting state that does not comply with the bylaws and rules.

(c) If a compacting state that receives a notice of noncompliance under subsection (b) fails to remedy the noncompliance within the time specified in the notice of noncompliance, the compacting state is considered to be in default under IC 27-18-14.

As added by P.L.111-2011, SEC.1.

IC 27-18-10

Chapter 10. Dispute Resolution

IC 27-18-10-1

Dispute resolution

Sec. 1. (a) The commission shall attempt, upon the request of a member, to resolve disputes or other issues that:

(1) are subject to this compact; and

(2) may arise between two (2) or more compacting states, contracting states, or noncompacting states.

A member may not bring an action in a court with jurisdiction alleging a violation of a provision, standard, or requirement of this compact unless the commission, at the member's request, has attempted to resolve the dispute concerning the alleged violation.

(b) The commission shall adopt a rule providing alternative dispute resolution procedures for disputes described in subsection (a).

As added by P.L.111-2011, SEC.1.

IC 27-18-10-2

Alternative dispute resolution; tax calculation and allocation issues

Sec. 2. The commission shall provide alternative dispute resolution procedures to resolve any disputes between insureds or surplus lines licensees concerning tax calculation or allocation or related issues that are the subject of this compact.

As added by P.L.111-2011, SEC.1.

IC 27-18-10-3

Alternative dispute resolution; home state determination

Sec. 3. Alternative dispute resolution procedures provided under this chapter must be used in circumstances where a dispute arises as to which state constitutes the home state.

As added by P.L.111-2011, SEC.1.

IC 27-18-11

Chapter 11. Review of Commission Decisions

IC 27-18-11-1

No authority to regulate insurance

Sec. 1. Except as necessary in adopting rules to fulfill the purposes of this compact, the commission does not have authority to regulate insurance in the compacting states.

As added by P.L.111-2011, SEC.1.

IC 27-18-11-2

Appeal of commission determinations

Sec. 2. (a) Not later than thirty (30) days after the commission has given notice of a rule or allocation formula, a third party filer or compacting state may appeal the commission's determination to a review panel appointed by the commission.

(b) The commission shall adopt rules to establish procedures for the appointment of a review panel to consider an appeal described in subsection (a) and to provide for notice and hearing in the appeal.

(c) An allegation that the commission, in making a compliance or tax determination, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law is subject to judicial review in accordance with IC 27-18-2-6.

As added by P.L.111-2011, SEC.1.

IC 27-18-11-3

Reconsideration of commission determinations

Sec. 3. (a) The commission may monitor and review commission decisions, and may reconsider commission decisions upon a finding that the determinations or allocations do not meet the relevant rule.

(b) The commission may withdraw or modify a determination or allocation described in subsection (a) after proper notice and hearing, subject to appeal under section 2 of this chapter.

As added by P.L.111-2011, SEC.1.

IC 27-18-12
Chapter 12. Finance

IC 27-18-12-1
Funding of commission operations

Sec. 1. (a) The commission shall pay or provide for the payment of the reasonable expenses of the commission's establishment and organization.

(b) To fund the cost of the commission's initial operations, the commission may accept contributions, grants, and other forms of funding from state stamping offices, compacting states, and other sources.

As added by P.L.111-2011, SEC.1.

IC 27-18-12-2
Collection of fees

Sec. 2. (a) The commission shall collect a fee, payable by the insured directly or through a surplus lines licensee, on each transaction processed through the compact clearinghouse, to cover the cost of the operations and activities of the commission and the commission's staff.

(b) The revenue from the fee collected under subsection (a) must be sufficient to cover the commission's annual budget.

As added by P.L.111-2011, SEC.1.

IC 27-18-12-3
Budget approval

Sec. 3. The commission's budget for a fiscal year shall not be approved until the budget has been subject to notice and comment as provided in IC 27-18-8.

As added by P.L.111-2011, SEC.1.

IC 27-18-12-4
Commission performance of essential governmental functions

Sec. 4. (a) The commission shall be regarded as performing essential governmental functions in:

(1) exercising the commission's powers and functions; and
(2) carrying out the provisions of:
(A) this compact; and
(B) any law relating to this compact.

(b) The commission is not required to pay a tax or assessment of any kind levied by a state or political subdivision upon:

(1) property used by the commission for; or
(2) income or revenue resulting from;

purposes described in subsection (a), including any profit from a sale or an exchange.

As added by P.L.111-2011, SEC.1.

IC 27-18-12-5
Commission fund accounts

Sec. 5. (a) The commission shall keep complete and accurate accounts of all of the commission's:

(1) internal receipts, including grants and donations; and
(2) disbursements;

for all funds under the commission's control.

(b) The internal financial accounts of the commission are subject to the accounting procedures established under the bylaws.

(c) The financial accounts and reports of the commission, including the system of internal controls and procedures of the commission, must be audited annually by an independent certified public accountant.

(d) Upon the determination of the commission, but not less than every three (3) years, the annual audit conducted by the independent auditor under subsection (c) must include a management and performance audit of the commission.

(e) The commission shall make an annual report to the governors and legislatures of the compacting states, including a report of the independent audit conducted under subsection (c).

(f) Subject to subsection (g), the commission's internal accounts are not confidential and may be shared with the commissioner, controller, or stamping office of a compacting state upon request.

(g) The commission shall maintain the confidentiality of the following:

(1) Work papers related to an internal or independent audit.
(2) Information regarding the privacy of individuals.
(3) Licensees' and insurers' proprietary information, including trade secrets.

As added by P.L.111-2011, SEC.1.

IC 27-18-12-6
Commission property; funds

Sec. 6. A compacting state does not have a claim to or ownership of:

(1) property held by or vested in the commission; or
(2) commission funds held under this compact.

As added by P.L.111-2011, SEC.1.

IC 27-18-12-7
Prohibition on political activities

Sec. 7. (a) The commission shall not make political contributions to candidates for elected office, elected officials, political parties, or political action committees.

(b) The commission shall not engage in lobbying, except with respect to changes to this compact.

As added by P.L.111-2011, SEC.1.

IC 27-18-13

Chapter 13. Compacting States, Effective Date, and Amendment

IC 27-18-13-1

Eligibility to become compacting state

Sec. 1. Any state is eligible to become a compacting state.

As added by P.L.111-2011, SEC.1.

IC 27-18-13-2

Effectiveness of compact; commission; clearinghouse operations

Sec. 2. (a) Subject to subsection (b), this compact becomes effective and binding upon legislative enactment of the compact into law by two (2) compacting states.

(b) The commission established by this compact becomes effective for purposes of adopting rules and creating the clearinghouse when:

(1) there is a total of ten (10) compacting states and contracting states; or

(2) there are compacting states and contracting states representing more than forty percent (40%) of the total surplus lines insurance premium volume, based on the following apportionment of the total surplus lines insurance premium volume among the states:

Alabama	1.47%
Alaska	0.29%
Arizona	2.18%
Arkansas	0.66%
California	18.49%
Colorado	1.79%
Connecticut	1.08%
Delaware	0.31%
Florida	8.75%
Georgia	2.95%
Hawaii	0.77%
Idaho	0.24%
Illinois	3.34%
Indiana	1.36%
Iowa	0.44%
Kansas	0.53%
Kentucky	0.55%
Louisiana	2.81%
Maine	0.20%
Maryland	1.43%
Massachusetts	2.33%
Michigan	2.31%
Minnesota	1.29%
Mississippi	0.87%

Missouri	1.33%
Montana	0.21%
Nebraska	0.30%
Nevada	1.17%
New Hampshire	0.34%
New Jersey	3.58%
New Mexico	0.22%
New York	9.11%
North Carolina	1.69%
North Dakota	0.12%
Ohio	1.12%
Oklahoma	1.05%
Oregon	1.03%
Pennsylvania	2.57%
Rhode Island	0.24%
South Carolina	1.36%
South Dakota	0.13%
Tennessee	1.49%
Texas	10.06%
Utah	0.47%
Vermont	0.14%
Virginia	2.01%
Washington	2.43%
West Virginia	0.43%
Wisconsin	0.82%
Wyoming	0.13%

(c) After the commission becomes effective under subsection (b), the compact becomes effective and binding as to any other compacting state upon the enactment of the compact into law by that state.

(d) The clearinghouse operations and the duty to report clearinghouse transaction data begin on the first January 1 or July 1 following the first anniversary of the commission's effective date under subsection (b).

(e) The commission shall:

(1) set a date for the reporting of clearinghouse transaction data by states that become compacting states after the commission's effective date under subsection (b); and

(2) provide notice of the date set under subdivision (1) to surplus lines licensees and all other interested parties at least ninety (90) days before the date set under subdivision (1).

As added by P.L.111-2011, SEC.1.

IC 27-18-13-3

Compact amendment

Sec. 3. (a) Amendments to this compact may be proposed by the commission for enactment by the compacting states.

(b) An amendment to this compact is not effective and binding

upon the commission and the compacting states until all compacting states enact the amendment into law.
As added by P.L.111-2011, SEC.1.

IC 27-18-13-4
Department of insurance authority to take action

Sec. 4. (a) Subject to subsection (b), if this compact does not take effect under section 2(b) of this chapter or becomes ineffective, the Indiana department of insurance has the authority to enter into contracts to implement the requirements of the NRRA.

(b) The Indiana department of insurance shall not enter into a contract under subsection (a) (including a compact or multistate agreement) that is related to reporting, payment, collection, or allocation of fees or taxes on nonadmitted insurance, unless the Indiana department of insurance has done all of the following:

(1) Completed a fiscal analysis of the impact of the contract.

(2) Studied the expected effect of the contract on Indiana's gross receipt of premium tax.

(3) Reviewed whether the contract will create undue administrative burdens on the state of Indiana or surplus lines licensees.

(4) Concluded that entering into the contract:

(A) is in Indiana's financial best interest; and

(B) is consistent with the requirements of the NRRA.

As added by P.L.111-2011, SEC.1.

IC 27-18-14

Chapter 14. Withdrawal, Default, and Termination

IC 27-18-14-1

Compact in force and binding; withdrawal

Sec. 1. (a) Subject to subsection (b), after this compact becomes effective, the compact continues in force and remains binding upon every compacting state.

(b) A compacting state may withdraw from this compact by enacting a statute specifically repealing the statute that enacted this compact into law.

As added by P.L.111-2011, SEC.1.

IC 27-18-14-2

Effect of withdrawal

Sec. 2. (a) The effective date of a compacting state's withdrawal under section 1 of this chapter is the effective date of the statute repealing the statute that enacted this compact.

(b) Except by mutual agreement of the commission and the withdrawing state, a withdrawal under subsection (a) does not apply to a tax or compliance determination that has already been approved on the date the repealing statute becomes effective, unless:

(1) the compacting state and commission mutually agree that the withdrawal applies to the tax or compliance determination; or

(2) the approval of the tax or compliance determination is rescinded by the commission.

As added by P.L.111-2011, SEC.1.

IC 27-18-14-3

Notice of repealing legislation; obligations of withdrawing state

Sec. 3. (a) The member representing a compacting state shall immediately notify the executive committee of the commission in writing upon the introduction in the state's legislature of legislation to repeal this compact in the state.

(b) Not more than ten (10) days after receiving notice under subsection (a) of the legislation under which a state would withdraw from this compact, the commission shall notify the other compacting states of the introduction of the legislation.

(c) A withdrawing state is responsible for all obligations, duties, and liabilities incurred through the effective date of the state's withdrawal, including obligations the performance of which extends beyond the effective date of withdrawal.

(d) To the extent that obligations described in subsection (c) have been released or relinquished by mutual agreement of the commission and the withdrawing state, the commission's determinations before the effective date of the state's withdrawal continue to be effective and shall be given full force and effect in the

withdrawing state, unless formally rescinded by the commission.

(e) A state that has withdrawn from this compact shall be reinstated upon the effective date of the state's legislature's reenactment of this compact.

As added by P.L.111-2011, SEC.1.

IC 27-18-14-4

Default; suspension; notice; termination

Sec. 4. (a) If the commission determines that a compacting state has defaulted in the performance of any of the compacting state's obligations or responsibilities under this compact or under the bylaws or rules, the commission shall, after notice and hearing under the bylaws, suspend all rights, privileges, and benefits conferred by this compact on the defaulting state, effective on the effective date of default as fixed by the commission.

(b) The grounds for the suspension of a compacting state for default under subsection (a) include:

(1) the failure of the compacting state to perform its obligations or responsibilities; and

(2) other grounds designated in commission rules.

(c) Upon making a determination under subsection (a), the commission shall immediately notify the defaulting state in writing of:

(1) the defaulting state's suspension, pending resolution of the default;

(2) the conditions for resolution of the default; and

(3) the period within which the defaulting state must resolve the default.

(d) If a defaulting state notified under subsection (c) fails to resolve the default within the period specified by the commission under subsection (c)(3):

(1) the defaulting state shall be terminated from this compact; and

(2) all rights, privileges, and benefits conferred on the state by this compact are terminated on the effective date of the state's termination from this compact.

(e) Decisions of the commission that have already been issued on the effective date of a state's termination under subsection (d) remain in force in the defaulting state in the same manner as they would under sections 2(b) and 3 of this chapter if the defaulting state had withdrawn voluntarily under section 1 of this chapter.

(f) Reinstatement following termination of a compacting state requires legislative reenactment of the compact in the state.

As added by P.L.111-2011, SEC.1.

IC 27-18-14-5

Dissolution of compact

Sec. 5. (a) This compact dissolves effective on the date of the

withdrawal or termination for default of the compacting state whose withdrawal or termination reduces membership in the compact to one (1) compacting state.

(b) Upon the dissolution of this compact:

(1) this compact becomes void and has no further force or effect; and

(2) the business and affairs of the commission shall be wound up and any surplus funds shall be distributed in accordance with the bylaws and rules.

As added by P.L.111-2011, SEC.1.

IC 27-18-15
Chapter 15. Severability and Construction

IC 27-18-15-1
Severability

Sec. 1. The provisions of this compact are severable in the manner provided in IC 1-1-1-8(b), and if any phrase, clause, sentence, or provision of this compact is considered unenforceable, the remaining provisions of this compact are enforceable.

As added by P.L.111-2011, SEC.1.

IC 27-18-15-2
Construction of compact

Sec. 2. The provisions of this compact shall be liberally construed to effectuate this compact's purposes.

As added by P.L.111-2011, SEC.1.

IC 27-18-16
Chapter 16. Binding Effect of Compact and Other Laws

IC 27-18-16-1
Enforcement of state laws

Sec. 1. Except as provided in section 2 of this chapter, this article does not prevent the enforcement of any other law of a compacting state.

As added by P.L.111-2011, SEC.1.

IC 27-18-16-2
Commission action constitutes exclusive rule; preemption of state law; limitations on preemption

Sec. 2. (a) Decisions of the commission and rules and other requirements of the commission constitute the exclusive rule or determination applicable to the compacting states.

(b) A law or regulation regarding nonadmitted insurance of multistate risks that is contrary to rules of the commission is preempted with respect to the following:

(1) Clearinghouse transaction data reporting requirements.

(2) Allocation formula.

(3) Clearinghouse transaction data collection requirements.

(4) Premium tax payment time frames and rules concerning dissemination of data among the compacting states for nonadmitted insurance of multistate risks and single state risks.

(5) Exclusive compliance with the surplus lines law of the home state of the insured.

(6) Rules for reporting to a clearinghouse for receipt and distribution of clearinghouse transaction data related to nonadmitted insurance of multistate risks.

(7) Uniform foreign insurers eligibility requirements.

(8) Uniform policyholder notice.

(9) Uniform treatment of purchasing groups procuring nonadmitted insurance.

(c) Except as provided in subsection (b), a rule, uniform standard, or other requirement of the commission constitutes the exclusive provision that a commissioner may apply to compliance or tax determinations. However, an action taken by the commission does not abrogate or restrict:

(1) the access of a person to state courts;

(2) the availability of alternative dispute resolution under IC 27-18-10;

(3) remedies available under state law related to breach of contract or torts, or other laws not specifically directed to compliance or tax determinations;

(4) state law relating to the construction of insurance contracts; or

(5) the authority of the attorney general of the state, including

the authority to maintain any actions or proceedings, as authorized by law.

As added by P.L.111-2011, SEC.1.

IC 27-18-16-3

Binding effect of commission action; advisory opinions; constitutional limitations

Sec. 3. (a) Except as provided in this section, lawful actions of the commission, including rules adopted by the commission, are binding upon the compacting states.

(b) Agreements between the commission and the compacting states are binding in accordance with the terms of the agreements.

(c) Upon:

(1) the request of a party to a conflict over the meaning or interpretation of a commission action; and

(2) the affirmative vote of a majority of the compacting states;

the commission may issue advisory opinions regarding the meaning or interpretation in dispute. This subsection may be implemented by rule at the discretion of the commission.

(d) If a provision of this compact exceeds the constitutional limits imposed on the legislature of a compacting state:

(1) the conferral upon the commission of obligations, duties, powers, and jurisdiction through this compact is ineffective as to the compacting state; and

(2) the obligations, duties, powers, and jurisdiction:

(A) remain in the compacting state; and

(B) shall be exercised by the agency of the compacting state to which the obligations, duties, powers, or jurisdiction are delegated by law in effect at the time this compact becomes effective.

As added by P.L.111-2011, SEC.1.

IC 27-19

ARTICLE 19. HEALTH BENEFIT EXCHANGE

IC 27-19-1

Chapter 1. General Provisions

IC 27-19-1-1

Reference to federal law

Sec. 1. Except as otherwise provided in this title, a reference to a federal law in this article is a reference to the federal law as in effect on January 1, 2012.

As added by P.L.278-2013, SEC.27.

IC 27-19-1-2

Application to state agency

Sec. 2. This article applies to a state agency with respect to the state agency's interactions with a health benefit exchange operated in Indiana.

As added by P.L.278-2013, SEC.27.

IC 27-19-1-3

Expiration of article

Sec. 3. This article expires immediately upon the occurrence of any of the following events:

(1) The complete repeal of PPACA.

(2) The repeal of the PPACA requirement that one (1) or more health benefit exchanges be established in each state.

(3) Any other congressional action, or federal court decision, rendering the establishment of a health benefit exchange unnecessary.

(4) The issuance of an executive order by the governor specifying that the establishment of a health benefit exchange in Indiana is unnecessary or inappropriate.

As added by P.L.278-2013, SEC.27.

IC 27-19-1-4

Implementation of article

Sec. 4. The commissioner may do the following to implement this article:

(1) Adopt rules under IC 4-22-2.

(2) Enter into a contract, agreement, or memorandum of understanding with the following:

(A) A health benefit exchange.

(B) An entity that contracts with, or is a subcontractor of, a health benefit exchange.

(C) A federal or state agency.

(D) A health benefit exchange operating in another state.

(E) An agency of another state.

(F) A health plan.

(G) Another person, for purposes of the performance of necessary functions, as determined by the commissioner.

(3) Enter with a person described in subdivision (2) into an information sharing agreement:

(A) that concerns the disclosure and receiving of data necessary to implement this article or PPACA; and

(B) that:

(i) includes adequate protections with respect to confidentiality of the shared information; and

(ii) complies with applicable state and federal law.

As added by P.L.278-2013, SEC.27.

IC 27-19-2
Chapter 2. Definitions

IC 27-19-2-1
Application of definitions
Sec. 1. The definitions in this chapter apply throughout this article.
As added by P.L.278-2013, SEC.27.

IC 27-19-2-2
"Administrator"
Sec. 2. "Administrator" refers to the administrator of the office of Medicaid policy and planning appointed under IC 12-8-6.5-2.
As added by P.L.278-2013, SEC.27.

IC 27-19-2-3
"Application organization"
Sec. 3. (a) Subject to subsections (b) and (c), "application organization" means an entity that:
(1) is a navigator described in Section 1311(i) of PPACA (42 U.S.C. 18031(i));
(2) assists individuals with application for and enrollment in a health benefit exchange or public health insurance program; or
(3) performs the functions of a navigator with respect to a health benefit exchange as established by the commissioner.
(b) In the commissioner's discretion, the term does not include an entity that does one (1) or more of the following:
(1) Provides assistance with application for and enrollment in Medicaid to individuals who, based on preliminary information obtained by the entity, may be eligible for Medicaid without respect to the individuals' income or assets.
(2) Provides individuals with general information concerning the application process for enrollment in a public health insurance program, but does not participate with the individuals in making application for the individuals' enrollment in a public health insurance program.
(c) The term does not include an entity that makes presumptive eligibility determinations concerning individuals' eligibility for enrollment in a public health insurance program.
As added by P.L.278-2013, SEC.27.

IC 27-19-2-4
"CHIP office"
Sec. 4. "CHIP office" refers to the office of the children's health insurance program established by IC 12-17.6-2-1.
As added by P.L.278-2013, SEC.27.

IC 27-19-2-5

"Commissioner"

Sec. 5. "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

As added by P.L.278-2013, SEC.27.

IC 27-19-2-6

"Department"

Sec. 6. "Department" refers to the department of insurance created by IC 27-1-1-1.

As added by P.L.278-2013, SEC.27.

IC 27-19-2-7

"Group health plan"

Sec. 7. "Group health plan" means a group health plan (as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. 300gg-91)) that provides health insurance coverage.

As added by P.L.278-2013, SEC.27.

IC 27-19-2-8

"Health benefit exchange"

Sec. 8. "Health benefit exchange" means an American health benefit exchange operating in Indiana under PPACA.

As added by P.L.278-2013, SEC.27.

IC 27-19-2-9

"Health insurance coverage"

Sec. 9. "Health insurance coverage" has the meaning set forth in Section 2791 of the federal Public Health Service Act (42 U.S.C. 300gg-91).

As added by P.L.278-2013, SEC.27.

IC 27-19-2-10

"Health plan"

Sec. 10. (a) "Health plan" means a policy or contract that provides health insurance coverage.

(b) The term includes a group health plan.

As added by P.L.278-2013, SEC.27.

IC 27-19-2-11

"Medicaid"

Sec. 11. "Medicaid" refers to the federal Medicaid program (42 U.S.C. 1396 et seq.).

As added by P.L.278-2013, SEC.27.

IC 27-19-2-12

"Navigator"

Sec. 12. (a) Subject to subsections (b), (c), and (d), "navigator" means an individual who:

(1) is described in Section 1311(i) of PPACA (42 U.S.C. 18031(i));

(2) assists other individuals with application for and enrollment in a health benefit exchange or public health insurance program; or

(3) performs the functions of a navigator with respect to a health benefit exchange as established by the commissioner.

(b) In the commissioner's discretion, the term does not include an individual who does one (1) or more of the following:

(1) Provides assistance with application for and enrollment in Medicaid to other individuals who, based on preliminary information obtained by the individual, may be eligible for Medicaid without respect to the other individuals' income or assets.

(2) Provides other individuals with general information concerning the application process for enrollment in a public health insurance program, but does not participate with the other individuals in making application for the other individuals' enrollment in a public health insurance program.

(c) The term does not include an individual who makes presumptive eligibility determinations concerning other individuals' eligibility for enrollment in a public health insurance program.

(d) The term does not include a representative authorized by an individual to perform functions on behalf of the individual in connection with Medicaid.

As added by P.L.278-2013, SEC.27.

IC 27-19-2-13
"Person"

Sec. 13. "Person" means an individual or an entity.

As added by P.L.278-2013, SEC.27.

IC 27-19-2-14
"PPACA"

Sec. 14. "PPACA" refers to the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

As added by P.L.278-2013, SEC.27.

IC 27-19-2-15
"Public health insurance program"

Sec. 15. (a) "Public health insurance program" refers to health coverage provided under a state or federal government program.

(b) The term includes the following:

(1) Medicaid (42 U.S.C. 1396 et seq.).

(2) The healthy Indiana plan established by IC 12-15-44.5-3.

(3) The children's health insurance program established under

IC 12-17.6.
As added by P.L.278-2013, SEC.27. Amended by P.L.213-2015, SEC.254; P.L.30-2016, SEC.43.

IC 27-19-2-16
"Qualified health plan"
Sec. 16. "Qualified health plan" means a health plan that has been certified under Section 1301 of PPACA (42 U.S.C. 18021(a)) to meet the criteria for availability through a health benefit exchange operated in Indiana.
As added by P.L.278-2013, SEC.27.

IC 27-19-2-17
"Secretary"
Sec. 17. "Secretary" refers to the secretary of family and social services appointed under IC 12-8-1.5-2.
As added by P.L.278-2013, SEC.27.

IC 27-19-3

Chapter 3. Health Benefit Exchange Authority

IC 27-19-3-1

Application of chapter

Sec. 1. This chapter applies to a health benefit exchange operating in Indiana.

As added by P.L.278-2013, SEC.27.

IC 27-19-3-2

Regulation of insurance in connection with health benefit exchange

Sec. 2. (a) The commissioner and the department may implement and enforce the insurance law of this state in connection with a health benefit exchange.

(b) A law of this state concerning a health benefit exchange does not preempt or supersede the authority of the commissioner or department to regulate the business of insurance in Indiana.

(c) This section does not require the department to perform any function related to a health benefit exchange without being appropriately compensated for the performance of the function.

As added by P.L.278-2013, SEC.27.

IC 27-19-3-3

Regulation of social services in connection with health benefit exchange

Sec. 3. (a) The secretary, the administrator, and the CHIP office may implement and enforce the social services law of this state in connection with a health benefit exchange.

(b) A law of this state concerning a health benefit exchange does not preempt or supersede the authority of the secretary, the administrator, or the CHIP office to administer and regulate social services in Indiana.

(c) This section does not require the secretary, the administrator, or the CHIP office to perform any function related to a health benefit exchange without being appropriately compensated for the performance of the function.

(d) The secretary may adopt rules under IC 4-22-2 to implement this section.

(e) The administrator and the CHIP office may do the following to implement this section:

(1) Enter into a contract, agreement, or memorandum of understanding with the following:

(A) A health benefit exchange.

(B) An entity that contracts with, or is a subcontractor of, a health benefit exchange.

(C) A federal or state agency.

(D) A health benefit exchange operating in another state.

(E) An agency of another state.

(F) A health plan.

(2) Enter with a person described in subdivision (1) into an information sharing agreement:

(A) that concerns the disclosure and receiving of data necessary to implement this section or PPACA; and

(B) that:

(i) includes adequate protections with respect to confidentiality of the shared information; and

(ii) complies with applicable state and federal law.

As added by P.L.278-2013, SEC.27.

IC 27-19-4

Chapter 4. Health Benefit Exchange Navigators and Application Organizations

IC 27-19-4-1

Application of chapter

Sec. 1. (a) This chapter applies to a person that acts as a navigator or an application organization for a health benefit exchange in Indiana. This chapter must be applied in conformity with PPACA.

(b) An individual who intends to act as a navigator shall obtain certification under this chapter before acting as a navigator.

(c) An entity that intends to act as an application organization shall obtain registration under this chapter before acting as an application organization.

(d) The following are subject to regulation by the commissioner and the secretary:

(1) A navigator.

(2) An application organization.

As added by P.L.278-2013, SEC.27.

IC 27-19-4-2

Regulation of navigator and application organization

Sec. 2. Neither a navigator nor an application organization is subject to the licensing requirements of IC 27-1-15.6.

As added by P.L.278-2013, SEC.27.

IC 27-19-4-3

Requirements for navigator and application organization; violation

Sec. 3. (a) A person that is a navigator or an application organization must meet all the following:

(1) Shall not provide incorrect, misleading, incomplete, or materially untrue information in an application for certification or registration.

(2) Shall not violate any of the following:

(A) An insurance law.

(B) A regulation.

(C) A subpoena of the commissioner.

(D) An order of the commissioner.

(E) A rule of a health benefit exchange operating in Indiana.

(F) A rule adopted under IC 27-19-3-3(d).

(G) PPACA or a federal regulation adopted under PPACA.

(3) Shall not intentionally misrepresent the terms of an actual or proposed insurance contract or application for insurance.

(4) Must not have had:

(A) an insurance producer or consultant license;

(B) a navigator certification or an application organization registration; or

(C) an equivalent to a license, certification, or registration

described in clause (A) or (B);

denied, suspended, or revoked in any state, province, district, or territory.

(5) If the person is a navigator, shall not fail to satisfy the continuing education requirements established under section 12 of this chapter.

(6) Shall not obtain or attempt to obtain a license, certification, or registration through misrepresentation or fraud.

(7) Shall not fail to disclose a conflict of interest to the commissioner:

(A) in an application under this chapter; or

(B) arising after application is made under this chapter.

(8) If the person is a navigator, must not have been convicted of a felony or other crimes determined by the commissioner or secretary.

(9) Must not have admitted to committing or have been found to have committed an unfair trade practice or fraud in the business of insurance.

(10) Shall not use fraudulent, coercive, or dishonest practices, or demonstrate incompetence or untrustworthiness, in acting as a navigator or an application organization.

(11) Shall not improperly use notes or other reference material to complete an examination for certification under this chapter.

(12) If the person is a navigator, must not have failed, and shall not fail, to comply with an administrative or court order imposing a child support obligation.

(13) Must not have failed, and shall not fail, to pay state income tax or comply with any administrative or court order directing payment of state income tax.

(14) Shall not fail to timely inform the commissioner of a change in legal name or address.

(15) If the person is an application organization, shall not fail to verify that each navigator working for the application organization meets the following requirements:

(A) The navigator is certified under this chapter.

(B) The navigator has not committed an act that would be grounds for denial, suspension, or revocation of certification under this chapter.

(16) Shall not receive consideration from a health insurance issuer (as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. 300gg-91)) in connection with the enrollment of an individual in a health plan.

(b) The commissioner may:

(1) reprimand a navigator or an application organization;

(2) levy a civil penalty against a navigator or an application organization;

(3) place a navigator or an application organization on probation;

(4) suspend a navigator's certification or an application organization's registration;
(5) revoke a navigator's certification or an application organization's registration for a period of years;
(6) permanently revoke a navigator's certification or an application organization's registration;
(7) issue a cease and desist order to a navigator or an application organization; or
(8) take any combination of the actions described in subdivisions (1) through (7);

for a violation described in subsection (a).

As added by P.L.278-2013, SEC.27.

IC 27-19-4-4

Implementation of chapter

Sec. 4. The commissioner shall, in consultation with the secretary, do the following to implement this chapter:

(1) Develop a policy concerning conflicts of interest affecting navigators and application organizations, including conflicts of interest involving financial and nonfinancial considerations.
(2) Develop a consumer complaint procedure and applicable forms for filing a complaint.
(3) Define a reasonable period for the duration of navigator certification, after which the navigator must pay a renewal fee, complete continuing education, and reapply for certification.
(4) Define a reasonable period for the duration of application organization registration, after which the application organization must pay a renewal fee and reapply for registration.
(5) Develop a policy, procedure, and form for use by an application organization to attest to the commissioner that a navigator who provides the navigator's services on behalf of the application organization meets the requirements of section 3 of this chapter.

As added by P.L.278-2013, SEC.27.

IC 27-19-4-4.5

Study concerning navigators; report

Sec. 4.5. (a) The department shall, in consultation with the office of the secretary of family and social services, review, study, and make recommendations concerning the current capacity, training, adequacy, and barriers to navigators who provide assistance to individuals in applying for and obtaining public health insurance program coverage.

(b) Before September 30, 2016, the department shall report, in writing and in an electronic format under IC 5-14-6, the department's findings under this section to the interim study committee on public health, behavioral health, and human services established by

IC 2-5-1.3-4.

(c) This section expires December 31, 2016.

As added by P.L.87-2016, SEC.7.

IC 27-19-4-5

Navigator application for certification

Sec. 5. (a) Before acting as a navigator in Indiana, an individual must:

(1) apply for certification as a navigator on a form prescribed by the commissioner; and

(2) declare, under penalty of denial, suspension, or revocation of the certification, that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief.

(b) Before approving an application submitted under subsection (a), the commissioner shall determine whether the individual meets the following requirements:

(1) The individual is at least eighteen (18) years of age.

(2) The individual has not committed any act described in section 3 of this chapter that would be grounds for denial, suspension, or revocation of certification.

(3) The individual has completed a precertification course of study prescribed by the commissioner.

(4) The individual has paid the nonrefundable fee established under section 7 of this chapter.

(5) The individual has successfully passed the examination required by section 11 of this chapter.

As added by P.L.278-2013, SEC.27.

IC 27-19-4-6

Application organization application for registration

Sec. 6. (a) Before acting as an application organization in Indiana, an entity must be registered as an application organization as follows:

(1) The entity must apply for registration as an application organization on a form prescribed by the commissioner.

(2) The entity's application for registration:

(A) must be signed by an individual who is an owner, partner, officer, director, member, or manager of the entity, under penalty of denial, suspension, or revocation of registration; and

(B) must declare that the statements made in the application are true, correct, and complete to the best of the signing individual's knowledge and belief.

(b) Before approving an application submitted under subsection (a), the commissioner shall:

(1) verify that the entity is in good standing with the Indiana secretary of state; and

(2) determine whether the entity meets the following requirements:

(A) The entity has paid the nonrefundable fee established under section 7 of this chapter.

(B) The entity has designated a certified navigator to be responsible for the entity's compliance with this chapter.

(C) The entity has not committed any act described in section 3 of this chapter that would be grounds for denial, suspension, or revocation of registration.

(D) No owner, partner, officer, director, member, or manager of the entity has committed an act described in clause (C) or in section 3 of this chapter that would be grounds for denial, suspension, or revocation of certification as a navigator under this chapter.

As added by P.L.278-2013, SEC.27.

IC 27-19-4-7

Verification of information; fees

Sec. 7. (a) The commissioner may require the production of any document that is reasonably necessary to verify the information contained in an application submitted under section 5 or 6 of this chapter.

(b) The commissioner shall collect from each applicant for certification or registration under this chapter a nonrefundable application fee established by the commissioner in an amount expected to generate revenue sufficient to cover the costs incurred by the commissioner in implementing this chapter.

As added by P.L.278-2013, SEC.27.

IC 27-19-4-8

Navigator appointment by application organization

Sec. 8. (a) A navigator who works for an application organization must be appointed by the application organization in writing.

(b) If an application organization, because of a violation described in section 3 of this chapter, revokes the appointment of a navigator described in subsection (a) who works for the application organization, the application organization shall, not more than thirty (30) days after the revocation occurs:

(1) submit a written report to the commissioner concerning the revocation; and

(2) provide a copy of the report to the navigator at the navigator's last known address by:

(A) certified mail, return receipt requested, postage prepaid; or

(B) overnight delivery using a nationally recognized carrier.

As added by P.L.278-2013, SEC.27.

IC 27-19-4-9

Navigator certification renewal; waiver

Sec. 9. A certified navigator who is unable to comply with the certification renewal procedures under this chapter due to military service or another extenuating circumstance may request from the commissioner:

(1) a temporary waiver of:

(A) the renewal procedure; or

(B) an examination requirement; or

(2) a waiver of a penalty or sanction that might otherwise be imposed for failure to comply with the renewal procedures.

As added by P.L.278-2013, SEC.27.

IC 27-19-4-10

Content of certification or registration; change of information

Sec. 10. (a) A certification or registration under this chapter must contain the navigator's or application organization's name and address, the date of issuance, the expiration date, and any other information the commissioner considers necessary.

(b) A navigator or an application organization shall inform the commissioner of a change of address or legal name:

(1) not more than thirty (30) days after the change occurs; and

(2) by any means acceptable to the commissioner.

As added by P.L.278-2013, SEC.27.

IC 27-19-4-11

Navigator course of study and examination

Sec. 11. (a) An individual who applies for certification as a navigator in Indiana must complete a course of study and pass a written examination as prescribed by the commissioner in consultation with the secretary.

(b) The course of study required under subsection (a) must provide instruction in:

(1) the functions of a health benefit exchange;

(2) the duties and responsibilities of a navigator;

(3) the insurance laws of Indiana that apply to the functions of a navigator with respect to a health benefit exchange, including rules related to public health insurance programs; and

(4) the obligations of a navigator related to confidentiality of information and conflicts of interest.

(c) The examination required by subsection (a) must test the knowledge of the individual concerning the applicable:

(1) functions of a health benefit exchange;

(2) duties and responsibilities of a navigator;

(3) insurance laws of Indiana that apply to the functions of a navigator with respect to a health benefit exchange, including rules related to public health insurance programs; and

(4) the obligations of a navigator related to confidentiality of information and conflicts of interest.

(d) The commissioner:

(1) in consultation with the secretary, shall develop:

(A) a curriculum for a course of study for navigators; and

(B) policies and procedures to allow a registered application organization to develop a training program and a course curriculum that meets the requirements of subsection (b) for use in training navigators who perform the navigators' services on behalf of the registered application organization; and

(2) may contract with one (1) or more third party organizations to do any of the following with respect to the course of study described in subdivision (1)(A):

(A) Develop examinations and course materials.

(B) Administer examinations and courses of study.

(C) Collect nonrefundable course and examination fees.

(e) All training programs, course curriculums, examinations, course materials, and examination fees referred to in subsection (d) must be approved in advance by the commissioner in consultation with the secretary.

As added by P.L.278-2013, SEC.27.

IC 27-19-4-12

Navigator continuing education

Sec. 12. (a) The commissioner:

(1) in consultation with the secretary, shall develop continuing education requirements for navigators; and

(2) may contract with one (1) or more third party organizations to:

(A) develop continuing education materials to meet the requirements developed under subdivision (1);

(B) administer continuing education programs; and

(C) collect nonrefundable continuing education program fees.

(b) All continuing education materials, programs, and fees referred to in subsection (a)(2) must be approved in advance by the commissioner in consultation with the secretary.

(c) The commissioner may require a navigator to complete specific continuing education requirements, as prescribed by the commissioner in consultation with the secretary, as a prerequisite to the authority to perform specific functions with respect to a health benefit exchange.

As added by P.L.278-2013, SEC.27.

IC 27-19-4-13

Reapplication for examination

Sec. 13. An individual who fails to:

(1) appear for a scheduled examination required under section 11(a) of this chapter; or

(2) pass the examination;

may not be rescheduled for the examination unless the individual reapplies for the examination and remits all required fees and forms.

As added by P.L.278-2013, SEC.27.

IC 27-19-4-14

Insurance producer acting as navigator

Sec. 14. (a) An insurance producer or insurance consultant:

(1) may not act as a navigator unless the insurance producer or insurance consultant has completed the continuing education requirements that apply to a navigator; and

(2) shall receive a designation from the commissioner as a navigator upon completion of the continuing education requirements;

under this chapter.

(b) The commissioner may require an insurance producer or insurance consultant to complete specific continuing education requirements, as prescribed by the commissioner in consultation with the secretary, as a prerequisite to the authority to perform specific functions with respect to a health benefit exchange.

(c) An insurance producer or insurance consultant is not required to complete continuing education hours of credit in excess of the required number of hours of credit in continuing education that apply to the insurance producer or insurance consultant under IC 27-1-15.7.

As added by P.L.278-2013, SEC.27.