INSURANCE CODE

The California Insurance Code (CIC) consists of statutes written and passed by the state legislature. The governor signs these statutes into law. The insurance code is changed by the legislature passing a new statute that amends or repeals an existing statute. The code originally consisted of six divisions, but two divisions have been repealed. The remaining four divisions are (1) general rules governing insurance, (2) classes of insurance, (3) the insurance commissioner, and (4) insurance adjusters. Each division is further broken down into parts, chapters, and articles.

The Insurance Commissioner is elected by the people to serve a four-year term in the same general election in which the governor is elected. If a vacancy should occur during the term of the office, the governor shall appoint a replacement subject to approval by the legislature. (CIC 12900) The commissioner shall perform all duties imposed upon him by provisions of the insurance code and other laws regulating the business of insurance in this State, and he shall enforce the execution of such provisions and laws. (CIC 12921)

The California Code of Regulations (CCR) is made up of rules issued by the commissioner. The regulations may be changed or withdrawn by the commissioner. The CCRs are needed in order to administer the code. Although the commissioner does not write the code, he is responsible for enforcing the code. Even though the CCRs are not law, they carry the same weight as law. A person who violates a regulation is subject to the same penalty as someone who violates the code.

An insurance professional should have knowledge of the California Insurance Code and the Code of Regulations. These documents identify many unethical and illegal practices. However, they are not a complete guide to ethical behavior.

CLASSES OF INSURANCE

Insurance in California is divided into the following 20 categories:

1. **Life** – Life includes annuities.

2. **Fire** – Fire includes homeowners, commercial property, and dwelling policies.

3. **Marine** – Marine includes both inland and ocean marine

4. **Title** – Protects owner of loss if problems relating to possession of property occur.

5. **Surety** – Guarantee of payment of one party for the fulfillment of an obligation of a second party; a bond.

6. **Disability (includes all forms of health insurance and disability income**) – Coverage of the event of illness, injury, or death, for those who are unable to work.

7. **Plate glass** – Coverage of the breaking of glass, frames, lettering, etc.

8. **Liability** – Protects against loss where policy holder is responsible for injury or malpractice to person or property.

9. **Workers compensation** – Payment of compensation to those injured or sick while under employment.

10. **Common carrier liability** - Insures against loss while property is in the care of a common carrier.

11. **Boiler and machinery** - Protection against injury or damages to person or property caused from the explosion or breakdown of a boiler or other machinery.

12. **Burglary** – Covers property of loss or damage occurring from theft or burglary.

13. **Credit** – Insurance for losses against the repayment of loans. Can also cover the risk of payment in the delivery of belongings.

14. **Sprinkler** – Coverage of liability or damages to person or property occurring through the malfunction, leaks or breaks, of sprinklers, water pipes or pumps, or other devices in place to extinguish fires

15. **Team and vehicle** – Protection against liability or damages caused by teams (horse drawn vehicles), or vehicles other than ships or boats. This does cover Trucker Insurance.

16. **Automobile** – Covers the policy holder of the dangers that occur in the operation or use of the maintenance of the vehicle. Protects against liability or damages of the vehicle or its parts.

17. **Mortgage** – Insurance that assures the mortgage lender that the amount owed to the lender will be paid.

18. **Aircraft** - Coverage of the operation, maintenance, and ownership of an aircraft. This does not include any coverage of damages or injury of a person or property because of an accidents.

19. **Mortgage guaranty (includes insolvency insurance and legal insurance)** – If the insurance company providing coverage goes insolvent, this still guarantees payment to the lender.

20. **Miscellaneous** – Coverage against loss occurring through earthquake, tornado, etc.

Prior to a discussion of the code, certain terms should be understood. These include:

> **Shall:** Shall is mandatory. There is no choice.
> **May:** May is permissive. There is a choice to do or not to do something. (CIC 16)

DEFINITIONS

Insurance: Insurance is a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent of unknown event. (CIC 22) In insurance the risk of loss is transferred to the insurer by the policyholder. There are many risks that may be insured as noted by the number of lines of insurance recognized by the California Department of Insurance.

Insurable events: Any contingent or unknown event, whether past or future, which may damage a person having an insurable interest, or create a liability against him, may be insured against. (CIC 250) In life or disability insurance, insurable interest shall be required to exist at the time the contract of life or disability interest becomes effective, but it need not exist at the time the loss occurs. (CIC 10110) In property and casualty insurance, insurable interest is required at the inception of the policy and when the loss occurs.

Admitted: "Admitted" in relation to a person, means entitled to transact insurance business in this State, having complied with the laws imposing conditions precedent to transaction of such business. (CIC 24)

Non-admitted: "Non-admitted in relation to a person, means not entitled to transact insurance business in this State, whether by reason of failure to comply with conditions precedent thereto, or by reason of inability so to comply. (CIC 25)

Domestic, foreign and alien insurers: Companies may be classified according to where the company is domiciled meaning where the company has its principal legal residence, where it was organized, or where it was incorporated.

> **Domestic:** A company is considered to be a domestic insurer in the state where it was organized. Therefore, any company organized under the laws of the state of California is considered to be a domestic insurer in California, whether or not it is admitted to do business in California. (CIC 26)

Foreign: A foreign insurer is an insurer organized under the laws of another state within the United States, whether or not it is admitted to do business. Thus, a company organized in Arizona is considered to be a foreign insurer in California. (CIC 27)

Alien: An alien insurer is an insurer organized under the laws of any jurisdiction other than a state of the United States, whether or not admitted to do business in California. For instance, a company organized in Canada is considered alien.

Person: "Person" means any person, association, organization, partnership, business trust, limited liability company, or corporation. (CIC 19)

Insurer: Any person capable of making a contract may be an insurer, subject to the restrictions of the code. (CIC 150)

Standard Market Insurer: An insurer who offers rates for insurance coverage to insureds who have an average or better than average loss exposure

Reinsurance: A contract of reinsurance is one by which an insurer procures a third person to insure him against loss or liability by reason of such original insurance. (CIC 620) An insurance company cedes part of the risk to another insurance company. The ceding insurer must disclose all knowledge and information to the reinsurer. The original insured does not need to be informed about the reinsurance contract. The ceding company will continue to service the contract.

Insurance agent (Life): "Insurance agent" means a person authorized, by and on behalf of an insurer, to transact all classes of insurance other than life, disability or health insurance. (CIC 31)

Insurance agent (PC): insurance agent by this definition means someone who holds a property broker-agent and/or casualty broker-agent license. Licenses to act as a property broker-agent and/or casualty broker-agent agent are of the following types: (1) Property which entitles the licensee to transact insurance coverage on the direct or consequential loss or damage to property of every kind and (2) Casualty which entitles the licensee to transact insurance coverage against legal liability including that for death, injury, disability, or damage to real or personal property. (CIC 1625)

Life-only agent: A life-only agent means an insurance agent authorized, by and on behalf of a life insurer, to transact insurance 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. (CIC 1626 [1]; 1622)

A licensed life agent may present a proposal for insurance to a prospective policyholder on behalf of a life insurer for which the life agent is not specifically appointed and may send an application for insurance to that insurer. (Life agents

cannot transmit an application to an insurer that only uses exclusive agents.) If a policy of insurance is issued, the insurer is considered to have authorized the agent to act on its behalf. The insurer must forward to the commissioner a notice of appointment of the life agent not more than 14 days after the life agent submits an application for insurance to the insurer for which the insurer issues a policy. Any payment made by the prospective insured must be made in the form of a draft, check, cashier's check, traveler's check, money order, or similar instrument made payable to the insurer. (CIC 1704.5)

Accident and health agent: An accident and health license entitles the licensee to transact insurance coverage for sickness, bodily injury, or accidental death and may include benefits for disability income. (CIC 1626[2]) An accident and health agent may be authorized to transact 24-hour care coverage pursuant to certain requirements. (CIC 32) There is no such thing as a life solicitor or life broker in California.

Broker: (a) An insurance broker is a person who, for compensation and on behalf of another person, transacts insurance other than life, disability, or health with, but not on behalf of, an insurer (CIC 33). It shall be presumed that the person is acting as an insurance broker if the person is licensed to act as an insurance broker, maintains the bond required by this chapter, and discloses, in a written agreement signed by the consumer, all of the following:

(1) That the person is transacting insurance on behalf of the consumer.
(2) A description of the basic services the person will perform as a broker.
(3) The amount of all broker fees being charged by the person.
(4) If applicable, the fact that the person may be entitled to receive compensation from the insurer, directly or indirectly, for the consumer's purchase of insurance as a consequence of the transaction.

(b) If a transaction involves both a retail broker and a wholesale intermediary broker, the wholesale intermediary broker shall be deemed to have satisfied its disclosure obligations under this section if it provides written disclosure to the retail broker of the criteria set forth in paragraphs (2), (3), and (4) of subdivision (a).

(c) The presumption of broker status is rebutted as to any transaction in the admitted market in which any of the following is present:

(1) The licensee is appointed, pursuant to Section 1704, as an agent of the insurer for the particular class or type of insurance being transacted.
(2) The licensee has a written agreement with an insurer containing express terms that authorize the licensee to obligate the insurer without first obtaining notification from the insurer that the insurer has accepted, conditionally or unconditionally, the submitted risk.
(3) The licensee is authorized, pursuant to a written agreement with an insurer, to appoint other licensees as agents of the insurer, pursuant to Section 1704.

(4) The licensee is authorized, pursuant to a written agreement with an insurer, to pay claims on behalf of the insurer.

(d) In all other cases, the presumption of broker status is rebutted based on the totality of the circumstances indicating that the broker-agent is acting on behalf of the insurer.
(e) For purposes of this section, "totality of the circumstances" means evidence indicating whether a broker-agent was acting on behalf of the insurer or was acting on behalf of a third person. In determining the totality of circumstances, all relevant facts and circumstances shall be reviewed and the review is not limited to any particular fact or factors and this section does not require that any particular circumstance receive greater or lesser weight. (CIC 1623)

There is no Life Broker or Accident & Health Broker.

Surplus lines broker: (CIC 1760) A surplus lines broker places insurance with non-admitted insurers. A surplus lines broker may act as an agent for a non-admitted insurer in the transaction of insurance business in California, advertise a non-admitted insurer, and aid a non-admitted insurer to transact insurance business in California.

It is a misdemeanor to transact for or advertise a non-admitted insurer unless licensed as a surplus lines broker. Any person who willfully violates the surplus lines regulations is guilty of a public offense and is punishable by imprisonment in the state prison, or in a county jail, for not exceeding one year or a fine not exceeding $10,000, or by both. (CIC 703;1764.7)

Solicitor: An insurance solicitor is a natural person employed to aid an insurance agent or insurance broker in transacting insurance other than life, disability or health. There is no such thing as a Life solicitor or Accident & Health solicitor. Agents are appointed by insurance companies and represent insurance companies. Solicitors are appointed by property broker-agent and/or casualty broker-agents that have permanent licences', not by insurance companies. A solicitor cannot be appointed by more than one agent/broker at a time. Solicitors have no power to bind coverage. Solicitors are licensed to sell property and casualty products and may hold either property broker-agent and/or casualty broker-agent or a Personal Lines broker/agent license. (CIC 1624)

Property & Casualty Licensee (aka Fire & Casualty) A property and casualty licensee is a person authorized to act as an insurance agent, broker, or solicitor, and a property and casualty broker-agent license is a license so to act. Licenses to act as a property and casualty broker-agent under this chapter shall be of the following types:

(1) Property, which shall entitle the licensee to transact insurance coverage on the direct or consequential loss or damage to property of every kind, some examples include auto, homeowners, flood, earthquake, commercial property.

(2) Casualty, which shall entitle the licensee to transact insurance coverage against legal liability, including that for death, injury, disability, or damage to real or personal property some examples include liability, commercial general liability

Notice of appointment as an agent: When a notice of appointment is filed with the Department of Insurance for a person licensed as a broker/agent by an insurer, that person is deemed to be acting as an agent for that insurer (CIC 1731)

Life and disability insurance analyst: "Life and disability insurance analyst" means a person who, for a fee or compensation of any kind, paid by or derived from any person or source other than an insurer, advises, purports to advise, or offers to advise any person insured under, named as beneficiary of, or having any interest in, a life or disability insurance contract, in any manner concerning that contract or his or her rights in respect thereto. (CIC 32.5)

The license qualifications for an insurance analyst are as follows (CIC 1831-1849):

- Age 18 or older and a California resident.
- Makes a written application on a prescribed form.
- Answers under oath any questions asked by the commissioner.
- Has a good business reputation.
- Has thorough knowledge of life and disability insurance. No person shall be eligible for a life and disability insurance analyst license unless for five years preceding the date of the examination, he/she has worked as a life or disability licensee or as an employee of such a licensee.
- Has not been connected with any business transaction that shows unfitness to act in a fiduciary capacity.
- Has not willfully misstated any material fact in a license application or obtained a license by concealment or misrepresentation.
- Is a fit and proper person to hold a license.
- Does not seek the license to avoid or prevent enforcement of the insurance laws.
- Has passed the required examination.

A life and disability insurance analyst shall not receive any fee unless that fee is based upon a written agreement signed by the party to be charged. The agreement shall include a statement that the information and services concerning insurance policies may be obtained directly from the insurer without cost, an outline of the services to be performed for which a fee is charged, and the fee to be charged. Additionally, if the licensee is also licensed as a life agent, there shall be a statement indicating this fact. A copy of such agreement shall be retained for not less than three years after the services have been fully performed. (CIC 1848)

An employee or officer of any insurer is not eligible for license as a life and disability insurance analyst. A life insurer shall not pay a life and disability insurance analyst any commission directly or indirectly, on any life or disability

insurance transacted by and in the capacity as a life and disability insurance analyst.

Anyone who acts or offers to act as a life analyst without a license can be punished by a fine of up to $1,000 or imprisonment for up to one year, or both imprisonment and fine.

Administrators: means any person who collects any charge or premium from, or who adjusts or settles claims on, residents of this state in connection with life or health insurance coverage or annuities or coverage. (CIC 1759)

Adjuster: (CIC 14021) An adjuster is a licensed person, other than a private investigator, who for a fee or other consideration, investigates and collects information for the purpose of adjusting or disposing of a claim under an insurance policy. It is most often a property and casualty policy. The requirements are as follows:

- Age 18 or older.
- Must not have committed any acts or violations of law for which a license could be denied.
- Must have at least two years of experience (or the equivalent) in adjusting insurance claims.
- Must meet any other qualifications established by the commissioner.
- Must pay the required license fee.

Public insurance adjuster: (CIC 15007) A public insurance adjuster is a licensed individual who, for compensation, works on behalf of an insured in settling a claim for loss or damage under a policy covering real or personal property.

Managing General Agent (MGA): Any person, firm, association, partnership, or corporation who negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer (including the management of a separate division, department or underwriting office).

An MGA acts as an agent for that insurer and produces and underwrites an amount of gross direct written premium equal to or more than 5 % of the policyholder surplus as reported in the last annual statement of: (CIC 769.81[c])

> (1) adjusts or pays claims in excess of an amount determined by the commissioner, or (2) negotiates reinsurance on behalf of the insurer.

Bail Licensee: An insurer shall not execute an undertaking of bail except by and through a person holding a bail license. A person shall not in this state solicit or negotiate in respect to execution or delivery of an undertaking of bail or bail bond by an insurer, or execute or deliver such an undertaking of bail or bail bond. (CIC 1800)

Personal Lines Licensee: (CIC 1625.5) A personal lines licensee is a person authorized to transact automobile insurance, as defined in Section 660, including insurance for recreational vehicles used for noncommercial purposes, personal watercraft insurance, residential property insurance, as defined in Section 10087, including earthquake and flood insurance, inland marine insurance covering personal property, and umbrella or excess liability insurance providing coverage when written over one or more underlying automobile or residential property insurance policies, and a personal lines broker-agent license is a license to so act.

Broker-Agent: A person licensed as a broker-agent shall be deemed to be acting as an insurance agent in the transaction of insurance placed with those insurers for whom a notice of appointment has been filed with the Insurance Commissioner in accordance with Section 1704 and is then in force.

Limited Lines Automobile Insurance Agent:
1625.55. (a) A limited lines automobile insurance agent is a person authorized to transact automobile insurance, as defined in Section 660. A limited lines automobile insurance agent license is a license to so act.

(b) A license under this section shall be applied for and renewed, following successful completion of a qualifying examination on this code, ethics, and products sold under the license, in the same manner as provided in this chapter for a license to act as a property broker-agent and/or casualty broker-agent.

(c) The commissioner shall require in advance a fee for filing any applications, renewals thereof, or changes in outstanding licenses, or for the filing of other required documents at an amount designated in this chapter for a personal lines licensee, and for filing any notice of appointment or notice of termination at an amount specified in Section 1751.3.

(d) A person licensed as a limited lines automobile insurance agent who makes an application to the commissioner to become a property broker-agent and/or casualty broker-agent pursuant to Section 1625 or a personal lines agent pursuant to Section 1625.5 shall do all of the following:

(1) Submit an application on a form provided by the commissioner.

(2) Complete prelicensing education as specified in Section 1749.

(3) Take and pass a qualifying examination pursuant to Section 1676.

1625.56. “License year” for a limited lines automobile insurance agent shall be determined as follows:
(a) Upon initial licensing, the license year starts on the date the license is issued.
(b) Subsequently, each license year starts the first day of the month following the month in which the initial license was issued.
(c) A license year ends the following calendar year on the last calendar day of the month in which the initial license was issued.

1625.57. “License term” for a limited lines automobile insurance agent means all of that two-year period beginning as described in subdivision (a) or (b) of Section 1625.56, as applicable, and ending the second succeeding year on the last calendar day of the month in which the initial license was issued.

Transact: “Transact” as applied to insurance includes any of the following:

(a) Solicitation (CIC 35[a])
(b) Negotiations preliminary to execution (CIC 35[b])
(c) Execution of a contract of insurance (CIC 35[c])
(d) Transaction of matters subsequent to execution of the contract and arising out of it (CIC 35[d]))

As noted above in the definitions section, an insurance agent, life-only agent, accident and health agent, broker, and solicitor are licensed to transact various lines of insurance. A person shall not act in any of the capacities defined in transacting (solicitation, negotiation, execution, and transaction) unless he holds a valid license from the commissioner authorizing him to act in such capacity. (CIC 1631) Any person who acts, offers to act, or assumes to act in a capacity for which a license is required without a valid license so to act is guilty of a misdemeanor. (CIC 1633)

The unlawful transaction of insurance business in willful violation of the requirement for a certificate of authority is a public offense punishable by imprisonment in the state prison, or in a county jail not exceeding one year, or by fine not exceeding one hundred thousand dollars ($100,000), or by both that fine and imprisonment, and shall be enforced by a court of competent jurisdiction on petition of the commissioner. (CIC 700(b).

Transacting without a license: (CIC 1631;1633) A person may not conduct any activities of an agent, broker, or solicitor unless he has a license issued by the commissioner authorizing him to act in that capacity. Anyone who acts, offers to act, or assumes to act in a capacity for which a license is required, without holding a license, is guilty of a misdemeanor. This is punishable by a fine not exceeding $50,000 or by imprisonment in a county jail for a period not exceeding one year, or by both fine and imprisonment.

Types of insurance companies:

Stock insurers are corporations organized for the purpose of making a profit for their stockholders. A stock company raises money by selling shares of stock; the stockholders are the owners of the company; and the affairs of the company are handled by a board of directors elected by the stockholders. The type of policy issued by stock companies is called **non-participating** (non-par) as the policyholders do not share in the company’s profits. When declared, dividends are paid to the stockholders.

Mutual insurers are corporations owned by the policyowners. When a person buys an insurance policy from a mutual insurer that person is becoming an owner in the company as well as a policyholder. As an owner, the policyholder votes for the board of directors. The policies issued by mutual insurers are referred to as **participating** (par) policies as any surplus is returned to the policyowner in the form of a **dividend**. Surplus can be defined as excess earned or saved by the insurance company. Earned surplus is generated by:

- Mortality-----fewer people die than expected
- Interest------company earns more interest than assumed
- Expenses---company overhead is less than projected

Dividends are regarded by the federal government as a return to the policyowners of excess premiums charged for the insurance coverage. As such, dividends paid by mutual insurers are not taxable income. However, it also should be noted that dividends cannot be guaranteed as surplus will vary from year to year.

An incorporated mutual insurer may be converted into an incorporated stock insurer. The process whereby a mutual insurer becomes a stock insurer is known as demutualization or conversion. (CIC 11535)

Fraternal insurers (fraternal benefit societies or fraternals) are life insurance carriers that are social organizations that normally are involved in charitable activities. Fraternal societies usually are incorporated without capital stock. To be considered a fraternal, the organization must be nonprofit, must have a lodge system with a ritualistic form of work involved, and have an elective form of government. Fraternal society insurance provides benefits for sickness, accident and death and such insurance may be sold only to members of the society for the benefit of its members and their families.

Distribution systems:

Agency system: Agents are appointed by insurers and solicit applications on behalf of insurers. Agents may be either exclusive or independent. The majority of policies are sold using the agency system.

Direct response marketing is achieved by advertising through the mail, in newspapers and magazines, on television and radio and the internet. If someone is interested in the advertised products, he/she will respond to the company for more information. Mass marketing is a cost effective method of distribution and may achieve efficient market penetration.

Home service life insurance is a variation of industrial life insurance. Industrial life insurance policies are small policies essentially to cover a person's last expenses. The agent is responsible for servicing the policies and must personally collect the premiums on a weekly or monthly basis and provide the client with a written receipt. The major difference with

home service life is that the face amount is larger. It normally is written for amounts of $10,000 or $15,000 and the premiums are either debited from a bank account or mailed.

Effective date of coverage: (C 1730.5) A life agent and a property broker-agent and/or casualty broker-agent shall provide to all insureds or applicants at the time of application or receipt of premium moneys the effective date of coverage, if known, or the circumstances under which coverage will be effective if there exists conditions precedent to coverage. This section applies only to coverage for personal lines of insurance, such as private passenger automobile, homeowner and renter insurance, personal liability, and individual disability and health insurance.

Free insurance: No insurer shall participate in any plan to offer or effect any kind or kinds of insurance or annuities in this state as an inducement to the purchase or rental by the public of any property, real or personal or mixed, or services, without a separate charge to the insured for such insurance, nor shall any agent, broker, or solicitor arrange the sale of any such insurance. (CIC 777.1) This article does not apply to insurance offered as a guarantee of the performance of goods which is insurance to protect the purchasers of such goods nor does it apply to any title insurance or life or disability insurance written to pay off the balance of a debt in the event of the death or disability of the insured.

If any insurer, agent, broker, or solicitor willfully violates this provision regarding free insurance, the commissioner may suspend or revoke the certificate or license or other authority to do business or engage in an insurance occupation for a period not exceeding one year.

Aiding non-admitted insurer to transact: (CIC 1760-1780) Except when performed by a surplus line broker, the following acts are misdemeanors when done in this State:

(a) Acting as agent for a non-admitted insurer in the transaction of insurance business in this State.
(b) In any manner advertising a non-admitted insurer in this State.
(c) In any other manner aiding a non-admitted insurer to transact insurance business in this State. (CIC 703)

The commissioner may penalize a person guilty of unauthorized dealings with a non-admitted insurer. The guilty person also will be penalized monetarily by the state.

Any person licensed by the commissioner who misrepresents to any surplus lines broker any material fact regarding insurance coverage, or facts regarding rules of submission or rates, or conspires to procure non-admitted insurance in violation of the law, may have his license suspended, revoked, or denied.

Surplus Lines Law: Any person may negotiate and effect insurance to protect himself, herself, or itself against loss, damage, or liability with any non-admitted insurer.

The rules limiting the insurance which may be placed with non-admitted insurers do not apply to:

(1) Reinsurance of the liability of an admitted insurer.
(2) Insurance against perils of navigation, transit or transportation upon hulls, freights or disbursements, or other shipowner interests; upon goods, wares, merchandise and all other personal property and interests therein, in course of exportation from or importation into any country, or transportation coastwise, including transportation by land or water from point of origin to final destination and including war risks; and marine builder's risks, drydocks and marine railways, including insurance of ship repairer's liability, and protection and indemnity insurance, but excluding insurance covering bridges and tunnels.
(3) Aircraft insurance.
(4) Insurance on property or operations of railroads engaged in interstate commerce.

The insurance specified in the above numbers 2, 3, and 4 may be placed with a non-admitted insurer only by and through a special lines' surplus lines broker.

A surplus line broker may solicit and place insurance with non-admitted insurers only if that insurance cannot be procured from insurers admitted for the particular class or classes of insurance and that actually write the particular type of insurance in this state. Each surplus line broker shall be responsible to ensure that a diligent search is made among admitted insurers before placing insurance with a non-admitted insurer. It shall be presumed that insurance is placed in violation of the code if the insurance is actually placed with a non-admitted insurer at a lower rate of premium or lower premium than the lowest rate of premium or the lowest premium that could be obtained from an admitted insurer unless, at the time the insurance attaches, there is filed with the commissioner a statement describing the insurance, specifying the rate and the nearest procurable rates from admitted insurers. The statement shall include an explanation of the reasons that the insurance must be placed with a non-admitted insurer even though it is available from an admitted insurer.

Every non-admitted insurer, in the case of insurance to be purchased by a resident of this state, and surplus line broker, in the case of any insurance with a non-admitted carrier to be transacted by the surplus line broker, shall be responsible to ensure that, at the time of accepting an application for any insurance policy, other than a renewal of that policy, issued by a non-admitted insurer, the signature of the applicant on a disclosure statement. The disclosure statement shall be in boldface 16-point type on a freestanding document. In addition, every policy issued by a non-admitted insurer and every certificate evidencing the

placement of insurance shall contain, or have affixed to it by the insurer or surplus line broker, the disclosure statement in boldface 16-point type on the front page of the policy. In the case where the applicant has not received and completed the signed disclosure form, he/she may cancel the insurance so placed.

The following notice shall be provided to policyholders and applicants for insurance with a non-admitted insurer and shall be printed in English and in the language principally used by the surplus line broker and non-admitted insurer to advertise, solicit, or negotiate the sale and purchase of surplus line insurance. The surplus line broker and non-admitted insurer shall use the appropriate bracketed language for application and issued policy disclosures:

"NOTICE:

1. **THE INSURANCE POLICY THAT YOU (HAVE PURCHASED) (ARE APPLYING TO PURCHASE) IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED "NON-ADMITTED" OR "SURPLUS LINE" INSURERS.**
2. **THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT WHICH APPLIES TO CALIFORNIA LICENSED INSURERS.**
3. **THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIM OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**
4. **CALIFORNIA MAINTAINS A LIST OF ELIGIBLE SURPLUS LINE INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST.**
5. **FOR ADDITIONAL INFORMATION ABOUT THE INSURER YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR "SURPLUS LINE" BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE, AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: ____."**

Absence of Binding Authority: Surplus lines brokers cannot bind risk with non-admitted insurers. Additionally, No surplus line broker shall issue any evidence of insurance or cause or purport to cause any risk to be insured by a non-admitted insurer or advise any insured or applicant for insurance that coverage has been or will be obtained from a non-admitted insurer unless:

(a) The broker has prior written authority from the non-admitted insurer to cause the risk to be insured;

(b) The broker has received advice in the ordinary course of business that the coverage has been obtained
(c) A policy of insurance covering the insured for the risk has actually been issued by the nonadmitted insurer and delivered to the insured or his or her representative.

The list of eligible surplus lines insurers maintained by the California Department of Insurance is known as the LASLI list (List of Approved Surplus Lines Insurers). The following link will provide access to this list: http://www.insurance.ca.gov/01-consumers/120-company/07-lasli/lasli.cfm

License qualifications: An applicant for an insurance license must submit (1) the Department of Insurance application form, (2) fees, and (3) certificates showing completion of the necessary course material. When applying as a life-only agent or an accident and health agent, the candidate must complete 20 hours of the material applicable to the license as well as 12 hours on code and ethics. If applying for a life-only/accident and health license, 40 hours of course material must be completed in addition to the 12 hours on code and ethics. The property broker-agent and/or casualty broker-agent must complete 40 hours of material regarding the lines of insurance they may sell as well as 12 hours of code and ethics. A person applying for a property and casualty personal lines license will need to complete 20 hours of study regarding personal lines and 12 hours of code and ethics. The commissioner may make an investigation or may require additional information, documents, or statements to determine if the applicant has met all the requirements for a license. The applicant will be required to pass the state licensing examination and achieve a score of 60% correct.

A life-only agent, an accident and health agent, a property broker-agent and/or casualty broker-agent, or a personal lines broker/agent to act as an insurance agent shall have filed on his behalf with the commissioner a notice of appointment to act as an agent executed by an admitted insurer. Additional notices of appointment may be filed by other insurers before the license is issued and thereafter. (CIC 1704) Every property broker-agent and/or casualty broker-agent or personal lines solicitor applicant shall have filed on his behalf a notice executed by a property broker-agent and/or casualty broker-agent or personal lines broker/agent agreeing to employ the applicant. To act as a property broker-agent and/or casualty broker-agent or personal lines broker, a $10,000 bond must be filed with the Department of Insurance.

An agent's appointment by an insurer serves as notice to the commissioner that the insurer has deemed the applicant to be a person of good reputation and character. Appointments are effective as of the date the notice of appointment is signed by the insurer and continues in force until (1) the cancellation or expiration of the license applied for or held at the time the appointment was filed or (2) one of the parties (licensee or insurer) files a notice of termination. When all the

appointments of a licensed life-only agent, accident and health agent, property broker-agent and/or casualty broker-agent, personal lines agent, or solicitor are terminated, the license becomes inactive. If a property broker-agent and/or casualty broker-agent or personal lines broker's bond is cancelled, his license becomes inactive. The license may be reactivated any time before it expires by filing a new appointment or broker's bond. An inactive license shall not permit its holder to transact any insurance for which a valid, active license is required. (CIC 1704a; 1705)

Certificate of convenience: Upon the filing of an application for a license, the commissioner may make such investigation and require the filing of such supplementary documents, affidavits and statements as may be necessary to obtain a full disclosure of such information as will aid him in determining whether the prerequisites for the license have been met. If the applicant makes a showing satisfactory to the commissioner that he meets all such prerequisites, the commissioner may issue a certificate of convenience and, upon the applicant meeting any applicable examination requirements, may issue a permanent license. (CIC 1666)

Causes for denial after a hearing: The commissioner may deny a license, after a notice and hearing into the issue, for any of the following reasons**:** (CIC 1668)

a. The applicant is not properly qualified to perform the duties of a person to hold the license for which applied.
b. Granting the license would not be in the public interest.
c. The applicant does not intend actively and in good faith to conduct business with the general public which would be permitted under the license for which applied.
d. The applicant is not of good business reputation.
e. The applicant lacks integrity.
f. The applicant has been refused a professional, occupational, or vocational license, or has had such a license suspended or revoked for a reason that should preclude the granting of an insurance license.
g. The applicant is seeking the license to avoid or prevent the operation or enforcement of the state's insurance laws.
h. The applicant has knowingly or willfully made a misstatement in the license application or in a document filed to support the application, or has made a false statement to the commissioner in testimony given under oath.
i. The applicant has previously engaged in a fraudulent practice or act or has conducted a business in a dishonest manner.
j. The applicant has shown that he has been incompetent or untrustworthy in the conduct of a business, or has exposed the public or those dealing with him to the danger of loss, by committing a wrongful act or practice in the course of business.
k. The applicant has knowingly misrepresented the terms or effect of an insurance policy or contract.

l. The applicant has failed to perform a duty expressly required by the insurance code or has committed an act expressly forbidden by the code.
m. The applicant has been convicted of a felony, a misdemeanor in violation of any insurance laws, or a public offense that involved fraud or dishonesty involving money or property.
n. The applicant has aided or abetted another person in an act or omission for which that person's license could be suspended, revoked, or refused.
o. The applicant has allowed any person employed by him to violate any provision of the insurance code.
p. The applicant has violated any law relating to conduct of a business which could lawfully be done only by authority conferred by such license.

A judgment, plea or verdict of guilty or a conviction following a plea of *nolo contendere* is considered to be the same as a conviction.

Denial of license application without a hearing: The commissioner may deny an application for a license without conducting a hearing for any of the following reasons: (CIC 1669)

a. The applicant has been convicted of a felony.
b. The applicant has been convicted of a misdemeanor denounced by any insurance law.
c. The applicant has had a previous application denied for cause within the last five (5) years.
d. The applicant has had a license suspended or revoked for cause within the last five (5) years.

License revocation or suspension: The commissioner may suspend or revoke a permanent license for any of the same grounds for which a license application may be denied. As noted above, some grounds require a hearing while others do not. (CIC 1738)

Title 18 United State Code Sections 1033-1034: According to Section 1033 it is a criminal offense for an individual who has been convicted of a felony involving dishonesty or breach of trust to willfully engage or participate in the business of insurance unless that person has first obtained the written consent of the appropriate regulatory official. Furthermore, it is a criminal offense for any person to willfully employ or willfully permit such prohibited persons to participate in the business of insurance without the required written consent.

The California Department of Insurance has jurisdiction under this act to consider requests for written consent filed by prohibited persons who propose to participate in the business of insurance in California with a domestic insurer or a resident licensee. Such prohibited persons who propose to engage in the business of insurance in California shall:

- File a 1033 consent waiver application
- Pay the application fee
- Provide all required documentation
- Receive written consent before engaging in such business

Disability insurance—dual authority: A person licensed as either a property and casualty agent/broker or as an accident and health agent may be authorized to transact disability insurance for an admitted insurer by filing a notice of appointment from that insurer. (CIC 1673)

Implied declarations with appointment: (CIC 1705)

1. When an insurer or licensed property and casualty broker/agent files an appointment for an agent or solicitor applying for an original license, the insurer or broker/agent is declaring that the applicant is of good reputation and is worthy of the license sought.
2. If an applicant will not be issued a certificate of convenience pending examination, the insurer or broker/agent who files the appointment is declaring that the applicant has had the required experience or instruction in the classes of insurance for which the license is sought or that he/she will be given the necessary instruction within 30 days after the license is issued.
3. If the applicant is a co-partnership, corporation, or association, the insurer making the appointment is deemed to have declared that the applicant is of good reputation and worthy of the license sought. This applies to the business organization and to each individual authorized to exercise agency powers who is named in the application. These implied declarations apply to any additional persons added to the license at a later date.

Termination of license: (CIC 1708-1714)

1. A licensee may voluntarily surrender his license for cancellation at any time by delivering the license to the commissioner. If the license is in the possession of the insurer or the licensee's employer, the license may be surrendered by providing written notice to the commissioner of the licensee's desire to cancel.
2. All licenses issued to a natural person terminate when the person dies.
3. An organization ceases to exist as an entity eligible to hold a license upon the following:
   a. A co-partnership dissolves or there is a change in membership.
   b. An association terminates.
   c. A corporation is dissolved.
4. A co-partnership may continue to transact business under its license if:
   a. The surviving partnership files an application within 30 days registering the change in membership, pays the required fee, and furnishes the required bond (if acting as a broker).
   b. At least one partner from the predecessor partnership continues to exercise the powers of agency or brokership with the new partnership.

c. The application is signed by a general partner.
Note: To return the old license to the commissioner with signatures of the original members is not a requirement.

5. When a licensed entity terminates, its right to transact insurance also terminates. However, a natural person, partnership, association, or corporation may continue to operate under an existing license as a different organization if:
   a. A natural person is named to exercise the agency or brokerage powers.
   b. There has been no substantial change in ownership or control of the licensed insurance business.
   c. Within 30 days after the change, the person or successor partnership, association or corporation files a license application and pays necessary fees.
6. The license of an organization licensed as a life-only agent, accident and health agent, property and casualty broker/agent, or personal lines broker/agent becomes inoperative when the last natural person named on the license is removed or is no longer eligible to be licensed. The license will not be reactivated unless all deficiencies are corrected, including the addition of a natural person to transact insurance under the organization's license.

License renewal: (CIC 1720) An application on a form prescribed by the commissioner for the renewal of a license filed on or before the last day of the period for which the previous license was issued, accompanied by the renewal fee, shall entitle the applicant to continue operating under the existing license for 60 days after its specified expiration date or until notified by the department of insurance that the renewal application is deficient.

Printing license number on documents and advertisements: (CIC 1725.5) Every licensee shall prominently print his license number on business cards, written price quotations for insurance products, and printed advertisements for insurance products distributed exclusively in California. The license number must be printed in the same size type as any telephone number, address, or fax number. If the licensee maintains more than one organization license, one of the organization license numbers is adequate for compliance.

In the case of solicitors working as exclusive employees of a motor club, organizational license numbers shall be used. These requirements do not apply to general advertisements of motor clubs that simply list insurance products as one of several services offered by the motor club and do not provide any details regarding insurance products.

Any person in violation of this section is subject to a fine of $200 for the first offense, $500 for the second offense, and $1,000 for the third and subsequent offenses. The penalty will not exceed $1,000 for any one offense. Separate penalties will not be imposed upon each piece of printed material that does not

conform to the requirements of this regulation. The money from these fines will be deposited into the Insurance Fund.

Internet advertisements: (CIC 1726) A person who is licensed in this state as an insurance agent or broker, advertises insurance on the Internet, and transacts insurance in this state, shall identify all of the following information on the Internet, regardless of whether the insurance agent or broker maintains his/her Internet presence or if the presence is maintained on his/her behalf:

1. His/her name as it appears on his/her insurance license and any fictitious name approved by the commissioner.
2. The state of his/her domicile and principal place of business.
3. His/her license number.

A person shall be deemed to be transacting insurance in this state when the person advertises on the Internet whether the licensee maintains his/her Internet presence or if it is maintained on his/her behalf and does any of the following:

1. Provides an insurance premium quote to a California resident.
2. Accepts an application for coverage from a California resident.
3. Communicates with a California resident regarding one or more terms of an agreement to provide insurance or an insurance policy.

Continuing Education: Licensees are subject to the following continuing education requirements:

License Type	*CE Requirements*
Life Only	24 hours per license term including 3 hours of Ethics
Accident & Health	24 hours per license term including 3 hours of Ethics
Life AND Accident & Health	24 hours per license term including 3 hours of Ethics
Property & Casualty	24 hours per license term including 3 hours of Ethics
Property Only	24 hours per license term including 3 hours of Ethics
Casualty Only	24 hours per license term including 3 hours of Ethics
Personal Lines	24 hours per license term including 2 hours of Ethics
Limited Lines Auto	20 hours per license term including 2 hours of Ethics
Long Term Care –For licensees issued a license AFTER January 1, 1992	8 hours LTC training in EACH of the first four 12-month periods, then 8 hours per license term
Long Term Care –For licensees issued a license BEFORE January 1, 1992	8 hours LTC training per license term
Licensee soliciting CA Partnership LTC	Individuals who will be involved in the sale or marketing of long-term care insurance policies certified by the California Partnership for Long-Term Care, are required to complete eight (8) hours of general long-term care continuing education (CE) and 8 hours of classroom only CE specifically on the California Partnership for Long-Term Care prior to the marketing of any Partnership certified policies/certificates. After your initial education requirement has been met, you are required to repeat eight hours of classroom training on the Partnership each two-year license approval period.
Licensee soliciting Annuities	8 hours of Annuities to begin, then 4 hours per license term (**Completion of the 8-hour annuity training DOES NOT SATISFY the 4-hour requirement**)

A license year upon initial licensing starts on the date the license is issued. After that, each license year starts the first day of the month following the month in which the initial license was issued. A license year ends the following calendar year on the last calendar day of the month in

which the initial license was issued. A license term is for two years. (CIC 1629-1630)

Failing to complete the continuing education requirements results in termination of license. In order to reactivate the license, the individual must complete the necessary continuing education requirements, pay late penalties and fees, and reinstate all appointments and endorsements. (CIC 1749.3)

Everyone has a need for some type of insurance during his/her lifetime. Consequently, the public is relying on the advice of insurance licensees to make sure that they have adequate insurance to protect their family and assets. The agent must be careful in identifying a customer's needs and then should make recommendations of appropriate products and services. The agent should keep in touch with his clients and conduct periodic reviews to ascertain that their insurance coverage is adequate to meet current circumstances. Agents should protect the confidential relationship they have with their clients.

To be professional, agents must observe insurance laws and the rules of the insurance companies that they represent. Agents must accurately and truthfully represent products and services. It is important to use simple language to make sure clients understand what the agent is saying. In other words, layman's language should be used when possible. Agents should maintain a friendly attitude toward competitors. Criticizing other agents and companies does not reflect a professional attitude. Agents should always be careful not to make misleading remarks about insurance companies or insurance products.

As a large percentage of the population has no knowledge about insurance, it is essential that the agent be well informed. Part of being informed is to constantly keep updated by doing continuing education courses and reading insurance trade journals and business publications. By being more knowledgeable, the agent will be better able to serve clients. The most important thing for the agent to remember is to place the client's welfare first, not his/her own. By keeping the foregoing in mind, the agent will provide exemplary service to clients.

Change of address: (CIC 1729) Every licensee and applicant for a license must immediately notify the commissioner in writing of any change in his residence address, business address, or mailing address. ***This must include licensee's email address***. The CDI sends notices and renewals to the email address so it is important the agent's maintain a current email address with the CDI

Notice: Any notice required to be given to any person by any provision of the code may be given by mailing notice, postage prepaid, addressed to the person to be notified at his residence or principal place of business in California. The affidavit of the person who mails the notice, stating the facts of such mailing, is prima facie evidence that the notice was thus mailed. (CIC 38)

Agency names: (CIC 1724.5, 1729.5) Every individual and organization licensee and every applicant for such a license shall file with the commissioner in writing the true name of the individual or organization and also all fictitious names under which he conducts or intends to conduct his business and after licensing shall file with the commissioner any change in or discontinuance of such names. The commissioner may in writing disapprove the use of any true or fictitious name (other than the bona fide natural name of an individual) by any licensee on any of the following grounds:

1. The name interferes with or is too similar to a name already filed and used by another licensee.
2. Using the name may mislead the public in any way.
3. The name states or implies that the licensee is an insurer, motor club, hospital service plan or that the licensee is entitled to engage in insurance activities not allowed under the license.
4. The name states or implies that the licensee is an underwriter. However, this does not prohibit a natural person from using a designation like Chartered Life Underwriter (CLU) or Charter Property and Casualty Underwriter (CPCU) or a trade association whose members are individually licensed from using a name that includes the word “underwriter” (e.g. National Association of Life Underwriters).
5. The licensee has filed and has not discontinued use of more than two names, including the true name. A licensee who has bought an insurance business may use two additional names used by the previous owner(s) in conducting the business.

A licensee may not continue to use a true or fictitious name after the commissioner has notified the licensee in writing to stop. If there are mitigating facts in connection with the use of a particular name, the commissioner may permit continued use of the name for a reasonable time if there are conditions imposed that adequately protect the public.

A property broker-agent and/or casualty broker-agent or life-only and/or accident and health agent who has a service contract with a corporation licensed under this code or who is a stockholder or member of any incorporated association or corporation organized under the Corporations Code for the purpose of providing services to property broker-agent and/or casualty broker-agent or life-only and/or accident and health agents may use the name of such a corporation or association on any stationery or advertisements and other written or printed matter used to identify the business of the property broker-agent and/or casualty broker-agent or life-only and/or accident and health agent provided that the name of the property broker-agent and/or casualty broker-agent or life-only and/or accident and health agent is clearly identified as bearing only that relationship to the corporation or association in one of the following ways:

- “Representing_____;”
- “A stockholder of_____:”
- “Placing business through_____:”

- "Using services of_____."

Policy defined: The written instrument, in which a contract of insurance is set forth, is the policy. (CIC 380)

Required contents: A policy shall specify:

(a) The parties between whom the contract is made.
(b) The property or life insured.
(c) The interest of the insured in property insured, if he is not the absolute owner thereof.
(d) The risks insured against.
(e) The period during which the insurance is to continue.
(f) Either:
    (1) A statement of the premium, or
    (2) If the insurance is of a character where the exact premium is only determinable upon the termination of the contract, a statement of the basis and rates upon which the final premium is to be determined and paid. (CIC 381)

The financial rating of the insurer is not required to be specific in the insurance policy.

Parties to the contract: Any person capable of making a contract may be an insurer, subject to the restrictions imposed by the code. (CIC 150) Any person except a public enemy may be insured. (CIC 151)

If the insured has no insurable interest, the contract is void. (CIC 280) The measure of insurable interest in property is the extent to which the insured might be damnified by loss or injury thereof. (CIC 284) An interest in property insured must exist when the insurance takes effect, and when the loss occurs, but need not exist in the meantime; an interest in the life or health of a person insured must exist when the insurance takes effect, but need not exist thereafter or when the loss occurs. (CIC 286)

Concealment: Concealment is defined as the neglect to communicate that which a party knows and ought to communicate. Whether or not concealment is intentional or unintentional, the injured party has the right to rescind the insurance contract. Rescission means the contract is made null and void. All parties to a contract shall communicate in good faith all information believed to be material to the contract.

Each party to the contract must: (1) communicate in good faith with one another; (2) disclose all facts of which the party has knowledge and which are of importance to the contract; and (3) identify all facts that the party cannot warranty and of which the party has no means to ascertain.

It is not necessary to disclose to the other party: (1) information which the other party already has knowledge; (2) information which, in the exercise of ordinary care, the other ought to know, and of which the party has no reason to suppose him ignorant; (3) information to which the other party waives communication; and (4) information which is not material to the contract. (CIC 330-333)

Materiality: Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due, in forming his estimate of the disadvantages of the proposed contract, or in making his inquiries. (CIC 334)

Each party to a contract of insurance is bound to know all the general causes open to inquiry that may affect either the political or material perils contemplated. The right to information of material facts may be waived either by the terms of insurance or by neglect to make inquiries as to such facts where they are distinctly implied in other facts which are communicated. Information regarding the nature or amount of one's insurable interest need not be communicated unless in response to an inquiry. An intentional and fraudulent omission on the part of one insured to communicate information of matters proving or tending to prove the falsity of a warranty entitles the insurer to rescind. (CIC 335-338)

Representation: A representation is a statement to the best knowledge and belief of the party making the statement. A representation can be written or oral. The language of a representation is to be interpreted by the same rules as a contract in general. A representation as to the future is a promise, unless it is merely a statement of belief or an expectation. **A representation** cannot qualify an express provision in a contract of insurance, but it **may qualify an implied warranty**. A representation may be made at the time of, or before, issuance of the policy. A representation may be altered or withdrawn before the insurance is effected, but not afterwards. (CIC 355) The completion of the contract of insurance is the time to which a representation must be presumed to refer.

When an insured has no personal knowledge of a fact, he may nevertheless repeat information which he has upon the subject, and which he believes to be true, with the explanation that he does so based on the information of others. He is not responsible for its truth, unless it proceeds from an agent of the insured, whose duty it is to give the information.

A representation is considered to be false when the facts fail to correspond with its assertions or stipulations. (CIC 358) If a representation is false in a material point, the injured party is entitled to rescind the contract from the time the representation becomes false. The materiality of a representation is determined by the same rule as the materiality of a concealment. All of the above provisions apply to the modification of a contract of insurance as well as to the original contract. (CIC 350-361)

Opinion: Neither party to a contract of insurance is bound to communicate, even upon inquiry, information of his own judgment upon the matters in question. (CIC 339)

Misrepresentation: (CIC 780-784) A misrepresentation is a false oral or written statement made with the intent to defraud another. An insurer or an insurance licensee shall not cause or permit to be issued, circulated or used, any misrepresentation of the following:

(1) The terms of a policy issued by the insurer or sought to be negotiated by the person making or permitting the misrepresentation.
(2) The benefits or privileges promised thereunder;
(3) The future dividends, payable thereunder. (CIC 780)

Twisting: A person shall not make any representation or comparison of insurers or policies to an insured which is misleading, for the purpose of inducing or tending to induce him to lapse, forfeit, change or surrender his insurance, whether on a temporary or permanent plan. (CIC 781)

Any person violating the rules regarding misrepresentation or twisting may be fined up to $25,000 or in a case in which the loss of the victim exceeds $10,000, by a fine not exceeding three times the amount of the loss suffered by the victim, by imprisonment in a county jail for a period not to exceed one year, or by both a fine and imprisonment. Following a hearing, the commissioner may suspend the license of the insurance producer for up to three years. If an insurer or its representatives violate the rules regarding misrepresentation or twisting, the commissioner, after a hearing, may suspend the insurer's certificate of authority to do the class of insurance in respect to which the violation occurred. (CIC 782- 783)

Any person may be compelled to testify and produce books and writings at the trial or hearing of any person charged with violating any provision regarding misrepresentation and twisting even though such testimony or evidence may incriminate him. A person shall not be prosecuted for any act concerning which he is compelled so to testify or produce evidence, except for perjury committed in so testifying. (CIC 784)

Warranty: A warranty is a guaranteed truth. Warranties are either express or implied. A statement in a policy of a matter relating to the person or thing insured, or to the risk, as a fact, is an express warranty thereof. An implied warranty is a statement, not in writing, that insurable conditions exist. An implied warranty is included in the policy even though not specifically stated in it. A representation in an insurance contract qualifies as an implied warranty.

A particular form of words is not necessary to create a warranty. Every express warranty made at or before the execution of a policy shall be contained in the policy or in another instrument signed by the insured and made part of the policy. A warranty may relate to the past, the present, the future, or to any or all of these. A statement in a policy that imports that there is an intention to do or not

to do a thing, which materially affects the risk, is a warranty that such act or omission will take place. (CIC 440-445)

If a loss insured against takes place and the performance of the warranty has become unlawful at the place of the contract or impossible, the omission to fulfill the warranty does not void the policy. If there is a violation of a material warranty, the wronged party may rescind the contract. The breach of an immaterial warranty will not void the policy unless the policy states that a violation of specified provisions will void it. A breach of warranty without fraud merely exonerates an insurer from the time that it occurs, or where the warranty is broken in its inception, prevents the policy from attaching to the risk. (CIC 447)

Rescission: To rescind a contract is to terminate or void the contract. The policy is considered null and void from the beginning and treated as if it had never existed. As noted above, a wronged party has the right to rescind the contract when there has been a material concealment whether intentional or unintentional (CIC 331), an intentional and fraudulent omission proving the falsity of a warranty (CIC 338), a material false representation (CIC 359), or a violation of a material warranty or other material provision of a policy (CIC 447).

Unfair trade practices: (CIC 790-790.10) The insurance industry is subject to the laws of California which apply to all types of business, including, but not limited to, the Unruh Civil Rights Act, anti-trust, and unfair business practice laws. The purpose of the rules regarding unfair practices is to define and regulate trade practices in the business of insurance that are considered to be unfair, deceptive, or misleading. These provisions apply to all types of insurers and to all producers engaged in the insurance business. No one may engage in any practice that is prohibited by law or that is considered to be an unfair method of competition or an unfair or deceptive trade practice in the business of insurance.

The article regarding unfair trade practices applies to reciprocal and interinsurance exchanges, Lloyds insurers, fraternal benefit societies, fraternal fire insurers, grants and annuities societies, insurers holding certificates of exemptions, motor clubs, nonprofit hospital associations, life agents, broker/agents, surplus line brokers and special lines surplus line brokers as well as all other persons engaged in the business of insurance.

The following are unfair trade practices:

(a) **Misrepresentation.** It is against the law to make, issue, or circulate any estimate, illustration, circular or statement which:
    1. Misrepresents the benefits, terms, or advantages of an insurance policy.
    2. Misrepresents the dividends to be paid on an insurance policy.
    3. Misrepresents the dividends paid in the past on a policy or similar policies.

4. Misrepresents the financial condition of an insurer or the legal reserve system used by an insurer.
5. Uses a policy name that misrepresents the true nature of a policy or class of policies.
6. Makes a misrepresentation to a policyholder that induces that policyholder to lapse, forfeit, or surrender his policy.

(b) **Untrue or deceptive information about a person engaged in insurance.** It is an unfair practice to advertise or distribute information about the insurance business, an insurer, or any person engaged in the business of insurance which is untrue, deceptive, or misleading.

(c) **Boycott, coercion, intimidation.** It is unlawful to commit or conspire to commit an act of boycott, coercion, or intimidation which results in unreasonable restraint of, or monopoly in the business of insurance.

(d) **Filing false financial statement.** It is unlawful to knowingly file with any public official or to publish, circulate, or place before the public a false statement of an insurer's financial condition, with intent to deceive.

(e) **False entries.** It is against the law to knowingly make an entry or deliberately omit an entry of a material fact in a book, report, statement or record which an insurer is required to file with the insurance department or any other public agency with intent to deceive a public official or examiner.

(f) **Unfair discrimination.** It is prohibited to make or allow unfair discrimination between persons of the same class and life expectancy in the rates charged or the terms, conditions, benefits, or dividends of a life insurance policy or an annuity. Differences based on sex are permitted it they can be substantiated by mortality data and other statistical information.

(g) **Advertising membership in the state's Guarantee Association.** Although membership in the California Insurance Guarantee Association is required for all insurers which offer the kinds of insurance protected by the Association, a member insurer may not advertise directly or indirectly that it is an Association member or that it is insured against insolvency.

(h) **Unfair claims practices.** The following unfair claims practices are prohibited:

1) Misrepresenting to claimants any pertinent facts or policy provisions which relate to the coverage at issue.
2) Failing to acknowledge and act reasonably promptly on communications relative to policy claims.
3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims.
4) Failing to affirm or deny coverage within a reasonable time after proof of loss statements have been completed and submitted.
5) Failing to make prompt, fair, and equitable settlement of claims where the company's liability has become reasonably clear.
6) Requiring claimants to sue to recover amounts due under a policy by offering substantially less than the amounts ultimately

recovered in lawsuits brought by insureds, when insureds have made claims for amounts similar to those ultimately recovered.

7) Trying to settle a claim for less than a reasonable person would expect to receive by referring to printed advertising material accompanying or made part of the application.
8) Trying to settle a claim on the basis of an application which was altered without the knowledge and consent of the insured.
9) After payment of a claim, failing to inform insureds or beneficiaries of the coverage under which payment was made, when such information has been requested by them.
10) Telling an insured or claimant that the insurer will appeal any judgment in favor of the claimant or insured in order to get him to accept less than the amount awarded in arbitration.
11) Delaying an investigation or settlement of a claim by requiring the insured, claimant, and/or physician to file a preliminary claim report, then making them file formal claim papers which contain substantially the same information.
12) Failing to settle claims promptly where liability is clear under one section of the policy in order to influence settlement under another section of the policy.
13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy for denying a claim or offering a compromise settlement.
14) Directly advising a claimant not to obtain the services of an attorney.
15) Misleading a claimant about the applicable statute of limitations.
16) Delaying the payment of or providing hospital, medical, or surgical benefits for services rendered for AIDS for more than 60 days after the insurer has received a claim in order to investigate and determine if the claim was for a pre-existing condition. Time spent waiting for information from an attending physician or other health care provider is not counted in this 60- day period.

Any person who engages in any unfair method of competition or any unfair or deceptive act or practice is liable to the state for a civil penalty to be fixed by the commissioner, not to exceed five thousand dollars ($5,000) for each act, or, if the act or practice was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each act. The commissioner shall have the discretion to establish what constitutes an act.

If any person violates a cease and desist order or an order of the court, after it has become final and while it remains in effect, the commissioner may call a hearing to determine whether such violation has occurred. If it is determined that a violation was committed, the commissioner may order the person to pay either (1) a fine up to $5,000 if the violation is not found to be willful plus the amount of any outstanding penalty for violating the code or (2) a fine of up to $55,000 if the violation is found to be willful plus the

amount of any outstanding penalty for violating the code. For any subsequent violation of a cease and desist order, court order, or order to pay a penalty, the commissioner may, after a hearing, suspend or revoke the person's license or Certificate of Authority for a period of up to one year.

The commissioner shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in the 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 the code. The powers vested in the commissioner in this section of the code are in addition to any other powers to enforce any penalties, fines or forfeitures, denials, suspensions or revocations of licenses or certificates authorized by law with respect to the methods, acts and practices herebv declared to be unfair or deceptive.

(i) **Advertising insurance that the insurer will not sell.** It is a misdemeanor in which carries a fine of up to $10,000. This section does not apply to an insurer which refuses to sell a policy on the basis of its underwriting guidelines. This section does not apply to advertisements by an insurer where the ads are broadcasted (TV, radio) and originate from outside the state.

Cancellation, lapse, renewal, and non-renewal:

Cancellation is the termination of coverage by an insurer during a policy period. It does not mean the termination of the contract at the request of the policyholder.

Lapse refers to policy termination due to non-payment of the premium by the policyholder. A policy will lapse at the end of the grace period, which is a period of time after the premium due date, during which the policy remains in force without penalty.

Renewal refers to continued coverage under the policy for an additional period of time upon expiration of the current policy period.

Non-renewal refers to the giving of notice by the insurer to the policyholder that the insurer is unwilling to renew a policy.

Life policies are incontestable after being in force for two years. After this period of time, the insurer can cancel only for non-payment. Some term contracts are written as renewable which means the policyholder has the right to renew without proof of insurability, but premiums can be adjusted.

Disability contracts may be cancelled for non-payment and on the grounds of fraud on the part of the insured. Disability contracts can be written as non-

renewable/cancelable, optionally renewable, conditionally renewable, guaranteed renewable, or non-cancelable.

of preexisting conditions unless they would have been excluded or reduced as preexisting conditions under the prior group policy. (CIC 10128.3.b)

Insurance Information and Privacy Protection Act (IPPA): (CIC 791-791.26) 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 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.

Notice of information practices: An insurance company or agent must provide a notice of information practices to all applicants or policyholders (1) when the policy is delivered if the only information to be used is collected from the applicant, insured or public records or (2) at the time of application if personal information will be collected from any source other than the applicant, insured or public records.

The notice must be in writing and must state:

1. Whether personal information may be collected from persons other than the applicant 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 the information.
3. The circumstances under which the disclosures may be made without prior authorization.
4. A description of the applicant's rights and the manner in which those rights may be exercised.
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.

An acknowledgment that the company's information practices have been disclosed must be signed by the applicant and submitted with the application. Further, an insurance institution or agent must clearly specify questions on an

application designed to obtain information solely for marketing or research purposes.

Disclosure authorizations are forms or statements with which a person authorizes personal or confidential information about him to be disclosed. This authorization must:

1. Be written in plain language.
2. Be dated.
3. Specify the types of persons authorized to disclose information (i.e. friends, neighbors, employer).
4. Specify the nature of the information authorized to be disclosed (habits, personal traits).
5. Name the insurance institution or agent to whom the individual authorizes information to be disclosed.
6. Specify the purposes for which the information is collected (e.g. to underwrite an application for insurance).
7. Specify the length of time for which the disclosure authorization is valid. The maximum length of time for life, health or disability insurance is 30 months and one year for property and casualty insurance.
8. Advise the individual that he is entitled to receive a copy of the authorization form.
9. This section shall not be construed to require any authorization for the receipt of personal or privileged information about an individual.

Corrections in reports may be requested by individuals. An individual may request that the information be corrected, amended, or deleted. The individual must provide the facts to support the request. Within 30 days of receiving the request, the insurance company, agent, or insurance support organization must (1) correct, amend or delete the portion of record information in dispute or (2) notify the individual that it will not make the alteration in the record, giving the reasons for that refusal and notify the individual of his right to file a statement.

Penalties: The commissioner has the right to examine and investigate every insurance organization or agent doing business in the state to determine if the privacy laws have been violated. If the commissioner has reason to believe that the law is being violated, he may serve notice and conduct a hearing into the allegation. An insurance support organization transacting business outside of the state, which has an effect on a person residing in California, is deemed to have appointed the commissioner to accept service of process on its behalf, provided that the commissioner sends a copy of the service by registered mail to the insurance support organization.

After a hearing, the commissioner must put his findings in writing and can issue a cease and desist order if he finds the law has been broken. If the person violates the cease and desist order, the commissioner can impose a fine of up to

$10,000 for each violation. If the violations occur with such frequency that they clearly are a general business practice, the fine can be up to $50,000. If a company or agent knew or should have known that the rules were being violated, the commissioner also may suspend or revoke the company's certificate of authority or the agent's license.

Any person who knowingly and willfully obtains information about an individual from an insurance institution, agent, or insurance support organization under false pretenses can be fined up to $10,000 or imprisoned for up to one year, or both.

Gramm-Leach-Bliley Act: The Financial Modernization Act of 1999, know as the "Gramm-Leach-Bliley Act" or GLB Act, has provisions to protect consumers' personal financial information held by financial institutions. There are three main parts to the privacy requirements. They are (1) the Financial Privacy Rule, (2) Safeguard Rule, and (3) pretexting provisions.

The Financial Privacy Rule governs the collection and disclosure of customers' personal financial information by financial institutions and other companies who receive such information. Customers are entitled to receive a privacy notice every year. The notice must be given to the customers or consumers by mail or in person. The privacy notice must be a clear, conspicuous, and accurate statement of the company's privacy practices. It should include what information the company collects about its consumers or customers, with whom the information is shared, and how it safeguards the information. The notice applies to the "nonpublic personal information" the company gathers and discloses about it customers and consumers. Customers and consumers have the right to "opt out" of having their information shared with certain third parties. The GLB Act does not give consumers the right to opt out when the financial institution shares other information with its affiliates.

The Safeguards Rule requires all financial institutions to design, implement, and maintain safeguards to protect customer information. This rule applies not only to financial institutions that collect information from their own customers, but it also applies to financial institutions such as credit reporting agencies that receive customer information from other financial institutions.

The pretexting provision prohibits the practice of obtaining customer information from financial institutions under false pretenses. A pretext interview is an interview whereby a person, in an effort to get confidential information about another person: (1) pretends to be someone he is not; (2) pretends to represent a person he is not in fact representing; (3) misrepresents the true purpose of the interview; or (4) refuses to identify himself upon request. Pretext interviews may not be used by anyone engaged in the business of insurance except when investigating claims where there is a reasonable basis for suspecting fraud, criminal activity, material misrepresentation or non-disclosure.

California Financial Information Privacy Act (SB1 or California Financial Code 4050): The intent of this act is to afford greater privacy protections than those provided by the GLBA (Gramm-Leach-Bliley Act). It unites the federal GLBA with the Insurance Information Privacy and Protection Act (IPPA) contained in the insurance code. Enacted in 2003, Cal-GLBA's biggest impact is the required implementation of greater "opt-out/opt-in" choices with enhanced privacy requirements. The following is a comparison of the California law (Cal-GLBA) and the federal law (GLBA).

Provision	**Cal-GLBA**	**GLBA**
Selling or sharing information with outside company	Opt-In	Opt-Out
Selling or sharing with affiliates and subsidiaries	Opt-Out	No-Opt
Sharing between 2 financial institutions jointly offering a financial product	Opt-Out	No-Opt
Sharing to complete a transaction	No-Opt	No-Opt
Clear & readable consumer form?	Yes	No

Legend:
Opt-In=Company must receive consumer permission first.
Opt-Out=Consumers can stop sharing if they object.
No-Opt=Consumers cannot stop the sharing

Fiduciary responsibilities: (CIC 1733-1735) A fiduciary is a person who is in a position of financial trust.

1. All funds received by a person who holds any kind of insurance license as agent, broker, or solicitor are received and held by that person in a fiduciary capacity (position of trust). Anyone who diverts or appropriates fiduciary funds for his own use is guilty of theft, which is punishable under criminal law.

   Premiums advanced by a premium financer under terms of a finance agreement are fiduciary funds only if they are received by a person who holds a license.

2. A licensed person who receives fiduciary funds (a) must remit premiums, minus commissions, and any return premiums received or held by him/her to the insurer or entity entitled to get them or (b) must maintain the fiduciary funds on California business in a trustee bank account or depository in California separate from any other account, in an amount at least equal to

the premiums and return premiums, less commissions, received by him which have not yet been paid to the persons entitled to them.

The person may commingle additional funds with fiduciary funds as he may deem prudent for the purpose of advancing premiums, establishing reserves to pay return commissions, or contingencies as may arise in his business of receiving and transmitting premium or return premiums.

3. Fiduciary funds which have not yet been remitted and which are not held in a trust account can be invested in the following instruments:

    - U.S. government bonds and treasury certificates or other obligations backed by the federal government.
    - Certificates of deposit of banks and savings and loan associations licensed by the federal government or any state government.
    - Repurchase agreements collateralized by U.S. government securities.

4. As a condition to maintaining the funds in one of the investment accounts, a written agreement must be obtained from each and every insurer or person entitled to the funds authorizing the maintenance and retention of earnings which accrue on the funds.

5. Evidence of the funds must be maintained on California business by a bank or savings and loan association in a trust account separate from any other account or depository in an amount at least equal to the premiums and return premiums, minus commissions, which have not yet been paid to the insurer or entity entitled to them. The commissioner shall not have jurisdiction over any disputes arising between parties concerning the maintenance of fiduciary funds.

6. A managing general agent must comply with all regulations concerning deposit, maintenance, and remittance of fiduciary funds. A managing general agent is a licensed property and casualty broker/agent or life-only and/or accident and health agent who has a written contract with one or more admitted insurers to manage the production of its business in a designated territory in California. A managing general agent:
    - Hires, supervises, and fire agents.
    - Accepts or declines risks.
    - Collects premiums from producing broker/agents and remits them to insurers under an account current system.
7. A property and casualty broker/agent, personal lines broker/agent, or surplus lines broker can deduct any return premiums due an insured from unpaid premiums the insured owes on the same or any other policy. An insurer may pay return premiums to a property broker-agent and/or casualty broker-agent for this purpose.

Fraudulent claims: It is against the law for a person to knowingly:

- Present a false or fraudulent claim for payment of a loss.
- Present multiple claims for the same loss or injury, including claims to more than one insurer, with intent to defraud.
- Cause or participate in a vehicle collision or other vehicular accident.
- Present a false or fraudulent claim for a loss due to theft, destruction, damage, or conversion of a motor vehicle, motor vehicle part, or motor vehicle contents.
- Prepare, make or subscribe any writing to support a false or fraudulent claim.
- Assist, abet, solicit, or conspire with any person who knowingly commits any of these violations.
- Make a false or fraudulent claim for payment of a health care benefit.
- Submit a claim for a health care benefit which was not used by the claimant.
- Present multiple claims for payment of the same health care benefit with intent to defraud.
- Present for payment any undercharges for health care benefits on behalf of a claimant unless known overcharges for health care benefits for that claimant are presented for reconciliation at the same time. (CIC 1871.4)

A violator can be imprisoned for up to one year in county jail, or 2, 3, or 5 years in state prison and/or be fined up to $150,000 or double the value of the fraud, whichever is greater, or by both imprisonment and fine. If the violator has a prior felony conviction for the same offense, there shall be an additional two year sentence for each previous conviction. Additional criminal charges also may be imposed.

An insurer's claim form must carry the statement: "For your protection, California law requires the following to appear on this form" (or similar wording) followed by "A person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison". (CIC 1871.2) The person may be found guilty of perjury.

The California legislature is aware that the business of insurance involves many transactions that have potential for abuse and illegal activities. Many law enforcement agencies at the state and local levels are responsible for investigating and prosecuting fraudulent activities. Every insurer admitted to do business in this state shall maintain a unit or division to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds (CIC 1875.20) Insurers and their agents shall have access to all relevant public records that are required to be open for inspection when they are investigating suspected fraudulent claims. (1871.1)

Fraudulent claims harm everyone as they add to an insurer's overall claims experience. This might skew the actuarial projections of the insurer. To make up for these losses, an insurer will need to increase premiums which is an expense that will be borne by all policyholders. (CIC 1871)

There is a Bureau of Fraudulent Claims within the Department of Insurance. It was created to enforce the provisions prohibiting fraudulent claims and to enforce related sections of the Penal Code. (CIC 1872) To help prevent fraud, there is the National Automobile Theft Bureau. Every insurer is required to report private passenger automobiles involved in theft and salvage total losses. (CIC 1874.6)

Before settling a claim involving vehicle theft, the insurer shall secure a claim form from the insured that includes a warning that false representations on the form subjects the insured to the penalty of perjury, a detailed description of the insured vehicle, the purchase location of the insured vehicle, purchase date and name of seller, a detailed statement of the circumstances surrounding the theft, and the insured's current driver's license number. The insured must sign the claim form in the presence of the insurance agent, broker, or adjuster, or other claims representative who must verify the insured's driver's license number, or submit a notarized claim form, and the claim form shall be signed under penalty of perjury. The insurer must retain for three years all settlement checks in settling an auto theft, the original claim form, and a legible copy of the police report. (1871.3)

The Arson Information Reporting System permits insurers, law enforcement agencies, fire investigative agencies, and district attorneys to deposit arson case information in a common database within the Department of Justice. The purpose of this database is to identify utilization patterns by individual claimants and methods of operation of individuals, groups, or businesses engaged in the commission of arson and to prevent the perpetration of insurance fraud by arson. (CIC 1875.8)

When an insurer knows or reasonably believes it knows the identity of a person whom it has reason to think committed a fraudulent act relating to a worker's compensation insurance claim and believes it has not been reported to an authorized governmental agency, the insurer or its agent shall notify the local district attorney's office and the Bureau of Fraudulent Claims of the Department of Insurance. The insurer must state in its notice the basis of its knowledge or reasonable belief. (CIC 1877.3(b)(1)

The commissioner may license an organization as an insurance claims analysis bureau provided it meets the necessary requirements. The commissioner shall license an insurance claims analysis bureau by class of claims for the following classes of insurance:

- Automobile bodily injury
- Automobile physical damage
- Automobile theft
- Fire and allied lines property damage
- General liability bodily injury
- Disability
- Life

- Workers' compensation (CIC 1875.13)

An insurance claims analysis bureau shall perform the following functions:

- Collect and compile information and data from members or subscribers concerning insurance claims.
- Disseminate information to members or subscribers relating to insurance claims for the purpose of preventing and suppressing insurance fraud.
- Promote training and education to further insurer investigation, suppression, and prosecution of insurance fraud.
- Provide, without a fee or charge, to the commissioner, all California data and information contained in the records of the insurance claims analysis bureau in furtherance of the prevention and prosecution of insurance fraud. (CIC 1875.14)

Every insurer admitted to do business in this state shall maintain a unit or division to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds. (CIC 1875.20)

Civil liability: (1872.5) No insurer or the insurer's employees, or agents, can be sued for libel, slander, or any other relevant cause of tort action for providing, without malice, any of the following:

- Any information or reports relating to suspected fraudulent insurance transaction furnished to law enforcement officials or licensing officials governed by the Business and Professions Code.
- Any reports or information relating to suspected fraudulent insurance transactions furnished to other persons subject to this ruling.
- Any information or reports required by the code or the commissioner under the authority granted by the code.

File and Record Documentation: (Title 10, CCR 2695.3)

Every licensee's claim files shall be subject to examination by the commissioner. These files shall contain all documents, notes and work papers (including copies of all correspondence) that 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.

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 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.

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.

The requirements of this section shall be satisfied where the licensee provides documentation evidencing inability to obtain data, non-existence 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 these rules continue to exist.

Duties upon Receipt of Communications: (Title 10. CCR 2695.5)

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 21 calendar day of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts known by the licensee. The response is to address all inquiries made by the Department of Insurance and include copies of any documentation and claim files requested.

When a licensee receives any communication from a claimant where a response is expected, the licensee shall immediately, but in no event more than 15 calendar days, furnish the claimant with a complete response based on the facts known by the licensee.

The person authorized to represent the claimant shall be stated in writing and signed and dated by the claimant. A claimant may revoke such a designation by writing the insurer to this effect.

Upon receiving notice of claim, every licensee or claims agent shall immediately transmit notice of claim to the insurer. Upon receipt of notice of claim, every insurer shall immediately, but in no event more than 15 calendar days later, (1) acknowledge receipt of such notice of claim unless payment has already been made; (2) provide to the claimant necessary forms, instructions, and reasonable assistance; and (3) begin any necessary investigation of the claim. An insurer cannot require that the notice of claim be provided in writing unless such requirement is specified in the insurance policy or an endorsement. If the acknowledgement is not in writing, a notation of acknowledgement shall be made in the insurer's claim file and dated.

Fair Claims Settlement Practices Regulations:

Definitions:

Claimant: Any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant, or any of the following persons properly designated by the claimant: an insurance adjuster, a public adjuster, or any member of the claimant's family. (Title 10, CCR 2695.2(c)

Notice of Legal Action: Notice of an action commenced against the insurer with respect to a claim, or notice of action against the insured received by the insurer, or notice of action against the principal under a bond, and includes any arbitration proceeding. (Title 10, CCR 2695.2(o)

Proof of Claim: Any documentation in the claimant's possession submitted to the insurer that provides any evidence of the claim and that supports the magnitude or the amount of the claimed loss. (Title 10, CCR 2695.2(s)

Standards for Prompt, Fair and Equitable Settlements: (Title 10, CCR 2695.7)

No insurer shall discriminate in its claims settlement practices based upon the claimant's age, race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured. (Title 10, CCR 2695.7(a) Upon receiving proof of claim every insurer shall immediately, but in no event more than 40 calendar days later, accept or deny the claim, in whole or in part. The amounts accepted or denied shall be clearly documented in the claim file unless the claim has been denied in its entirety. This time frame does not apply to disability insurance, disability income insurance, mortgage guaranty insurance, or automobile repair bills arising from collision and comprehensive claims. (Title 10, CCR 2695.7(b)

When an insurer denies or rejects an insured's claim, in whole or in part, it must do so in writing and contain the basis for such rejection or denial. If a claimant believes that a claim has been wrongfully denied or rejected, he/she may have the matter reviewed by the California Department of Insurance and the insurer must inform the claimant of this fact as well as providing address and telephone of the unit of the Department that reviews claim practices.

If more time is required than the allotted 40 days to determine whether a claim should be accepted or denied, every insurer shall provide the claimant 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 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. An insurer does have 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. (Title 10, CCR 2695.7(c)

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 legal authority or 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 is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim. (Title 10, CCR 2695.7(g)

Upon acceptance of the claim in whole or in part and, when necessary, upon receipt of a properly executed release, every insurer shall immediately, but in no event more then 30 calendar days later, tender payment or otherwise take action to perform its claim obligation. In claims where multiple coverage is involved, and where the payee is known, amounts that have been accepted by the insurer shall be paid immediately, but in no event more the 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. These time frames do not apply to disability insurance, disability income insurance, mortgage guaranty insurance, automobile repair bills arising from collision and comprehensive insurance, and title insurance. (Title 10, CCR 2695.7(h) No insurer shall inform a claimant that his/her right may be lost if a form or release is not completed within a specified time period unless the information is given to advise 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.

No insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the Department of Insurance regarding the handling of a claim as a condition to the settlement of any claim.

ERRORS AND OMISSIONS INSURANCE

Insurance agents can be held legally liable for the consequences of any errors or omissions they have made while conducting their business. For this reason, insurance agents need to carry professional liability insurance which is called errors and omissions insurance (E&O). E&O insurance provides coverage for an act, error, or omission the agent makes in rendering or failing to render professional services in the conduct of his/her insurance profession.

E&O insurance does not offer protection from intentional acts, criminal acts, liability assumed under contract, or bodily and personal injury. Apart from this, E&O policies have few exclusions. Although there is no standard E&O policy, there are certain characteristics that they do have. These policies normally have high deductibles—usually $1,000 or more. Coverage normally is written on a limit per claim basis, but aggregate limits for all claims during the policy period are available. Limits of coverage commonly range from $100,000 to several million dollars.

The insurance company providing E&O coverage will provide a defense for the agent even if the charge is frivolous.

SOLVENCY Definitions:

Insolvency means any impairment of minimum “paid-in capital” required of an insurer for the class(es) of insurance which it transacts. An insurer cannot escape the condition of insolvency by being able to provide for all its liabilities and for reinsurance of all outstanding risks. An insurer must also be possessed of additional assets equivalent to such aggregate “paid-in capital” required by the code after making provision for all such liabilities and for such reinsurance. (CIC 985)

Paid-in capital is capital received from investors in exchange for stock as distinguished from capital generated from earnings or donated. According to the code, a foreign mutual insurer must have the value of its assets in excess of the sum of its liabilities for losses reported, expenses, taxes, and all other indebtedness and reinsurance of outstanding risks plus its paid-in capital must be composed of available cash assets amounting to at least $200,000. In the case of other insurers, they must possess the lower of the following amounts:

(1) The value of its assets in excess of the sum of its liabilities for losses reported, expenses, taxes, and all other indebtedness and reinsurance of outstanding risks.

(2) The aggregate par value of its issued shares of stock, including treasury shares. (CIC 36)

Conservation means the commissioner thinks an insurer can be saved from insolvency. The commissioner may apply to the superior court of the county in which the insurer has its principal office and become the conservator of the business. The commissioner will take over the insurer's assets, property, books, records, and run the business. The following are grounds for the commissioner to take over an insurer:

a. The company has refused to submit books, papers, or accounts to the commissioner for inspection.
b. The company has neglected or refused a commissioner's order to make good any deficiency in its capital (stock company) or reserve (mutual company).
c. Without getting the commissioner's written consent, the company transfers or tries to transfer all its property or business to another person or consolidates its property and assets with another business.
d. After an examination by the commissioner, the company is found to be in such bad financial condition that continuing to conduct its business is hazardous to the public, creditors, or policyholders.
e. The business entity has violated its charter or state law.
f. Any officer of the business refuses to be examined under oath about the company's affairs.
g. An officer or attorney in fact has wrongfully diverted or embezzled any of the company's assets.
h. A domestic insurer does not comply with the state's requirements for a certificate of authority or that the company's certificate has been revoke.
i. The insurer was found to be insolvent at its last examination by the insurance department. (CIC 1011)

Whenever the above conditions exist or it appears that irreparable loss and injury to property or business may occur, the commissioner, without notice and before applying to the court for any order, shall take possession of the property, business, books, records and accounts and of the offices and premises occupied for the transaction of business and retain possession subject to the order of the court. Any person having possession of and refusing to deliver any of the books, records or assets of a person against whom a seizure order has been issued, shall be guilty of a misdemeanor and punishable by fine not exceeding one thousand dollars or imprisonment not exceeding one year, or both such fine and imprisonment. (CIC 1013)

Liquidation means the commissioner feels it would be futile to proceed as conservator of the insurer and applies to the court for an order to liquidate and wind up the business of the insurer. (CIC 1016)

California Life and Health Insurance Guarantee Association (CIC 1067-1067.18)

The purpose of the California Life and Health Insurance Guarantee Association is to protect policyowners, insureds, and beneficiaries against loss when a member company is financially impaired and cannot pay its contractual obligations under life insurance, health insurance, and annuity contracts. To provide this protection, an association of insurers is created to pay benefits and members of the association are subject to assessment to provide funds. (CIC 1067.01) All admitted life and health insurers are obligated to join this association. The association is managed by a board of directors and shall consist of not less than 9 nor more than 13 member insurers. The members of the board shall be selected by member insurers and approved by the commissioner. (CIC 1067.06)

The protection of the association extends to persons who are owners of policies or certificate holders and who are residents of this state. The association also provides coverage to nonresidents if all of the following conditions are met: (1) the insurer that issued the policy is domiciled in this state; (2) the insurer never held a license or Certificate of Authority in the state in which the person resides; (3) the state in which the person resides has an association similar to the association that exists in California; and (4) the person is not eligible for coverage by the association in the state of residence. (CIC 1067.02(a)(1)

If an impaired member is a domestic company, the association may do one of the following after receiving the commissioner's approval:

1. Guarantee, assume or reinsure the impaired company's policies or contracts.
2. Provide monies, pledges, notes, guarantees or other means to ensure payment of an impaired insurer's obligations.
3. Loan money to the impaired company.

To provide funds to run the association, the association may assess the member insurers for the necessary amounts. If an insurer does not pay the assessment when due, it is subject to having its certificate of authority suspended or revoked by the commissioner.

The contracts covered by the guarantee association are direct, non-group life, health, annuity, and supplemental policies or contracts and certificates under direct group life, health, annuity, and supplemental policies and contracts. (CIC 1067.02(b)(1) Coverage is not provided for:

- Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policyholder.

- Any policy or contract of reinsurance, unless assumption certificates have been issued.
- Any portion of a policy or contract to the extent that the rate of interest on which it is based exceeds statutory limitations.
- Guaranteed investment contracts, guaranteed interest contracts, funding agreements, deposit administration contracts, and all other unallocated annuity contracts.
- 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.
- Any portion of a policy or contract 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 or contract.
- Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a Certificate of Authority to issue the policy or contract in the state.
- Any annuity issued by a charitable organization that is duly qualified as such under applicable provisions of the Internal Revenue Code, and that is not engaged in the business of insurance as its primary business. (CIC 1067.02(b)(2)

The benefits that the association may be liable to pay for any one life may not exceed the lesser of:

1. 80% of contractual obligations (subject to certain limitations);
2. $250,000 in life insurance death benefits, but no more than $100,000 in net cash surrender value for life insurance;
3. $100,000 in the present value of annuity benefits, including net cash surrender values.

There is a maximum aggregate amount of $250,000 with respect to any one individual for which the association will assume liability.

With respect to any one owner of multiple policies of individual life insurance, whether the policy owner is an individual, firm, corporation, or other legal entity, and whether the persons insured are officers, employees, or other persons in whose lives the policy owner has an insurable interest, the maximum benefit is $5,000,000 regardless of the number of the policies and contracts held by the owner.

The health insurance benefits for which the association may become liable shall in no event exceed the lesser of the following:

1. The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not impaired or insolvent.
2. With respect to any one individual, regardless of the number of contracts, $200,000 in health insurance

benefits. This amount shall increase or decrease based upon changes in the health care cost component of the consumer price index from January 1, 1991 to the date on which the insurer becomes insolvent.

California Insurance Guarantee Association

Insurers selling fire, marine, plate glass, liability, workers' compensation, common carrier liability, boiler and machinery, burglary, sprinkler, team and vehicle, automobile, aircraft and miscellaneous insurance in California must belong to the California Insurance Guarantee Association. This includes nearly all types of property and casualty insurance except the ocean marine portion of marine insurance, reinsurance, or fraternal fire insurance. (CIC 1063)

The purpose of the association is to protect the interests of policyholders and beneficiaries against loss because an insolvent insurer is unable to pays its contractual obligations under property and casualty insurance policies. The association is managed by a board of nine member insurers who are appointed by the commissioner. If a company becomes insolvent, each member company is assessed money on a percentage basis to pay contractual obligations of the insolvent insurer and necessary administrative expenses. The percentage for any one company is determined by dividing the company's premiums from that line of business in California by all premiums for that line of business in the state.

Covered claims (except in the case of workers' compensation claims) do not include claims of $100 or less, nor the first $100 of any claim that exceeds $100, nor the part of any claim that exceeds $500,000 or the policy limit of the contract.

DISCRIMINATORY PRACTICES

Certain property and liability insurance: (CIC 679.70) The prohibitions regarding discrimination apply to policies in California other than automobile and worker's compensation. They include insurance against loss or damage to residential real and personal property and coverage for the legal liability of a natural person. Most of these provisions also apply to life and disability insurance.

Failure or refusal to accept application: (CIC 679.71) Unless the insurance will be issued by another insurer under the same management and control, an insurance company cannot refuse to accept an application, issue a policy, or cancel a policy because of a person's marital status, sex, race, color, religion, national origin, or ancestry. An insurer may not charge a higher premium for insurance because of any of these reasons.

Application or report carrying identification: (CIC 10141-10142) An application or investigative report furnished by an insurer to its agents or employees in the course of determining an applicant's insurability, cannot carry any identification as

to the applicant's race, color, religion, national origin, or ancestry. If it is used only to identify the applicant and not as a basis for discrimination, the insurer may ask where an applicant was born.

Practices based on race or color: A licensed insurer may not refuse to accept an application, issue, or cancel insurance or charge a higher premium because of a person's race, color, religion, national origin, ancestry, or sexual orientation. In underwriting life and disability insurance, an insurer may not consider an applicant's sexual orientation or use marital status, living arrangements, occupation, gender, beneficiary designation, or zip codes to establish an applicant's sexual orientation or to decide if the applicant should be tested for HIV antibodies. The penalty for knowingly violating this provision can be a fine of $1,000 up to $5,000 plus court costs. (CIC 10140)

The insurance code requires strict confidentiality of personal information obtained through HIV testing and requires informed consent before any insurer tests for HIV. (CIC 799)

Genetic disability traits: (CIC 10143) An insurer may not refuse to issue, sell, or renew a life or disability policy solely because the person to be insured carries a gene which may cause a disability in the insured's children but which causes no ill effects to the carrier. Examples include sickle cell, Tay-Sachs, and X-linked hemophilia. An insurer may not charge an applicant a higher premium (individual or group) due to a person to be insured having these traits.

An insurer may not insert a condition or stipulation in a policy that the insured person with such a trait, his/her heirs, or beneficiaries must accept less than the full value of the policy in event of a claim. An insurer may not pay a lower commission to an agent or broker for selling or renewing life or disability policies on persons possessing these traits.

Physically or mentally impaired: (CIC 10144) An insurer who issues individual or group life, annuity, or disability policies may not refuse to insure, continue to insure, limit the amount or kind of coverage available, or charge a higher premium for the same coverage to a physically or mentally impaired person except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual and reasonably anticipated experience.

Physical or mental impairment means any physical, sensory, or mental impairment that substantially limits one or more of that person's major life activities.

Blindness or partial blindness: (CIC 10145) An insurer who issues individual or group life, annuity, or disability policies may not refuse to insure, continue to insure, limit the amount or kind of coverage available, or charge a higher premium for the same coverage because an applicant is blind or partially blind.

Special Concerns—Senior citizens

All insurers and licensees owe a prospective insured who is 65 years of age or older, a duty of honesty, good faith, and fair dealing.

Pretext Interviews

Pretext interviews are illegal. A pretext interview is when the interviewer does not reveal his true identity, pretends to be someone who he is not, or misrepresents the true purpose of the interview. The insurance industry does not want unscrupulous agents preying on senior citizens by selling them unnecessary policies or policies that are over-priced.

Pretext interviews are legal when conducted by insurance adjusters when there is sufficient evidence of fraud or material misrepresentation. (CIC 791.03)

Post Claims Underwriting

No insurer issuing or providing any policy of disability insurance covering hospital, medical, or surgical expenses shall engage in the practice of post claims underwriting. Post claims underwriting means the rescinding, canceling, or limiting of a policy or certificate due to the insurer's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the policy or certificate. (CIC 10384)

Insurers cannot legally refuse to pay a claim which is not excluded by the contract. As long as the applicant for insurance answered all questions on the application form truthfully, the insurer must cover the claim. Of course, if the applicant lied or concealed material information, the insurer would have the right to refuse coverage or to rescind the policy.

The applications for Medicare supplement insurance and long-term care insurance contain questions to elicit information concerning the applicant's health status. This is to make sure that there is not a problem in the future regarding his/her coverage.

Agency Law

Applications: This is the document in which an applicant answers questions and facts with regards to the insurance they are wishing to acquire. The insurer will use the information on the application to decide whether or not to accept the applicant

Binders: Sometimes referred to as “covering notes”, these provide temporary insurance pending issuance of the insurance contract. A binder includes all the usual policy terms and endorsements and expires when the policy is issued.

A binder shall be deemed an insurance policy for the purpose of proving that the insured has the insurance coverage specified in the binder. "Binder" means a writing which includes the name and address of the insured and any additional named insureds, mortgagees, or lienholders, a description of the property insured, if applicable, a description of the nature and amount of coverage and any special exclusions not contained in a standard policy, the identity of the insurer and the agent executing the binder, the effective date of coverage, the binder number or the policy number where applicable to a policy extension. This temporarily obligates the insurer to provide that insurance coverage pending issuance of the insurance policy.

"Binder" does not include, and this section does not apply to life or disability insurance or insurance in the amount of one million dollars ($1,000,000) or more.

A binder shall be valid for the period specified therein not exceeding 90 days from the date of execution of the binder or, if not specified, for that period of 90 days. No binder shall remain valid on or after the date the insurance policy is issued with respect to which the binder was given. Expiration of coverage under a binder shall not be considered a cancellation or nonrenewal of a policy. (CIC 382.5)

Certificate of Liability Insurance: In liability coverage, a certificate of insurance shows that the individual or business has insurance coverage currently in force. In property and casualty policies, certificates of insurance are issued as evidence of property insurance to a third party as proof that the insured has coverage.

Renewal Responsibilities: The insurance company, instead of the agent or broker, generally handles policy renewals and cancellation notices. Even so, the agent or Broker should follow-up to make sure the client does not need to make some changes to their policy and that the renewals are issued
Suspense/Diary System: The suspense/diary system is the agent’s record keeping system for tracking client transactions and communication. The California Department of Insurance determines specifics regarding type of information to maintain and length of time the information must be maintained on site.

Lost Policy Release (LPR): A lost policy release is an agreement, signed by the policyholder that relieves the insurer from liability under an insurance contract that has been lost, misplaced, or is otherwise unavailable. The lost policy release form is used to fulfill the requirement that a policy be returned when the insured requests that coverage be cancelled.

CIC 703.5: Any person, including, but not limited to, persons licensed or certificated under this code or exempted from regulation under this code, who as a part of any business advertises as, or holds himself or herself out as, qualified to advise the public concerning insurance or qualified to administer workers' compensation for employers and who in connection with or as part of that business also, with or without consideration, (a) suggests or recommends to an employer, or advises an employer, that the employer purchase aggregate excess or aggregate stop-loss workers' compensation insurance, or (b) names or suggests to an employer, or advises an employer of, a nonadmitted insurer from whom aggregate excess or aggregate stop-loss workers' compensation insurance might be purchased, is guilty of a misdemeanor. This section does not apply if the employer is a self-insured public entity, including any agency, board, or commission provided for by a joint exercise of powers agreement, or those who have been issued a certificate by the Director of the Department of Industrial Relations to self-insure.

Insurance in Connection with Sales and Loans

No person engaged in the business of financing the purchase of real or personal property or of lending money on the security of real or personal property and no trustee, director, officer, agent or other employee, or affiliate of, any such person shall require, as a condition precedent to financing the purchase of such property or to loaning money upon the security thereof, or as a condition prerequisite for the renewal or extension of any such loan or for the performance of any other act in connection therewith, that the person for whom such purchase is to be financed or to whom the money is to be loaned or for whom such extension, renewal or other act is to be granted or performed negotiate any insurance or renewal thereof covering such property through a particular insurance agent or broker. (CIC 770)

No person making a loan of money on the security of real property shall use or make available to any person information contained in a policy of fire or casualty insurance for the purpose of soliciting either type of insurance coverage if the borrower has filed with the lender a statement signed by the borrower that the policy information shall not be so used or made available. The statement may be included by the borrower in his or her letter of authorization designating an insurance agent or broker to the lender. The statement or letter of authorization shall be effective until superseded or revoked by the borrower. (CIC 770.1)

The commissioner may suspend or revoke any license held by any person who violates this section (CIC 773)

The commissioner, after hearing upon notice, may issue a cease and desist order to any person if he finds that such person has, in more than one transaction, violated this section. The violation of such a cease and desist order is a misdemeanor. (CIC 774)

Free Insurance
No insurer shall participate in any plan to offer or effect any kind or kinds of insurance or annuities in this state as an inducement to the purchase or rental by the public of any property, real or personal or mixed, or services, without any separate charge to the insured for such insurance, nor shall any agent, broker, or solicitor arrange the sale of any such insurance.

Agency Names
Every individual and organization licensee and every applicant for such a license shall file with the commissioner in writing the true name of the individual or organization and also all fictitious names under which he conducts or intends to conduct his business and after licensing shall file with the commissioner any change in or discontinuance of such names. The commissioner may in writing disapprove the use of any true or fictitious name (other than the bona fide natural name of an individual) by any licensee on any of the following grounds: (CIC 1724.5)

(a) Such name is an interference with or is too similar to a name already filed and in use by another licensee;

(b) The use of the name may mislead the public in any respect;

(c) The name states, infers or implies that the licensee is an insurer, motor club, hospital service plan or entitled to engage in insurance activities not permitted under licenses held or applied for;

(d) The name states or implies that the licensee is an underwriter. This subdivision shall not prevent a natural person who is a life licensee from describing himself as an "underwriter" or from using the designation "Chartered Life Underwriter" if entitled thereto nor shall it prevent a natural person who is a property broker-agent and/or casualty broker-agent licensee from using the designation "Chartered Property and Casualty Underwriter" if entitled thereto nor a producers trade association each member of which is also separately licensed from having a name containing the word underwriter; or

(e) The licensee has already filed and not discontinued the use of more than two names including the true name. This subdivision shall not prevent a licensee who has lawfully purchased or succeeded to the business or businesses of other licensees from using for each such business not more than two additional names, true or fictitious, consisting of names used by his predecessors in the conduct of such businesses.

A licensee may not use a true or fictitious name after being notified by the commissioner in writing that such use is contrary to this section. If the commissioner determines that there are facts in mitigation in connection with the continued use of such name he may permit its use for a specified reasonable period of time. Any such permission and any such conditions shall be written.

A property broker-agent and/or casualty broker-agent or life agent who has a service contract with a corporation licensed under this code or who is a stockholder or member of any incorporated association or corporation organized under the Corporations Code for the purpose of providing services to property broker-agent and/or casualty broker-agent or life agents may use the name of such a corporation or association on any stationery or advertisements and other written or printed matter used
to identify the business of the property broker-agent and/or casualty broker-agent or life agent provided that the name of the property broker-agent and/or casualty broker-agent or life agent is clearly identified as bearing only that relationship to the corporation or association in one of the following ways:

"Representing ____;"
"A stockholder of ____;"
"Placing business through ____;"
"Using services of ____."

The use of the corporation or association name in the manner provided in this section shall not constitute such use as would mislead the public. (CIC 1729.5)

Displaying of Insurance License
Every license to act as a property broker-agent and/or casualty broker-agent shall be prominently displayed by the holder thereof in his or her office in a manner whereby anyone may readily inspect it and ascertain both its currency and the capacity in which its holder is licensed to act. (CIC 1725)

Records
The commissioner shall, after notice and hearing, promulgate reasonable rules and regulations specifying the manner and type of records to be maintained by those licensees acting as insurance agents and brokers and the location where the records shall be kept. Those records shall be open to inspection or examination by the commissioner at all times, and the commissioner may at any time require the licensee to furnish any information maintained or required to be maintained in those records.

Every licensee acting as an insurance agent and broker shall keep the records as required by the regulations.

Every licensee acting as an insurance agent and broker employing a licensee in the capacity of an insurance solicitor shall keep the records required by the regulations promulgated pursuant to subdivision (a) for any insurance transacted by the insurance solicitor in the capacity of employee of the employing licensee. (CIC 1727[a-c])

Life and Disability Records

It is the obligation of every insurer admitted in this state to transact life or disability insurance, or both, to maintain certain records specified in this article pertaining to the activities of its life, life and disability, and disability agents and any other agents for the inspection and examination of the commissioner. The original or certified copies of the records shall be delivered to the commissioner within a period of 30 days following receipt of written demand. The records required to be maintained or made available in this state may be in the form of originals, carbon, faxed copies, microfilm copies, or electronic data-processing records if printouts are available within a reasonable period of time, and shall include the names, dates, amounts and policy numbers involved. The records are composed of all of the following: (CIC 10508)

(1) The original application for each insurance policy or contract sold in this state.

(2) Records showing, for each insurance policy or contract issued, the premiums received by the insurer.

(3) Production records showing all insurance policies or contracts sold by each agent or other agent in the expired portion of the current calendar year and the whole of each of the preceding five calendar years.

(4) Records showing, for each insurance policy or contract issued, the amount of commissions paid and to whom.

(5) Records or memoranda identifying any agent other, than the agent whose name appears on the application who, to the actual knowledge of the insurer, handled any part of an insurance transaction for which the other agent was not compensated.

(6) Correspondence, written solicitations or proposals, or other written communications sent by the insurer to a prospect, applicant, or insured, or received from him or her by the insurer, excluding printed material in general use distributed by the insurer, either directly or indirectly through its life agents.

(7) Correspondence, written proposals, notices, a statement of reasons, or other written communications, if any, pertaining to the rescission, termination, or nonrenewal of a policy or contract, or the election of nonforfeiture values thereunder, sent by an insurer to a policyholder or contract holder or received from him or her by an insurer.

(8) A copy of a written comparison of benefits, limitations, exclusions, and costs of existing accident, sickness, or long-term care coverage and proposed coverage.

(9) A copy of the outline of coverage or disclosure statement required by law or regulation.

(10) Copies of any correspondence between the policyholder or prospective policyholder and the agent or insurer.

(11) Copies of correspondence between anyone acting on behalf of the policyholder or prospective policyholder and the agent or insurer.

Except as otherwise provided, the records shall be maintained for a minimum period of 5 years following the actual delivery of the insurance policy. Or, if no policy or contract was issued, for a minimum period of 5 years after the date of the application.

It shall be the obligation of each life, life and disability, and disability insurance agent and any other agent and insurer to preserve and maintain all applicable records in his or her possession, in addition to those records transmitted to the insurer, at his or her principal place of business for a minimum of 5 years. The records shall be kept in an orderly manner so that the information therein is readily available, and shall be open to inspection or examination by the commissioner at all times. (CIC 10508.5)

Records General

Wherever applicable, the following records shall be maintained by every agent or broker or surplus lines broker or special lines' surplus lines broker with respect to each and every insurance transaction for at least five years after expiration or cancellation date of the policy to which the records pertain: (Title 10, CCR 2190)

(a) Name of insured,
(b) Name of insurer,
(c) Policy number,
(d) Effective date, termination date and mid-term cancellation date of coverage,
(e) Amount of gross premium,
(f) Amount of net premium,
(g) Amount of commission and basis on which computed,
(h) Names of persons who receive, or are promised, any commissions or other valuable consideration related to the transaction,
(i) Amount of premium received including itemization of any partial payments or additional premium,
(j) Date premium received by agent or broker,
(k) Date deposited in bank account or bank depository into which premiums are deposited or maintained in accord with Section 1733 of the Insurance Code, including but not limited to trustee accounts maintained pursuant to Section 1734 of the Insurance Code,
(l) Name and address of bank and number of account in which premium is deposited or maintained in accord with Section 1733 of the Insurance Code, including but not limited to trustee accounts maintained pursuant to Section 1734 of the Insurance Code,
(m) Date premium paid by agent or broker to the person entitled thereto and identification of the means of transmittal,
(n) Amount of net and gross return premium,
(o) Date return premium is received from insurer by agent or broker which may be the date the credit is taken from the insurer or the date the check

or draft is received, and
(p) Date gross return premium is remitted to person entitled thereto by agent or broker and identification of means of transmittal.

Office Location
All resident property broker-agent and/or casualty broker-agent are required to maintain an principal office in the State of California in order to transact business. This address must be specified on all renewal and license applications.

Premium Financing Compensation Disclosures
778.02. (a) Any person engaged in business as an insurance agent or broker and who participates in the arrangement of a premium financing agreement shall, if he accepts compensation for arranging, directing, or performing services in connection with the premium financing agreement, disclose to the insured, in a manner and form established by the commissioner, the amount of compensation he is to receive from the premium financer and maintain for three years and make available to the commissioner a list of accounts in connection with which he has accepted compensation for premium financing services showing the amount of such compensation with respect to each premium financing agreement and with respect to each financing schedule used by the agent or broker. The requirements of this subdivision shall not apply with respect to interest paid to the broker or agent by the premium financer based upon delay in payment
of the premium due the insurer as permitted under subdivision (a) or (b) of Section 18628 of the Financial Code. (b) The commissoner shall hold a hearing and adopt by regulation a standard procedure and form for making the disclosure to the insured required by subdivision (a).

Broker Fees
A broker cannot receive any fee unless based on a written agreement signed by the party being charged. Broker fees are not subject to a premium tax.

Charges for Extra Services may be permitted for services that are above and beyond the normal duties of a producer. These extra services may include additional research activities, or services performed as a convenience to the insured that result in extra expense to the broker or agent. It is generally recommended whenever any extra services will be performed that a written agreement be signed by the insured in advance indicating approval and acknowledging their responsibility for paying the extra charges.

Insurance Industry Code of Ethics

1) Place the customer's interest first.
2) Know your job—and continue to increase your level of competence
3) Identify customer needs and recommend products/services that meet those needs
4) Accurately and truthfully, represent products and services

5) Use simple language—talk “laypersons” language – when possible
6) Stay in touch with customers, and conduct periodic coverage reviews
7) Protect your confidential relationship with your client
8) Keep informed of, and obey, all insurance laws and regulations
9) Provide exemplary service to your clients.
10) Avoid unfair or inaccurate remarks about the competition.

Insurance Companies

Insurance is mostly provided privately. In other words, most types of insurance available are offered by private companies. Companies may be organized in a variety of different ways, and may be limited as to where and what types of insurance they are authorized to provide.

As previously mentioned in this chapter, insurance is a business. The four main business functions of an insurance company are:

1. **Actuarial,**
2. **Sales & Marketing,**
3. **Underwriting, and**
4. **Claims handling.**

Although an agent operates primarily in the sales & marketing function, he or she may participate in at least three of the four functions at some point.
An insurance company’s **actuarial** function is often its least-understood function. Actuaries—who are certified by professional organizations—take an academic look at loss histories, laws and financial trends to develop the guidelines, terms and conditions under which an insurance company will write policies. In some insurance companies, the actuarial staff is small and doesn’t interact much with the other functions. You may hear actuaries referred to as “wizards” or “elves”—since they operate apart from the rest of the company and their decisions are sometimes confusing to others.

Sales & marketing is usually the most visible part of an insurance company (in this way, it’s much different than the actuarial function). Sales & marketing is the company’s “public face.” For most of the insurance industry’s history, independent agents were the main method of sales and marketing. And, in many ways, the independent agent remains the classic example of how policies are marketed and sold. However, in the last few decades, other marketing and sales channels have grown.

Captive agents—who only sell the policies of one insurance company—have become a significant alternative to independent agents.

Also, a number of companies have begun using **direct marketing** as their main method of selling coverage. Direct marketers don’t use agents or brokers to sell their insurance; they sell through direct mail and telemarketing. Since they

eliminate a sales staff—and a commission structure—these companies usually offer cheaper premium. The problem is: Some of those companies handle claims the same way they sell policies. In other words, the price break usually comes at the cost of service.

Underwriting is the application of actuarial guidelines to specific individuals and companies. It's the process by which premiums are determined…and insureds are judged to be preferred, standard, substandard or uninsurable.

Preferred risks are entitled to premium discounts, while substandard risks may be declined, or they may have to pay an extra premium for the policy or have a policy issued with a rider omitting some element of the coverage.

Agents play an important role in gathering the information that a company's underwriters will use to make these determinations. In some cases, the agent will also be trusted to make some preliminary underwriting judgments in the field.

Claims handling covers the entire process of evaluating and paying claims made under policies. This is the part of the insurance company that often draws the most attention from consumers, politicians and media outlets.

In some cases, the insurance company's customer service operations will fall under the supervision of the claims managers.

Reciprocal Company: A reciprocal insurer is an unincorporated company consisting of subscribers managed by an attorney in fact. The California State Automobile Association (CSAA) is a reciprocal insurer.

Risk Retention Groups:
Risk Retention Groups are liability insurers owned by their policyholders. Commonly, the policyholders are involved in the same type of risk and find it cost effective and practical to establish their own company. For example, Risk Retention Groups have been formed to offer professional liability coverage to physicians who also are part owners of the company. In this way, the physicians can choose to structure the underwriting guidelines to only insure physicians who are moderate risks, therefore allowing a lower premium for all insured.

An entity seeking to be licensed in this state as a risk retention group shall be organized under the laws of this state and licensed as a liability insurance company. [131] Risk retention groups chartered, incorporated, or licensed in states other than this state and seeking to do business as a risk retention group in this state shall file a notice of operation with the commissioner of its intention to do business in this state. The notice shall be filed with e commissioner within 60 days of the filing by the group of any notice filed with its chartering state of its intention to do business in this state. In no event may a notice of intended operation be filed with the commissioner less than 60 days prior to the group commencing business in this state. [132]

No risk retention group shall be required or permitted to join or contribute financially to any insurance insolvency guaranty fund, or similar mechanism, in this state, nor shall any risk retention group, or its insured's or claimants against its insured's, receive any benefit from any such fund for claims arising under the insurance policies issued by that risk retention group. [133(a)]

No person, firm, association, or corporation shall act or aid in any manner in soliciting, negotiation, or procuring liability insurance in this state from a risk retention group unless that person, firm, association, or corporation is licensed as a property broker-agent and/or casualty broker-agent. The individual or entity is authorized to act as an insurance broker; except salaried employees or officers of a risk retention group, provided no part of the compensation of such person is on a commission basis or otherwise based on production of business. [137(a)]

No person, firm, association, or corporation shall act or aid in any manner in soliciting, negotiating, or procuring liability insurance from an insurer not authorized to do business in this state on behalf of a purchasing group in this state unless that person, firms, association, or corporation is licensed as a surplus line broker.

A nonresident person may be licensed as a surplus lines broker for purposes of placing insurance on behalf of a purchasing group. [137(b)]

The McCarren-Ferguson Act (1945)
This law recognized that state regulation of insurance was in the public's best interest and thus exempted the insurance industry from the federal regulation required for most interstate commerce industries. However, it did give the federal government the right to apply antitrust laws "to the extent that such business (insurance) is not regulated by the state level." To avoid federal intervention, each state has revised its insurance laws to conform to these requirements.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA was enacted in 1996 and affects almost all healthcare providers. This law defines that the information in client files belongs to the client and must be protected. HIPAA has made sweeping changes in the way that medical information is handled and protected.

HIPAA, in general, is designed to make health coverage more portable for individuals who change jobs or health plans by limiting the coverage exclusions that can be imposed when such a change occurs. Employers who provide health insurance for their employees are required to offer full health care coverage immediately to newly hired employees if they previously had "creditable" coverage for 12 straight months with no lapse in coverage of 63 days or more. If an individual did not have creditable coverage, the new insurer can refuse to pay for any pre-existing conditions for 12 months. However, the individual may reduce the exclusion period if he/she had group health plan coverage or health

insurance prior to enrolling in the plan. HIPAA allows an individual to reduce the exclusion period by the amount of time that he/she had creditable coverage prior to enrolling in the plan and after any "significant breaks" in coverage. If the enrollee had creditable coverage for the last eight months, there would only be a four-month exclusion period. Late enrollees in group health plans might have to wait up to 18 months for coverage for pre-existing conditions.

When someone leaves a health plan, he/she should get a "certificate of creditable coverage". The certificate should list the following: coverage dates; policy ID number; insurer's name and address; and insured's name as well as any family members included under the coverage. When an entire business changes health insurance carriers, certificates of creditable coverage are not necessary as the new health insurance is issued with full take-over benefits for all eligible members enrolled on the date that the new insurance starts. This means all pre-existing conditions are covered immediately by the new insurance policy.

HIPAA's rules apply to every employer group health plan that has at least two participants that are current employees, including companies that are self-insured. The law prohibits group health plans and health insurers from discriminating against individuals with regard to eligibility, premiums, or contributions based on any health status related factor (e.g. a plan may not require an individual to pay a premium greater than do similarly situated individuals enrolled on the basis of any health status related factor). HIPAA's rules provide no protection if a person switches from one individual health plan to another individual health

Policy Cancellations / Failure to renew

Definitions (CIC 660)
"Renewal" or "to renew" means to continue coverage with either the insurer which issued the policy or an affiliated insurer, as defined in Section 1215, for an additional policy period upon expiration of the current policy period of a policy, provided that if coverage is continued with an affiliated insurer, it shall be the same or broader coverage as provided by the present insurer, and the insured shall be notified in writing at least 20 days prior to expiration of the current policy period of all of the following:

(1) That the insurer has determined that it will not offer renewal of the policy with the present insurer,
(2) That it is offering replacement in an affiliated insurer,
(3) That the insured may obtain in writing the reasons for the change in insurers if he or she requests in writing not later than one month following the expiration of the policy period the reason or reasons for the change in insurers.

Any policy with a policy period or term of six months or less, whether or not made continuous for successive terms upon the payment of additional premiums, shall for the purpose of this chapter be considered as if written for a policy period or term of six months.

Any policy written for a term longer than one year, or any policy with no fixed expiration date, shall for the purpose of this chapter, be considered as if written for successive policy periods or terms of one year.

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

"Cancellation" means termination of coverage by an insurer (other than termination at the request of the insured) during a policy period.

"Nonrenewal" means a notice by the insurer to the named insured that the insurer is unwilling to renew a policy.

"Expiration" means termination of coverage by reason of the policy having reached the end of the term for which it was issued or the end of the period for which a premium has been paid.

CIC 481.5 (a) Whenever a policy of personal lines insurance terminates for any reason, or there is a reduction in coverage, the insurer shall tender the gross unearned premium resulting from the termination, or the amount of the unearned premium generated by the reduction in coverage, to the insured or, pursuant to Section 673, to the insured's premium finance company. The gross unearned premium shall be tendered within 25 business days after the insurer either receives notice of the event that generated the gross unearned premium, or receives notice from a premium finance company of a cancellation.

(b) (1) Whenever a policy other than a policy of personal lines insurance terminates for any reason, or there is a reduction in coverage, the gross unearned premium shall be tendered to the insured or, pursuant to Section 673, to the insured's premium finance company. If the policy is not auditable, the gross unearned premium shall be tendered within 80 business days after the insurer either receives notice of the event that generated the gross unearned premium, or receives notice from a premium finance company of a cancellation. If the policy is auditable, the gross unearned premium shall be tendered within 80 business days after the insured provides all requested audit information to the insurer or the insurer's designee.

(2) Notwithstanding paragraph (1), an insurer shall not be required to tender the unearned premium within 80 business days if the final unearned premium

amount cannot be determined due to the insured's failure, in breach of a policy requirement, to cooperate with the insurer in a premium audit, or if the amount of the unearned premium determined by a premium audit remains in dispute.

(c) An insurer may tender gross or net unearned premium to an agent or broker, or net unearned premium to a finance company, but shall remain liable to the insured or finance company for payment of any portion of the gross unearned premium that the agent or broker fails to remit to the insured or premium finance company.

(d) Any unearned premium that an insurer fails to tender within the time periods specified in subdivisions (a) and (b) shall bear interest at the rate of 10 percent per annum from and after the date on which the unearned premium was required to be tendered. For the purposes of this section, the tender of any unearned premium to the insured or premium finance company shall be deemed complete upon the deposit of the unearned premium in the United States mail, prepaid,addressed to the named insured or premium finance company at the last known address, or to an agent or broker with an assignment pursuant to paragraph (1) of subdivision (g).

Prohibited cancellations: CIC 670. No admitted insurer may cancel or refuse to renew motor vehicle liability insurance policy covering drivers hired by a commercial business establishment merely because those drivers have been convicted of violations of the Vehicle Code or the traffic laws of any subdivision of the state while driving their personal cars.

No lender may exercise the right to cancel a financed insurance policy because of the default of the insured under a premium loan agreement (impound account) until the lender has given the insured a 10-day notice of cancellation.
A policy of liability insurance issued to a local public entity or state agency as a named insured may not be cancelled or have renewal declined for reasons other than nonpayment of premium, unless notice is mailed to the named insured at least 45 days prior to the effective date of non-renewal. Notice must be mailed at least 60 days prior to the effective date for any cancellation other than non-payment. This notice doesn't need to be sent if a renewal notice stating the premium for an additional period of coverage has been sent to the named insured at least 45 days before cancellation or expiration of an existing policy, and this premium has not been processed by the insurer before such cancellation or expiration.

Cancellation for personal lines covering real, personal property, and liability other than auto, cancellation after a policy has been in force for 60 days or if it is a renewal, no notice of cancellation is effective unless based on:

1. Non-payment of premium 10-day notice
2. Conviction of the named insured of a crime that increases any hazard insured against

3. Discovery of fraud or misrepresentation either by the insured in obtaining the insurance, or in pursuing a claim under the policy
4. Discovery of grossly negligent acts or omissions by the insured which substantially increases the hazards insured against
5. Physical changes in the property which result in it becoming uninsurable

Commercial insurance policies, excluding auto, ocean marine, surplus lines, reinsurance, government programs, workers compensation or disability insurance, the following applies to cancellation of commercial insurance policies. Grounds for cancellation of commercial insurance other than the exclusions named above, after a policy has been in effect for 60 days, no notice of cancellation shall be effective unless it is based on:

1. Nonpayment of premium – 10 days
2. A court judgment that the insured has violated a law and as a result increased the risk
3. Discovery of fraud or material misrepresentation
4. Willful or grossly negligent acts or omissions
5. Failure to implement reasonable loss control requirements agreed to as a condition of policy issuance
6. Commissioner's determination that the insurer's financial integrity is threatened
7. Changes in the property or activities on the property result in an increase in risk

Any increase in premium, reduction in limits, change in conditions of coverage must be accompanied by a notice at least 30 days before the change and must be based on:

1. Discovery of willful or grossly negligent acts or omissions
2. Failure to implement reasonable loss control requirements agreed to
3. Insurer's financial integrity is threatened
4. Material increase in risk

Notice of cancellation for commercial umbrellas, or excess property or liability coverage, after the policy has been in force for 60 days or if it is a renewal, may be canceled for:

1. Material change in limits, type or scope of coverage, or exclusions in one or more of the underlying policies
2. Cancellation or nonrenewal of one or more of the underlying policies
3. A reduction in financial rating or grade of one or more insurers insuring the underlying policies

Notice of Cancellation. A notice of cancellation shall:

1. Be in writing
2. Be delivered to the producer of record and the named insured
3. State which grounds set forth is relied upon for cancellation
4. State that the insured has the right upon written request mailed to the insurer within 15 days of date of cancellation to have the insurer specify the reason for cancellation

5. Include the effective date of cancellation and reasons for cancellation
6. Be given at least 30 days prior to effective date of cancellation (10 days for nonpayment of premium or fraud) (CIC 677; 677.2)

OTHER CANCELLATIONS

Family Day Care : The arbitrary cancellation of a homeowners insurance policy based solely on the insured having a license to operate a family home daycare at the insured location will subject the insurer to administrative sanctions, unless: (CIC 676.1)

1. There has been a material misrepresentation of fact;
2. The risk has been changed substantially since the policy was issued;
3. There has been nonpayment of premium; or
4. The insurer no longer writes homeowners policies.

Foster Home Business : Insurers may not fail to accept an application, refuse to issue, cancel or non-renew a homeowners or tenant's policy because the policy holder is engaged in licensed foster home activities to a licensed foster family home or small family home. (CIC 676.6)

Malpractice Insurance : Limitations and/or exclusions on professional liability policies may be imposed if recommended by a qualified underwriting committee advising the insurer. A 30 day notice is required. (CIC 676.3)

Health Care Facilities : Premium changes for health care facilities may be imposed if recommended by a qualified professional liability advisory committee advising the insurer with a 30 day notice. (CIC 676.4)

Policy Terms : A policy with no fixed expiration, or with a term of less than one year, shall be considered to be a policy for a term of one year, and a policy written for a term of more than one year shall be considered as if written for successive terms of one year. (CIC 676.5)

Non-renewal - Personal lines: Notice at least 45 days prior to expiration must be delivered or mailed to the named insured at the address listed in the policy, with one of the following:

1. An offer to renew pending payment of premium, any reduction of limits or coverage elimination must be stated.
2. A notice of nonrenewal along with a statement that upon written request by the named insured, within 20 days the insurer will provide a written explanation for nonrenewal
3. In the event the insurer fails to complete either items #1 or #2 listed above, the existing policy must remain in effect for 45 days from the date that either the offer to renew or the reasons for nonrenewal is delivered or mailed to the insured (CIC 678)

Non-renewal - Commercial lines: Notice at least 60 days, but not more than 120 days prior to the end of the policy period, along with reasons for nonrenewal.

Failure by the insurer to meet the specified time period the existing policy will remain in effect for an additional 60 days.

No notice is required with any of the following:
1. The policy has been extended for 90 days or less
2. The insured has obtained replacement coverage.
3. The insurance has been renewed or transferred without changes.
4. The insured requests a change in terms, conditions or risks within 60 days prior to the end of the policy period
5. The insurer has made a written offer to renew the policy under different terms, conditions or rates. (CIC 678.1)

No policy may be canceled or nonrenewed due to corrosive soil conditions if the policy contains an existing exclusion of payment of loss for that period (CIC 678.5)

Immunity from Liability: There shall be no liability on the part of, and no cause of action of any nature shall arise against, any insurer or its authorized representatives, agents, or employees, or any licensed insurance agent or broker, for any statement made, unless shown to have been made in bad faith with malice in fact, by any of them in (a) any written notice of cancellation or in any other oral or written communication specifying the reasons for cancellation, (b) any communication providing information pertaining to such cancellation, or (c) evidence submitted at any court proceeding or informal inquiry in which such cancellation is an issue. (CIC 679)