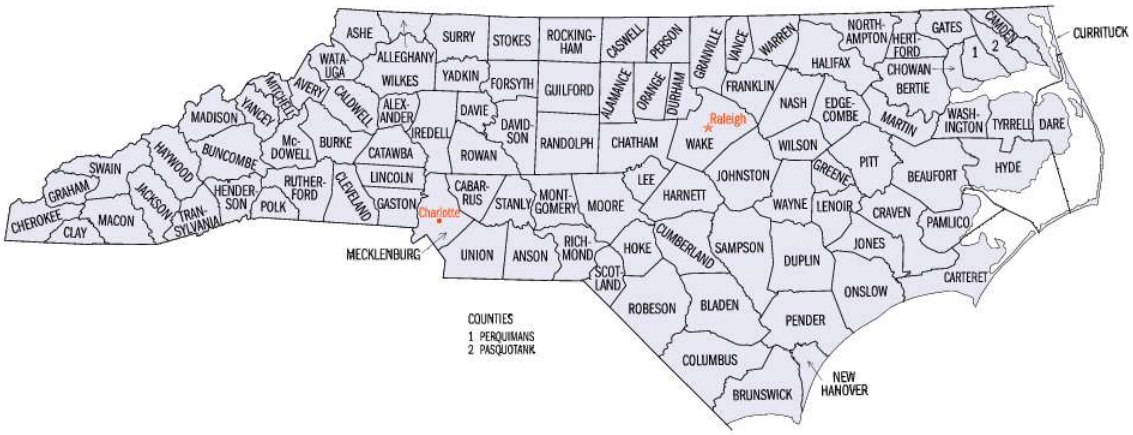
LIFE and HEALTH Manual for North Carolina



Unit IV: State Law (Ethics)
Module 25

Module 25: State Law *(ethics)*

- **Agent** *(May be a person, firm or corporation, that represents the "company's best interest", captive; works only for the company, may be either licensed as "resident" [lives in the state] or "non resident" [lives outside of the state]).*

- **Broker** *(represents the "customers best interest" and is appointed to sell for many insurance companies) must be licensed.*

- **Solicitor** *(finds prospects for agents/brokers, does not sell insurance).*

- **Consultant** *(Advises prospects of insurance products and charges fees).*

- **Personal Status Changes:** Personal status change must be reported to the state insurance department within **30 days** of such change. Personal status changes include: name, personal address, and principal business mailing/physical address changes.

- **Fictitious Group:** Combining several partiers together with the only purpose for the group obtaining insurance. This is not permitted

- **Forbidden Practices:**
    - **Control business** *(prohibited from selling only to friends, family & business associates – must sell insurance to general public).* means life or health insurance contracts covering himself or herself or members of his or her family; officers, directors, stockholders, partners or employees of a business in which he or she or a member of his or her family is engaged; or the debtors of a firm, association, or corporation of which the agent is an officer, director, stockholder, partner or employee. If "Controlled Business" written

by an agent exceeds 50% of the overall amount of insurance sold by that agent, the agent may be subject to having their license revoked.

- **Split Commissions** *(prohibited from splitting commissions with non licensed people).* Neither a life insurance company nor a licensed life insurance agent shall pay directly or indirectly any commission or other valuable consideration to any person for services as a life insurance agent within this state, unless such person holds a currently valid license and appointment to act as a life insurance agent as required by the laws of state. Except, a life insurance company may pay such commission or other valuable consideration to, and a licensed life insurance agent may share any commission or other valuable consideration with, an incorporated insurance agency in which all employees, stockholders, directors, or officers who solicit, negotiate, or effect life insurance contracts are qualified life insurance agents holding currently valid licenses as required by state law. This requirement also applies to health insurance companies and agents. A licensed agent may share a commission with another agent who is also licensed and appointed to write that line of business.

- **Rebating** *(prohibited from paying customer a part of commission).* This is the act of refunding part of the commission, premium, services or anything of value to the purchaser as an inducement to buy an insurance policy.

- **Twisting** *(prohibited from replacing a policy with a lower grade policy).* Twisting is the replacing of an old established insurance policy with a new policy which has fewer benefits to the insured. It involves the failure to disclose all relevant facts *(misrepresentation)*.

- **Churning** *(prohibited from replacing a policy with "like policy" just to generate a commission).* is defined as the practice by which policy values in an existing life insurance policy or annuity contract are used to purchase another policy or contract with that same insurer for the purpose of earning additional premiums or commissions under any of the following conditions:
  1. without an objectively reasonable basis for believing that the new policy will result in an actual and demonstrable benefit,
  2. in a deceptive or misleading manner,
  3. without informing the applicant that the policy value of the existing policy will be used to purchase the new policy, or

4. without informing the applicant that the new policy will not be a paid-up policy or that additional premiums will be due.

- **Misrepresentation** *(an agent must know their products in order to sell them).*

- **Replacement:** Agents are required to determine if any fixed dollar annuity or life insurance policy will be replaced by the proposed new annuity on the application form.

- **Attempting to deceive or defraud**: any person, firm or corporation in connection with an insurance transaction;

- **Violating state law:** any of the provisions of state law in any way relating to insurance;

- **Committing fraud or any dishonest practice**;

- **Demonstrating incompetence or untrustworthiness**: to transact business as an insurance agent;

The following North Carolina state insurance law is offered without interpretation or editing, these topics will be on your state exam.

A. § 58-1-10. Contract of insurance.
A contract of insurance is an agreement by which the insurer is bound to pay money or its equivalent or to do some act of value to the insured upon, and as an indemnity or reimbursement for the destruction, loss, or injury of something in which the other party has an interest. (1899, c. 54, s. 2; Rev., s. 4679; C.S., s. 6262; 1945, c. 383.)

B. § 58-2-5. Commissioner's election and term of office.
The chief officer of the Insurance Department shall be called the Commissioner of Insurance; whenever in the statutes of this State the words "Insurance Commissioner" appear, they shall be deemed to refer to and to be synonymous with the term "Commissioner of Insurance." He shall be elected by the people in the manner prescribed for the election of members of the General Assembly and State officers, and the result of the election shall be declared in the same manner and at the same time as the election of State officers is now declared. His term of office begins on the first day of January next after his election, and is for four years or until his successor is elected and qualified. If a vacancy occurs during the term, it shall be filled by the Governor for the unexpired term. (Rev., ss. 4680, 4681; 1907, c. 868; C.S., s. 6264; 1943, c. 170.)

§ 58-2-40. Powers and duties of Commissioner.
The Commissioner shall:
(1) See that all laws of this State that the Commissioner is responsible for administering and the provisions of this Chapter are faithfully executed; and to that end the Commissioner is authorized to adopt rules in accordance with Chapter 150B of the General Statutes, in order to enforce, carry out and make effective the provisions of those laws. The Commissioner is also authorized to adopt such further rules not contrary to those laws that will prevent persons subject to the Commissioner's regulatory authority from engaging in practices injurious to the public.

(2) Have the power and authority to adopt rules pertaining to and governing the solicitation of proxies, including financial reporting in connection therewith, with respect to the capital stock or other equity securities of any domestic stock insurance company.
(3) Prescribe to the companies, associations, orders, or bureaus required by Articles 1 through 64 of this Chapter to report to the Commissioner, the necessary forms for the statements required. The Commissioner may change those forms from time to time when necessary to secure full information as to the standing, condition, and such other information desired of companies, associations, orders, or bureaus under the jurisdiction of the Department.
(4) Receive and thoroughly examine each financial statement required by Articles 1 through 64 of this Chapter.
(5) Report in detail to the Attorney General any violations of the laws relative to insurance companies, associations, orders and bureaus or the business of insurance; and the Commissioner may institute civil actions or criminal prosecutions either by the Attorney General or another attorney whom the Attorney General may select, for any violation of the provisions of Articles 1 through 64 of this Chapter.
(6) Upon a proper application by any citizen of this State, give a statement or synopsis of the provisions of any insurance contract offered or issued to the citizen.
(7) Administer, or the Commissioner's deputy may administer, all oaths required in the discharge of the Commissioner's official duty.
(8) Compile and make available to the public such lists of rates charged, including deviations, and such explanations of coverages that are provided by insurers for and in connection with contracts or policies of (i) insurance against loss to residential real property with not more than four housing units located in this State and any contents thereof or valuable interest therein and other insurance coverages written in connection with the sale of such property insurance and (ii) private passenger (nonfleet) motor vehicle liability, physical damage, theft, medical payments, uninsured motorists, and other insurance coverages written in connection with the sale of such insurance, as may be advisable to inform the public of insurance premium differentials and of the nature and types of coverages provided. The explanations of coverages provided for in this section must comply with the provisions of Article 38 of this Chapter.
(9) Repealed by Session Laws 2000, c. 19, s. 3. (1899, c. 54, s. 8; 1905, c. 430, s. 3; Rev., s. 4689; C.S., s. 6269; 1945, c. 383; 1947, c. 721; 1965, c. 127, s. 1; 1971, c. 757, s. 1; 1977, c. 376, s. 1; 1979, c. 755, s. 19; c. 881, s. 1; 1981, c. 846, s. 2; 1989, c. 485, s. 29; 1991, c. 644, s. 26; 1997-392, s. 3; 2000-19, s. 3.)

§ 58-2-50. Examinations, hearings, and investigations.
All examinations, hearings, and investigations provided for by this Chapter may be conducted by the Commissioner personally or by one or more deputies, investigators, actuaries, examiners or employees designated for the purpose. If the Commissioner or any investigator appointed to conduct the investigations is of the opinion that there is evidence to charge any person or persons with a criminal violation of any provision of this Chapter, the Commissioner may arrest with warrant or cause the person or persons to be arrested. All hearings shall, unless otherwise specially provided, be held in accordance with this Article and Article 3A of Chapter 150B of the General Statutes and at a time and place designated in a written notice given by the Commissioner to the person cited to appear. The notice shall state the subject of inquiry and the specific charges, if any. (1945, c. 383; 1969, c. 1009; 1995, c. 193, s. 6; 1999-219, s. 1.1.)

§ 58-2-60. Restraining orders; criminal convictions.
(a) Whenever it appears to the Commissioner that any person has violated, is violating, or threatens to violate any provision of Articles 1 through 64, 65 and 66, 67, 69, 70, or 71 of this Chapter, or Article 9A of Chapter 143 of the General Statutes, he may apply to the superior court of any county in which the violation has occurred, is occurring, or may occur for a restraining order and injunction to restrain such violation. If upon application the court finds that any provision of said statutes has been violated, is being violated, or a violation thereof is threatened, the court shall issue an order restraining and enjoining such violations; and such relief may be granted regardless of whether criminal prosecution is instituted under any provision of law.
(b) The conviction in any court of competent jurisdiction of any licensee for any criminal violation of the statutes referred to in subsection (a) of this section automatically has the effect of suspending the license of that person until such time that the license is reinstated by the Commissioner. As

used in this subsection, "conviction" includes an adjudication of guilt, a plea of guilty, and a plea of nolo contendere. (1989, c. 485, s. 30.)

§ 58-2-65. License surrenders.

This section applies to persons or entities licensed under Articles 1 through 64, 65 and 66, 67, 69, 70, or 71 of this Chapter, or Article 9A of Chapter 143 of the General Statutes. When a licensee is accused of any act, omission, or misconduct that would subject the license to suspension or revocation, the licensee, with the consent and approval of the Commissioner, may surrender the license for a period of time established by the Commissioner. A person or entity who surrenders a license shall not thereafter be eligible for or submit any application for licensure during the period of license surrender. (1989, c. 485, s. 30.)

§ 58-2-69. Notification of criminal convictions and changes of address; service of notice.

(a) As used in this section:
  (1) "License" includes any license, certificate, registration, or permit issued under this Chapter.
  (2) "Licensee" means any person who holds a license.

(b) Every applicant for a license shall inform the Commissioner of the applicant's residential address. Every licensee shall give written notification to the Commissioner of any change of the licensee's residential address within 10 business days after the licensee moves into the licensee's new residence. This requirement applies if the change of residential address is by governmental action and there has been no actual change of residence location; in which case the licensee must notify the Commissioner within 10 business days after the effective date of the change. A violation of this subsection is not a ground for revocation, suspension, or nonrenewal of the license or for the imposition of any other penalty by the Commissioner.

(c) If a licensee is convicted in any court of competent jurisdiction for any crime or offense other than a motor vehicle infraction, the licensee shall notify the Commissioner within 10 days after the date of the conviction. As used in this subsection, "conviction" includes an adjudication of guilt, a plea of guilty, or a plea of nolo contendere.

(d) Notwithstanding any other provision of law, whenever the Commissioner is authorized or required to give any notice under this Chapter to a licensee, the notice may be given personally or by sending the notice by first-class mail to the licensee at the address that the licensee has provided to the Commissioner under subsection (b) of this section.

(e) The giving of notice by mail under subsection (d) of this section is complete upon the expiration of four days after the deposit of the notice in the post office. Proof of the giving of notice by mail may be made by the certificate of any employee of the Department. (1998-211, s. 16.)

§ 58-2-70. Civil penalties or restitution for violations; administrative procedure.

(a) This section applies to any person who is subject to licensure or certification under this Chapter.

(b) Whenever the Commissioner has reason to believe that any person has violated any of the provisions of this Chapter, and the violation subjects the license or certification of that person to suspension or revocation, the Commissioner may, after notice and opportunity for a hearing, proceed under the appropriate subsections of this section.

(c) If, under subsection (b) of this section, the Commissioner finds a violation of this Chapter, the Commissioner may, in addition to or instead of suspending or revoking the license or certification, order the payment of a monetary penalty as provided in subsection (d) of this section or petition the Superior Court of Wake County for an order directing payment of restitution as provided in subsection (e) of this section, or both. Each day during which a violation occurs constitutes a separate violation.

(d) If the Commissioner orders the payment of a monetary penalty pursuant to subsection (c) of this section, the penalty shall not be less than one hundred dollars ($100.00) nor more than one thousand dollars ($1,000). In determining the amount of the penalty, the Commissioner shall consider the degree and extent of harm caused by the violation, the amount of money that inured to the benefit of the violator as a result of the violation, whether the violation was committed willfully, and the prior record of the violator in complying or failing to comply with laws, rules, or orders applicable to the violator. The clear proceeds of the penalty shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2. Payment of the civil penalty under this section shall be in addition to payment of any other penalty for a violation of the criminal laws of this State.

(e) Upon petition of the Commissioner the court may order the person who committed a violation specified in subsection (c) of this section to make restitution in an amount that would make whole any person harmed by the violation. The petition may be made at any time and also in any appeal of the Commissioner's order.

(f) Restitution to any State agency for extraordinary administrative expenses incurred in the investigation and hearing of the violation may also be ordered by the court in such amount that would reimburse the agency for the expenses.

(g) Nothing in this section prevents the Commissioner from negotiating a mutually acceptable agreement with any person as to the status of the person's license or certificate or as to any civil penalty or restitution.

(h) Unless otherwise specifically provided for, all administrative proceedings under this Chapter are governed by Chapter 150B of the General Statutes. Appeals of the Commissioner's orders under this section shall be governed by G.S. 58-2-75. (1985, c. 666, s. 35; 1987, c. 752, ss. 3-5; c. 864, s. 1; 1989, c. 485, s. 46; 1998-211, s. 15; 1998-215, s. 83(a).)

§ 58-2-155. Investigation of charges.

Upon his own motion or upon complaint being filed by a citizen of this State that a company authorized to do business in the State has violated any of the provisions of Articles 1 through 64 of this Chapter, the Commissioner shall investigate the matter, and, if necessary, examine, under oath, by himself or his accredited representatives the president and such other officer or agents of such companies as may be deemed proper; also all books, records, and papers of the same. In case the Commissioner shall find upon substantial evidence that any complaint against a company is justified, said company, in addition to such penalties as are imposed for violation of any of the provisions of Articles 1 through 64 of this Chapter, shall be liable for the expenses of the investigation, and the Commissioner shall promptly present said company with a statement of such expenses. If the company refuses or neglects to pay, the Commissioner is authorized to bring a civil action for the collection of these expenses. (1899, c. 54, s. 111; 1903, c. 438, s. 11; Rev., s. 4694; C.S., s. 6277; 1921, c. 136, s. 4; 1925, c. 275, s. 6; 1945, c. 383.)

§ 58-2-160. Reporting and investigation of insurance and reinsurance fraud and the financial condition of licensees; immunity from liability.

(a) As used in this section, "Commissioner" includes an employee, agent, or designee of the Commissioner. A person, or an employee or agent of that person, acting without actual malice, is not subject to civil liability for libel, slander, or any other cause of action by virtue of furnishing to the Commissioner under the requirements of law or at the direction of the Commissioner reports or other information relating to (i) any known or suspected fraudulent insurance or reinsurance claim, transaction, or act or (ii) the financial condition of any licensee. In the absence of actual malice, members of the NAIC, their duly authorized committees, subcommittees, task forces, delegates, and employees, and all other persons charged with the responsibility of collecting, reviewing, analyzing, or disseminating the information developed from filings of financial statements or examinations of licensees are not subject to civil liability for libel, slander, or any other cause of action by virtue of their collection, review, analysis, or dissemination of the data and information collected from such filings or examinations.

(b) The Commissioner, acting without actual malice, is not subject to civil liability for libel or slander by virtue of an investigation of (i) any known or suspected fraudulent insurance or reinsurance claim, transaction, or act or (ii) the financial condition of any licensee; or by virtue of the publication or dissemination of any official report related to any such investigation, which report is published or disseminated in the absence of fraud, bad faith, or actual malice on the part of the Commissioner. The Commissioner is not subject to civil liability in relation to the collecting, reviewing, analyzing, or dissemination of information that is developed by the NAIC from the filing of financial statements with the NAIC or from the examination of insurers by the NAIC and that is communicated to the Commissioner, including any investigation or publication or dissemination of any report or other information in relation thereto, which report is published or disseminated in the absence of fraud, bad faith, negligence, or actual malice on the part of the Commissioner.

(c) During the course of an investigation of (i) a known or suspected fraudulent insurance or reinsurance claim, transaction, or act or (ii) the financial condition of any licensee, the Commissioner may request any person to furnish copies of any information relative to the (i) known or suspected claim, transaction, or act or (ii) financial condition of the licensee. The person shall release the information requested and cooperate with the Commissioner pursuant to

this section. (1985 (Reg. Sess., 1986), c. 1013, s. 3; 1987, c. 864, s. 43; 1987 (Reg. Sess., 1988), c. 975, s. 3; 1989 (Reg. Sess., 1990), c. 1054, s. 1.)

§ 58-2-161. False statement to procure or deny benefit of insurance policy or certificate.

(a) For the purposes of this section:

(1) "Insurer" has the same meaning as in G.S. 58-1-5(3) and also includes:

a. Any hull insurance and protection and indemnity club operating under Article 20 of this Chapter.
b. Any surplus lines insurer operating under Article 21 of this Chapter.
c. Any risk retention group or purchasing group operating under Article 22 of this Chapter.
d. Any local government risk pool operating under Article 23 of this Chapter.
e. Any risk-sharing plan operating under Article 42 of this Chapter.
f. The North Carolina Insurance Underwriting Association operating under Article 45 of this Chapter.
g. The North Carolina Joint Insurance Underwriting Association operating under Article 46 of this Chapter.
h. The North Carolina Insurance Guaranty Association operating under Article 48 of this Chapter.
i. Any multiple employer welfare arrangement operating under Article 49 of this Chapter.
j. The North Carolina Life and Health Insurance Guaranty Association operating under Article 62 of this Chapter.
k. Any service corporation operating under Article 65 of this Chapter.
l. Any health maintenance organization operating under Article 67 of this Chapter.
m. The Teachers' and State Employees' Comprehensive Major Medical Plan operating under Chapter 135 of the General Statutes.
n. A group of employers self-insuring their workers' compensation liabilities under Article 47 of this Chapter.
o. An employer self-insuring its workers' compensation liabilities under Article 5 of Chapter 97 of the General Statutes.
p. The North Carolina Self-Insurance Security Association under Article 4 of Chapter 97 of the General Statutes.
q. Any reinsurer licensed or accredited under this Chapter.

(2) "Statement" includes any application, notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, X rays, test result, or other evidence of loss, injury, or expense.

(b) Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant:

(1) Presents or causes to be presented a written or oral statement, including computer-generated documents as part of, in support of, or in opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning any fact or matter material to the claim, or

(2) Assists, abets, solicits, or conspires with another person to prepare or make any written or oral statement that is intended to be presented to an insurer or insurance claimant in connection with, in support of, or in opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning a fact or matter material to the claim is guilty of a Class H felony. Each claim shall be considered a separate count. Upon conviction, if the court imposes probation, the court may order the defendant to pay restitution as a condition of probation. In determination of the amount of restitution pursuant to G.S. 15A-1343(d), the reasonable costs and attorneys' fees incurred by the victim in the investigation of, and efforts to recover damages arising from, the claim, may be considered part of the damage caused by the defendant arising out of the offense.

In a civil cause of action for recovery based upon a claim for which a defendant has been convicted under this section, the conviction may be entered into evidence against

the defendant. The court may award the prevailing party compensatory damages, attorneys' fees, costs, and reasonable investigative costs. If the prevailing party can demonstrate that the defendant has engaged in a pattern of violations of this section, the court may award treble damages. (1899, c. 54, s. 60; Rev., s. 3487; 1913, c. 89, s. 28; C.S., s. 4369; 1937, c. 248; 1967, c. 1088, s. 1; 1979, c. 760, s. 5; 1989 (Reg. Sess., 1990), c. 1054, s. 2; 1995, c. 43, s. 1; 1999-294, s. 3; 2005-400, s. 17.)

§ 58-2-162. Embezzlement by insurance agents, brokers, or administrators.
If any insurance agent, broker, or administrator embezzles or fraudulently converts to his own use, or, with intent to use or embezzle, takes, secretes, or otherwise disposes of, or fraudulently withholds, appropriates, lends, invests, or otherwise uses or applies any money, negotiable instrument, or other consideration received by him in his performance as an agent, broker, or administrator, he shall be guilty of a felony. If the value of the money, negotiable instrument, or other consideration is one hundred thousand dollars ($100,000) or more, violation of this section is a Class C felony. If the value of the money, negotiable instrument, or other consideration is less than one hundred thousand dollars ($100,000), violation of this section is a Class H felony. (1889, c. 54, s. 103; Rev., s. 3489; 1911, c. 196, s. 8; C.S., s. 4274; 1989 (Reg. Sess., 1990), c. 1054, s. 2; 1997-443, s. 19.25(n).)

§ 58-2-163. Report to Commissioner.
Whenever any insurance company, or employee or representative of such company, or any other person licensed or registered under Articles 1 through 67 of this Chapter knows or has reasonable cause to believe that any other person has violated G.S. 58-2-161, 58-2-162, 58-2-180, 58-8-1, or 58-24-180(e), or whenever any insurance company, or employee or representative of such company, or any other person licensed or registered under Articles 1 through 67 of this Chapter knows or has reasonable cause to believe that any entity licensed by the Commissioner is financially impaired, it is the duty of such person, upon acquiring such knowledge, to notify the Commissioner and provide the Commissioner with a complete statement of all of the relevant facts and circumstances. Such report is a privileged communication, and when made without actual malice does not subject the person making the same to any liability whatsoever. The Commissioner may suspend, revoke, or refuse to renew the license of any licensee who willfully fails to comply with this section. (1989 (Reg. Sess., 1990), c. 1054, s. 2.)

§ 58-2-180. Punishment for making false statement.
If any person in any financial or other statement required by this Chapter willfully misstates information, that person making oath to or subscribing the statement is guilty of a Class I felony; and the entity on whose behalf the person made the oath or subscribed the statement is subject to a fine imposed by the court of not less than two thousand dollars ($2,000) nor more than ten thousand dollars ($10,000). (1899, c. 54, s. 97; Rev., s. 3493; C.S., s. 6281; 1985, c. 666, s. 13; 1989 (Reg. Sess., 1990), c. 1054, s. 5; 1993 (Reg. Sess., 1994), c. 767, s. 23.)

§ 58-2-185. Record of business kept by companies and agents; Commissioner may inspect.
All companies, agents, or brokers doing any kind of insurance business in this State must make and keep a full and correct record of the business done by them, showing the number, date, term, amount insured, premiums, and the persons to whom issued, of every policy or certificate or renewal. Information from these records must be furnished to the Commissioner on demand, and the original books of records shall be open to the inspection of the Commissioner when demanded. (1899, c. 54, s. 108; 1903, c. 438, s. 11; Rev., s. 4696; C.S., s. 6284; 1945, c. 383; 1991, c. 720, s. 4.)

§ 58-2-195. Commissioner may require records, reports, etc., for agencies, agents and others.
(a) The Commissioner is empowered to make and promulgate reasonable rules and regulations governing the recording and reporting of insurance business transactions by insurance agencies, agents, brokers and producers of record, any of which agencies, agents, brokers or producers of record are licensed in this State or are transacting insurance business in this State to the end that such records and reports will accurately and separately reflect the insurance business transactions of such agency, agent, broker or producer of record in this State. Information from records required to be kept pursuant to the provisions of this section must be furnished the Commissioner on demand and the original records required to be kept pursuant to the provisions of this section shall be open to the inspection for the Commissioner or any other authorized employee described in G.S. 58-2-25 when demanded.

(b) Every insurance agency transacting insurance business in this State shall at all times have appointed some person employed or associated with such agency who shall have the responsibility of seeing that such records and reports as are required pursuant to the provisions of this section are kept and maintained.

(c) Any person subject to the provisions of subsection (a) of this section who violates the provisions of this section or the rules and regulations prescribed by the Commissioner pursuant to the provisions of this section may after notice and hearing: for the first offense have his license or licenses (in case license be issued for more than one company in such person's case) suspended or revoked for not less than one month nor more than six months and for the second offense shall have his license or licenses (in case license be issued from more than one company in his case) suspended or revoked for the period of one year and such person shall not thereafter be licensed for one year from the date said revocation or suspension first became effective.

(d) For the purpose of enforcing the provisions of this section the Commissioner or any other authorized employee described in G.S. 58-2-25 is authorized and empowered to examine persons, administer oaths and require production of papers and records relative to this section.

(e) Whenever the Commissioner deems it to be prudent for the protection of policyholders in this State, he or any other authorized employee described in G.S. 58-2-25 shall visit and examine any insurance agency, agent, broker, adjuster, motor vehicle damage appraiser, or producer of record. The refusal of any agency, agent, broker, adjuster, motor vehicle damage appraiser, or producer of record to submit to examination is grounds for the revocation or refusal of a license. (1971, c. 948, s. 1; 1987, c. 629, ss. 14, 15; c. 752, s. 1; 1995, c. 360, s. 2(e).)

§ 58-2-200. Books and papers required to be exhibited.

It is the duty of any person having in his possession or control any books, accounts, or papers of any company licensed under Articles 1 through 64 of this Chapter, to exhibit the same to the Commissioner or to any deputy, actuary, accountant, or persons acting with or for the Commissioner. Any person who shall refuse, on demand, to exhibit the books, accounts, or papers, as above provided, or who shall knowingly or willfully make any false statement in regard to the same, shall be subject to suspension or revocation of his license under Articles 1 through 64 of this Chapter; and shall be deemed guilty of a Class 1 misdemeanor. (1899, c. 54, s. 76; Rev., ss. 3494, 4697; 1907, c. 1000, s. 3; C.S., s. 6286; 1945, c. 383; 1985 (Reg. Sess., 1986), c. 1013, s. 6; 1991, c. 720, s. 4; 1993, c. 539, s. 445; 1994, Ex. Sess., c. 24, s. 14(c).)

11 NCAC 19 .0103 COMPLAINT RECORDS

Each insurer or its agents shall maintain or cause to be maintained an itemization register or log of all written complaints listing the Department file number, the name of the insured, the nature of the complaint, the Department subject to the complaint, the policy or claim number of the insured, and the disposition of the complaint. This record shall be retained for at least three years.

C. § 58-3-25. Discriminatory practices prohibited.

(a) No insurer shall after September 1, 1975, base any standard or rating plan for private passenger automobiles or motorcycles, in whole or in part, directly or indirectly, upon the age or sex of the persons insured.

(b) No insurer shall refuse to insure or refuse to continue to insure an individual, limit the amount, extent, or kind of coverage available to an individual, or charge an individual a different rate for the same coverage, solely because of blindness or partial blindness or deafness or partial deafness. With respect to all other physical conditions, including the underlying cause of the blindness or partial blindness or deafness or partial deafness, individuals who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted individuals or individuals whose hearing is not impaired. Refusal to insure or refusal to continue to insure includes denial by an insurer providing disability insurance on the grounds that the policy defines disability as being presumed in the event that the insured loses his eyesight or hearing: Provided that an insurer providing disability insurance may except disability coverage for blindness, partial blindness, deafness, or partial deafness when those conditions existed at the time the application was made for the disability insurance policy. The provisions of this subsection shall be construed to supplement the provisions of G.S. 58-63-15(7) and G.S. 168-10. This subsection shall apply only to the underwriting of life insurance, accident, health, or accident and health insurance under Articles 1 through 66 of this Chapter, and annuities.

(c) No insurer shall refuse to insure or refuse to continue to insure an individual; limit the amount, extent, or kind of coverage available to an individual; or charge an individual a different rate for the same coverage, because of the race, color, or national or ethnic origin of that individual. This subsection supplements the provisions of G.S. 58-3-120, 58-33-80, 58-58-35, and 58-63-15(7). (1975, c. 666, s. 1; 1985, c. 267, s. 1; 1989, c. 485, s. 22; 1991, c. 720, s. 67.)

§ 58-3-30. Meaning of terms "accident", "accidental injury", and "accidental means".

(a) This section applies to the provisions of all group life, group accident, group health, and group accident and health insurance policies and group annuities under Articles 1 through 64 of this Chapter that are issued on or after October 1, 1989, and preferred provider arrangements under Articles 1 through 64 of this Chapter that are entered into on or after October 1, 1989.

(b) "Accident", "accidental injury", and "accidental means" shall be defined to imply "result" language and shall not include words that establish an accidental means test. (1989, c. 485, s. 10.)

§ 58-3-40. Proof of loss forms required to be furnished.

When any company under any insurance policy requires a written proof of loss after notice of such loss has been given by the insured or beneficiary, the company or its representative shall furnish a blank to be used for that purpose. If such forms are not so furnished within 15 days after the receipt 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, character, and extent of the loss for which claim is made. (1945, c. 377.)

§ 58-3-115. Twisting with respect to insurance policies; penalties.

No insurer shall make or issue, or cause to be issued, any written or oral statement that willfully misrepresents or willfully makes an incomplete comparison as to the terms, conditions, or benefits contained in any policy of insurance for the purpose of inducing or attempting to induce a policyholder in any way to terminate or surrender, exchange, or convert any insurance policy. Any person who violates this section is subject to the provisions of G.S. 58-2-70 or G.S. 58-3-100. (1961, c. 823; 1987, c. 629, s. 4; c. 787, s. 2; c. 864, ss. 3(a), 74; 1989, c. 485, s. 25; 1999-132, s. 1.3.)

§ 58-3-120. Discrimination forbidden.

(a) No company doing the business of insurance as defined in G.S. 58-7-15 shall make any discrimination in favor of any person.

(b) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through 55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited. (1903, c. 488, s. 2; 1905, c. 170, s. 2; Rev., s. 4766; C.S., s. 6430; 1923, c. 4, s. 70; 1925, c. 70, s. 6; 1945, c. 458; 1987, c. 629, s. 5; 2001-297, s. 4.)

§ 58-3-130. Agent, adjuster, etc., acting without a license or violating insurance law.

If any person shall assume to act either as principal, agent, broker, limited representative, adjuster or motor vehicle damage appraiser without license as is required by law or, pretending to be a principal, agent, broker, limited representative, adjuster or licensed motor vehicle damage appraiser, shall solicit, examine or inspect any risk, or shall examine into, adjust, or aid in adjusting any loss, investigate or advise relative to the nature and amount of damages to motor vehicles or the amount necessary to effect repairs thereto, or shall receive, collect, or transmit any premium of insurance, or shall do any other act in the soliciting, making or executing any contract of insurance of any kind otherwise than the law permits, or as principal or agent shall violate any provision of law contained in Articles 1 through 64 of this Chapter, the punishment for which is not elsewhere provided for, he shall be deemed guilty of a Class 1 misdemeanor. (1899, c. 54, s. 115; Rev., s. 3490; C.S., s. 6310; 1945, c. 458; 1949, c. 958, s. 1; 1951, c. 105, s. 1; 1971, c. 757, s. 7; 1985, c. 666, s. 20; 1987, c. 629, s. 9; 1993, c. 539, s. 448; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 58-3-135. Certain insurance activities by lenders with customers prohibited.

No lender shall require the purchase of insurance from such lender or subsidiary or affiliate of such lender as a condition to the making, renewing or refinancing of any loan or to the establishing of any of the terms or conditions of such loan. Lenders shall not include organizations of the Farm Credit System. (1985, c. 679, s. 1.)

§ 58-3-140. Temporary contracts of insurance permitted.
A lender engaged in making or servicing real estate mortgage or deed of trust loans on one to four family residences shall accept as evidence of insurance a temporary written contract of insurance meeting the requirements of G.S. 58-44-20(4) and issued by any duly licensed insurance agent, broker, or insurance company.

Nothing herein prohibits the lender from refusing to accept a binder or from disapproving such insurer or agent provided such refusal or disapproval is reasonable.

Such lender need not accept a binder unless such binder:

(1) Includes:
   a. The name and address of the insured;
   b. The name and address of the mortgagee;
   c. A description of the insured collateral;
   d. A provision that it may not be cancelled within a term of the binder except upon 10 days' written notice to the mortgagee; and
   e. The amount of insurance bound.
(2) Is accompanied by a paid receipt for one year's premium, except in the case of the renewal of a policy subsequent to the closing of a loan; and
(3) Includes an undertaking of agent to use his best efforts to have the insurance company issue a policy.

The Department may require binders to contain any additional information to permit the binders to comply with the reasonable requirements of Fannie Mae, the Government National Mortgage Association, or the Federal Home Loan Mortgage Corporation for purchase of mortgage loans. (1989, c. 459, s. 1; 1991, c. 720, s. 4; 2001-487, s. 14(f).)

§ 58-3-145. Solicitation, negotiation or payment of premiums on insurance policies.
An insurer, agent, or broker may accept payment of an insurance premium by credit card if the insurer accepting payment by credit card meets the following conditions:

(1) The insurer makes payment by credit card available to all existing and prospective insureds and does not limit the use of credit card payments to certain persons.
(2) The insurer pays the fees charged by the credit card company for the payment of premiums by credit card. (1967, c. 1245; 1979, c. 528; 1991, c. 720, s. 7; 1999-365, s. 1.)

D. Licensing of Agents, Brokers, Limited Representatives, and Adjusters.

§ 58-33-1. Scope.
This Article governs the qualifications and procedures for the licensing of agents, brokers, limited representatives, adjusters, and motor vehicle damage appraisers. This Article applies to any and all kinds of insurance and insurers under this Chapter. For purposes of this Article, all references to insurance include annuities, unless the context otherwise requires. (1987, c. 629, s. 1; 2001-203, s. 1.)

§ 58-33-5. License required.
A person shall not sell, solicit, or negotiate insurance in this State unless the person is licensed for that kind of insurance in accordance with this Article. (2001-203, s. 2.)

§ 58-33-10. Definitions.
As used in this Article, the following definitions apply:

(1) "Agent" means a person licensed to solicit applications for, or to negotiate a policy of, insurance. A person not duly licensed who solicits or negotiates a policy of insurance on behalf of an insurer is an agent within the intent of this Article, and thereby becomes liable for all the duties, requirements, liabilities and penalties to which an agent of such company is subject, and such company by compensating such person through any of its officers, agents or employees for soliciting policies of insurance shall thereby accept and acknowledge such person as its agent in such transaction.
(2) "Adjuster" means any individual who, for salary, fee, commission, or other compensation of any nature, investigates or reports to his principal relative to claims arising under insurance contracts other than life or annuity. An attorney at law who adjusts insurance losses from time to time incidental to the practice of his profession or an adjuster of marine losses is not deemed to be an adjuster for purposes of this Article. An individual may not simultaneously hold an agent's and an adjuster's license in this State.

(3) "Broker" means a person who, being a licensed agent, procures insurance for a party other than himself through a duly authorized agent of an insurer that is licensed to do business in this State but for which the broker is not authorized to act as agent. A person not duly licensed who procures insurance for a party other than himself is a broker within the intent of this Article, and thereby becomes liable for all the duties, requirements, liabilities and penalties to which such licensed brokers are subject.
(4) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity. "Business entity" does not mean a sole proprietorship.
(5) "Home state" means the District of Columbia and any state or territory of the United States in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer.
(6) "Insurance" means any of the kinds of insurance in G.S. 58-7-15.
(7) "Insurance producer" or "producer" means a person required to be licensed under this Article to sell, solicit, or negotiate insurance. "Insurance producer" or "producer" includes an agent, broker, and limited representative.
(8) "License" means a document issued by the Commissioner authorizing a person to act as an insurance producer for the kinds of insurance 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.
(9) "Limited line credit insurance" includes any type of credit insurance written under Article 57 of this Chapter, mortgage life, mortgage guaranty, mortgage disability, automobile dealer gap insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation and that the Commissioner determines should be designated a form of limited line credit insurance.
(10) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.
(11) "Limited lines insurance" means motor vehicle physical damage insurance and title insurance, or any other kind of insurance that the Commissioner considers necessary to recognize for the purposes of complying with G.S. 58-33-32(f).
(12) "Limited lines producer" means a person authorized by the Commissioner to sell, solicit, or negotiate limited lines insurance.
(13) "Limited representative" means a person who is authorized by the Commissioner to solicit or negotiate contracts for the particular kinds of insurance identified in G.S. 58-33-26(g) and which kinds of insurance are restricted in the scope of coverage afforded.
(14) "Motor vehicle damage appraiser" means an individual who, for salary, fee, commission, or other compensation of any nature, regularly investigates or advises relative to the nature and amount of damage to motor vehicles located in this State or the amount of money deemed necessary to effect repairs thereto and who is not:
    a. An adjuster licensed to adjust insurance claims in this State;
    b. An agent for an insurance company who is not required by law to be licensed as an adjuster;
    c. An attorney at law who is not required by law to be licensed as an adjuster; or
    d. An individual who, incident to his regular employment in the business of repairing defective or damaged motor vehicles, investigates and advises relative to the nature and amount of motor vehicle damage or the amount of money deemed necessary to effect repairs thereto.
(15) "Negotiate" means the act of conferring directly with, or offering advice directly to, a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, only if the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers. "Negotiate" does not mean a referral to a licensed insurance agent or broker that does not include a discussion of specific insurance policy terms and conditions.
(16) "Person" means an individual or a business entity, but does not mean a county, city, or other political subdivision of the State of North Carolina.
(17) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company. "Sell" does not mean a referral to a licensed insurance agent or broker that does not include a discussion of specific insurance policy terms and conditions.

(18) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company. "Solicit" does not mean a referral to a licensed insurance agent or broker that does not include a discussion of specific insurance policy terms and conditions.
(19) "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance.
(20) "Uniform Business Entity Application" means the current version of the NAIC Uniform Business Entity Application for resident and nonresident business entities.
(21) "Uniform Application" means the current version of the NAIC Uniform Application for resident and nonresident producer licensing. (1987, c. 629, s. 1; c. 864, ss. 76, 77; 1987 (Reg. Sess., 1988), c. 975, s. 8; 2001-203, s. 3.)

§ 58-33-15. Restricted license for overseas military agents.
Notwithstanding any other provision of this Article, an individual may be licensed by the Commissioner as a foreign military sales agent to represent a life insurance company domiciled in this State, provided the agent represents the insurance company only in a foreign country or territory and either on a United States military installation or with United States military personnel. The Commissioner may, upon request of the insurance company on application forms furnished by the Commissioner and upon payment of the fee specified in G.S. 58-33-125, issue to the applicant a restricted license which will be valid only for the representation of the insurance company in a foreign country or territory and either on a United States military installation or with United States military personnel. The insurance company shall certify to the Commissioner that the applicant has the necessary training to hold himself out as a life insurance agent, and that the insurance company is willing to be bound by the acts of the applicant within the scope of his employment. A restricted license issued under this section shall be renewed annually as provided in G.S. 58-33-25(n). (1987, c. 629, s. 1; 1987 (Reg. Sess., 1988), c. 975, s. 9.)

§ 58-33-17. Limited license for rental car companies.
(a) As used in this section:
  (1) "Limited licensee" means a person authorized to sell certain coverages relating to the rental of motor vehicles pursuant to the provisions of this section and Article 28 of Chapter 66 of the General Statutes.
  (2) "Rental agreement" means any written agreement setting forth the terms and conditions governing the use of a vehicle provided by the rental car company.
  (3) "Rental car company" means any person in the business of providing vehicles to the public.
  (4) "Renter" means any person obtaining the use of a vehicle from a rental car company under the terms of a rental agreement.
  (5) "Vehicle" means a motor vehicle of the private passenger type including passenger vans and minivans that are primarily intended for the transport of persons.
(b) The Commissioner may issue to a rental car company, or to a franchisee of a rental car company, that has complied with the requirements of this section, a limited license authorizing the licensee, known as a "limited licensee" for the purpose of this Article, to act as agent, with reference to the kinds of insurance specified in this section, of any insurer authorized to write such kinds of insurance in this State.
(c) The prerequisites for issuance of a limited license under this section are the filing with the Commissioner of the following:
  (1) A written application, signed by an officer of the applicant, for the limited license in such form or forms, and supplements thereto, and containing such information, as the Commissioner may prescribe; and
  (2) A certificate by the insurer that is to be named in such limited license, stating that it has satisfied itself that the named applicant is trustworthy and competent to act as its insurance agent for this limited purpose and that the insurer will appoint such applicant to act as the agent in reference to the doing of such kind or kinds of insurance as are permitted by this section, if the limited license applied for is issued by the Commissioner. Such certificate shall be subscribed by an officer or managing agent of such insurer and affirmed as true under the penalties of perjury.
(d) In the event that any provision of this section is violated by a limited licensee, the Commissioner may:

(1) Revoke or suspend a limited license issued under this section in accordance with the provisions of G.S. 58-33-46; or
(2) After notice and hearing, impose such other penalties, including suspending the transaction of insurance at specific rental locations where violations of this Article have occurred, as the Commissioner deems to be necessary or convenient to carry out the purposes of this section.

(e) The rental car company or franchisee licensed pursuant to subsection (b) of this section may act as agent for an authorized insurer only in connection with the rental of vehicles and only with respect to the following kinds of insurance:
(1) Excess liability insurance that provides coverage to the rental car company or franchisee and renters and other authorized drivers of rental vehicles, in excess of the standard liability limits provided by the rental car company in its rental agreement, for liability arising from the negligent operation of the rental vehicle;
(2) Accident and health insurance that provides coverage to renters and other vehicle occupants for accidental death or dismemberment and for medical expenses resulting from an accident that occurs during the rental period;
(3) Personal effects insurance that provides coverage to renters and other vehicle occupants for the loss of, or damage to, personal effects that occurs during the rental period; or
(4) Any other coverage that the Commissioner may approve as meaningful and appropriate in connection with the rental of vehicles.

(f) No insurance may be issued pursuant to this section unless:
(1) The rental period of the rental agreement does not exceed 30 consecutive days; and
(2) At every rental car location where rental car agreements are executed, brochures or other written materials are readily available to the prospective renter that:
a. Summarize, clearly and correctly, the material terms of insurance coverage, including the identity of the insurer, offered to renters;
b. Disclose that these policies offered by the rental car company may provide a duplication of coverage already provided by a renter's personal automobile insurance policy, homeowner's insurance policy, personal liability insurance policy, or other source of coverage;
c. State that the purchase by the renter of the kinds of insurance specified in this section is not required in order to rent a vehicle;
d. Describe the process for filing a claim in the event the renter elects to purchase coverage and in the event of a claim; and
e. Contain any additional information on the price, benefits, exclusions, conditions or other limitations of such policies as the Commissioner may by regulation prescribe; and
(3) Evidence of coverage is provided to every renter who elects to purchase such coverage.

(g) Any limited license issued under this section shall also authorize any salaried employee of the licensee who, pursuant to subsection (h) of this section, is trained to act individually on behalf, and under the supervision, of the licensee with respect to the kinds of insurance specified in this section.

(h) Each rental car company or franchisee licensed pursuant to this section shall conduct a training program which shall be submitted to the commissioner for approval prior to use and which shall meet the following minimum standards:
(1) Each trainee shall receive basic instruction about the kinds of insurance specified in this section offered for purchase by prospective renters of rental vehicles;
(2) Each trainee shall be instructed to acknowledge to a prospective renter of a rental vehicle that purchase of any such insurance specified in this section is not required in order for the renter to rent a vehicle; and
(3) Each trainee shall be instructed to acknowledge to a prospective renter of a rental vehicle that the renter may have insurance policies that already provide the coverage being offered by the rental car company pursuant to this section.

(i) Limited licensees acting pursuant to and under the authority of this section shall comply with all applicable provisions of this Article, except that notwithstanding any other provision of this Article, or any rule adopted by the Commissioner, a limited licensee pursuant to this section shall not be

required to treat premiums collected from renters purchasing such insurance when renting vehicles as funds received in a fiduciary capacity, provided that:

(1) The insurer represented by the limited licensee has consented in writing, signed by the insurer's officer, that premiums need not be segregated from funds received by the rental car company on account of vehicle rental; and

(2) The charges for insurance coverage are itemized but not billed to the renter separately from the charges for rental vehicles.

(j) No limited licensee under this section shall advertise, represent, or otherwise hold itself or any of its employees themselves out as licensed insurance agents or brokers. (1991, c. 139, s. 1; 2001-203, s. 4.)

§ 58-33-20. Representation.

(a) Every agent or limited representative who solicits or negotiates an application for insurance of any kind, in any controversy between the insured or his beneficiary and the insurer, is regarded as representing the insurer and not the insured or his beneficiary. This provision does not affect the apparent authority of an agent.

(b) Every broker who solicits an application for insurance of any kind, in any controversy between the insured or his beneficiary and the insurer issuing any policy upon such application, is regarded as representing the insured or his beneficiary and not the insurer; except any insurer that directly or through its agents delivers in this State to any insurance broker a policy of insurance pursuant to the application or request of such broker, acting for an insured other than himself, is deemed to have authorized such broker to receive on its behalf payment of any premium that is due on such policy of insurance at the time of its issuance or delivery. (1987, c. 629, s. 1.)

§ 58-33-26. General license requirements.

(a) No person shall act as or hold himself or herself out to be an agent, broker, limited representative, adjuster, or motor vehicle damage appraiser unless duly licensed.

(b) No agent, broker, or limited representative shall make application for, procure, negotiate for, or place for others, any policies for any kinds of insurance as to which that person is not then qualified and duly licensed.

(c) An agent or broker may be licensed for the following kinds of insurance:

(1) Life and health insurance, meaning:

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

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

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

(2) Property and liability insurance, meaning:

a. Coverage for the direct or consequential loss or damage to property of every kind.

b. Coverage against legal liability, including that for death, injury, or disability or damage to real or personal property.

(3) Personal lines, meaning property and liability insurance coverage sold to individuals and families for primarily noncommercial purposes.

(4) Medicare supplement insurance and long-term care insurance, as a supplement to a license for the kinds of insurance listed in subdivision (1) of this subsection.

(d) A property and liability insurance license does not authorize an agent to sell accident and health insurance. An agent must hold a life and health insurance license to sell accident and health insurance.

(e) A life and health insurance license authorizes a resident agent to sell variable contracts if the agent satisfies the Commissioner that the agent has met the National Association of Securities Dealers requirements of the Secretary of State of North Carolina.

(f) A life and health insurance license authorizes a resident agent to sell Medicare supplement and long-term care insurance policies as defined respectively in Articles 54 and 55 of this Chapter, provided that the licensee takes and passes a supplemental written examination for the

insurance as provided in G.S. 58-33-30(e) and pays the supplemental registration fee provided in G.S. 58-33-125(c).

(g) A limited representative may receive qualification for one or more licenses without examination for the following kinds of insurance:
- (1) Dental services.
- (2) Limited line credit insurance.
- (3) Limited lines insurance.
- (4) Motor club.
- (5) Prearrangement insurance, as defined in G.S. 58-60-35(a)(2), when offered or sold by a preneed sales licensee licensed under Article 13D of Chapter 90 of the General Statutes.
- (6) Travel accident and baggage.
- (7) Vehicle service agreements and mechanical breakdown insurance.

(h) No licensed agent, broker, or limited representative shall solicit anywhere in the boundaries of this State, or receive or transmit an application or premium of insurance, for a company not licensed to do business in this State, except as provided in G.S. 58-28-5 and Article 21 of this Chapter.

(i) No agent shall place a policy of insurance with any insurer unless the agent has a current appointment as agent for the insurer in accordance with G.S. 58-33-40 or has a valid temporary license issued in accordance with G.S. 58-33-66.

(j) A business entity that sells, negotiates, or solicits insurance shall be licensed in accordance with G.S. 58-33-31(b). Every member of the partnership and every officer, director, stockholder, and employee of the business entity personally engaged in this State in soliciting or negotiating policies of insurance shall qualify as an individual licensee.

(k) The license shall state the name and social security number, or other identifying number of the licensee, date of issue, kind or kinds of insurance covered by the license, and any other information as the Commissioner deems to be proper.

(l) A license issued to an agent authorizes him to act until his license is otherwise suspended or revoked. Upon the suspension or revocation of a license, the licensee or any person having possession of such license shall return it to the Commissioner.

(m) A license of a broker, limited representative, adjuster, or motor vehicle damage appraiser shall be renewed on April 1 each year, and renewal fees shall be paid. The Commissioner is not required to print licenses for the purpose of renewing licenses. The Commissioner may establish for licenses "staggered" license renewal dates that will apportion renewals throughout each calendar year. If the system of staggered licensing is adopted, the Commissioner may extend the licensure period for some licensees. License renewal fees prescribed by G.S. 58-33-125 shall be prorated to the extent they are commensurate with extensions.

(n) A license as an insurance producer is not required of the following:
- (1) An officer, director, or employee of an insurer or of an insurance producer, provided that the officer, director, or employee does not receive any commission on policies written or sold to insure risks residing, located, or to be performed in this State, except for indirect receipt of proceeds of commissions in the form of salary, benefits, or distributions, and:
  - a. The officer, director, or employee's activities are executive, administrative, managerial, clerical, or a combination of these, and are only indirectly related to the sale, solicitation, or negotiation of insurance; or
  - b. The officer, director, or employee's function relates to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance; or
  - c. The officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation, or negotiation of insurance.
- (2) A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance; or for the purpose of enrolling individuals under plans; issuing certificates under plans or otherwise assisting in administering plans; or performs administrative services related to mass-marketed property and casualty insurance; where no commission is paid to the person for the service.

(3) An employer or association or its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the employers, officers, employees, director, or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, as long as the employers, associations, officers, directors, employees, or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts.

(4) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating, or classification of risks, or in the supervision of the training of insurance producers and who are not individually engaged in the sale, solicitation, or negotiation of insurance.

(5) A person whose activities in this State are limited to advertising without the intent to solicit insurance in this State through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of this State, provided that the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this State.

(6) A person who is not a resident of this State who sells, solicits, or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract, provided that that person is otherwise licensed as an insurance producer to sell, solicit, or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state.

(7) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer provided that the employee does not sell or solicit insurance or receive a commission.

(8) Licensed insurers authorized to write the kinds of insurance described in G.S. 58-7-15(1) through G.S. 58-7-15(3) that do business without the involvement of a licensed agent.

(9) A person indirectly receiving proceeds of commissions as part of the transfer of insurance business or in the form of retirement or similar benefits.

(o) Nothing in this Article requires an insurer to obtain an insurance producer license. In this subsection, "insurer" does not include an insurer's officers, directors, employees, subsidiaries, or affiliates. (2001-203, s. 6.)

§ 58-33-30. License requirements.

The Commissioner shall not issue or continue any license of an agent, broker, limited representative, adjuster, or motor vehicle damage appraiser except as follows:

(a) Application. – The applicable license application requirements of G.S. 58-33-31 shall be satisfied.

(b) Repealed by Session Laws 2001-203, s. 7, effective July 1, 2002

(c) Repealed by Session Laws 2001-203, s. 7, effective July 1, 2002

(d) Education and Training. –

(1) Each applicant must have had special education, training, or experience of sufficient duration and extent reasonably to satisfy the Commissioner that the applicant possesses the competence necessary to fulfill the responsibilities of an agent, broker, limited representative, adjuster, or motor vehicle damage appraiser.

(2) All individual applicants for licensing as life and health agents or as property and liability agents shall furnish evidence satisfactory to the Commissioner of successful completion of at least 40 hours of instruction, which shall in all cases include the general principles of insurance and any other topics that the Commissioner establishes by regulation; and which shall, in the case of life and health insurance applicants, include the principles of life, accident, and health insurance and, in the case of property and liability insurance applicants, shall include instruction in property and liability insurance. Any applicant who submits satisfactory evidence of having successfully completed an agent training course that has been approved by the Commissioner and that is offered by or under the auspices of a property or liability or life or health insurance company admitted to do business in this State or a professional insurance association shall be deemed to have

satisfied the educational requirements of this subdivision. The requirement in this subdivision for completion of 40 hours of instruction applies only to applicants for life and health or property and liability insurance licenses.

(3) Each resident applicant for a Medicare supplement and long-term care insurance license shall furnish evidence satisfactory to the Commissioner of successful completion of 10 hours of instruction, which shall in all cases include the principles of Medicare supplement and long-term care insurance and federal and North Carolina law relating to such insurance. A resident applicant who submits satisfactory evidence of having successfully completed an agent training course that has been approved by the Commissioner and that is offered by or under the auspices of a licensed life or health insurer or a professional insurance association satisfies the educational requirements of this subdivision.

(e) Examination.

(1) After completion and filing of the application with the Commissioner, except as provided in G.S. 58-33-35, the Commissioner shall require each applicant for license as an agent or an adjuster to take an examination as to the applicant's competence to be licensed. The applicant must take and pass the examination according to requirements prescribed by the Commissioner.

(2) The Commissioner may require any licensed agent, adjuster, or motor vehicle damage appraiser to take and successfully pass an examination in writing, testing his competence and qualifications as a condition to the continuance or renewal of his license, if the licensee has been found guilty of any violation of any provision of this Chapter. If an individual fails to pass such an examination, the Commissioner shall revoke all licenses issued in his name and no license shall be issued until such individual has passed an examination as provided in this Article.

(3) Each examination shall be as the Commissioner prescribes and shall be of sufficient scope to test the applicant's knowledge of:

a. The terms and provisions of the policies or contracts of insurance the applicant proposes to effect; or
b. The types of claims or losses the applicant proposes to adjust; and
c. The duties and responsibilities of the license; and
d. The current laws of this State applicable to the license.

(4) The answers of the applicant to the examination shall be provided by the applicant under the Commissioner's supervision. The Commissioner shall give examinations at such times and places within this State as the Commissioner considers necessary reasonably to serve the convenience of both the Commissioner and applicants: Provided that the Commissioner may contract directly with persons for the processing of examination application forms and for the administration and grading of the examinations required by this section; the Commissioner may charge a reasonable fee in addition to the registration fee charged under G.S. 58-33-125, to offset the cost of the examination contract authorized by this subsection; and such contracts shall not be subject to Article 3 of Chapter 143 of the General Statutes.

(5) The Commissioner shall collect in advance the examination and registration fees provided in G.S. 58-33-125 and in subsection (4) of this section. The Commissioner shall make or cause to be made available to all applicants, for a reasonable fee to offset the costs of production, materials that he considers necessary for the applicants' proper preparation for examinations. The Commissioner may contract directly with publishers and other suppliers for the production of the preparatory materials, and contracts so let by the Commissioner shall not be subject to Article 3 of Chapter 143 of the General Statutes.

(6) In addition to the examinations for the kinds of insurance specified in G.S. 58-33-25(c)(1) and (2), before any resident may sell Medicare supplement or long-term care insurance policies defined respectively in Articles 54 and 55 of this Chapter, the resident must take and pass a supplemental written examination according to requirements prescribed by the Commissioner.

(7) An individual who fails to appear for the examination as scheduled or fails to pass the examination shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

(f) Brokers.

(1) Bond. – Prior to issuance of a license as a broker, the applicant shall file with the Commissioner and thereafter, for as long as the license remains in effect, shall keep in force a bond in favor of the State of North Carolina for the use of aggrieved parties in the sum of not less than fifteen thousand dollars ($15,000), executed by an authorized corporate surety approved by the Commissioner. The aggregate liability of the surety for any and all claims on any such bond shall in no event exceed the sum thereof. The bond shall be conditioned on the accounting by the broker (i) to any person requesting the broker to obtain insurance for moneys or premiums collected in connection therewith, (ii) to any licensed insurer or agent who provides coverage for such person with respect to any such moneys or premiums, and (iii) to any premium finance company or to any association of insurers under any plan or plans for the placement of insurance under the laws of North Carolina which afforded coverage for such person with respect to any such moneys or premiums. No such bond shall be terminated unless at least 30 days' prior written notice thereof is given by the surety to the licensee and the Commissioner. Upon termination of the license for which the bond was in effect, the Commissioner shall notify the surety within 10 business days. A person required by this subdivision to maintain a bond may, in lieu of that bond, deposit with the Commissioner the equivalent amount in cash, in certificates of deposit issued by banks organized under the laws of the State of North Carolina, or any national bank having its principal office in North Carolina, or securities, which shall be held in accordance with Article 5 of this Chapter. Securities may only be obligations of the United States or of federal agencies listed in G.S. 147-69.1(c)(2) guaranteed by the United States, obligations of the State of North Carolina, or obligations of a city or county of this State. Any proposed deposit of an obligation of a city or county of this State is subject to the prior approval of the Commissioner.

(2) Other Requirements. – An applicant must hold a valid agent's license at the time of application for the broker's license and throughout the duration of the broker's license. A broker's license shall be issued to cover only those kinds of insurance authorized by his agent's license. Suspension or revocation of the agent's license shall cause immediate revocation of the broker's license.

(g) Denial of License. – If the Commissioner finds that the applicant has not fully met the requirements for licensing, the Commissioner shall refuse to issue the license and shall notify in writing the applicant and the appointing insurer, if any, of the denial, stating the grounds for the denial. The application may also be denied for any reason for which a license may be suspended or revoked or not renewed under G.S. 58-33-46. In order for an applicant to be entitled to a review of the Commissioner's action to determine the reasonableness of the action, the applicant must make a written demand upon the Commissioner for a review no later than 30 days after service of the notification upon the applicant. The review shall be completed without undue delay, and the applicant shall be notified promptly in writing of the outcome of the review. In order for an applicant who disagrees with the outcome of the review to be entitled to a hearing under Article 3A of Chapter 150B of the General Statutes, the applicant must make a written demand upon the Commissioner for a hearing no later than 30 days after service upon the applicant of the notification of the outcome.

(h) Resident-Nonresident Licenses. – The Commissioner shall issue a resident or nonresident license to an agent, broker, limited representative, adjuster, or motor vehicle damage appraiser as follows:

(1) Resident.
An individual may qualify for a license as a resident if he resides in this State. Any license issued pursuant to an application claiming residency in this State shall be void if the licensee, while holding a resident license in this State, also holds or makes application for a resident license in, or thereafter claims to be a resident of, any other state, or ceases to be a resident of this State; provided, however, if the applicant is a resident of a county in another state, the border of which county is contiguous with the state line of this State, the applicant may qualify as a resident for licensing purposes in this State.

(2) Nonresident.

a. An individual may qualify for a license under this Article as a nonresident if he holds a like license in another state or territory of the United States. An individual may qualify for a license as a nonresident motor vehicle damage

appraiser or a nonresident adjuster if the applicant's state of residency does not offer such licenses and such applicant meets all other requirements for licensure of a resident. A license issued to a nonresident of this State shall grant the same rights and privileges afforded a resident licensee, except as provided in subsection (i) of this section.

b. Except as provided in G.S. 58-33-32, a nonresident of this State may be licensed without taking an otherwise required written examination if the insurance regulator of the state of the applicant's residence certifies that the applicant has passed a similar written examination or has been a continuous holder, prior to the time such written examination was required, of a license like the license being applied for in this State.

c. Notwithstanding other provisions of this Article, no new bond shall be required for a nonresident broker if the Commissioner is satisfied that an existing bond covers his insurance business in this State.

d. Process Against Nonresident Licensees.

1. Each licensed nonresident agent, broker, adjuster, limited representative, or motor vehicle damage appraiser shall by the act of acquiring such license be deemed to appoint the Commissioner as his attorney to receive service of legal process issued against the agent, broker, adjuster, limited representative, or motor vehicle damage appraiser in this State upon causes of action arising within this State.
2. The appointment shall be irrevocable for as long as there could be any cause of action against the nonresident arising out of his insurance transactions in this State.
3. Duplicate copies of such legal process against such nonresident licensee shall be served upon the Commissioner either by a person competent to serve a summons, or through certified or registered mail. At the time of such service the plaintiff shall pay to the Commissioner a fee in the amount set in G.S. 58-16-30, taxable as costs in the action to defray the expense of such service.
4. Upon receiving such service, the Commissioner or his duly appointed deputy shall within three business days send one of the copies of the process, by registered or certified mail, to the defendant nonresident licensee at his last address of record as filed with the Commissioner.
5. The Commissioner shall keep a record of the day and hour of service upon him of all such legal process. No proceedings shall be had against the defendant nonresident licensee, and such defendant shall not be required to appear, plead or answer until the expiration of 40 days after the date of service upon the Commissioner.

e. If the Commissioner revokes or suspends any nonresident's license through a formal proceeding under this Article, he shall promptly notify the appropriate Commissioner of the licensee's residence of such action and of the particulars thereof.

(i) Retaliatory Provision. – Whenever, by the laws or regulations of any other state or jurisdiction, any limitation of rights and privileges, conditions precedent, or any other requirements are imposed upon residents of this State who are nonresident applicants or licensees of such other state or jurisdiction in addition to, or in excess of, those imposed on nonresidents under this Article, the same such requirements shall be imposed upon such residents of such other state or jurisdiction. This subsection does not apply to fees charged to insurance producers.

(j) Reciprocity Provision. – To the extent that other states that provide for the licensing and regulation of and payment of commissions to agents, limited representatives, or brokers, waive restrictions on the basis of reciprocity with respect to North Carolina licensees applying for or holding nonresident licenses in those states, the same restrictions on licensees from those states applying for or holding North Carolina nonresident licenses shall be waived. (1987, c. 629, s. 1; c. 864, ss. 80, 86; 1987 (Reg. Sess., 1988), c. 975, s. 30; 1989, c. 485, s. 21; c. 645, s. 5; c. 657, s. 1.1; 1989 (Reg. Sess., 1990), c. 941, ss. 3, 7; 1991, c. 212, s. 2; c. 476, s. 3; 1993, c. 409, s. 2; c. 504, ss. 26, 37; 1998-211, s. 18; 2000-122, s. 3; 2001-203, ss. 7, 8, 9, 10, 11, 29; 2005-240, s. 1.)

§ 58-33-31. Application for license.

(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 denial, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the Commissioner shall find that the individual:
  (1) Is at least 18 years of age.
  (2) Has not committed any act that is a ground for probation, suspension, nonrenewal, or revocation set forth in G.S. 58-33-46.
  (3) Has satisfied any applicable requirements of G.S. 58-33-30(d).
  (4) Has paid the applicable fees set forth in G.S. 58-33-125.
  (5) Has successfully passed any examinations required by G.S. 58-33-30(e).

(b) A business entity selling, soliciting, or negotiating insurance shall obtain an insurance producer license. Application shall be made using the Uniform Business Entity Application. Before approving the application, the Commissioner shall find that:
  (1) The business entity has paid the applicable fees set forth in G.S. 58-33-125.
  (2) The business entity has designated a licensed producer, who is a natural person, responsible for the business entity's compliance with the insurance laws and administrative rules of this State and orders of the Commissioner.

(c) The Commissioner may require any documents reasonably necessary to verify the information contained in an application. (2001-203, s. 12.)

§ 58-33-32. Interstate reciprocity in producer licensing.

(a) The purpose of this section is to make North Carolina insurance producer licensing comply with the reciprocity requirements in the federal Gramm-Leach-Bliley Act, Public Law 106-102. This section does not apply to surplus lines licensees in Article 21 of this Chapter, except as provided in subsections (c) and (d) of this section.

(b) Repealed by Session Laws 2001-203, s. 13, effective July 1, 2002.

(c) Unless denied licensure under G.S. 58-33-30 or G.S. 58-33-50, a nonresident person shall receive a nonresident producer license if:
  (1) The person is currently licensed as a resident and in good standing in that person's home state;
  (2) The person has submitted the request for licensure in the form prescribed by the Commissioner and has paid the applicable fees required by G.S. 58-33-125;
  (3) The person has submitted or transmitted to the Commissioner a copy of the application for licensure that the person submitted to that person's home state, or in lieu of the same, a completed Uniform Application or Uniform Business Entity Application; and
  (4) The person's home state awards nonresident producer licenses to residents of this State on a reciprocal basis.

The Commissioner may verify the producer's licensing status through the producer database maintained by the NAIC or affiliates or subsidiaries of the NAIC.

(d) A person licensed as a surplus lines producer in that person's home state shall receive a nonresident surplus lines license under subsection (c) of this section. Except for the licensure provisions of this section, nothing in this section otherwise amends or supersedes any provision of Article 21 of this Chapter.

(e) A person licensed or registered as a viatical settlement broker or provider, as defined in G.S. 58-58-205, in that person's home state shall receive a nonresident viatical settlement broker or provider license under subsection (c) of this section. Except for the licensure provisions of this section, nothing in this section otherwise amends or supersedes any provision of Part 5 of Article 58 of this Chapter.

(f) A person licensed as a limited line credit insurance producer or other type of limited lines producer in that person's home state may, under subsection (c) of this section, receive a nonresident limited lines producer license granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this subsection, limited lines insurance is any authority granted by the home state that restricts the authority of the license to less than the total authority prescribed in the associated major lines under G.S. 58-33-26(c)(1), 58-33-26(c)(2), 58-33-26(c)(3), and 58-33-26(c)(4).

(g) An individual who applies for an insurance producer license in this State who was previously licensed for the same kinds of insurance in that individual's home state shall not be required to complete any prelicensing education or examination. This exemption is available only if:
(1) The applicant is currently licensed in the applicant's home state; or
(2) The application is received within 90 days after the cancellation of the applicant's previous license and the applicant's home state issues a certification that, at the time of cancellation, the applicant was in good standing in that state; or
(3) The home state's producer database records, maintained by the NAIC or affiliates or subsidiaries of the NAIC, indicate that the producer is or was licensed in good standing for the kind of insurance requested.
A person licensed as an insurance producer in another state who moves to this State and who wants to be licensed as a resident under G.S. 58-33-31 shall apply within 90 days after establishing legal residence.

(h) The Commissioner shall not assess a greater fee for an insurance license or related service to a nonresident producer based solely on the fact that the producer does not reside in this State.

(i) The Commissioner shall waive any license application requirements for a nonresident license applicant with a valid license from the applicant's home state, except the requirements imposed by subsection (c) of this section, if the applicant's home state awards nonresident licenses to residents of this State on the same basis.

(j) A nonresident producer's satisfaction of the nonresident producer's home state's continuing education requirements for licensed insurance producers shall constitute satisfaction of this State's continuing education requirements if the nonresident producer's home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this State on the same basis.

(k) A producer shall report to the Commissioner any administrative action taken against the producer in another state or by another governmental agency in this State within 30 days after the final disposition of the matter. This report shall include a copy of the order or consent order and other information or documents filed in the proceeding necessary to describe the action.

(l) Within 30 days after the initial pretrial hearing date or similar proceeding, a producer shall report to the Commissioner any criminal prosecution of the producer. The report shall include a copy of the initial complaint filed, the order resulting from the hearing or similar proceeding, and any other information or documents filed in the proceeding necessary to describe the prosecution. (2000-122, s. 2; 2001-203, s. 13; 2001-436, s. 4.)

§ 58-33-35. Exemption from examination.

The following are exempt from the requirement for a written examination:
(1) Repealed by Session Laws 1993, c. 409, s. 3.
(2) Repealed by Session Laws 1989, c. 485, s. 66.
(3) An applicant who has attained the designation of Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC), Life Underwriter Training Council Fellow (LUTCF) or Fellow of Life Management Institute (FLMI), shall be exempt from the examination for licenses in G.S. 58-33-25(c)(1).
(4) An applicant who has attained the designation of Chartered Property and Casualty Underwriter (CPCU) shall be exempt from the examination for licenses in G.S. 58-33-25(c)(3) and (7).
(5) Applicants for license as limited representatives or as motor vehicle damage appraisers.
(6) Applicants for license as agents for companies or associations specified in G.S. 58-36-50; provided that with respect to town or county farmers mutual fire insurance companies, this exemption applies only to those agents who solicit and sell only those kinds of insurance specified in G.S. 58-7-75(5)d for such companies. (1987, c. 629, s. 1, c. 864, s. 81; 1989, c. 485, s. 66; 1989 (Reg. Sess., 1990), c. 1021, s. 8; 1993, c. 409, s. 3.)

§ 58-33-40. Appointment of agents.

(a) No individual who holds a valid insurance agent's license issued by the Commissioner shall, either directly or for an insurance agency, solicit, negotiate, or otherwise act as an agent for an insurer by which the individual has not been appointed.

(b) Any insurer authorized to transact business in this State may appoint as its agent any individual who holds a valid agent's license issued by the Commissioner. Upon the appointment, the

individual shall be authorized to act as an agent for the appointing insurer for all kinds of insurance for which the insurer is authorized in this State and for which the appointed agent is licensed in this State, unless specifically limited.

(c) Within 30 days the insurer shall file in a form prescribed by the Commissioner the names, addresses, and other information required by the Commissioner for its newly-appointed agents.

(d) Every insurer shall remit in a manner prescribed by the Commissioner the appointment fee specified in G.S. 58-33-125 for each appointed agent.

(e) An appointment shall continue in effect as long as the appointed agent is properly licensed and the appointing insurer is authorized to transact business in this State, unless the appointment is cancelled.

(f) Prior to April 1 of each year, every insurer shall remit in a manner prescribed by the Commissioner the renewal appointment fee specified in G.S. 58-33-125.

(g) Any agent license in effect on February 1, 1988, shall be deemed to be an appointment for the unexpired term of that license.

(h) No insurer shall accept an insurance application from an individual who is not currently appointed by the insurer. (1987, c. 629, s. 1; 2001-203, s. 14.)

§ 58-33-46. Suspension, probation, revocation, or nonrenewal of licenses.

(a) The Commissioner may place on probation, suspend, revoke, or refuse to renew any license issued under this Article, in accordance with the provisions of Article 3A of Chapter 150B of the General Statutes, for any one or more of the following causes:

(1) Providing materially incorrect, misleading, incomplete, or materially untrue information in the license application.

(2) Violating any insurance laws, or violating any administrative rule, subpoena, or order of the Commissioner or of another state's insurance regulator.

(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 or of a misdemeanor involving dishonesty or a breach of trust.

(7) Having admitted or been found to have committed any insurance unfair trade practice or fraud.

(8) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this State or elsewhere.

(9) Having an insurance producer license, or its equivalent, denied, suspended, or revoked in any other jurisdiction for reasons substantially similar to those listed in this subsection.

(10) Forging another's name to an application for insurance or to any document related to an insurance transaction.

(11) Willfully failing to provide the notification required by subsection (c) of this section.

(12) Knowingly accepting brokered insurance business from an individual who is not licensed to broker that kind of insurance.

(12a) Soliciting, negotiating, or selling insurance in this State for an unauthorized insurer, regardless of whether the licensee or applicant knew that the insurer was unauthorized. As used in this section, the terms "soliciting", "negotiating", and "selling" shall have the meaning of "solicit", "negotiate", and "sell", respectively, set forth in G.S. 58-33-10.

(13) Failing to comply with an administrative or court order imposing a child support obligation, after entry of a final judgment or order finding the violation to have been willful.

(14) Failing to pay State income tax or comply with any administrative or court order directing payment of State income tax, after entry of a final judgment or order finding the violation to have been willful.

(15) Cheating on an examination for an insurance license or for a prelicensing or continuing education course, including improperly using notes or any other reference material to complete an examination for an insurance license or for a prelicensing or continuing education course.

(16) Willfully overinsuring property.
(17) Any cause for which issuance of the license could have been refused had it then existed and been known to the Commissioner at the time of issuance.

(b) G.S. 58-2-50 applies to any investigation under this section. G.S. 58-2-70 applies to any person subject to licensure under this Article.

(c) Any person licensed under this Article shall notify the Commissioner of the commencement of any bankruptcy, insolvency, or receivership proceeding affecting the person licensed, or upon making an assignment for the benefit of creditors of the person licensed. Each owner, manager, or officer of a business entity that is a licensed person shall be responsible for providing this notification. Any person responsible for notifying the Commissioner shall provide the notice within three business days after the commencement of the proceeding or the making of the assignment.

(d) If the Commissioner refuses to grant a license, or suspends or revokes a license, any appointment of the applicant or licensee shall likewise be revoked. No individual whose license is revoked shall be issued another license without first complying with all requirements of this Article.

(e) No person shall be issued a license or appointment to enter the employment of any other person, which other person is at that time found by the Commissioner to be in violation of any of the insurance laws of this State, or which other person has been in any manner disqualified under any state or federal law to engage in the insurance business.

(f) The Commissioner shall retain the authority to enforce the provisions of, and impose any penalty or remedy authorized by, this Chapter against any person who is under investigation for or charged with a violation of this Chapter even if the person's license or registration has been surrendered or has lapsed by operation of law. (2001-203, s. 16; 2004-166, s. 2.)

§ 58-33-50. Notices; loss of residency; duplicate licenses.

(a) The Commissioner shall notify every appointing insurer about any suspension, revocation, or nonrenewal of a license by the Commissioner and about any surrender of a license by a licensee, whether by consent order or otherwise.

(b) Upon suspension, revocation, nonrenewal, surrender, or reinstatement of any license, the Commissioner shall notify the Central Office of the NAIC.

(c) Any licensee who ceases to maintain his residency in this State shall deliver his insurance license or licenses to the Commissioner by personal delivery or by mail within 30 days after terminating residency.

(d) The Commissioner may issue a duplicate license for any lost, stolen, or destroyed license issued pursuant to this Article upon a written request from the licensee and payment of appropriate fees. (1987, c. 629, s. 1; 1993, c. 504, s. 29.)

§ 58-33-56. Notification to Commissioner of termination.

(a) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract, or other insurance business relationship with a producer shall notify the Commissioner within 30 days after the effective date of the termination, using a form prescribed by the Commissioner, if the reason for termination is for or related to one of the causes listed in G.S. 58-33-46(a) or the insurer has knowledge the producer was found by a court, government body, or self-regulatory organization authorized by law to have engaged in any of the activities in G.S. 58-33-46(a). Upon the written request of the Commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the producer.

(b) An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with a producer for any reason that is not for or related to one of the causes listed in G.S. 58-33-46(a) shall notify the Commissioner within 30 days after the effective date of the termination, using a form prescribed by the Commissioner. Upon written request of the Commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination.

(c) The insurer or the authorized representative of the insurer shall promptly notify the Commissioner in a form acceptable to the Commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the Commissioner in accordance with subsection (a) of this section had the insurer then known of its existence.

(d) Within 15 days after making the notification required by subsections (a), (b), and (c) of this section, the insurer shall mail a copy of the notification to the producer at the producer's last known address. If the producer is terminated for cause for any of the reasons listed in G.S. 58-33-46(a), 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.

(e) Within 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, 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 (h) of this section.

(f) In the absence of actual malice, neither an insurer, the authorized representative of the insurer, a producer, the Commissioner, an organization of which the Commissioner is a member, nor the respective employees and agents of such persons acting on behalf of such persons shall be subject to civil liability as a result of any statement or information provided pursuant to this section.

(g) In any action brought against a person that may have immunity under subsection (f) of this section for making any statement required by this section or for providing any information relating to any statement that may be requested by the Commissioner, the party bringing the action shall plead specifically in any allegation that subsection (f) of this section does not apply because the person making the statement or providing the information did so with actual malice. Subsections (f) and (g) of this section do not abrogate or modify any existing statutory or common law privileges or immunities.

(h) Notwithstanding any other provision of this Chapter, any documents, materials, or other information in the control or possession of the Commissioner or any organization of which the Commissioner is a member that is (i) furnished by an insurer, producer, or an employee or agent thereof acting on behalf of the insurer or producer under this section, or (ii) obtained by the Commissioner in an investigation under this section shall be confidential by law and privileged, shall not be subject to or public records under G.S. 58-2-100 or Chapter 132 of the General Statutes, shall not be subject to subpoena, and shall not be subject to discovery in any civil action other than a proceeding brought by the Commissioner against a person to whom such documents, materials, or other information relate. 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. Neither the Commissioner nor any person who received documents, materials, or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any civil action other than a proceeding brought by the Commissioner against a person to whom such documents, materials, or other information relate concerning any such documents, materials, or information.

(i) In order to assist in the performance of the Commissioner's duties under this Article, the Commissioner may:

(1) Share documents, materials, or other information, including the confidential documents, materials, or information described in this section, with other state, federal, and international regulatory agencies, with the NAIC, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities. The Commissioner may condition such sharing on an agreement by the recipient to maintain the confidentiality and privileged status of the document, material, or other information;

(2) Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information from other state, federal, and international regulatory agencies, from the NAIC, its affiliates or subsidiaries, and from state, federal, and international law enforcement authorities, and may agree to maintain the confidential and privileged status of the document, material, or other information received under the laws of the jurisdiction that is the source of the document, material, or information; and

(3) Enter into agreements governing sharing and use of information consistent with this subsection.

(j) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (i) of this section.

(k) Nothing in this Article prohibits the Commissioner from releasing final, adjudicated actions including for cause terminations that are open to public inspection under G.S. 58-2-100, to a database or other clearinghouse service maintained by the NAIC, its affiliates, or subsidiaries of the NAIC.

(l) An insurer, the authorized representative of the insurer, or producer that fails to report as required under this section or that is found to have reported with actual malice by a court of competent jurisdiction may, after notice and hearing, have its license suspended or revoked and may be fined in accordance with G.S. 58-2-70. (2001-203, s. 18.)

§ 58-33-60. Countersignature and related laws.

Subject to the retaliatory provisions of G.S. 58-33-30(i), there shall be no requirement that a licensed resident agent or broker must countersign, solicit, transact, take, accept, deliver, record, or process in any manner an application, policy, contract, or any other form of insurance on behalf of a nonresident agent or broker or an authorized insurer; or share in the payment of commissions, if any, related to such business. (1987, c. 629, s. 1.)

§ 58-33-66. Temporary licensing.

(a) The Commissioner may issue a temporary insurance producer license for a period not to exceed 180 days or longer, for good cause, without requiring an examination if the Commissioner deems that the temporary license is necessary for the servicing of an insurance business in any of the following cases:

(1) To the spouse or surviving spouse or court-appointed personal representative or guardian of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the transfer of the insurance business owned by the producer, for the recovery or return of the producer to the business, or for the training and licensing of new personnel to operate the producer's business.

(2) To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license.

(3) To the designee of a licensed insurance producer entering active service in the armed forces of the United States of America.

(4) In any other circumstance where the Commissioner deems that the public interest will be served best by the issuance of this license.

(b) The Commissioner may by order limit the authority of any temporary licensee in any way deemed 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. The Commissioner may by order revoke a temporary license if the interest of insureds or the public are endangered. A temporary license terminates upon the transfer of the business.

(c) An individual requesting a temporary license on account of death or disability of an agent or broker shall be licensed to represent only those insurers that had appointed such agent at the time of death or commencement of disability. (2001-203, s. 20.)

§ 58-33-70. Special provisions for adjusters and motor vehicle damage appraisers.

(a) It shall be unlawful and cause for revocation of license for a licensed adjuster to engage in the practice of law.

(b) On behalf and on request of an insurer by which an agent or limited representative is appointed, the agent or limited representative may from time to time act as an adjuster and investigate and report upon claims without being licensed as an adjuster. No agent or limited representative shall adjust any losses where the agent's or representative's remuneration for the sale of insurance is in any way dependent upon the adjustment of those losses.

(c) Upon the filing of the application for an adjuster's license, the advance payment of the examination fee, and the filing with the Commissioner of a certificate signed by the applicant's employer, the Commissioner may issue a learner's permit authorizing the applicant to act as an adjuster for a learning period of 90 days without a requirement of any other license. Not more than one learner's permit shall ever be issued to one individual. The employer's certificate required by this subsection shall certify that:

(1) The applicant is an individual of good character.

(2) The applicant is employed by the signer of the certificate.

(3) The applicant will operate as a student or learner under the instruction and general supervision of a licensed adjuster.
(4) The employer will be responsible for the adjustment acts of the applicant during the learning period.

(d) Repealed by Session Laws 1998-211, s. 19.

(e) The Commissioner may permit an experienced adjuster, who regularly adjusts in another state and who is licensed in the other state (if that state requires a license), to act as an adjuster in this State without a North Carolina license only for an insurance company authorized to do business in this State, for emergency insurance adjustment work, for a period to be determined by the Commissioner, done for an employer who is an adjuster licensed by this State or who is a regular employer of one or more adjusters licensed by this State; provided that the employer shall furnish to the Commissioner a notice in writing immediately upon the beginning of any such emergency insurance adjustment work. As used in this subsection, "emergency insurance adjustment work" includes, but is not limited to, (i) adjusting of a single loss or losses arising out of an event or catastrophe common to all of those losses or (ii) adjusting losses in any area declared to be a state of disaster by the Governor under G.S. 166A-6 or by the President of the United States under applicable federal law.

(f) The Commissioner may permit an experienced motor vehicle damage appraiser who is regularly appraising in another state and who is licensed in such other state (if that state requires a license) to act as a motor vehicle damage appraiser in this State without a North Carolina license for emergency motor vehicle damage appraisal work for a period not exceeding 30 days done for an employer who notifies the Commissioner, in writing, at the beginning of the period of emergency appraisal work and who is:
(1) An insurance adjuster licensed by this State;
(2) A motor vehicle damage appraiser licensed by this State;
(3) A regular employer of one or more insurance adjusters licensed by this State; or
(4) A regular employer of one or more motor vehicle damage appraisers licensed by this State. (1987, c. 629, s. 1; 1998-211, s. 19.)

§ 58-33-75. Twisting with respect to insurance policies; penalties.

No licensee shall make or issue, or cause to be issued, any written or oral statement that willfully misrepresents or willfully makes an incomplete comparison as to the terms, conditions, or benefits contained in any policy of insurance for the purpose of inducing or attempting to induce a policyholder in any way to terminate or surrender, exchange, or convert any insurance policy. Any person who violates this section is subject to the provisions of G.S. 58-2-70 and G.S. 58-33-46. (1987, c. 629, s. 1; c. 864, s. 75; 2001-203, s. 21.)

§ 58-33-76. Referral of business to repair source; prohibitions.

(a) No insurance company, agent, adjuster or appraiser or any person employed to perform their service shall recommend the use of a particular service or source for the repair of property damage without clearly informing the claimant that the claimant is under no obligation to use the recommended repair service.

(b) No insurance company, agent, adjuster or appraiser or any person employed to perform their service shall accept any gratuity or other form of remuneration from a repair service for recommending that repair service to a claimant. Provided, however, discounts agreed to by repair services shall not violate this section.

(c) Any person who violates this section is subject to the provisions of G.S. 58-2-70 and G.S. 58-33-46. (1991, c. 386, s. 1; 1993, c. 525, s. 1; 2001-203, s. 22.)

§ 58-33-80. Discrimination forbidden.

No agent or representative of any company doing the business of insurance as defined in G.S. 58-7-15 shall make any discrimination in favor of any person. (1987, c. 629, s. 1.)

§ 58-33-82. Commissions.

(a) An insurance company or insurance producer shall not pay a commission, service fee, or other valuable consideration to a person for selling, soliciting, or negotiating insurance in this State if that person is required to be licensed under this Article and is not so licensed.

(b) A person shall not accept a commission, service fee, brokerage, or other valuable consideration for selling, soliciting, or negotiating insurance in this State if that person is required to be licensed under this Article and is not so licensed.

(c) Renewal or other deferred commissions may be paid to a person for selling, soliciting, or negotiating insurance in this State if the person was required to be licensed under this Article at the time of the sale, solicitation, or negotiation and was so licensed at that time.

(d) Except as provided in subsection (e) of this section, only agents who are duly licensed with appropriate company appointments, licensed brokers, licensed limited lines producers, or licensed limited representatives may accept, directly or indirectly, any commission, fee, or other valuable consideration for the sale, solicitation, or negotiation of insurance.

(e) Commissions, fees, or other valuable consideration for the sale, solicitation, or negotiation of insurance may be assigned or directed to be paid in the following circumstances:

(1) To a business entity by a person who is an owner, shareholder, member, partner, director, employee, or agent of that business entity.

(2) To a producer in connection with renewals of insurance business originally sold by or through the licensed person or for other deferred commissions.

(3) In connection with the indirect receipt of commissions in circumstances in which a license is not required under G.S. 58-33-26(n). (2001-203, s. 23; 2004-199, s. 20(e).)

§ 58-33-83. Assumed names.

An insurance producer doing business under any name other than the producer's legal name shall notify the Commissioner before using the assumed name. (2001-203, s. 24; 2003-221, s. 13.)

§ 58-33-85. Rebates and charges in excess of premium prohibited; exceptions.

(a) No insurer, agent, broker or limited representative shall knowingly charge, demand or receive a premium for any policy of insurance except in accordance with the applicable filing approved by the Commissioner. No insurer, agent, broker or limited representative shall pay, allow, or give, or offer to 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. No insured named in a policy of insurance, nor any employee of such insured, shall knowingly receive or accept, directly or indirectly, any such rebate, discount, abatement or reduction of premium, or any special favor or advantage or valuable consideration or inducement. Nothing herein contained shall be construed as prohibiting the payment of commissions or other compensation to duly licensed agents, brokers and limited representatives, nor as prohibiting any participating insurer from distributing to its policyholders dividends, savings or the unused or unabsorbed portion of premiums and premium deposits. As used in this section the word "insurance" includes suretyship and the word "policy" includes bond.

(b) No insurer, agent, broker, or limited representative shall knowingly charge to or demand or receive from an applicant for insurance any money or other consideration in return for the processing of applications or other forms or for the rendering of services associated with a contract of insurance, which money or other consideration is in addition to the premium for such contract, unless the applicant consents in writing before any services are rendered. This subsection does not apply to the charging or collection of any fees otherwise provided for by law. (1987, c. 629, s. 1; c. 864, ss. 49, 89; 1989, c. 485, s. 52; 1991, c. 720, s. 4; 2001-203, s. 25.)

§ 58-33-90. Rebate of premiums on credit life and credit accident and health insurance; retention of funds by agent.

It shall be unlawful for any insurance carrier, or officer, agent or representative of an insurance company writing credit life and credit accident and health insurance, as defined in G.S. 58-58-10 and G.S. 58-51-100, or combination credit life, accident and health, hospitalization and disability insurance in connection with loans, to permit any agent or representative of such company to retain any portion of funds received for the payment of losses incurred, or to be incurred, under such policies of insurance issued by such company, or to pay, allow, permit, give or offer to pay, allow, permit 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, to any loan agency, insurance agency or broker, or to any creditor of the debtor on whose account the insurance was issued, or to any person, firm or corporation which received a commission or fee in

connection with the issuance of such insurance: Provided, that this section shall not prohibit the payment of commissions to a licensed insurance agent or agency or limited representative on the sale of a policy of credit life and credit accident and health insurance, or combination credit life, accident and health, hospitalization and disability insurance in connection with loans.

It shall be unlawful for any agent, agency, broker, limited representative, or insured named in any such policy, or for any loan agency or broker, or any agent, officer or employee of any loan agency or broker to receive or accept, directly or indirectly, any such rebate, discount, abatement, credit or reduction of the premium as set out in this section. (1987, c. 629, s. 1.)

§ 58-33-95. Agents personally liable; representing unlicensed company prohibited; penalty.

(a) Any person or entity who solicits, negotiates, or sells insurance or acts as a third-party administrator in this State for an unauthorized insurer:
  (1) Is the representative of that insurer and shall be strictly liable for any losses or unpaid claims if an unauthorized insurer fails to pay in full or in part any claim or loss within the provisions of any insurance contract sold, directly or indirectly, by or through that person or entity on behalf of the unauthorized insurer.
  (2) Shall be guilty of a Class 1 misdemeanor if the person or entity does not know that the insurer is an unauthorized insurer. Each solicitation, negotiation, or sale shall constitute a separate offense.
  (3) Shall be guilty of a Class H felony if the person or entity knew or should have known that the insurer is an unauthorized insurer. Each solicitation, negotiation, or sale shall constitute a separate offense.

(b) A civil action may be filed or a license revocation proceeding may be initiated under this section regardless of whether a criminal action is brought or a criminal conviction is obtained for the act alleged in the civil action or revocation proceeding.

(c) For the purposes of this section, the status of an entity or person as an "unauthorized insurer" shall be determined in accordance with Article 28 of this Chapter and, if applicable, Article 49 of this Chapter.

(d) As used in this section, "third-party administrator" means a person who performs administrative functions, including claims administration and payment, marketing, premium accounting, premium billing, coverage verification, underwriting authority, or certificate issuance in regard to any kind of insurance; but does not include the persons specified in G.S. 58-56-2(5)a. through (5)l. (1987, c. 629, s. 1; 1993, c. 539, s. 457; 1994, Ex. Sess., c. 24, s. 14(c); 2004-166, s. 1; 2006-105, s. 2.8.)

§ 58-33-100. Payment of premium to agent valid; obtaining by fraud a crime.

(a) Any agent, broker or limited representative who acts for a person other than himself negotiating a contract of insurance is, for the purpose of receiving the premium therefore, the company's agent, whatever conditions or stipulations may be contained in the policy or contract. This subsection does not apply to the Insurance Underwriting Association established under Article 45 of this Chapter or the Joint Underwriting Association established under Article 46 of this Chapter.

(b) Any agent, broker or limited representative knowingly procuring by fraudulent representations payment, or the obligation for the payment, of a premium of insurance, shall be guilty of a Class 1 misdemeanor. (1987, c. 629, s. 1; 1993, c. 539, s. 458; 1994, Ex. Sess., c. 24, s. 14(c); 1997-498, s. 4.)

§ 58-33-105. False statements in applications for insurance.

If any agent, examining physician, applicant, or other person shall knowingly or willfully make any false or fraudulent statement or representation in or with reference to any application for insurance, or shall make any such statement for the purpose of obtaining any fee, commission, money or benefit from any company engaged in the business of insurance in this State, he shall be guilty of a Class 1 misdemeanor. This section shall also apply to contracts and certificates issued under Articles 65 through 67 of this Chapter. (1987, c. 629, s. 1; 1993, c. 539, s. 459; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 58-33-110. Agents signing certain blank policies.

Any agent or limited representative who signs any blank contract or policy of insurance is guilty of a Class 3 misdemeanor and, upon conviction, shall be punished only by a fine of not less than one thousand dollars

($1,000) nor more than five thousand dollars ($5,000); provided, however, that transportation ticket policies of accident insurance and baggage insurance policies may be countersigned in blank for issuance only through coin-operated machines, subject to regulations prescribed by the Commissioner. (1987, c. 629, s. 1; 1993, c. 539, s. 460; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 58-33-115. Adjuster acting for unauthorized company.

If any person shall act as adjuster on a contract made otherwise than as authorized by the laws of this State, or by any insurance company or other person not regularly licensed to do business in this State, or shall adjust or aid in the adjustment, either directly or indirectly, of a claim arising under a contract of insurance not authorized by the laws of the State, he shall be deemed guilty of a Class 1 misdemeanor. (1987, c. 629, s. 1; 1993, c. 539, s. 461; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 58-33-120. Agent, adjuster, etc., acting without a license or violating insurance law.

If any person shall assume to act either as principal, agent, broker, limited representative, adjuster or motor vehicle damage appraiser without license as is required by law or pretending to be a principal, agent, broker, limited representative, adjuster or licensed motor vehicle damage appraiser, shall solicit, examine or inspect any risk, or shall examine into, adjust, or aid in adjusting any loss, investigate or advise relative to the nature and amount of damages to motor vehicles or the amount necessary to effect repairs thereto, or shall receive, collect, or transmit any premium of insurance, or shall do any other act in the soliciting, making or executing any contract of insurance of any kind otherwise than the law permits, or as principal or agent shall violate any provision of law contained in Articles 1 through 64 of this Chapter, the punishment for which is not elsewhere provided for, he shall be deemed guilty of a Class 1 misdemeanor. (1987, c. 629, s. 1; 1987 (Reg. Sess., 1988), c. 975, s. 11; 1993, c. 539, s. 462; 1994, Ex. Sess., c. 24, s. 14(c).)

58-33-125. Fees.

(a) The following table indicates the annual fees that are required for the respective licenses issued, renewed, or cancelled under this Article and Article 21 of this Chapter:

Adjuster	$75.00
Adjuster, crop hail only	20.00
Agent appointment cancellation (paid by insurer)	10.00
Agent appointment, individual	20.00
Agent appointment, nonindividual	50.00
Agent appointment, Medicare supplement and long-term care, individual	10.00
Agent appointment, Medicare supplement and long-term care, nonindividual	20.00
Agent, overseas military	20.00
Broker, nonresident	50.00
Broker, resident	50.00
Limited representative	20.00
Limited representative cancellation (paid by insurer)	10.00
Motor vehicle damage appraiser	75.00
Recertification, continuing education	5.00
Surplus lines licensee, corporate	50.00
Surplus lines licensee, individual	50.00

These fees are in lieu of any other license fees. Fees paid by an insurer on behalf of a person who is licensed or appointed to represent the insurer shall be paid to the Commissioner on a quarterly or monthly basis, in the discretion of the Commissioner. The recertification fee in this subsection shall be paid by persons subject to G.S. 58-33-130 at the time they renew their licenses or appointments under G.S. 58-33-130(c).

(b) Whenever a temporary license may be issued pursuant to this Article, the fee shall be at the same rate as provided in subsection (a) of this section; and any amounts so paid for a temporary license may be credited against the fee required for an appointment by the sponsoring company.

(c) Any person not registered who is required by law or administrative rule to secure a license shall, upon application for registration, pay to the Commissioner a fee of thirty dollars ($30.00). In the event additional licensing for other kinds of insurance is requested, a fee of thirty dollars ($30.00) shall be paid to the Commissioner upon application for registration for each additional kind of insurance.

In addition to the fees prescribed by this subsection, any person applying for a supplemental license to sell Medicare supplement and long-term care insurance policies shall pay an additional fee of thirty dollars ($30.00) upon application for registration for those kinds of insurance.

(d) The requirement for an examination, prelicensing education, continuing education, or a registration fee does not apply to agents for domestic farmers' mutual assessment fire insurance companies or associations who solicit and sell only those kinds of insurance specified in G.S. 58-7-75(5)d for such companies or associations.

(e) In the event a license issued under this Article is lost, stolen, or destroyed, the Commissioner may issue a duplicate license upon a written request from the licensee and payment of a fee of five dollars ($5.00).

(f) Whenever a printed record of an agent's file is requested, the fee shall be ten dollars ($10.00) for each copy whether or not the agent is currently licensed, previously licensed, or no record of that agent exists.

(g) All fees prescribed by this section are nonrefundable. (1987, c. 629, s. 1; c. 864, ss. 84, 85; 1989 (Reg. Sess., 1990), c. 941, ss. 4-5; c. 1021, s. 9; c. 1069, s. 14; 1991, c. 476, s. 3; c. 721, s. 7; 1991 (Reg. Sess., 1992), c. 837, s. 3; 2000-122, s. 1.)

§ 58-33-130. Continuing education program for licensees.

(a) The Commissioner may adopt rules to provide for a program of continuing education requirements for the purpose of enhancing the professional competence and professional responsibility of adjusters and motor vehicle damage appraisers. The rules may include criteria for:
- (1) The content of continuing education courses;
- (2) Accreditation of continuing education sponsors and programs;
- (3) Accreditation of videotape or other audiovisual programs;
- (4) Computation of credit;
- (5) Special cases and exemptions;
- (6) General compliance procedures; and
- (7) Sanctions for noncompliance.

(b) The Commissioner may adopt rules to provide for the continuing professional education of all agents and brokers, including fraternal field marketers, but excluding limited representatives. In adopting the rules, the Commissioner may use the same criteria as specified in subsection (a) of this section and shall provide that agents holding more than one license under G.S. 58-33-25(c) are required to complete no more than 18 credit hours per year.

(c) The license of any person who fails to comply with the continuing education requirements under this section shall lapse. The Commissioner may, for good cause shown, grant extensions of time to licensees to comply with these requirements.

(d) Annual continuing professional education hour requirements shall be determined by the Commissioner, but shall not be more than 12 credit hours.

(e) No more than seventy-five percent (75%) of the requirement relating to life or health insurance agents or brokers may be met by taking courses offered by licensed life or health insurance companies with which those agents or brokers have appointments.

(f) Repealed by Session Laws 1993 (Reg. Sess., 1994), c. 678, s. 18, effective July 5, 1994.

(g) The Commissioner shall permit any licensee to carry over to a subsequent calendar year up to seventy-five percent (75%) of the required annual hours of continuing professional education.

(h) Any licensee who, after obtaining an extension under subsection (c) of this section, offers evidence satisfactory to the Commissioner that the licensee has satisfactorily completed the required continuing professional education courses is in compliance with this section.

(i) The Commissioner is authorized to approve continuing professional education courses.

(j) Repealed by Session Laws 2002-144, s. 3, as amended by Session Laws 2003-284, s. 22.2, and as amended by Session Laws 2004-124, s. 21.1, effective July 1, 2002.

(k) Repealed by Session Laws 1993, c. 409, s. 4, effective July 1, 1993. (1989, c. 657, s. 1; 1989 (Reg. Sess., 1990), c. 941, s. 6; 1991, c. 476, s. 2; c. 554, s. 1; c. 720, s. 22; 1993, c. 409, s. 4; 1993 (Reg. Sess., 1994), c. 678, s. 18; 1998-211, ss. 20, 21; 2002-144, s. 3; 2003-284, s. 22.2; 2004-124, s. 21.1.)

§ 58-33-132. Qualifications of instructors.

(a) The Commissioner may adopt rules to establish requisite qualifications for and issuance, renewal, summary suspension, and termination of provider, presenter, and instructor authority for

prelicensing and continuing insurance education courses. During any suspension, the instructor shall not engage in any instruction of prelicensing or continuing insurance education courses prior to an administrative review. No person shall provide, present, or instruct any course unless that person has been qualified and possesses a license from the Commissioner.

(b) The Commissioner may summarily suspend or terminate the authority of an instructor, course provider, or presenter if the course presentation:
  (1) Is determined to be inaccurate; or
  (2) Receives an evaluation of poor from any Department monitor and a majority of attendees responding to Department questionnaires about the presentation. (1995, c. 517, s. 17; 1999-132, s. 9.1.)

§ 58-33-135. Continuing education advisory committee.

(a) The Commissioner shall appoint, in accordance with G.S. 58-2-30, one advisory committee for fire and casualty insurance licensees and one advisory committee for life and health insurance licensees. The advisory committees shall recommend reasonable rules to the Commissioner for promulgation under G.S. 58-33-130. The Commissioner may adopt, reject, or modify such recommendations. After the promulgation of rules under G.S. 58-33-130, the committees may from time to time make further recommendations to the Commissioner for additional rules or changes in existing rules.

(b) The property and liability advisory committee shall comprise:
  (1) Two employees of the Department of Insurance;
  (2) Two representatives from a list of four nominees submitted by the Independent Insurance Agents of North Carolina;
  (3) Repealed by Session Laws 1999-132, s. 6.3.
  (4) One representative of a licensed property and liability insurance company writing business in this State that operates through an exclusive agency force;
  (5) One representative from a list of two nominees submitted by the North Carolina Adjusters Association;
  (6) One representative of property and liability insurers from a list of two nominees submitted by the Association of North Carolina Property and Casualty Insurance Companies; and
  (7) One representative from a list of two nominees submitted by the Community Colleges System Office.

(c) The life and health advisory committee shall comprise:
  (1) Two employees of the Department of Insurance, which may be the same persons appointed under the subsection (b) of this section;
  (2) One representative from a list of two nominees submitted by the North Carolina Association of Life Underwriters;
  (3) One representative of life and health insurers from a list of two nominees submitted by the Association of North Carolina Life Insurance Companies;
  (4) One representative from a list of two nominees submitted by the General Agents and Managers Conference;
  (5) One representative from a licensed medical or hospital service corporation;
  (6) One licensed health insurance agent from a list of two nominees submitted by the North Carolina Association of Health Underwriters;
  (7) One representative of a licensed life or health insurer writing business in this State that operates through an exclusive agency force;
  (8) One representative from a list of two nominees submitted by the North Carolina Fraternal Congress; and
  (9) One representative from a list of two nominees submitted by the Community Colleges System Office. (1989, c. 657, s. 1; 1999-84, ss. 17, 18; 1999-132, s. 6.3.)

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(a) Every agent, limited representative, broker, adjuster, appraiser, or other insurer's representative shall, when in contact with the public:
  (1) promptly identify himself and his occupation;
  (2) carry the license issued to him by the Department of Insurance while performing his duties and display it upon request to any claimant, any repairer at which he is investigating a claim or loss, any department representative, or any other person with whom he has contact while performing his duties;

(3) conduct himself in such a manner as to inspire confidence by fair and honorable dealings.

(b) No claims management person, agent, agency employee, limited representative, broker, adjuster, appraiser, or other insurer's representative shall:

(1) accept any gratuity or other form of remuneration from any provider of services for recommending that provider to claimants;

(2) purchase salvage from a claimant;

(3) intimidate or discourage any claimant from seeking legal advice and counsel by withdrawing and reducing a settlement offer previously tendered to the claimant or threatening to do so if the claimant seeks legal advice or counsel. No adjuster shall advise a claimant of the advisability of seeking legal counsel nor recommend any legal counsel to any claimant under any circumstance;

(4) cause any undue delay in the settlement of a property damage claim on account of the claimant's choice of a motor vehicle repair service.

(c) No claims management person, agent, agency employee, limited representative, broker, or other insurer's representative shall recommend the utilization of a particular motor vehicle repair service without clearly informing the claimant that he is under no obligation to use the recommended repair service and that he may use the service of his choice.

Insurance Information and Privacy Protection Act

§ 58-39-5. Purpose.

The purpose of this Article is to establish standards for the collection, use, and disclosure of information gathered in connection with insurance transactions by insurance institutions, agents, or insurance-support organizations; to maintain a balance between the need for information by those conducting the business of insurance and the public's need for fairness in insurance information practices, including the need to minimize intrusiveness; to establish a regulatory mechanism to enable natural persons to ascertain what information is being or has been collected about them in connection with insurance transactions and to have access to such information for the purpose of verifying or disputing its accuracy; to limit the disclosure of information collected in connection with insurance transactions; and to enable insurance applicants and policyholders to obtain the reasons for any adverse underwriting decision. (1981, c. 846, s. 1; 2003-262, s. 2(1).)

§ 58-39-10. Scope.

(a) The obligations imposed by this Article shall apply to those insurance institutions, agents, or insurance-support organizations that:

(1) In the case of life, health, or disability insurance:

a. Collect, receive, or maintain information in connection with insurance transactions that pertains to natural persons who are residents of this State; or

b. Engage in insurance transactions with applicants, individuals, or policyholders who are residents of this State; and

(2) In the case of property or casualty insurance:

a. Collect, receive, or maintain information in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State;

b. Engage in insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State; or

c. Engage in transactions involving mortgage guaranty insurance where the mortgage guaranty policies, contracts, or certificates of insurance are delivered, issued for delivery, or renewed in this State.

(b) The rights granted by this Article shall extend to:

(1) In the case of life, health, or disability insurance, the following persons who are residents of this State:

a. Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions; and

b. Applicants, individuals, or policyholders who engage in or seek to engage in insurance transactions;

(2) In the case of property or casualty insurance, the following persons:

a. Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State; and
b. Applicants, individuals, or policyholders who engage in or seek to engage in (i) insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State; or (ii) mortgage guaranty insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this State.

(c) For purposes of this section, a person shall be considered a resident of this State if the person's last known mailing address, as shown in the records of the insurance institution, agent, or insurance-support organization, is located in this State.

(d) Notwithstanding subsections (a) and (b) of this section, this Article shall not apply to information collected from the public records of a governmental authority and maintained by an insurance institution or its representatives for the purpose of insuring the title to real property located in this State.

(e) This Article applies to credit insurance that is subject to Article 57 of this Chapter. (1981, c. 846, s. 1; 2001-351, s. 1; 2003-262, s. 2(1).)

§ 58-39-15. Definitions.

As used in this Article:

(1) "Adverse underwriting decision" means:
a. Any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:
1. A declination of insurance coverage;
2. A termination of insurance coverage;
3. Failure of an agent to apply for insurance coverage with a specific insurance institution that an agent represents and that is requested by an applicant;
4. In the case of a property or casualty insurance coverage:
I. Placement by an insurance institution or agent of a risk with a residual market mechanism, an unauthorized insurer, or an insurance institution that specializes in substandard risks; or
II. The charging of a higher rate on the basis of information that differs from that which the applicant or policyholder furnished; or
5. In the case of a life, health, or disability insurance coverage, an offer to insure at higher than standard rates.
b. Notwithstanding subdivision (1)a. of this section, the following actions shall not be considered adverse underwriting decisions, but the insurance institution or agent responsible for their occurrence shall nevertheless provide the applicant or policyholder with the specific reason or reasons for their occurrence:
1. The termination of an individual policy form on a class or statewide basis;
2. A declination of insurance coverage solely because such coverage is not available on a class or statewide basis; or
3. The rescission of a policy.

(2) "Affiliate" or "affiliated" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(3) "Agent" has the meaning as set forth in G.S. 58-33-10, and includes limited representatives, limited line credit insurance producers, limited lines producers, insurance producers, and surplus lines licensees.

(4) "Applicant" means any person who seeks to contract for insurance coverage other than a person seeking group insurance that is not individually underwritten.

(5) "Consumer report" means any written, oral, or other communication of information bearing on a natural person's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living that is used or expected to be used in connection with an insurance transaction.

(6) "Consumer reporting agency" means any person who:
a. Regularly engages, in whole or in part, in the practice of assembling or preparing consumer reports for a monetary fee;
b. Obtains information primarily from sources other than insurance institutions; and

c. Furnishes consumer reports to other persons.

(7) "Control," including the terms "controlled by" or "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

(8) "Declination of insurance coverage" means a denial, in whole or in part, by an insurance institution or agent of requested insurance coverage.

(9) "Individual" means any natural person who:

a. In the case of property or casualty insurance, is a past, present, or proposed named insured or certificate holder;

b. In the case of life, health, or disability insurance, is a past, present, or proposed principal insured or certificate holder;

c. Is a past, present or proposed policy owner;

d. Is a past or present applicant;

e. Is a past or present claimant;

f. Derived, derives, or is proposed to derive insurance coverage under an insurance policy or certificate subject to this Article; or

g. Is the subject of personal information collected or maintained by an insurance institution, agent, or insurance-support organization in connection with mortgage guaranty insurance.

(10) "Institutional source" means any person or governmental entity that provides information about an individual to an agent, insurance institution, or insurance-support organization, other than:

a. An agent;

b. The individual who is the subject of the information; or

c. A natural person acting in a personal capacity rather than in a business or professional capacity.

(11) "Insurance institution" means any corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's insurer, fraternal benefit society, or other person engaged in the business of insurance, including health maintenance organizations and medical, surgical, hospital, dental, and optometric service plans, governed by Articles 65 through 67 of this Chapter. "Insurance institution" shall not include agents or insurance-support organizations.

(12) "Insurance-support organization" means any person who regularly engages, in whole or in part, in the practice of assembling or collecting information about natural persons for the primary purpose of providing the information to an insurance institution or agent for insurance transactions, including: (i) the furnishing of consumer reports or investigative consumer reports to an insurance institution or agent for use in connection with an insurance transaction; or (ii) the collection of personal information from insurance institutions, agents, or other insurance-support organizations for the purpose of detecting or preventing fraud, material misrepresentation, or material nondisclosure in connection with insurance underwriting or insurance claim activity; provided, however, the following persons shall not be considered "insurance-support organizations" for purposes of this Article: agents, governmental institutions, insurance institutions, medical-care institutions, and medical professionals.

(13) "Insurance transaction" means any transaction involving insurance primarily for personal, family, or household needs rather than business or professional needs that entails:

a. The determination of an individual's eligibility for an insurance coverage, benefit, or payment; or

b. The servicing of an insurance application, policy, contract, or certificate.

(14) "Investigative consumer report" means a consumer report or portion thereof in which information about a natural person's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances, or others who may have knowledge concerning such items of information.

(15) "Life insurance" includes annuities.

(16) "Medical-care institution" means any facility or institution that is licensed to provide health care services to natural persons, including but not limited to, hospitals, skilled nursing facilities, home-health agencies, medical clinics, rehabilitation agencies, public health agencies, or health-maintenance organizations.

(17) "Medical professional" means any person licensed or certified to provide health care services to natural persons, including but not limited to, a physician, dentist, nurse, chiropractor, optometrist,

physical or occupational therapist, licensed clinical social worker, clinical dietitian, clinical psychologist, pharmacist, or speech therapist.

(18) "Medical-record information" means personal information that:
   a. Relates to an individual's physical or mental condition, medical history, or medical treatment; and
   b. Is obtained from a medical professional or medical-care institution, from the individual, or from the individual's spouse, parent, or legal guardian.

(19) "Personal information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. "Personal information" includes an individual's name and address and medical-record information, but does not include privileged information.

(20) "Policyholder" means any person who:
   a. In the case of individual property or casualty insurance, is a present named insured;
   b. In the case of individual life or accident and health insurance, is a present policy owner; or
   c. In the case of group insurance that is individually underwritten, is a present group certificate holder.

(21) "Pretext interview" means an interview whereby a person, in an attempt to obtain information about a natural person, performs one or more of the following acts:
   a. Pretends to be someone he is not;
   b. Pretends to represent a person he is not in fact representing;
   c. Misrepresents the true purpose of the interview; or
   d. Refuses to identify himself upon request.

(22) "Privileged information" means any individually identifiable information that (i) relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual, and (ii) is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual: Provided, however, information otherwise meeting the requirements of this subsection shall nevertheless be considered personal information under this Article if it is disclosed in violation of G.S. 58-39-75.

(23) "Residual market mechanism" means any reinsurance facility, joint underwriting association, assigned risk plan, or other similar plan established under the laws of this State.

(24) "Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure to pay a premium as required by the policy.

(25) "Unauthorized insurer" means an insurance institution that has not been granted a license by the Commissioner to transact the business of insurance in this State. (1981, c. 846, s. 1; 1987, c. 629, s. 13; 1993, c. 464, s. 1; 2001-203, s. 30; 2001-351, ss. 2, 3; 2001-487, s. 40(f); 2003-262, s. 2(1).)

§ 58-39-20. Pretext interviews.

No insurance institution, agent, or insurance-support organization shall use or authorize the use of pretext interviews to obtain information in connection with an insurance transaction: Provided, however, a pretext interview may be undertaken to obtain information from a person or institution that does not have a generally or statutorily recognized privileged relationship with the person about whom the information relates for the purpose of investigating a claim where, based upon specific information available for review by the Commissioner, there is a reasonable basis for suspecting criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with the claim. (1981, c. 846, s. 1; 2003-262, s. 2(1).)

§ 58-39-25. Notice of insurance information practices.

(a) An insurance institution or agent shall provide a notice of information practices to all applicants or policyholders in connection with insurance transactions as provided in this section:
   (1) In the case of an application for insurance a notice shall be provided no later than:
      a. At the time of the delivery of the insurance policy or certificate when personal information is collected only from the applicant or from public records; or
      b. At the time the collection of personal information is initiated when personal information is collected from a source other than the applicant or public records;

(2) In the case of a policy renewal, a notice shall be provided no later than the policy renewal date, except that no notice shall be required in connection with a policy renewal if:
   a. Personal information is collected only from the policyholder or from public records; or
   b. A notice meeting the requirements of this section has been given within the previous 24 months; or
(3) In the case of a policy reinstatement or change in insurance benefits, a notice shall be provided no later than the time a request for a policy reinstatement or change in insurance benefits is received by the insurance institution, except that no notice shall be required if personal information is collected only from the policyholder or from public records.

(b) The notice required by subsection (a) of this section shall be in writing and shall state:
(1) Whether personal information may be collected from persons other than the individual or individuals proposed for coverage;
(2) The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such information;
(3) The types of disclosures identified in subsections (2), (3), (4), (5), (6), (9), (11), (12), and (14) of G.S. 58-39-75 and the circumstances under which such disclosures may be made without prior authorization: Provided, however, only those circumstances need be described that occur with such frequency as to indicate a general business practice;
(4) A description of the rights established under G.S. 58-39-45 and 58-39-50 and the manner in which such rights may be exercised; and
(5) That information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

(c) In lieu of the notice prescribed in subsection (b) of this section, the insurance institution or agent may provide an abbreviated notice informing the applicant or policyholder that:
(1) Personal information may be collected from persons other than the individual or individuals proposed for coverage;
(2) Such information, as well as other personal or privileged information subsequently collected by the insurance institution or agent, in certain circumstances, may be disclosed to third parties without authorization;
(3) A right of access and correction exists with respect to all personal information collected; and
(4) The notice prescribed in subsection (b) of this section will be furnished to the applicant or policyholder upon request.

(d) The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf. (1981, c. 846, s. 1; 2003-262, s. 2(1).)

§ 58-39-26. Federal privacy disclosure notice requirements.

(a) Disclosure Required. – In addition to the notice requirements of G.S. 58-39-25, an insurance institution or agent shall provide, to all applicants and policyholders no later than (i) before the initial disclosure of personal information under G.S. 58-39-75(11) or (ii) the time of the delivery of the insurance policy or certificate, a clear and conspicuous notice, in written or electronic form, of the insurance institution or agent's policies and practices with respect to:
(1) Disclosing nonpublic personal information to affiliates and nonaffiliated third parties, consistent with section 502 of Public Law 106-102, including the categories of information that may be disclosed.
(2) Disclosing nonpublic personal information of persons who have ceased to be customers of the financial institution.
(3) Protecting the nonpublic personal information of consumers.
These disclosures shall be made in accordance with the regulations prescribed under section 505 of Public Law 106-102.

(b) Information to Be Included. – The disclosure required by subsection (a) of this section shall include:
(1) The policies and practices of the insurance institution or agent with respect to disclosing nonpublic personal information to nonaffiliated third parties, other than agents of the

insurance institution or agent, consistent with section 502 of Public Law 106-102, and including:

a. The categories of persons to whom the information is or may be disclosed, other than the persons to whom the information may be provided under section 502(e) of Public Law 106-102.

b. The policies and practices of the insurance institution or agent with respect to disclosing of nonpublic personal information of persons who have ceased to be customers of the insurance institution or agent.

(2) The categories of nonpublic personal information that are collected by the insurance institution or agent.

(3) The policies that the insurance institution or agent maintains to protect the confidentiality and security of nonpublic personal information in accordance with section 501 of Public Law 106-102.

(4) The disclosures required, if any, under section 603(d)(2)(A)(iii) of the Fair Credit Reporting Act.

(c) In the case of a policyholder, the notice required by this section shall be provided not less than annually during the continuation of the policy. As used in this subsection, "annually" means at least once in any period of 12 consecutive months during which the policy is in effect. (2001-351, s. 4; 2003-262, s. 2(1).)

§ 58-39-27. Privacy notice and disclosure requirement exceptions.

(a) Under G.S. 58-39-25 and G.S. 58-39-26, an insurance institution or agent may provide a joint notice from the insurance institution or agent and one or more of its affiliates or other financial institutions, as defined in the notice, as long as the notice is accurate with respect to the insurance institution or agent and the other institutions.

(b) An insurance institution or agent may satisfy the notice requirements of G.S. 58-39-25 and G.S. 58-39-26 by providing a single notice if two or more applicants or policyholders jointly obtain or apply for an insurance product.

(c) An insurance institution or agent may satisfy the notice requirements of G.S. 58-39-25 and G.S. 58-39-26 through the use of separate or combined notices.

(d) An insurance institution or agent is not required to provide the notices required by G.S. 58-39-25 and G.S. 58-39-26 to:

(1) Any applicant or policyholder whose last known address, according to the insurance institution's or agent's records is deemed invalid. The applicant's or policyholder's last known address shall be deemed invalid if mail sent to that address has been returned by the postal authorities as undeliverable and if subsequent reasonable attempts to obtain a current valid address for the applicant or policyholder have been unsuccessful; or

(2) Any policyholder whose policy is lapsed, expired, or otherwise inactive or dormant under the insurance institution's business practices, and the insurance institution has not communicated with the policyholder about the relationship for a period of 12 consecutive months, other than annual privacy notices, material required by law or regulation, or promotional materials.

(e) If an agent does not share information with any person other than the agent's principal or an affiliate of the principal, and if the principal provides all notices required by G.S. 58-39-25 and G.S. 58-39-26, the agent is not required to provide the notices required by G.S. 58-39-25 and G.S. 58-39-26. G.S. 58-39-75 applies to the sharing of information with an affiliate under this subsection.

(f) When an agent discloses a policyholder's personal information, other than medical information, to an insurance institution solely for the purposes of renewal, transfer, replacement, reinstatement, or modification of an existing policy, the agent is not required to provide the notices required by G.S. 58-39-25 and G.S. 58-39-26.

(g) For the purposes of G.S. 58-39-26 only, the terms "applicant" or "policyholder" include respectively a person who applies for, or a certificate holder who obtains, insurance coverage under a group or blanket insurance contract, employee benefit plan, or group annuity contract, regardless of whether the coverage is individually underwritten. An insurance institution or agent that does not disclose personal information about an applicant or policyholder under a group or blanket insurance contract, employee benefit plan, or group annuity contract, except as permitted under G.S. 58-39-75(1) through (10) and G.S. 58-39-75(12) through (21), may satisfy any notice

requirement that otherwise exists under G.S. 58-39-26 with respect to that applicant or policyholder by providing a notice of information practices to the holder of the group or blanket insurance or annuity contract or the employee benefit plan sponsor. If an insurance institution or agent discloses personal information about an applicant or policyholder as permitted by G.S. 58-39-75(11), it shall provide the notice required by G.S. 58-39-26 to the applicant or policyholder not less than 30 days before the information is disclosed, and it may satisfy any other notice requirement that otherwise exists under this section with respect to that applicant or policyholder by providing a notice of information practices to the holder of the group or blanket insurance or annuity contract or employee benefit plan sponsor. (2001-351, s. 5; 2003-262, s. 2(1).)

§ 58-39-28. Exception for title and mortgage guaranty insurance.

(a) A title insurance company shall give notice of its insurance information practices under G.S. 58-39-25 and G.S. 58-39-26 only at the time the final policy of title insurance is issued and is not subject to any annual notice requirement thereafter.

(b) In the case of mortgage guaranty insurance, the notice required by G.S. 58-39-25 and G.S. 58-39-26 shall be provided at the time a master policy is issued and thereafter only if there is a material change in the insurer's policies and practices regarding the use or disclosure of personal information. (2001-351, s. 6; 2003-262, s. 2(1).)

§ 58-39-30. Marketing and research surveys.

An insurance institution or agent shall clearly specify those questions designed to obtain information solely for marketing or research purposes from an individual in connection with an insurance transaction. (1981, c. 846, s. 1; 2003-262, s. 2(1).)

§ 58-39-35. Content of disclosure authorization forms.

Notwithstanding any other provision of law of this State, no insurance institution, agent, or insurance-support organization shall utilize as its disclosure authorization form in connection with insurance transactions involving insurance policies or contracts issued after July 1, 1982, a form or statement that authorizes the disclosure of personal or privileged information about an individual to the insurance institution, agent, or insurance-support organization unless the form or statement:

(1) Complies with the provisions of Article 38 of this Chapter;
(2) Is dated;
(3) Specifies the types of persons authorized to disclose information about the individual;
(4) Specifies the nature of the information authorized to be disclosed;
(5) Names the insurance institution or agent and identifies by generic reference representatives of the insurance institution to whom the individual is authorizing information to be disclosed;
(6) Specifies the purposes for which the information is collected;
(7) Specifies the length of time such authorization shall remain valid, which shall be no longer than:
    a. In the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits:
        1. Thirty months from the date the authorization is signed if the application or request involves life, health, or disability insurance; or
        2. One year from the date the authorization is signed if the application or request involves property or casualty insurance;
    b. In the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy:
        1. The term of coverage of the policy if the claim is for a health insurance benefit; or
        2. The duration of the claim if the claim is not for a health insurance benefit; and
(8) Advises the individual or a person authorized to act on behalf of the individual that the individual or the individual's authorized representative is entitled to receive a copy of the authorization form. (1981, c. 846, s. 1; c. 1127, s. 56; 2003-262, s. 2(1).)

§ 58-39-40. Investigative consumer reports.

(a) No insurance institution, agent, or insurance-support organization may prepare or request an investigative consumer report about an individual in connection with an insurance transaction involving an application for insurance, a policy renewal, a policy reinstatement, or a change in insurance benefits unless the insurance institution or agent informs the individual:

(1) That he may request to be interviewed in connection with the preparation of the investigative consumer report; and
(2) That upon a request pursuant to G.S. 58-39-45 he is entitled to receive a copy of the investigative consumer report.

(b) If an investigative consumer report is to be prepared by an insurance institution or agent, the insurance institution or agent shall institute reasonable procedures to conduct a personal interview requested by an individual.

(c) If an investigative consumer report is to be prepared by an insurance-support organization, the insurance institution or agent desiring such report shall inform the insurance-support organization whether a personal interview has been requested by the individual. The insurance-support organization shall institute reasonable procedures to conduct such interviews, if requested. (1981, c. 846, s. 1; 2003-262, s. 2(1).)

§ 58-39-45. Access to recorded personal information.

(a) If any individual, after proper identification, submits a written request to an insurance institution, agent, or insurance-support organization for access to recorded personal information about the individual that is reasonably described by the individual and reasonably locatable and retrievable by the insurance institution, agent, or insurance-support organization, the insurance institution, agent, or insurance-support organization shall within 30 business days from the date such request is received:
(1) Inform the individual of the nature and substance of such recorded personal information in writing, by telephone, or by other oral communication, whichever the insurance institution, agent, or insurance-support organization prefers;
(2) Permit the individual to see and copy, in person, such recorded personal information pertaining to him or to obtain a copy of such recorded personal information by mail, whichever the individual prefers, unless such recorded personal information is in coded form, in which case an accurate translation in plain language shall be provided in writing;
(3) Disclose to the individual the identity, if recorded, of those persons to whom the insurance institution, agent, or insurance-support organization has disclosed such personal information within two years prior to such request, and if the identity is not recorded, the names of those insurance institutions, agents, insurance-support organizations or other persons to whom such information is normally disclosed; and
(4) Provide the individual with a summary of the procedures by which he may request correction, amendment, or deletion of recorded personal information.

(b) Any personal information provided pursuant to subsection (a) of this section shall identify the source of the information if such source is an institutional source.

(c) Medical-record information supplied by a medical-care institution or medical professional and requested under subsection (a) of this section together with the identity of the medical professional or medical-care institution that provided such information, shall be supplied either directly to the individual or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the insurance institution, agent, or insurance-support organization prefers. If it elects to disclose the information to a medical professional designated by the individual, the insurance institution, agent, or insurance-support organization shall notify the individual, at the time of the disclosure, that it has provided the information to the medical professional.

(d) Except for personal information provided under G.S. 58-39-55, an insurance institution, agent, or insurance-support organization may charge a reasonable fee to cover the costs incurred in providing a copy of recorded personal information to individuals.

(e) The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf. With respect to the copying and disclosure of recorded personal information pursuant to a request under subsection (a) of this section, an insurance institution, agent, or insurance-support organization may make arrangements with an insurance-support organization or a consumer reporting agency to copy and disclose recorded personal information on its behalf.

(f) The rights granted to individuals in this section shall extend to all natural persons to the extent information about them is collected and maintained by an insurance institution, agent, or insurance-support organization in connection with an insurance transaction. The rights granted to all natural persons by this subsection shall not extend to information about them that relates to

and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

(g) For purposes of this section, the term, "insurance-support organization" does not include the term, "consumer reporting agency." (1981, c. 846, s. 1; 2003-262, s. 2(1).)

§ 58-39-50. Correction, amendment, or deletion of recorded personal information.

(a) Within 30 business days from the date of receipt of a written request from an individual to correct, amend, or delete any recorded personal information about the individual within its possession, an insurance institution, agent, or insurance-support organization shall either:
  (1) Correct, amend, or delete the portion of the recorded personal information in dispute; or
  (2) Notify the individual of:
    a. Its refusal to make such correction, amendment, or deletion;
    b. The reasons for the refusal; and
    c. The individual's right to file a statement as provided in subsection (c) of this section.

(b) If the insurance institution, agent, or insurance-support organization corrects, amends, or deletes recorded personal information in accordance with subdivision (a)(1) of this section, the insurance institution, agent, or insurance-support organization shall so notify the individual in writing and furnish the correction, amendment, or fact of deletion to:
  (1) Any person specifically designated by the individual who, within the preceding two years, may have received such recorded personal information;
  (2) Any insurance-support organization whose primary source of personal information is insurance institutions if the insurance-support organization has systematically received such recorded personal information from the insurance institution within the preceding seven years. The correction, amendment, or fact of deletion need not be furnished if the insurance-support organization no longer maintains recorded personal information about the individual; and
  (3) Any insurance-support organization that furnished the personal information that has been corrected, amended, or deleted.

(c) Whenever an individual disagrees with an insurance institution's, agent's, or insurance-support organization's refusal to correct, amend, or delete recorded personal information, the individual shall be permitted to file with the insurance institution, agent, or insurance-support organization:
  (1) A concise statement setting forth what the individual thinks is the correct, relevant, or fair information; and
  (2) A concise statement of the reasons why the individual disagrees with the insurance institution's, agent's, or insurance-support organization's refusal to correct, amend, or delete recorded personal information.

(d) In the event an individual files either statement as described in subsection (c) of this section, the insurance institution, agent, or support organization shall:
  (1) File the statement with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the individual's statement and have access to it; and
  (2) In any subsequent disclosure by the insurance institution, agent, or support organization of the recorded personal information that is the subject of disagreement, clearly identify the matter or matters in dispute and provide the individual's statement along with the recorded personal information being disclosed; and
  (3) Furnish the statement to the persons and in the manner specified in subsection (b) of this section.

(e) The rights granted to individuals in this section shall extend to all natural persons to the extent information about them is collected and maintained by an insurance institution, agent, or insurance-support organization in connection with an insurance transaction. The rights granted to all natural persons by this subsection shall not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

(f) For purposes of this section, the term, "insurance-support organization" does not include the term, "consumer reporting agency." (1981, c. 846, s. 1; 1991, c. 720, s. 74; 2003-262, s. 2(1).)

§ 58-39-55. Reasons for adverse underwriting decisions.

(a) In the event of an adverse underwriting decision, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the Commissioner that:
  (1) Either provides the applicant, policyholder, or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advises such person that upon written request he may receive the specific reason or reasons in writing; and
  (2) Provides the applicant, policyholder, or individual proposed for coverage with a summary of the rights established under subsection (b) of this section and G.S. 58-39-45 and 58-39-50.

(b) Upon receipt of a written request within 90 business days from the date of the mailing of notice or other communication of an adverse underwriting decision to an applicant, policyholder or individual proposed for coverage, the insurance institution or agent shall furnish to such person within 21 business days from the date of receipt of such written request:
  (1) The specific reason or reasons for the adverse underwriting decision, in writing, if such information was not initially furnished in writing pursuant to subdivision (a)(1) of this section;
  (2) The specific items of personal and privileged information that support those reasons: Provided, however:
    a. The insurance institution or agent shall not be required to furnish specific items of privileged information if it has a reasonable suspicion, based upon specific information available for review by the Commissioner, that the applicant, policyholder, or individual proposed for coverage has engaged in criminal activity, fraud, material misrepresentation, or material nondisclosure, and
    b. Specific items of medical-record information supplied by a medical-care institution or medical professional shall be disclosed either directly to the individual about whom the information relates or to the medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the insurance institution or agent prefers; and
  (3) The names and addresses of the institutional sources that supplied the specific items of information given pursuant to subdivision (b)(2) of this section: Provided, however, the identity of any medical professional or medical-care institution shall be disclosed either directly to the individual or to the designated medical professional, whichever the insurance institution or agent prefers.

(c) The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf.

(d) When an adverse underwriting decision results solely from an oral request or inquiry, the explanation of reasons and summary of rights required by this section may be given orally. (1981, c. 846, s. 1; 2003-262, s. 2(1).)

§ 58-39-60. Information concerning previous adverse underwriting decisions.

No insurance institution, agent, or insurance-support organization may seek information in connection with an insurance transaction concerning: (i) any previous adverse underwriting decision experienced by an individual; or (ii) any previous insurance coverage obtained by an individual through a residual market mechanism, unless such inquiry also requests the reasons for any previous adverse underwriting decision or the reasons why insurance coverage was previously obtained through a residual market mechanism. (1981, c. 846, s. 1; 2003-262, s. 2(1).)

§ 58-39-65. Previous adverse underwriting decisions.

No insurance institution or agent may base an adverse underwriting decision in whole or in part:

(1) On the fact of a previous adverse underwriting decision or on the fact that an individual previously obtained insurance coverage through a residual market mechanism: Provided, however, an insurance institution or agent may base an adverse underwriting decision on further information obtained from an insurance institution or agent responsible for a previous adverse underwriting decision;

(2) On personal information received from an insurance-support organization whose primary source of information is insurance institutions: Provided, however, an insurance institution or agent may base an adverse underwriting decision on further personal information obtained as the result of

information received from such insurance-support organization. (1981, c. 846, s. 1; 2003-262, s. 2(1).)

§ 58-39-70: Recodified as G.S. 58-39-125 by Session Laws 2003-262, s. 2(3), effective June 26, 2003.

§ 58-39-75. Disclosure limitations and conditions.

An insurance institution, agent, or insurance-support organization shall not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure is:

(1) With the written authorization of the individual, provided:
  a. If such authorization is submitted by another insurance institution, agent, or insurance-support organization, the authorization meets the requirements of G.S. 58-39-35; or
  b. If such authorization is submitted by a person other than an insurance institution, agent, or insurance-support organization, the authorization meets the requirements of G.S. 58-39-35 and is:
    1. Dated;
    2. Signed by the individual; and
    3. Obtained one year or less before the date a disclosure is sought pursuant to this paragraph; or

(2) To a person other than an insurance institution, agent, or insurance-support organization, provided such disclosure is reasonably necessary:
  a. To enable that person to perform a business, professional, or insurance function for the disclosing insurance institution, agent, or insurance-support organization, including, but not limited to, performing marketing functions and other functions regarding the provision of information concerning the disclosing institution's own products, services, and programs, and that person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:
    1. Would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or
    2. Is reasonably necessary for that person to perform its function for the disclosing insurance institution, agent, or insurance-support organization; or
  b. To enable that person to provide information to the disclosing insurance institution, agent, or insurance-support organization for the purpose of:
    1. Determining an individual's eligibility for an insurance benefit or payment; or
    2. Detecting or preventing criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with an insurance transaction; or

(3) To an insurance institution, agent, insurance-support organization, or self-insurer, provided the information disclosed is limited to that which is reasonably necessary:
  a. To detect or prevent criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with insurance transactions; or
  b. For either the disclosing or receiving insurance institution, agent, or insurance-support organization to perform its function in connection with an insurance transaction involving the individual; or

(4) To a medical-care institution or medical professional for the purpose of (i) verifying insurance coverage or benefits, (ii) informing an individual of a medical problem of which the individual may not be aware, or (iii) conducting an operations or services audit, provided only such information is disclosed as is reasonably necessary to accomplish the foregoing purposes; or

(5) To an insurance regulatory authority; or

(6) To a law-enforcement or other government authority:
  a. To protect the interests of the insurance institution, agent, or insurance-support organization in preventing or prosecuting the perpetration of fraud upon it; or
  b. If the insurance institution, agent, or insurance-support organization reasonably believes that illegal activities have been conducted by the individual; or

(7) Otherwise permitted or required by law; or

(8) In response to a facially valid administrative or judicial order, including a search warrant or subpoena; or

(9) Made for the purpose of conducting actuarial or research studies, provided:
  a. No individual may be identified in any actuarial or research report;

b. Materials allowing the individual to be identified are returned or destroyed as soon as they are no longer needed; and
c. The actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or

(10) To a party or a representative of a party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the insurance institution, agent, or insurance-support organization, provided:
a. Prior to the consummation of the sale, transfer, merger, or consolidation only such information is disclosed as is reasonably necessary to enable the recipient to make business decisions about the purchase, transfer, merger, or consolidation, and
b. The recipient agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent or insurance-support organization; or

(11) To a person whose only use of such information will be in connection with the marketing of a product or service, provided:
a. No medical-record information, privileged information, or personal information relating to an individual's character, personal habits, mode of living, or general reputation is disclosed, and no classification derived from such information is disclosed;
b. The individual has been given an opportunity to indicate that he does not want personal information disclosed for marketing purposes and has given no indication that such individual does not want the information disclosed; and
c. The person receiving such information agrees not to use it except in connection with the marketing of a product or service; or

(12) To an affiliate whose only use of the information will be in connection with an audit of the insurance institution or agent or the marketing of an insurance product or service, provided the affiliate agrees not to disclose the information for any other purpose or to unaffiliated persons; and further provided that no medical record information may be disclosed to the affiliate for the marketing of an insurance product or service; or

(13) By a consumer reporting agency, provided the disclosure is to a person other than an insurance institution or agent; or

(14) To a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurance institution's or agent's operations or services, provided the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit; or

(15) To a professional peer review organization for the purpose of reviewing the service or conduct of a medical-care institution or medical professional; or

(16) To a governmental authority for the purpose of determining the individual's eligibility for health benefits for which the governmental authority may be liable; or

(17) To a certificate holder or policyholder for the purpose of providing information regarding the status of an insurance transaction; or

(18) To a lien holder, mortgagee, assignee, lessor, or other person shown on the records of an insurance institution or agent as having a legal or beneficial interest in a policy of insurance only if:
a. No medical record information is disclosed unless the disclosure would otherwise be permitted by this section; and
b. The information disclosed is limited to that which is reasonably necessary to permit such person to protect its interest in such policy; or

(19) To authorized personnel of the Division of Motor Vehicles upon requests pursuant to G.S. 20-309(c) or G.S. 20-309(f).

(20) To the Department of Health and Human Services and the information disclosed is immunization information described in G.S. 130A-153.

(21) To a person whose only use of an applicant's or policyholder's personal information, but not including medical record information, will be in connection with the marketing of a financial product or service intended to be provided by participants in a marketing program where the program participants and the types of information to be shared are identified to the applicant or policyholder when the applicant or policyholder is first offered the financial product or service. As used in this subdivision:

a. "Financial institution" means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. § 1843(k)).
b. "Financial product or service" means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such financial activity under section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. § 1843(k)).
c. "Marketing program" includes only those programs established by written agreement by the insurance institution and one or more financial institutions under which they jointly offer, endorse, or sponsor a financial product or service. (1981, c. 846, s. 1; 1985, c. 666, s. 68; 1993, c. 134, s. 2; 1997-443, s. 11A.20A; 2001-351, ss. 7, 8, 10, 11, 12; 2003-262, s. 2(1).)

§ 58-39-76. Limits on sharing account number information for marketing purposes.

(a) General Prohibition on Disclosure of Account Numbers. – An insurance institution, insurance agent, or insurance-support organization shall not disclose, other than to a consumer reporting agency, an account number or similar form of access number or access code for a credit card account, deposit account, or transaction account of a consumer to any nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail to the consumer.

(b) Definitions. – As used in this section:
(1) "Account number" means an account number, or similar form of access number or access code, but does not include a number or code in an encrypted form, as long as the insurance institution, insurance agent, or insurance-support organization does not provide the recipient with a means to decode the number or code.
(2) "Transaction account" means an account other than a deposit account or credit card account. A transaction account does not include an account to which third parties cannot initiate charges.

(c) Exceptions. – Subsection (a) of this section does not apply if an insurance institution, insurance agent, or insurance-support organization discloses an account number or similar form of access number or access code:
(1) To the insurance institution's, insurance agent's, or insurance-support organization's agent or service provider solely in order to perform marketing for the insurance institution's, insurance agent's, or insurance-support organization's own products or services, as long as the agent or service provider is not authorized to directly initiate charges to the account; or
(2) To a participant in a private label credit card program or an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program. (2001-351, s. 9; 2003-262, s. 2(1).)

Part 2. Enforcement, Sanctions, Remedies, and Rights.

§ 58-39-80. Hearings and procedures.

(a) Whenever the Commissioner has reason to believe that an insurance institution, agent, or insurance-support organization has been or is engaged in conduct in this State that violates this Article, or whenever the Commissioner has reason to believe that an insurance-support organization has been or is engaged in conduct outside this State that has an effect on a person residing in this State and that violates this Article, the Commissioner may issue and serve upon such insurance institution, agent, or insurance-support organization a statement of charges and notice of hearing to be held at a time and place fixed in the notice. The date for such hearing shall be not less than 10 days after the date of service.

(b) At the time and place fixed for such hearing the insurance institution, agent, or insurance-support organization charged shall have an opportunity to answer the charges against it and present evidence on its behalf. Upon good cause shown, the Commissioner shall permit any adversely affected person to intervene, appear, and be heard at such hearing by counsel or in person. (1981, c. 846, s. 1; 2003-262, s. 2(2).)

§ 58-39-85. Service of process; insurance-support organizations.

For the purpose of this Article, an insurance-support organization transacting business outside this State that has an effect on a person residing in this State shall be deemed to have appointed the Commissioner to

accept service of process on its behalf. The provisions of G.S. 58-16-30 and 58-16-45 shall apply to service of process under this section, except that such service shall be mailed to the insurance-support organization at its last known principal place of business. (1981, c. 846, s. 1; 1985, c. 666, s. 9; 2003-262, s. 2(2).)

§ 58-39-90. Cease and desist orders.

If, after a hearing pursuant to G.S. 58-39-80, the Commissioner determines that the insurance institution, agent, or insurance-support organization charged has engaged in conduct or practices in violation of this Article, he may issue an order requiring such insurance institution, agent, or insurance-support organization to cease and desist from the conduct or practices constituting a violation of this Article. (1981, c. 846, s. 1; 2003-262, s. 2(2).)

§ 58-39-95. Penalties.

(a) In any case where a hearing pursuant to G.S. 58-39-80 results in the findings of a violation of this Article, the Commissioner, in addition to the issuance of a cease and desist order as prescribed in G.S. 58-39-90, may levy a civil penalty under G.S. 58-2-70.

(b) Any person who violates a cease and desist order of the Commissioner under G.S. 58-39-90, after notice and hearing and upon order of the court, may be subject to one or more of the following penalties, at the discretion of the court:

(1) A monetary fine of not more than ten thousand dollars ($10,000) for each violation; or

(2) A monetary fine of not more than fifty thousand dollars ($50,000) if the court finds that violations have occurred with such frequency as to constitute a general business practice; or

(3) Suspension or revocation of an insurance institution's or agent's license.

(c) The clear proceeds of any civil penalties levied pursuant to this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2. (1981, c. 846, s. 1; 1991, c. 720, s. 73; 1998-215, s. 89(b); 2003-262, s. 2(2).)

§ 58-39-100. Appeal of right.

From any final order of the Commissioner issued pursuant to the provisions of this Article there shall be an appeal as provided in G.S. 58-2-75. (1981, c. 846, s. 1; 2003-262, s. 2(2).)

§ 58-39-105. Individual remedies.

(a) If any insurance institution, agent, or insurance-support organization fails to comply with G.S. 58-39-45, 58-39-50, or 58-39-55 with respect to the rights granted under those sections, any person whose rights are violated may apply to the superior court in the county in which such person resides for appropriate equitable relief.

(b) An insurance institution, agent, or insurance-support organization that discloses information in violation of G.S. 58-39-75 shall be liable for damages sustained by the individual to whom the information relates. No individual, however, shall be entitled to a monetary award that exceeds the actual damages sustained by the individual as a result of a violation of G.S. 58-39-75.

(c) In any action brought pursuant to this section, the court may award the cost of the action and reasonable attorney's fees to the prevailing party.

(d) An action under this section must be brought within two years from the date the alleged violation is or should have been discovered.

(e) Except as specifically provided in this section, there shall be no remedy or recovery available to individuals for any occurrence that constitutes a violation of any provision of this Article. (1981, c. 846, s. 1; 2003-262, s. 2(2).)

§ 58-39-110. Immunity.

No cause of action in the nature of defamation, invasion of privacy, or negligence shall arise against any person for disclosing personal or privileged information in accordance with this Article, nor shall such a cause of action arise against any person for furnishing personal or privileged information to an insurance institution, agent, or insurance-support organization: Provided, however, this section shall provide no immunity for disclosing or furnishing false information with malice or willful intent to injure any person. (1981, c. 846, s. 1; 2003-262, s. 2(2).)

§ 58-39-115. Obtaining information under false pretenses.

Any person who knowingly and willfully obtains information about an individual from an insurance institution, agent, or insurance-support organization under false pretenses shall, upon conviction, be guilty of a Class 1

misdemeanor. (1981, c. 846, s. 1; 1985, c. 666, s. 33; 1993, c. 539, s. 465; 1994, Ex. Sess., c. 24, s. 14(c); 2003-262, s. 2(2).)

§ 58-39-120. Rights.
The rights granted under G.S. 58-39-45, 58-39-50, and 58-39-75 shall take effect on July 1, 1982, regardless of the date of the collection or receipt of the information that is the subject of such sections. (1981, c. 846, s. 1; c. 1127, s. 56; 2003-262, s. 2(2).)

Unfair Trade Practices

§ 58-63-15. Unfair methods of competition and unfair or deceptive acts or practices defined.
The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) Misrepresentations and False Advertising of Policy Contracts. – Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statement as to the dividends or share or surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance.

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

(3) Defamation. – Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(4) Boycott, Coercion and Intimidation. – Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(5) False Financial Statements. – Filing with any supervisory or other public official, or making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive.
Making any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.

(6) Stock Operations and Insurance Company Advisory Board Contracts. – Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or any insurance company advisory board contracts or other contracts of any kind promising returns and profit as an inducement to insurance.

(7) Unfair Discrimination.
a. Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life

annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

b. Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

c. Making or permitting any unfair discrimination between or among individuals or risks of the same class and of essentially the same hazard by refusing to issue, refusing to renew, cancelling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:

1. The refusal or limitation is for the purpose of preserving the solvency of the insurer and is not a mere pretext for unfair discrimination, or
2. The refusal, cancellation, or limitation is required by law.

d. Making or permitting any unfair discrimination between or among individuals or risks of the same class and of essentially the same hazard by refusing to issue, refusing to renew, cancelling, or limiting the amount of insurance coverage on a residential property risk, or the personal property contained therein, because of the age of the residential property, unless:

1. The refusal or limitation is for the purpose of preserving the solvency of the insurer and is not a mere pretext for unfair discrimination, or
2. The refusal, cancellation, or limitation is required by law.

(8) Rebates.

a. Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

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

1. In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided, that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;
2. 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;
3. Readjustment of the rate of premium for a group insurance policy based on the loss or expense experienced thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

c. No insurer or employee thereof, and no broker or agent shall pay, allow, or give, or offer to 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. Nothing herein contained shall be construed as prohibiting the payment of commissions or other compensation to regularly appointed and licensed agents and to brokers duly licensed by this State; nor as

prohibiting any participating insurer from distributing to its policyholders dividends, savings or the unused or unabsorbed portion of premiums and premium deposits.

(9) Advertising of Health, Accident or Hospitalization Insurance. – In all advertising of policies, certificates or service plans of health, accident or hospitalization insurance, except those providing group coverage, where details of benefits provided by a particular policy, certificate or plan are set forth in any advertising material, such advertising material shall contain reference to the major exceptions or major clauses limiting or voiding liability contained in the policy, certificate or plan so advertised. The references to such exceptions or clauses shall be printed in a type no smaller than that used to set forth the benefits of the policy, certificate or plan. In all advertising of such policies, certificates or plans which contain a cancellation provision or a provision that the policies, certificates or plans may be renewed at the option of the company or medical service corporation only, such advertising material shall contain clear and definite reference to the fact that the policies, certificates or plans are cancellable or that the same may be renewed at the option of the company only.

In advertising, sale, or solicitation for sale of any insurance policy represented or advertised to afford coverages and benefits supplemental to or in addition to Medicare coverage, all such advertising materials, except for advertisements which have as their objective the creation of a desire to inquire further about an insurance product and do nothing more than generally describe the product and invite inquiries for costs and further details of the coverage, including limitations, exclusions, reductions or limitations and terms under which the policy may be continued in force, in whatever medium, and all solicitation and presentations for the sale of such policies, shall contain specific references to major exclusions or major exceptions that may result in voiding liability or in a reduction of benefits below those primarily advertised. When such policies contain a coordination of benefits clause whereby benefits are limited by or prorated with other outstanding coverages, such provision shall be called to the attention of the prospective purchaser by conspicuously printed type no smaller than 10 point type. When such policies are advertised to provide coverage above Medicare payments, but contain provisions limiting benefits to those approved for payment by Medicare under Part B, such limitation in benefits shall be called to the attention of the prospective purchaser regardless of the advertising medium; and when policies containing such provisions are delivered, there shall be incorporated therein the language or affixed thereto a sticker in conspicuously printed type no smaller than 10 point type stating: CAUTION: POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT. Any person engaged in the solicitation or sale of such supplemental Medicare policies in this State shall, as a part of the application, determine and list on the application all policies of Medicare supplement or other health insurance currently in force that cover the prospective insured. In compiling such information, the person is entitled to rely upon information furnished by the prospective purchaser or insured.

(10) Soliciting, etc., Unauthorized Insurance Contracts in Other States. – Soliciting, advertising or entering into insurance contracts in foreign states and any other jurisdiction in which such domestic insurer is not licensed in accordance with the laws of such state or jurisdiction, except as provided in G.S. 58-14-5.

(11) Unfair Claim Settlement Practices. – Committing or performing with such frequency as to indicate a general business practice of any of the following: Provided, however, that no violation of this subsection shall of itself create any cause of action in favor of any person other than the Commissioner:

a. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
b. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;
c. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
d. Refusing to pay claims without conducting a reasonable investigation based upon all available information;
e. Failing to affirm or deny coverage of claims within a reasonable time after proof-of-loss statements have been completed;
f. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

g. Compelling [the] insured 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 insured;
h. Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled;
i. Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured;
j. Making claims payments to insureds or beneficiaries not accompanied by [a] statement setting forth the coverage under which the payments are being made;
k. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;
l. Delaying the investigation or payment of claims by requiring an insured claimant, or the physician, of [or] either, to submit a preliminary claim report and then requiring the subsequent submission of formal proof-of-loss forms, both of which submissions contain substantially the same information;
m. Failing to promptly settle claims where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; and
n. Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(12) Misuse of Borrowers' Confidential Information. – Soliciting, accepting, or using any information from a lender concerning policies of insurance held by such lender as a mortgagee of real property, except from a lender who is an insurer where the loan has been made by or sold or held for sale to such insurer. Provided, however, this subdivision shall not apply to the use of such information by a lender for the solicitation of life or accident and health insurance.

(13) Overinsurance in Credit or Loan Transactions. – In connection with a loan or extension of credit secured by real or personal property or both, requiring the applicant to procure property and casualty insurance against any one risk which results in coverage which exceeds the replacement value of the secured property at the time of the loan or extension of credit. In connection with a secured or unsecured loan or extension of credit, requiring the applicant to procure life or health insurance against any one risk which exceeds the amount of the loan. In connection with a loan secured by both real and personal property, requiring credit property insurance, as defined in G.S. 58-57-90, on the personal property. For the purposes of this subsection "amount of loan" shall be deemed to be the amount of principal and accrued interest to be paid by the debtor including other allowable charges. (1949, c. 1112; 1955, c. 850, s. 3; 1967, c. 935, s. 2; 1975, c. 668; 1983, c. 831; 1985 (Reg. Sess., 1986), c. 1027, ss. 18, 20; 1987, c. 787, ss. 1, 3.)

§ 58-63-20. Power of Commissioner.

The Commissioner shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in this State in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by G.S. 58-63-10. (1949, c. 1112; 1991, c. 720, s. 62.)

§ 58-63-50. Penalty.

Any person who willfully violates a cease and desist order of the Commissioner under G.S. 58-63-32, after it has become final, and while the order is in effect, shall forfeit and pay to the Commissioner the sum of not less than one thousand dollars ($1,000) nor more than five thousand dollars ($5,000) for each violation, which if not paid shall be recovered in a civil action instituted in the name of the Commissioner in the Superior Court of Wake County. The clear proceeds of forfeitures provided for in this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2. (1949, c. 1112; 1985, c. 666, s. 21; 1991, c. 720, ss. 33, 63; 1995, c. 193, s. 51; 1998-215, s. 88.)

False Pretenses and Cheats

§ 14-100. Obtaining property by false pretenses.

(a) If any person shall knowingly and designedly by means of any kind of false pretense whatsoever, whether the false pretense is of a past or subsisting fact or of a future fulfillment or event, obtain or attempt to obtain from any person within this State any money, goods, property, services, chose in action, or other thing of value with intent to cheat or defraud any person of such money, goods, property, services, chose in action or other thing of value, such person shall be guilty of a felony: Provided, that if, on the trial of anyone indicted for such crime, it shall be proved that he obtained the property in such manner as to amount to larceny or embezzlement, the jury shall have submitted to them such other felony proved; and no person tried for such felony shall be liable to be afterwards prosecuted for larceny or embezzlement upon the same facts: Provided, further, that it shall be sufficient in any indictment for obtaining or attempting to obtain any such money, goods, property, services, chose in action, or other thing of value by false pretenses to allege that the party accused did the act with intent to defraud, without alleging an intent to defraud any particular person, and without alleging any ownership of the money, goods, property, services, chose in action or other thing of value; and upon the trial of any such indictment, it shall not be necessary to prove either an intent to defraud any particular person or that the person to whom the false pretense was made was the person defrauded, but it shall be sufficient to allege and prove that the party accused made the false pretense charged with an intent to defraud. If the value of the money, goods, property, services, chose in action, or other thing of value is one hundred thousand dollars ($100,000) or more, a violation of this section is a Class C felony. If the value of the money, goods, property, services, chose in action, or other thing of value is less than one hundred thousand dollars ($100,000), a violation of this section is a Class H felony.

(b) Evidence of nonfulfillment of a contract obligation standing alone shall not establish the essential element of intent to defraud.

(c) For purposes of this section, "person" means person, association, consortium, corporation, body politic, partnership, or other group, entity, or organization. (33 Hen. VIII, c. 1, ss. 1, 2; 30 Geo. II, c. 24, s. 1; 1811, c. 814, s. 2, P.R.; R.C., c. 34, s. 67; Code, s. 1025; Rev., s. 3432; C.S., s. 4277; 1975, c. 783; 1979, c. 760, s. 5; 1979, 2nd Sess., c. 1316, s. 47; 1981, c. 63, s. 1; c. 179, s. 14; 1997-443, s. 19.25(l).)

Continuing Education

SECTION .0800 - CONTINUING EDUCATION

11 NCAC 06A .0801 DEFINITIONS

As used in this Section:

(1) "Cluster of courses" means a number of courses, each of which is less than 100 minutes in length, but altogether 100 minutes or more in length, that are offered within one state or national program or convention.

(2) "Course" means a continuing education course directly related to insurance principles and practices or a course designed and approved specifically for licensees; but does not mean a business course of a general nature or an insurance marketing or sales course.

(3) "Disinterested third party" means a person not concerned, with respect to possible gain or loss, in the result of a pending course final examination.

(4) "Distance learning" means an educational program in which the licensee and the instructor are in different physical locations and interact with each other through various methods of telecommunication.

(5) "Insurance continuing education credit or "ICEC"" means a value assigned to a course by the Commissioner after review and approval of a course information. This term means the same as "credit hour" as used in G.S. 58-33-130.

(6) "Instructor" means an individual who teaches, lectures, leads, or otherwise instructs a course.

(7) "Licensee" means a duly licensed property and liability insurance or life and health insurance agent or broker who is required to comply with this Section.

(8) "Supervised examination" means a timed, closed book examination that is monitored by a disinterested third party and graded by a nationally recognized insurance education program.

(9) "Supervised individual study" means audio tapes, video tapes, computer programs, programmed learning courses, and similar types of learning experiences that are completed in the presence of an instructor.

11 NCAC 06A .0802 LICENSEE REQUIREMENTS

(a) Life and health licensees shall obtain 12 ICECs during each calendar year in approved life and health courses. Each person holding a life and health license shall complete a continuing education course on ethics within two years after January 1, 2008, and every two years thereafter. The course shall comprise three ICECs and shall be approved by the Commissioner.
(b) Property and liability licensees shall obtain 12 ICECs during each calendar year in approved property and liability courses. Each person holding a property and liability license shall complete a continuing education course on ethics within two years after January 1, 2008, and every two years thereafter. The course shall comprise three ICECs and shall be approved by the Commissioner.
(c) Any person holding more than one license to which this Section applies shall obtain 18 ICECs during each calendar year, including a minimum of six ICECs for each kind of license.
(d) An instructor shall receive the maximum ICECs awarded to a student for the course.
(e) Licensees shall not receive ICECs for the same course more often than one time in any three calendar year period.
(f) Licensees do not have to obtain ICECs for the calendar year in which they are initially licensed.
(g) Licensees shall receive ICECs for a course only for the calendar year in which the course is completed. Any course requiring an examination shall not be considered completed until the licensee passes the examination.
(h) Licensees shall maintain records of all ICECs for three years following the obtaining of such ICECs, which records shall be available for inspection upon the Commissioner's request.
(i) Nonresident licensees who meet continuing education requirements in their home states meet the continuing education requirements of this Section. Nonresident licensees whose home states have no continuing education requirements shall meet the requirements of this Section.
(j) Licensees are exempt from the requirements of this Section if they:
    (1) are age 65 or older; and
    (2) have been continuously licensed in the line of insurance for at least 25 years; and
        (A) either hold a nationally recognized professional designation for the line of insurance. Acceptable designations include those listed in 11 NCAC 6A .0803(a) and (b); or
        (B) certify to the Department annually they are inactive agents who neither solicit applications for insurance nor take part in the day to day operation of an agency.
(k) Any licensee holding more than one license to which this Section applies and qualifies for exemption under Paragraph (j) of this Rule for one license type shall obtain a minimum of six ICECs in each calendar year for the license type not exempted.
(l) Courses completed before the issue date of a new license do not meet the requirements of this Section for that new license.
(m) No credit shall be given for courses taken before they have been approved by the Department.
(n) Persons who hold adjuster licenses shall obtain 12 ICECs during each calendar year in approved property and liability courses. As used in this Section, "licensee" includes a person who holds an adjuster license and who is required to comply with this Section.
(o) Each person holding a property and liability, personal lines, or adjuster license shall complete a continuing education course on flood insurance and the National Flood Insurance Program within two years after January 1, 2008, and every four years thereafter. The course shall comprise three ICECs and shall be approved by the Commissioner.

11 NCAC 06A .0803 COURSES SPECIFICALLY APPROVED

(a) Courses that are necessary to obtain the following nationally recognized designations are approved for 18 ICECs upon successful completion of the national examination for each part:
    (1) Accredited Advisor in Insurance (AAI);
    (2) Associate in Claims (AIC);
    (3) Associate in Loss Control Management (ALCM);
    (4) Associate in Risk Management (ARM);
    (5) Associate in Underwriting (AU);
    (6) Certified Employees Benefit Specialist (CEBS);

(7) Chartered Financial Consultant (ChFC);
(8) Chartered Life Underwriter (CLU);
(9) Chartered Property and Casualty Underwriter (CPCU);
(10) Fellow Life Management Institute (FLMI);
(11) General Insurance (INS);
(12) Life Underwriter Training Council Fellow, 26 week (LUTCF);
(13) Certified Financial Planner (CFP).

(b) Courses that are necessary to obtain the following nationally recognized designations are approved for an amount of ICECs to be determined by the Commissioner under this Section.
(1) Agency Management Training Course Graduate;
(2) Certified Insurance Counselor (CIC);
(3) Certified Insurance Service Representative (CISR);
(4) Certified Professional Service Representative (CPSR);
(5) Fraternal Insurance Counselor (FIC);
(6) Health Insurance Associate (HIA);
(7) Life Underwriter Training Council Fellow, 13 weeks (LUTCF);
(8) Registered Health Underwriter (RHU).

(c) Courses that are taught by a college or university that is accredited by the Southern Association of Colleges and Schools or by an accreditation agency recognized by the U.S. Department of Education are approved for a number of ICECs to be determined by the Commissioner under this Section.

(d) Any course prepared by the Commissioner is approved as a component of each resident licensee's continuing education requirement for a number of ICECs to be determined by the Commissioner under this Section.

11 NCAC 06A .0804 CARRYOVER CREDIT

(a) No more than 75 percent of the ICECs required shall be carried forward from the previous year. Licensees holding one license shall carry over no more than nine ICECs. Licensees holding more than one license shall carry over no more than six ICECs for any one license.

(b) Only whole ICECs may be carried over.

11 NCAC 06A .0805 CALCULATION OF ICECS

The following standards shall be used to evaluate courses submitted for continuing education approval:

(1) Programs requiring meeting or classroom attendance:
(a) Courses or clusters of courses of less than 50 minutes shall not be evaluated for continuing education ICECs.
(b) Courses shall not be approved for less than one ICEC.
(c) One ICEC shall be awarded for each 50 minutes of instruction unless the Commissioner assigns fewer ICECs based upon the evaluation of the submitted course materials. Courses shall only be approved for whole ICECs.
(d) Course providers shall monitor participants for attendance and attention.

(2) Independent study programs:
(a) Independent study programs qualify for continuing education only when there is a supervised examination. No examination administered or graded by insurance company personnel for its own employees shall be considered to be administered by a disinterested third party.
(b) Each course shall be assigned ICECs, which shall be awarded upon the passing of the supervised examination.

(3) Distance Learning Programs:
(a) Distance learning qualifies only when an instructor is available to respond to questions and to maintain attendance records.
(b) Any organization sponsoring a teleconference shall have an on-site instructor.

11 NCAC 06A .0806 ATTENDANCE

(a) If six or fewer ICECs are assigned to a course, the licensee shall attend 100 percent of the course to receive any ICECs.

(b) If more than six ICECs are assigned to a course, and the licensee passes the exam and attends at least 80 percent of the course, the licensee shall receive 100 percent of the ICECs assigned to the course.

(c) If more than six ICECs are assigned to a course, and the licensee does not pass the exam but attends at least 80 percent of the course, the licensee shall receive 80 percent of the ICECs assigned to the course.
(d) An instructor may conduct a class with up to 30 students with no additional assistance. For classes with attendance exceeding 30 students, one assistant to the instructor is required for each additional 50 students or any portion thereof. Each assistant shall be physically present in the classroom during the instructor's presentation.

11 NCAC 06A .0807 HARDSHIP

Licensees shall make appeals for extensions of time under G.S. 58-33-130(c) on or before January 30 of the year immediately following the calendar year in which the required ICECs were not obtained.

11 NCAC 06A .0808 INSTRUCTOR QUALIFICATION

(a) Instructor qualification requirements shall be the same as those for instructors as provided in 11 NCAC 6A .0705(c), except that the Commissioner may approve instructors possessing specific areas of expertise to instruct courses comprising those areas of expertise.
(b) Insurance company trainers as instructors must be full time salaried employees of the insurance company sponsoring the course and must have as part of their full time responsibilities the duty to provider insurance company training.
(c) College and university instructors may be full time or adjunct faculty of the accredited college or university, must be teaching a curriculum course in his or her field of expertise, and must meet the requirements of the association that accredits the college or university.
(d) The Commissioner shall require applicants and current instructors to submit to a personal interview, provide a video or audio tape, a written history of courses taught or any other documentation that will verify the applicant=s qualifications to instruct approved insurance courses.
(e) Temporary instructor authority shall be given to each qualified applicant. The instructor authority shall become permanent after six months unless otherwise denied, suspended, terminated or revoked by the Commissioner.
(f) As a condition to continued instructor approval, instructors shall teach one prelicensing or continuing education course each calendar year beginning in 1996.

11 NCAC 06A .0809 APPROVAL OF COURSES

(a) Providers of all courses specifically approved under 11 NCAC 6A .0803 must file copies of program catalogs, course outlines, copies of advertising literature, a nonrefundable, nontransferable filing fee of one hundred dollars ($100.00) per course up to a two thousand five hundred dollar ($2,500) per calendar year maximum, and any other documents or related materials that the Commissioner requests, prior to January 1, 1991, and within 30 days of any changes to such programs in the future.
(b) All providers of courses not specifically approved under 11 NCAC 6A .0803 must do the following:
  (1) Any individual, school, insurance company, insurance industry association, or other organization intending to provide classes, seminars, or other forms of instruction as approved courses shall apply on forms provided by the Commissioner; pay a nonrefundable, nontransferable filing fee of one hundred dollars ($100.00) per course up to a two thousand five hundred dollar ($2,500) per calendar year maximum and provide the requested number of copies of detailed outlines of the subject matter to be covered, copies of handouts to be given, the qualifications of each instructor, and other information requested by the Commissioner to support the request for approval.
  (2) Providers of supervised individual study programs must file the requested number of copies of the study programs. Extra copies will be returned to a provider after course approval if a return fee is paid in advance.
  (3) Such applications and accompanying information must be received by the Commissioner at least 30 days prior to the intended beginning date of the course.
  (4) The Commissioner shall approve or deny the application; and shall indicate the number of ICECs that have been assigned to the course if approved. If a course is not approved or disapproved within 60 days after receipt of all required information, the course is deemed to be approved at the end of the 60-day period.
  (5) If a course approval application is denied, a written explanation of the reason for such action shall be furnished with the denial.

(c) Course approval applications must include all of the following forms and attached information in exactly the following order:
  (1) A cover letter with payment of the nonrefundable, nontransferable filing fee of one hundred dollars ($100.00) per course attached with separate paragraphs for the following:
    (A) a request that the course be evaluated;
    (B) for whom the course is designed;
    (C) the course objectives;
    (D) the names and duties of all persons who will be affiliated in an official capacity with the course;
    (E) the course provider's tuition and fee refund policy; and
    (F) an outline that shall include a statement of the method used to determine whether there will be meaningful attainments of education by licensees to be certified upon their satisfactory completion of the course. Such method may be a written examination, a written report, certification of attendance only, or other methods approved by the Commissioner. The outline shall describe the method of presentation;
  (2) The course content outline with instruction hours assigned to the major topics;
  (3) Instructor approval application and instructor qualification documentation or resume ;
  (4) Schedule of dates, beginning and ending times and places the course will be offered, along with the names of instructors for each course session. Schedules shall be submitted at least 30 days in advance of any subsequent course offerings but it will not be necessary that courses be resubmitted unless there are substantial changes in content;
  (5) A copy of the course completion certificate ;
  (6) A course rating form;
  (7) A course bibliography.

(d) The Commissioner may waive any part of this Section for programs offered by the University of North Carolina system schools or the North Carolina Department of Community Colleges.

(e) A provider may request that its materials be kept confidential if they are of a proprietary nature. The Commissioner will review and promptly return such extra copies of materials if a return fee is paid in advance.

(f) Courses awarded more than six ICECs must have an Insurance Department approved exam for the student to get full credit; otherwise, the limitations of 11 NCAC 6A .0806(c) will apply.

(g) Cancelled course schedules must be submitted five days before the scheduled course offering. All students scheduled to attend the cancelled course must be informed of the cancellation.

(h) Course rosters shall be submitted within 15 business days after course completion in accordance with 11 NCAC 6A .0803(d).

11 NCAC 06A .0810 ADVERTISING

(a) Courses shall not be advertised as approved for ICECs unless such approval has been granted by the Commissioner in writing.

(b) When a course has been approved for ICECs and is advertised as such, the advertisement shall include:
  (1) the provider name, assigned provider number, course(s) title(s), assigned course number course(s) date(s) and course location;
  (2) the number of approved ICECs;
  (3) the type of licensee for whom the course would be most applicable;
  (4) all fees and associated expenses; and
  (5) course rating.

(c) Advertisements shall be complete, truthful, clear, and not deceptive or misleading.

(d) The Commissioner may withdraw his approval of any violator to provide or conduct courses.

11 NCAC 06A .0811 SANCTIONS FOR NONCOMPLIANCE

(a) This Rule establishes sanctions for licensees who fail to complete their annual continuing education requirements and for licensees, course providers, course provider personnel, course presenters, course presenter personnel, and course instructors who falsify any records or documents in connection with the continuing education program or who do not comply with G.S. 58-33-130, G.S. 58-33-132, or this Section.

(b) If the license of any person lapses under G.S. 58-33-130(c), the Commissioner shall reinstate the license when the person has completed the continuing education requirements. If the person does

not satisfy the requirements for licensure reinstatement by July 1 of that year, the person shall complete the appropriate prelicensing education requirement and pass the appropriate licensing examination, at which time the Commissioner shall reinstate the person's license.

(c) The Commissioner may suspend, revoke, or refuse to renew a license for any of the following causes:
  (1) Failing to respond to Department inquiries, including continuing education audit requests, within seven calendar days after the receipt of the inquiry or request.
  (2) Requesting an extension or waiver under false pretenses.
  (3) Refusing to cooperate with Department employees in an investigation or inquiry.

(d) The Commissioner may suspend, revoke, or refuse to renew a course provider's, presenter's or instructor's authority to offer courses for any of the following causes:
  (1) Advertising that a course is approved before the Commissioner has granted such approval in writing.
  (2) Submitting a course outline with material inaccuracies, either in length, presentation time, or topic content.
  (3) Presenting or using unapproved material in providing an approved course.
  (4) Failing to conduct a course for the full time specified in the approval request submitted to the Commissioner.
  (5) Preparing and distributing certificates of attendance or completion before the course has been approved.
  (6) Issuing certificates of attendance or completion before the completion of the course.
  (7) Failing to issue certificates of attendance or completion to any licensee who satisfactorily completes a course.
  (8) Failing to notify the Commissioner in writing of suspected or known violations of the North Carolina General Statutes or Administrative Code within 30 days after suspecting or knowing about the violations.
  (9) Violating the North Carolina General Statutes or Administrative Code.
  (10) Failing to monitor attendance and attention of attendees.

(e) Course providers and presenters are responsible for the activities of persons conducting, supervising, instructing, proctoring, monitoring, moderating, facilitating, or in any way responsible for the conduct of any of the activities associated with the course.

(f) The Commissioner may require any one of the following upon a finding of a violation of this Section:
  (1) Refunding all course tuition and fees to licensees.
  (2) Providing licensees with a course to replace the course that was found in violation.
  (3) Withdrawal of approval of courses offered by the provider, presenter, or instructor.

(g) Each nonresident licensee shall certify to the Commissioner that the licensee has complied with the continuing education requirements in the licensee's home state and paid a recertification fee by March 1 of each year. If the license lapses under G.S. 58-33-125(c) and an extension of time is not sought, the Commissioner shall reinstate the license when the licensee has completed the home state continuing education requirements and paid a recertification fee.

11 NCAC 06A .0812 SPECIAL CASES

(a) In addition to the courses in 11 NCAC 6A .0803, the Commissioner shall prepare courses to address and remedy deficiencies in licensee professional performance or conduct detected by the Commissioner through analyses of consumer complaints or from Departmental audits or examinations of insurance companies, licensees, or insurance agencies or brokerages.

(b) The Commissioner shall require individual licensees to take remedial or rehabilitative courses because of complaints or examination or audit findings:
  (1) showing a pattern of irregularities in professional performance or conduct; or
  (2) resulting in the finding of civil violations.

11 NCAC 06A .0813 ISSUANCE/CONTINUATION OF PROVIDER APPROVAL

(a) Any individual or entity intending to provide classes, seminars, or other forms of instruction as approved courses shall submit:
  (1) an application as approved by the Commissioner for provider approval; and
  (2) a course approval application in accordance with 11 NCAC 6A .0809.

(b) The Commissioner shall approve or deny the provider and course approval application.

(c) Any provider approval that is denied shall be furnished a written explanation for the denial in accordance with 11 NCAC 6A .0809(4).

(d) Any provider receiving a provider approval denial shall have 15 business days to respond to the denial; previously submitted materials will be destroyed; and the one hundred dollar ($100.00) nonrefundable, nontransferable course filing fee shall be forfeited if the applicant fails to respond within the required timeframe.
(e) As a condition to continued provider approval, providers shall conduct a minimum of one course within the State of North Carolina each calendar year.

General Regulations of Business

Part 1. General Provisions.

§ 58-58-1. Definitions; requisites of contract.
All corporations or associations doing business in this State, under any charter or statute of this or any other state, involving the payment of money or other thing of value to families or representatives of policy and certificate holders or members, conditioned upon the continuance or cessation of human life, or involving an insurance, guaranty, contract, or pledge for the payment of endowments or annuities, or who employ agents to solicit such business, are life insurance companies, in all respects subject to the laws herein made and provided for the government of life insurance companies, and shall not make any such insurance, guaranty, contract, or pledge in this State with any citizen, or resident thereof, which does not distinctly state the amount of benefits payable, the manner of payment, the consideration therefor and such other provisions as the Commissioner may require. (1899, c. 54, s. 55; Rev., s. 4773; C.S., s. 6455; 1945, c. 379.)

58-58-5. Industrial life insurance defined.
Industrial life insurance is hereby declared to be that form of life insurance under which the premiums are payable monthly or oftener, provided the face amount of insurance stated in the policy does not exceed one thousand dollars ($1,000) and the words "Industrial Policy" are printed upon the policy as a part of the descriptive matter. (1945, c. 379; 1947, c. 721.)

§ 58-58-10. Credit life insurance defined.
Credit life insurance is declared to be insurance upon the life of a debtor who may be indebted to any person, firm, or corporation extending credit to said debtor. Credit life insurance may include the granting of additional benefits in the event of total and permanent disability of the debtor. (1953, c. 1096, s. 1.)

§ 58-58-15. Any type of survivorship fund in life insurance contract prohibited.
No life insurance company shall hereafter deliver in this State, as a part of or in combination with any insurance, endowment or annuity contract, any agreement or plan, additional to the rights, dividends, and benefits arising out of any such insurance, endowment or annuity contract, which provides for the accumulation of profits over a period of years and for payment of all or any part of such accumulated profits only to members or policyholders of a designated group or class who continue as members or policyholders until the end of a specified period of years. Nor shall any such company deliver in this State any individual life insurance policy which provides that on the death of anyone not specifically named therein, the owner or beneficiary of the policy shall receive the payment or granting of anything of value. (1955, c. 492.)

§ 58-58-20. Tie-in sales with life insurance prohibited.
No life insurance company shall hereafter deliver in this State, as a part of or in combination with any insurance, endowment or annuity contract, any agreement or plan, additional to the rights, dividends, and benefits arising out of any such insurance, endowment, or annuity contract which provides for the sale, solicitation, or delivery of any stock or shares of stock in the company issuing the policy or in any other insurance company or other corporation, or benefit certificate, securities, or any special advisory board contract, or other contracts or resolutions of any kind promising returns and profits, or dividends equivalent to stock dividends as an inducement to or in connection with the sale of the insurance or to the taking of the policy. Nothing herein contained shall be construed as prohibiting any participating insurer from distributing to its policyholders dividends, savings or the unused or unabsorbed portion of premiums and premium deposits. (1957, c. 752.)

§ 58-58-22. Individual policy standard provisions.
No policy of individual life insurance shall be delivered in this State unless it contains in substance the following provisions, or provisions that in the Commissioner's opinion are more favorable to the person insured:

(1) Grace period. – A provision that the insured is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force. The policy may provide that if a claim arises under the policy during the grace period, the amount of any premium due or overdue may be deducted from any amount payable under the policy in settlement.

(2) Incontestability. – A provision that the validity of the policy shall not be contested, except for nonpayment of premium, once it has been in force for two years after its date of issue; and that no statement made by any person insured under the policy about that person's insurability shall be used during the person's lifetime to contest the validity of the policy after the insurance has been in force for two years.

(3) Misstatement of age or gender. – A provision specifying an equitable adjustment of premiums or benefits, or both, to be made if the age or gender of the person insured has been misstated; the provision to contain a clear statement of the method of adjustment to be used.

(4) Suicide. – A provision that may not limit payment of benefits for a period more than two years after the date of issue of the policy because of suicide and that provides for at least the return of premiums paid on the policy if there is suicide during the two-year period.

(5) Reinstatement. – A provision that, unless the policy has been surrendered for its cash surrender value, or its cash surrender value has been exhausted, the policy will be reinstated at any time within five years after the date of premium default upon written application therefor, the production of evidence of insurability satisfactory to the insurer, the payment of all overdue premiums, and the payment of reinstatement of any other indebtedness to the insurer upon the policy, all with interest at the rate specified. (1995, c. 517, s. 31(a).)

§ 58-58-25. Policies to be issued to any person possessing the sickle cell trait or hemoglobin C trait.
No insurance company licensed in this State pursuant to the provisions of Articles 1 through 64 of this Chapter shall refuse to issue or deliver any policy of life insurance authorized thereunder solely by reason of the fact that the person to be insured possesses sickle cell trait or hemoglobin C trait; nor shall any such policy issued and delivered in this State carry a higher premium rate or charge by reason of the fact that the person to be insured possesses said traits. The term "sickle cell trait" is defined as the condition wherein the major natural hemoglobin components present in the blood of the individual are hemoglobin A (normal) and hemoglobin S (sickle hemoglobin) as defined by standard chemical and physical analytic techniques, including electrophoresis, and the proportion of hemoglobin A is greater than the proportion of hemoglobin S or one natural parent of the individual is shown to have only normal hemoglobin components (hemoglobin A, hemoglobin A2, hemoglobin F) in the normal proportions by standard chemical and physical analytic tests. The term "hemoglobin C trait" is defined as the condition wherein the major natural hemoglobin components present in the blood of the individual are hemoglobin A (normal) and hemoglobin C as defined by standard chemical and physical analytic techniques, including electrophoresis, and the proportion of hemoglobin A is greater than the proportion of hemoglobin C or one natural parent of the individual is shown to have only normal hemoglobin components (hemoglobin A, hemoglobin A2, hemoglobin F) in the normal proportions by standard chemical and physical analytic tests. (1975, c. 600, s. 1.)

§ 58-58-30. Soliciting agent represents the company.
A person who solicits an application for insurance upon the life of another, in any controversy relating thereto between the insured or his beneficiary and the company issuing a policy upon such application, is the agent of the company and not of the insured. (1907, c. 958, s. 1; C.S., s. 6457.)

§ 58-58-35. Discrimination between insurants forbidden.
A life insurance company doing business in this State shall not make any distinction or discrimination in favor of individuals between insurants of the same class and equal expectation of life in the amount of payment of premiums or rates charged for policies of life or endowment insurance, or in the dividends or other benefits payable thereon, or in any of the terms and conditions of the contracts it makes; nor shall any such company or any agent thereof make any contract of insurance or agreement as to such contract other than as plainly expressed in the policy issued thereon, nor pay or allow as inducement to insurance any rebate of premium payable on the policy, or any special favor or advantage in the dividends or other benefit to accrue thereon, or any valuable consideration or inducement whatever not specified in the policy contract of insurance; nor give, sell, or purchase, or offer to give, sell, or purchase as inducement to insurance or in connection therewith any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits to accrue therein, or anything of value whatsoever not

specified in the policy. (1899, c. 54, s. 57; 1903, c. 438, ss. 5, 10; Rev., s. 4775; 1911, c. 196, s. 7; C.S., s. 6458.)

§ 58-58-40. Misrepresentations of policy forbidden.
No life insurance company doing business in this State, and no officer, director, solicitor, or other agent thereof, shall make, issue, or circulate, or cause to be made, issued, or circulated any estimate, illustration, circular, or statement of any sort misrepresenting the terms of the policy issued by it or the dividends or share of 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 any such company, agent, or broker make any misrepresentation to any person insured in said company or in any other insurer or governmental agency for the purpose of inducing or tending to induce such person to lapse, forfeit, or surrender his said insurance. (1913, c. 95; C.S., s. 6459; 1947, c. 721.)

Part 3. Insurable Interests and Other Rights.

§ 58-58-70. Insurable interest as between stockholders, partners, etc.
Where two or more persons have heretofore contracted or hereafter contract with one another for the purchase, at the death of one, by the survivor or survivors, of the stock, share or interest of the deceased in any corporation, partnership or business association of any kind, the person or persons making the contract of purchase shall be deemed to have, and are hereby declared to have, an insurable interest in the life or lives of the person or persons contracting to sell. (1941, c. 201; 1969, c. 751, s. 44.)

§ 58-58-75. Insurable interest in life and physical ability of employee or agent.
(a) An employer, whether a partnership, joint venture, business trust, mutual association, corporation, any other form of business organization, or one or more individuals, or any religious, educational, or charitable corporation, institution or body, has an insurable interest in and the right to insure the physical ability or the life, or both the physical ability and the life, of an employee for the benefit of such employer. Any principal shall have a life insurable interest in and the right to insure the physical ability or the life, or both the physical ability and the life, of an agent for the benefit of such principal.
(b) An employee described in subsection (a) of this section shall be insured for the benefit of an employer described in subsection (a) of this section only if the employee receives written notification from the insurer of the existence of the coverage or that coverage will be purchased. The notice shall be provided to the employee in connection with the application for coverage or within 30 days after the effective date of the coverage and shall include a statement that the employer may maintain the life insurance coverage on the employee even after employment is terminated.
(c) For nonkey or nonmanagerial employees, the aggregate amount of coverage shall be reasonably related to the benefits provided to the employees in the aggregate.
(d) With respect to employer-provided pension and welfare plans, the life insurance coverage purchased to finance the plans may only cover the lives of those employees and retirees who, at the time their lives were first insured under the plan, either are participants, or would be eligible to participate, upon the satisfaction of age, service, or similar eligibility criteria in the plan. (1951, c. 283, s. 1; 1957, c. 1086; 2005-234, s. 2.)

§ 58-58-80. Insurable interest in life and physical ability of partner.
Any partner has an insurable interest in and the right to insure the physical ability or the life, or both the physical ability and the life, of any other partner or partners who are members of the same partnership for his benefit, either alone or jointly with another partner or partners of the same partnership. A partnership has a like insurable interest in and the right to insure the physical ability or the life, or both the physical ability and the life, of one or more partners of the partnership. (1951, c. 283, s. 2.)

§ 58-58-85. Insurable interest in life of person covered by pension plan.
A trustee under a written document providing for a pension plan for payments of money or delivery of other benefits to be made to persons eligible to receive them under the terms and provisions of such written document shall be deemed to have and is hereby declared to have an insurable interest in the lives of any person or persons covered by the pension plan, to the extent that contracts or policies of insurance are in conformity with and in furtherance of the purposes of the pension plan. (1951, c. 283, s. 2 1/2.)

§ 58-58-95. Rights of beneficiaries.

When a policy of insurance is effected by any person on his own life, or on another life in favor of some person other than himself having an insurable interest therein, the lawful beneficiary thereof, other than himself or his legal representatives, is entitled to its proceeds against the creditors and representatives of the person effecting the insurance. The person to whom a policy of life insurance is made payable may maintain an action thereon in his own name. A person may insure his or her own life for the sole use and benefit of his or her spouse, or children, or both, and upon his or her death the proceeds from the insurance shall be paid to or for the benefit of the spouse, or children, or both, or to a guardian, free from all claims of the representatives or creditors of the insured or his or her estate. Any insurance policy which insures the life of a person for the sole use and benefit of that person's spouse, or children, or both, shall not be subject to the claims of creditors of the insured during his or her lifetime, whether or not the policy reserves to the insured during his or her lifetime any or all rights provided for by the policy and whether or not the policy proceeds are payable to the estate of the insured in the event the beneficiary or beneficiaries predecease the insured. (Const., Art. X, s. 7; 1899, c. 54, s. 59; Rev., ss. 4771, 4772; C.S., s. 6464; 1977, c. 518, s. 1.)

§ 58-58-100. Minors may enter into insurance or annuity contracts and have full rights, powers and privileges thereunder.

All minors in North Carolina of the age of 15 years and upwards shall have full power and authority to make contracts of insurance or annuity with any life insurance company authorized to do business in the State of North Carolina, either domestic or foreign, and to exercise all the powers, rights, and privileges of ownership conferred upon them under the terms of any and all such contracts applied for by and issued to them, and with full power to surrender, assign, modify, pledge, or change such contracts, and to receive any dividends thereon and generally to have the full power and authority in the premises that persons 18 years and upwards could and would have relative to any and all such contracts. (1945, c. 379; 1947, c. 721; 1971, c. 1231, s. 1.)

58-58-110. Interest payments on death benefits.

(a) Each insurer admitted to transact insurance in this State which, without the written consent of the beneficiary, fails or refuses to pay the death proceeds or death benefits in accordance with the terms of any policy providing a death benefit issued by it in this State within 30 days after receipt of satisfactory proof of loss because of the death, whether accidental or otherwise, of the insured shall pay interest, at a rate not less than the then current rate of interest on death proceeds left on deposit with the insurer computed from the date of the insured's death, on any moneys payable and unpaid after the expiration of the 30-day period. As used in this subsection, the phrase "satisfactory proof of loss because of the death" includes, but is not limited to, a certified copy of the death certificate; or a written statement by the attending physician at the time of death that contains the following information: (i) the name and address of the physician, who must be duly licensed to practice medicine in the United States; (ii) the name of the deceased; (iii) the date, time, and place of the death; and (iv) the immediate cause of the death.

(b) Within the meaning of this section, payment of proceeds or benefits shall be deemed to have been made on the date upon which a check, draft or other valid instrument equivalent to the payment of money was placed in the United States mails in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery of such instrument to the beneficiary.

(c) This section does not allow an insurer to withhold payment of money payable under any policy providing a death benefit to any beneficiary for a period longer than reasonably necessary to determine whether benefits are payable and to transmit the payment.

(d) This section shall not apply to policies of insurance issued prior to the effective date of this section to the extent that such policies contain specific provisions in conflict with this section. (1977, c. 395, s. 1; 1983, c. 749; 1985, c. 666, s. 45; 1991, c. 644, s. 8; 1995, c. 193, s. 46.)

§ 58-58-115. Creditors deprived of benefits of life insurance policies except in cases of fraud.

If a policy of insurance is effected by any person on his own life or on another life in favor of a person other than himself, or, except in cases of transfer with intent to defraud creditors, if a policy of life insurance is assigned or in any way made payable to any such person, the lawful beneficiary or assignee thereof, other than the insured or the person so effecting such insurance or the executor or administrator of such insured or of the person effecting such insurance, shall be entitled to its proceeds and avails against creditors and representatives of the insured and of the person effecting same, whether or not the right to change the beneficiary is reserved or permitted, and whether or not the policy is made payable to the person whose life is insured if the beneficiary or assignee shall predecease such person: Provided, that subject to the statute of limitations, the amount of any premiums for said insurance paid with the intent to defraud creditors, with

interest thereon, shall inure to their benefit from the proceeds of the policy; but the company issuing the policy shall be discharged of all liability thereon by payment of its proceeds in accordance with its terms unless, before such payment, the company shall have written notice by or in behalf of the creditor, of a claim to recover for transfer made or premiums paid with intent to defraud creditors, with specifications of the amount claimed. (1931, c. 179, s. 1; 1947, c. 721.)

§ 58-58-120. Notice of nonpayment of premium required before forfeiture.

No life insurance corporation doing business in this State shall, within one year after the default in payment of any premium, installment, or interest, declare forfeited or lapsed any policy hereafter issued or renewed, except policies on which premiums are payable monthly or at shorter intervals and except group insurance contracts and term insurance contracts for one year or less, nor shall any such policy be forfeited or lapsed by reason of nonpayment, when due, of any premium, interest, or installment or any portion thereof required by the terms of the policy to be paid, within one year from the failure to pay such premium, interest, or installment, unless a written or printed notice stating the amount of such premium, interest, installment, or portion thereof due on such policy, the place where it shall be paid, and the person to whom the same is payable has been duly addressed and mailed, postage paid, to the person whose life is insured, or to the assignee or owner of the policy, or to the person designated in writing by such insured, assignee or owner, if notice of the assignment has been given to the corporation, at his or her last known post-office address in this State, by the corporation or by any officer thereof or person appointed by it to collect such premium, at least 15 and not more than 45 days prior to the day when the same is payable, as regards policies which do not contain a provision for grace or are not entitled to grace in the payment of premiums and at least five and not more than 45 days prior to the day when the same is payable as regards policies which do contain a provision for grace or are entitled to grace in the payment of premiums. The notice shall also state that unless such premium, interest, installment, or portion thereof then due shall be paid to the corporation or to the duly appointed agent or person authorized to collect such premium, by or before the day it falls due, the policy and all payments thereon will become forfeited and void, except as to the right to a surrender value or paid-up policy, as in the contract provided. If the payment demanded by such notice shall be made within its time limit therefor, it shall be taken to be in full compliance with the requirements of the policy in respect to the time of such payment; and no such policy shall in any case be forfeited or declared forfeited or lapsed until the expiration of 30 days after the mailing of such notice. The affidavit of any officer, clerk, or agent of the corporation, or of anyone authorized to mail such notice, that the notice required by this section has been duly addressed and mailed by the corporation issuing such policy, shall be presumptive evidence that such notice has been duly given. No action shall be maintained to recover under a forfeited policy unless the same is instituted within three years from the day upon which default was made in paying the premium, installment, interest, or portion thereof for which it is claimed that forfeiture ensued. (1909, c. 884; C.S., s. 6465; 1929, c. 308, s. 1; 1931, c. 317; 1945, c. 379.)

§ 58-58-135. "Group life insurance" defined.

No policy of group life insurance shall be delivered in this State unless it conforms to one of the following descriptions:

(1) A policy issued to an employer, or to the trustee of a fund established by an employer, which employer or trustee shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer subject to the following requirements:

a. The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof determined by conditions pertaining to their employment. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietors or partnerships if the business of the employer and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership, contract, or otherwise. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include retired employees. The term "employer" as used herein may be deemed to include any county, municipality, or the proper officers, as such, of any unincorporated municipality or any department, division, agency, instrumentality or subdivision of a county, unincorporated municipality or municipality. In all cases where counties, municipalities or unincorporated municipalities or any officer, agent, division, subdivision or agency of the same have heretofore entered into contracts

and purchased group life insurance for their employees, such transactions, contracts and insurance and the purchase of the same is hereby approved, authorized and validated.

b. The premium for the policy shall be paid either wholly or partly from the employer's funds or funds contributed by him, or wholly or partly from funds contributed by the insured employees, or by both. A policy on which all or part of the premium is to be derived from funds contributed by the insured employees may be placed in force provided the group is structured on an actuarially sound basis. A policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

c. The policy must cover at least 10 employees at date of issue.

d. Repealed by Session Laws 1991 (Regular Session, 1992), c. 837, s. 6, effective July 2, 1992.

§ 58-58-170. Contestability after reinstatement.

A reinstated policy of life insurance or annuity contract may be contested on account of fraud or misrepresentation of facts material to the reinstatement only for the same period following reinstatement and with the same conditions and exceptions as the policy provides with respect to contestability after original issuance. The reinstatement application shall be deemed to be a part of the policy whether or not attached thereto. (1987, c. 752, s. 13.)

Regulation of Life Insurance Solicitation.

§ 58-60-1. Short title; purpose.

(a) This Part may be cited as the "Life Insurance Disclosure Act".

(b) The purpose of this Part is to require insurers to deliver to purchasers of life insurance, information which will improve the buyer's ability to select the most appropriate plan of life insurance for the buyer's needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration and to improve the ability of the buyer to evaluate the relative costs of similar plans of life insurance.

This Part does not prohibit an insurer from using additional material that is not in violation of Articles 1 through 64 of this Chapter nor any other statute or regulation. (1979, c. 447; 2005-234, s. 1.3.)

§ 58-60-15. Disclosure requirements.

(a) The insurer shall provide to all prospective purchasers a Buyer's Guide and a Policy Summary prior to accepting any applicant's initial premium deposit, unless the policy for which application is made contains an unconditional refund provision of at least 10 days or unless the Policy Summary contains such an unconditional refund offer, in which event the Buyer's Guide and Policy Summary must be delivered with the policy or prior to delivery of the policy.

(b) The insurer shall provide a Buyer's Guide and a Policy Summary to any prospective purchaser upon request.

(c) In the case of policies whose Equivalent Level Death Benefit does not exceed five thousand dollars ($5,000), the requirement for providing a Policy Summary will be satisfied by delivery of a written statement containing the information described in G.S. 58-60-10(7), subdivisions b, c, d, e1, e2, e3, f, g, j, and k. (1979, c. 447; 1993, c. 553, s. 21.)

§ 58-60-20. General rules relating to solicitation.

(a) Each insurer subject to this Part shall maintain at its home office or principal office a complete file containing one copy of each document authorized by the insurer for use pursuant to this Part. Such file shall contain one copy of each authorized form for a period of three years following the date of its last authorized use.

(b) An agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which he is representing to the buyer. In sales situations in which an agent is not involved, the insurer shall identify its full name.

(c) Terms such as financial planner, investment advisor, financial consultant, or financial counseling shall not be used in such a way as to imply that the insurance agent is generally engaged in an advisory business in which compensation is unrelated to sales unless such is actually the case.

(d) Any reference to policy dividends must include a statement that dividends are not guaranteed.

(e) A system or presentation which does not recognize the time value of money through the use of appropriate interest adjustments shall not be used for comparing the cost of two or more life insurance policies. Such a system may be used for the purpose of demonstrating the cash-flow pattern of a policy if such presentation is accompanied by a statement disclosing that the presentation does not recognize that, because of interest, a dollar in the future has less value than a dollar today.

(f) A presentation of benefits shall not display guaranteed and nonguaranteed benefits as a single sum unless they are shown separately in close proximity thereto.

(g) A statement regarding the use of the Life Insurance Cost Indexes shall include an explanation to the effect that the indexes are useful only for the comparison of the relative costs of two or more similar policies.

(h) A Life Insurance Cost Index which reflects dividends or an Equivalent Level Annual Dividend shall be accompanied by a statement that it is based on the insurer's current dividend scale and is not guaranteed.

(i) For the purposes of this Part, the annual premium for a basic policy or rider, for which the insurer reserves the right to change the premium, shall be the maximum annual premium. (1979, c. 447; 2005-234, ss. 1.7, 1.8

§ 58-60-30. Failure to comply.

The failure of an insurer to provide or deliver a Buyer's Guide, or a Policy Summary as provided in G.S. 58-60-15(a) and (b) shall constitute an omission which misrepresents the benefits, advantages, conditions or terms of an insurance policy within the meaning of G.S. 58-58-40 and Article 63 (Unfair Trade Practice Act) of this Chapter. (1979, c. 447.)

§ 58-60-35. Disclosure of prearrangement insurance policy provisions.

(a) As used in this section:

(1) "Prearrangement" means any contract, agreement, or mutual understanding, or any series or combination of contracts, agreements or mutual understandings, whether funded by trust deposits or prearrangement insurance policies, or any combination thereof, which has for a purpose the furnishing or performance of specific funeral services, or the furnishing or delivery of specific personal property, merchandise, or services of any nature in connection with the final disposition of a dead human body, to be furnished or delivered at a time determinable by the death of the person whose body is to be disposed of, but does not mean the furnishing of a cemetery lot, crypt, niche, mausoleum, grave marker or monument.

(2) "Prearrangement insurance policy" means a life insurance policy, annuity contract, or other insurance contract, or any series of contracts or agreements in any form or manner, issued on a group or individual basis by an insurance company authorized by law to do business in this State, which, whether by assignment or otherwise, has for its sole purpose the funding of a specific preneed funeral contract or a specific insurance-funded funeral or burial prearrangement, the insured being the person for whose service the funds were paid.

(b) The following information shall be adequately disclosed by the insurance agent or limited representative at the time an application is made, prior to accepting the applicant's initial premium, for a prearrangement insurance policy:

(1) The fact that a prearrangement insurance policy is involved or being used to fund a prearrangement;

(2) The nature of the relationship among the insurance agent or limited representative, the provider of the funeral or cemetery merchandise or services, the administrator, and any other person;

(3) The relationship of the prearrangement insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;

(4) The effect on the prearrangement of (i) any changes in the prearrangement insurance policy, including but not limited to, changes in the assignment, beneficiary designation, or use of the policy proceeds; (ii) any penalties to be incurred by the insured as a result of failure to make premium payments; and (iii) any penalties to be incurred or monies to be received as a result of cancellation or surrender of the prearrangement insurance policy;

(5) All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the policy proceeds and the amount actually needed to fund the prearrangement; and
(6) Any penalties or restrictions, including geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services, or the prearrangement guarantee. (1989, c. 738, s. 1; 1991, c. 644, s. 10; 1995, c. 517, s. 32.)

Replacement Regulations

SECTION .0600 - REPLACEMENT REGULATIONS

11 NCAC 12 .0601 PURPOSE AND SCOPE

The purpose of the rules in this Section are:

(1) To regulate the activities of insurers and producers with respect to the replacement of existing life insurance and annuities.
(2) To protect the interests of life insurance and annuity purchasers by establishing minimum standards of conduct to be observed in replacement or financed purchase transactions that will:
  (a) assure that purchasers receive information with which a decision can be made in their own best interest;
  (b) reduce the opportunity for misrepresentation and incomplete disclosures; and
  (c) establish penalties for failure to comply with requirements of the rules in this section.

11 NCAC 12 .0602 DEFINITION OF REPLACEMENT

When used in the rules in this Section, "replacement" means a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that by reason of the transaction, an existing policy or contract has been or is to be:

(1) lapsed, forfeited, surrendered, or partially surrendered, assigned to the replacing insurer or otherwise terminated;
(2) converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
(3) amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
(4) reissued with any reduction in cash value; or
(5) used in a financed purchase.

11 NCAC 12 .0603 OTHER DEFINITIONS

When used in the rules in this Section:

(1) "Direct-response solicitation" means a solicitation through a sponsoring or endorsing entity, or individually, solely through mails, telephone, the Internet or other mass communication media.
(2) "Existing insurer" means the insurance company whose policy or contract is or will be changed or affected in a manner described within the definition of "replacement" in 11 NCAC 12 .0602.
(3) "Existing policy or contract" means an individual life insurance policy (policy) or annuity contract (contract) in force, including a policy under a binding or conditional receipt or a policy or contract that is within an unconditional refund period.
(4) "Financed purchase" means the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from values of an existing policy to pay all or part of any premium due on the new policy. For purposes of a regulatory review of an individual transaction only, if a withdrawal, surrender or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same company within four months before or 13 months after the effective date of the new policy, it shall be deemed prima facie evidence of the policyholder's intent to finance the purchase of the new policy with existing policy values. This prima facie standard is not intended to increase or decrease the monitoring obligations contained in 11 NCAC 12 .0607(1)(e).
(5) "Illustration" means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years as defined in 11 NCAC 04 .0501(b)(8).
(6) "Policy summary" means:

(a) For policies or contracts other than universal life policies, a written statement regarding a policy or contract which contains, to the extent applicable, the following information:
  (i) current death benefit;
  (ii) annual contract premium;
  (iii) current cash surrender value;
  (iv) current dividend;
  (v) application of current dividend; and
  (vi) amount of outstanding loan.

(b) For universal life policies, a written statement that contains the following information:
  (i) the beginning and end date of the current report period;
  (ii) the policy value at the end of the previous report period and at the end of the current report period;
  (iii) the total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);
  (iv) the current death benefit at the end of the current report period on each life covered by the policy;
  (v) the net cash surrender value of the policy as of the end of the current report period; and
  (vi) the amount of outstanding loans, if any, as of the end of the current report period.

(7) "Producer" includes duly licensed agents and brokers as defined by G.S. 58-33-10(7).

(8) "Replacing insurer" means the insurance company that issues or proposes to issue a new policy or contract that replaces an existing policy or contract or is a financed purchase.

(9) "Registered contract" means a variable annuity contract or variable life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

(10) "Sales material" means a sales illustration and any other written, printed or electronically presented information created, or completed or provided by the company or producer and used in the presentation to the policy or contract owner related to the policy or contract purchased.

11 NCAC 12 .0604 EXEMPTIONS

(a) Unless the statutes state otherwise, this Section shall not apply to transactions involving:
  (1) Credit life insurance;
  (2) Group life insurance or group annuities where there is no direct solicitation of individuals by an insurance producer. Direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating or enrolling individuals or, when initiated by an individual member of the group, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual. Group life insurance or group annuity certificates marketed through direct response solicitation shall be subject to the provisions of 11 NCAC 12 .0608;
  (3) Group life insurance and annuities used to fund prearranged funeral contracts;
  (4) An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the Commissioner;
  (5) Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company;
  (6) Policies or contracts used to fund:
    (A) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);
    (B) A plan described by Sections 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;
    (C) A governmental or church plan defined in Section 414 of the Internal Revenue Code, a governmental or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the Internal Revenue Code; or
    (D) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(7) Where new coverage is provided under a life insurance policy or annuity contract and the cost is borne wholly by the insured's employer or by an association of which the insured is a member;
(8) Existing life insurance that is a non-convertible term life insurance policy that will expire in five years or less and cannot be renewed;
(9) Immediate annuities that are purchased with proceeds from an existing contract. Immediate annuities purchased with proceeds from an existing policy are not exempt from the rules in this Section; or
(10) Structured settlements.

(b) Notwithstanding 11 NCAC 12 .0604(a)(6), the rules in this Section shall apply to policies or contracts used to fund any plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after tax-basis, and where the insurer has been notified that plan participants may chose from among two or more insurers and there is a direct solicitation of an individual employee by an insurance producer for the purchase of a contract or policy. As used in this Paragraph, direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating individuals about the plan or arrangement or enrolling individuals in the plan or arrangement, or when initiated by an individual employee, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual employee.

(c) Registered contracts shall be exempt from the requirements of 11 NCAC 12 .0606(2) and 12 .0612(a)(2) with respect to the provision of illustrations or policy summaries; however, premium or contract contribution amounts and identification of the appropriate prospectus or offering circular shall be required instead.

11 NCAC 12 .0605 DUTIES OF PRODUCERS

(a) A producer who initiates an application shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the producer as to whether the applicant has existing policies or contracts. Electronic capture of signature is acceptable in accordance with The Uniform Electronic Transactions Act, G.S. 66, Article 40. If the answer is "no," the producer's duties with respect to replacement are complete.

(b) If the applicant answered "yes" to the question regarding existing coverage referred to in Paragraph (a) of this Rule, the producer shall present and read to the applicant, not later than at the time of taking the application, a notice regarding replacements in the format required by 11 NCAC 12 .0611. The notice shall be signed by both the applicant and the producer attesting that the notice has been read aloud by the producer or that the applicant did not wish the notice to be read aloud (in which case the producer need not have read the notice aloud) and left with the applicant. If the notice and any required signatures are captured electronically, the notice shall be delivered to the applicant within two business days of receipt by the home office of the insurer.

(c) The notice shall list all life insurance policies or annuities proposed to be replaced, identified by name of insurer, the insured or annuitant, and policy or contract number if available; and shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract. If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

(d) In connection with a replacement transaction, the producer shall leave with the applicant at the time an application for a new policy or contract is completed the original or a copy of all sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract owner in printed form no later than at the time of policy or contract delivery.

(e) Except as provided in 11 NCAC 12 .0612(c), in connection with a replacement transaction the producer shall submit to the insurer to which an application for a policy or contract is presented, a copy of each document required by this Section, a statement identifying any preprinted or electronically presented company approved sales materials used, and copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

11 NCAC 12 .0606 DUTIES OF THE EXISTING INSURER

Where a replacement is involved in the transaction, the existing insurer shall:

(1) Retain and be able to produce all replacement notifications received, indexed by replacing insurer, for at least five years or until the conclusion of the next regular examination conducted by the Insurance Department of its state of domicile, whichever is later.

(2) Send a letter to the policy or contract owner of the right to receive information regarding the existing policy or contract values including, if available, an in force illustration. If an in force illustration cannot be produced within five business days after receipt of a notice that an existing policy or contract is being replaced, the insurer shall provide a policy summary. The information shall be provided within five business days after receipt of the request from the policy or contract owner.

(3) Upon receipt of a request to borrow, surrender or withdraw any policy values, send a notice advising the policy owner that the release of policy values may affect the guaranteed elements, non-guaranteed elements, face amount or surrender value of the policy from which the values are released. The notice shall be sent separate from the check if the check is sent to anyone other than the policy owner. When consecutive automatic premium loans are made, the insurer is only required to send the notice at the time of the first loan.

11 NCAC 12 .0607 DUTIES OF INSURERS THAT USE AGENTS OR BROKERS (effective until August 1, 2004)

Each insurer that uses an agent or broker in a life insurance or annuity sale shall:

(1) Require with or as part of each completed applicant for life insurance or annuity, a statement signed by the agent or broker as to whether he or she knows replacement is or may be involved in the transaction.

(2) Where a replacement is involved:

(a) Require from the agent or broker with the application for life insurance or annuity:

(i) a list of all of the applicant's existing life insurance or annuity to be replaced; and

(ii) a copy of the Replacement Notice provided the applicant pursuant to 11 NCAC 12 .0605(b)(1).

Such existing life insurance or annuity shall be identified by name of insurer, insured and contract number. If a number has not been assigned by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

(b) Send to each existing insurer a written communication advising of the replacement or proposed replacement and the identification information obtained pursuant to 11 NCAC 12 .0607(2)(a) and a Policy Summary, Contract Summary or ledger statement containing Policy Data as required by G.S. 58-60-1 through G.S. 58-60-30 and for an annuity a contract summary as required in 11 NCAC 12 .0607(2)(c). Cost indices and equivalent level annual dividend figures need not be included in the Policy Summary or ledger statement. The aforementioned Policy Summary, Contract Summary or ledger statement shall be based upon the EXACT face amount, plan, premium and supplemental riders or agreements, if any, contained in the applicant's application to the replacing insurer. In the event that multiple applications are made by or for an applicant, Policy Summary, Contract Summary or ledger statement shall be provided for each. All required items shall be sent within five working days of the date the application is received in the replacing insurer's home or regional office, or the date the proposed policy or contract is issued, whichever is sooner.

(c) Where annuities are involved, the Contract Summary must be a separate document. All information required to be disclosed must be set out in such a manner as not to minimize or render any portion thereof obscure. Any amounts which remain level for two or more contract years may be represented by a single number if it is clearly indicated what amounts are applicable for each contract year. Amounts in items (2)(c)(i) and (iii) in this Rule, in the case of flexible premium annuity contracts, shall be determined either according to an anticipated pattern of consideration payments of on the assumption that considerations payable will be one hundred dollars ($100.00) a month or one thousand dollars ($1,000.00) a year. "Contract Summary" means a written statement describing the elements of the annuity contract and deposit fund, including but not limited to where applicable, the following items:

(i) One of the options under the contract available for annuity payout.

(ii) A prominent statement that the contract does not provide cash surrender values if such is the case.

(iii) The following amounts, where applicable, for the first ten contract years and representative contract years thereafter sufficient to clearly illustrate the patterns of considerations and benefits, including but not limited to, the twentieth contract year and at least one year from age 60 to 70 and at the scheduled commencement of annuity payments:

(A) The gross annual or single consideration for the annuity contract. Any additional considerations for optional benefits, such as disability premium waiver, should be shown separately.

(B) Scheduled annual or single deposit for the deposit fund, if any.

(C) The total guaranteed death benefit and cash surrender value at the end of the year or, if no guaranteed cash surrender values are provided, the total guaranteed paid-up annuity at the end of the year. Values for deposit fund must be shown separately from those for a basic contract.

(D) The total illustrative death benefit and cash surrender value or paid-up annuity at the end of the year, not greater in amount than that based on:

(I) the current dividend scale and the interest rate credited by the insurer, and

(II) current annuity purchase rates.

A dividend scale or excess interest rate which has been publicly declared by the insurer with an effective date not more than two months subsequent to the date of declaration shall be considered a current dividend scale or current excess interest rate.

(iv) A Contract Summary which includes values based on the current dividend scale or the current dividend accumulation or excess interest rate, and a statement that such values are for illustration and are not guaranteed.

(v) A statement of the interest rates used in calculating the guaranteed and illustrative contract or fund values.

(vi) The date on which the Contract Summary is prepared.

(d) Each existing insurer or such insurer's agent or broker that undertakes a conversion shall furnish the policy-owner with a Policy Summary for the existing life insurance or ledger statement containing Policy Data on the existing policy and/or annuity. Such Policy Summary or ledger statement shall be completed in accordance with the provisions of G.S. 58-60-1 through G.S. 58-60-30, except that information relating to premiums, cash values, death benefits and dividends, if any, shall be computed from the current policy year of the existing life insurance. The Policy Summary or ledger statement shall include the amount of any outstanding indebtedness, and the sum of any dividend accumulations or additions, and may include any other information that is not in violation of any regulation or statute. Cost indices and equivalent level annual dividend figures need not be included. When annuities are involved, the disclosure information shall be that required in Subparagraph (2)(c) in this Rule. The replacing insurer may request the existing insurer to furnish it with a copy of the Summaries or ledger statement, which shall be done within five working days of the receipt of the request.

(3) The replacing insurer shall maintain evidence of the "Notice Regarding Replacement", the Policy Summary, the Contract Summary and any ledger statements used, and a replacement register, listing the replacing agent and existing insurer to be replaced. The existing insurer shall maintain evidence of Policy Summaries, Contract Summaries or ledger statements used in any conversion. Evidence that all requirements were met shall be maintained for at least three years or until the conclusion of the next succeeding regular examination by the Insurance Department of its state of domicile, whichever is earlier.

(4) The replacing insurer shall provide in its policy or in a separate written notice which is delivered with the policy a statement that the applicant has a right to an unconditional refund of all premiums paid, which right may be exercised within a period of twenty days commencing from the date of delivery of the policy.

(5) Registered contracts shall be exempt from the requirements of 11 NCAC 12 .0607(2)(b),(c) and (d) requiring provision of Policy Summary or ledger statement information; however, premium or contract contribution amounts and identification of the appropriate prospectus or offering circular shall be required in lieu thereof.

General Regulations

§ 58-50-5. Application.

(a) On and after January 1, 1956, each individual or family accident, health, hospitalization policy, certificate or service plan of hospitalization and medical and/or dental service corporations shall be issued only on application in writing signed by the insured or the head of the household or guardian. Any application or enrollment form that is taken by a resident agent shall also contain the certificate of the agent that he has truly and accurately recorded on the application or enrollment form the information supplied by the insured. Every policy subject to the provisions of this section shall contain as a part of such policy the original or a reproduction of the application required by this section. This section shall not apply to travel or dread disease policies or to policies issued pursuant to a group insurance conversion privilege. 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 15 days after the receipt of such request at his 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 Articles 50 through 55 of this Chapter may not bar the right to recover thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer. (1913, c. 91, s. 8; C.S., s. 6485; 1953, c. 1095, s. 9; 1955, c. 850, s. 6; 1961, c. 1149; 1985, c. 484, s. 4.2; 1991, c. 720, s. 29.)

§ 58-50-20. Age limit.

If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy. (1953, c. 1095, s. 11.)

§ 58-50-25. Nurses' services.

(a) No agency, institution or physician providing a service for which payment or reimbursement is required to be made under a policy governed by Articles 1 through 64 of this Chapter shall be denied such payment or reimbursement on account of the fact that such services were rendered through a registered nurse acting under authority of rules and regulations adopted by the North Carolina Medical Board and the Board of Nursing pursuant to G.S. 90-6 and 90-171.23.

(b) A licensed registered nurse who has successfully completed a program established under G.S. 90-171.38(b) may receive direct payment for conducting medical examinations or medical procedures for the purpose of collecting evidence from victims of offenses described in that subsection if the payment would have otherwise been permitted. (1973, c. 437; 1991, c. 720, s. 37; 1993, c. 347, s. 1; 1995, c. 94, s. 2; 1997-197, s. 1; 1997-375, s. 3.)

§ 58-50-26. Physician services provided by physician assistants.

No agency, institution, or physician providing a service for which payment or reimbursement is required to be made under a policy governed by Articles 1 through 64 of this Chapter shall be denied the payment or reimbursement on account of the fact that the services were rendered through a physician assistant acting under the authority of rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1. (1999-210, s. 1.)

§ 58-50-30. Right to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant.

(a) Repealed by Session Laws 2001-297, s. 1, effective January 1, 2001.

(a1) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter provides for coverage for, payment of, or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, a duly licensed marriage and family therapist, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to coverage of, payment of, or reimbursement for the services, whether the services be performed by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provision contained in the plan or policy limiting access to the providers. The policyholder, insured, or beneficiary shall have the right to choose the provider of services notwithstanding any provision to the contrary in any other statute, subject to the utilization review, referral, and prior approval requirements of the plan that apply to all providers for that service; provided that:

(1) In the case of plans that require the use of network providers as a condition of obtaining benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network; and

(2) In the case of plans that require the use of network providers as a condition of obtaining a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network in order to obtain the higher level of benefits.

(a2) Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, a duly licensed marriage and family therapist, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute; provided that for plans that require the use of network providers either as a condition of obtaining benefits under the plan or policy or to access a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network, subject to the requirements of the plan or policy.

(a3) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician. An insurer shall not impose as a limitation on treatment or level of coverage a co-payment amount charged to the insured for chiropractic services that is higher than the co-payment amount charged to the insured for the services of a duly licensed primary care physician for a comparable medically necessary treatment or condition.

(b) For the purposes of this section, a "duly licensed psychologist" is a:

(1) Licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board; or

(2) Licensed psychological associate who holds permanent licensure.

(c) For the purposes of this section, a "duly licensed clinical social worker" is a "licensed clinical social worker " as defined in G.S. 90B-3(2) and licensed by the North Carolina Social Work Certification and Licensure Board pursuant to Chapter 90B of the General Statutes.

(c1) For purposes of this section, a "duly certified fee-based practicing pastoral counselor" shall be defined only to include fee-based practicing pastoral counselors certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.

(c2) For purposes of this section, a "duly certified substance abuse professional" is a person certified by the North Carolina Substance Abuse Professional Certification Board pursuant to Article 5C of Chapter 90 of the General Statutes.

(c3) For purposes of this section, a "duly licensed professional counselor" is a person licensed by the North Carolina Board of Licensed Professional Counselors pursuant to Article 24 of Chapter 90 of the General Statutes.

(c4) For purposes of this section, a "duly licensed marriage and family therapist" is a person licensed by the North Carolina Marriage and Family Therapy Licensure Board pursuant to Article 18C of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision, unless these plan requirements apply to all providers for that service.

For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(f) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

(1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1;

(2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section, a "duly licensed physician assistant" is a physician assistant as defined by G.S. 90-18.1.

(g) A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network

or from eligibility to provide particular covered services under the plan or policy any duly licensed physician or provider listed in subsection (a1) of this section, acting within the scope of the provider's license or certification under North Carolina law, solely on the basis of the provider's license or certification. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that offers coverage through a network plan may condition participation in the network on satisfying written participation criteria, including credentialing, quality, and accessibility criteria. The participation criteria shall be developed and applied in a like manner consistent with the licensure and scope of practice for each type of provider. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that excludes a provider listed in subsection (a1) of this section from participation in its network or from eligibility to provide particular covered services under the plan or policy shall provide the affected listed provider with a written explanation of the basis for its decision. A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network a provider listed in subsection (a1) of this section acting within the scope of the provider's license or certification under North Carolina law solely on the basis that the provider lacks hospital privileges, unless use of hospital services by the provider on behalf of a policy holder, insured, or beneficiary reasonably could be expected.

(h) Nothing in this section shall be construed as expanding the scope of practice of any duly licensed physician or provider listed in subsection (a1) of this section. (1913, c. 91, s. 11; C.S., s. 6488; 1965, c. 396, s. 2; c. 1169, s. 2; 1967, c. 690, s. 2; 1969, c. 679; 1973, c. 610; 1977, c. 601, ss. 2, 31/2; 1991, c. 720, s. 29; 1993, c. 347, s. 2; c. 375, s. 3; c. 464, s. 2; c. 554, s. 1; 1995, c. 193, s. 41, c. 223, s. 1; c. 406, s. 3; 1997-197, ss. 1, 2; 1999-186, s. 1; 1999-199, s. 1; 1999-210, s. 2; 2001-297, s. 1; 2001-446, s. 1.7; 2001-487, s. 40(g); 2003-117, s. 1; 2003-368, s. 1; 2005-276, s. 6.29; 2005-345, ss. 3(a), 3(b).)

§ 58-50-35. Notice of nonpayment of premium required before forfeiture.

No insurance company doing business in this State and issuing health and/or accident insurance policies, other than contracts of group insurance or disability and/or accidental death benefits in connection with policies of life insurance, the premium for which is to be collected in weekly, monthly, or other periodical installments by authority of a payroll deduction order executed by the assured and delivered to such insurance company or the assured's employer authorizing the deduction of such premium installments from the assured's salary or wages, shall, during the period for which such policy is issued, declare forfeited or lapsed any such policy hereafter issued or renewed until and unless a written or printed notice of the failure of the employer to remit said premium or installment thereof stating the amount or portion thereof due on such policy and to whom it must be paid, has been duly addressed and mailed to the person who is insured under such policy at least 15 days before said policy is canceled or lapsed. (1909, c. 884; C.S., s. 6465; 1929, c. 308, s. 1; 1931, c. 317; 1945, c. 379.)

§ 58-50-40. Willful failure to pay group insurance premiums; willful termination of a group health plan; notice to persons insured; penalty; restitution; examination of insurance transactions.

(a) As used in this section and in G.S. 58-50-45:

(1) "Group health insurance" means any policy described in G.S. 58-51-75, 58-51-80, or 58-51-90; any group insurance certificate or group subscriber contract issued by a service corporation pursuant to Articles 65 and 66 of this Chapter; any health care plan provided or arranged by a health maintenance organization pursuant to Article 67 of this Chapter; or any multiple employer welfare arrangement as defined in G.S. 58-49-30(a).

(2) "Group health plan" means a single employer self-insured group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1167(1), as amended.

(3) "Insurance fiduciary" means any person, employer, principal, agent, trustee, or third-party administrator who is responsible for the payment of group health or group life insurance premiums or who is responsible for funding a group health plan.

(4) "Premiums" includes contributions to a group health plan or to a multiple employer welfare arrangement.

(b) No insurance fiduciary shall:

(1) Cause the cancellation or nonrenewal of group health or group life insurance and the consequential loss of the coverages of the persons insured by willfully failing to pay such premiums in accordance with the terms of a group health or group life insurance contract; or, in the case of a group health plan to which there are no premiums contributed, terminate the plan by willfully failing to fund the plan; and

(2) Willfully fail to deliver, at least 45 days before the termination of the group health or group life insurance or group health plan, to all persons covered by the group policy or group health plan a written notice of the insurance fiduciary's intention to stop payment of premiums for the group life or health insurance or the insurance fiduciary's intention to cease funding of a group health plan.

(c) Any insurance fiduciary who violates subsection (b) of this section shall be guilty of a Class H felony.

(d) Repealed by Session Laws 1991, c. 644, s. 37.

(e) Upon conviction under subsection (c) of this section the court shall order the insurance fiduciary to make full restitution to persons insured who incurred expenses that would have been covered by the group health insurance or group health plan or full restitution to beneficiaries of the group life insurance for death benefits that would have been paid if the coverage had not been terminated.

(f) Insurance fiduciaries subject to this section shall be subject to the provisions of G.S. 58-2-200 with respect only to transactions involving group health or life insurance.

(g) In the notice required by subsection (b) of this section, the insurance fiduciary shall also notify those persons of their rights to health insurance conversion policies under Article 53 of this Chapter and their rights to purchase individual policies under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, and Article 68 of this Chapter.

(h) In the event of the insolvency of an employer or insurance fiduciary who has violated this section, any person specified in subsection (e) of this section shall have a lien upon the assets of the employer or insurance fiduciary for the expenses or benefits specified in subsection (e) of this section. With respect to personal property within the estate of the insolvent employer or insurance fiduciary, the lien shall have priority over unperfected security interests.

(i) Upon the termination of a group health insurance contract by the insurer, the insurer shall notify every subscriber and certificate holder under the contract of the termination of the contract along with the certification required to be provided under G.S. 58-68-30(e). Upon the termination of a group health insurance contract by the insurance fiduciary, the insurance fiduciary shall notify every subscriber and certificate holder under the contract of the termination of the contract along with the certification required to be provided under G.S. 58-68-30(e).

(j) This section shall not apply to the cessation of individual contributions made by any person covered by a group health or group life insurance policy or group health plan. (1985, c. 507, s. 1; 1989, c. 485, s. 51; 1989 (Reg. Sess., 1990), c. 1055, ss. 2, 3.1; 1991, c. 644, s. 37; 1993, c. 539, s. 1274; 1994, Ex. Sess., c. 24, s. 14(c); 2001-422, s. 1; 2006-105, s. 1.8.)

§ 58-50-45. Group health or life insurers to notify insurance fiduciaries of obligations.

(a) Upon the issuance or renewal of any policy, contract, certificate, or evidence of coverage of group health or life insurance, the insurer, corporation, or health maintenance organization shall give written notice to the insurance fiduciary of the provisions of G.S. 58-50-40.

(b) The notice required by subsection (a) of this section shall be printed in 10 point type and shall read as follows:

"Under north carolina general statute section 58-50-40, no person, employer, principal, agent, trustee, or third party administrator, who is responsible for the payment of group health or life insurance or group health plan premiums, shall: (1) cause the cancellation or nonrenewal of group health or life insurance, hospital, medical, or dental service corporation plan, multiple employer welfare arrangement, or group health plan coverages and the consequential loss of the coverages of the persons insured, by willfully failing to pay those premiums in accordance with the terms of the insurance or plan contract, and (2) willfully fail to deliver, at least 45 days before the termination of those coverages, to all persons covered by the group policy a written notice of the person's intention to stop payment of premiums. This written notice must also contain a notice to all persons covered by the group policy of their rights to health insurance conversion policies under article 53 of chapter 58 of the general statutes and their rights to purchase individual policies under the federal health insurance portability and accountability act and under

article 68 of chapter 58 of the general statutes. Violation of this law is a felony. Any person violating this law is also subject to a court order requiring the person to compensate persons insured for expenses or losses incurred as a result of the termination of the insurance." (1985, c. 507, s. 1; 1989 (Reg. Sess., 1990), c. 1055, s. 3; 1991, c. 644, s. 38; 2001-422, s. 2.)

§ 58-50-56. Insurers, preferred provider organizations, and preferred provider benefit plans.

(a) Definitions. – As used in this section:
- (1) "Insurer" means an insurer or service corporation subject to this Chapter.
- (2) "Preferred provider" means a health care provider who has agreed to accept special reimbursement or other terms for health care services from an insurer for health care services on a fee-for-service basis. A "preferred provider" is not a health care provider participating in any prepaid health service or capitation arrangement implemented or administered by the Department of Health and Human Services or its representatives.
- (3) "Preferred provider benefit plan" means a health benefit plan offered by an insurer in which covered services are available from health care providers who are under a contract with the insurer in accordance with this section and in which enrollees are given incentives through differentials in deductibles, coinsurance, or copayments to obtain covered health care services from contracted health care providers.
- (4) "Preferred provider organization" or "PPO" means an insurer holding contracts with preferred providers to be used by or offered to insurers offering preferred provider benefit plans.

(b) Insurers may enter into preferred provider contracts or enter into other cost containment arrangements approved by the Commissioner to reduce the costs of providing health care services. These contracts or arrangements may be entered into with licensed health care providers of all kinds without regard to specialty of services or limitation to a specific type of practice. A preferred provider contract or other cost containment arrangement that is not disapproved by the Commissioner within 90 days of its filing by the insurer shall be deemed to be approved.

(c) At the initial offering of a preferred provider plan to the public, health care providers may submit proposals for participation in accordance with the terms of the preferred provider plan within 30 days after that offering. After that time period, any health care provider may submit a proposal, and the insurer offering the preferred provider benefit plan shall consider all pending applications for participation and give reasons for any rejections or failure to act on an application on at least an annual basis. Any health care provider seeking to participate in the preferred provider benefit plan, whether upon the initial offering or subsequently, may be permitted to do so in the discretion of the insurer offering the preferred provider benefit plan. G.S. 58-50-30 applies to preferred provider benefit plans.

(d) Any provision of a contract between an insurer offering a preferred provider benefit plan and a health care provider that restricts the provider's right to enter into preferred provider contracts with other persons is prohibited, is void ab initio, and is not enforceable. The existence of that restriction does not invalidate any other provision of the contract.

(e) Except where specifically prohibited either by this section or by rules adopted by the Commissioner, the contractual terms and conditions for special reimbursements shall be those that the parties find mutually agreeable.

(f) Every insurer offering a preferred provider benefit plan and contracting with a PPO shall require by contract that the PPO shall provide all of the preferred providers with whom it holds contracts information about the insurer and the insurer's preferred provider benefit plans. This information shall include for each insurer and preferred provider benefit plan the benefit designs and incentives that are used to encourage insureds to use preferred providers.

(g) The Commissioner may adopt rules applicable to insurers offering preferred provider benefit plans under this section. These rules shall provide for:
- (1) Accessibility of preferred provider services to individuals within the insured group.
- (2) The adequacy of the number and locations of health care providers.
- (3) The availability of services at reasonable times.
- (4) Financial solvency.

(h) Each insurer offering a preferred provider benefit plan shall provide the Commissioner with summary data about the financial reimbursements offered to health care providers. All such insurers shall disclose annually the following information:
- (1) The name by which the preferred provider benefit plan is known and its business address.

(2) The name, address, and nature of any PPO or other separate organization that administers the preferred provider benefit plan for the insurer.
(3) The terms of the agreements entered into by the insurer with preferred providers.
(4) Any other information necessary to determine compliance with this section, rules adopted under this section, or other requirements applicable to preferred provider benefit plans.

(i) A person enrolled in a preferred provider benefit plan may obtain covered health care services from a provider who does not participate in the plan. In accordance with rules adopted by the Commissioner and subject to G.S. 58-3-200(d), the preferred provider benefit plan may limit coverage for health care services obtained from a nonparticipating provider. The Commissioner shall adopt rules on product limitations, including payment differentials for services rendered by nonparticipating providers. These rules shall be similar in substance to rules governing HMO point-of-service products.

(j) A list of the current participating providers in the geographic area in which a substantial portion of health care services will be available shall be provided to insureds and contracting parties. The list shall include participating physician assistants and their supervising physician.

(k) Publications or advertisements of preferred provider benefit plans or organizations shall not refer to the quality or efficiency of the services of nonparticipating providers. (1997-443, s. 11A.122; 1997-519, s. 3.1; 1998-211, s. 2; 1999-210, s. 3; 2001-297, s. 3; 2001-334, s. 2.1.)

§ 58-50-57. Offsets against provider reimbursement for workers' compensation payments forbidden.

(a) An insurer that provides a health benefit plan as defined in G.S. 58-3-167 shall not offset or reverse a health plan payment against a provider reimbursement for other medical charges unless the health plan payment was for a specific medical charge for which the employee, employer, or carrier is liable or responsible according to a final adjudication of the claim under the Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes or an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article.

(b) No contract between an insurer that provides a health benefit plan as defined in G.S. 58-3-167 and a medical provider shall contain a provision that authorizes the insurer to offset or reverse a health plan payment against a provider reimbursement for other medical charges unless the health plan payment was for a specific medical charge for which the employee, employer, or carrier is liable or responsible according to a final adjudication of the claim under the Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes or an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article. (2001-216, s. 5; 2001-487, s. 102(b).)

§ 58-50-61. Utilization review.

(a) Definitions. – As used in this section, in G.S. 58-50-62, and in Part 4 of this Article, the term:
(1) "Certificate of coverage" includes a policy of insurance issued to an individual person or a franchise policy issued pursuant to G.S. 58-51-90.
(1a) "Clinical peer" means a health care professional who holds an unrestricted license in a state of the United States, in the same or similar specialty, and routinely provides the health care services subject to utilization review.
(2) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by an insurer to determine medically necessary services and supplies.
(3) "Covered person" means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. "Covered person" includes another person, other than the covered person's provider, who is authorized to act on behalf of a covered person.
(4) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:
a. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.

(5) "Emergency services" means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

(6) "Grievance" means a written complaint submitted by a covered person about any of the following:
   a. An insurer's decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a covered person about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the certificate of coverage.
   b. Claims payment or handling; or reimbursement for services.
   c. The contractual relationship between a covered person and an insurer.
   d. The outcome of an appeal of a noncertification under this section.

(7) "Health benefit plan" means any of the following if offered by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:
   a. Accident.
   b. Credit.
   c. Disability income.
   d. Long-term or nursing home care.
   e. Medicare supplement.
   f. Specified disease.
   g. Dental or vision.
   h. Coverage issued as a supplement to liability insurance.
   i. Workers' compensation.
   j. Medical payments under automobile or homeowners.
   k. Hospital income or indemnity.
   l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(8) "Health care provider" means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes or the laws of another state to provide health care services in the ordinary care of business or practice or a profession or in an approved education or training program; a health care facility as defined in G.S. 131E-176(9b) or the laws of another state to operate as a health care facility; or a pharmacy.

(9) "Health care services" means services provided for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(10) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.

(11) "Managed care plan" means a health benefit plan in which an insurer either (i) requires a covered person to use or (ii) creates incentives, including financial incentives, for a covered person to use providers that are under contract with or managed, owned, or employed by the insurer.

(12) "Medically necessary services or supplies" means those covered services or supplies that are:
   a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.
   b. Except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.
   c. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

d. Within generally accepted standards of medical care in the community.
e. Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subdivision precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

(13) "Noncertification" means a determination by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of emergency services in G.S. 58-3-190, and the requested service is therefore denied, reduced, or terminated. A "noncertification" is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. A "noncertification" includes any situation in which an insurer or its designated agent makes a decision about a covered person's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision.

(14) "Participating provider" means a provider who, under a contract with an insurer or with an insurer's contractor or subcontractor, has agreed to provide health care services to covered persons in return for direct or indirect payment from the insurer, other than coinsurance, copayments, or deductibles.

(15) "Provider" means a health care provider.

(16) "Stabilize" means to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies, and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. § 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred.

(17) "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities. These techniques may include:

a. Ambulatory review. – Utilization review of services performed or provided in an outpatient setting.
b. Case management. – A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.
c. Certification. – A determination by an insurer or its designated URO that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the insurer's requirements for medically necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness.
d. Concurrent review. – Utilization review conducted during a patient's hospital stay or course of treatment.
e. Discharge planning. – The formal process for determining, before discharge from a provider facility, the coordination and management of the care that a patient receives after discharge from a provider facility.
f. Prospective review. – Utilization review conducted before an admission or a course of treatment including any required preauthorization or precertification.
g. Retrospective review. – Utilization review of medically necessary services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review includes the review of claims for emergency services to determine whether the prudent layperson standard in G.S. 58-3-190 has been met.

h. Second opinion. – An opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

(18) "Utilization review organization" or "URO" means an entity that conducts utilization review under a managed care plan, but does not mean an insurer performing utilization review for its own health benefit plan.

(b) Insurer Oversight. – Every insurer shall monitor all utilization review carried out by or on behalf of the insurer and ensure compliance with this section. An insurer shall ensure that appropriate personnel have operational responsibility for the conduct of the insurer's utilization review program. If an insurer contracts to have a URO perform its utilization review, the insurer shall monitor the URO to ensure compliance with this section, which shall include:

(1) A written description of the URO's activities and responsibilities, including reporting requirements.

(2) Evidence of formal approval of the utilization review organization program by the insurer.

(3) A process by which the insurer evaluates the performance of the URO.

(c) Scope and Content of Program. – Every insurer shall prepare and maintain a utilization review program document that describes all delegated and nondelegated review functions for covered services including:

(1) Procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health services.

(2) Data sources and clinical review criteria used in decision making.

(3) The process for conducting appeals of noncertifications.

(4) Mechanisms to ensure consistent application of review criteria and compatible decisions.

(5) Data collection processes and analytical methods used in assessing utilization of health care services.

(6) Provisions for assuring confidentiality of clinical and patient information in accordance with State and federal law.

(7) The organizational structure (e.g., utilization review committee, quality assurance, or other committee) that periodically assesses utilization review activities and reports to the insurer's governing body.

(8) The staff position functionally responsible for day-to-day program management.

(9) The methods of collection and assessment of data about underutilization and over utilization of health care services and how the assessment is used to evaluate and improve procedures and criteria for utilization review.

(d) Program Operations. – In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review criteria. Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be either (i) the diagnostic criteria contained in the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders or (ii) criteria adopted by the insurer or its URO. The Department, in consultation with the Department of Health and Human Services, may require proof of compliance with this subsection by a plan or URO.

Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor licensed to practice medicine in this State shall evaluate the clinical appropriateness of noncertifications.

Compensation to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section.

(e) Insurer Responsibilities. – Every insurer shall:

(1) Routinely assess the effectiveness and efficiency of its utilization review program.

(2) Coordinate the utilization review program with its other medical management activity, including quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing satisfaction of covered persons, and risk management.

(3) Provide covered persons and their providers with access to its review staff by a toll-free or collect call telephone number whenever any provider is required to be available to provide services which may require prior certification to any plan enrollee. Every insurer shall establish standards for telephone accessibility and monitor telephone service as indicated by average speed of answer and call abandonment rate, on at least a month-by-month basis, to ensure that telephone service is adequate, and take corrective action when necessary.

(4) Limit its requests for information to only that information that is necessary to certify the admission, procedure or treatment, length of stay, and frequency and duration of health care services.

(5) Have written procedures for making utilization review decisions and for notifying covered persons of those decisions.

(6) Have written procedures to address the failure or inability of a provider or covered person to provide all necessary information for review. If a provider or covered person fails to release necessary information in a timely manner, the insurer may deny certification.

(f) Prospective and Concurrent Reviews. – As used in this subsection, "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. Prospective and concurrent determinations shall be communicated to the covered person's provider within three business days after the insurer obtains all necessary information about the admission, procedure, or health care service. If an insurer certifies a health care service, the insurer shall notify the covered person's provider. For a noncertification, the insurer shall notify the covered person's provider and send written or electronic confirmation of the noncertification to the covered person. In concurrent reviews, the insurer shall remain liable for health care services until the covered person has been notified of the noncertification.

(g) Retrospective Reviews. – As used in this subsection, "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. For retrospective review determinations, an insurer shall make the determination within 30 days after receiving all necessary information. For a certification, the insurer may give written notification to the covered person's provider. For a noncertification, the insurer shall give written notification to the covered person and the covered person's provider within five business days after making the noncertification.

(h) Notice of Noncertification. – A written notification of a noncertification shall include all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the noncertification, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification. An insurer shall provide the clinical review criteria used to make the noncertification to any person who received the notification of the noncertification and who follows the procedures for a request. An insurer shall also inform the covered person in writing about the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

(i) Requests for Informal Reconsideration. – An insurer may establish procedures for informal reconsideration of noncertifications and, if established, the procedures shall be in writing. After a written notice of noncertification has been issued in accordance with subsection (h) of this section, the reconsideration shall be conducted between the covered person's provider and a medical doctor licensed to practice medicine in this State designated by the insurer. An insurer shall not require a covered person to participate in an informal reconsideration before the covered person may appeal a noncertification under subsection (j) of this section. If, after informal reconsideration, the insurer upholds the noncertification decision, the insurer shall issue a new notice in accordance with subsection (h) of this section. If the insurer is unable to render an informal reconsideration decision within 10 business days after the date of receipt of the request for an informal reconsideration, it shall treat the request for informal reconsideration as a request for an appeal; provided that the requirements of subsection (k) of this section for acknowledging the request shall apply beginning on the day the insurer determines an informal reconsideration decision cannot be made before the tenth business day after receipt of the request for an informal reconsideration.

(j) Appeals of Noncertifications. – Every insurer shall have written procedures for appeals of noncertifications by covered persons or their providers acting on their behalves, including expedited review to address a situation where the time frames for the standard review procedures set forth in this section would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. Each appeal shall be evaluated by a medical doctor licensed to practice medicine in this State who was not involved in the noncertification.

(k) Nonexpedited Appeals. – Within three business days after receiving a request for a standard, nonexpedited appeal, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, nonexpedited appeals, the insurer shall give written notification of the decision, in clear terms, to the covered person and the covered person's provider within 30 days after the insurer receives the request for an appeal. If the decision is not in favor of the covered person, the written decision shall contain:

(1) The professional qualifications and licensure of the person or persons reviewing the appeal.

(2) A statement of the reviewers' understanding of the reason for the covered person's appeal.

(3) The reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the insurer's position.

(4) A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria.

(5) A statement advising the covered person of the covered person's right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under G.S. 58-50-62.

(6) Notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

(l) Expedited Appeals. – An expedited appeal of a noncertification may be requested by a covered person or his or her provider acting on the covered person's behalf only when a nonexpedited appeal would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. The insurer may require documentation of the medical justification for the expedited appeal. The insurer shall, in consultation with a medical doctor licensed to practice medicine in this State, provide expedited review, and the insurer shall communicate its decision in writing to the covered person and his or her provider as soon as possible, but not later than four days after receiving the information justifying expedited review. The written decision shall contain the provisions specified in subsection (k) of this section. If the expedited review is a concurrent review determination, the insurer shall remain liable for the coverage of health care services until the covered person has been notified of the determination. An insurer is not required to provide an expedited review for retrospective noncertifications.

(m) Disclosure Requirements. – In the certificate of coverage and member handbook provided to covered persons, an insurer shall include a clear and comprehensive description of its utilization review procedures, including the procedures for appealing noncertifications and a statement of the rights and responsibilities of covered persons, including the voluntary nature of the appeal process, with respect to those procedures. An insurer shall also include in the certificate of coverage and the member handbook information about the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program. An insurer shall include a summary of its utilization review procedures in materials intended for prospective covered persons. An insurer shall print on its membership cards a toll-free telephone number to call for utilization review purposes.

(n) Maintenance of Records. – Every insurer and URO shall maintain records of each review performed and each appeal received or reviewed, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. These records shall be retained by the insurer and URO for a period of three years or until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, whichever is later.

(o) Violation. – A violation of this section subjects an insurer to G.S. 58-2-70. (1997-443, s. 11A.122; 1997-519, s. 4.1; 1999-116, s. 1; 1999-391, ss. 1-4; 2001-417, ss. 2-7; 2001-416, ss. 4.4, 5; 2003-105, s. 1; 2005-223, s. 8.)

§ 58-50-62. Insurer grievance procedures.

(a) Purpose and Intent. – The purpose of this section is to provide standards for the establishment and maintenance of procedures by insurers to assure that covered persons have the opportunity for appropriate resolutions of their grievances.

(b) Availability of Grievance Process. – Every insurer shall have a grievance process whereby a covered person may voluntarily request a review of any decision, policy, or action of the insurer that affects that covered person. A decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question is not subject to the insurer's grievance procedures, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. The grievance process may provide for an immediate informal consideration by the insurer of a grievance. If the insurer does not have a procedure for informal consideration or if an informal consideration does not resolve the grievance, the grievance process shall provide for first- and second-level reviews of grievances. Appeal of a noncertification that has been reviewed under G.S. 58-50-61 shall be reviewed as a second-level grievance under this section.

(b1) Informal Consideration of Grievances. – If the insurer provides procedures for informal consideration of grievances, the procedures shall be in writing, and the following requirements apply:

(1) If the grievance concerns a clinical issue and the informal consideration decision is not in favor of the covered person, the insurer shall treat the request as a request for a first-level grievance review, except that the requirements of subdivision (e)(1) of this section apply on the day the decision is made or on the tenth business day after receipt of the request for informal consideration, whichever is sooner;

(2) If the grievance concerns a nonclinical issue and the informal consideration decision is not in favor of the covered person, the insurer shall issue a written decision that includes the information set forth in subsection (c) of this section; or

(3) If the insurer is unable to render an informal consideration decision within 10 business days after receipt of the grievance, the insurer shall treat the request as a request for a first-level grievance review, except that the requirements of subdivision (e)(1) of this section apply beginning on the day the insurer determines an informal consideration decision cannot be made before the tenth business day after receipt of the grievance.

(c) Grievance Procedures. – Every insurer shall have written procedures for receiving and resolving grievances from covered persons. A description of the grievance procedures shall be set forth in or attached to the certificate of coverage and member handbook provided to covered persons. The description shall include a statement informing the covered person that the grievance procedures are voluntary and shall also inform the covered person about the availability of the Commissioner's office for assistance, including the telephone number and address of the office. The description shall also inform the covered person about the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

(d) Maintenance of Records. – Every insurer shall maintain records of each grievance received and the insurer's review of each grievance, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. The insurer shall retain these records for three years or until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, whichever is later.

(e) First-Level Grievance Review. – A covered person or a covered person's provider acting on the covered person's behalf may submit a grievance.

(1) The insurer does not have to allow a covered person to attend the first-level grievance review. A covered person may submit written material. Except as provided in subdivision (3) of this subsection, within three business days after receiving a grievance, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material.

(2) An insurer shall issue a written decision, in clear terms, to the covered person and, if applicable, to the covered person's provider, within 30 days after receiving a grievance.

The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. Except as provided in subdivision (3) of this subsection, if the decision is not in favor of the covered person, the written decision issued in a first-level grievance review shall contain:

a. The professional qualifications and licensure of the person or persons reviewing the grievance.
b. A statement of the reviewers' understanding of the grievance.
c. The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the insurer's position.
d. A reference to the evidence or documentation used as the basis for the decision.
e. A statement advising the covered person of his or her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under this section.
f. Notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

(3) For grievances concerning the quality of clinical care delivered by the covered person's provider, the insurer shall acknowledge the grievance within 10 business days. The acknowledgement shall advise the covered person that (i) the insurer will refer the grievance to its quality assurance committee for review and consideration or any appropriate action against the provider and (ii) State law does not allow for a second-level grievance review for grievances concerning quality of care.

(f) Second-Level Grievance Review. – An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review decision or a utilization review appeal decision. A covered person or the covered person's provider acting on the covered person's behalf may submit a second-level grievance.

(1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, make known to the covered person:

a. The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.
b. A statement of a covered person's rights, which include the right to request and receive from an insurer all information relevant to the case; attend the second-level grievance review; present his or her case to the review panel; submit supporting materials before and at the review meeting; ask questions of any member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without limitation to: a provider, family member, employer representative, or attorney. If the covered person chooses to be represented by an attorney, the insurer may also be represented by an attorney.
c. The availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

(2) An insurer shall convene a second-level grievance review panel for each request. The panel shall comprise persons who were not previously involved in any matter giving rise to the second-level grievance, are not employees of the insurer or URO, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level grievance involving a noncertification or a clinical issue shall be providers who have appropriate expertise, including at least one clinical peer. Provided, however, an insurer that uses a clinical peer on an appeal of a noncertification under G.S. 58-50-61 or on a first-level grievance review panel under this section may use one of the insurer's employees on the second-level grievance review panel in the same matter if the second-level grievance review panel comprises three or more persons.

(g) Second-Level Grievance Review Procedures. – An insurer's procedures for conducting a second-level grievance review shall include:

(1) The review panel shall schedule and hold a review meeting within 45 days after receiving a request for a second-level review.
(2) The covered person shall be notified in writing at least 15 days before the review meeting date.
(3) The covered person's right to a full review shall not be conditioned on the covered person's appearance at the review meeting.

(h) Second-Level Grievance Review Decisions. – An insurer shall issue a written decision to the covered person and, if applicable, to the covered person's provider, within seven business days after completing the review meeting. The decision shall include:
(1) The professional qualifications and licensure of the members of the review panel.
(2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.
(3) The review panel's recommendation to the insurer and the rationale behind that recommendation.
(4) A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.
(5) In the review of a noncertification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.
(6) The rationale for the insurer's decision if it differs from the review panel's recommendation.
(7) A statement that the decision is the insurer's final determination in the matter. In cases where the review concerned a noncertification and the insurer's decision on the second-level grievance review is to uphold its initial noncertification, a statement advising the covered person of his or her right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance.
(8) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.
(9) Notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

(i) Expedited Second-Level Procedures. – An expedited second-level review shall be made available where medically justified as provided in G.S. 58-50-61(l), whether or not the initial review was expedited. The provisions of subsections (f), (g), and (h) of this section apply to this subsection except for the following timetable: When a covered person is eligible for an expedited second-level review, the insurer shall conduct the review proceeding and communicate its decision within four days after receiving all necessary information. The review meeting may take place by way of a telephone conference call or through the exchange of written information.

(j) No insurer shall discriminate against any provider based on any action taken by the provider under this section or G.S. 58-50-61 on behalf of a covered person.

(k) Violation. – A violation of this section subjects an insurer to G.S. 58-2-70. (1997-519, s. 4.2; 2001-417, ss. 8-11; 2001-446, s. 4.6; 2003-105, s. 2(a)-(d).)

§ 58-50-63: Expired pursuant to Session Laws 2005-453, s. 3, effective July 1, 2005.

Part 3. Scope and Sanctions.

§ 58-50-65. Certain policies of insurance not affected.

(a) Nothing in Articles 50 through 55 of this Chapter applies to or affects any policy of liability or workers' compensation insurance, except that the provisions of G.S. 58-50-56(g) and (h) apply to policies of workers' compensation insurance and to individual and group self-funded workers' compensation insurance plans. If there is any conflict between managed care provisions of this Chapter and managed care provisions of Chapter 97 of the General Statutes with respect to workers' compensation insurance, the provisions of Chapter 97 govern.

(b) Nothing in Articles 50 through 55 of this Chapter shall apply to or in any way affect contracts supplemental to contracts of life or endowment insurance where such supplemental contracts contain no provisions except such as operate to safeguard such insurance against lapse or to provide special benefits therefor in the event that the insured shall be totally, or totally and permanently disabled by reason of accidental bodily injury or by sickness, nor to contracts issued

as supplements to life insurance contracts or contracts of endowment insurance, and intended to increase the amount insured by such life or endowment contracts in the event that the death or disability of the insured shall result from accidental bodily injuries: Provided, that no such supplemental contracts shall be issued or delivered to any person in this State unless and until a copy of the form thereof has been submitted to and approved by the Commissioner under such reasonable rules and regulations as he shall make concerning the provisions in such contracts, and their submission to and approval by him.

(c) Nothing in Articles 50 through 55 of this Chapter shall apply to or in any way affect fraternal benefit societies.

(d) The provisions of G.S. 58-51-5(5) and G.S. 58-51-15(a)(1), (4), and (10) may be omitted from railroad ticket policies sold only at railroad stations or at railroad ticket offices by railroad employees. (1911, c. 209, s. 5; 1913, c. 91, s. 12; C.S., s. 6489; 1921, c. 136, s. 5; 1945, c. 385; 1947, c. 721; 1991, c. 636, s. 3; c. 720, ss. 4, 42; 1993 (Reg. Sess., 1994), c. 679, s. 10.4; 1995, c. 193, s. 42; 1999-219, s. 4.1.)

§ 58-50-70. Punishment for violation.

Any company, association, society, or other insurer or any officer or agent thereof, which or who issues or delivers to any person in this State any policy in willful violation of Articles 50 through 55 of this Chapter, shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be punished only by a fine of not more than five thousand dollars ($5,000) for each offense; and the Commissioner may revoke the license of any company, corporation, association, society, or other insurer of another state or country, or of the agent thereof, which or who willfully violates any provision of Articles 50 through 55 of this Chapter. (1911, c. 209, s. 6; 1913, c. 91, s. 13; C.S., s. 6490; 1985, c. 666, s. 28; 1991, c. 720, ss. 4, 42; 1993, c. 539, s. 467; 1994, Ex. Sess., c. 24, s. 14(c).)

Nature of Policies

Nature of Policies.

§ 58-51-1. Form, classification and rates to be approved by Commissioner.

No policy of insurance against loss or damage from the sickness or the bodily injury or death of the insured by accident shall be issued or delivered to any person in this State until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with, and the forms approved by, the Commissioner. If the Commissioner shall notify, in writing, the company or other insurer which has filed such form that it does not comply with the requirements of law, specifying the reasons for his opinion, it shall be unlawful thereafter for any such insurer to issue any policy in such form. The action of the Commissioner in this regard shall be subject to review by any court of competent jurisdiction; but nothing in this Article shall be construed to give jurisdiction to any court not already having jurisdiction. (1911, c. 209, s. 1; 1913, c. 91, s. 1; C.S., s. 6477; 1945, c. 385; 1991, c. 720, s. 4.)

§ 58-51-5. Form of policy.

(a) No policy of accident and health insurance shall be delivered or issued for delivery to any person in this State unless:

(1) The entire money and other considerations therefor are expressed therein; and

(2) The time at which the insurance takes effect and terminates is expressed therein; and

(3) It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed 19 years and any other persons dependent upon the policyholder; and

(4) The style, arrangement, and overall appearance of the policy, any endorsements, or attached papers give no undue prominence to any portion of the text. For the purpose of this subdivision, "text" includes all printed matter except the name and address of the insurer, the name or title of the policy, 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 G.S. 58-51-15, 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; and

(6) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

(7) It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the Commissioner.

(8) It contains no provision excluding from coverage claims that are subject to the Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes, unless the exclusion extends to only specific medical charges for which the employee, employer, or carrier is liable or responsible according to a final adjudication of the claim under that Article or an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article.

(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) of this section and in G.S. 58-51-15. (1913, c. 91, s. 2; C.S., s. 6478; 1945, c. 385; 1953, c. 1095, s. 1; 1979, c. 755, s. 8; 2001-216, s. 4; 2001-487, s. 102(b).)

§ 58-51-10. Right to return policy and have premium refunded.

Every individual or family hospitalization policy, certificate, contract or plan issued for delivery in the State of North Carolina on and after July 1, 1961, must have printed thereon or attached thereto a notice stating substantially: "YOUR POLICY MAY NOT BE IN FORCE WHEN YOU HAVE A CLAIM! PLEASE READ! Your policy was issued based on the information entered in your application, a copy of which is attached to the policy. If, to the best of your knowledge and belief, there is any misstatement in your application or if any information concerning the medical history of any insured person has been omitted, you should advise the Company immediately regarding the incorrect or omitted information; otherwise, your policy may not be a valid contract. RIGHT TO RETURN POLICY WITHIN 10 DAYS. If for any reason you are not satisfied with your policy, you may return it to the Company within 10 days of the date you received it and the premium you paid will be promptly refunded." If a policyholder or certificate holder or purchaser of a contract or plan returns same pursuant to such notice, coverage under such policy, certificate, contract or plan shall become void immediately upon the mailing or delivery of the contract, certificate, policy or plan to the insurance company at its home or branch office or to the agent through whom it was purchased. Coverage shall exist under such policy, certificate, contract or plan within said 10-day period until said mailing or delivery of the contract. (1955, c. 850, s. 10; 1961, c. 962.)

§ 58-51-15. Accident and health policy provisions.

(a) Required Provisions. – Except as provided in subsection (c) of this section each such policy delivered or issued for delivery to any person in this State shall contain the provisions specified in this subsection in the substance of the words that appear in this section. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

(1) A provision in the substance of the following language:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or waive any of its provisions.

(2) A provision in the substance of the following language:

TIME LIMIT ON CERTAIN DEFENSES:

a. After two years from the date of issue or reinstatement 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 deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

The foregoing policy provision may be used in its entirety only in major or catastrophe hospitalization policies and major medical policies each affording benefits of five thousand dollars ($5,000) or more for any one sickness or injury; disability income policies affording benefits of one hundred dollars ($100.00) or more per month for not less than 12 months; and franchise policies. Other policies to which this section applies must delete the words "except fraudulent misstatements."

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of G.S. 58-51-15(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 50 or,
2. In the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE."

After this policy has been in force for a period of two 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. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions are covered under this policy ____ (insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions mean "those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the person's coverage." Except for the excepted benefits described in G.S. 58-68-25(b), credit for having satisfied some or all of the preexisting condition waiting periods under previous health benefits coverage shall be given in accordance with G.S. 58-68-30.

(3) A provision in the substance of the following language:

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 which contains a cancellation provision may add, at the end of the above provision, subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision,

Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the record of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.)

(4) A provision in the substance of the following language:

REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer, or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of

reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 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:

a. Until at least age 50 or,
b. In the case of a policy issued after age 44, for at least five years from its date of issue.)

(5) A provision in the substance of the following language:

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 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 years, an insurer may at its option insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six 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 months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.)

(6) A provision in the substance of the following language:

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 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 in the substance of the following language:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in the case of a claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 180 days after the termination of the period for which the insurer is liable and in case of a claim for any other loss within 180 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 of the insured, later than one year from the time proof is otherwise required.

(8) A provision in the substance of the following language:

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any period payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid _____ (insert period for payment which must not be less

frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

(9) A provision in the substance of the following language:

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 three thousand dollars ($3,000)), 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.)

(10) A provision in the substance of the following language:

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 in the substance of the following language:

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 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 years after the time written proof of loss is required to be furnished.

(12) A provision in the substance of the following language:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

(The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.)

(b) Other Provisions. – Except as provided in subsection (c) of this section, no such policy delivered or issued for delivery to any person in this State shall contain provisions respecting the matters set forth below unless such provisions are in the substance of the words that appear in this section. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

(1) A provision in the substance of the following language:

CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous

occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(2) A provision in the substance of the following language:

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 in the substance of the following language:

OTHER INSURANCE IN THIS INSURER: If an accident or health or accident and health policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for _____ (insert type of coverage or coverages) in excess of $ _____ (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

Or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(4) A provision in the substance of the following language:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

(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 workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provisions no third-party liability coverage shall be included as "other valid coverage.")

(5) A provision in the substance of the following language:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such 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 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 workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third-party liability coverage shall be included as "other valid coverage.")

(6) A provision in the substance of the following language:

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 his average monthly earnings for the period of two 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 years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars ($200.00) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(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:

a. Until at least age 50 or,
b. In the case of a policy issued after age 44, for at least five 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 such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.)

(7) A provision in the substance of the following language:

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) Repealed by Session Laws 1955, c. 886, s. 1.

(9) A provision in the substance of the following language:

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.

(10) A provision in the substance of the following language:

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.

(11) Repealed by Session Laws 2001-334, s. 4.1, effective October 1, 2001.

(c) Inapplicable or Inconsistent Provisions. – If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the 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) Order of Certain Policy Provisions. – The provisions which are the subject of subsections (a) and (b) of this section, or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

(e) Third-Party Ownership. – The word "insured," as used in Articles 50 through 55 of 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) Requirements of Other Jurisdictions.

(1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this State, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of Articles 50 through 55 of this Chapter and which is prescribed or required by the law of the state under which the insurer is organized.

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

(g) Filing Procedure. – The Commissioner may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to Articles 50 through 55 of this Chapter as are necessary, proper or advisable to the administration of Articles 50 through 55 of this Chapter. This provision shall not abridge any other authority granted the Commissioner by law.

(h) Preexisting Condition Exclusion Clarification. – Sub-subdivision (a)(2)b. of this section does not apply to policies issued to eligible individuals under G.S. 58-68-60. (1953, c. 1095, s. 2; 1955, c. 850, s. 8; c. 886, s. 1; 1961, c. 432; 1979, c. 755, ss. 9-12; 1983 (Reg. Sess., 1984), c. 1110, s. 13; 1987, c. 864, s. 42; 1987 (Reg. Sess., 1988), c. 975, s. 2; 1991, c. 636, s. 3; c. 720, s. 35; 1993, c. 506, s. 4; c. 553, s. 17; 1995, c. 507, s. 23A.1(g); 1995 (Reg. Sess., 1996), c. 742, s. 27; 1997-259,

ss. 7, 7.1; 1999-351, s. 1; 2000-162, s. 4(d); 2001-334, s. 4.1; 2002-187, s. 5.2; 2005-223, ss. 4(a), 4(b).)

§ 58-51-16. Intoxicants and narcotics.

(a) Except for the payment of benefits for the necessary care and treatment of chemical dependency as provided by law, an accident and health 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.
(b) The provision in subsection (a) of this section may not be used with respect to a medical expense policy.
(c) For purposes of this section, "medical expense policy" means an accident and health insurance policy that provides hospital, medical, and surgical expense coverage. (2001-334, s. 4.2.)

§ 58-51-20. Renewability of individual and blanket hospitalization and accident and health insurance policies.

(a) Every individual or blanket family hospitalization policy and accident and health policy, other than noncancelable or nonrenewable policies but including group, blanket and franchise policies, as defined in Articles 1 through 64 of this Chapter, covering less than 10 persons, issued in North Carolina after January 1, 1956, shall include in substance the following provision:
Renewability: This policy is renewable at the option of the policyholder unless sufficient notice of nonrenewal is given the policyholder in writing by the insurer.
Sufficient notice shall be, during the first year of any policy, or during the first year following any lapse and reinstatement, a period of 30 days before the premium due date. After one continuous year of coverage and acceptance of premium for any portion of the second or subsequent year sufficient notice shall be a number of full months most nearly equivalent to one fourth the number of months of continuous coverage from the inception date of the policy, to the date of mailing of the notice: Provided no period of required notice shall exceed two years.
(b) No insurance company issuing individual or blanket family hospitalization or accident and health policies of insurance shall have the right to unilaterally restrict coverage, reduce benefits or increase rates upon any contract of hospitalization or accident and health insurance which is subject to the provisions of this section except as provided herein.
(c) Any hospitalization or accident and health policy reissued or renewed in the name of the insured during the grace period shall be construed to be a continuation of the policy first issued.
(d) The requirements of this section do not apply to a refusal or renewal because of a change of occupation of an insured to one classified by the insurer as uninsurable nor to an increase in rate due to a change of occupation of an insured to a more hazardous occupation. (1955, c. 886, s. 2; 1957, c. 1085, s. 2; 1979, c. 755, s. 13; 1985, c. 666, s. 71; 1989, c. 485, s. 55; 1991, c. 644, s. 27.)

§ 58-51-25. Policy coverage to continue as to mentally retarded or physically handicapped children.
An individual or group accident and health insurance policy, hospital service policy, or medical service plan policy, delivered or issued for delivery in this State after July 1, 1969, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract, shall also provide in substance that attainment of such limiting age shall not operate or terminate the coverage of such child while the child is and continues to be (i) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (ii) chiefly dependent upon the policyholder or subscriber for support and maintenance: Provided, proof of such incapacity and dependency is furnished to the insurer, hospital service plan corporation, or medical service plan corporation by the policyholder or subscriber within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation, but not more frequently than annually after the child's attainment of the limiting age. (1969, c. 745, s. 1; 1971, c. 1126, s. 1.)

§ 58-51-30. Policies to cover newborn infants, foster children, and adopted children.

(a) As used in this section:
(1) "Foster child" means a minor (i) over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina; or (ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction;
(2) "Placement in the foster home" means physically residing with a person appointed as guardian or custodian of a foster child as long as that guardian or custodian has assumed the legal obligation for total or partial support of the foster child with the

intent that the foster child reside with the guardian or custodian on more than a temporary or short-term basis.

(3) "Placement for adoption" has the same meaning as defined in G.S. 58-51-125(a)(2).

(b) Every health benefit plan, as defined in G.S. 58-51-115(a)(1), that provides benefits for any sickness, illness, or disability of any minor child or that provides benefits for any medical treatment or service furnished by a health care provider or institution to any minor child shall provide the benefits for those occurrences beginning with the moment of the child's birth if the birth occurs while the plan is in force. Every health benefit plan shall extend coverage to a newborn child without requirements for prior notification unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, the health benefit plan shall cover the newborn child from the moment of birth if the newborn is enrolled within 30 days after the date of birth. Foster children and adopted children shall be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home or placement for adoption. Every health benefit plan shall extend coverage to a foster child or adopted child without requirements for prior notification unless an additional premium charge to add the foster child or adopted child is due. If an additional premium charge is due to cover the foster child or adopted child, the health benefit plan shall cover the foster child or adopted child upon placement in the foster home or placement for adoption if the foster child or adopted child is enrolled within 30 days after the placement in the foster home or placement for adoption.

(c) Benefits in such plans shall be the same for congenital defects or anomalies as are provided for most sicknesses or illnesses suffered by minor children that are covered by the plans. Benefits for congenital defects or anomalies shall specifically include, but not be limited to, all necessary treatment and care needed by individuals born with cleft lip or cleft palate.

(d) No plan shall be approved by the Commissioner under this Chapter that does not comply with this section.

(e) This section applies to insurers governed by Articles 1 through 63 of this Chapter and to corporations governed by Articles 65, 66, and 67 of this Chapter.

(f) This section and G.S. 58-51-125 shall be construed in pari materia. (1973, c. 345, ss. 1, 2; 1981 (Reg. Sess., 1982), c. 1349; 1991, c. 644, s. 12; 1993, c. 504, s. 32; c. 553, s. 18; 1993 (Reg. Sess., 1994), c. 644, s. 2; 2001-334, s. 5; 2005-223, s. 3.)

§ 58-51-35. Insurers and others to afford coverage to mentally retarded and physically handicapped children.

(a) No insurance company licensed in this State pursuant to the provisions of Articles 1 through 64 of this Chapter and no corporation governed by the provisions of Articles 65 and 66 of this Chapter shall refuse to issue or deliver any individual or group accident and health insurance policy of hospital or medical service plan policy in this State which it is currently issuing for delivery in this State and which affords benefits or coverage for minor children of the applicant, by reason of the physical handicap or mental retardation of any minor children of the applicant; nor shall any such policy issued and delivered in this State carry a higher premium rate or charge or restrict or exclude coverage or benefits by reason of said mental retardation or physical handicap. Provided, however, such policy may exclude benefits, otherwise payable for disability, hospitalization, or medical or other therapeutic expense directly and solely attributable to such mental retardation or such physical handicap.

(b) The Commissioner shall revoke the license of any insurer or any corporation governed by the provisions of Articles 65 and 66 of this Chapter if it fails to comply with the provisions of this section.

(c) The provisions of this section shall apply to corporations governed by the provisions of Articles 65 and 66 of this Chapter. (1973, c. 754, ss. 1, 2; 1991, c. 720, s. 4.)

§ 58-51-37. Pharmacy of choice.

(a) This section shall apply to all health benefit plans providing pharmaceutical services benefits, including prescription drugs, to any resident of North Carolina. This section shall also apply to insurance companies and health maintenance organizations that provide or administer coverages and benefits for prescription drugs. This section shall not apply to any entity that has its own facility, employs or contracts with physicians, pharmacists, nurses, and other health care personnel, and that dispenses prescription drugs from its own pharmacy to its employees and to enrollees of its health benefit plan; provided, however, this section shall apply to an entity otherwise excluded that contracts with an outside pharmacy or group of pharmacies to provide prescription

drugs and services. This section shall not apply to any federal program, clinical trial program, hospital or other health care facility licensed pursuant to Chapter 131E or Chapter 122C of the General Statutes, when dispensing prescription drugs to its patients.

(b) As used in this section:
- (1) "Copayment" means a type of cost sharing whereby insured or covered persons pay a specified predetermined amount per unit of service with their insurer paying the remainder of the charge. The copayment is incurred at the time the service is used. The copayment may be a fixed or variable amount.
- (2) "Contract provider" means a pharmacy granted the right to provide prescription drugs and pharmacy services according to the terms of the insurer.
- (3) "Health benefit plan" is as that term is defined in G.S. 58-50-110(11).
- (4) "Insurer" means any entity that provides or offers a health benefit plan.
- (5) "Pharmacy" means a pharmacy registered with the North Carolina Board of Pharmacy.

(c) The terms of a health benefit plan shall not:
- (1) Prohibit or limit a resident of this State, who is eligible for reimbursement for pharmacy services as a participant or beneficiary of a health benefit plan, from selecting a pharmacy of his or her choice when the pharmacy has agreed to participate in the health benefit plan according to the terms offered by the insurer;
- (2) Deny a pharmacy the opportunity to participate as a contract provider under a health benefit plan if the pharmacy agrees to provide pharmacy services that meet the terms and requirements, including terms of reimbursement, of the insurer under a health benefit plan, provided that if the pharmacy is offered the opportunity to participate, it must participate or no provisions of G.S. 58-51-37 shall apply;
- (3) Impose upon a beneficiary of pharmacy services under a health benefit plan any copayment, fee, or condition that is not equally imposed upon all beneficiaries in the same benefit category, class, or copayment level under the health benefit plan when receiving services from a contract provider;
- (4) Impose a monetary advantage or penalty under a health benefit plan that would affect a beneficiary's choice of pharmacy. Monetary advantage or penalty includes higher copayment, a reduction in reimbursement for services, or promotion of one participating pharmacy over another by these methods.
- (5) Reduce allowable reimbursement for pharmacy services to a beneficiary under a health benefit plan because the beneficiary selects a pharmacy of his or her choice, so long as that pharmacy has enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage area; or
- (6) Require a beneficiary, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy.

(d) A pharmacy, by or through a pharmacist acting on its behalf as its employee, agent, or owner, may not waive, discount, rebate, or distort a copayment of any insurer, policy, or plan, or a beneficiary's coinsurance portion of a prescription drug coverage or reimbursement and if a pharmacy, by or through a pharmacist's acting on its behalf as its employee, agent or owner, provides a pharmacy service to an enrollee of a health benefit plan that meets the terms and requirements of the insurer under a health benefit plan, the pharmacy shall provide its pharmacy services to all enrollees of that health benefit plan on the same terms and requirements of the insurer. A violation of this subsection shall be a violation of the Pharmacy Practice Act subjecting the pharmacist as a licensee to disciplinary authority of the North Carolina Board of Pharmacy pursuant to G.S. 90-85.38.

(e) At least 60 days before the effective date of any health benefit plan providing reimbursement to North Carolina residents for prescription drugs, which restricts pharmacy participation, the entity providing the health benefit plan shall notify, in writing, all pharmacies within the geographical coverage area of the health benefit plan, and offer to the pharmacies the opportunity to participate in the health benefit plan. All pharmacies in the geographical coverage area of the plan shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. The entity providing the health benefit plan shall, through reasonable means, on a timely basis, and on regular intervals in order to effectuate the purposes of this section, inform the beneficiaries of the plan of the names and locations of pharmacies that are participating in the plan as providers of pharmacy services and prescription drugs. Additionally, participating pharmacies shall be entitled to announce their participation to their customers through

a means acceptable to the pharmacy and the entity providing the health benefit plans. The pharmacy notification provisions of this section shall not apply when an individual or group is enrolled, but when the plan enters a particular county of the State.

(f) If rebates or marketing incentives are allowed to pharmacies or other dispensing entities providing services or benefits under a health benefit plan, these rebates or marketing incentives shall be offered on an equal basis to all pharmacies and other dispensing entities providing services or benefits under a health benefit plan when pharmacy services, including prescription drugs, are purchased in the same volume and under the same terms of payment. Nothing in this section shall prevent a pharmaceutical manufacturer or wholesale distributor of pharmaceutical products from providing special prices, marketing incentives, rebates, or discounts to different purchasers not prohibited by federal and State antitrust laws.

(g) Any entity or insurer providing a health benefit plan is subject to G.S. 58-2-70. A violation of this section shall subject the entity providing a health benefit plan to the sanctions of revocation, suspension, or refusal to renew license in the discretion of the Commissioner pursuant to G.S. 58-3-100.

(h) A violation of this section creates a civil cause of action for damages or injunctive relief in favor of any person or pharmacy aggrieved by the violation.

(i) The Commissioner shall not approve any health benefit plan providing pharmaceutical services which does not conform to this section.

(j) Any provision in a health benefit plan which is executed, delivered, or renewed, or otherwise contracted for in this State that is contrary to any provision of this section shall, to the extent of the conflict, be void.

(k) It shall be a violation of this section for any insurer or any person to provide any health benefit plan providing for pharmaceutical services to residents of this State that does not conform to the provisions of this section. (1993, c. 293, s. 1.)

§ 58-51-38. Direct access to obstetrician-gynecologists.

(a) Each health benefit plan shall allow each female plan participant or beneficiary age 13 or older direct access within the health benefit plan, without prior referral, to the health care services of an obstetrician-gynecologist participating in the health benefit plan, within the benefits provided under that health benefit plan pertaining to obstetrician-gynecologist services.
For purposes of this section:
  (1) "Health benefit plan" means an HMO subscriber contract or any preferred provider, exclusive provider, or other managed care arrangement offered under a health benefit plan, as defined in G.S. 58-50-110(11).
  (2) "Health care services" means the full scope of medically necessary services provided by the participating obstetrician-gynecologist in the care of or related to the female reproductive system and breasts, and in performing annual screening, counseling, and immunization for disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists, and includes services provided by nurse practitioners, physician's assistants, and certified nurse midwives in collaboration with the obstetrician-gynecologist in the care of the participant or beneficiary.
  (3) "Benefits" are those medical services or other items to which an individual is entitled under the terms of her contract with a health benefit plan, as approved by the Department of Insurance.

(b) Each health benefit plan shall inform female participants and beneficiaries in writing of the provisions of this section. The information shall be provided in benefit handbooks and materials and enrollment materials. (1995, c. 63, s. 1.)

§ 58-51-40. Insurers and others to afford coverage for active medical treatment in tax-supported institutions.

(a) Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for benefits for charges of hospitals or physicians, the policy shall provide for payments of benefits for charges made for medical care rendered in or by duly licensed State tax-supported institutions, including charges for medical care of cerebral palsy, other orthopedic and crippling disabilities, mental and nervous diseases or disorders, mental retardation, alcoholism and drug or chemical dependency, and respiratory illness, on a basis no less favorable than the basis which would apply had the medical care been rendered in or by any other public or private institution or provider. The

term "State tax-supported institutions" shall include community mental health centers and other health clinics which are certified as Medicaid providers.

(b) No policy shall exclude payment for charges of a duly licensed State tax-supported institution because of its being a specialty facility for one particular type of illness nor because it does not have an operating room and related equipment for the performance of surgery, but it is not required that benefits be payable for domiciliary or custodial care, rehabilitation, training, schooling, or occupational therapy.

(c) The restrictions and regulations of this section shall not apply to any policy which is individually underwritten or provided for a specific individual and the members of his family as a nongroup policy but shall apply to any group policy of insurance governed by Articles 1 through 64 of this Chapter. (1975, c. 345, s. 1; 1981, c. 816, ss. 1, 2.)

§ 58-51-45. Policies to be issued to any person possessing the sickle cell trait or hemoglobin C trait.

No insurance company licensed in this State pursuant to the provisions of Articles 1 through 64 of this Chapter shall refuse to issue or deliver any policy (regardless of whether any of such policies shall be defined as individual, family, group, blanket, franchise, industrial or otherwise) which is currently being issued for delivery in this State, and which affords benefits or coverage for any medical treatment or service authorized or permitted to be furnished by a hospital, clinic, family health plan, neighborhood health plan, health maintenance organization, physician, physician's assistant, nurse practitioner or any medical service facility or personnel by reason of the fact that the person to be insured possesses sickle cell trait or hemoglobin C trait, nor shall any such policy issued and delivered in this State carry a higher premium rate or charge by reason of the fact that the person to be insured possesses said trait. (1975, c. 599, s. 1.)

§ 58-51-50. Coverage for chemical dependency treatment.

(a) As used in this section, the term "chemical dependency" means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(b) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance that is issued, renewed, or amended on or after January 1, 1985, shall offer to its insureds benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally. Except as provided in subsection (c) of this section, benefits for treatment of chemical dependency shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits for physical illness generally.

(c) Every group policy or group contract of insurance that provides benefits for chemical dependency treatment and that provides total annual benefits for all illnesses in excess of eight thousand dollars ($8,000) is subject to the following conditions:

(1) The policy or contract shall provide, for each 12-month period, a minimum benefit of eight thousand dollars ($8,000) for the necessary care and treatment of chemical dependency.

(2) The policy or contract shall provide a minimum benefit of sixteen thousand dollars ($16,000) for the necessary care and treatment of chemical dependency for the life of the policy or contract.

(d) Provisions for benefits for necessary care and treatment of chemical dependency in group policies or group contracts of insurance shall provide benefit payments for the following providers of necessary care and treatment of chemical dependency:

(1) The following units of a general hospital licensed under Article 5 of General Statutes Chapter 131E:

a. Chemical dependency units in facilities licensed after October 1, 1984;
b. Medical units;
c. Psychiatric units; and

(2) The following facilities or programs licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:

a. Chemical dependency units in psychiatric hospitals;
b. Chemical dependency hospitals;
c. Residential chemical dependency treatment facilities;
d. Social setting detoxification facilities or programs;
e. Medical detoxification or programs; and

(3) Duly licensed physicians and duly licensed practicing psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C.
Provided, however, that nothing in this subsection shall prohibit any policy or contract of insurance from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

(e) Coverage for chemical dependency treatment as described in this section shall not be applicable to any group policy holder or group contract holder who rejects the coverage in writing. (1983 (Reg. Sess., 1984), c. 1110, s. 7; 1985, c. 589, s. 43(a), (b); 1989, c. 175, s. 1; 1991, c. 720, s. 64.)

§ 58-51-55. No discrimination against the mentally ill and chemically dependent.

(a) Definitions. – As used in this section, the term:
(1) "Mental illness" has the same meaning as defined in G.S. 122C-3(21); and
(2) "Chemical dependency" has the same meaning as defined in G.S. 58-51-50 with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. – No insurance company licensed in this State under this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:
(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;
(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or
(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Mental Illness or Chemical Dependency Coverage Not Required. – Nothing in this section requires an insurer to offer coverage for mental illness or chemical dependency, except as provided in G.S. 58-51-50.

(d) Applicability. – Subsection (b1) of this section applies only to group health insurance contracts, other than excepted benefits as defined in G.S. 58-68-25, covering more than 50 employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-49-30(a). (1989, c. 369, s. 3; 1991, c. 720, s. 81; 1997-259, s. 21; 1999-132, s. 4.2.)

§ 58-51-57. Coverage for mammograms and cervical cancer screening.

(a) Every policy or contract of accident or health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(a1) As used in this section, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:
(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:
a. The woman has a personal history of breast cancer;
b. The woman has a personal history of biopsy-proven benign breast disease;

c. The woman's mother, sister, or daughter has or has had breast cancer; or
d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;
(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and
(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation standards established by the North Carolina Medical Care Commission.
(e) Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission. (1991, c. 490, s. 1; 1997-519, s. 3.3; 2003-186, s. 2.)

§ 58-51-58. Coverage for prostate-specific antigen (PSA) tests.

(a) Every policy or contract of accident and health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer.
(b) As used in this section, "prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer" means serological tests for determining the presence of prostate cytoplasmic protein (PSA) and the generation of antibodies to it, as a novel marker for prostatic disease.
(c) Coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer shall be provided when recommended by a physician. (1993, c. 269, s. 1; 1997-519, s. 3.4.)

§ 58-51-59. Coverage of certain prescribed drugs for cancer treatment.

(a) No policy or contract of accident or health insurance, and no preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:
(1) The American Medical Association Drug Evaluations;
(2) The American Hospital Formulary Service Drug Information; or
(3) The United States Pharmacopeia Drug Information.
(b) Notwithstanding subsection (a) of this section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.
(c) This section shall apply only to cancer drugs and nothing in this section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition. (1993, c. 506, s. 4.1; 1997-519, s. 3.5.)

§ 58-51-60. Meaning of term "preexisting conditions" in certain policies.

At the time of issuing any new policy of individual or family hospitalization insurance or individual accident and health insurance to insureds over age 65, the term "preexisting conditions," or its equivalent in said policy shall include only conditions specifically eliminated by rider. (1955, c. 850, s. 5.)

§ 58-51-61. Coverage for certain treatment for diabetes.

(a) Every policy or contract of accident or health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after October 1, 1997, shall provide coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a physician or a health care professional designated by the physician. The insurer shall determine who shall provide and be reimbursed for the diabetes outpatient self-management training and educational services. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to the diabetes coverage required under this section.
(b) For the purposes of this section, "physician" is a person licensed to practice in this State under Article 1 or Article 7 of Chapter 90 of the General Statutes. (1997-225, s. 1; 1997-519, s. 3.11.)

§ 58-51-62. Coverage for reconstructive breast surgery following mastectomy.

(a) Every policy or contract of accident and health insurance, and every preferred provider benefit plan under G.S. 58-50-56 that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery following a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry if reconstructive surgery on a diseased breast is performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.
(b) As used in this section, the following terms have the meanings indicated:
    (1) "Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.
    (2) "Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. "Reconstructive breast surgery" also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.
(c) A policy, contract, or plan subject to this section shall not:
    (1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;
    (2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;
    (3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;
    (4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or
    (5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.
(d) Written notice of the availability of the coverage provided by this section shall be delivered to every policyholder under an individual policy, contract, or plan and to every certificate holder under a group policy, contract, or plan upon initial coverage under the policy, contract, or plan and annually thereafter. The notice required by this subsection may be included as a part of any yearly informational packet sent to the policyholder or certificate holder. (1997-312, s. 1; 1997-456, s. 40(a); 1997-519, s. 3.9; 1999-351, s. 3.1; 2001-334, s. 13.1.)

§ 58-51-70. Industrial sick benefit insurance; provisions.

Policies issued under the industrial sick benefit plan shall contain the substance of provisions contained in G.S. 58-51-15 and in addition shall contain the following:

(1) A provision for grace for the payment of the additional premium or assessment or proportion thereof for such death benefits of not less than four weeks during which period the death benefit shall continue in force;
(2) A provision for incontestability of the death benefit coverage after not more than two years except for
a. Nonpayment of premiums, and
b. Misstatement of age;
(3) A provision that the death benefit is noncancellable by the company except for nonpayment of premium.
The Commissioner may approve any form of certificate to be issued under the industrial sick benefit plan which omits or modifies any of the provisions hereinbefore required, if he deems such omission or modification suitable for the character of such insurance and not unjust to the persons insured thereunder. (1945, c. 385; 1953, c. 1095, s. 4; 1979, c. 755, s. 14.)

§ 58-51-75. Blanket accident and health insurance defined.

(a) Any policy or contract of insurance against death or injury resulting from accident or from accidental means which insures a group of persons conforming to the requirements of one of the following subdivisions (1) to (7), inclusive, shall be deemed a blanket accident policy. Any policy or contract which insures a group of persons conforming to the requirements of one of the following subdivisions (3), (5), (6) or (7) against total or partial disability, excluding such disability from accident or from accidental means, shall be deemed a blanket health insurance policy. Any policy or contract of insurance which combines the coverage of blanket accident insurance and of blanket health insurance on such a group of persons shall be deemed a blanket accident and health insurance policy:
(1) Under a policy or contract issued to any railroad, steamship, motorbus or airplane carrier of passengers, which shall be deemed the policyholder, a group defined as all persons who may become such passengers may be insured against death or bodily injury either while, or as a result of, being such passengers.
(2) Under a policy or contract issued to an employer, or the trustee of a fund established by the employer, who shall be deemed the policyholder, covering any group of employees defined by reference to exceptional hazards incident to such employment, insuring such employee against death or bodily injury resulting while, or from, being exposed to such exceptional hazard.
(3) Under a policy or contract issued to a college, school or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder.
(4) Under a policy or contract issued in the name of any volunteer fire department, which shall be deemed the policyholder, covering all of the members of such department.
(5) Under a policy or contract issued to and in the name of an incorporated or unincorporated association of persons having a common interest or calling, which association shall be deemed the policyholder, having not less than 25 members, and formed for purposes other than obtaining insurance, covering all of the members of such association.
(6) Under a policy or contract issued to the head of a family, who shall be deemed the policyholder, whereunder the benefits thereof shall provide for the payment by the insurer of amounts for expenses incurred by the policyholder on account of hospitalization or medical or surgical aid for himself, his spouse, his child or children, or other persons chiefly dependent on him for support and maintenance.
(7) Under a policy or contract issued in the name of any municipal or county recreation commission or department which shall be deemed the policyholder.

(b) All benefits under any blanket accident, blanket health or blanket accident and health insurance policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate, except that if the person insured be a minor, such benefits may be made payable to his parent, guardian, or other person actually supporting him, or to a person or persons chiefly dependent upon him for support and maintenance.

(c) Nothing contained in this section shall be deemed to affect the legal liability of policyholders for the death of or injury to, any such member of such group. (1945, c. 385; 1947, c. 721; 1953, c. 1095, s. 5; 1961, c. 603.)

§ 58-51-80. Group accident and health insurance defined.

(a) Any policy or contract of insurance against death or injury resulting from accident or from accidental means which covers more than one person except blanket accident policies as defined in G.S. 58-51-75, shall be deemed a group accident insurance policy. Any policy or contract which insures against disablement, disease or sickness of the insured (excluding disablement which results from accident or from accidental means) and which covers more than one person, except blanket health insurance policies as defined in G.S. 58-51-75, shall be deemed a group health insurance policy or contract. Any policy or contract of insurance which combines the coverage of group accident insurance and of group health insurance shall be deemed a group accident and health insurance policy. No policy or contract of group accident, group health or group accident and health insurance, and no certificates thereunder, shall be delivered or issued for delivery in this State unless it conforms to the requirements of subsection (b).

(b) No policy or contract of group accident, group health or group accident and health insurance shall be delivered or issued for delivery in this State unless the group of persons thereby insured conforms to the requirements of the following subdivisions:

(1) Under a policy issued to an employer, principal, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, or by a principal or two or more principals in the same industry or kind of business, which employer, principal, or trustee shall be deemed the policyholder, covering, except as hereinafter provided, only employees, or agents, of any class or classes thereof determined by conditions pertaining to employment, or agency, for amounts of insurance based upon some plan which will preclude individual selection. The premium may be paid by the employer, by the employer and the employees jointly, or by the employee; and where the relationship of principal and agent exists, the premium may be paid by the principal, by the principal and agents, jointly, or by the agents. If the premium is paid by the employer and the employees jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis.

(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least five years; and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members, other than associate members, have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

a. The policy may insure members of the association or associations, employees of the association or associations, or employees of members, or one or more of the preceding or all of any class or classes for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members. The premium rates for each association policy shall be developed, and applied to the certificates thereunder, on an actuarially sound basis.

c. Repealed by Session Laws 1997-259, s. 8.

(1b) Under a policy issued to a creditor as defined in G.S. 58-57-5 who shall be deemed the policyholder, to insure debtors as defined in G.S. 58-57-5 of the creditor to provide indemnity for payments becoming due on a specific loan or other credit transaction as defined in G.S. 58-51-100, with or without insurance against death by accident, subject to the following requirements:

a. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor whose indebtedness is repayable in installments, or all of any class or classes thereof determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness. The policy may provide that

the term "debtors" shall include the debtors of one or more subsidiary corporations, and the debtors of one or more affiliated corporations, proprietors or partnerships if the business of the policyholder and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership, contract or otherwise.

b. The premium for the policy shall be paid from the creditor's funds, from charges collected from the insured debtors, or from both. A policy on which part or all of the premium is to be derived from the collection from the insured debtors or identifiable charges not required of uninsured debtors shall not include, in the class or classes of debtors eligible for insurance, debtors under obligations outstanding at its date of issue without evidence of individual insurability unless the group is structured on an actuarially sound basis. A policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

c. The policy may be issued only if the group of eligible debtors is then receiving new entrants at the rate of at least 100 persons yearly, or may reasonably be expected to receive at least 100 new entrants during the first policy year, and only if the policy reserves to the insurer the right to require evidence of individual insurability if less than seventy-five percent (75%) of the new entrants become insured.

d. Premiums for this coverage shall be actuarially equivalent to the rates authorized under Article 57 of Chapter 58 of the General Statutes for credit accident and health insurance.

(2), (3) Repealed by Session Laws 1997-259, s. 8.

(c) The term "employees" as used in this section shall be deemed to include, for the purposes of insurance hereunder, employees of a single employer, the officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms of which the business is controlled by the insured employer through stock ownership, contract or otherwise. With the exception of disability income insurance, employees shall be added to the group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term "employee" is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis. The term "employer" as used herein may be deemed to include the State of North Carolina, any county, municipality or corporation, or the proper officers, as such, of any unincorporated municipality or any department or subdivision of the State, county, such corporation, or municipality determined by conditions pertaining to the employment. When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees.

(d) The term "agents" as used in this section shall be deemed to include, for the purposes of insurance hereunder, agents of a single principal who are under contract to devote all, or substantially all, of their time in rendering personal services for such principal, for a commission or other fixed or ascertainable compensation.

(e) The benefits payable under any policy or contract of group accident, group health and group accident and health insurance shall be payable to the employees, or agents, or to some beneficiary or beneficiaries designated by the employee or agent, other than the employer or principal, but if there is no designated beneficiary as to all or any part of the insurance at the death of the employee or agent, then the amount of insurance payable for which there is no designated beneficiary shall be payable to the estate of the employee or agent, except that the insurer may in such case, at its option, pay such insurance to any one or more of the following surviving relatives of the employee or agent: wife, husband, mother, father, child, or children, brothers or sisters; and except that payment of benefits for expenses incurred on account of hospitalization or medical or surgical aid, as provided in subsection (f), may be made by the insurer to the hospital or other person or persons furnishing such aid. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

(f) Any policy or contract of group accident, group health or group accident and health insurance may include provisions for the payment by the insurer of benefits to the employee or agent of the insured group, on account of hospitalization or medical or surgical aid for himself, his spouse, his child or children, or other persons chiefly dependent upon him for support and maintenance.

(g) Any policy or contract of group accident, group health or group accident and health insurance may provide for readjustment of the rate of premium based on the experience thereunder at the end of the first year, or at any time during any subsequent year based upon at least 12 months of experience: Provided that any such readjustment after the first year shall not be made any more frequently than once every six months. Any rate adjustment must be preceded by a 45-day notice to the contract holder before the effective date of any rate increase or any policy benefit revision. A notice of nonrenewal shall be given to the contract holder 45 days prior to termination. Any refund under any plan for readjustment of the rate of premium based on the experience under group policies and any dividend paid under the policies may be used to reduce the employer's or principal's contribution to group insurance for the employees of the employer, or the agents of the principal, and the excess over the contribution by the employer, or principal, shall be applied by the employer, or principal, for the sole benefit of the employees or agents.

(h) Nothing contained in this section applies to any contract issued by any corporation defined in Article 65 of this Chapter. (1945, c. 385; 1947, c. 721; 1951, c. 282; 1953, c. 1095, ss. 6, 7; 1987, c. 752, s. 19; 1989, c. 485, s. 41; c. 775, ss. 1, 2; 1991, c. 644, s. 11; c. 720, s. 88; 1991 (Reg. Sess., 1992), c. 837, s. 4; 1993, c. 408, ss. 3, 3.1; c. 409, s. 14; 1995, c. 507, ss. 23A.1(c), 23A.1(d); 1997-259, ss. 8, 9; 2000-132, s. 1; 2003-221, s. 12; 2005-223, ss. 1(a), 2(c).)

§ 58-51-81. Group accident and health insurance for public school students.

(a) Notwithstanding G.S. 58-51-80, a policy of group accident, health, or accident and health insurance may be delivered or issued to a local board of education or to any of its schools, as policyholder, covering only students for amounts of insurance based upon some plan that will preclude individual selection. The premium may be paid by the board, jointly by the board and the students or any other persons on behalf of the students, or by the students and any other persons on behalf of the students. In addition to the authority granted in G.S. 115C-47(6), any board may establish fees for the payment of premiums by or on behalf of the covered students.

(b) Entities subject to Articles 65 and 67 of this Chapter may provide their products in the same manner described in subsection (a) of this section. (1993 (Reg. Sess., 1994), c. 716, s. 1.)

§ 58-51-85. Group or blanket accident and health insurance; approval of forms and filing of rates.

No policy of group or blanket accident, health or accident and health insurance shall be delivered or issued for delivery in this State unless the form of the policy contracts including the master policy contract, the individual certificates thereunder, the applications for the contract, and a schedule of the premium rates pertaining to such form or forms, have been filed with and the forms approved by the Commissioner. (1945, c. 385; 1991, c. 720, s. 34.)

§ 58-51-90. Definition of franchise accident and health insurance.

Accident and health insurance on a franchise plan is hereby declared to be that form of accident and health insurance issued to five or more employees of any corporation, copartnership or individual employer or any governmental corporation, agency or department thereof, or 10 or more members of any trade or professional association or of a labor union or of any other association where such association or union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance, where such persons, with or without their dependents, are issued the same form of an individual policy varying only as to amounts and kinds of coverage applied for by such persons, under an arrangement whereby the premiums on such policies may be paid to the insurer periodically by the employer, with or without payroll deductions, or by the association for its members, or by some designated person acting on behalf of such employer or association. The provisions of this section shall not be construed so as to repeal G.S. 58-51-75 and 58-51-80 or any parts thereof. (1947, c. 721; 1961, c. 646.)

§ 58-51-95. Approval by Commissioner of forms, classification and rates; hearing; exceptions.

(a) No policy of insurance against loss or expense from the sickness, or from the bodily injury or death by accident of the insured shall be issued or delivered to any person in this State nor shall any application, rider or endorsement be used in connection therewith until a copy of the form thereof and of the classification of risks and the premium rates, or, in the case of cooperatives or

assessment companies the estimated cost pertaining thereto, have been filed with the Commissioner.

(b) No such policy shall be issued, nor shall any application, rider or endorsement be used in connection therewith, until the expiration of 90 days after it has been so filed unless the Commissioner shall sooner give his written approval thereto.

(c) The Commissioner may within 90 days after the filing of any such form, disapprove such form
  (1) If the benefits provided therein are unreasonable in relation to the premium charged, or
  (2) If it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of such policy.

(d) If the Commissioner shall notify the insurer which has filed any such form that it does not comply with the provisions of this section or sections, it shall be unlawful thereafter for such insurer to issue such form or use it in connection with any policy. In such notice the Commissioner shall specify the reasons for his disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer.

(e) The Commissioner may at any time, after a hearing of which not less than 20 days' written notice shall have been given to the insurer, withdraw his approval of any such form on any of the grounds stated in this section. It shall be unlawful for the insurer to issue such form or use it in connection with any policy after the effective date of such withdrawal of approval. The notice of any hearing called under this paragraph shall specify the matters to be considered at such hearing and any decision affirming disapproval or directing withdrawal of approval under this section shall be in writing and shall specify the reasons therefor: Provided, that the provisions of this section shall not apply to workers' compensation insurance, accidental death or disability benefits issued supplementary to life insurance or annuity contracts, medical expense benefits under liability policies or to group accident and health insurance.

(f) An insurer may revise rates chargeable on policies subject to this section, other than noncancellable policies, with the approval of the Commissioner if the Commissioner finds that the revised rates are not excessive, not inadequate, and not unfairly discriminatory; and exhibit a reasonable relationship to the benefits provided by the policies. The approved rates shall be guaranteed by the insurer, as to the policyholders affected by the rates, for a period of not less than 12 months; or as an alternative to the insurer giving the guarantee, the approved rates may be applicable to all policyholders at one time if the insurer chooses to apply for that relief with respect to those policies no more frequently than once in any 12-month period. The rates shall be applicable to all policies of the same type; provided that no rate revision may become effective for any policy unless the insurer has given the policyholder written notice of the rate revision 45 days before the effective date of the revision. The policyholder must then pay the revised rate in order to continue the policy in force. The Commissioner may adopt reasonable rules, after notice and hearing, to require the submission of supporting data and such information as the Commissioner considers necessary to determine whether the rate revisions meet these standards. In adopting the rules under this subsection, the Commissioner may require identification of the types of rating methodologies used by filers and may also address issue age or attained age rating, or both; policy reserves used in rating; and other recognized actuarial principles of the NAIC, the American Academy of Actuaries, and the Society of Actuaries.

(g) For policies subject to this section, an individual health insurer shall not increase an individual's renewal premium for continued health insurance coverage under the terms of the individual's health insurance policy based on any health status-related factors in relation to the individual or a dependent of the individual, including:
  (1) Health status.
  (2) Medical condition (including physical and mental illnesses).
  (3) Claims experience.
  (4) Duration from issue.
  (5) Receipt of health care.
  (6) Medical history.
  (7) Genetic information.

(h) Every policy that is subject to this section and that provides individual accident and health insurance benefits to a resident of this State shall return to policyholders benefits that are reasonable in relation to the premium charged. The Commissioner may adopt rules or utilize existing rules to establish minimum standards for loss ratios of policies on the basis of incurred claims experience and earned premiums in accordance with accepted actuarial principles and practices to assure that the benefits are reasonable in relation to the premium charged. Every

insurer providing policies in this State subject to this section shall not less than annually file for approval its rates, rating schedules, and supporting documentation to demonstrate compliance with the applicable loss ratio standards of this State as adopted by the Commissioner. All filings of rates and rating schedules shall comply with the standards adopted by the Commissioner. The filing shall include a certification by an individual who is either a Fellow or an Associate of the Society of Actuaries or a Member of the American Academy of Actuaries that the rates are not excessive, not inadequate, and not unfairly discriminatory; and that the rates exhibit a reasonable relationship to the benefits provided by the policy. Nothing in this subsection shall require an insurer to provide certification with respect to a previous rate period, or to require an insurer to reduce properly filed and approved rates before the end of a rate period. This subsection does not apply to any long-term care policy issued in this State on or after February 1, 2003, and noncancellable accident and health insurance.

(i) For any long-term care policy issued in this State on or after February 1, 2003, an insurer shall on or before March 15 of each year:
   (1) Provide to the Commissioner an actuarial certification listing all of its long-term care policy forms available for sale in this State as of December 31 of the prior year, stating that the current premium rate schedule for each form is sufficient to cover anticipated costs under moderately adverse experience and stating that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated.
   (2) For any policy form for which the statement in subdivision (1) of this subsection cannot be made or is qualified, submit a plan of corrective action to the Commissioner for approval.

(j) For purposes of this section, accident and health insurance means insurance against death or injury resulting from accident or from accidental means and insurance against disablement, disease, or sickness of the insured. This includes Medicare supplemental insurance, long-term care, nursing home, or home health care insurance, or any combination thereof, specified disease or illness insurance, hospital indemnity or other fixed indemnity insurance, short-term limited duration health insurance, dental insurance, vision insurance, and medical, hospital, or surgical expense insurance or any combination thereof. Notwithstanding any other provision to the contrary, subsection (h) of this section does not apply to disability income insurance. (1951, c. 784; 1979, c. 755, s. 15; 1989, c. 485, s. 56; 1991, c. 636, s. 3; c. 720, s. 4; 2001-334, s. 17.3; 2005-223, s. 1(b); 2005-412, ss. 1(a), 1(b).)

§ 58-51-100. Credit accident and health insurance.

Credit accident and health insurance is declared to be insurance against death or personal injury by accident or by any specified kind or kinds of accident, and insurance against sickness, ailment, or bodily injury of a debtor who may be indebted to any person, firm, or corporation extending credit to such debtor. The amount of credit accident and health insurance written shall not exceed the installment payment. (1953, c. 1096, s. 2; 1961, c. 1071.)

§ 58-51-105. Hospitalization insurance defined.

Hospitalization insurance is declared to be any form of accident and health insurance which provides indemnity or payment for expenses incurred due to or in connection with hospitalization of the insured, or his dependents. (1953, c. 1096, s. 3.)

§ 58-51-110. Renewal, discontinuance, or replacement of group health insurance.

(a) This section applies to group accident, group health, or group accident and health policies or certificates that are delivered, issued for delivery, renewed, or used in this State which provide hospital, surgical, or major medical expense insurance, or any combination of these coverages, on an expense incurred or service basis. It specifically includes a certificate issued under a policy that was issued to a trust located out of this State, but which includes participating employers located in this State. Renewal of these policies or certificates is presumed to occur on the anniversary date that the coverage was first effective on the employees of the employer.

(b) Whenever a contract described in subsection (a) of this section is replaced by another group contract within 15 days of termination of coverage of the previous group contract, the liability of the succeeding insurer for insuring persons covered under the previous group contract is:
   (1) Each person who is eligible for coverage in accordance with the succeeding insurer's plan of benefits, regardless of any other provisions of the new group contract relating to

active employment or hospital confinement or pregnancy, shall be covered by the succeeding insurer's plan of benefits; and

(2) Each person not covered under the succeeding insurer's plan of benefits in accordance with subdivision (b)(1) of this section must nevertheless be covered by the succeeding insurer if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding insurer's plan. (1989, c. 775, s. 3; 1991, c. 720, s. 88; 1991 (Reg. Sess., 1992), c. 837, s. 4; 2001-334, s. 6.)

§ 58-51-115. Coordination of benefits with Medicaid.

(a) As used in this section and in G.S. 58-51-120 and G.S. 58-51-125:

(1) "Health benefit plan" means any accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; the Teachers' and State Employees' Comprehensive Major Medical Plan under Chapter 135 of the General Statutes; or a plan provided by another benefit arrangement. "Health benefit plan" does not mean a Medicare supplement policy as defined in G.S. 58-54-1(5).

(2) "Health insurer" means any health insurance company subject to Articles 1 through 63 of this Chapter, including a multiple employee welfare arrangement, and any corporation subject to Articles 65 and 67 of this Chapter; a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974; and the Teachers' and State Employees' Comprehensive Major Medical Plan under Chapter 135 of the General Statutes.

(b) No health insurer shall take into account that an individual is eligible for or is provided medical assistance in this or any other state under 42 U.S.C. § 1396a (section 1902 of the Social Security Act) in insuring that individual or making payments under its health benefit plan for benefits to that individual or on that individual's behalf. (1993 (Reg. Sess., 1994), c. 644, s. 1; 1995, c. 193, s. 43; 1999-293, s. 9.)

§ 58-51-116. ERISA plans may not require Medicaid to pay first.

An employee benefit plan as defined in ERISA shall not include any provision which, because an individual is provided or is eligible for benefits or service pursuant to a State plan under Title XIX of the Social Security Act (Medicaid), has the effect of limiting or excluding coverage or payment for any health care for that individual under the terms of the employee benefit plan, provided that the individual is one who would otherwise be covered or entitled to benefits or services under the employee benefit plan. (1993, c. 321, s. 238.1; 2001-446, s. 4.3.)

§ 58-51-120. Coverage of children.

(a) No health insurer shall deny enrollment of a child under the health benefit plan of the child's parent on any of the following grounds:

(1) The child was born out of wedlock.

(2) The child is not claimed as a dependent on the parent's federal income tax return.

(3) The child does not reside with the parent or in the insurer's service area.

(b) If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through a health insurer, the health insurer:

(1) Must allow 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) Must enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.

(3) May not disenroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that:

a. The court or administrative order is no longer in effect; or

b. The child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.

(c) If a child has health benefit plan coverage through the health insurer of a noncustodial parent, that health insurer shall do all of the following:
  (1) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage.
  (2) Permit the custodial parent (or the health care provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent.
  (3) Make payments on claims submitted in accordance with subdivision (2) of this subsection directly to the custodial parent, the provider, or the Department of Health and Human Services.

(d) No health insurer may impose requirements on any State agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered. (1993 (Reg. Sess., 1994), c. 644, s. 1; 1997-443, s. 11A.118(a).)

§ 58-51-125. Adopted child coverage.

(a) Definitions. – As used in this section:
  (1) "Child" means, in connection with any adoption or placement for adoption of the child, an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption.
  (2) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations.

(b) Coverage Effective Upon Placement for Adoption. – If a health benefit plan provides coverage for dependent children of persons covered by the plan, the plan shall provide benefits to dependent children placed with covered persons for adoption under the same terms and conditions that apply to the natural, dependent children of covered persons, irrespective of whether the adoption has become final.

(c) Restrictions Based on Preexisting Conditions at Time of Placement for Adoption Prohibited. – A health benefit plan may not restrict coverage under the plan of any dependent child adopted by a covered person, or placed with a covered person for adoption, solely on the basis of any preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the covered person is eligible for coverage under the plan. (1993 (Reg. Sess., 1994), c. 644, s. 1.)

Group Health Insurance Continuation and Conversion Privileges

Part 1. Continuation.

§ 58-53-1. Definitions.

As used in this Article, the following terms have the meanings specified:
  (1) "Group policy" means a group accident and health insurance policy issued by an insurance company and a group contract issued by a service corporation or health maintenance organization or similar corporation or organization.
  (2) "Individual policy" or "converted policy" means an individual health insurance policy issued by an insurance company or an individual contract issued by a service corporation or health maintenance organization or similar corporation or organization.
  (3) "Insurance" and "insured" refer to coverage under a group policy, individual policy or converted policy on a premium-paying basis, and do not include coverage provided by reason of a disability extension.
  (4) "Insurer" means the entity issuing a group policy or an individual or converted policy.
  (5) "Medicare" means Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded.
  (5a) "Member" or "employee" includes an insured spouse or dependent of a member or of an employee.
  (6) "Premium" includes any premium or other consideration payable for coverage under a group or individual policy.
  (7) "Reasonable and customary" means the most frequently used level of charge made for the supplies or for a specific service in the geographic subarea in which such supplies

or services are received, of like kind or by physicians, or other practitioners, with similar qualifications. (1981, c. 706, s. 1; 1983, c. 142, s. 1; 1997-259, s. 10.)

§ 58-53-5. Continuation of group hospital, surgical, and major medical coverage after termination of employment or membership.

A group policy delivered or issued for delivery in this State that insures employees or members for hospital, surgical or major medical insurance on an expense incurred or service basis under this Chapter, other than for specific diseases or for accidental injuries only, shall provide that employees or members whose coverage under the group policy would otherwise terminate because of termination of active employment or membership, or termination of membership in the eligible class or classes under the policy, shall be entitled to continue their hospital, surgical, and medical insurance under that group policy, for themselves and their eligible spouses and dependents with respect to whom they were insured on the date of termination, subject to all of the group policy's terms and conditions and to the conditions specified in this Part. Provided, the terms and conditions set forth in this Part are intended as minimum requirements and shall not be construed to impose additional or different requirements upon those group hospital, surgical, or major medical plans that provide continuation benefits equal to or better than those required in this Part. (1981, c. 706, s. 1; 1997-259, s. 11.)

§ 58-53-10. Eligibility.

Continuation shall only be available to an employee or member who has been continuously insured under the group policy, or for similar benefits under any other group policy that it replaced, during the period of three consecutive months immediately before the date of termination. The employee or member may elect continuation for a period of not fewer than 60 days after the date of termination or loss of eligibility. The employee or member shall make the first contribution upon the election to continue coverage, and the coverage shall be retroactive to the date of termination or loss of eligibility. (1981, c. 706, s. 1; 2001-334, s. 7.1.)

§ 58-53-15. Exception.

Continuation shall not be available for any person who is or could be covered by any other arrangement of hospital, surgical, or medical coverage for individuals in a group, whether insured or uninsured, within 31 days immediately following the date of termination; or whose insurance terminated because he failed to pay any required contribution for the insurance. (1981, c. 706, s. 1.)

§ 58-53-20. Benefits not included.

Continuation is not required to include dental, vision care, or prescription drug benefits, or any other benefits provided under the group policy in addition to its hospital, surgical, or major medical benefits. (1981, c. 706, s. 1.)

§ 58-53-25. Notification to employee.

In addition to the notification requirement set forth in G.S. 58-53-40, notification may be included on insurance identification cards or may be given by the employer, orally or in writing as a part of the exit process from the employment. (1981, c. 706, s. 1.)

§ 58-53-30. Payment of premiums.

An employee or member electing continuation must pay to the group policyholder or his employer, in advance, the amount of contribution required by the policyholder or employer, but not more than one hundred two percent (102%) of the full group rate for the insurance applicable under the group policy on the due date of each payment. The employee or member may not be required to pay the amount of the contribution less often than monthly. In order to be eligible for continuation of coverage, the employee or member must make a written election of continuation, on a form furnished by the group policyholder or by the insurer. (1981, c. 706, s. 1; 1999-273, s. 1; 2001-334, s. 7.2.)

§ 58-53-35. Termination of continuation.

(a) Continuation of insurance under the group policy for any person shall terminate on the earliest of the following dates:

(1) The date 18 months after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or members;

(2) The date ending the period for which the employee or member last makes his required contribution, if he discontinues his contributions;
(3) The date the employee or member becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured;
(4) The date on which the group policy is terminated or, in the case of a multiple employer plan, the date his employer terminates participation under the group master policy. When this occurs the employee or member shall have the privilege described in G.S. 58-53-45 if the date of termination precedes that on which his actual continuation of insurance under that policy would have terminated. The insurer that insured the group before the date of termination shall make a converted policy available to the employee or member.

(b) Notwithstanding subdivision (a)(4) of this section, if the employer replaces the group policy with another group policy, the employee is entitled to continue under the successor group policy for any unexpired period of continuation to which the employee is entitled. (1981, c. 706, s. 1; 1983, c. 142, s. 2; 1993, c. 529, s. 3.8; 1997-259, s. 12.)

§ 58-53-40. Notification.

A notification of the continuation privilege shall be included in each individual certification of coverage. (1981, c. 706, s. 1.)

Part 2. Conversion.

§ 58-53-45. Right to obtain individual policy upon termination of group hospital, surgical or major medical coverage.

A group policy delivered or issued for delivery in this State that insures employees or members for hospital, surgical, or medical insurance on an expense incurred or service basis under Articles 1 through 67 of this Chapter other than for specific diseases or for accidental injuries only, shall provide that an employee or member whose insurance under the group policy has been terminated shall be entitled to have a converted policy issued to him by the insurer under whose group policy he was last insured, without evidence of insurability, subject to the terms and conditions specified in this Part. Provided, the terms and conditions set forth in this Part are intended as minimum requirements and shall not be construed to impose additional or different requirements upon those group hospital, surgical, or major medical plans already in force, or hereafter placed into effect, that provide conversion benefits equal to or better than those required in this Part. (1981, c. 706, s. 1.)

§ 58-53-50. Restrictions.

A converted policy shall not be available to an employee or member if termination of his insurance under the group policy occurred because:

(1) Of termination of employment or membership and either he was not entitled to continuation of group coverage under Part 1 of this Article or failed to elect such continuation;
(2) He failed to make timely payment of any required contribution for the cost of continuation of insurance;
(3) He had not been continuously covered under the group policy or for similar benefits under any other group policy that it replaced during the period of three consecutive months immediately prior to termination of active employment ending with such termination;
(4) The group policy terminated or an employer's participation terminated, and the insurance is replaced by similar coverage under another group policy within 31 days of date of termination; or
(5) He failed to continue his insurance for the entire maximum period of 18 months following termination of active employment as provided for in Part 1 of this Article, unless that failure to continue was because of change of insurer by the employer and the change of insurer was consummated during the one year continuation period. In that event the employee or member shall be entitled to be issued a converted policy by the insurer that provided the group policy to the employer before the change of insurer. (1981, c. 706, s. 1; 1983, c. 142, s. 3; 1993 (Reg. Sess., 1994), c. 569, s. 9; 1997-259, s. 13.)

§ 58-53-55. Time limit.
In order to be eligible for conversion, written application and the first premium payment for the converted policy must be made to the insurer not later than 31 days after the date of termination of insurance provided under Part 1 of this Article. The effective date of the converted policy shall be the day following the later of:

(1) The termination of insurance under the group policy when it is not replaced by one providing similar coverage within 31 days of the termination date of the immediately prior group plan; or
(2) The termination of the period of continued coverage under the group policy or policies. (1981, c. 706, s. 1; 1993 (Reg. Sess., 1994), c. 569, s. 10; 1997-259, s. 14.)

§ 58-53-60. Premium.

(a) The premium for the converted policy or group conversion trust certificate shall be determined in accordance with the insurer's table of premium rates applicable to the age and class of risk to be covered under that policy and to the type and amount of insurance provided.
(b) All insurers licensed to do business in this State, who issue conversion policies or group conversion trust certificates under this Part, have the right to increase that element of the premium that applies to hospital room and board benefit increases provided for in G.S. 58-53-95(5) by an amount proportionate to the increase promulgated by the Commissioner. Such premium increases shall be filed with the Commissioner.
(c) All premium rates and adjustments to premium rates for converted policies or group conversion trust certificates shall be reasonable and must be filed with and approved by the Commissioner prior to use. A premium rate shall be deemed to be reasonable if the insurer demonstrates that the premium charged is expected to produce an incurred loss ratio to earned premiums of not less than sixty percent (60%) for all policies or group conversion trust certificates providing similar benefits offered and issued by the insurer. If an insurer experiences an incurred loss ratio of greater than eighty percent (80%) for all such policies, it shall be deemed reasonable for that insurer to increase premium rates to a level that will produce a prospective incurred loss ratio of no greater than eighty percent (80%), and the insurer shall file such new rates with the Commissioner not more often than once a year. (1981, c. 706, s. 1; 1983, c. 669; 1995, c. 517, s. 30.)

§ 58-53-65. Coverage.
The converted policy shall cover the employee or member and his eligible dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any such eligible dependent. (1981, c. 706, s. 1.)

§ 58-53-70. Exclusions.
An insurer shall not be required to issue a converted policy covering any person if such person is or can be covered by Medicare. Furthermore, an insurer shall not be required to issue a converted policy covering any person if:

(1) -
a. Such person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy, or hospital or medical service subscriber contract or medical practice or other prepayment plan, or by any other plan or program;

b. Such person is or could be covered for similar benefits, whether or not covered for such benefits, under any arrangement of coverage for individuals in a group, whether insured or uninsured; or
c. Similar benefits are provided for or available to such person, whether or not covered for such benefits, by reason of any State or federal law; and

(2) The benefits under sources of the kind referred to in subdivision (1)a of this section for such person, or benefits provided or available under sources of the kind referred to in subdivisions (1)b and (1)c of this section for such person, together with the converted policy's benefits would result in overinsurance according to the insurer's standards for overinsurance; or
(3) An enrollee's enrollment in a health maintenance organization has been terminated for cause in accord with the terms of the enrollee's evidence of coverage or the health

maintenance organization's contract with the group. (1981, c. 706, s. 1; 1991, c. 195, s. 2.)

§ 58-53-75. Information.

A converted policy may provide that an insurer may at any time request information of an insured policyholder with respect to any person covered thereunder as to whether he is covered for the similar benefits described in G.S. 58-53-70(1)a or is or could be covered for the similar benefits described in G.S. 58-53-70(1)b and 58-53-70(1)c. The converted policy may provide that as of any premium due date an insurer may refuse to renew the policy or the coverage of any insured person for the following reasons only:

(1) Either those similar benefits for which such person is or could be covered, together with the converted policy's benefits, would result in overinsurance according to the insurer's standards for overinsurance, or the policyholder of the converted policy fails to provide the requested information;

(2) Fraud or material misrepresentation in applying for any benefits under the converted policy;

(3) Eligibility of any insured person for coverage under Medicare, or under any other State or federal law providing benefits substantially similar to those provided by the converted policy; or

(4) Termination of an enrollee's enrollment in a health maintenance organization for cause in accord with the terms of the enrollee's evidence of coverage or the health maintenance organization's contract with the group. (1981, c. 706, s. 1; 1991, c. 195, s. 3.)

§ 58-53-80. Excess benefits.

An insurer shall not be required to issue a converted policy providing benefits in excess of the equivalent value of hospital, surgical, or major medical insurance under the group policy from which conversion is made. (1981, c. 706, s. 1.)

§ 58-53-85. Preexisting conditions.

The converted policy shall not exclude, as a preexisting condition, any condition covered by the group policy. However, the converted policy may provide for a reduction of its hospital, surgical or medical benefits by the amount of any such benefits payable under the group policy after the individual's insurance terminates thereunder. The converted policy may also provide that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force and effect. (1981, c. 706, s. 1.)

§ 58-53-90. Basic coverage plans.

(a) Subject to the provisions of this Article, if the group insurance policy from which conversion is made insures the employee or member for basic hospital and surgical expense insurance, the employee or member shall be entitled to obtain a converted policy providing, at his option, coverage on an expense incurred basis under any of the following plans:

(1) Plan A:

a. Hospital room and board daily expense benefits in a maximum dollar amount approximating the average semiprivate rate charged in the major metropolitan area of this State, for a maximum duration of 70 days;

b. Miscellaneous hospital expense benefits up to a maximum amount of 10 times the hospital room and board daily expense benefits; and

c. Surgical expense benefits according to a surgical procedures schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of eight hundred dollars ($800.00).

(2) Plan B:

Identical to Plan A, except that (i) the maximum hospital room and board daily expense benefit is seventy-five percent (75%) of the corresponding Plan A maximum and (ii) the surgical schedule maximum is six hundred dollars ($600.00).

(3) Plan C:

Identical to Plan A, except that (i) the maximum hospital room and board daily expense benefit is fifty percent (50%) of the corresponding Plan A maximum and (ii) the surgical schedule maximum is four hundred dollars ($400.00).

(b) The maximum dollar amount for the maximum hospital room and board daily expense benefit of Plan A shall be determined by the Commissioner and may be redetermined by him from time to time as to converted policies issued subsequent to such redetermination. Such redetermination shall not be made more often than once in three years. The Plan A maximum, and the corresponding maximums in Plans B and C, shall be rounded to the nearest multiple ten dollars ($10.00), provided that rounding may be to the next higher or lower multiple of ten dollars ($10.00) if otherwise exactly midway between. (1981, c. 706, s. 1.)

§ 58-53-95. Major medical plans.

Subject to the provisions of this Article, if the group policy from which conversion is made insures the employee or member for major medical expense insurance, the employee or member shall be entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:

(1) A maximum benefit at least equal to either, at the option of the insurer,
   a. A maximum payment per covered person for all covered medical expenses incurred during that person's lifetime, equal to the lesser of the maximum benefit provided under the group policy or one hundred thousand dollars ($100,000); or
   b. A maximum payment for each unrelated injury or sickness, equal to the lesser of the maximum benefit provided under the group policy or one hundred thousand dollars ($100,000).

(2) Payment of benefits at the rate of eighty percent (80%) of covered medical expenses that are in excess of the deductible, until twenty percent (20%) of such expenses in a benefit period reaches one thousand dollars ($1,000), after which benefits will be paid at the rate of one hundred percent (100%) during the remainder of such benefit period. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than fifty percent (50%).

(3) A deductible for each benefit period which, at the option of the insurer, shall be (i) the sum of the benefits deductible and one hundred dollars ($100.00), or (ii) the corresponding deductible in the group policy. The term "benefits deductible," as used in this Part, means the value of any benefits provided on an expense incurred basis that are provided with respect to covered medical expenses by any other group or individual hospital, surgical, or medical insurance policy or medical practice or other prepayment plan, or any other plan, or program whether insured or uninsured, or by reason of any State or federal law and if, pursuant to G.S. 58-53-100, the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits.
   If the maximum benefit is determined by subdivision (1)a of this section, the insurer may require that the deductible be satisfied during a period of not less than three months if the deductible is one hundred dollars ($100.00) or less, and not less than six months if the deductible exceeds one hundred dollars ($100.00).

(4) The benefit period shall be each calendar year when the maximum benefit is determined by subdivision (1)a of this section or 24 months when the maximum benefit is determined by subdivision (1)b of this section.

(5) The term "covered medical expenses," as used in this Part, shall include, in the case of hospital room and board charges, at a minimum the lesser of the dollar amount in G.S. 58-53-90(a)(1) and the average semiprivate room and board rate for the hospital in which the individual is confined, and at a minimum twice such amount for charges in an intensive care unit. Any surgical procedures schedule shall be consistent with those customarily offered by the insurer under group or individual health insurance policies and must provide at least a one thousand two hundred dollar ($1,200) maximum. (1981, c. 706, s. 1.)

§ 58-53-100. Alternative plans.

At the option of the insurer, such plans of benefits set forth in G.S. 58-53-90 and 58-53-95 may be provided under one policy. Instead of providing the plans of benefits set forth in G.S. 58-53-90 and 58-53-95, the insurer may elect to provide a policy of comprehensive medical expense benefits without first dollar coverage. Said policy shall conform to the requirements of G.S. 58-53-95; provided, however, that an insurer electing to provide such a policy shall make available the following deductible options: one hundred dollars

($100.00), five hundred dollars ($500.00), and one thousand dollars ($1,000). Alternatively, such a policy may provide for deductible options equal to the greater of the benefits deductible and the amount specified in the preceding sentence. (1981, c. 706, s. 1.)

§ 58-53-105. Insurer option.
The insurer may, at its option, offer alternative plans for group health conversion in addition to those required by this Part. Furthermore, if any insurer customarily offers individual policies on a service basis, that insurer may, in lieu of converted policies on an expense incurred basis, make available converted policies on a service basis which, in the opinion of the Commissioner satisfy the intent of this Part. (1981, c. 706, s. 1.)

§ 58-53-110. Other conversion provisions.
(a) If coverage would in any event have been continued under the group policy on an employee following his retirement prior to the time he is or could be covered by Medicare and provided he would have been eligible for continuation under the group policy as specified in G.S. 58-53-10, the employee or member may elect, in lieu of such continuation of group insurance, to have the same conversion rights as would apply had that insurance terminated at retirement.
(b) The converted policy may provide for reduction or termination of coverage of any person upon his eligibility for coverage under Medicare or under any other State or federal law providing for benefits similar to those provided by the converted policy.
(c) Subject to the conditions set forth in this subsection, the conversion privilege shall also be available (i) to the surviving spouse, if any, at the death of the employee or member, with respect to the spouse and any eligible children whose coverage under the group policy terminates by reason of such death, or if the group policy provides for continuation of dependents' coverage following the employee's or member's death, at the end of such continuation, or (ii) to the spouse of the employee or member upon termination of coverage of the spouse because the spouse becomes ineligible because of divorce, separation, or otherwise, while the employee or member remains insured under the group policy, with respect to the spouse and such children whose coverage under the group policy terminates at the same time, or (iii) to a child solely with respect to himself upon termination of his coverage by reason of ceasing to be an eligible family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.
(d) The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual policy, notwithstanding the maximum period of group continuation specified in G.S. 58-53-35(1).
(e) A notification of the conversion privilege shall be included in each certificate of coverage.
(f) A converted policy which is delivered outside this State may be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction. (1981, c. 706, s. 1; 1983, c. 668, s. 1.)

§ 58-53-115. Article inapplicable to certain plans.
The provisions of this article shall not apply to hospital, surgical or major medical plans offered by employers on a self-insured basis. (1981, c. 706, s. 2.)

Fraternal Benefit Societies

§ 58-24-1. Fraternal benefit societies.
Any incorporated society, order or supreme lodge, without capital stock, including one exempted under the provisions of G.S. 58-24-185(a)(2) whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides benefits in accordance with this Article, is hereby declared to be a fraternal benefit society. (1987, c. 483, s. 2.)

§ 58-24-75. Benefits.
(a) A society may provide the following contractual benefits in any form:
(1) Death benefits;
(2) Endowment benefits;
(3) Annuity benefits;
(4) Temporary or permanent disability benefits;

(5) Hospital, medical or nursing benefits;
(6) Monument or tombstone benefits to the memory of deceased members; and
(7) Such other benefits as authorized for life insurers and which are not inconsistent with this Article.

(b) A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in subsection (a), 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. (1987, c. 483, s. 2.)

§ 58-24-160. Licensing of agents.

(a) Agents of societies shall be licensed in accordance with the provisions of the general insurance laws regulating the licensing, revocation, suspension or termination of license of resident and nonresident agents; provided that agents licensed pursuant to former G.S. 58-268 as of July 1, 1977, shall be exempt from examination.
(b) No examination or license shall be required of any regular salaried officer, employee or member of a licensed society who devotes substantially all of his or her services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained. (1987, c. 483, s. 2.)

§ 58-24-165. Unfair methods of competition and unfair and deceptive acts and practices.

Every society authorized to do business in this State shall be subject to the provisions of Article 63 of this Chapter relating to unfair methods of competition and unfair or deceptive acts or practices; provided, however, that nothing in such provisions shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society. (1987, c. 483, s. 2.)

§ 58-24-180. Penalties.

(a) Any person, officer, member, or examining physician of any society authorized to do business under this Article who shall knowingly or willfully make 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 benefit in any society transacting business under this Article, shall be guilty of a Class 1 misdemeanor.
(b) Any person who shall solicit membership for, or in any manner assist in procuring membership in any fraternal benefit society not licensed to do business in this State, or who shall solicit membership for, or in any manner assist in procuring membership in any such society not authorized as herein provided to do business as herein defined in this State, shall be guilty of a Class 3 misdemeanor and upon conviction thereof shall be punished only by a fine of not less than one thousand dollars ($1,000) nor more than five thousand dollars ($5,000).
(c) Any society, or any officer, agent, or employee thereof, neglecting or refusing to comply with, or violating, any of the provisions of this Article, the penalty for which neglect, refusal, or violation is not specified in this section, shall be guilty of a Class 3 misdemeanor, and upon conviction shall be punished only by a fine not to exceed five thousand dollars ($5,000).
(d) Any person violating the provisions of G.S. 58-24-65 shall be guilty of a Class I felony.
(e) Any person who willfully makes any false statement under oath in any verified report or declaration that is required by law from fraternal benefit societies, is guilty of a Class I felony. (1987, c. 483, s. 2; 1989 (Reg. Sess., 1990), c. 1054, s. 3; 1993, c. 539, ss. 451, 1273; 1994, Ex. Sess., c. 24, s. 14(c); 1993 (Reg. Sess., 1994), c. 767, s. 25.)

Life and Health Insurance Guaranty Association

§ 58-62-6. Purpose.

(a) The purpose of this Article is to protect, subject to certain limitations, the persons specified in G.S. 58-62-21(a) against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in G.S. 58-62-21(b), because of the delinquency of the member insurer that issued the policies.

(b) To provide this protection, an association of insurers is created to pay benefits and to continue coverages as limited herein, and members of the Association are subject to assessment to provide funds to carry out the purpose of this Article. (1991, c. 681, s. 56.)

§ 58-62-21. Coverage and limitations.

(a) This Article provides coverage for the policies and contracts specified in subsection (b) of this section:
  (1) To persons who, regardless of where they reside (except for nonresident certificate holders under group policies), are the beneficiaries, assignees, or payees of the persons covered under subdivision (2) of this subsection, and
  (2) To persons who are owners or certificate holders under the policies, or in the case of unallocated annuity contracts to the persons who are the contract holders, and who are residents of this State, or who are not residents of this State, but only under all of the following conditions: (i) the insurers that issued the policies are domiciled in this State; (ii) the insurers never held a license in the states in which the persons reside; (iii) the states have associations similar to the association created by this Article; and (iv) the persons are not eligible for coverage by the associations.

(b) This Article provides coverage to the persons specified in subsection (a) of this section for direct, nongroup life, health, annuity, and supplemental policies, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this Article. Annuity contracts and certificates under group annuity contracts include guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement agreements, lottery contracts, and any immediate or deferred annuity contracts.

(c) This Article does not provide coverage for:
  (1) Any part of a policy not guaranteed by the insurer, or under which the risk is borne by the policyholder;
  (2) Any policy or contract of reinsurance, unless assumption certificates have been issued;
  (3) Any part of a policy to the extent that the rate of interest on which it is based:
    a. Averaged over the period of four years before the date on which the Association becomes obligated with respect to the policy, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for a lesser period if the policy was issued less than four years before the Association became obligated; and
    b. On and after the date on which the Association becomes obligated with respect to the policy, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;
  (4) Any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association, or similar entity under:
    a. A multiple employer welfare arrangement as defined in section 514 of the Employee Retirement Income Security Act of 1974, as amended;
    b. A minimum premium group insurance plan;
    c. A stop-loss group insurance plan; or
    d. An administrative services only contract;
  (5) Any part of a policy to the extent that it provides dividends or experience-rating credits, or provides that any fees or allowances be paid to any person, including the policyholder, in connection with the service to or administration of the policy;
  (6) Any policy issued in this State by a member insurer at a time when it was not licensed to issue the policy in this State;
  (7) Any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation; and
  (8) Any part of any unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery.

(d) The benefits for which the Association is liable do not, in any event, exceed the lesser of:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not a delinquent insurer; or
(2) With respect to any one individual, regardless of the number of policies, three hundred thousand dollars ($300,000) for all benefits, including cash values; or
(3) With respect to each individual participating in a governmental retirement plan established under section 401, 403(b), or 457 of the Internal Revenue Code covered by an unallocated annuity contract, or the beneficiaries of each individual if deceased, in the aggregate, three hundred thousand dollars ($300,000) in present value annuity benefits, including net cash surrender and net cash withdrawal values; or
(4) With respect to any one contract holder covered by any unallocated annuity contract not included in subdivision (3) of this subsection, five million dollars ($5,000,000) in benefits, regardless of the number of such contracts held by that contract holder.

(e) In no event is the Association liable to expend more than three hundred thousand dollars ($300,000) in the aggregate with respect to any one individual under this section. (1991, c. 681, s. 56, c. 720, s. 93; 1993, c. 452, s. 61.)

§ 58-62-26. Creation of the Association.

(a) There is created a nonprofit legal entity to be known as the North Carolina Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the Association as a condition of their authority to transact insurance in this State. The Association shall perform its functions under the Plan established and approved under G.S. 58-62-46 and shall exercise its powers through the Board established under G.S. 58-62-31. For purposes of administration and assessment, the Association shall maintain two accounts:
(1) The life insurance and annuity account, which includes the following subaccounts:
a. Life insurance account;
b. Annuity account.
(2) The health insurance account.

(b) The Association is under the immediate supervision of the Commissioner and is subject to the applicable provisions of this Chapter. Meetings or records of the Association may be opened to the public upon majority vote of the Board. (1991, c. 681, s. 56.)

§ 58-62-86. Prohibited advertisement of Article in insurance sales; notice to policyholders.

(a) No person 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 oral or written advertisement, announcement, or statement that uses the existence of the Association or this Article for the purpose of sale or solicitation of or inducement to purchase any kind of insurance covered by this Article. However, this subsection does not apply to the Association or any other person who does not sell or solicit insurance.

(b) Within 180 days after the effective date of this Article, the Association shall prepare a summary document that describes the general purposes and current limitations of this Article and that complies with subsection (c) of this section. This document shall be submitted to the Commissioner for the Commissioner's approval. Sixty days after receiving approval, no insurer may deliver a policy described in G.S. 58-62-21(b) to any person unless the document is delivered to that person before or at the time of delivery of the policy, unless subsection (d) of this section applies. The document shall also be available upon request by a policyholder. The distribution, delivery, contents, or interpretation of this document does not mean that either the policy or the policyholder would be covered in the event of the delinquency of a member insurer. The document shall be revised by the Association as amendments to this Article require. Failure to receive this document does not give any person greater rights than those stated in this Article.

(c) The document prepared under subsection (b) of this section shall contain a clear and conspicuous disclaimer on its face. The Commissioner shall prescribe the form and content of the disclaimer. The disclaimer shall:
(1) State the name and addresses of the Association and Department;
(2) Prominently warn the policyholder that the Association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this State;

(3) State that the insurer and its agents are prohibited by law from using the existence of the Association for the purpose of sale or solicitation of or inducement to purchase any kind of insurance;
(4) Emphasize that the applicant or policyholder should not rely on coverage under the Association when selecting an insurer; and
(5) Provide other information as directed by the Commissioner.

(d) No insurer or agent may deliver a policy described in G.S. 58-62-21(b) and excluded

Viaticals

§ 58-58-205. Definitions.

As used in this Article:

(1) "Advertising" means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet, or similar communications media, including filmstrips, motion pictures, and videos, published, disseminated, circulated, or placed before the public, directly or indirectly, for the purpose of creating an interest in or inducing a person to sell a life insurance policy under a viatical settlement contract.
(2) "Business of viatical settlements" means an activity involved in, but not limited to, the offering, solicitation, negotiation, procurement, effectuation, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, hypothecating, or in any other manner, of viatical settlement contracts. "Business of viatical settlements" does not include an activity involving viatical settlement contracts as investments as regulated by Chapter 78A of the General Statutes.
(3) "Chronically ill" means:
    a. Being unable to perform at least two activities of daily living (i.e., eating, toileting, transferring, bathing, dressing, or continence);
    b. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or
    c. Having a level of disability similar to that described in sub-subdivision a. of this subdivision as determined by the Secretary of Health and Human Services.
(4) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy from a viatical settlement provider, credit enhancer, or any entity that has a direct ownership in a policy that is the subject of a viatical settlement contract, but:
    a. Whose principal activity related to the transaction is providing funds to effect the viatical settlement or purchase of one or more viaticated policies; and
    b. Who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts. "Financing entity" does not include a nonaccredited investor or viatical settlement purchaser.
(5) "Fraudulent viatical settlement act" includes:
    a. Acts or omissions committed by any person who, knowingly and with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits, or permits its employees or its agents to engage in acts including:
        1. Presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to or by a viatical settlement provider, viatical settlement broker, viatical settlement purchaser, financing entity, insurer, insurance producer, viator, insured or any other person false material information, or concealing material information, as part of, in support of, or concerning a fact material to one or more of the following:
            I. An application for the issuance of a viatical settlement contract or insurance policy.
            II. The underwriting of a viatical settlement contract or insurance policy.
            III. A claim for payment or benefit under a viatical settlement contract or insurance policy.
            IV. Premiums paid on an insurance policy.

V. Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or insurance policy.
VI. The reinstatement or conversion of an insurance policy.
VII. The solicitation, offer, effectuation, or sale of a viatical settlement contract or insurance policy.
VIII. The issuance of written evidence of viatical settlement contract or insurance.
IX. A financing transaction.

2. Employing any device, scheme, or artifice to defraud related to viaticated policies.

b. In the furtherance of a fraud or to prevent the detection of a fraud, any person commits or permits the person's employees or agents to:
1. Remove, conceal, alter, destroy, or sequester from the Commissioner the assets or records of a licensee or other person engaged in the business of viatical settlements;
2. Misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person;
3. Transact the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of viatical settlements; or
4. File with the Commissioner or the insurance regulator of another jurisdiction a document containing false information or otherwise conceal information about a material fact from the Commissioner.

c. Embezzlement, theft, misappropriation, or conversion of monies, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policy owner, or any other person engaged in the business of viatical settlements or insurance; or

d. Attempting to commit, assisting, aiding, or abetting in the commission of, or conspiracy to commit, the acts or omissions specified in this subdivision.

(6) "Policy" means an individual or group life insurance policy, group life insurance certificate, group life insurance contract, or any other arrangement of life insurance affecting the rights of a resident of this State or bearing a reasonable relation to this State, regardless of whether delivered or issued for delivery in this State.

(7) "Related provider trust" means a titling trust or other trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction.

(8) "Special purpose entity" means a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide either directly or indirectly access to institutional capital markets for a financing entity or licensed viatical settlement provider.

(9) "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death in 24 months or fewer.

(10) "Viatical settlement broker" or "broker" means a person that on behalf of a viator and for a fee, commission, or other valuable consideration offers or attempts to negotiate viatical settlement contracts between a viator and one or more viatical settlement providers. The term does not include an attorney, certified public accountant, or a financial planner accredited by a nationally recognized accreditation agency who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser.

(11) "Viatical settlement contract" means a written agreement establishing the terms under which compensation or anything of value will be paid, which compensation or value is less than the expected death benefit of the policy, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of any portion of the policy. A viatical settlement contract also includes a contract for a loan or other financing transaction with a viator secured primarily by a policy, other than a loan by a life insurance company under the terms of the life insurance contract, or a loan secured by the cash value of a policy. A viatical settlement contract includes an agreement with

a viator to transfer ownership or change the beneficiary designation at a later date regardless of the date that compensation is paid to the viator.

(12) "Viatical settlement provider" or "provider" means a person, other than a viator, that enters into or effectuates a viatical settlement contract. Viatical settlement provider does not include:

a. A bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan;
b. The issuer of a life insurance policy providing accelerated benefits under rules adopted by the Commissioner and under the contract;
c. An authorized or eligible insurer that provides stop-loss coverage to a viatical settlement provider, purchaser, financing entity, special purpose entity, or related provider trust;
d. A natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit;
e. A financing entity;
f. A special purpose entity;
g. A related provider trust;
h. A viatical settlement purchaser; or
i. An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, and who purchases a viaticated policy from a viatical settlement provider.

(13) "Viatical settlement purchase agreement" or "purchase agreement" means an agreement, entered into by a viatical settlement purchaser, to which the viator is not a party, to purchase a life insurance policy or an interest in a life insurance policy, that is entered into for the purpose of deriving an economic benefit.

(14) "Viatical settlement purchaser" or "purchaser" means a person who gives a sum of money as consideration for a life insurance policy or an interest in the death benefits of a life insurance policy or a person who owns or acquires or is entitled to a beneficial interest in a trust that owns a viatical settlement contract or is the beneficiary of a life insurance policy that has been or will be the subject of a viatical settlement contract for the purpose of deriving an economic benefit. "Viatical settlement purchaser" does not include:

a. A licensee under this Part;
b. An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended;
c. A financing entity;
d. A special purpose entity; or
e. A related provider trust.

(15) "Viaticated policy" means a policy that has been acquired by a viatical settlement provider under a viatical settlement contract.

(16) "Viator" means the owner of a policy or a certificate holder under a group policy who enters or seeks to enter into a viatical settlement contract. For the purposes of this Part, a viator shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal or chronic illness or condition except where specifically addressed. "Viator" does not include:

a. A licensee under this Part;
b. An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended;
c. A financing entity;
d. A special purpose entity; or
e. A related provider trust. (2001-436, s. 3.)