THE CALIFORNIA CODE OF REGULATIONS

Fair Claims Settlement Practices Regulations

Sections 2695.3. File and Record Documentation.

Summary: *Insurers are required to maintain complete and legible files with respect to insiders' claims. These files must contain, among other things, hard copies of all correspondence pertaining to the claim, and records of all pertinent dates and occurrences with respect to the file. Files, both open and closed, must be maintained for the current year and the preceding four years.*

2695.3.

(a) Every licensee's claim files shall be subject to examination by the Commissioner or by his or her duly appointed designees. These files shall contain all documents, notes and work papers (including copies of all correspondence) which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined;

(b) To assist in such examination all insurers shall:

(1) maintain claim data that are accessible, legible and retrievable for examination so that an insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of acceptance, denial or date closed without payment; this data must be available for all open and closed files for the current year and the four preceding years;

(2) record in the file the date the licensee received, date(s) the licensee processed and date the licensee transmitted or mailed every material and relevant document in the file; and

(3) maintain hard copy files or maintain claim files that are accessible, legible and capable of duplication to hard copy; files shall be maintained for the current year and the preceding four years.

(c) The requirements of this section shall be satisfied where the licensee provides documentation evidencing

inability to obtain data, nonexistence of data, or difficulty in obtaining clear documentary support for actions due to catastrophic losses, or other unusual circumstances providing the licensee establishes to the satisfaction of the Commissioner that the circumstances alleged by the licensee do exist and have materially affected the licensee's ability to comply with this regulation. Any licensee that alleges an inability to comply with this section shall establish and submit to the Commissioner a plan for file and record documentation to be used by such licensee while the circumstances alleged to preclude compliance with this subsection continue to exist.

Sections 2695.4. Representation of Policy Provisions and Benefits.

Summary: *Section 2695.4 requires full disclosure by insurers to claimants of all of the benefits, coverage, time limits and other policy provisions which may apply to a first party claim. If you are the named insured on an insurance policy and assert your rights to recover following a disaster, you are a "first party claimant."*

2695.4.

(a) Every insurer shall disclose to a first party claimant or beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant. When additional benefits might reasonably be payable under an insured'' policy upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer'' additional liability.

(b) No insurer shall conceal benefits, coverages or other provisions of the bond which may apply to the claim presented under a surety bond.

(c) No insurer shall deny a claim on the basis of the claimant's failure to exhibit property, unless there is documentation in the file (1) of demand by the insurer, and unfounded refusal by the claimant, to exhibit property, or (2) of the breach of any policy

provision providing for the exhibition of property.

(d) Except where a time limit is specified in the policy, no insurer shall require a first party claimant under a policy to give notification of a claim or proof of claim within a specified time.

(e) No insurer shall:

(1) request that a claimant sign a release that extends beyond the subject matter which gave rise to the claim payment unless, prior to execution of the release the legal effect of the release is disclosed and fully explained by the insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature;

(2) be precluded from including in any release a provision requiring the claimant to waive the provisions of California Civil Code Section 1542, provided that prior to execution of the release the legal effect of the release is disclosed and fully explained by insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature.

(f) No insurer shall issue checks or drafts in partial settlement of a loss or claim that contain or are accompanied by language releasing the insurer, the insured, or the principal on a surety bond from total liability unless the policy or bond limit has been paid, or there has been a compromise settlement agreed to by the claimant and the insurer as to coverage and amount payable under the insurance policy or bond.

Sections 2695.5. Duties upon Receipt of Communications.

Summary: *Your insurer has an obligation, within fifteen (15) days after receipt of your claim, to acknowledge your claim. Some policies require a written*

acknowledgment, while a verbal acknowledgment is acceptable under others. Check your policy to ascertain whether the notice must be in writing. Only if the insurance policy or some endorsement thereto requires that it be in writing must it be so. This notice is separate from a complaint or other legal action that may be instituted against you for a claim the insurance company makes. An insurer cannot simply serve a legal action and consider this notice. Unless you have an attorney who has served a complaint or other legal action on an insurer, the insurer must also provide necessary claim forms, instructions, and reasonable assistance.

2695.5.

(a) Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim, every licensee shall immediately, but in no event more than twenty-one (21) calendar days of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any documentation and claim files requested. This section is not intended to permit delay in responding to inquiries by Department personnel conducting a scheduled examination on the insurer’s premises.

(b) Upon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.

(c) The designation specified in subsection 2695.2 (c) shall be in writing, signed and dated by the claimant, and shall indicate that the designated person is authorized to handle the claim. All designations shall be transmitted to the insurer and shall be valid from the date of execution until the claim is settled or the designation is revoked. A designation may be revoked by a writing transmitted to the insurer, signed and dated by the claimant, indicating that the designation is to be revoked the

effective date of the revocation.

(d) Upon receiving notice of claim, every licensee or claims agent shall immediately transmit notice of claim to the insurer. Failure of the licensee or claims agent to immediately transmit notice of claim to the insurer shall constitute a separate and distinct violation of California Insurance Code Section 790.03 (h) (3) and this subsection, where the insurer has provided the appointed licensee or claims agent with written instructions as to the proper handling of a notice of claim. Transmission of the notice of claim by the licensee or claims agent to the insurer in conformity with the written instructions received from the insurer shall satisfy the licensee's or claims agent's duty under this section to promptly transmit the notice to the insurer.

(e) Upon receiving notice of claim, every insurer, expect as specified in Subsection 2695.5 (e) (4) below, shall immediately, but in no event more than fifteen (15) calendar days later, do the following unless the notice of claim received is a notice of legal action:

(1) acknowledge receipt of such notice to the claimant unless payment is made within that period of time. If the acknowledgment is not in writing, a notation of acknowledgment shall be made in the insurer's claim file and dated. Failure of an insurance agent or claims agent to promptly transmit notice of claim to the insurer shall be imputed to the insurer except where the subject policy was issued pursuant to the California Automobile Assigned Risk Program.

(2) provide to the claimant necessary form, instructions, and reasonable assistance, including but not limited to, specifying the information the claimant must provide for proof of claim;

(3) begin any necessary investigation of the claim.

(4) Subsection 2695.5 (e) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the

Insurance Code or life insurance subject to Section 10172.5 of the Insurance Code.

(f) An insurer may not require that the notice of claim under a policy be provided in writing unless such requirement is specified in the insurance policy or an endorsement thereto.

Sections 2695.6. Training and Certification.

Summary: *Your insurer also has an obligation to immediately begin any necessary investigation of your claim. Your insurer must conduct investigations using written standards and processes and must employ thoroughly and adequately trained personnel.*

2695.6.

(a) Every insurer shall adopt and communicate to all its claims agents written standards for the prompt investigation and processing of claims, and shall do so within ninety (90) days after the effective date of the regulations or any revisions thereto.

(b) All licensees shall provide thorough and adequate training regarding the regulations to all their claims agents. Licensees shall certify that their claims agents have been trained regarding these regulations and any revisions thereto. However, licensees need not provide such training or certification to duly licensed attorneys.

A licensee shall demonstrate compliance with this subsection by the following methods:

(1) where the licensee is an individual, the licensee shall annually certify in writing under penalty of perjury that he or she has read an understands the regulations and any and all amendments thereto;

(2) where the licensee is an entity, the annual written certification shall be executed, under penalty of perjury, by a principal of the entity as follows:

(A) that the licensee’s claims adjusting manual contains a copy of these regulations and all amendments thereto;

and,

(B) that clear written instructions regarding the procedures to be followed to effect proper compliance with this subchapter were provided to all its claims agents;

(3) where the licensee retains independent adjusters, the licensee must provide training to the independent adjusters regarding these regulations and annually certify, in declaration executed under penalty of perjury, that such training is provided. Alternately, the independent adjuster may annually certify in writing, under penalty of perjury, on an annual basis, that he or she has read and understands these regulations and all amendments thereto or has successfully completed a training seminar which explains these regulations;

(4) a copy of the certification required by subsections 2695.6 (b) (1), (2) or (3) shall be maintained at all times at the principal place of business of the licensee, to be provided to the Commissioner only upon request.

(5) the annual certification required by this subsection shall be completed on or before September 1 of each calendar year.

Sections 2695.7. Standards for Prompt, Fair and Equitable Settlements.

Summary: *Discrimination by insurers against insiders is strictly prohibited. Claims must be accepted or denied, in whole or in part, on a timely basis. Denials must be made in writing.*

2695.7.

(a) No insurer shall discriminate in its claims settlement practices based upon the claimant’s race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

(b) Upon receiving proof of claim, every insurer, except as specified in subsection 2695.7 (b) (4) below, shall immediately, but in no event more than

forty (40) calendar days later, accept or deny the claim, in whole or in part.

(1) Where an insurer denies or rejects a first party claim in whole or in part, it shall do so in writing and shall provide to the claimant a statement listing all bases for such rejection or denial and the factual and legal bases for each reason given for such rejection or denial which is then within the insurer's knowledge. Where an insurer's denial of a first party claim, in whole or in part, is based on a specific policy provision, condition or exclusion, the written denial shall include reference thereto and provide an explanation of the application of the provision, condition or exclusion to the claim. Every insurer that denies or rejects a third party claim in whole or in part, or disputes liability or damages shall do so in writing.

(2) Subject to the provisions of subsection 2695.7 (k), nothing contained in subsection 2695.7 (b) (1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim.

(3) Written notification pursuant to this subsection shall include a statement that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, and shall include the address and telephone number of the unit of the Department which reviews claims practices.

(4) The time frame in subsection 2695.7 (b) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the Insurance Code, life insurance subject to Section 10172.5 of the Insurance Code, or mortgage guaranty insurance subject to Section 12640.09 (a) of the Insurance Code, and shall not apply to automobile repair bills arising from policies of automobile collision and comprehensive insurance subject to Section 560 of the Insurance Code.

(c) (1) If more time is required than is allotted in subsection 2695.7 (b) to determine whether a claim should be accepted and/or denied in whole or in part, then, every insurer shall provide the claimant, within the time frame specified in subsection 2696.7 (b), with written notice of the need for additional time. This written notice shall specify any additional information the insurer requires in order to make a determination and state any continuing reasons for the insurer's inability to make a determination. Thereafter, the written notice shall be provided every thirty (30) calendar days until a determination is made or notice of legal action is served. If the determination cannot be made until some future event occurs, then the insurer shall comply with this continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made.

(2) Subject to the provisions of subsection 2695.7 (k), nothing contained in subsection 2695.7 (c) (1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the claim is being investigated as a possible suspected fraudulent claim.

(d) No insurer shall persist in seeking information not reasonably required for or material to the resolution of a claim dispute.

(e) No insurer shall delay or deny settlement of a first party claim on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions, statutes or regulations, including those pertaining to coordination of benefits.

(f) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a timely claim. Such notice shall be given to the claimant not less than sixty (60) days prior to the expiration date; except, if notice of claim is first received by

the insurer within that sixty days, then notice of the expiration date must be given to the claimant immediately. With respect to a first party claimant in a matter involving an uninsured motorist, this notice shall be given at least thirty (30) days prior to the expiration date; except, if notice of claim is first received by the insurer within that thirty days, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter.

(g) No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low;

(1) the extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

(2) the extent to which the insurer considered evidence made known to it or reasonably available;

(3) the extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;

(4) the extent to which the insurer considered the advice of its counsel that there was a substantial likelihood of recovery in excess of policy limits;

(5) the procedures used by the insurer in determining the dollar amount of property damage;

(6) the extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter;

(7) any other credible evidence presented to the Commissioner that demonstrates that the final amount offered in settlement of the claim

by the insurer is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

(h) Upon acceptance of the claim and, when necessary, upon receipt of a properly executed release, every insurer, except as specified in subsection 2695.7 (h) (1) and (2) below, shall immediately, but in no event more than thirty (30) calendar days later, tender payment of the amount of the claim which has been determined and is not disputed by the insurer. In claims where multiple coverage is involved, payments which are not in dispute and where the payee is known shall be tendered immediately, but in no event in more than thirty (30) calendar days, if payment would terminate the insurer's known liability under that individual coverage, unless impairment of the insured's interests would result. This subsection shall not apply where the policy provides for a waiting period after acceptance of claim and before payment of benefits.

(1) Subsection 2695.7 (h) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the Insurance Code, of life insurance subject to section 10172.5 of the Insurance Code, of mortgage guaranty insurance subject to Section 12640.09 (a) of the Insurance Code, or of fire insurance subject to Section 2057 of the Insurance Code, and shall not apply to automobile repair bills arising from policies of automobile collision and comprehensive insurance subject to section 560 of the Insurance Code.

(2) Any insurer issuing a title insurance policy shall either tender payment pursuant to subsection 2695.7 (h) or take action to resolve the problem which gave rise to the claim immediately upon, but in no event more than thirty (30) calendar days after, acceptance of the claim.

(i) No insurer shall inform a claimant that his or her rights may be impaired if a form or release is not completed within a specified

time period unless the information is given for the purpose of notifying the claimant of any applicable statute of limitations or policy provision or the time limitation within which claims are required to be brought against state or local entities.

(j) No insurer shall request or require an insured to submit to a polygraph examination unless authorized under the applicable insurance contract and state law.

(k) Subject to the provisions of subsection 2695.7 (c), where there is a reasonable basis, supported by specific information available for review by the California Department of Insurance, for the belief that the claimant has submitted or caused to be submitted to an insurer a suspected false or fraudulent claima s specified in California Insurance Code Sections 1871.1 (a) and 1871.4 (a), the number of calendar days specified in subsection 2695.7 (b) shall be:

(1) increased to eighty (80) calendar days; or,

(2) suspended until otherwise ordered by the Commissioner, provided the insurer has complied with California Insurance Cody Section 1872.4 and the insurer can demonstrate to the Commissioner that it has made a diligent attempt to determine whether the subject claim is false or fraudulent within the eighty day period specified by subsection 2695.7 (k) (1).

(1) No insurer shall deny a claim based upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of Section 2695.3.

(m) No insurer shall make a payment to a provider, pursuant to a policy provision to pay medical benefits, and thereafter seek recovery or set-off from the insured on the basis that the amount was excessive and/or the services where unnecessary, except in the event of a proven false or fraudulent claim, subject to

the provisions of Section 10123.145 of the California Insurance Code.

(n) Every insurer requesting a medical examination for the purpose of determining liability under a policy provision to pay medical benefits shall do so only when the insurer has a good faith belief that such an examination is necessary to enable the insurer to determine the reasonableness and/or necessity of any medical treatment.

(o) No insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the California Department of Insurance regarding the handling of a claim or any other matter complained of as a condition precedent to the settlement of any claim.

Sections 2695.9. Additional Standards Applicable to Fire and Extended Coverage Type Policies with Replacement Cost Coverage.

Summary: *Insiders who have fire and extended coverage type policies with replacement cost coverage are entitled not only to repair and replacement of damaged property, but to repair of any damage incurred in making such repairs or replacements. When items or parts are replaced, such items or parts should be of the same quality as those they are replacing.*

2695.9.

(a) When a fire and extended coverage insurance policy provides for the adjustment and settlement of first party losses based on replacement cost, the following standards apply:

(1) When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making the repair or replacement not otherwise excluded by the policy shall be included in the loss. The insured shall not have to pay for depreciation nor any other cost except for the applicable deductible.

(2) When a loss requires replacement of items and

the replaced items do not match in quality, color or size, the insurer shall replace all items in the damaged area so as to conform to a reasonably uniform appearance.