

REPORT OF MARKET CONDUCT EXAMINATION

**AUTO CLUB OF MISSOURI GROUP
GROUP # 1148**

**AUTOMOBILE CLUB INTER-INSURANCE EXCHANGE
FEIN # 43-6029277
NAIC # 15512
NAIC ETS # KS057-M1**

**AUTO CLUB FAMILY INSURANCE COMPANY
FEIN # 43-1453212
NAIC # 27235
NAIC ETS # KS 057-M2**

12901 NORTH FORTY DRIVE

ST. LOUIS, MO 63141

AS OF

December 31, 2007

BY

KANSAS INSURANCE DEPARTMENT

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Honorable Sandy Praeger
Insurance Commissioner
Kansas Insurance Department
420 SW Ninth Street
Topeka, KS 66612

Dear Commissioner Praeger:

In accordance with your respective authorization, and pursuant to K.S.A. 40-222, a market conduct examination has been conducted on the business affairs of:

Automobile Club Inter-Insurance Exchange

and

Auto Club Family Insurance Company

12901 North Forty Drive

St. Louis, MO 63141

hereafter referred to as “the Auto Club” or “the Company”, and the following report of such examination is respectfully submitted,

Lyle Behrens, CPCU, CIE, FLMI, ARM, ARe
Market Conduct Supervisor
Examiner in Charge

PURPOSE AND SCOPE OF REVIEW

A targeted market conduct examination of The Auto Club was conducted pursuant to, but not limited to, K.S.A. 40-222 by the Kansas Insurance Department (KID). The exam team reviewed underwriting files and complaints to determine if the Company was in compliance with the Department's order issued in January 2007 addressing certain findings of a 2006 market conduct exam. This review focused on the Company's compliance with applicable statutes, regulations and bulletins of the state of Kansas.

The audit was conducted according to the guidelines and procedures recommended in the NAIC Market Conduct Examiners Handbook (Handbook). The exam team utilized the standards and tests recommended in the Handbook. An acceptable tolerance standard per the Handbook of 10% was used for complaint and underwriting and rating categories. The examination report is a report written by test rather than a report written by exception. This means all standard tests are described and results indicated.

The testing and file review for the Company's complaint handling and underwriting and rating practices consisted of several samplings from the Company's corporate headquarters in St. Louis, MO.

The examination included a review of the Company's underwriting and complaint files from January 1, 2006 to December 31, 2007.

General topics were covered in Interrogatories submitted to the Company for their written response. Subjects covered were Complaints and Underwriting. The responses received addressed the issues presented.

The examination included, but was **not limited to the following:**

COMPANY OVERVIEW

- History and Profile
- Prior Market Conduct Examination Reports
- Fines and/or Penalties

COMPLAINT HANDLING

- Record Keeping
- Timely Response

UNDERWRITING & RATING

- Proper Rating
- Underwriting Acceptance/Termination
- Use of Appropriate Forms
- Promptness of Policy Issuance
- Proper Maintenance of Underwriting Files

EXECUTIVE SUMMARY

KID performed a targeted market conduct examination of the Auto Club. This targeted exam was a follow-up to a 2006 market conduct exam where certain deficiencies were identified, and the Company was subsequently ordered to implement changes in their rating and underwriting practices.

The exam team reviewed the Auto Club's general operations, underwriting and complaint files in the Company's home office in St. Louis, MO. A series of meetings were held with the Auto Club staff that focused on their current operations. To supplement and verify the understanding of how the Company currently is doing business, several samples were selected for review to verify their procedures and practices in complaint handling and underwriting and rating processes.

The Company passed most tests, and the examiners were impressed with the overall positive and very professional performance by the Auto Club staff and management.

THE FOLLOWING 2006 RECOMMENDATIONS WERE THE FOCUS OF THE 2008 TARGETED EXAM.

Underwriting and Rating

4. The Auto Club should review the "Kansas insurance score act" to make sure that their forms and underwriting activities conform to K.S.A. 40-5101 through 40-5114. The Company must present a plan to KID within 30 days from the issuance of the Final Order for this exam of how they are conforming to this recommendation.

5. The Company should review their underwriting cancellation and non-renewal procedures to insure that they are in compliance with K.S.A. 40-276, K.S.A. 276a and K.S.A. 40-277 and the "Kansas insurance score act". The Auto Club must present a plan to KID within 30 days from the issuance of the Final Order for this exam of how they are conforming to this recommendation.

General Recommendation

1. The exam team recommends that a targeted follow up exam be completed in 15 months to insure that the Auto Club has taken the necessary steps to correct the problems cited in recommendations #4 and #5 of the Underwriting and Rating portion of this exam and are now complying with the Kansas Credit Scoring Act.

THE FOLLOWING RECOMMENDATIONS ARE THE RESULT OF THE 2008 TARGETED EXAM

Underwriting and Rating Recommendations

1. Overall the Company was within the tolerances for Standard 1. However due to a programming error, there was a group of 250 policyholders potentially affected by this oversight. 131 accounts did receive a refund from the Company due to this overcharge. The Auto Club should review their procedures to insure that future rate filings whether they be rate factor or rating methodology changes are correctly programmed into their processing system to be in compliance with K.S.A. 40-955 (a)(g).
2. The exam team recommends the Company prepare a filing for cancellation letters with appropriate language when a C.L.U.E. report is involved since the current letter allows the underwriter to free-form all such language. This will insure that the Auto Club is in compliance with K.S.A. 40-2,122; K.A.R. 40-3-31(b)(1); K.S.A. 40-5107 (b).

DESK EXAMINATION/ON-SITE EXAMINATION

COMPANY OVERVIEW

History and Profile

History - ACIIE

The Automobile Club Inter-Insurance Exchange (ACIIE) commenced its automobile insurance business in Missouri on April 15, 1927. The ACIIE is organized as a reciprocal insurance company. The ACIIE is essentially an insurer of private passenger automobiles.

Over the years ACIIE expanded into several neighboring states and currently writes preferred auto in Missouri, Arkansas, Louisiana, Mississippi and Alabama, as well as portions of Illinois, Indiana and Kansas

In January 1990 the ACIIE purchased the Alternative Insurance Company of North America, Inc. This Missouri domiciled, stock company was incorporated in June 1987 and was licensed to sell fire and casualty lines. Upon purchase, the name was changed to the Auto Club Family Insurance Company (ACFIC).

In February 1990, the ACFIC commenced writing homeowners insurance in Missouri. In the subsequent years ACFIC continued to expand writing homeowners and non-standard automobile coverages in each of the states where they were doing business with ACIIE.

Effective June 2006, the Missouri Department of Insurance gave approval to the Inter-Insurance Exchange of the Automobile Club (IIEAC) to acquire control of ACIIE and ACFIC (formerly the Automobile Club of Missouri Group). The IIEAC is part of the Auto Club Enterprises Insurance Group which is a top twenty private passenger auto insurer and a top fifty property and casualty insurer within the United States.

IIEAC business is written predominantly in California with the majority of the remaining business written in Missouri, Texas, Louisiana, Kansas, Arkansas and New Mexico. The group's underwriting operation consists primarily of private passenger auto and homeowners coverages. A small book of personal liability and boat insurance constitute the remaining premium volume.

Tests for Company Operations/Management

Standard 7

Records are adequate, accessible, consistent and orderly and comply with state record retention requirements. K.S.A. 40-222 (a)(b)(c)(g).

The Company provided the exam team with the necessary records and documents in a timely fashion.

The Company passed Standard 7.

Standard 9

The company cooperates on a timely basis with examiners performing the examinations. K.S.A. 40-222 (c)(g).

The Company was very cooperative and provided the exam team with the items requested within the time frames established for this exam.

The Company passed Standard 9.

COMPLAINT HANDLING

The Auto Club defines a “complaint” as any written correspondence primarily expressing a grievance.

A division of insurance complaint is a complaint from any State Insurance Department and must be immediately forwarded to the Home Office to the attention of General Counsel/Secretary of AAA Missouri, for a response. Complaints are to be resolved within ten working days from date of receipt.

As of the first of 2007, the Company changed their complaint handling procedures regarding non-insurance department complaints. The complaint is handled by the appropriate person in the department that the grievance was issued against. A written insurance complaint worksheet is completed and forwarded to the Manager of Insurance Administration.

Insurance department complaints are reviewed quarterly by the VP of Insurance, Director of Claims and Manager of Insurance Administration. A quarterly meeting is held with management to review all complaints received.

Tests for Complaint Handling

Standard 1

All complaints are recorded in the required format on the company complaint register. K.S.A. 40-2404 (10).

In the last exam, the company was not using the required format for recording complaints per K.S.A. 40-2404 (10). This was corrected by the Auto Club while the examiners were on site for the 2006 exam. A review of the current complaint logs confirmed that the Company was following the requirements of the Kansas Statute.

The Company passed this standard.

Standard 2

The company has adequate complaint handling procedures in place and communicates such procedures to policyholders. K.A.R. 40-1-34, Sections 5(a) & 6.

The Auto Club maintains one log for all Insurance Department complaints. There is a separate log for all non-insurance department complaints.

The Company passed this standard.

Standard 3

The company takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language. K.A.R. 40-1-34, 6.

The Company passed this standard.

Standard 4

The time frame within which the company responds to complaints is in accordance with applicable statutes, rules and regulations. K.A.R. 40-1-34, Sections 6 & 8(a)(c).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Insurance Dept. Complaints	34	0	100

The Company passed Standard 4.

UNDERWRITING AND RATING

The Company's Underwriting & Rating Process:

New Business Processing – Auto

ACIIE

New business is processed through a point of sale program in offices of captive and independent agents. All information required to qualify and rate an applicant is entered on an online application.

As of June 2005, ACIIE implemented a Financial Responsibility Score (FRS) as part of their new business rating program. The automated underwriting system determines basic rating components such as rating territory, driver classification, auto symbol based on the vehicle identification number, tier, merit rating and FRS to calculate a basic premium.

A Comprehensive Loss Underwriting Evaluation (CLUE) report is ordered along with motor vehicle reports as part of the new business underwriting process.

ACFIC

A similar process is followed for ACFIC as outlined for ACIIE.

Renewal Business Processing – Auto

The auto renewal process involves a review of the claim history as part of the overall eligibility process. The FRS will be updated every three years or upon request of the policyholder.

New Business Processing - Homeowners

New business is processed through a point of sale program in offices of captive and independent agents. All information required to qualify and rate an applicant is entered on an online application.

As of May 2006, ACFIC has implemented an Insurance Score Model as part of their Homeowners rating program. The automated underwriting system determines basic rating components using basic property and personal rating characteristics and an FRS score to develop the basic premium.

A Comprehensive Loss Underwriting Evaluation (CLUE) report is ordered as part of the new business underwriting process.

Renewal Business Processing – Homeowners

The homeowners renewal process involves a review of the Insurance Score Model variables to determine proper pricing. The FRS will be updated every three years or upon request of the policyholder.

Tests for Underwriting and Rating

Standard 1: Rating Practices

The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the company rating plan. K.S.A. 40-955.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Auto New Business	50	0	100%
Auto Renewal Business	50	1	98%
HO New Business	50	0	100%
HO Renewal Business	50	3	94%

- One auto renewal was issued with the wrong territory. This is a violation of K.S.A. 40-955 (a)(g).

- Three homeowner rental renewals were not rated per the filed Insurance Score Model. This is a violation of K.S.A. 40-955 (a)(g).

The Company failed the HO Renewal Business portion of Standard 1. While the overall group, HO Renewal Business, passed the standard. There was an error in the programming and one segment of their tenants renewal business was mis-rated.

Standard 2: Rating Practices

Disclosures to insureds concerning rates and coverage are accurate and timely. K.S.A. 40-955.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Auto New Business	50	1	98%
Auto Renewal Business	50	0	100%
HO New Business	50	0	100%
HO Renewal Business	50	0	100%

- One Auto non-standard new business application did not have the insured’s signature on the non-standard rate disclosure. This is a violation of K.A.R. 40-3-25.

The Company passed Standard 2.

Standard 3 Rating Practices

Company does not permit illegal rebating, commission cutting or inducements.

The exam team did not specifically test for this standard. In the normal review of the sample files, any indications of rebating, commission cutting or inducements would have been reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 4: Rating Practices

Credits and deviations are consistently applied on a non-discriminatory basis. K.S.A. 40-953 & K.S.A. 40-954.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Auto New Business	50	4	92%
Auto Renewal Business	50	1	98%
HO New Business	50	0	100%
HO Renewal Business	50	0	100%

- One non-standard auto policy was issued with a prior insurance discount in error. This is a violation of K.S.A. 40-955 (a)(g).

- One non-standard auto policy was issued without a prior insurance discount in error. This is a violation of K.S.A. 40-955 (a)(g).

- One auto new business policy did not have a multi-car discount applied. This is a violation of K.S.A. 40-955 (a)(g).
- One auto new business policy had the multi-car discounts-applied. This is a violation of K.S.A. 40-955 (a)(g).
- One auto renewal policy did not have the new driver credit applied. This is a violation of K.S.A. 40-955 (a)(g).

The Company passed Standard 4.

Standard 11: Underwriting Practices

The company underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and company guidelines in the selection of risks. K.S.A. 40-953, K.S.A. 40-954, & K.S.A. 40-955.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Auto New Business	50	0	100%
Auto Renewal Business	50	0	100%
HO New Business	50	0	100%
HO Renewal Business	50	0	100%

The Company passed Standard 11.

Standard 12: Underwriting Practices

All forms and endorsements forming a part of the contract are listed on the declaration page and should be filed with the department of insurance (if applicable). K.S.A. 40-216.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Auto New Business	50	0	100%
Auto Renewal Business	50	0	100%
HO New Business	50	0	100%
HO Renewal Business	50	0	100%

The Company passed Standard 12.

Standard 14: Underwriting Practices

Underwriting, rating and classification are based on adequate information developed at or near inception of the coverage rather than near expiration, or following a claim. K.S.A. 40-953.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Auto New Business	50	0	100%
Auto Renewal Business	50	0	100%
HO New Business	50	0	100%

HO Renewal Business	50	0	100%
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The Company passed Standard 14.

Standard 15: Underwriting Practices

File documentation adequately supports decisions made. K.S.A. 40-953 & K.S.A. 40-955.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Auto New Business	50	0	100%
Auto Renewal Business	50	0	100%
HO New Business	50	0	100%
HO Renewal Business	50	0	100%

The Company passed Standard 15.

Standard 16: Underwriting Practices

Policies and endorsements are issued or renewed accurately, timely and completely. K.S.A. 40-216, K.S.A. 40-953 & K.S.A. 40-955.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Auto New Business	50	0	100%
Auto Renewal Business	50	0	100%
HO New Business	50	0	100%
HO Renewal Business	50	0	100%

The Company passed Standard 16.

Standard 23: Termination Practices

Cancellation/non-renewal notices comply with policy provisions and state laws and company guidelines. K.S.A. 40-276(a), K.S.A. 40-277, K.S.A. 40-278, K.S.A. 40-2,111, K.S.A. 40-2,112, K.S.A. 40-2,120, K.S.A. 40-2,121, K.S.A. 40-2,122, K.A.R. 40-3-15, K.A.R. 40-3-23, K.A.R. 40-3-28 & K.A.R. 40-3-31.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
New Business - Cancellations	57	9	84%
Renewal- Canc/Non-renewal	39	0	100%

- One new business policy was cancelled because the named insured was a minor and could not enter into an insurance contract. This is a violation of K.S.A. 40-237.

- General comment: The Auto Club used in their cancellation notices a statement that the “Adverse information (was) contained in a consumer report...” An address was cited for C.L.U.E. along with a reference number. No other details regarding the specific adverse information were given to the insured nor were they given

instructions for using the C.L.U.E. address. Eight (8) policies out of the sample of 57, 14%, were identified for not having clear wording to meet Kansas law that requires a cancellation notice to contain either a written explanation specifically detailing the reasons why the policy was canceled or the opportunity to request the reasons for cancellation from the company. The reasons cited in these cancellation notices do not meet either statutory or regulatory requirements. “Adverse information” is a general statement, not a specific reason. This is a violation of K.S.A. 40-2,122; K.A.R. 40-3-31(b)(1); K.S.A. 40-5107 (b).

The Company failed the new business portion of Standard 23.

Standard 24: Termination Practices

Cancellation/non-renewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract. K.S.A. 40-276(a), K.S.A. 40-277, K.S.A. 40-278, K.S.A. 40-2,111, K.S.A. 40-2,112, K.S.A. 40-2,120, K.S.A. 40-2,121, K.S.A. 40-2,122, K.A.R. 40-3-15, K.A.R. 40-3-23, K.A.R. 40-3-28 & K.A.R. 40-3-31.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
New Business - Cancellations	57	0	100%
Renewal- Canc/Non-renewal	39	0	100%

The Company passed Standard 24.

Underwriting and Rating Recommendations

1. Overall the Company was within the tolerances for Standard 1. However due to a programming error, there was a group of potentially 250 policyholders affected by this oversight. 131 accounts did receive a refund from the Company due to this overcharge, but the Auto Club should review their procedures to insure that future rate filings whether they be rate factor or rating methodology changes are correctly programmed into their processing system to be in compliance with K.S.A. 40-955 (a)(g).
2. The exam team recommends the Company prepare a filing for cancellation letters with appropriate language when a C.L.U.E. report is involved since the current letter allows the underwriter to free-form all such language. This will insure that the Auto Club is in compliance with K.S.A. 40-2,122; K.A.R. 40-3-31(b)(1); K.S.A. 40-5107 (b).

GENERAL COMMENTS

The following recommendations were from the 2006 targeted exam. AAA complied with all the items in the KID order regarding the 2006 Market Conduct Exam issues.

GENERAL COMMENTS FROM THE 2006 EXAM REPORT

Company Operations and Management

1. The exam team recommends that the Auto Club complete their formalizing an internal audit program for the claims department and look into developing similar programs for underwriting and policy processing.

Complaint Handling

1. The exam team recommends that the control and record keeping of the non-insurance department complaints be coordinated and maintained with the same unit that keeps department of insurance complaints.

Underwriting and Rating

1. The Company needs to re-file their ACFIC rating factor for PIP coverage. The company revised their filing on 12/22/05.

2. The current ACIIE auto territory pages show Territory 24 comprising a single zip code. Given the small geographic size of one zip code and small population base of that area, it would appear that ACIIE may be in violation of K.S.A. 40-953. The exam team recommends that in the next rate filing, ACIIE look at this territory definition. This territory filing was approved twelve years ago. It wasn't until 1996 that KID began to look at territories closely to make sure that companies were not over segmenting.

3. The Company should allow three days for mail time on all notices of cancellation and non-renewal in the interest of consistency.

The Company indicated that they are implementing a new procedure. The cancellation notice will be prepared far enough in advance that the policyholder will be given at least 10 days actual notice (3+ days for mailing and 10 days for the notice).

4. The Auto Club should review the "Kansas insurance score act" to make sure that their forms and underwriting activities conform to K.S.A. 40-5101 through 40-5114. The Company must present a plan to KID within 30 days from the issuance of the Final Order for this exam of how they are conforming to this recommendation.

5. The Company should review their underwriting cancellation and non-renewal procedures to insure that they are in compliance with K.S.A. 40-276, K.S.A. 276a and K.S.A. 40-277 and the "Kansas insurance score act". The Auto Club must present a plan to

KID within 30 days from the issuance of the Final Order for this exam of how they are conforming to this recommendation.

General Recommendation

The exam team recommends that a targeted follow up exam be completed in 15 months to insure that the Auto Club has taken the necessary steps to correct the problems cited in recommendations #4 and #5 of the Underwriting and Rating portion of this exam and are now complying with the Kansas Credit Scoring Act.

RECOMMENDATIONS FROM THE 2008 MARKET CONDUCT EXAM

Underwriting and Rating Recommendations

1. Overall the Company was within the tolerances for Standard 1. However due to a programming error, there was a group of potentially 250 policyholders affected by this oversight. 131 accounts did receive a refund from the Company due to this overcharge, but the Auto Club should review their procedures to insure that future rate filings whether they be rate factor or rating methodology changes are correctly programmed into their processing system to be in compliance with K.S.A. 40-955 (a)(g).
2. The exam team recommends the Company prepare a filing for cancellation letters with appropriate language when a C.L.U.E. report is involved since the current letter allows the underwriter to free-form all such language. This will insure that the Auto Club is in compliance with K.S.A. 40-2,122; K.A.R. 40-3-31(b)(1); K.S.A. 40-5107 (b).

CONCLUSION

I would like to acknowledge the cooperation and courtesy extended to the examination team by Deborah Miller and the staff of the Auto Club.

The following examiners of the Office of the Commissioner of Insurance in the State of Kansas participated in the review:

Market Conduct Division

Lyle Behrens
Supervisor

Mary Lou Maritt
Market Conduct Examiner

Tate Flott
Market Conduct Examiner

Respectfully submitted,

Lyle Behrens,
CPCU, CIE, FLMI, ARM, Are

APPENDIX I

A. K.A.R. 40-1-34 - UNFAIR CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

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Section 8.	Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers:
Section 9.	Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance

Section 1. Authority

Section 1 is not adopted.

Section 2. Scope

This regulation applies to all persons and to all insurance policies and insurance contracts except policies of Workers' Compensation insurance. This regulation is not exclusive, and other acts, not herein specified, may also be deemed to be a violation of K.S.A. 40-2404, and amendments thereto.

Section 3. Definitions

The definitions of "person" and of "insurance policy or insurance contract" contained in K.S.A. 40-2404, and amendments thereto shall apply to this regulation and, in addition, where used in this regulation:

- (a) "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;
- (b) "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;
- (c) "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract;
- (d) "Insurer" means a person licensed to issue or who issues any insurance policy or insurance contract in this State;

(e) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

(f) "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

(g) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer; and

(h) "Workers' Compensation" includes, but is not limited to, Longshoremen's and Harbor Workers' Compensation.

Section 4. File and Record Documentation

The insurer's claim files shall be subject to examination by the (Commissioner) or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

Section 5. Misrepresentation of Policy Provisions

(a) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(b) No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(c) No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

(d) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.

(e) No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(f) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which release the insurer or its insured from its total liability.

Section 6. Failure to Acknowledge Pertinent Communications

(a) Every insurer, upon receiving notification of a claim shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the

insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

(b) Every insurer, upon receipt of any inquiry from the insurance department respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within ten working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within ten working days of notification of a claim shall constitute compliance with subsection (a) of this section.

Section 7. Standards for Prompt Investigation of Claim

Every insurer shall complete investigation of a claim within thirty days after notification of claim, unless such investigation cannot reasonably be completed within such time.

Section 8. Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

(a) Within fifteen working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(b) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority that the first party claimant has fraudulently caused or contributed to the loss by arson, the insurer is relieved from the requirements of this subsection. Provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(c) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five days from the date of the initial notification and every forty-five days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

(d) Section 8(d) is not adopted.

(e) An insurer shall not attempt to settle a loss with a first party claimant on the basis of a cash settlement which is less than the amount the insurer would pay if repairs were made, other than in total loss situations, unless such amount is agreed to by the insured.

- (f) If a claim is denied for reasons other than those described in section 8(a) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.
- (g) Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.
- (h) Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or a contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to first party claimants thirty days and to third party claimants sixty days before the date on which such time limit may expire.
- (i) No insurer shall make statements which indicate the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

Section 9. Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance

- (a) When the insurance policy provides, for the adjustment and settlement of automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods must apply:
 - (1) The insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the claimant, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.
 - (2) The insurer may elect to pay a cash settlement, based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost shall be determined by any source or method for determining statistically valid fair market value that meets both of the following criteria:
 - (A) The source or method's database, including nationally recognized automobile evaluation publications, shall provide values for at least eighty-five percent (85%) of all makes and models of private passenger vehicles for the last fifteen (15) model years taking into account the values for all major options for such vehicles; and
 - (B) The source, method, or publication shall provide fair market values for a comparable automobile based on current data available for the local market area as defined in subsection (j)(2).
 - (3) When an automobile total loss is settled on a basis which deviates from the methods and criteria described in subsection (a)(1) and (a)(2)(A) and (B) of this section, the deviation must be supported by documentation giving the

particulars of the automobile condition and the basis for the deviation. Any deviations from such cost, including deductions for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the claimant.

(b) Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make claim under their own policies solely to avoid paying claims under such insurer's insurance policy or insurance contract.

(c) Insurers shall not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

(e) If an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one or more conveniently located repair shops.

(f) When the amount claimed is reduced because of betterment or depreciation all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

(g) When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

(h) Insurers shall include consideration of applicable taxes, license fees, and other fees incident to transfer of evidence of ownership in third party automobile total losses and shall have sufficient documentation relative to how the settlement was obtained in the claim file. A measure of damages shall be applied which will compensate third party claimants for the reasonable loss sustained as the proximate result of the insured's negligence.

(i) A claimant has the right of recourse if the claimant notifies the insurer, within thirty (30) days after the receipt of the claim draft, that claimant is unable to purchase a comparable automobile for the amount of the claim draft. Upon receipt of this notice, the insurer shall reopen its claim file within five (5) business days, and one of the following actions shall apply.

(1) the Insurer shall either pay the claimant the difference between the market value as determined by the insurer and the cost of the comparable vehicle of like kind and quality which the claimant has located, or negotiate and effect the purchase price of this vehicle for the claimant; or

(2) the insurer may elect to offer a replacement in accordance with provisions of subsection 9(a)(1).

(j) As used in this regulation the following terms shall have the following meanings:

(1) comparable automobile means a vehicle of the same make, model, year, style and condition, including all major options of the claimant vehicle;

(2) local market area means the fifty (50) mile area surrounding the place where the claimant vehicle was principally garaged.

K.S.A. 40-216 Business prohibited until certain filings made; contracts effective on filing; filing of contracts on behalf of insurer by rating organization or another insurer; contracts written in foreign language; suspension or modification of filing requirements by commissioner; hearing, order.

(a) (1) No insurance company shall hereafter transact business in this state until certified copies of its charter and amendments thereto shall have been filed with and approved by the commissioner of insurance. A copy of the bylaws and amendments thereto of insurance companies organized under the laws of this state shall also be filed with and approved by the commissioner of insurance. The commissioner may also require the filing of such other documents and papers as are necessary to determine compliance with the laws of this state.

(2) (A) Except as provided in subparagraph (B), each contract of insurance or indemnity issued or delivered in this state shall be effective on filing, or any subsequent date selected by the insurer, unless the commissioner disapproves such contract of insurance within 30 days after filing because the rates are determined to be inadequate, excessive, unfairly discriminatory or otherwise fail to meet the requirements of this act.

(B) The following contracts of insurance or indemnity shall not be subject to the provisions of subsection (A):

- (i) Contracts pertaining to large risks as defined in subsection (i) of K.S.A. 40-955, and amendments thereto, which are exempt from the filing requirements of this section;
- (ii) personal lines contracts filed in accordance with paragraph (3) of this section;
- (iii) any form filing for the basic coverage required by K.S.A. 40-3401 et seq., and amendments thereto; and
- (iv) form filing for workers compensation.

No form filing listed in clauses (iii) and (iv) of this subparagraph shall be used in this state by any insurer until such form filing has been approved by the commissioner.

(3) Each personal lines contract of insurance or indemnity issued or delivered in this state shall be on file for a period of 30 days before becoming effective unless the commissioner disapproves such personal lines contract if the rates are determined by the commissioner to be inadequate, excessive, unfairly discriminatory or otherwise fail to meet the requirements of this act. For the purposes of this paragraph, the term "personal lines" shall mean insurance for noncommercial automobile, homeowners, dwelling, fire and renters insurance policies as defined by the commissioner by rules and regulations.

(4) Under such rules and regulations as the commissioner of insurance shall adopt, the commissioner may, by written order, suspend or modify the requirement of filing forms of contracts of insurance or indemnity, which cannot practicably be filed before they are used. Such orders, rules and regulations shall be made known to insurers and rating organizations affected thereby. The commissioner may make an examination to ascertain whether any forms affected by such order meet the standards of this code.

(5) The failure of any insurance company to comply with this section shall not constitute a defense to any action brought on its contracts. An insurer may satisfy its obligation to file its contracts of insurance or indemnity either individually or by authorizing the commissioner to accept on its behalf the filings made by a licensed rating organization or another insurer.

(b) The commissioner of insurance shall allow any insurance company authorized to transact business in this state to deliver to any person in this state any contract of insurance

or indemnity, including any explanatory materials, written in any language other than the English language under the following conditions:

(1) The insured or applicant for insurance who is given a copy of the same contract of insurance or indemnity or explanatory materials written in the English language;

(2) the English language version of the contract for insurance or indemnity or explanatory materials delivered shall be the controlling version; and

(3) any contract of insurance or indemnity or explanatory materials written in any language other than English shall contain a disclosure statement in 10 point boldface type, printed in both the English language and the other language used, stating the English version of the contract of insurance or indemnity is the official or controlling version and that the version is written in any language other than English is furnished for informational purposes only.

(c) All contracts of insurance or indemnity that are required to be filed with the commissioner of insurance shall be accompanied by any version of such contract of insurance or indemnity written in any language other than the English language.

(d) Any insurance company or insurer, including any agent or employee thereof, who knowingly misrepresents the content of a contract of insurance or indemnity or explanatory materials written in a language other than the English language shall be deemed to have violated the unfair trade practice law.

(e) For the purposes of this section, the term "contract of insurance or indemnity" shall include any rider, endorsement or application pertaining to such contract of insurance or indemnity.

(f) (1) If at any time after a filing becomes effective, the commissioner finds that such filing does not comply with this act, after the commissioner shall send written notice to every insurer and rating organization making such filing that a hearing concerning such filing will be held in not less than 10 days.

(2) After the hearing, the commissioner shall issue an order stating:

(A) The reasons why such filing failed to comply with the act; and

(B) the date, within a reasonable time after the date the order is issued, upon which such filing shall no longer be effective.

(3) A copy of the commissioner's order shall be sent to every insurer and rating organization that made such filing.

(4) No order issued pursuant to this subsection shall affect any contract or policy made or issued under such filing prior to the date specified upon which such filing shall no longer be effective.

History: L. 1927, ch. 231, 40-216; L. 1967, ch. 248, § 2; L. 1979, ch. 134, § 1; L. 1999, ch. 63, § 1; L. 2004, ch. 159, § 5; L. 2006, ch. 130, § 1; L. 2007, ch. 150, § 1; July 1

K.S.A. 40-237. Contracts and promissory notes by minors.

Minors may consummate contracts respecting insurance the same as adults, and any policy, certificate or other evidence of such contract shall be binding upon the minor to the same extent, as though of legal age, and any minor entering into any such insurance contract also may enter into a promissory note or installment contract for the payment of the first or subsequent premiums due under such insurance contract, the same as an adult, and any such promissory note or installment contract shall be binding upon such minor to the same extent

as though he were of legal age: *Provided*, That all such contracts made by a minor shall have the written consent of either a parent, guardian, or conservator: *Provided further*, That if any insurance company or any insurance agent accepts from a minor a promissory note or installment contract for the payment of the first or subsequent premiums on a policy of life insurance, said note or contract shall be cosigned by a person over the age of eighteen (18) years, and a copy of said note or contract shall be furnished all parties thereto. A copy of said note or contract shall be furnished to the consenting parent, guardian, or conservator.

History: L. 1927, ch. 231, 40-237; L. 1965, ch. 297, § 1; L. 1971, ch. 160, § 1; L. 1972, ch. 161, § 10; July 1.

K.S.A. 40-276. Cancellation of automobile liability insurance; definitions.

As used in this act: "Policy of automobile liability insurance" means a policy insuring against the liability of the insured for the death, disability or damages of another and against loss or damage to the property of another, arising from the use of an automobile that is issued to cover the following types of automobiles owned by an individual or by husband and wife, including automobiles hired under a long term contract and written on a specified car basis:

(a) A motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers, nor rented to others;

(b) Any other four-wheel motor vehicle with a load capacity of one thousand five hundred (1,500) pounds or less which is not used in the occupation, profession or business of the named insured, other than farming: *Provided*, That the term "policy of automobile liability insurance" shall not include policies of automobile liability insurance (1) issued through the Kansas automobile assigned risk plan, (2) insuring more than four automobiles, nor (3) insuring the automobile hazard of garages, automobile sales agencies, repair shops, service stations or public parking places.

History: L. 1967, ch. 271, § 1; Jan. 1, 1968.

K.S.A. 40-276a. Automobile liability insurance policies; denial of renewal; notice; conditions; exceptions.

(a) Any insurance company that denies renewal of an automobile liability insurance policy in this state shall give at least 30 days written notice to the named insured, at his last known address, or cause such notice to be given by a licensed agent of its intention not to renew such policy. No insurance company shall deny the renewal of an automobile liability insurance policy except in one or more of the following circumstances or as permitted in subsection (b):

(1) When such insurance company is required or has been permitted by the commissioner of insurance, in writing, to reduce its premium volume in order to preserve the financial integrity of such insurer;

(2) when such insurance company ceases to transact such business in this state;

(3) when such insurance company is able to show competent medical evidence that the insured has a physical or mental disablement that impairs his ability to drive in a safe and reasonable manner;

(4) when unfavorable underwriting factors, pertinent to the risk, are existent, and of a substantial nature, which could not have reasonably been ascertained by the company at the initial issuance of the policy or the last renewal thereof;

(5) when the policy has been continuously in effect for a period of five years. Such five-year period shall begin at the first policy anniversary date following the effective date of the policy, except that if such policy is renewed or continued in force after the expiration of such period or any subsequent five-year period, the provisions of this subsection shall apply in any such subsequent period; or

(6) when any of the reasons specified as reasons for cancellation in K.S.A. 40-277 are existent, except that (A) when failure to renew is based upon termination of agency contract, obligation to renew will be satisfied if the insurer has manifested its willingness to renew, and (B) obligation to renew is terminated on the effective date of any other automobile liability insurance procured by the named insured with respect to any automobile designated in both policies.

Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal. Nothing in this section shall require an insurance company to renew an automobile liability insurance policy if such renewal would be contrary to restrictions of membership in the company which are contained in the articles of incorporation or the bylaws of such company.

(b) (1) No insurance company shall refuse to renew a policy until after June 30, 2002, based on an insured's failure to maintain membership in a bona fide association, until both the insurance company and bona fide association have complied with the requirements of this subsection. No insurance company shall refuse to renew any coverage continuously in effect before July 1, 2002, unless:

(A) The application for insurance and the insurance policy shall clearly disclose that both the payment of dues and current membership in the bona fide association are prerequisites to obtaining or renewing the insurance;

(B) the bona fide association has filed a certification with the commissioner of insurance verifying the eligibility of the insurance company to refuse to renew an insurance policy based on the membership in the bona fide association; and

(C) any money paid to the bona fide association as a membership fee:

(i) Shall not be used by the insurance company directly or indirectly to defray any costs or expenses in connection with the sale or purchase of the insurance; and

(ii) shall be set independently of any factor used by the insurance company to make any judgment or determination about the eligibility of any individual to purchase or renew such insurance. For the purposes of this provision, the individual may be a member of the bona fide organization or an employee or dependent of such a member.

(2) (A) Upon request the bona fide association shall file a statement with the commissioner of insurance verifying that the bona fide association meets the requirements of this paragraph.

(B) For the purposes of this subsection, "bona fide association" means an association which:

(i) Has been in active existence for at least five consecutive years immediately preceding the date the statement is filed;

(ii) has been formed and maintained in good faith for purposes other than obtaining or providing insurance and does not condition membership in the association on the purchase of insurance;

(iii) has articles of incorporation and bylaws or other similar governing documents;

(iv) has a relationship with one or more specific insurance companies and identifies each such insurance company; and

(v) and does not condition membership in the association or set membership fees on the eligibility of any individual to purchase or renew the insurance or on any factor that the insurance company could not lawfully consider when setting rates. For the purposes of this provision, the individual may be a member of the bona fide organization or an employee or dependent of such a member.

(3) Membership fees collected by the bona fide association shall not be deemed to be premiums of the insurance company that issued the coverage unless the bona fide association:

(A) Uses any portion of such membership fees directly or indirectly to defray any costs or expenses in connection with the sale or purchase of the insurance; or

(B) sets or adjusts membership fees for any member of the bona fide association based on any factor used by the insurance company that issues the insurance to make any judgment or determination about the eligibility of any individual to purchase or renew the insurance. For the purposes of this provision, the individual may be a member of the bona fide organization or an employee or dependent of such a member.

(4) If the membership fees are determined to constitute premiums pursuant to paragraph (3) of this subsection, the insurance company shall not refuse to renew a policy as otherwise permitted by this subsection.

History: L. 1972, ch. 176, § 1; L. 2002, ch. 58, § 1; July 1.

K.S.A. 40-277. Automobile liability insurance policies; limitations on policy conditions for cancellation.

No insurance company shall issue a policy of automobile liability insurance in this state unless the cancellation condition of the policy or endorsement thereon includes the following limitations pertaining to cancellation by the insurance company:

After this policy has been in effect for 60 days, or if the policy is a renewal, effective immediately, the company shall not exercise its right to cancel the insurance afforded under (here insert the appropriate coverage references) solely because of age or unless

1. The named insured fails to discharge when due any obligations in connection with the payment of premium for this policy or any installment thereof whether payable directly or under any premium finance plan; or

2. the insurance was obtained through fraudulent misrepresentation; or

3. the insured violates any of the terms and conditions of the policy; or

4. the named insured or any other operator, either resident in the same household, or who customarily operates an automobile insured under the policy,

(a) has had such person's driver's license suspended or revoked during the policy period, or

(b) is or becomes subject to epilepsy or heart attacks, and such individual cannot produce a certificate from a physician testifying to such person's ability to operate a motor vehicle, or

(c) is or has been convicted during the 36 months immediately preceding the effective date of the policy or during the policy period, for:

- (1) Any felony, or
- (2) criminal negligence, resulting in death, homicide or assault, arising out of the operation of a motor vehicle, or
- (3) operating a motor vehicle while in an intoxicated condition or while under the influence of drugs, or
- (4) leaving the scene of an accident without stopping to report, or
- (5) theft of a motor vehicle, or
- (6) making false statements in an application for a driver's license, or
- (7) a third moving violation, committed within a period of 18 months, of (i) any regulation limiting the speed of motor vehicles, (ii) any of the provisions in the motor vehicle laws of any state, the violation of which constitutes a misdemeanor or traffic infraction, or (iii) any ordinance traffic infraction, or ordinance which prohibits the same acts as a misdemeanor statute of the uniform act regulating traffic on highways, whether or not the violations were repetitious of the same offense or were different offenses.

History: L. 1967, ch. 271, § 2; L. 1984, ch. 39, § 47; Jan. 1, 1985

K.S.A. 40-953. Same; excessive, inadequate or unfairly discriminatory rates or rates resulting in destruction of competition, standards.

Rates shall not be excessive, inadequate or unfairly discriminatory, nor shall an insurer charge any rate which if continued will have or tend to have the effect of destroying competition or creating a monopoly. Rates are presumed not to be excessive if a reasonable degree of market competition exists at the consumer level with respect to the class of business to which they apply. Rates in a noncompetitive market are excessive if they are producing or are likely to produce unreasonably high profits for the insurance provided or if expenses are unreasonably high in relation to services rendered. A competitive market in a type of insurance subject to this act is presumed to exist unless the commissioner after notice of hearing determines and orders that a reasonable degree of competition does not exist in the market. Such order shall expire no later than one year after issuance unless the commissioner renews the rule after a hearing and a finding of the continued lack of a reasonable degree of competition. In determining whether a reasonable degree of market competition exists, the commissioner shall consider all relevant tests, including: (1) The number, market share, and concentration of insurers, as measured by the 1992 Horizontal Merger Guidelines published in the Federal Register September 10, 1992 (57 FR 41552), actively engaged in the class of business, (2) the existence of rate differentials in that class of business, (3) ease of entry into the market, and (4) whether long-run profitability for insurers in that class of business is unreasonably high in relation to its riskiness. If such competition does not exist, rates are excessive if they are likely to produce a long run profit that is unreasonably high in relation to the riskiness of the class of business, or if expenses are unreasonably high in relation to the services rendered.

Rates are inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

One rate is unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the differences in expected losses and expenses. Rates are not

unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors or like expense factors but different loss exposures, so long as the rates reflect the differences with reasonable accuracy. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, franchise, mass marketed plan or blanket policy.

History: L. 1997, ch. 154, § 3; July 1.

K.S.A. 40-954 Same; determining factors; expense provisions; classification of risks; modification for individual risks; contingencies and allowances for profit; exemptions; mandatory rating plan use.

In determining whether rates are not excessive or inadequate or not unfairly discriminatory:

- (a) Due consideration shall be given to:
 - (1) Past and prospective loss and expense experience within and outside the state;
 - (2) catastrophe hazards and contingencies;
 - (3) trends within and outside this state;
 - (4) loadings for leveling premium rates over time;
 - (5) dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers and the investment income of the insurer; and
 - (6) all other relevant factors within and outside the state, including the judgment of technical personnel.
- (b) The expense provisions included in the rates to be used by an insurer may reflect the operating methods of the insurer, or group of insurers, and, so far as it is credible, its own expense experience.
- (c) Risks may be classified in any reasonable way for the establishment of rates and minimum premiums, except that no classification may be based on race, color, creed or national origin and classifications in automobile insurance may not be based on physical disability of an insured. Rates thus produced may be modified for individual risks in accordance with rating plans, schedules, except for workers compensation, individual risk premium modification plans and expense reduction plans that establish reasonable standards for measuring probable variations in experience, hazards, expenses or any combination of those factors.

Such standards shall permit recognition of expected differences in loss or expense characteristics, and shall be designed so that such plans are reasonable and equitable in their application, and are not unfairly discriminatory, violative of public policy or otherwise contrary to the best interests of the people of this state. This section shall not prevent the development of new or innovative rating methods which otherwise comply with this act.
- (d) Rates may be modified for individual risks, upon written application of the insured, stating the insured's reasons therefore, filed with and not disapproved by the commissioner within 10 days after filings.
- (e) The rates may contain provisions for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of the profit, consideration shall be given to the investment income attributable to the line of insurance.
- (f) The commissioner may by rule exempt any person or class of persons, line of insurance, or any market segment from any or all of the provisions of this chapter, if and to

the extent that the commissioner finds their application unnecessary to achieve the purposes of this act.

(g) Once it has been filed, use of any rating plan shall be mandatory and such plan shall be applied uniformly for eligible risks in a manner that is not unfairly discriminatory.

History: L. 1997, ch. 154, § 4; July 1.

K.S.A. 40-955 Same; rate filings; review and approval of certain lines; effective dates; exemptions from filing.

(a) Every insurer shall file with the commissioner, except as to inland marine risks where general custom of the industry is not to use manual rates or rating plans, every manual of classifications, rules and rates, every rating plan, policy form and every modification of any of the foregoing which it proposes to use. Every such filing shall indicate the proposed effective date and the character and extent of the coverage contemplated and shall be accompanied by the information upon which the insurer supports the filings. A filing and any supporting information shall be open to public inspection after it is filed with the commissioner. An insurer may satisfy its obligations to make such filings by authorizing the commissioner to accept on its behalf the filings made by a licensed rating organization or another insurer. Nothing contained in this act shall be construed to require any insurer to become a member or subscriber of any rating organization.

(b) Certificate of insurance forms must be filed with the commissioner of insurance and approved prior to use. Notwithstanding the "large risk" filing exemption in subsection (j), a certificate of insurance cannot be used to modify, alter or amend the insurance policy it describes. The certificate of insurance shall contain the following or similar language: The certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by the policies listed thereon. An industry standard setting organization may be authorized by the commissioner of insurance to file certificate of insurance forms on behalf of authorized insurers.

(c) Any rate filing for the basic coverage required by K.S.A. 40-3401 et seq. and amendments thereto, loss costs filings for workers compensation, and rates for assigned risk plans established by article 21 of chapter 40 of the Kansas Statutes Annotated or rules and regulations established by the commissioner shall require approval by the commissioner before its use by the insurer in this state. As soon as reasonably possible after such filing has been made, the commissioner shall in writing approve or disapprove the same, except that any filing shall be deemed approved unless disapproved within 30 days of receipt of the filing.

(d) Any other rate filing, except personal lines filings, shall become effective on filing or any prospective date selected by the insurer, subject to the commissioner disapproving the same if the rates are determined to be inadequate, excessive, unfairly discriminatory or otherwise fails to meet the requirements of this act. Personal lines rate filings shall be on file for a waiting period of 30 days before becoming effective, subject to the commissioner disapproving the same if the rates are determined to be inadequate, excessive, unfairly discriminatory or otherwise fail to meet requirements of this act. The term "personal lines" shall mean insurance for noncommercial automobile, homeowners, dwelling fire-and-renters insurance policies, as defined by the commissioner by rules and regulations. A filing complies with this act unless it is disapproved by the commissioner within the waiting period or pursuant to subsection (f).

(e) In reviewing any rate filing the commissioner may require the insurer or rating organization to provide, at the insurer's or rating organization's expense, all information necessary to evaluate the reasonableness of the filing, to include payment of the cost of an actuary selected by the commissioner to review any rate filing, if the department of insurance does not have a staff actuary in its employ.

(f) (1) (A) If a filing is not accompanied by the information required by this act, the commissioner shall promptly inform the company or organization making the filing. The filing shall be deemed to be complete when the required information is received by the commissioner or the company or organization certifies to the commissioner the information requested is not maintained by the company or organization and cannot be obtained.

(B) If the commissioner finds a filing does not meet the requirements of this act, the commissioner shall send to the insurer or rating organization that made the filing, written notice of disapproval of the filing, specifying in what respects the filing fails to comply and stating the filing shall not become effective.

(C) If at any time after a filing becomes effective, the commissioner finds a filing does not comply with this act, the commissioner shall after a hearing held on not less than 10 days' written notice to every insurer and rating organization that made the filing issue an order specifying in what respects the filing failed to comply with the act, and stating when, within a reasonable period thereafter, the filing shall be no longer effective. Copies of the order shall be sent to such insurer or rating organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(2) (A) In the event an insurer or organization has no legally effective rate because of an order disapproving rates, the commissioner shall specify an interim rate at the time the order is issued. The interim rate may be modified by the commissioner on the commissioner's own motion or upon motion of an insurer or organization.

(B) The interim rate or any modification thereof shall take effect prospectively in contracts of insurance written or renewed 15 days after the commissioner's decision setting interim rates.

(C) When the rates are finally determined, the commissioner shall order any overcharge in the interim rates to be distributed appropriately, except refunds to policyholders the commissioner determines are de minimis may not be required.

(3) (A) Any person or organization aggrieved with respect to any filing that is in effect may make written application to the commissioner for a hearing thereon, except that the insurer or rating organization that made the filing may not proceed under this subsection. The application shall specify the grounds to be relied on by the applicant.

(B) If the commissioner finds the application is made in good faith, that the applicant would be so aggrieved if the applicant's grounds are established, and that such grounds otherwise justify holding such a hearing, the commissioner shall, within 30 days after receipt of the application, hold a hearing on not less than 10 days' written notice to the applicant and every insurer and rating organization that made such filing.

(C) Every rating organization receiving a notice of hearing or copy of an order under this section, shall promptly notify all its members or subscribers affected by the hearing or order. Notice to a rating organization of a hearing or order shall be deemed notice to its members or subscribers.

(g) No insurer shall make or issue a contract or policy except in accordance with filings which have been filed or approved for such insurer as provided in this act.

(1) On an application for personal motor vehicle insurance where the applicant has applied for collision or comprehensive coverage, the applicant shall be allowed to identify a lienholder listed on the certificate of title for the motor vehicle described in the application.

(2) On an application for property insurance on real property, the applicant shall be allowed to identify a mortgagee listed on a mortgage for the real property described in the application.

(h) The commissioner may adopt rules and regulations to allow suspension or modification of the requirement of filing and approval of rates as to any kind of insurance, subdivision or combination thereof, or as to classes of risks, the rates for which cannot practicably be filed before they are used.

(i) Except for workers compensation and employer's liability line, the following categories of commercial lines risks are considered special risks which are exempt from the filing requirements in this section: (1) Risks that are written on an excess or umbrella basis; (2) commercial risks, or portions thereof, that are not rated according to manuals, rating plans, or schedules including "a" rates; (3) large risks; and (4) special risks designated by the commissioner, including but not limited to risks insured under highly protected risks rating plans, commercial aviation, credit insurance, boiler and machinery, inland marine, fidelity, surety and guarantee bond insurance risks.

(j) For the purposes of this subsection, "large risk" means: (1) An insured that has total insured property values of \$5,000,000 or more; (2) an insured that has total annual gross revenues of \$10,000,000 or more; or (3) an insured that has in the preceding calendar year a total paid premium of \$50,000 or more for property insurance, \$50,000 or more for general liability insurance, or \$100,000 or more for multiple lines policies.

(k) The exemption for any large risk contained in subsection (h) shall not apply to workers compensation and employer's liability insurance, insurance purchasing groups, and the basic coverage required by K.S.A. 40-3401 et seq. and amendments thereto.

(l) Underwriting files, premium, loss and expense statistics, financial and other records pertaining to special risks written by any insurer shall be maintained by the insurer and shall be subject to examination by the commissioner.

History: L. 1997, ch. 154, § 5; L. 1999, ch. 63, § 2; L. 2006, ch. 124, § 1; L. 2007, ch. 150, § 2; July 1.

B. K.S.A. 40-2404. - Unfair methods of competition or unfair and deceptive acts or practices; disclosure of nonpublic personal information; rules and regulations

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(9) *Unfair claim settlement practices.* It is an unfair claim settlement practice if any of the following or any rules and regulations pertaining thereto are: (A) Committed flagrantly and in conscious disregard of such provisions, or (B) committed with such frequency as to indicate a general business practice.

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

- (b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;
- (c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
- (d) refusing to pay claims without conducting a reasonable investigation based upon all available information;
- (e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;
- (f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;
- (g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;
- (h) attempting to settle a claim for less than the amount to which a reasonable person would have believed that such person was entitled by reference to written or printed advertising material accompanying or made part of an application;
- (i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;
- (j) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;
- (k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;
- (l) delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;
- (m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or
- (n) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) *failure to maintain complaint handling procedures.* Failure of any person, who is an insurer on an insurance policy, to maintain a complete record of all the complaints which it has received since the date of its last examination under K.S.A. 40-222, and amendments thereto; but no such records shall be required for complaints received prior to the effective date of this act. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaints, the date each complaint was originally received by the insurer and the date of final disposition of each complaint. For purposes of this subsection, "complaint" means any written communication primarily expressing a grievance related to the acts and practices set out in this section.

K.S.A. 40-3110 - Payment of PIP benefits

(a) Except for benefits payable under any workmen's compensation law, which shall be credited against the personal injury protection benefits provided by subsection (f) of K.S.A. 40-3107, personal injury protection benefits due from an insurer or self-insurer under this act shall be primary and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued in compliance with this act. An insurer or self-insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the insurer's policy of motor vehicle liability insurance affords the coverage required by this act. No claim for personal injury protection benefits may be made after two (2) years from the date of the injury.

(b) Personal injury protection benefits payable under this act shall be overdue if not paid within thirty (30) days after the insurer or self-insurer is furnished written notice of the fact of a covered loss and of the amount of same, except that disability benefits payable under this act shall be paid not less than every two (2) weeks after such notice. If such written notice is not furnished as to the entire claim, any partial amounts supported by written notice is overdue if not paid within thirty (30) days after such written notice is furnished. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within thirty (30) days after such written notice is so furnished: Provided, That no such payment shall be deemed overdue where the insurer or self-insurer has reasonable proof to establish that it is not responsible for the payment, notwithstanding that written notice has been furnished. For the purpose of calculating the extent to which any personal injury protection benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery. All overdue payments shall bear simple interest at the rate of eighteen percent (18%) per annum.

C. K.S.A. 40-2,126. - Interest Due On Insurance Settlements,

Except as otherwise provided by K.S.A. 40-447, 40-3110 and 44-512a, and amendments thereto, each insurance company, fraternal benefit society and any reciprocal or interinsurance exchange licensed to transact the business of insurance in this state which fails or refuses to pay any amount due under any contract of insurance within the time prescribed herein shall pay interest on the amount due. If payment is to be made to the claimant and the same is not paid within 30 calendar days after the amount of the payment is agreed to between the claimant and the insurer, interest at the rate of 18% per annum shall be payable from the date of such agreement. If payment is to be made to any other person for providing repair or other services to the claimant and the same is not paid within 30 calendar days following the date of completion of such services and receipt of the billing statement, interest at the rate of 18% per annum shall be payable on the amount agreed to between the claimant and the insurer from the date of receipt of the billing statement.

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