THE INSURANCE CODE OF 1956
Act 218 of 1956

AN ACT to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; to provide for assessment fees on certain health maintenance organizations; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for regulation over worker's compensation self-insurers; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to provide for an appropriation; to repeal acts and parts of acts; and to provide penalties for the violation of this act.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1977, Act 42, Imd. Eff. June 28, 1977;—Am. 1979, Act 145, Imd. Eff. Nov. 13, 1979;—Am. 1980, Act 41, Imd. Eff. Mar. 17, 1980;—Am. 1982, Act 194, Imd. Eff. June 28, 1982;—Am. 1986, Act 10, Imd. Eff. Feb. 28, 1986;—Am. 1986, Act 121, Imd. Eff. May 28, 1986;—Am. 1986, Act 173, Imd. Eff. July 7, 1986;—Am. 1989, Act 214, Eff. Jan. 1, 1990;—Am. 1991, Act 24, Imd. Eff. May 20, 1991;—Am. 1994, Act 228, Imd. Eff. June 30, 1994;—Am. 1998, Act 457, Imd. Eff. Jan. 4, 1999;—Am. 2002, Act 304, Imd. Eff. May 10, 2002.

Compiler's note: Act 143 of 1993, which amended this act, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled MCL 445.2003 of the Michigan compiled laws.

Popular name: Act 218

The People of the State of Michigan enact:

CHAPTER 1
SCOPE OF CODE

500.100 Insurance code of 1956; short title.

Sec. 100. This act shall be known and may be cited as "the insurance code of 1956".

History: 1956, Act 218, Eff. Jan. 1, 1957.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No.

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2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

Popular name: Act 218

Popular name: Essential Insurance

500.102 Definitions.

Sec. 102. As used in this act:

(a) "Commissioner" means the director.

(b) "Department" means the department of insurance and financial services.

(c) "Director" means, unless the context clearly implies a different meaning, the director of the department.

(d) "Office of financial and insurance regulation" and "office of financial and insurance services" mean the department.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2014, Act 509, Imd. Eff. Jan. 14, 2015;—Am. 2014, Act 566, Imd. Eff. Jan. 15, 2015;—Am. 2014, Act 571, Eff. Mar. 31, 2015.

Compiler's note: Enacting section 1 of Act 566 of 2014 provides:

"Enacting section 1. (1) This amendatory act shall not be construed to do any of the following:

(a) Authorize this state or an agency of this state to conduct or oversee state-level governmental consumer assistance functions for an American health benefit exchange established or operating in this state under the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(b) Convey any administrative, statutory, rule-making, or other power to this state or an agency of this state to authorize, establish, or operate an American health benefit exchange in this state that did not exist before the effective date of this amendatory act.

(2) It is the intent of this legislature that any consumer assistance functions by or overseen by this state or an agency of this state with regard to an American health benefit exchange shall be conducted in a manner that utilizes and highlights Michigan-based resources, including insurance producers, in order to best serve the residents of this state and to ensure appropriate health care decisions."

Enacting section 2 of Act 566 of 2014 provides:

"Enacting section 2. This amendatory act applies to policies, certificates, or contracts delivered, issued for delivery, or renewed in this state on and after the effective date of this amendatory act."

Popular name: Act 218

Popular name: Essential Insurance

500.103 “Revenue commissioner” defined.

Sec. 103. As used in this code, "revenue commissioner" means the state commissioner of revenue appointed under Act No. 122 of the Public Acts of 1941, being sections 205.1 to 205.31 of the Michigan Compiled Laws.

History: Add. 1990, Act 256, Imd. Eff. Oct. 15, 1990.

Popular name: Act 218

Popular name: Essential Insurance

500.106 "Health maintenance organization" and "insurer" defined.

Sec. 106. As used in this act:

(a) "Health maintenance organization" means that term as defined in section 3501.

(b) "Insurer" means an individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds organization, fraternal benefit society, or other legal entity, engaged or attempting to engage in the business of making insurance or surety contracts. Except as otherwise provided in section 3503 and unless the context requires otherwise, insurer includes a health maintenance organization.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: Essential Insurance

500.108 Authorized, unauthorized insurer; definitions.

Sec. 108. As used in this code:

(1) "Authorized" insurer means an insurer duly authorized, by a subsisting certificate of authority issued by the commissioner, to transact insurance in this state.

(2) "Unauthorized" insurer means an insurer not so authorized to transact insurance in this state.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

Popular name: Essential Insurance

500.110 Domestic, foreign, alien; definitions.

Sec. 110. As used in this code:

(1) "Domestic" insurer means an insurer formed under the laws of this state.

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(2) "Foreign" insurer means an insurer formed under the laws of the District of Columbia, or some state, commonwealth, territory, or possession of the United States of America other than the state of Michigan.

(3) "Alien" insurer means an insurer formed under the laws of a country other than the United States of America or any state, district, commonwealth, territory, or possession of the United States of America.

(4) Unless the context otherwise requires or unless the same subject is treated in this code by a provision expressly applying to alien insurers, the term "foreign insurer" as used in a particular section of this code shall be deemed to include also alien insurers.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

Popular name: Essential Insurance

500.114 Person; definition.

Sec. 114. "Person" as used in this code includes an individual, insurer, company, association, organization, Lloyds, society, reciprocal or inter-insurance exchange, partnership, syndicate, business trust, corporation, and any other legal entity.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

Popular name: Essential Insurance

500.115 Definitions.

Sec. 115. As used in this act unless the context clearly indicates otherwise:

(a) "Affiliate" or a person "affiliated" with a specific person means a person that directly, or indirectly through 1 or more intermediaries, controls, is controlled by, or is under common control with the person specified.

(b) "Control" including the terms "controlling", "controlled by", and "under common control with" mean the following:

(*i*) Except as otherwise provided in subparagraph (*ii*), the possession or the contingent or noncontingent right to acquire possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract including acquisition of assets or bulk reinsurance, other than a commercial contract for goods or nonmanagement services, by pledge of securities, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, by formal or informal arrangement, device, or understanding, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of any other person or for a mutual insurer owns 10% or more of the insurer's surplus through surplus notes, guarantee fund certificates or other evidence of indebtedness issued by the insurer. This presumption may be rebutted by a showing made in the manner provided by section 1332 that control does not in fact exist. The commissioner may determine after furnishing to all persons in interest notice and an opportunity to be heard and making specific findings of fact to support the determination that control in fact exists notwithstanding the absence of a presumption to that effect.

(*ii*) "Control", for the purpose of section 1243 and chapter 5 only, means 1 or more of the following:

(A) Ownership, control, or power to vote 25% or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through 1 or more other persons.

(B) Control in any manner over the election of a majority of the directors, trustees, or general partners or individuals exercising similar functions of the company.

(C) The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the commissioner determines.

(c) "Insurance holding company system" means 2 or more affiliated persons, 1 or more of which is an insurer.

(d) "Securityholder" of a specified person means a person who owns any security of the person, including common stock, preferred stock, debt obligations, and any other security convertible into or evidencing the right to acquire any of the foregoing.

(e) "Subsidiary" of a specified person means an affiliate controlled by that person directly or indirectly through 1 or more intermediaries.

(f) "Voting security" includes any security convertible into or evidencing a right to acquire a voting security.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

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Popular name: Essential Insurance

500.116 Additional definitions.

Sec. 116. As used in this act:

(a) "Enrollee" means an individual who is entitled to receive health services under a health insurance contract, unless the context requires otherwise.

(b) "Hazardous to policyholders, creditors, and the public" means that an insurer, with respect to the financial condition of its business, is not safe, reliable, and entitled to public confidence.

(c) "In the reasonable exercise of discretion" means that an order, decision, determination, finding, ruling, opinion, action, or inaction was based upon facts reasonably found to exist and was not inconsistent with generally acceptable standards and practices of those knowledgeable in the field in question.

(d) "Insurance policy" or "insurance contract" means a contract of insurance, indemnity, suretyship, or annuity issued or proposed or intended for issuance by a person engaged in the business of insurance. Unless the context requires otherwise, insurance contract includes a health maintenance contract, as that term is defined in section 3501.

(e) "Insurance producer" means that term as defined in section 1201.

(f) "Large employer" means an employer that is not a small employer as defined in section 3701.

(g) "Participating provider" means a provider that, under contract with an insurer that issues policies of health insurance or with such an insurer's contractor or subcontractor, has agreed to provide health care services to covered individuals and to accept payment by the insurer, contractor, or subcontractor for covered services as payment in full, other than coinsurance, copayments, or deductibles.

(h) "Safe, reliable, and entitled to public confidence" means that an insurer meets all of the following:

(*i*) With respect to its financial standards and conduct and discharge of its obligations to policyholders and creditors, has complied and continues to comply with the specific requirements of this act and, if relevant, the insurance codes or acts of its state of domicile and other states in which it is authorized to conduct an insurance business.

(*ii*) Has made and continues to make reasonable financial provisions and apply sound insurance principles so as to provide reasonable margins of financial safety with respect to the insurance and other obligations it has assumed and continues to assume such that the insurer will be able to discharge those obligations under any reasonable conditions and contingencies taking into account without limitation reasonably anticipated contingencies, including those affecting changes in the projections of liabilities, fluctuations in value of assets, alterations in projections as to when obligations may become due, and expected and unexpected new claims with respect to obligations.

(i) "Service area" means that term as defined in section 3501, unless the context requires otherwise.

(j) Except as used in chapters 24, 26, 72, 76, and 81, "subscriber" means an individual who enters into an insurance contract for health insurance, or on whose behalf an insurance contract for health insurance is entered into, with an insurer.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: Essential Insurance

500.118 Treatment of alien insurer as foreign insurer.

Sec. 118. If an alien insurer is domiciled in a country other than the United States that has an agreement with the United States whereby each agrees to treat insurers domiciled in the other country the same as insurers domiciled in its own country, the alien insurer may apply for a certificate of authority as a foreign insurer pursuant to section 424. If the certificate of authority as a foreign insurer is granted, the alien insurer shall be treated as a foreign insurer under this act, but only to the extent that the other country and its political subdivisions in which the alien insurer is domiciled actually extend like treatment to insurers domiciled in the United States.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

Popular name: Essential Insurance

500.120 Insurance, surety, or health maintenance organization transactions; compliance with act.

Sec. 120. A person shall not transact an insurance, surety, or health maintenance organization business in this state, or relative to a subject resident, located or to be performed in this state, without complying with the applicable provisions of this act.

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History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: Essential Insurance

500.121 Surety; rights; remedies; relief.

Sec. 121. (1) A person and a surety may agree to deposit any asset that the surety may be held responsible for into a financial institution that is authorized to transact business in this state in such manner as to prevent the withdrawal of the asset or any part of the asset except with the written consent of the surety or an order of the court made on such notice to the person and the surety as the court directs.

(2) A person acting in a fiduciary capacity who is required to obtain a bond may include the cost of obtaining the bond as part of the expense of acting as a fiduciary if allowed by the court to which the fiduciary is required to account and so long as the cost does not exceed 1% annually of the bond amount or an amount otherwise approved by the commissioner. The surety on a bond under this subsection may apply to the court for an order relieving the surety of liability for future acts of the fiduciary. Following notice and a hearing, the court may enter an order discharging the surety from liability arising out of acts or omissions occurring after the date of the order on such terms and conditions as the court considers necessary to protect the fiduciary estate and its beneficiaries.

(3) A person required to furnish a bond may use any surety that holds a certificate of authority issued under this chapter and so long as the amount of the bond is within the surety's risk limitation under section 640.

(4) Upon payment of the obligation secured by the bond, a surety is subrogated to the rights of the party to whom it made payment including any security or priority to which its subrogor was entitled.

(5) The corporate surety on a bond shall be released or discharged from its liability on the same terms and conditions as are applicable to the release or discharge of individual sureties. A surety has all rights, remedies, and relief to which an individual guarantor or indemnitor would be entitled.

History: Add. 2001, Act 182, Imd. Eff. Dec. 21, 2001.

Popular name: Act 218

Popular name: Essential Insurance

500.122 Applicability of Michigan antitrust reform act.

Sec. 122. Transactions or conduct authorized, prohibited, or permitted under a regulatory scheme under this code shall not be subject to the Michigan antitrust reform act, Act No. 274 of the Public Acts of 1984, being sections 445.771 to 445.788 of the Michigan Compiled Laws. The fact that a transaction or conduct concerns the business of insurance shall not exempt it from the Michigan antitrust reform act unless the activity has been authorized, prohibited, or permitted under a regulatory scheme under this code.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

Popular name: Essential Insurance

500.124 Exceptions.

Sec. 124. This code shall not apply to:

(a) Domestic farmers' and other special risk mutual property insurers, as identified in chapter 68, except as stated in chapter 68.

(b) Fraternal benefit societies, except as stated in chapter 81a.

(c) A multiple employer welfare arrangement regulated under chapter 70, except as provided in chapter 70.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1986, Act 121, Imd. Eff. May 28, 1986;—Am. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

Popular name: Essential Insurance

500.125 Service contract not subject to act; "consumer product" and "service contract" defined.

Sec. 125. (1) A service contract is not insurance or the business of insurance and is not subject to this act.

(2) As used in this section:

(a) "Consumer product" means any tangible personal property that is distributed in commerce and is normally used for personal, family, or household purposes, including any tangible personal property intended to be attached to or installed in any real property without regard to whether it is so attached or installed.

(b) "Service contract" means a written contract that is sold for stated consideration for a specific duration that provides any of the following:

(*i*) To perform or provide reimbursement for the repair, replacement, or maintenance of a consumer

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product because of the operational or structural failure of the consumer product due to a defect in materials or workmanship; accidental damage from handling, power surge, or interruption; or normal wear and tear, with or without additional provisions for incidental payment of indemnity under limited circumstances, including, but not limited to, towing, rental, and emergency road service.

(*ii*) The repair or replacement or indemnification for the repair or replacement of a motor vehicle for the operational or structural failure of 1 or more parts or systems of the motor vehicle brought about by the failure of an additive product to perform as represented.

(*iii*) The repair or replacement of tires or wheels on a motor vehicle damaged as a result of coming into contact with road hazards, including, but not limited to, potholes, rocks, wood debris, metal parts, glass, plastic, curbs, or composite scraps.

(*iv*) The removal of dents, dings, or creases on a motor vehicle that can be repaired using the process of paintless dent removal without affecting the existing paint finish and without replacing vehicle body panels, sanding, bonding, or painting.

(*v*) The repair of small motor vehicle windshield chips or cracks, or if a windshield cannot be repaired, the replacement of the windshield.

(*vi*) The replacement of an inoperable, lost, or stolen motor vehicle key or key fob.

History: Add. 2014, Act 110, Imd. Eff. Apr. 10, 2014.

Popular name: Act 218

Popular name: Essential Insurance

500.126 Waiver of customer liability agreement; definitions.

Sec. 126. (1) A waiver of customer liability agreement is not insurance or the business of insurance and is not subject to this act.

(2) As used in this section:

(a) "Service provider" means a public or private provider of electricity, natural gas, water, sewer, solid waste collection, or any other similar service, and any provider of communications services involving the transmission of data or any other information or signals utilizing any medium or method, including, but not limited to, cable or broadband service, IP-enabled voice service, cellular or mobile service, or any other similar service.

(b) "Waiver of customer liability agreement" means an optional agreement between a service provider and a customer of the service provider under which the service provider agrees, in return for a specified charge payable by the customer to the service provider, to waive all or a portion of the customer's liability to the service provider for incurred charges during a defined period in the event of any 1 or more of the following: the customer's call to active military service; involuntary unemployment; death; disability; hospitalization; marriage; divorce; evacuation; displacement due to natural disaster or other cause; qualification for family leave; or similar qualifying event or condition. A waiver of customer liability may be contained in the agreement under which the service provider provides services to the customer or in a separate agreement between the service provider and the customer.

History: Add. 2006, Act 432, Imd. Eff. Oct. 5, 2006.

Popular name: Act 218

Popular name: Essential Insurance

500.127 Guaranteed asset protection waiver; certificate of authority or license not required; issuance not construed as insurance; definitions.

Sec. 127. (1) A guaranteed asset protection waiver that is subject to the guaranteed asset protection waiver act is not insurance or the business of insurance and is not subject to this act.

(2) A person is not required to obtain a certificate of authority or license under this act to market, sell, or offer to sell guaranteed asset protection waivers in compliance with the guaranteed asset protection waiver act to borrowers.

(3) A guaranteed asset protection waiver issued before the effective date of the amendatory act that added this section shall not be construed as insurance.

(4) As used in this section, "borrower" and "guaranteed asset protection waiver" mean those terms as defined in section 3 of the guaranteed asset protection waiver act.

History: Add. 2009, Act 230, Imd. Eff. Jan. 8, 2010.

Popular name: Act 218

Popular name: Essential Insurance

500.128 Additional exceptions.

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Sec. 128. This code shall not apply to:

(a) Nonprofit organizations of a purely philanthropic or social character, which may issue protection for the benefit of their members in amounts not to exceed $150.00 death benefit or $6.00 per week sickness or accident benefit upon compliance with provisions of the nonprofit corporation act, Act No. 162 of the Public Acts of 1982, being sections 450.2101 to 450.3192 of the Michigan Compiled Laws, and with the further and additional requirements that commissions or fees shall not be charged in such transactions, nor shall these organizations be formed or operated principally or primarily for the purpose of issuing such policies or contracts of insurance.

(b) Organizations legally operating under exceptions to the application of the insurance code in force and effect heretofore, provided these organizations shall notify the commissioner of their intention to so continue, and shall furnish with that notice satisfactory proof of their eligibility under said exceptions. The commissioner shall not be required to accept any notice filed later than December 31, 1945.

(c) Those fraternal and other societies, orders, associations, and organizations exempted pursuant to section 8199, exempted fraternal societies and other organizations, but subject to the provisions of section 8199.

(d) Voluntary associations of employees which provide death, accident, or sickness benefits to persons employed by the same employer.

(e) The Mennonite aid association of Indiana and Michigan.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1986, Act 318, Eff. June 1, 1987;—Am. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

Popular name: Essential Insurance

500.129 Medical retainer agreement not subject to act.

Sec. 129. (1) A medical retainer agreement is not insurance and is not subject to this act. Entering into a medical retainer agreement is not the business of insurance and is not subject to this act.

(2) A health care provider or agent of a health care provider is not required to obtain a certificate of authority or license under this act to market, sell, or offer to sell a medical retainer agreement.

(3) To be considered a medical retainer agreement for the purposes of this section, the agreement must meet all of the following requirements:

(a) Be in writing.

(b) Be signed by the health care provider or agent of the health care provider and the individual patient or his or her legal representative.

(c) Allow either party to terminate the agreement on written notice to the other party.

(d) Describe and quantify the specific routine health care services that are included in the agreement.

(e) Specify the fee for the agreement.

(f) Specify the period of time under the agreement.

(g) Prominently state in writing that the agreement is not health insurance.

(h) Prohibit the health care provider and the patient from billing an insurer or other third party payer for the services provided under the agreement.

(i) Prominently state in writing that the individual patient must pay the provider for all services not specified in the agreement and not otherwise covered by insurance.

(4) As used in this section:

(a) "Health care provider" means an individual or other legal entity that is licensed, registered, or otherwise authorized to provide a health care service in this state under the public health code, 1978 PA 368, MCL 333.1101 to 333.25211. Health care provider includes an individual or other legal entity alone or with others professionally associated with the individual or other legal entity.

(b) "Medical retainer agreement" means a contract between a health care provider and an individual patient or his or her legal representative in which the health care provider agrees to provide routine health care services to the individual patient for an agreed-upon fee and period of time.

(c) "Routine health care service" means only the following:

(*i*) Screening, assessment, diagnosis, and treatment for the purpose of promotion of health or the detection and management of disease or injury.

(*ii*) Medical supplies and prescription drugs that are dispensed in a health care provider's office or facility site.

(*iii*) Laboratory work including routine blood screening or routine pathology screening performed by a laboratory that meets either of the following requirements:

(A) Is associated with the health care provider that is a party to the medical retainer agreement.

(B) If not associated with the health care provider as described in sub-subparagraph (A), has entered into

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an agreement with the health care provider that is a party to the medical retainer agreement to provide the laboratory work without charging a fee to the patient for the laboratory work.

History: Add. 2014, Act 522, Eff. Mar. 31, 2015.

500.132 Saving clause; incumbent officers.

Sec. 132. Continuation by this act of any state department or any office existing under any act repealed herein preserves such department and preserves the tenure of the individual holding such office at the effective date of this act.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

Popular name: Essential Insurance

500.134 Validity of certificate of authority or license in force prior to January 1, 1957; validity of plan of operation and premium or assessment; association or facility not state agency and money thereof not state money; records exempt from disclosure; premium or assessment not burden under MCL 500.476a; "association or facility" defined.

Sec. 134. (1) Every certificate of authority or license in force immediately prior to January 1, 1957 and existing under any act repealed by this act is valid until its original expiration date, unless earlier terminated in accordance with this act.

(2) Any plan of operation adopted by an association or facility, and any premium or assessment levied against an insurer member of that association or facility, is hereby validated retroactively to the date of its original adoption or levy and shall continue in force and effect according to the terms of the plan of operation, premium, or assessment until otherwise changed by the commissioner or the board of directors of the association or facility pursuant to this act.

(3) An association or facility or the board of directors of the association or facility is not a state agency and the money of an association or facility is not state money.

(4) A record of an association or facility shall be exempted from disclosure pursuant to section 13 of the freedom of information act, Act No. 442 of the Public Acts of 1976, being section 15.243 of the Michigan Compiled Laws.

(5) Any premium or assessment levied by an association or facility, or any premium or assessment of a similar association or facility formed under a law in force outside this state, is not a burden or special burden for purposes of a calculation under section 476a, and any premium or assessment paid to an association or facility shall not be included in determining the aggregate amount a foreign insurer pays to the commissioner under section 476a.

(6) As used in this section, "association or facility" means an association of insurers created under this act and any other association or facility formed under this act as a nonprofit organization of insurer members, including, but not limited to, the following:

(a) The Michigan worker's compensation placement facility created under chapter 23.

(b) The Michigan basic property insurance association created under section 29.

(c) The catastrophic claims association created under chapter 31.

(d) The Michigan automobile insurance placement facility created under chapter 33.

(e) The Michigan life and health insurance guaranty association created under chapter 77.

(f) The property and casualty guaranty association created under chapter 79.

(g) The assigned claims facility created under section 3171.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1988, Act 349, Imd. Eff. Nov. 15, 1988;—Am. 1990, Act 256, Imd. Eff. Oct. 15, 1990.

Compiler's note: Section 2 of Act 349 of 1988 provides:

The amendment to section 134 of Act No. 218 of the Public Acts of 1956, being section 500.134 of the Michigan Compiled Laws, pursuant to this amendatory act is intended to codify, approve, and validate the actions and long-standing practices taken by the associations and facilities mentioned in this amendatory act retroactively to the time of their original creation. It is the intent of this amendatory act to rectify the misconstruction of the applicability of the administrative procedures act of 1969 by the court of appeals in League General Insurance Company v Catastrophic Claims Association, Case No. 93744, December 21, 1987, with respect to the imposition of rule promulgation requirements on the catastrophic claims association as a state agency, and to further assure that the associations and facilities mentioned in this amendatory act, and their respective boards of directors, shall not hereafter be treated as a state agency or public body."

Popular name: Act 218

Popular name: Essential Insurance

500.140 Saving clause; existence of domestic insurer continued.

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Sec. 140. Any insurer heretofore formed or incorporated under any insurance law of this state, whose act of incorporation or act under which formed was repealed by Act No. 256 of the Public Acts of 1917 or is repealed by this act, shall continue to have a corporate existence (if a corporation) or existence (if other than a corporation), and shall have all the rights, privileges, immunities and limitations, obtained under such acts of incorporation or formation, as evidenced by their articles of incorporation, bylaws, power of attorney or constituent agreements made pursuant to such acts, as existing at the time this act takes effect; except, that all amendments to such articles of incorporation or powers of attorney or agreements shall be made hereafter in compliance with the provisions of this act, and all such insurers shall be otherwise governed by the provisions of this act. All reincorporations of such incorporated insurers, for the purpose of extending their corporate existence or for any other purpose shall be made only in compliance with this act, and any incorporated insurer heretofore incorporated under any insurance law of this state may reincorporate under this act.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

Popular name: Essential Insurance

500.142 Repealed. 1992, Act 182, Imd. Eff. Oct. 1, 1992

Compiler's note: The repealed section pertained to incorporation requirements for insurance companies.

Popular name: Act 218

Popular name: Essential Insurance

500.150 Violation of act; hearing; order of director; penalties; court order.

Sec. 150. (1) Any person who violates any provision of this act for which a specific penalty is not provided under any other provision of this act or of other laws applicable to the violation must be afforded an opportunity for a hearing before the director under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. If the director finds that a violation has occurred, the director shall reduce the findings and decision to writing and issue and cause to be served on the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from the violation. In addition, the director may order any of the following:

(a) Payment of a civil fine of not more than $1,000.00 for each violation. However, if the person knew or reasonably should have known that he or she was in violation of this act, the director may order the payment of a civil fine of not more than $5,000.00 for each violation. With respect to filings made under chapters 21, 22, 23, 24, and 26, "violation" means a filing not in compliance with those chapters and does not include an action with respect to an individual policy based on a noncomplying filing. An order of the director under this subdivision must not require the payment of civil fines exceeding $50,000.00. A fine collected under this subdivision must be turned over to the state treasurer and credited to the general fund.

(b) The suspension, limitation, or revocation of the person's license or certificate of authority.

(2) After notice and opportunity for hearing, the director may by order reopen and alter, modify, or set aside, in whole or in part, an order issued under this section if, in the director's opinion, conditions of fact or law have changed to require that action or the public interest requires that action.

(3) If a person knowingly violates a cease and desist order under this section and has been given notice and an opportunity for a hearing held under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director may order a civil fine of $20,000.00 for each violation, or a suspension, limitation, or revocation of the person's license, or both. A fine collected under this subsection must be turned over to the state treasurer and credited to the general fund.

(4) The director may apply to the court of claims for an order of the court enjoining a violation of this act.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1984, Act 7, Imd. Eff. Feb. 1, 1984;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

Popular name: Essential Insurance

CHAPTER 2
THE INSURANCE COMMISSIONER

500.200 Insurance department; establishment.

Sec. 200. There is hereby established a separate and distinct state department which shall be especially charged with the execution of the laws in relation to insurance and surety business and to perform such other duties as may be required by law: Provided, however, That the said department so established shall be deemed and considered as in continuation of and the successor to the insurance bureau established by Act No. 108 of

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the Session Laws of 1871, and other acts amending and supplementing the same, and as in continuation of and the successor to the state department established by Act No. 256 of the Public Acts of 1917 and other acts amending or supplementing the same.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Compiler's note: Act 108 of 1871, referred to in this section, was superseded by Act 256 of 1917. Act 256 of 1917, also referred to in this section, was repealed by Act 218 of 1956.

For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the commissioner of insurance to the commissioner of the office of financial and insurance services by type III transfer, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

Transfer of powers: See MCL 16.329 and 16.732.

Popular name: Act 218

500.202 Insurance commissioner; qualifications, office, term, appointment, approval, vacancy.

Sec. 202. (1) The chief officer of the department shall be known as the commissioner of insurance. He shall be a citizen of this state, shall have his office at the seat of government, shall personally superintend the duties of his office, and shall not be a stockholder or directly or indirectly connected with the management of affairs of any insurer. He shall be appointed by the governor for a term of 4 years by and with the consent of the senate.

(2) Whenever a vacancy occurs in the office of commissioner by reason of death, removal, or otherwise, the governor shall fill such vacancy by appointment, by and with the advice and consent of the senate, if in session.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

Transfer of powers: See MCL 16.732.

Popular name: Act 218

500.204 Insurance commissioner; salary; oath; bond.

Sec. 204. The commissioner shall receive an annual salary as the legislature shall appropriate, payable as other state officers are paid under the accounting laws of the state. Within 15 days from the time of notice of his or her appointment, the commissioner shall take and subscribe the constitutional oath of office and file the oath in the office of the secretary of state, and shall also within the same period give to the people of the state of Michigan a bond in the penal sum of $50,000.00, with sureties to be approved by the state treasurer, conditioned for the faithful discharge of the duties of his or her office.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2002, Act 105, Imd. Eff. Mar. 27, 2002.

Popular name: Act 218

500.205 Commissioner; powers.

Sec. 205. Orders, decisions, findings, rulings, determinations, opinions, actions, and inactions of the commissioner in this act shall be made or reached in the reasonable exercise of discretion.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.206 Insurance commissioner; seal, approval, renewal.

Sec. 206. The commissioner, with the approval of the governor, shall devise a seal, with suitable inscriptions, for his office, a description of which, with certificate of the approval of the governor, shall be filed in the office of the secretary of state, with an impression thereof, which seal shall thereupon be and become the seal of office of the commissioner of insurance and the same may be renewed whenever necessary.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.208 Office of financial and insurance services; offices; expense; audit.

Sec. 208. The department of management and budget shall assign to the office of financial and insurance services at Lansing suitable rooms for conducting the business of the division, the necessary expense of which

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shall be audited by the department of management and budget.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2002, Act 105, Imd. Eff. Mar. 27, 2002.

Popular name: Act 218

500.210 Insurance commissioner; regulatory powers.

Sec. 210. The commissioner shall promulgate rules and regulations in addition to those now specifically provided for by statute as he may deem necessary to effectuate the purposes and to execute and enforce the provisions of the insurance laws of this state in accordance with the provisions of Act No. 88 of the Public Acts of 1943, as amended, being sections 24.71 to 24.80 of the Compiled Laws of 1948, and subject to Act No. 197 of the Public Acts of 1952, as amended, being sections 24.101 to 24.110 of the Compiled Laws of 1948.

History: Add. 1966, Act 73, Imd. Eff. June 10, 1966.

Popular name: Act 218

Administrative rules: R 500.301 et seq.; R 500.351; R 500.402 et seq.; R 500.701 et seq.; R 500.801 et seq.; R 500.831; R 500.841 et seq.; R 500.901 et seq.; R 500.1051 et seq.; R 500.1201 et seq.; R 500.1301 et seq.; R 500.1351 et seq.; R 500.1371 et seq.; R 500.2031, R 500.2032; R 500.2101 et seq.; R 501.3 et seq.; R 501.152 et seq.; R 501.201; and R 550.1 et seq. of the Michigan Administrative Code.

500.212 Deputies, chief clerk and accountant, examiners, clerks, actuaries, and other assistants; oath; powers and duties; hearings; rights of parties; revocation of appointments, designations, and delegations of authority; compensation.

Sec. 212. (1) The commissioner may appoint a first deputy and second deputy who shall subscribe and file the constitutional oath of office. Either of these deputies may perform any duty or act of the commissioner during the commissioner's absence from the bureau. The commissioner may assign either of the deputies to take charge of the bureau during the commissioner's absence.

(2) The commissioner may appoint and employ a chief clerk and accountant, examiners, clerks, actuaries, and other necessary assistants, and may designate a chief examiner. The commissioner may designate special deputies from the commissioner's staff to perform specified duties, including supervision of the bureau during the absence of the commissioner and the first and second deputies.

(3) The commissioner may designate 1 or more persons to conduct hearings provided for under this code, hearings required by Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.315 of the Michigan Compiled Laws, and hearings which the commissioner considers necessary and appropriate for fact-finding or information gathering before making decisions, policies, and determinations allowable or required by law in the course of carrying out the duties of the commissioner. Before a person may conduct hearings, the person shall subscribe the constitutional oath of office and file the oath with the commissioner. Limitations imposed by the commissioner upon the authority of a deputy or a person designated by the commissioner to conduct hearings shall not be binding upon or limit the rights of the parties heard.

(4) The commissioner may revoke appointments, designations, and delegations of authority made pursuant to this section, in his or her discretion. Appointees and designees provided for in this section shall be paid in the manner prescribed by law.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1978, Act 497, Imd. Eff. Dec. 11, 1978.

Popular name: Act 218

500.214 Commissioner; immunity from civil liability; conditions.

Sec. 214. (1) The commissioner or his or her representatives are immune from civil liability, both personally and professionally, for any of their acts or omissions if all of the following are met:

(a) The commissioner or his or her representatives acted or reasonably believed he or she acted within the scope of his or her authority.

(b) The commissioner's or his or her representatives' conduct did not amount to gross negligence that was proximate cause of the injury or damages suffered.

(2) The commissioner or his or her representatives shall not be personally liable for the acts or omissions of others.

(3) Except as otherwise provided in this section, defense and indemnification of the commissioner or his or her representatives for an act or omission under this act shall be conducted in accordance with Act No. 170 of the Public Acts of 1964, being sections 691.1401 to 691.1415 of the Michigan Compiled Laws.

(4) If a claim is made or a civil action is commenced against the commissioner or his or her representatives, either personally or professionally, for an act or omission done in the course of employment as it pertains to chapter 78, chapter 81, or any successor chapter, legal representation shall be provided by the

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attorney general or a special assistant attorney general appointed to provide such representation.

(5) If the attorney general appoints a special assistant attorney general to represent the commissioner or his or her representatives, the costs of the defense shall be paid, as incurred, out of the insurer estate that is the subject of a claim arising out of a chapter 78, chapter 81, or any successor chapter proceeding.

(6) As a condition of the acceptance of the defense, the commissioner or his or her representatives shall agree to reimburse the costs of the defense, if it is finally determined by a final adjudication on the merits that the commissioner or his or her representatives acted outside of the scope of his or her authority and had no reasonable basis for believing that he or she acted within the scope of his or her authority and that his or her conduct amounted to gross negligence that was the proximate cause of the injury or damages suffered.

(7) If a judgment is awarded or a settlement is entered into in a civil action against the commissioner or his or her representatives for an act or omission pertaining to a chapter 78, chapter 81, or any successor chapter proceeding, the state shall indemnify the commissioner or his or her representatives out of the involved insurer's estate.

(8) This section does not apply to those persons acting as the commissioner's agents under section 438a.

(9) For purposes of this section:

(a) "Gross negligence" means conduct so reckless as to demonstrate substantial lack of concern for whether injury results.

(b) "Representative" means any employee of the commissioner or the insurance bureau or any person exercising power delegated by the commissioner in accordance with this act, but does not include accountants, actuaries, or lawyers retained as independent contractors and acting in their professional capacity.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.216 Insurance commissioner and employees; traveling and other expenses.

Sec. 216. The necessary traveling and other necessary and actual expenses of the commissioner, his deputies, examiners, actuaries or other employees, in discharging the duties imposed by this code, shall in all cases be allowed and audited by the accounting division of the department of administration, upon the approval of the commissioner, in accordance with the accounting laws of this state.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.220 Insurance commissioner and employees; service fees, prohibited gifts.

Sec. 220. The commissioner shall not retain as perquisites any fees or any moneys received by him directly or indirectly, for the performance of duties connected with his office. No insurance corporation or insurer or any officer, director, or agent thereof shall directly or indirectly, pay by way of gift, credit, loan or any other pretense whatsoever, any sum of money or other valuable thing to the commissioner, his deputies or any clerk or employee of the insurance department for extra service; and it shall be unlawful for the commissioner, his deputies or any clerk or employee of the insurance department to accept any such payment for extra service except such fees as may be specifically authorized by law to be paid to the commissioner to be covered into the state treasury.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.221 Insurance compliance self-evaluative audit document; privilege; disclosure; exceptions; definitions.

Sec. 221. (1) Except as otherwise provided in this section, an insurance compliance self-evaluative audit document is privileged information and is not discoverable or admissible as evidence in a civil, criminal, or administrative proceeding.

(2) Except as otherwise provided in this section, a person involved in preparing an insurance compliance self-evaluative audit or insurance compliance self-evaluative audit document is not subject to examination concerning the audit or audit document in a civil, criminal, or administrative proceeding. However, if the insurance compliance self-evaluative audit, insurance compliance self-evaluative audit document, or a portion of the audit or audit document is not privileged, the individual involved in the preparation of the audit or audit document may be examined concerning the portion of the audit or audit document that is not privileged. A person involved in preparing an insurance compliance self-evaluative audit or insurance compliance self-evaluative audit document who becomes aware of an alleged criminal violation of this act shall report the act to the insurer. Within 30 days after receiving the report, the insurer shall provide the information to the

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director.

(3) The director shall not provide an insurance compliance self-evaluative audit document, furnished to the director voluntarily or as a result of a request of the director under a claim of authority to compel disclosure under subsection (7), to any other person. The insurance compliance self-evaluative audit document must be accorded the same confidentiality and other protections as provided in section 222(7) without waiving the privileges in subsections (1) and (2). Any use of an insurance compliance self-evaluative audit document furnished voluntarily or as a result of a request of the director under a claim of authority to compel disclosure under subsection (7) is limited to determining whether or not any disclosed defects in an insurer's policies and procedures or inappropriate treatment of customers has been remedied or that an appropriate plan for remedy is in place.

(4) An insurance compliance self-evaluative audit document submitted to the director remains subject to all applicable statutory or common law privileges including, but not limited to, the work product doctrine, attorney-client privilege, or the subsequent remedial measures exclusion. An insurance compliance self-evaluative audit document submitted to the director remains the property of the insurer and is not subject to disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(5) Disclosure of an insurance compliance self-evaluative audit document to a governmental agency, whether voluntary or pursuant to compulsion of law, does not constitute a waiver of the privileges under subsections (1) and (2) with respect to any other person or other governmental agency.

(6) The privileges under subsections (1) and (2) do not apply to the extent that they are expressly waived by the insurer that prepared or caused to be prepared the insurance compliance self-evaluative audit document.

(7) The privileges in subsections (1) and (2) do not apply as follows:

(a) If a court, after an in camera review, requires disclosure in a civil or administrative proceeding after determining 1 or more of the following:

(*i*) The privilege is asserted for a fraudulent purpose.

(*ii*) The material is not subject to the privilege as provided under subsection (13).

(b) If a court, after an in camera review, requires disclosure in a criminal proceeding after determining 1 or more of the following:

(*i*) The privilege is asserted for a fraudulent purpose.

(*ii*) The material is not subject to the privilege as provided under subsection (13).

(*iii*) The material contains evidence relevant to the commission of a criminal offense under this act.

(8) Within 14 days after the director or the attorney general makes a written request by certified mail for disclosure of an insurance compliance self-evaluative audit document, the insurer that prepared the document or caused the document to be prepared may file with the Ingham County circuit court a petition requesting an in camera hearing on whether the insurance compliance self-evaluative audit document or portions of the audit document are subject to disclosure. Failure by the insurer to file a petition waives the privilege provided by this section for the request. An insurer asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this subsection shall include in its request for an in camera hearing all of the information listed in subsection (10). Within 30 days after the filing of the petition, the court shall issue an order scheduling an in camera hearing to determine whether the insurance compliance self-evaluative audit document or portions of the audit document are privileged or are subject to disclosure.

(9) If the court requires disclosure under subsections (7) and (8), the court may compel the disclosure of only those portions of an insurance compliance self-evaluative audit document relevant to issues in dispute in the underlying proceeding. Information required to be disclosed shall not be considered a public document and shall not be considered to be a waiver of the privilege for any other civil, criminal, or administrative proceeding.

(10) An insurer asserting the privilege under this section in response to a request for disclosure under subsection (8) shall provide to the director or the attorney general, at the time of filing an objection to the disclosure, all of the following information:

(a) The date of the insurance compliance self-evaluative audit document.

(b) The identity of the entity or individual conducting the audit.

(c) The general nature of the activities covered by the insurance compliance self-evaluative audit.

(d) An identification of the portions of the insurance compliance self-evaluative audit document for which the privilege is being asserted.

(11) An insurer asserting the privilege under this section has the burden of demonstrating the applicability of the privilege. Once an insurer has established the applicability of the privilege, a party seeking disclosure under subsection (7)(a)(*i*) has the burden of proving that the privilege is asserted for a fraudulent purpose. The director or attorney general seeking disclosure under subsection (7)(b)(*iii*) has the burden of proving the

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elements listed in subsection (7)(b)(*iii*).

(12) The parties may at any time stipulate in proceedings under this section to entry of an order directing that specific information contained in an insurance compliance self-evaluative audit document is or is not subject to the privileges provided under subsections (1) and (2). Any such stipulation may be limited to the instant proceeding and, absent specific language to the contrary, is not applicable to any other proceeding.

(13) The privileges provided under subsections (1) and (2) do not extend to any of the following:

(a) Documents, communications, data, reports, or other information expressly required to be collected, developed, maintained, or reported to a regulatory agency under this act or other federal or state law.

(b) Information obtained by observation or monitoring by any regulatory agency.

(c) Information obtained from a source independent of the insurance compliance audit.

(d) Documents, communication, data, reports, memoranda, drawings, photographs, exhibits, computer records, maps, charts, graphs, and surveys kept or prepared in the ordinary course of business.

(14) This section does not limit, waive, or abrogate the scope or nature of any other statutory or common law privilege.

(15) As used in this section:

(a) "Insurance compliance audit" means a voluntary, internal evaluation, review, assessment, audit, or investigation for the purpose of identifying or preventing noncompliance with or promoting compliance with laws, regulations, orders, or industry or professional standards, conducted by or on behalf of an insurer licensed or regulated under this act or that involves an activity regulated under this act.

(b) "Insurance compliance self-evaluative audit document" means a document prepared as a result of or in connection with an insurance compliance audit. An insurance compliance self-evaluative audit document may include a written response to the findings of an insurance compliance audit. An insurance compliance self-evaluative audit document may include, but is not limited to, field notes and records of observations, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, exhibits, computer-generated or electronically recorded information, phone records, maps, charts, graphs, and surveys, if this supporting information is collected or prepared in the course of an insurance compliance audit or attached as an exhibit to the audit. An insurance compliance self-evaluative audit document also includes, but is not limited to, any of the following:

(*i*) An insurance compliance audit report prepared by an auditor, who may be an employee of the insurer or an independent contractor, that may include the scope of the audit, the information gained in the audit, and conclusions and recommendations, with exhibits and appendices.

(*ii*) Memoranda and documents analyzing portions or all of the insurance compliance audit report and discussing potential implementation issues.

(*iii*) An implementation plan that addresses correcting past noncompliance, improving current compliance, and preventing future noncompliance.

(*iv*) Analytic data generated in the course of conducting the insurance compliance audit.

(c) "Insurer" means that term as defined in section 106 and includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

History: Add. 2001, Act 275, Eff. Mar. 22, 2002;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.222 Examination of insurers; examination report; hearing; public inspection; disclosure of confidential information; effect of current examination; director's authority to terminate or suspend examination not limited; limitation on foreign insurer examination.

Sec. 222. (1) The director, in person or by any of his or her authorized deputies or examiners, may examine any or all of the books, records, documents, and papers of an insurer at any time after its articles of incorporation have been executed and filed, or after it has been authorized to do business in this state. The director in his or her discretion may examine the affairs of a domestic insurer and, if he or she considers it expedient to do so, examine the affairs of a foreign or alien insurer doing business in this state.

(2) Instead of an examination under this act of a foreign or alien insurer authorized to do business in this state, the director may accept an examination report on the insurer as prepared by the insurance regulator for the insurer's state of domicile or port-of-entry state if that state accepts examination reports prepared by the director. This subsection applies only as follows:

(a) Until this state becomes accredited by the National Association of Insurance Commissioners' financial regulation standards and accreditation program.

(b) If this state loses accreditation by the National Association of Insurance Commissioners' financial regulation standards and accreditation program.

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(3) Instead of an examination under this act of a foreign or alien insurer authorized to do business in this state, the director may accept an examination report on the insurer as prepared by the insurance regulator for the insurer's state of domicile or port-of-entry state if that state accepts examination reports prepared by the director and if the insurance regulatory agency of the state of domicile or port-of-entry state was accredited by the National Association of Insurance Commissioners' financial regulation standards and accreditation program at the time of the examination or if the examination is performed under the supervision of an accredited insurance regulatory agency or with the participation of 1 or more examiners who are employed by an accredited insurance regulatory agency and who, after a review of the examination work papers and report, state under oath that the examination was prepared in a manner consistent with the standards and procedures required by their accredited regulatory agency. This subsection only applies during the time this state is accredited by the National Association of Insurance Commissioners' financial regulation standards and accreditation program.

(4) The director, in person or by any of his or her authorized deputies or examiners, shall once every 5 years examine the books, records, documents, and papers of each authorized insurer. The director may examine an insurer more frequently and on its request shall examine a domestic insurer that has not been examined for the 3 years preceding the request. This section does not authorize the examination of books, records, documents, or papers if those items involve matters that are a subject of a currently pending administrative or judicial proceeding against the insurer from whom the information is sought, unless the director or judge specifically finds on the record of the proceeding that the examination is reasonably necessary to protect the interests of policyholders, creditors, or the public or to make a determination of whether an insurer is safe, reliable, and entitled to public confidence.

(5) The business affairs, assets, and contingent liabilities of insurers are subject to examination by the director at any time. The director may supervise and make the same examination of the business and affairs of every foreign or alien insurer doing business in this state as of domestic insurers doing the same kind of business and of its assets, books, accounts, and general condition. A foreign or alien insurer and the agents and officers of the insurer are subject to the same obligations, the same examinations, and, if the insurer, agent, or officer defaults in an obligation, the same penalties and liabilities that a domestic insurer doing the same kind of business and the agents and officers of the insurer are subject to under the laws of this state or the rules promulgated by the director. The director may, whenever he or she considers it expedient to do so, either in person or by a person appointed by him or her, go to the general office or other offices of the foreign or alien insurer, wherever located, and make an investigation and examination of the insurer's affairs and condition.

(6) On an examination under this section, the director, his or her deputy, or any examiner authorized by him or her may examine in person, by writing, and, if appropriate, under oath the officers or agents of the insurer or all persons considered to have material information regarding the insurer's property, assets, business, or affairs. The director may compel the attendance and testimony of witnesses and the production of any books, accounts, papers, records, documents, and files relating to the insurer's business or affairs, and may sign subpoenas, administer oaths and affirmations, examine witnesses, and receive evidence for this purpose. The insurer and its officers and agents shall produce its books and records and all papers in its or their possession relating to its business or affairs, and any other person may be required to produce any books, records, or papers considered relevant to the examination for the inspection of the director, or his or her deputy or examiners, whenever required. The insurer's officers or agents shall facilitate the examination and aid in making the examination so far as it is in their power to do so. If the director's order or subpoena is not followed, the director may request the Ingham County circuit court to issue an order requiring compliance with the order or subpoena.

(7) Not later than 60 days after completing an examination under this section, the deputy or examiners shall make a full and true report, and furnish the insurer a copy of the examination report, that shall comprise only facts appearing on the insurer's books, records, or documents or ascertained from examination of its officers or agents or other persons concerning its affairs and the conclusions and recommendations as may be reasonably warranted from the facts disclosed. On request by an insurer examined under this section, the director shall grant the insurer a hearing before the director or his or her designee before the report is filed. On request of the insurer, the director shall close the hearing to the public. A hearing under this subsection is not subject to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. Each examination report must be withheld from public inspection until the report is final and filed with the director. In addition, the director may withhold any examination report or any analysis of an insurer's financial condition from public inspection for any time that he or she considers proper. In any event, the department shall withhold from public inspection all information and testimony furnished to the department and the department's work papers, correspondence, memoranda, reports, records, and other written or oral information related to an

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examination report or an investigation and these items are confidential, are not subject to subpoena, and must not be divulged to any person, except as provided in this section. If assurances are provided that the information will be kept confidential, the director may disclose confidential work papers, correspondence, memoranda, reports, records, or other information as follows:

(a) To the governor or the attorney general.

(b) To any relevant regulatory agency or authority, including regulatory agencies or authorities of other states, the federal government, or other countries.

(c) In connection with an enforcement action brought under this or another applicable act.

(d) To law enforcement officials.

(e) To persons authorized by the Ingham County circuit court to receive the information.

(f) To persons entitled to receive the information in order to discharge duties specifically provided for in this act.

(8) The confidentiality requirements of subsection (7) apply to a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373. The confidentiality requirements of subsection (7) do not apply in any proceeding or action brought against or by the insurer under this act or any other applicable act of this state, any other state, or the United States.

(9) Notwithstanding the other provisions of this section, the director is not required to finalize and file an examination report for an insurer for a year in which an examination report was not finalized and filed, if the insurer is currently undergoing an examination subsequent to the year for which an examination report was not finalized and filed. This section does not limit the director's authority to terminate or suspend any examination to pursue other legal or regulatory action under the insurance laws of this state. Findings of fact and conclusions made in connection with any examination under this section are prima facie evidence in any legal or regulatory action.

(10) The examination of an alien insurer is limited to its United States business, except as otherwise required by the director.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1959, Act 39, Eff. Mar. 19, 1960;—Am. 1986, Act 173, Imd. Eff. July 7, 1986;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 1994, Act 443, Imd. Eff. Jan. 10, 1995;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

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500.223 Application for certificate of authority; fee; withdrawal of application; reapplication fee; disposition.

Sec. 223. Any insurer making application for an original certificate of authority to transact insurance, or applying for a reissuance of a certificate of authority after the certificate has been terminated for any reason, shall pay to the commissioner the fee of $500.00 for examination, investigation, and processing of the application. If the application is withdrawn for any reason, the examination fee shall not be refunded. Any reapplication for an original certificate, after withdrawal, shall be subject to the same fee of $500.00 as in the case of an original application. The fees shall be deposited in the state treasury to the credit of the general fund.

History: Add. 1962, Act 50, Imd. Eff. Apr. 17, 1962;—Am. 1981, Act 1, Imd. Eff. Mar. 30, 1981.

Popular name: Act 218

500.224 Examinations and investigations of insurers; expenses; statement to insurers; employment of expert personnel; regulatory fees; expense of administering delinquency proceeding; definitions.

Sec. 224. (1) All actual and necessary expenses incurred in connection with the examination or other investigation of an insurer or other person regulated under the director's authority must be certified by the director, together with a statement of the work performed including the number of days spent by the director and each of the director's deputies, assistants, employees, and others acting under the director's authority. If correct, the expenses must be paid to the persons by whom they were incurred, on the warrant of the state treasurer payable from appropriations made by the legislature for this purpose.

(2) Except as otherwise provided in subsection (4), the director shall prepare and present to the insurer or other person examined or investigated a statement of the expenses and reasonable cost incurred for each person engaged on the examination or investigation, including amounts necessary to cover the pay and allowances granted to the persons by the Michigan civil service commission, and the administration and supervisory expense including an amount necessary to cover fringe benefits in conjunction with the examination or investigation. Except as otherwise provided in subsection (4), the insurer or other person, on receiving the statement, shall pay to the director the stated amount. The director shall deposit the money with

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the state treasurer as provided in section 225.

(3) The director may employ attorneys, actuaries, accountants, investment advisers, and other expert personnel not otherwise employees of this state reasonably necessary to assist in the conduct of the examination or investigation or proceeding with respect to an insurer or other person regulated under the director's authority at the insurer's or other person's expense except as otherwise provided in subsection (4). Except as otherwise provided in subsection (4), on certification by the director of the reasonable expenses incurred under this section, the insurer or other person examined or investigated shall pay those expenses directly to the person or firm rendering assistance to the director. Expenses paid directly to such person or firm and the regulatory fees imposed by this section are examination expenses under section 22e of the former single business tax act, 1975 PA 228, or under section 239(1) of the Michigan business tax act, 2007 PA 36, MCL 208.1239.

(4) An insurer is subject to a regulatory fee instead of the costs and expenses provided for in subsections (2) and (3). By June 30 of each year or within 30 days after the enactment into law of any appropriation for the department's operation, the director shall impose on all insurers authorized to do business in this state a regulatory fee calculated as follows:

(a) As used in this subsection:

(*i*) "A" means total annuity considerations written in this state in the preceding year.

(*ii*) "B" means base assessment rate. The base assessment rate must not exceed .00038 and must be a fraction, the numerator of which is the total regulatory fee and the denominator of which is the total amount of direct underwritten premiums written in this state by all insurers for the preceding calendar year, as reported to the director on the insurer's annual statements filed with the director.

(*iii*) "I" means all direct underwritten premiums other than life insurance premiums and annuity considerations written in this state in the preceding year by all insurers.

(*iv*) "L" means all direct underwritten life insurance premiums written in this state in the preceding year by all life insurers.

(*v*) Total regulatory fee must not exceed 80% of the gross appropriations for the department's operation for a fiscal year and must be the difference between the gross appropriations for the department's operation for that current fiscal year and any restricted revenues, other than the regulatory fee itself, as identified in the gross appropriation for the department's operation.

(*vi*) Direct premiums written in this state do not include any amounts that represent claims payments that are made on behalf of, or administrative fees that are paid in connection with, any administrative service contract, cost-plus arrangement, or any other noninsured or self-insured business.

(b) Two actual assessment rates must be calculated so as to distribute 75% of the burden of the regulatory fee shortfall created by the exclusion of annuity considerations from the assessment base to life insurance and 25% to all other insurance. The 2 actual assessment rates must be determined as follows:

(*i*) $\frac{L \times B + .75 \times B \times A}{L}$ = assessment rate for life insurance.

(*ii*) $\frac{I \times B + .25 \times B \times A}{I}$ = assessment rate for insurance other than life insurance.

(c) Each insurer's regulatory fee must be a minimum fee of $250.00 and must be determined by multiplying the actual assessment rate by the assessment base of that insurer as determined by the director from the insurer's annual statement for the immediately preceding calendar year filed with the director.

(5) Not less than 55% of the revenue derived from the regulatory fee under subsection (4) may be used for the regulation of financial conduct of persons regulated under the director's authority and for the regulation of persons regulated under the director's authority engaged in the business of health care and health insurance in this state.

(6) The amount, if any, by which amounts credited to the director under section 225 exceed actual expenditures under appropriations for the department's operation for a fiscal year must be credited toward the appropriation for the department in the next fiscal year.

(7) All money paid into the state treasury by an insurer under this section must be credited as provided under section 225.

(8) An insurer shall not treat a regulatory fee under this section as a levy or excise on premium but as a regulatory burden that is apportioned in relation to insurance activity in this state. A regulatory fee under this section reflects the insurance regulatory burden on this state as a result of this insurance activity. A foreign or alien insurer authorized to do business in this state may consider the liability required under this section as a burden imposed by this state in the calculation of the insurer's liability required under section 476a.

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(9) An insurer may file with the director a protest to the regulatory fee imposed not later than 15 days after receipt of the regulatory fee. The director shall review the grounds for the protest and hold a conference with the insurer at the insurer's request. The director shall transmit his or her findings to the insurer with a restatement of the regulatory fee based on the findings. Statements of regulatory fees to which protests have not been made and restatements of regulatory fees are due and must be paid not later than 30 days after their receipt. Regulatory fees that are not paid when due bear interest on the unpaid fee, which must be calculated at 6-month intervals from the date the fee was due at a rate of interest equal to 1% plus the average interest rate paid at auctions of 5-year United States treasury notes during the 6 months preceding July 1 and January 1, as certified by the state treasurer, and compounded annually, until the assessment is paid in full. An insurer who fails to pay its regulatory fee within the prescribed time limits may have its certificate of authority or license suspended, limited, or revoked as the director considers warranted until the regulatory fee is paid. If the director determines that a regulatory fee or a part of a regulatory fee paid by an insurer is in excess of the amount legally due and payable, the amount of the excess must be refunded or, at the insurer's option, be applied as a credit against the regulatory fee for the next fiscal year. An overpayment of $100.00 or less must be applied as a credit against the insurer's regulatory fee for the next fiscal year unless the insurer had a $100.00 or less overpayment in the immediately preceding fiscal year. If the insurer had a $100.00 or less overpayment in the immediately preceding fiscal year, at the insurer's option, the current fiscal year overpayment of $100.00 or less must be refunded.

(10) Any amounts stated and presented to or certified, assessed, or imposed on an insurer as provided in subsections (2), (3), and (4) that are unpaid as of the date that the insurer is subjected to a delinquency proceeding under chapter 81 are regarded as an expense of administering the delinquency proceeding and are payable as such from the general assets of the insurer.

(11) In addition to the regulatory fee provided in subsection (4), each insurer that locates records or personnel knowledgeable about those records outside this state under section 476a(3) or section 5256 shall reimburse the department for expenses and reasonable costs incurred by the department as a result of travel and other costs related to examinations or investigations of those records or personnel. The reimbursement must not include any costs that the department would have incurred if the examination had taken place in this state.

(12) As used in this section:

(a) "Annuity considerations" means receipts on the sale of annuities as used in section 22a of the former single business tax act, 1975 PA 228, or in section 235 of the Michigan business tax act, 2007 PA 36, MCL 208.1235.

(b) "Insurer" means an insurer authorized to do business in this state and includes nonprofit health care corporations, dental care corporations, and health maintenance organizations.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957;—Am. 1958, Act 196, Imd. Eff. Apr. 21, 1958;—Am. 1968, Act 275, Imd. Eff. July 1, 1968;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 228, Imd. Eff. June 30, 1994;—Am. 1998, Act 121, Imd. Eff. June 10, 1998;—Am. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2001, Act 143, Imd. Eff. Oct. 26, 2001;—Am. 2007, Act 187, Imd. Eff. Dec. 21, 2007;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.224a Report relating to regulatory fees.

Sec. 224a. Beginning June 1, 1995 and annually thereafter the commissioner shall report to the senate and house of representatives standing committees on insurance issues on revenues raised by the regulatory fees required by the amendatory act that added this section, how the regulatory fees were spread among domestic, foreign, and alien insurers, how the regulatory fees are being expended in regulating the domestic, foreign, and alien insurance industry, and whether new regulatory policy is needed to better protect the citizens of Michigan.

History: Add. 1994, Act 228, Imd. Eff. June 30, 1994.

Popular name: Act 218

500.224b Repealed. 2008, Act 440, Eff. Apr. 1, 2009.

Compiler's note: The repealed section pertained to quality assurance assessment fee.

Popular name: Act 218

500.225 Insurance bureau fund; creation; deposit of fees; reversion to general fund; use of fund.

Sec. 225. The insurance bureau fund is created in the state treasury as a separate fund. Except as otherwise specifically provided, all fees collected pursuant to this act or under the commissioner's authority shall be

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deposited in the insurance bureau fund. Money in the insurance bureau fund shall not revert to the general fund at the close of the fiscal year but shall remain in the insurance bureau fund. Money in the insurance bureau fund shall be used only for regulatory purposes under the commissioner's authority. However, money in the insurance bureau fund may be appropriated by the legislature to pay for legislators designated by the senate majority leader and speaker of the house of representatives to participate in insurance activities coordinated by insurance and legislative associations including the national association of insurance commissioners and the national council of insurance legislators.

History: Add. 1994, Act 228, Imd. Eff. June 30, 1994;—Am. 1998, Act 279, Imd. Eff. July 27, 1998.

Popular name: Act 218

500.225a Contract for services, supplies, and materials.

Sec. 225a. The commissioner shall contract for services, supplies, and materials pursuant to Act No. 428 of the Public Acts of 1980, being sections 450.771 to 450.776 of the Michigan Compiled Laws, and pursuant to the competitive bid requirements of the management and budget act, Act No. 431 of the Public Acts of 1984, being sections 18.1101 to 18.1594 of the Michigan Compiled Laws.

History: Add. 1994, Act 228, Imd. Eff. June 30, 1994.

Popular name: Act 218

500.226 Disclosure of confidential information; penalty.

Sec. 226. The commissioner or any of the commissioner's employees or agents shall not divulge confidential information acquired in the course of an examination or investigation except as permitted by section 222(7). A person appointed or acting under this act who discloses any fact or information that is confidential under this act is guilty of a misdemeanor, punishable by a fine of not more than $1,000.00, or imprisonment of not more than 1 year, or both. A conviction under this section shall automatically remove the person from his or her position or office.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.228 Examinations and investigations of insurers; report of crimes to attorney general.

Sec. 228. If it appears from an examination or other investigation made by the commissioner or if it appears from a report made to the commissioner pursuant to this act that a crime has been committed under a provision of this act or other law of the state, the commissioner shall immediately report the crime to the attorney general in writing, and the attorney general shall take such action on the report as the facts warrant.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.230 Recovery of penalty; disposition of funds.

Sec. 230. Every penalty provided for by this code, if not otherwise provided for, shall be sued for and recovered in the name of the people by the prosecuting attorney of the county in which the insurer or the agent or agents so violating shall be situated; and shall be paid into the treasury of said county; such penalties may also be sued for and recovered in the name of the people, by the attorney general, and, when sued for and collected by him, shall be paid into the state treasury.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.234 Insurance department; records of office; public inspection, exceptions, destruction, rules and regulations.

Sec. 234. (1) The office of the insurance department is a public office and the records, books, and papers thereof on file therein shall be public records, accessible to the inspection of the public, except as the commissioner, for good reason, may decide otherwise, or except as may be otherwise provided under this code.

(2) The commissioner is authorized to destroy or otherwise dispose of all records, books, papers, and other data on file with the department which in his opinion and on the advice of the attorney general, are of no further material value to the state of Michigan; but no destruction or other disposal thereof may be ordered or made by him of any records, books, papers, or other data required by law to be filed or kept on file with the department until the expiration of a period of 10 years, nor of any such records, books, papers, or other data filed during his administration or administrations. Such authorization shall be effected through official rules and regulations of the commissioner: Provided, however, That this authorization shall not extend to articles of

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incorporation, and amendments thereto, copies of bylaws and amendments thereto, copies of certificates or other written evidence of authorization to transact business or of approval of articles of incorporation and bylaws. A copy of the commissioner's rules and regulations herein provided for and any amendments thereto shall be mailed to each insurer authorized to do business in this state 60 days prior to the effective date thereof.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.236 Repealed. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Compiler's note: The repealed section pertained to a study assessing the condition of the commercial liability insurance market.

Popular name: Act 218

500.238 Insurance commissioner; annual report to governor, contents, publication.

Sec. 238. (1) The commissioner shall compile a report of the conduct of his office annually at such time each year as the information to be contained therein is available, which report shall be printed for public information and use in such number as the commissioner may deem advisable, not to exceed 1,500 copies. Such report shall be addressed to the governor and be for his information primarily.

(2) The commissioner shall publish in such annual report information contained in the annual statements of insurers filed with him pursuant to this code.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.240 Fees and charges; collection, payment, and disposition.

Sec. 240. (1) The director shall collect, and the person affected shall pay to the director, the following fees:

(a) Filing fee for original authorization to transact insurance or health maintenance organization business in this state, for each domestic, foreign, and alien insurer, and each health maintenance organization.....	$	25.00.
(b) Until the effective date of the 2016 amendatory act that amended this subdivision, filing fee for annual statement of foreign and alien insurers, each year, subject to section 476a.....	$	25.00.
(c) Producer's appointment fee, resident or nonresident, payable by insurer or health maintenance organization so represented, for each producer, each year.....	$	5.00.
(d) Application fee payable by each initial applicant for license as resident producer, nonresident producer, surplus lines producer, solicitor, counselor, or adjuster, not transferable or refundable.....	$	10.00.
(e) Solicitor's license, each year.....	$	10.00.
(f) Insurance counselor license, each year.....	$	10.00.
(g) Adjuster's license, each year.....	$	5.00.
(h) License examination fee, payable by applicant for all subjects covered in any 1 examination, or portion of an examination, for license as resident producer, surplus lines producer, solicitor, counselor, or adjuster, each examination, not transferable or refundable.....	$	10.00.
(i) Surplus lines producer license each year.....	$	100.00.

(2) An incorporated domestic insurer shall pay to the attorney general, for the examination of the insurer's articles of incorporation or any amendments to the articles of incorporation, $25.00.

(3) The fees and charges for official services performed by the director or the director's deputies or employees, when collected, must be turned over to the state treasurer and a receipt taken. The fees and charges provided for in this section must be deposited in the state treasury to the credit of the general fund.

(4) The examination fees described in subsection (1)(h) are applicable only if the examinations are administered by the director. If the examinations are administered by a designated authority other than the director, appropriate examination fees are payable directly to the designated authority.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1967, Act 221, Imd. Eff. July 10, 1967;—Am. 1979, Act 181, Imd. Eff. Dec. 18, 1979;—Am. 1981, Act 1, Imd. Eff. Mar. 30, 1981;—Am. 1987, Act 261, Imd. Eff. Dec. 28, 1987;—Am. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 558, Eff. Apr. 10, 2017.

Popular name: Act 218

500.244 Judicial review.

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Sec. 244. (1) A person aggrieved by a final order, decision, finding, ruling, opinion, rule, action, or inaction provided for under this act may seek judicial review in the manner provided for in chapter 6 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.301 to 24.306.

(2) An insurer may petition of right for a stay of an order issued pursuant to sections 436, 436a, and 437 or any other proceeding for the suspension, revocation, or limitation of a certificate of authority. The petition shall be on an emergency basis to the circuit court for the county in which the insurer has its principal place of business in the state or to the circuit court for Ingham county. The petition shall be disposed of within 14 days. The court shall direct the filing and time of filing of appropriate pleadings. A court shall not issue a stay unless the court finds that the issuance of a stay is not hazardous to policyholders, creditors, or the public. The decision of the court shall be limited to the issue of a stay, and the court shall not decide the merits of the case, which shall be determined pursuant to section 437 or to any other provision of this act under which the proceeding for the suspension, revocation, or limitation of the certificate of authority is being conducted.

(3) An order of a court issuing a stay may be appealed on an emergency basis, and during the pendency of an appeal the stay issued shall be without force or effect, unless the insurer deposits cash or securities pursuant to subsection (4). The appeal shall be disposed of within 14 days. The court shall direct the filing and time of filing of appropriate pleadings. The court may affirm, modify, or set aside the commissioner's order and restrain the enforcement of the order. To the extent that the commissioner's order is affirmed, the court shall issue its own order commanding obedience to the terms of the commissioner's order.

(4) A stay shall not take effect until the insurer has made deposits of cash or securities of the kinds defined by section 901 with the state treasurer under the supervision of the court granting the stay in amounts as follows:

(a) For a domestic insurer, the total liabilities of the insurer as computed in accordance with section 901 less the amounts of special or other deposits already made by the insurer with the Michigan state treasurer and with any other state pursuant to the requirements of that state.

(b) Except as otherwise provided in this subdivision, for a foreign insurer, 125% of the aggregate sum of Michigan direct unpaid losses and unpaid loss adjustment expenses plus 100% of Michigan direct unearned premiums less the amount of any other special deposits already made with the Michigan state treasurer for the exclusive protection of Michigan policyholders and creditors. For a foreign life or health insurer, 125% of Michigan reserves and liabilities for policies and contracts for which coverage is provided by the Michigan life and health insurance guaranty association, without respect to the limitations and exclusions provided under chapter 77.

(c) For an alien insurer entering the United States through this state, the same as those applied to domestic insurers with credit given for amounts already held in trust and the amount shall equal the total liabilities in the United States computed in accordance with section 901.

(5) The deposit and any accrued interest on the deposit shall be returned to the insurer at the conclusion of the entire proceedings under section 437 or at the conclusion of such other proceedings for the suspension, revocation, or limitation of the certificate of authority and any appeal therefrom, unless those proceedings result in a finding that all or a portion shall remain on deposit for the protection of Michigan policyholders and creditors or unless an order of rehabilitation or liquidation is entered, in which case the deposit shall be turned over to the liquidator.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2001, Act 272, Imd. Eff. Jan. 11, 2002 .

Popular name: Act 218

500.246 Repealed. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Compiler's note: The repealed section pertained to actions for violation of the act and immunity of witnesses.

Popular name: Act 218

500.248 Violations of act; actions; perjury.

Sec. 248. Any persons required by the provisions of this code to take any oath, or affirmation, who shall make any false oath or affirmation, shall be deemed guilty of perjury.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.249 Insurance commissioner; investigations of agents, adjusters, counselors, managers, promoters, officers and directors.

Sec. 249. For the purposes of ascertaining compliance with the provisions of the insurance laws of the state or of ascertaining the business condition and practices of an insurer or proposed insurer, the commissioner, as

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often as he deems advisable, may initiate proceedings to examine the accounts, records, documents and transactions pertaining to:

(a) Any insurance agent, surplus line agent, general agent, adjuster, public adjuster or counselor.

(b) Any person having a contract under which he enjoys in fact the exclusive or dominant right to manage or control an insurer.

(c) Any person holding the shares of voting stock or policyholder proxies of an insurer, for the purpose of controlling the management thereof, as voting trustee or otherwise.

(d) Any person engaged in or proposing to be engaged in or assisting in the promotion or formation of an insurer or insurance holding corporation, or corporation to finance an insurer or the production of its business.

(e) A person or organization owning stock representing 10% or more of the voting shares of an insurer.

(f) Any officer or director of an insurer.

History: Add. 1967, Act 262, Eff. Nov. 2, 1967.

Popular name: Act 218

500.249a Fingerprints required; costs; providing criminal history records.

Sec. 249a. (1) The following persons shall appear, at the commissioner's request, before the sheriff or any police agency for the county in which the person resides and request an impression of his or her fingerprints and shall pay the costs incurred under this section:

(a) Officers and directors or proposed officers and directors of the insurer and its affiliates.

(b) Controlling stockholders or proposed controlling stockholders of the insurer and its affiliates.

(c) Individuals who are or will be the source of direct or indirect funding of the insurer and its affiliates.

(d) Individuals involved or proposed to be involved in the management of the insurer and its affiliates.

(2) To the extent allowed by federal law, the commissioner may request and the department of state police shall provide state, multistate, and federal criminal history records for the commissioner's use in determining whether a certificate of authority to transact insurance in this state should be issued, suspended, or revoked; for approving any change of control of an insurer authorized to transact insurance in this state; or for determining the fitness of an officer or director of an insurer.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.250 Insurers; stock transfer; officers or directors; appointment; notice to director; grounds for removal; hearing; order; civil immunity; review; "insurer" defined.

Sec. 250. (1) All insurers licensed to do business in this state shall notify the director within 30 days of any transfer of stock that results in any 1 person holding 10% or more of the voting shares of an insurer. In addition, a domestic insurer shall notify the director within 30 days of the appointment or election of any new officers or directors.

(2) If, after proceedings under section 249, the director has reason to believe that an officer or director is untrustworthy or has abused his or her trust and that continuation as an officer or director is hazardous or injurious to the insurer, the policyholders, or the public, the director shall hold a hearing. After the hearing and after written findings that the officer or director is untrustworthy or has abused his or her trust and that continuation as an officer or director is hazardous or injurious to the insurer, the policyholders, or the public, the director may order the removal of the officer or director.

(3) If the insurer does not comply with a removal order under subsection (2) within 30 days, the director may suspend or revoke the insurer's certificate of authority until the insurer complies with the order.

(4) Any action under this section taken by an insurer or its directors or officers pursuant to an order of the director under this act must be considered to be in good faith and not be the basis for subjecting the insurer or its directors or officers to civil liabilities.

(5) An order of the director issued under this section is subject to review as provided in section 244.

(6) As used in this section, "insurer" includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

History: Add. 1967, Act 262, Eff. Nov. 2, 1967;—Am. 2002, Act 684, Imd. Eff. Dec. 30, 2002;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.251 Cease and desist order.

Sec. 251. (1) In the reasonable exercise of discretion, the commissioner may issue a cease and desist order if the commissioner finds any of the following:

(a) A person is conducting transactions of insurance for which a certificate of authority is required by this

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act without having obtained a certificate of authority.

(b) A person is acting as an insurance agent, solicitor, adjuster, or counselor without a license as required by this act.

(c) A person is engaged in an act or practice in the business of insurance for which authority from or notification to the commissioner is required by this act and the person has not received authority or given notification.

(d) A person authorized to engage in the business of insurance under this act is engaged in conduct that presents an immediate danger to public health, safety, or welfare.

(2) A cease and desist order under this section shall contain a description of the conduct to which the order applies and shall require the person to immediately cease and desist from that conduct.

(3) The commissioner shall serve the cease and desist order directly on the person affected by the order or shall serve the person by registered or certified mail, return receipt requested, to the address last known to the commissioner.

(4) A person who is the subject of a cease and desist order under this section may contest the order by requesting a hearing before the commissioner not later than 30 days after the order is delivered or mailed to the person. Within 10 days after receiving the request, the commissioner shall commence a hearing in accordance with the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws. Pending the hearing, the cease and desist order continues in full force and effect unless the order is stayed by the commissioner.

(5) Within 5 business days after the hearing, the commissioner shall affirm, modify, or set aside in whole or in part the cease and desist order.

(6) A person who violates or otherwise fails to comply with a cease and desist order under this section is subject to 1 or more of the following:

(a) Payment of a civil fine of not more than $1,000.00 for each violation not to exceed an aggregate civil fine of $30,000.00. However, if the person knew or reasonably should have known the person was in violation of the order, payment of a civil fine of not more than $25,000.00 for each violation not to exceed an aggregate civil fine of $250,000.00.

(b) Suspension or revocation of the person's license or certificate of authority.

(c) Complete restitution, in the form, amount, and within the period determined by the commissioner, to all persons in this state damaged by the violation or failure to comply.

(7) The commissioner may recover reasonable attorney fees if judicial action is necessary for enforcement of a cease and desist order under this section.

History: Add. 1996, Act 314, Eff. Mar. 31, 1997.

Popular name: Act 218

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500.261 Internet website; publication of changes and rights regarding automobile insurance in this state; reporting of fraud and unfair practices.

Sec. 261. (1) The department shall maintain on its internet website a page that does all of the following:

(a) Advises that the department may be able to assist a person who believes that an automobile insurer is not paying benefits, not making timely payments, or otherwise not performing as it is obligated to do under an insurance policy.

(b) Advises the person of selected important rights that the person has under chapter 20 that specifically relate to automobile insurers and the payment of benefits by automobile insurers.

(c) Allows the person to submit an explanation of the facts of the person's problems with the automobile insurer.

(d) Allows the person to submit electronically, or instructs the person how to provide paper copies of, any documentation to support the facts submitted under subdivision (c).

(e) Explains to the person the steps that the department will take and that may be taken after information is submitted under this section.

(2) The department shall maintain on its internet website a page that advises consumers about the changes to automobile insurance in this state that were made by the amendatory act that added this section, including, among any other information that the director determines to be important, ways to shop for insurance.

(3) The department shall maintain on its internet website a page or pages that allow a person to report fraud and unfair settlement and claims practices.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.271 Report to legislature on the effect of the limits imposed on charges for products,

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services, and accommodations under MCL 500.3157.

Sec. 271. By December 31 of 2022 and every year afterward through 2030, the department shall review the effect of changes made to section 3157 by the amendatory act that added this section and provide a report to the legislature on the department's findings.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

CHAPTER 4

AUTHORIZATION OF INSURERS AND GENERAL REQUIREMENTS

500.402 Insurers; certificate of authority requirement.

Sec. 402. A person shall not act as an insurer and an insurer shall not issue a policy or otherwise transact insurance in this state except as authorized by a subsisting certificate of authority granted to it by the director under this act.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.402a Transactions of insurance requiring certificate of authority.

Sec. 402a. In this state, the following transactions of insurance, whether effected by mail or otherwise, require a certificate of authority:

(a) The issuance or delivery of insurance contracts to residents of this state.

(b) The solicitation of applications for insurance contracts from residents of this state.

(c) The collection of premiums, membership fees, assessments, or other consideration for insurance contracts from residents of this state.

(d) The doing or proposing to do any act in substance equivalent to subdivisions (a) to (c).

History: Add. 1967, Act 111, Eff. Nov. 2, 1967;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.402b Transactions of insurance not requiring certificate of authority.

Sec. 402b. In this state, the following constitute transactions of insurance for which a certificate of authority is not required:

(a) Transaction of insurance under chapter 19.

(b) Transaction of reinsurance, except a transfer of direct obligations to policyholders by assumption reinsurance or other transaction to the same effect.

(c) Transaction of insurance on a risk not resident or located in this state at the time the insurance took effect, if the insurance was not written in this state.

(d) Transaction of group or blanket insurance or group annuities in which a master policy was lawfully issued to an employer located in another state for the benefit of employees residing in this state.

(e) Transaction of property or casualty insurance, under the same policy, on 1 or more risks resident or located both within and outside this state, if, under all the circumstances of the transaction, any appropriate part of the premium on the policy was apportioned to this state and if the policy was lawfully issued to a person resident in another state.

(f) Transaction of insurance as defined in sections 614 and 616.

(g) Transaction of insurance independently procured through negotiations occurring entirely outside of this state.

(h) Transaction of insurance by a nonprofit life insurance company, if the transactions involve life insurance, disability, or annuity contracts issued direct from the home office of the company, without agents or representatives in this state other than representatives servicing life insurance, disability, annuity contracts, or providing information upon request concerning other products of the company, only to or for the benefit of employees of nonprofit educational, scientific, or religious institutions. The transactions defined in this subdivision do not include those of a fraternal benefit society, as defined in section 8164.

(i) Transaction of group health insurance and incidental death and disability insurance if all of the following are met:

(*i*) The group health insurance and incidental death and disability insurance is maintained pursuant to a written collective bargaining agreement between a labor organization and 1 or more city, village, township, or county employers.

(*ii*) The labor organization demonstrates to the commissioner's satisfaction that it meets the definition of the term "labor organization" as defined in section 2(5) of the national labor relations act, chapter 372, 49

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Stat. 450, 29 U.S.C. 152.

(*iii*) The group health insurance and incidental death and disability insurance is regulated under the employee retirement income security act of 1974, Public Law 93-406, 88 Stat. 829, and is funded by a trust fund as described in section 302(c)(5) of title III of the labor management relations act, 1947, chapter 120, 61 Stat. 157, 29 U.S.C. 186.

History: Add. 1967, Act 111, Eff. Nov. 2, 1967;—Am. 1980, Act 341, Imd. Eff. Dec. 23, 1980;—Am. 1982, Act 195, Imd. Eff. June 30, 1982;—Am. 1987, Act 261, Imd. Eff. Dec. 28, 1987;—Am. 1988, Act 341, Imd. Eff. Oct. 18, 1988;—Am. 1990, Act 1, Eff. Apr. 1, 1990;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.402c Motor vehicle rental company; insurance transaction; definitions.

Sec. 402c. (1) A certificate of authority to transact insurance in this state is not required for the sale of any travel or auto-related insurance coverages by a motor vehicle rental company or its officers or employees in connection with and incidental to the rental of a motor vehicle.

(2) As used in this section:

(a) "Motor vehicle" means a motorized vehicle designed for transporting passengers or goods.

(b) "Motor vehicle rental company" means any person in the business of providing motor vehicles to the public under a rental agreement for a period not to exceed 90 days.

History: Add. 2002, Act 737, Imd. Eff. Dec. 30, 2002.

Compiler's note: Former MCL 500.402c, which pertained to determination that insurer is safe, reliable, and entitled to public confidence, was repealed by Act 158 of 1996, Imd. Eff. Apr. 3, 1996.

Popular name: Act 218

500.403 Insurers; authorization to do business.

Sec. 403. A domestic, foreign, or alien insurer shall not be authorized to do business in this state or continue to be authorized to do business in this state if the insurer is not or does not continue to be safe, reliable, and entitled to public confidence.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.404 Insurers; financial conditions; compliance required.

Sec. 404. Every like domestic, foreign, or alien insurer doing business in this state shall at all times be subject to the same standards and requirements concerning financial conditions and shall be in substantial compliance with those standards and requirements.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.405 Foreign insurer; revocation of certificate of authority; conditions; requalification for certificate of authority if control acquired; determination.

Sec. 405. (1) Except as provided in subsection (2), the certificate of authority of a foreign insurer with respect to whom control as defined in 115 changes after October 1, 1992 without being subject to the commissioner's approval shall be automatically revoked 90 days after the change in control without further action by the commissioner unless, within 90 days of the change of control or a longer period if the commissioner allows, the insurer requalifies for a certificate of authority under the provisions of this act in force as of the change of control. The certificate of authority shall be revoked under such conditions for the protection of policyholders, creditors, and the public as the commissioner may require. An insurer does not have to requalify for a certificate of authority under this subsection if the commissioner finds all of the following:

(a) The insurer's most recent a.m. best financial rating is at least an "A-" or is a comparable rating as assigned by a nationally recognized statistical rating organization approved by the commissioner.

(b) Following the change in control, the insurer meets the minimum capital and surplus requirements to qualify for and maintain authority to transact insurance in this state under section 410(2) and (3). However, the commissioner may waive the requirement of this subdivision if both of the following apply:

(*i*) The insurer possessed a certificate of authority to transact insurance in this state prior to the effective date of the amendatory act that added this subparagraph.

(*ii*) The commissioner finds that the insurer is otherwise safe, reliable, and entitled to public confidence.

(c) The insurer's total capital exceeds 2 times the company's authorized control level.

(d) The insurer's certificate of authority has not been suspended, revoked, or limited under section 436 at

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any time during the 5-year period immediately preceding the change of control.

(e) The insurer is not subject to an insurance regulatory information system priority 1 or 2 designation by the national association of insurance commissioners during the year immediately preceding the change of control.

(2) A person seeking to acquire control of a foreign insurer may request the commissioner to determine whether or not the commissioner would requalify the insurer for a certificate of authority if control is acquired. The commissioner shall determine within 90 days after the request is made whether or not the insurer would requalify for a certificate of authority if control is acquired. The commissioner's determination shall be in writing and shall state the commissioner's reasons as to why the commissioner would either grant or deny requalification for a certificate of authority if control is acquired. If the commissioner does not issue his or her determination within this 90-day period and the person seeking the request acquires control of the foreign insurer within 180 days after the request for a determination was made, the insurer shall be automatically requalified for a certificate of authority. If the commissioner issues an affirmative requalification determination and the person requesting the determination acquires control of the foreign insurer within 180 days after the request for a determination was made, the commissioner is prohibited from proceeding under subsection (1).

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 228, Imd. Eff. June 30, 1994;—Am. 1998, Act 457, Imd. Eff. Jan. 4, 1999.

Compiler's note: In the first sentence of subsection (1), the phrase “as defined in 115” evidently should read “as defined in section 115.”

Popular name: Act 218

500.405a Insurer subject to delinquency proceedings; revocation of certificate of authority; conditions.

Sec. 405a. If an insurer is subject in its state or country of domicile to formal delinquency proceedings within the meaning of chapter 81 or to a proceeding of similar effect, and the formal delinquency proceeding was properly commenced by the appropriate domiciliary regulatory authority on or after October 1, 1991, the certificates of authority of the insurer and of any current affiliated insurers of the insurer shall be automatically revoked 90 days after the effective date of the delinquency or other proceedings without further action by the commissioner unless, within the 90-day period or a longer period if the commissioner allows, each insurer requalifies for a certificate of authority under the provisions of this act then in force. A domestic insurer for purposes of requalification shall be treated as though it is a foreign insurer. The certificate of authority shall be revoked under such conditions for the protection of the public as the commissioner may require.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.405b Requalification pursuant to MCL 500.405 or 500.405a; formal review.

Sec. 405b. An insurer that seeks requalification pursuant to sections 405 or 405a is entitled to a formal review by the commissioner during which the insurer may submit information, documents, or other data to the commissioner in support of the application for requalification. The commissioner shall act upon the application by an order that embodies the commissioner's findings and reasons for the decision. A record of the review, including the information, documents, or other data submitted by the insurer to the commissioner in support of the application for requalification, shall be prepared by the insurance bureau and made available.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.406 Foreign insurer; limitation on corporate purposes and powers; election of statute; denial of admission or authority; continuation of license to transact insurance business previously authorized; exception.

Sec. 406. (1) A foreign insurer shall not be admitted to this state if the insurer's corporate purposes exceed those permitted for Michigan insurers.

(2) For the purpose of obtaining admission or renewal of authority to do business in this state, a foreign insurer, by proper corporate action, may limit its corporate purposes and powers with respect to business in this state, so that the corporate purposes do not exceed those of Michigan insurers authorized under the same classification. However, the foreign insurer, in its application for certificate of authority or for the corporate action referred to, shall elect the particular statute under which it desires admission or recertification.

(3) The commissioner may deny admission or continuance of authority to any foreign insurer engaged

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outside of this state in any kind or combination of kinds of business not permitted to be transacted by similar domestic insurers by the laws of this state, when in the commissioner's judgment the transacting of these kinds or combination of kinds of business is prejudicial to the best interests of the people of this state.

(4) Notwithstanding subsection (3), a foreign insurer which has been licensed to transact the business of life insurance in this state continuously since January 1, 1921, shall continue to be licensed to transact the kind or kinds of insurance business which it was authorized to transact in this state immediately before January 1, 1941. However, this subsection shall not apply if the commissioner finds, as to a specific insurer, that the kinds of business or combinations of kinds of business has become prejudicial to the best interests of the people of this state.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 12, Eff. Sept. 27, 1957;—Am. 1980, Act 342, Imd. Eff. Dec. 23, 1980.

Popular name: Act 218

500.407 Authorization to transact kinds of insurance; exceptions.

Sec. 407. An insurer that otherwise qualifies to transact insurance under this act may be authorized to transact any 1 kind or combination of kinds of insurance as defined in chapter 6 except:

(a) A life insurer is not authorized to transact any other kind of insurance except disability insurance as defined in section 606 unless it was engaged in transacting that other kind of insurance in this state prior to January 1, 1909.

(b) A reciprocal insurer is not authorized to transact life or health insurance.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1982, Act 501, Imd. Eff. Dec. 31, 1982;—Am. 1996, Act 548, Imd. Eff. Jan. 15, 1997.

Popular name: Act 218

500.407a Noninsured benefit plan; offering and writing excess loss insurance; definition; authority of insurer not limited.

Sec. 407a. (1) An insurer authorized to write insurance described in section 602 or 606 may offer and write specific or aggregate excess loss insurance to a noninsured benefit plan. An insurer that writes excess loss insurance shall comply with the applicable policy rate and form requirements under chapters 22, 24, and 30.

(2) As used in this section, "noninsured benefit plan" means that term as defined in section 5208.

(3) This section does not limit the authority of an insurer authorized to write insurance described in section 624 to offer and write specific or aggregate excess loss insurance to a noninsured benefit plan.

History: Add. 2002, Act 146, Imd. Eff. Apr. 2, 2002.

Popular name: Act 218

500.408 Insurers; capital, surplus, or asset requirement; schedule; multiple lines; provisions for transacting certain insurance; applicability of section; compliance with MCL 500.403.

Sec. 408. (1) To qualify for authority to transact insurance in this state a domestic, foreign, or alien insurer shall possess and thereafter maintain paid-in capital or surplus or assets in amounts that are not less than those shown by the applicable portion of the following schedule:

Kind of insurance	Domestic, foreign stock insurers CAPITAL	Domestic, foreign mutual life insurers SURPLUS	Domestic, foreign mutual insurers other than life ASSETS	Alien insurers United States ASSETS
Life	$ 200,000.00	$ 200,000.00	not applicable	$ 200,000.00
Life and disability	300,000.00	300,000.00	not applicable	300,000.00
Disability, except as provided in subsection (2), (3), or (4)	200,000.00	not applicable	$ 50,000.00	200,000.00
Property & marine	200,000.00	not applicable	50,000.00	200,000.00
Automobile	200,000.00	not applicable	50,000.00	200,000.00
Casualty	200,000.00	not applicable	50,000.00	200,000.00
Surety & fidelity	250,000.00	not applicable	250,000.00	250,000.00

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Surety, fidelity, casualty	450,000.00	not applicable	250,000.00	450,000.00

Kind of insurance	Reciprocal insurers ASSETS
Disability, except as provided in subsection (2), (3), or (4)	$ 50,000.00
Property & marine	50,000.00
Automobile	50,000.00
Casualty	50,000.00
Surety & fidelity	50,000.00
Surety, fidelity, casualty	50,000.00

Multiple lines: Any insurer may reinsure risks of every kind or description and write any and all kinds of insurance other than life insurance for which it is authorized while it maintains paid-up capital and surplus of not less than $500,000.00.

(2) An insurer authorized to transact casualty insurance shall also have authority to transact disability insurance without additional capital, surplus, or assets, as the case may be.

(3) A domestic stock insurer organized to insure on the monthly or weekly premium payment plan any person against bodily injury or death by accident or against disability on account of sickness, or to provide a cash funeral benefit not exceeding $500.00, shall have paid-in capital stock of not less than $25,000.00.

(4) As to a reciprocal insurer the authority to transact disability insurance, either alone or in combination with other insuring powers, does not include authority to transact health insurance.

(5) Financial requirements as to cooperative assessment life, disability, and loss of position insurers, as identified in chapter 64, shall be as provided in that chapter. Financial requirements as to domestic stock insurers formed to insure railway employees against loss of position, to transact disability and life insurance, and to make annuities as identified in section 6604 shall be as provided in section 6608.

(6) This section applies to domestic insurers organized prior to July 21, 1965 and to foreign and alien insurers not subject to the provisions of section 410. However, a domestic insurer organized prior to July 21, 1965 and any foreign or alien insurer not subject to the provisions of section 410 that attains the level of capital and surplus required by section 410(1), (2), or (3) is required thereafter to maintain that level of capital and surplus under section 410 unless the direct premiums written and any reinsurance assumed by the insurer in an annual period are less than the insurer's surplus.

(7) An insurer authorized to transact insurance on or after July 21, 1965 and before January 1, 1999 that attains the level of capital and surplus required by section 410(2) is required thereafter to maintain that level of capital and surplus under section 410 unless the direct premiums written and any reinsurance assumed by the insurer in an annual period are less than the insurer's surplus.

(8) Notwithstanding the specific requirements of this section, domestic, foreign, and alien insurers shall also comply with the standard set forth in section 403.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1958, Act 211, Eff. Sept. 13, 1958;—Am. 1965, Act 242, Imd. Eff. July 21, 1965;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 1994, Act 443, Imd. Eff. Jan. 10, 1995;—Am. 1998, Act 457, Imd. Eff. Jan. 4, 1999.

Popular name: Act 218

500.410 Minimum amount of unimpaired capital and surplus; minimum amount and use of additional surplus; transacting life insurance or property insurance; continuing to transact insurance; transacting legal expense insurance; compliance with MCL 500.403.

Sec. 410. (1) To qualify for and maintain authority to transact insurance in this state on or after July 21, 1965 and before January 1, 1999, a domestic, foreign, or alien insurer shall possess and thereafter maintain unimpaired capital and surplus in an amount determined adequate by the commissioner to continue to comply

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with section 403 but not less than $1,000,000.00. The commissioner shall take into account the risk based capital requirements as developed by the national association of insurance commissioners in order to determine adequate compliance with section 403.

(2) To qualify for and maintain authority to transact insurance in this state on or after January 1, 1999, a domestic, foreign, or alien insurer shall possess and thereafter maintain unimpaired capital and surplus in an amount determined adequate by the commissioner to continue to comply with section 403 but not less than $7,000,000.00. The commissioner shall take into account the risk based capital requirements as developed by the national association of insurance commissioners in order to determine adequate compliance with section 403.

(3) In addition to the minimum capital and surplus specified in subsections (1) and (2), an insurer applying for an initial certificate of authority after July 21, 1965 in this state shall possess and maintain surplus or additional surplus in an amount determined by the commissioner adequate to comply with section 403 for the kind or kinds of insurance it writes or proposes to write, but in no event less than $500,000.00.

(4) Except as provided by section 407, every insurer authorized to transact insurance in this state may transact life insurance or property insurance but not both, unless it was authorized to transact such other kind or kinds of insurance in this state immediately prior to January 1, 1965. For the purpose of this section, life insurance includes any 1 or more of the insurances described in sections 602 and 606; property insurance includes any 1 or more of the insurances described in chapter 6, excepting only section 602 and those provisions of section 632 that apply to insurances described in section 602. Nothing in this section shall be construed to broaden the authority of reciprocal insurers.

(5) Except as provided in subsection (7), an insurer authorized to transact insurance prior to July 21, 1965 may continue to transact insurance so long as it maintains the minimum financial requirements of section 408. However, an insurer authorized to transact insurance prior to July 21, 1965, that attains the level of minimum capital and surplus required by subsection (1) shall maintain compliance with this section unless the direct premiums written and any reinsurance assumed by the insurer in an annual period are less than the insurer's surplus.

(6) Except as provided in subsection (7), an insurer authorized to transact insurance on or after July 21, 1965 and before January 1, 1999 that attains the level of minimum capital and surplus required by subsection (2) shall maintain compliance with this section unless the direct premiums written and any reinsurance assumed by the insurer in an annual period are less than the insurer's surplus.

(7) An insurer shall not be authorized to transact legal expense insurance unless it meets the capital and surplus requirements of subsections (1), (2), and (3).

(8) Notwithstanding the specific requirements of this section, domestic, foreign, and alien insurers shall also comply with the standard set forth in section 403.

History: Add. 1965, Act 242, Imd. Eff. July 21, 1965;—Am. 1982, Act 501, Imd. Eff. Dec. 31, 1982;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 1994, Act 443, Imd. Eff. Jan. 10, 1995;—Am. 1998, Act 457, Imd. Eff. Jan. 4, 1999.

Popular name: Act 218

500.410a Bail bond surety and fidelity insurance company; authority to transact insurance.

Sec. 410a. (1) To qualify for and maintain authority to transact insurance in this state solely as a bail bond surety and fidelity insurance company on or after February 1, 2004, an insurer in good standing in its state of domicile that is subject to regulation by the commissioner shall possess and thereafter maintain unimpaired capital and surplus in an amount determined adequate by the commissioner to continue to comply with section 403 but not less than $4,500,000.00 and have, in addition, not less than $3,000,000.00 in current guarantees and security with respect to bail bonds issued by the insurer in states in which it is then authorized. An insurer with authority to transact bail bond surety and fidelity insurance in this state shall not offer or provide surety and fidelity coverages other than bail bonds.

(2) The commissioner shall take into account the risk based capital requirements as developed by the national association of insurance commissioners and the claims history for Michigan bail bonds issued by the licensed bail bond agencies for which the insurer will be or is issuing bail bonds in Michigan in order to determine adequate compliance with section 403.

(3) As used in this section, "bail bond surety and fidelity insurance" is surety and fidelity insurance that is limited to the provision of bail bonds.

History: Add. 2004, Act 113, Imd. Eff. May 21, 2004.

Popular name: Act 218

500.411 Deposits required to transact insurance.

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Sec. 411. (1) To qualify for and maintain authority to transact insurance in this state a domestic insurer shall maintain a deposit with the state treasurer of $300,000.00 or such larger amount as the commissioner considers appropriate taking into consideration the actual or anticipated premium volume of the insurer and the characteristics of, and the degree of risk inherent in, the insurance business written by the insurer. If a domestic insurer doing business on January 9, 1973 has assets of less than $750,000.00, the commissioner may approve a smaller deposit appropriate to the size of the insurer and the character of its business but not less than $50,000.00. The deposit shall consist of cash or securities at market value, exclusive of interest, of the kinds described in section 912. The deposit shall be held by the state treasurer for the benefit of the policyholders of the insurer and shall be administered as directed in section 464. A policyholder of an insurer includes any person having a legal or equitable right arising out of an insurance or annuity contract issued by the insurer.

(2) To qualify for and maintain authority to transact insurance in this state a foreign insurer shall maintain a deposit with the state treasurer or with the treasurer or other state officer of the state in which the insurer is domiciled of the same kinds, in the same amounts, and for the same purpose as required in subsection (1) for domestic insurers.

(3) To qualify for and maintain authority to transact insurance in this state an alien insurer entering through this state to transact insurance in the United States shall maintain a deposit with the state treasurer and an alien insurer entering through a state other than this state to transact insurance in the United States shall maintain a deposit with the state treasurer or with the treasurer or other state officer of the state through which the insurer entered of the same kinds, in the same amounts, and for the same purpose as required in subsection (1) for domestic insurers.

(4) To qualify for and maintain authority to transact insurance in this state an alien insurer shall maintain deposits, including those required in subsection (3), with the state treasurer, with officers of states other than this state or with trustees resident in the United States or with any combination of such persons, under trust indentures approved by the commissioner. The insurer shall cause the persons holding the deposits to make to the insurance regulatory authority of the state through which the insurer entered to transact insurance in the United States a report, under oath on or before March 1 of each year, of the insurer's deposits as of December 31 of the preceding year. The deposits shall be in cash or in securities of the kinds described in sections 910 to 947 and shall satisfy the following conditions:

(a) The deposits shall be not less than the amount of liabilities with respect to the insurer's business in the United States.

(b) The deposits, if the insurer is a life insurer, shall be held for the benefit of policyholders who were residents of the United States on the date of issuance of the policy and for the benefit of creditors of the insurer within the United States.

(c) The deposits, if the insurer is not a life insurer, shall be held for the benefit of policyholders and creditors within the United States.

(d) The securities deposited under this subsection shall be valued and limited in accordance with section 901.

History: Add. 1972, Act 360, Imd. Eff. Jan. 9, 1973;—Am. 1982, Act 338, Imd. Eff. Dec. 17, 1982;—Am. 1986, Act 321, Imd. Eff. Dec. 26, 1986;—Am. 1992, Act 2, Imd. Eff. Jan. 31, 1992;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.412 Procedure for becoming domestic insurer.

Sec. 412. (1) An insurer organized under the laws of any other state and admitted to do business in this state for the purpose of writing insurance may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a place in this state.

(2) An insurer who complies with subsection (1) shall be entitled to domestic insurer certificates and licenses to transact business in this state and shall be subject to the authority and jurisdiction of this state.

History: Add. 1989, Act 92, Imd. Eff. June 20, 1989.

Compiler's note: Former MCL 500.412, which pertained to deposits required to transact insurance business, was repealed by Act 137 of 1966, Eff. Mar. 10, 1967.

Popular name: Act 218

500.413 Transfer of domicile of domestic insurer to another state; effect of transfer; approval of transfer; "U.S. branch" defined.

Sec. 413. (1) Upon the approval of the commissioner, a domestic insurer may transfer its domicile to any other state in which it is admitted to transact the business of insurance, and upon the transfer shall cease to be

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a domestic insurer but shall be admitted to this state if qualified as a foreign insurer. The commissioner shall approve a proposed transfer unless he or she determines the transfer is not in the interest of the policyholders of this state. For purposes of this section, an alien insurer using this state as a state of entry to transact insurance in the United States through a U.S. branch is considered to be a domestic insurer.

(2) As used in this section, "U.S. branch" means that term as defined in section 431.

History: Add. 1989, Act 92, Imd. Eff. June 20, 1989;—Am. 1994, Act 227, Imd. Eff. June 27, 1994.

Compiler's note: Former MCL 500.413, which pertained to deposits required to transact insurance business, was repealed by Act 137 of 1966, Eff. Mar. 10, 1967;—Am. 1994, Act 227, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.414 Certificate of authority, agent's appointments, licenses, rates, and other items of transferring insurer continue in full force and effect; outstanding policies remain in full force and effect; filing new or existing policy forms; notice of proposed transfer; filing amendments to corporate documents.

Sec. 414. The certificate of authority, agent's appointments, licenses, rates, and other items which the commissioner allows, in his or her discretion, which are in existence at the time an insurer licensed to transact the business of insurance in this state transfers its corporate domicile to this or any other state by merger, consolidation, or any other lawful method shall continue in full force and effect upon the transfer if the insurer remains duly qualified to transact the business of insurance in this state. All outstanding policies of a transferring insurer shall remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the commissioner. Each transferring insurer shall file new policy forms with the commissioner on or before the effective date of the transfer, but may use existing policy forms with appropriate endorsements if allowed by, and under such conditions as approved by, the commissioner. Each transferring insurer shall notify the commissioner of the details of the proposed transfer and shall file promptly any resulting amendments to corporate documents filed or required to be filed with the commissioner.

History: Add. 1989, Act 92, Imd. Eff. June 20, 1989.

Compiler's note: Former MCL 500.414, which pertained to deposits required to transact insurance business, was repealed by Act 137 of 1966, Eff. Mar. 10, 1967.

Popular name: Act 218

500.415 Rules.

Sec. 415. The commissioner shall promulgate rules pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, to carry out the purposes of sections 412 to 414.

History: Add. 1989, Act 92, Imd. Eff. June 20, 1989.

Compiler's note: Former MCL 500.415, which pertained to deposits required to transact insurance business, was repealed by Act 137 of 1966, Eff. Mar. 10, 1967.

Popular name: Act 218

500.416 Special deposit.

Sec. 416. As a condition of qualifying for and maintaining authority to transact insurance in this state or for qualifying as an eligible unauthorized insurer, the commissioner may require an insurer to maintain a special deposit with the state treasurer in such amount as the commissioner considers necessary for the protection of Michigan policyholders and claimants. The special deposit is subject to special deposit claims pursuant to section 8141a.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Compiler's note: Former MCL 500.416, which pertained to deposits required to transact business was repealed by Act 360 of 1972, Imd. Eff. Jan. 9, 1973.

Popular name: Act 218

500.417 Repealed. 1966, Act 137, Eff. Mar. 10, 1967.

Compiler's note: The repealed section made provisions of code pertaining to stock life insurers relative to deposit of securities governing domestic automobile insurers.

Popular name: Act 218

500.418 Identification of payers subject to child support arrearages; "title IV-D agency" defined.

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Sec. 418. (1) An insurer may voluntarily cooperate with a title IV-D agency and the child support lien network in identifying payers subject to child support arrearages who may be entitled to money to be paid under a liability insurance policy or the liability coverage portion of a multiperil insurance policy.

(2) As used in this section, "title IV-D agency" means that term as defined in section 2 of the support and parenting time enforcement act, 1982 PA 295, MCL 552.602.

History: Add. 2004, Act 482, Imd. Eff. Dec. 28, 2004.

Compiler's note: Former MCL 500.418, which pertained to deposits required to transact insurance business, was repealed by Act 360 of 1972, Eff. Jan. 9, 1973.

Popular name: Act 218

500.422 Repealed. 1994, Act 226, Imd. Eff. June 27, 1994.

Compiler's note: The repealed section pertained to competition agreements by foreign or alien fire, marine, or inland insurers.

Popular name: Act 218

500.424 Admission of foreign or alien insurer to state; application; report of financial standing; issuance of certificate of authority; filing fees.

Sec. 424. (1) A foreign or alien insurer shall not be admitted to this state until the insurer files with the commissioner an application for admission upon a form as prescribed by the commissioner. The application shall be accompanied by a copy of the insurer's charter, compact, or articles of incorporation or agreement, and bylaws, duly certified by the commissioner of insurance or corresponding officer of the state of origin or entry, together with a sworn statement of the insurer's business affairs up to any date required by the commissioner to be furnished and any other information, under oath or otherwise, that the commissioner may demand of the applicant.

(2) In addition to subsection (1), an alien insurer shall make and execute under oath a report of its financial standing and of its deposit together with a full statement of its business in the United States for the year preceding the statement pursuant to section 438.

(3) The commissioner shall examine the application and if satisfied that the applicant is safe, reliable, and entitled to public confidence and meets the same financial conditions required of like insurers organized in this state, is authorized to do the kind or class of insurance it seeks to transact, and has complied in all other respects with the applicable laws of this state, the commissioner shall issue a certificate of authority to the applicant.

(4) The applicant shall pay the filing fees as provided by sections 223 and 240.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1972, Act 360, Imd. Eff. Jan. 9, 1973;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.425, 500.426 Repealed. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Compiler's note: The repealed sections pertained to admission of foreign mutual insurers to doing business and to application by foreign reciprocal insurer for application for certificate of authority to transact business.

Popular name: Act 218

500.430 Repealed. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Compiler's note: The repealed section pertained to a foreign or alien life or sickness and accident insurer on cooperative assessment plan.

Popular name: Act 218

500.431 Definitions.

Sec. 431. As used in sections 432 through 434:

(a) "Claimant" means any person or entity, supervisor, receiver, liquidator, rehabilitator, or conservator appointed for an alien insurer, and any guaranty association responsible for the payment of claims against the insurer, who has claims for costs and expenses of investigation or supervision pursuant to section 8109(11) or for receivership, liquidation, or payments of policyholders' claims.

(b) "Policy" means either of the following:

(*i*) Any contract of insurance or any agreement containing a covenant to insure that an alien insurer may be authorized to issue in any state and that is made by an alien insurer and delivered in or issued for delivery in the United States to any person resident in the United States at the time of issue, including any life insurance contract, annuity contract, disability insurance contract, guaranteed investment contract, reinsurance contract, and any contract issued on the maturity of and pursuant to any of the previously listed contracts, but excluding any contract, agreement, or portion of a contract or agreement either not guaranteed by an alien insurer or

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under which the risk is borne by the policyholder or claimant or where the recourse of policyholders or claimants for claims is limited to separate accounts.

(*ii*) For separate accounts, any group annuity or deposit contract or any other contract that an alien insurer is authorized to issue in any state, made by an alien insurer and delivered in or issued for delivery in the United States to any person resident in the United States at the time of issue that provides the right to allocate amounts to a particular trust as a separate account, including any contract issued on the maturity of and pursuant to a group annuity or deposit contract or any other contract that an alien insurer is authorized to issue in any state.

(c) "Policyholder" means the owner of, the certificate holder under, or the beneficiary under, a policy, including any other insurer if an alien insurer has issued to that insurer a reinsurance contract, and any pledgee, assignee, or other creditor having a security interest in the obligation arising out of a policy.

(d) "Qualified United States financial institution" means a state or nationally chartered bank or trust company, organized under the laws of any state or of the United States that has been granted authority to operate with fiduciary powers.

(e) "U.S. branch" means the business unit through which insurance is transacted within the United States by an alien insurer and the assets and liabilities of the insurer within the United States.

History: Add. 1994, Act 227, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.431a State of entry by alien insurer through U.S. branch; requirements.

Sec. 431a. (1) An alien insurer may use this state as a state of entry to transact insurance in the United States through a U.S. branch by qualifying as an insurer licensed to do business in this state and establishing a trust account pursuant to a trust agreement approved by the commissioner with a qualified United States financial institution approved by the commissioner, in an amount at least equal to the amount required by section 431c. With the prior approval of the commissioner, an alien insurer may establish more than 1 trust account pursuant to 1 or more trust agreements, provided that the aggregate of all amounts held in such trust accounts is at least equal to the amount required by section 431c.

(2) Before authorizing the entry through this state of a U.S. branch of an alien insurer, the commissioner shall require the alien insurer to do all of the following:

(a) Submit a copy of the proposed trust indenture for the commissioner's approval.

(b) Submit a copy of its charter, any current bylaws, and any other documents necessary to show the kinds of business that it is authorized to do in its domiciliary jurisdiction, attested to as accurate and complete by the insurance supervisory official in its domiciliary jurisdiction.

(c) Submit a full statement, subscribed and affirmed as true under the penalties of perjury by 2 officers or equivalent responsible representatives in such manner as the commissioner prescribes, of its financial condition as of the close of its latest fiscal year, showing its assets, liabilities, income, disbursements, business transacted, and other facts required to be shown in its annual statement, as reported to the insurance supervisory official in its domiciliary jurisdiction, together with an English language translation, as necessary, of any of the documents required.

(d) Submit to an examination of the insurer's affairs at its principal office within the United States unless the commissioner instead accepts a report of the insurance supervisory official of the insurer's domiciliary jurisdiction.

History: Add. 1994, Act 227, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.431b U.S. branch using state as state of entry to transact insurance; compliance.

Sec. 431b. A U.S. branch using this state as a state of entry to transact insurance in the United States is subject to all laws applicable to an insurer domiciled in this state except as otherwise provided. A U.S. branch using this state as a state of entry to transact insurance in the United States shall comply with all of the following requirements:

(a) Provide the commissioner, at intervals and in such form as the commissioner may require, having stated the reason for the requirement, with complete and accurate copies, current to within 10 days, of any of its books, records, and files requested by the commissioner, including all of the following:

(*i*) Corporate accounting records.

(*ii*) Records of its securities, notes, mortgages, and other evidences of indebtedness, representing investment of funds.

(*iii*) Minutes of meetings and resolutions of the board of directors, any committee of the board of directors, and the audit committee.

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(*iv*) Records of current premium billing and collection processing and active claims inventory.

(*v*) Records of all policies held by policyholders of the U.S. branch, including policy type, amount of reserve, riders, dividend accumulation, unit values, endowment, and policy loan balances.

(b) Upon the commissioner's request, provide the commissioner, for the commissioner's regulatory use, with appropriate waivers for the commissioner concerning rights in the information, including copyright or goodwill, information, manuals, and documentation sufficient for regulatory purposes concerning the computer system and software through which the insurer maintains its books, records, and files for its business in the United States.

(c) Upon the commissioner's request, obtain for the commissioner the right to use, at no additional charge, the computer software employed to maintain the books, records, and files listed in subdivision (a). This right of use shall be irrevocable and unconditional and shall include all revisions and upgrades, notwithstanding the insolvency or reorganization of the insurer.

(d) Arrange for testing to the commissioner's reasonable satisfaction of the processing of copies of the books, records, and files of the insurer listed in subdivision (a). This testing shall be performed annually or more frequently if requested by the commissioner at the office of the commissioner or at a business office of the insurer where such testing may take place at reasonable cost to the insurer.

History: Add. 1994, Act 227, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.431c Trusteed assets; value.

Sec. 431c. The assets in the trust accounts shall be known as trusteed assets. The total value of trusteed assets shall at all times be at least equal to the sum of the U.S. branch's reserves and other liabilities, the minimum capital and surplus required to be maintained by section 410, and any additional amounts considered necessary by the commissioner. The trusteed assets shall be valued and limited in accordance with section 901.

History: Add. 1994, Act 227, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.432 Trust agreement and amendments; authentication; withdrawal of approval; form; hearing; modifications or variations; contents and provisions of trust agreement; withdrawal of trusteed assets in another state; notice; examination by commissioner; effect of refusal or neglect to comply with subsection (8); review.

Sec. 432. (1) The trust agreement and all amendments to the trust agreement shall be authenticated in a form and manner prescribed by the commissioner and shall not be effective unless approved by the commissioner upon a finding of all of the following:

(a) That the trust agreement or its amendments are sufficient in form and in conformity with law.

(b) That the trustee or trustees are eligible to be trustees.

(c) That the trust agreement is adequate to protect the interests of the beneficiaries of the trust.

(2) If at any time the commissioner finds after reasonable notice and hearing that the trust agreement no longer meets the requirements of subsection (1), the commissioner may withdraw approval of the trust agreement. The withdrawal of approval shall be in the form of a final order or decision and shall clearly set forth the findings and the reasons for the withdrawal of approval. A hearing under this subsection is not subject to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws.

(3) The commissioner may from time to time approve modifications of or variations in any trust agreement that in the commissioner's judgment are not prejudicial to the interests of the people of this state or the United States and of policyholders and claimants of the U.S. branch.

(4) The trust agreement shall contain all of the following:

(a) The vesting of legal title to trusteed assets in a trustee and its lawfully appointed successors.

(b) A requirement that, except with the approval of the commissioner for assets held in custodial or similar accounts, all assets deposited in the trust shall be continuously kept within the United States.

(c) Provisions for substitution of a new trustee in case of a vacancy subject to the commissioner's approval.

(d) A requirement that the trustee shall continuously maintain a record at all times sufficient to identify the trust's assets.

(e) A requirement that the trusteed assets shall consist of cash or investments eligible for investment of the funds of domestic insurers and accrued interest on those assets if collectible by the trustee.

(f) A requirement that the trust shall be for the exclusive benefit, security, and protection of the policyholders and claimants of the U.S. branch and that it shall be maintained as long as there is outstanding

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any liability of the alien insurer arising out of its insurance transactions in the United States.

(g) A provision that no withdrawals of assets, other than income as specified in subsection (5), shall be made or permitted by the trustee without the commissioner's approval except to do the following:

(*i*) Substitute other assets permitted by law and at least equal in value and quality to those withdrawn, upon the specific written direction of the United States manager when duly empowered and acting pursuant to either general or specific written authority previously given or delegated by the board of directors. Substituted assets are of the same quality if, for securities, they are rated "BBB" or above by Moody's or Standard & Poor's or are rated category 1 or 2 by the national association of insurance commissioners or, for other assets, are not in arrears, were acquired by the alien insurer in an arm's length transaction from an unaffiliated third party within 30 days prior to the substitution and, for interests in mortgages, the mortgages comply with section 942.

(*ii*) If the income of the trust is not paid over as specified in subsection (5), pay liabilities of the insurer to a policyholder or in satisfaction of a contractual provision in a policy, provided that the total trusteed assets are not thereby less than the amount required to be maintained pursuant to section 431c.

(*iii*) Transfer assets to an official liquidator or rehabilitator pursuant to an order of a court of competent jurisdiction.

(h) A provision that withdrawals of assets shall be made or permitted by the trustee only with the commissioner's approval and only if a deposit is required by law in any state for the security or benefit of all policyholders, or policyholders and claimants, of the U.S. branch in the United States.

(5) The trust agreement may provide that income, earnings, dividends, or interest accumulations of the fund's assets may be paid over to the United States manager of the U.S. branch upon request, provided that the total trusteed assets are not thereby less than the amount required to be maintained pursuant to section 431c.

(6) Upon withdrawal of trusteed assets deposited in another state in which the insurer is authorized to do business, it is sufficient if the trust agreement requires similar written approval of the insurance supervising official of that state in lieu of approval by the commissioner provided that the total trusteed assets are not thereby less than the amount required to be maintained pursuant to section 431c.

(7) For all withdrawals, the U.S. branch shall give the commissioner at least 15 days' prior notice in writing of the nature and extent of the proposed withdrawal. For a withdrawal due to overfunding, it shall be considered that the commissioner has approved the withdrawal in either of the following cases:

(a) The commissioner has not responded to the request in any manner within 15 days after receipt of the notice.

(b) After the U.S. branch has replied to any request by the commissioner for further information concerning the proposed withdrawal, the commissioner does not respond further in any manner within 15 days after receipt of the reply.

(8) The commissioner may make examinations from time to time of the trusteed assets of any authorized U.S. branch and may require the trustee to file a statement, in such form as the commissioner may prescribe, certifying the trust fund's assets and amount.

(9) Refusal or neglect of any trustee to comply with the requirements of subsection (8) is grounds for injunctive relief and other remedies including suspension, limitation, or revocation of the insurer's license, liquidation of its U.S. branch, or the trustee's removal. If removal occurs prior to the appointment of a new trustee, the trusteed assets shall be deposited with the commissioner or as the commissioner directs. Failure of any trustee to comply with the other requirements of this section is grounds for suspension, limitation, or revocation of the insurer's license or the liquidation of its U.S. branch.

(10) Within 90 days after the effective date of this section, the commissioner shall inform each U.S. branch that the trust agreement in force on that date to which the U.S. branch is party is subject to review by the commissioner and the approximate date of the review. Following the review, the commissioner shall inform the relevant U.S. branch in a written notice of any deficiencies in its trust agreements. The U.S. branch shall amend or replace its trust agreement in accordance with this amendatory act within 30 days after receiving the notice from the commissioner.

History: Add. 1994, Act 227, Imd. Eff. June 27, 1994.

Compiler's note: Former MCL 500.432, which pertained to the continuation of certificate of authority, was repealed by Act 360 of 1972, Imd. Eff. Jan. 9, 1973.

Popular name: Act 218

500.432a Certificate of authority to do business; issuance or amendment to U.S. branch; proof that insurer will not violate act or charter; noncompliance.

Sec. 432a. (1) Before issuing or amending a certificate of authority to do business to any U.S. branch, the commissioner may require satisfactory proof, either in the alien insurer's charter or by an agreement

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evidenced by a duly certified resolution of its board of directors or otherwise as the commissioner requires, that the insurer will not engage in any insurance business that violates this act or that is not authorized by its charter.

(2) A U.S. branch that does outside of this state any kind or combination of kinds of insurance business not permitted to be done in this state by similar domestic insurers hereafter organized, shall not be or continue to be authorized to do any insurance business in this state, unless in the commissioner's judgment the doing of those kinds of insurance outside of this state will not be prejudicial to the best interests of the residents of this state.

(3) Except as otherwise specifically provided, a U.S. branch, entering through this state or another state, shall not be or continue to be authorized to do the business of insurance in this state if it fails to comply substantially with any requirement or limitation of this act applicable to similar domestic insurers hereafter organized that in the judgment of the commissioner is reasonably necessary to protect the interest of the policyholders.

History: Add. 1994, Act 227, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.433 Trusteed assets below minimum required; proceeding against alien insurer.

Sec. 433. If it appears to the commissioner from any annual or quarterly statement or any other report that a U.S. branch's trusteed assets are below the minimum required to be maintained pursuant to section 431c, the commissioner may proceed against the alien insurer pursuant to the provisions of chapter 81 as an insurer whose condition no longer meets the requirements of section 403.

History: Add. 1994, Act 227, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.434 Repealed. 1972, Act 360, Imd. Eff. Jan. 9, 1973.

Compiler's note: The repealed section pertained to grounds for revocation of certificates of authority.

Popular name: Act 218

500.435 Certificate of authority as evidence of authority to transact insurance; duration of certificate; certificate as property of state; prerequisites to termination of certificate.

Sec. 435. (1) The certificate of authority issued by the commissioner to an insurer is evidence of its authority to transact the kind or kinds of insurance specified in the certificate in this state.

(2) A certificate of authority shall remain in force until terminated at the request of the insurer or suspended or revoked by the commissioner.

(3) A certificate of authority at all times remains the property of the state. Upon termination at the request of the insurer or revocation by the commissioner, the certificate of authority shall be delivered promptly by the insurer to the commissioner.

(4) The commissioner shall not grant the request of an insurer to terminate its certificate of authority as long as the insurer has any obligations outstanding under a policy of insurance to policyholders or claimants who are residents of this state unless either of the following occurs:

(a) The insurer has deposited with the state treasurer securities acceptable to the commissioner in an amount equal to its liabilities including its reserves as required by this act in respect to its business in this state, as computed by the commissioner, for the sole benefit of its policyholders and creditors resident in this state. The deposits shall be held by the state treasurer and administered as directed by section 464.

(b) The insurer has made other provisions satisfactory to the commissioner to secure obligations to Michigan policyholders or claimants.

History: Add. 1972, Act 360, Imd. Eff. Jan. 9, 1973;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.436 Conditions for suspension, revocation, or limitation of certificate of authority; "insurer" defined.

Sec. 436. (1) The director may suspend, revoke, or limit the certificate of authority of an insurer if he or she determines that any of the following conditions exist:

(a) The insurer no longer meets the requirements of this act respecting capital, surplus, deposits, or assets.

(b) The insurer's condition is such that it is no longer safe, reliable, or entitled to public confidence or is unsound, or the insurer is using financial methods and practices in the conduct of its business that render further transaction of insurance by the insurer in this state hazardous to policyholders, creditors, or the public.

(c) The insurer's certificate of authority to transact business in its state of domicile, or in the case of an

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alien insurer, in its state of entry, has been suspended or revoked.

(d) The insurer has failed, after written request by the director, to remove or discharge an officer or director whose record of business conduct does not satisfy the requirements of section 436a(1)(k) or 1315(1)(f) or who has been convicted of any crime involving fraud, dishonesty, or like moral turpitude.

(e) The insurer fails to promptly comply with sections 222 or 438.

(f) The insurer has failed for an unreasonable period to pay any final judgment rendered against it in this state on any policy, bond, recognizance, or undertaking issued or guaranteed by it.

(g) The insurer has failed, within 30 days after notice of delinquency from the director, to cure its failure to pay the taxes, fees, assessments, or expenses required by this act.

(h) The insurer has violated any other provision of this act that provides for suspension or revocation of its certificate of authority.

(2) As used in this section, "insurer" includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

History: Add. 1972, Act 360, Imd. Eff. Jan. 9, 1973;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.436a Continuing operation of insurer transacting insurance in state or nonprofit dental corporation operating under MCL 550.351 to 550.373; standards; subscription to private rating organization not required; determination of financial condition; issuance of order by director; hearing requested by insurer.

Sec. 436a. (1) In addition to any other relevant standards, the director may consider 1 or more of the following to determine whether the continued operation of an insurer transacting an insurance business in this state or a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373, is safe, reliable, and entitled to public confidence or is considered hazardous to policyholders, creditors, or the public:

(a) Affirmative or adverse findings reported in financial condition and market conduct examination reports.

(b) The National Association of Insurance Commissioners' insurance regulatory information system and its related reports.

(c) Whether the ratios of commission expense, general insurance expense, policy benefits, and reserve increases as to annual premium and net investment income could likely lead to an impairment of capital and surplus.

(d) Whether the insurer's asset portfolio, when viewed in light of current economic conditions, is of sufficient value, liquidity, or diversity to assure the insurer's ability to meet its outstanding obligations as they mature.

(e) Whether the ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the insurer's remaining surplus after taking into account the insurer's cash flow, the classes of business written, and the financial condition of the assuming reinsurer.

(f) The insurer's operating loss in the last 12-month period or any shorter period of time, including, but not limited to, net capital gain or loss, change in assets, and cash dividends paid to shareholders, in relation to the insurer's remaining capital and surplus in excess of the amount required to comply with section 403.

(g) Whether any affiliate, subsidiary, or reinsurer is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligation.

(h) Contingent liabilities, pledges, or guaranties that either individually or collectively involve a total amount that in the director's opinion may affect the insurer's solvency.

(i) Whether any controlling person of an insurer is delinquent in transmitting or the payment of net premiums to the insurer or has caused the insurer to divert assets, make investments, or assume liabilities with respect to the affiliates of the insurer that have had a material adverse effect on the insurer's financial solidity.

(j) The age and collectibility of receivables.

(k) Whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of the insurer, possesses and demonstrates the competence, fitness, and character considered necessary to serve the insurer in such a position.

(*l*) Whether management of an insurer has failed to respond to inquiries relative to the insurer's condition or has furnished false and misleading information concerning an inquiry.

(m) Whether management of an insurer has filed a materially false or misleading financial statement, has released a materially false or misleading financial statement to lending institutions or to the general public, or has made a materially false or misleading entry or has omitted an entry of material amount in the insurer's books.

(n) Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and

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administrative capacity to timely meet its obligations.

(o) Whether the insurer has experienced or will experience in the foreseeable future cash flow or liquidity problems.

(p) Subject to subsection (3), ratings and rating reports concerning the insurer from rating organizations that meet all of the following requirements:

(*i*) Are registered under the investment advisors act of 1940, 15 USC 80b-1 to 80b-21.

(*ii*) Have adequate training, supervision, and continuing education for its analysts.

(*iii*) Make a determination as to whether the company being rated has the ability to service and repay its debts.

(*iv*) Assign a credit committee to each rated company, members of which are changed annually.

(*v*) Give rated companies a right of appeal as to the rating received prior to publication.

(*vi*) Maintain continuous monitoring as to the rating in the event of significant developments.

(*vii*) Maintain an employee code of ethics and an internal procedure to prevent misuse of information, such as a prohibition against conflict of interest.

(q) Whether the insurer demonstrates material adverse deviations from industry averages with respect to significant indicators of financial solidity such as leverage, liquidity, profitability, reinsurance, investment risk, and reserve adequacy.

(r) The extent to which the insurer meets standards of financial solidity such as risk based capital requirements as developed by organizations with recognized expertise in evaluating the financial condition of insurers such as the National Association of Insurance Commissioners.

(s) The size of the insurer as measured by its assets, capital and surplus reserves, premium writings, insurance in force, and other appropriate criteria.

(t) The extent to which the insurer's business is diversified among the several lines of insurance, the number and size of risks insured in each line of business, and the extent of the geographical dispersion of the insurer's insured risks.

(u) The nature and extent of the insurer's reinsurance program.

(v) The quality, diversification, and liquidity of the insurer's investment portfolio.

(w) The recent past and projected future trend in the size of the insurer's surplus as regards policyholders and the surplus as regards policyholders maintained by other comparable insurers.

(x) The adequacy of the insurer's reserves.

(y) The quality and liquidity of investments in affiliates.

(z) Compliance by the insurer with section 901.

(2) For purposes of the standards set forth in subsection (1), the director may consider a nonprofit dental care corporation in the same manner as an insurer.

(3) The director shall not require an insurer to subscribe to a private rating organization.

(4) The director may do any of the following in making a determination of an insurer's financial condition under this section:

(a) Disregard any credit or amount receivable resulting from transactions with a reinsurer that has totally ceased writing new business or that is insolvent, impaired, or otherwise subject to a delinquency proceeding.

(b) Make appropriate adjustments including disallowance to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates.

(c) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the account's age or the debtor's financial condition.

(d) Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken.

(5) If the director determines that an insurer authorized to transact business in this state has ceased to be safe, reliable, and entitled to public confidence or that the insurer's continued operation may be hazardous to policyholders, creditors, or the public, the director, in addition to his or her authority under section 437 and chapter 81, may issue an order requiring the insurer to do any of the following:

(a) Reduce the total amount of present and potential liability for policy benefits by sound reinsurance transactions approved by the director.

(b) Reduce, suspend, or limit the volume of business being accepted or renewed.

(c) Reduce general insurance and commission expenses by specified methods.

(d) Increase the insurer's capital and surplus.

(e) Suspend or limit the declaration and payment of dividends by an insurer to its stockholders or to its policyholders.

(f) File reports in a form acceptable to the director concerning the market value of an insurer's assets.

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(g) Limit or withdraw from certain investments or discontinue certain investment practices.

(h) Document the adequacy of premium rates in relation to the risks insured.

(i) File, in addition to regular annual statements, interim financial reports on the form or in the format promulgated by the director.

(j) Correct corporate governance practice deficiencies and adopt and use governance practices that are acceptable to the director.

(6) An insurer subject to an order under subsection (5) may request a hearing as in a contested case pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to review the order. The notice of hearing must be served on the insurer and state the time and place of hearing and the conduct, conditions, or grounds on which the director based the order. Unless mutually agreed between the director and the insurer, the hearing must occur not less than 10 days or more than 30 days after notice is served. The director shall hold all hearings under this subsection privately unless the insurer requests a public hearing, in which case the hearing must be public.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.436b Certificate of authority limited by order of commissioner.

Sec. 436b. If the commissioner finds on the basis of appropriate investigation and public hearings that a type of insurance or a subset of a type of insurance or of other contracts entered into by insurers authorized to do business in this state present a degree of risk or hazard to the insurer not adequately taken into account by insurance accounting techniques or normal methods of measuring insurance or other contractual risk, the commissioner may conclude that only those authorized insurers possessed of a sufficient degree of financial strength, measured by relevant methods, techniques, analysis, rating systems, and other appropriate financial standards uniformly applied, may engage with safety to policyholders, creditors, or the public in assuming obligations of such a type or subset of a type of insurance or other contracts. In these circumstances, the commissioner may limit by appropriate order the certificate of authority of an insurer that does not possess such a sufficient degree of financial strength so as to preclude prospectively the authority of the insurer to engage in assuming obligations in this state of such a type or subset of a type of insurance or other contracts.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.437 Proceeding for suspension, revocation, or limitation of certificate of authority; notice; imposition of conditions in order of limitation.

Sec. 437. (1) A proceeding to suspend, revoke, or limit an insurer's certificate of authority shall be initiated by the commissioner by granting the insurer an opportunity to show compliance with all lawful requirements as provided under section 92 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being section 24.292 of the Michigan Compiled Laws. If the commissioner subsequently determines pursuant to section 436 to suspend, revoke, or limit the insurer's certificate of authority, the determination and the reasons for the determination shall be stated in the order of suspension, revocation, or limitation.

(2) The insurer aggrieved by the commissioner's determination and order issued under section 436 shall be entitled to a contested case hearing pursuant to Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws. During the pendency of the contested case proceeding, the commissioner's order shall remain in effect, except as modified by the commissioner or as stayed by a court pursuant to section 244.

(3) The commissioner's order and determination may be confirmed or modified by the commissioner as the result of a contested case hearing and shall be the final decision or order in the contested case.

(4) Upon suspension, revocation, or limitation of an insurer's certificate of authority, if the commissioner considers it necessary or desirable for the protection of the public, he or she may mail notice of the action to the insurer's agents and publish notice of the suspension, revocation, or limitation in 1 or more newspapers of general circulation in the state.

(5) The commissioner's order of limitation may restrict the solicitation of new business within the state, may restrict the renewal of business in force within the state, may require the reinsurance of business in force within the state and, if reinsurance is not effected within 30 days after the order requiring reinsurance is issued, may require cancellation of business in force within the state and may impose such other conditions to continued authorization as are reasonably necessary to protect policyholders, creditors, and the public.

History: Add. 1972, Act 360, Imd. Eff. Jan. 9, 1973;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

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500.438 Annual statement; filing; extensions; format and content; reply to inquiries; availability of report to public; penalty for failure to file statement or reply to inquiry; statement of alien insurer; "U.S. branch" defined.

Sec. 438. (1) An insurer, foreign, alien, U.S. branch, or domestic, transacting business within this state, shall annually, on or before March 1, prepare under oath and deposit with the director a statement concerning its affairs in a form and manner as prescribed by the director. The annual statement must be filed on or before March 1 of the year following that covered by the statement. On request and for good cause shown, the director may grant to a company reasonable extensions of the March 1 filing date for periods not to exceed 30 days.

(2) The director shall prescribe the format and content of statements that are suitable and adaptable to each kind of insurer authorized by this act. The director shall include requests for information on important elements of an insurer's business, including any matter, condition, or requirement regulated by this act. An annual statement filed by an insurer under this section must be prepared in accordance with instructions provided by, and accounting practices and procedures designated by, the director.

(3) The director may address inquiries to an insurer, in relation to the insurer's activities or conditions, or any matter connected with the insurer's transactions. The insurer shall promptly reply in writing to each inquiry described in this subsection.

(4) A report filed with the director under this section must be made available to the public in compliance with the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(5) An authorized insurer that does not make or deposit the annual statement required by this section, or does not reply within 30 days to an inquiry of the director, is subject to a civil penalty of not less than $1,000.00 or more than $5,000.00, and an additional $50.00 for every day that the insurer does not make and deposit the annual statement or reply to the inquiry. In addition, an insurer that does not make and deposit an annual statement, or does not make a satisfactory reply to an inquiry of the director, concerning the insurer's affairs is subject to proceedings under section 436.

(6) The annual statement of an alien insurer must relate only to the insurer's assets, transactions, and affairs in the United States unless the director requires otherwise.

(7) As used in this section, "U.S. branch" means that term as defined in section 431.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957;—Am. 1959, Act 39, Eff. Mar. 19, 1960;—Am. 1978, Act 506, Imd. Eff. Dec. 13, 1978;—Am. 1986, Act 173, Imd. Eff. July 7, 1986;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 227, Imd. Eff. June 27, 1994;—Am. 2016, Act 558, Eff. Apr. 10, 2017.

Popular name: Act 218

500.438a Domestic, foreign, and alien insurers; filing annual statement with national association of insurance commissioners; foreign insurers considered in compliance with section; agents of commissioner; confidentiality of information.

Sec. 438a. (1) Each domestic, foreign, and alien insurer authorized to transact insurance in this state shall file annually on or before March 1 of each year, with the national association of insurance commissioners a copy of its annual statement along with additional filings for the preceding year as prescribed by the commissioner. The information filed with the national association of insurance commissioners shall be in the same format and scope as that required by the commissioner and shall include the signed jurat page and any actuarial certification. An amendment or addendum to the annual statement filing subsequently filed with the commissioner shall also be filed with the national association of insurance commissioners.

(2) A foreign insurer that is domiciled in a state that has a law substantially similar to subsection (1) shall be considered in compliance with this section.

(3) In the absence of actual malice, members of the national association of insurance commissioners, their duly authorized committees, subcommittees, and task forces, their delegates, national association of insurance commissioners employees, and all others charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from the filing of an annual statement shall be acting as the commissioner's agents under the authority of this act and shall not be subject to civil liability for libel, slander, or any other cause of action because of their collection, review, and analysis or dissemination of the data and information collected from the filings.

(4) All financial analysis ratios and examination synopses concerning insurers that are submitted to the commissioner by the national association of insurance commissioners' insurance regulatory information system are confidential and may not be disclosed by the commissioner or those acting under the commissioner's authority.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

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Popular name: Act 218

500.439 Repealed. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Compiler's note: The repealed section pertained to reciprocal insurers, annual report, and fee.

Popular name: Act 218

500.440 Repealed. 1987, Act 261, Imd. Eff. Dec. 28, 1987.

Compiler's note: The repealed section pertained to specific premium tax on business written by foreign insurer.

Popular name: Act 218

500.440a Credit against tax imposed by MCL 500.476a; claim; refund; retroactive application.

Sec. 440a. (1) Beginning August 3, 1987, an insurer that is subject to the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, may credit against the tax imposed by section 476a an amount equal to the amount paid during that tax year by the insurer under section 352 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.352, as certified by the director of the bureau of worker's disability compensation under section 391 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.391.

(2) The credit under this section shall be claimed in the manner prescribed by the revenue commissioner.

(3) A taxpayer claiming a credit under this section shall claim a portion of the credit allowed by this section equal to the payments made during a calendar quarter pursuant to section 352 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.352, against the quarterly payments required under section 443. The state treasurer shall refund a credit in excess of a quarterly payment to the taxpayer on a quarterly basis within 60 days after receipt of a properly completed quarterly filing as required by this act. A subsequent increase or decrease in the amount claimed for payments made by the insurer or self-insurer shall be reflected in the amount of the credit taken for the calendar quarter in which the amount of the adjustment is finalized.

(4) Except as otherwise provided in this subsection, the state treasurer shall refund, without interest, a credit under this section that is in excess of the insurer's tax liability for the calendar year to the insurer within 60 days after receipt of a properly completed annual tax return as required by this act. The state treasurer shall only make a refund to an insurer whose tax liability or fee amount under this act is greater than its tax liability under the former single business tax act, 1975 PA 228, or the Michigan business tax act, 2007 PA 36, MCL 208.1101 to 208.1601.

(5) This section shall be applied retroactively to August 3, 1987.

History: Add. 1990, Act 256, Imd. Eff. Oct. 15, 1990;—Am. 2007, Act 187, Imd. Eff. Dec. 21, 2007.

Compiler's note: Former MCL 500.440a, which pertained to credit against premium tax by foreign insurer, was repealed by Act 261 of 1987, Imd. Eff. Dec. 28, 1987.

Popular name: Act 218

500.441, 500.442 Repealed. 1987, Act 261, Imd. Eff. Dec. 28, 1987.

Compiler's note: The repealed sections pertained to tax on premiums, deductions, and deposit premiums.

Popular name: Act 218

500.443 Foreign insurer; payment of quarterly installments of estimated tax; filing statement with revenue commissioner.

Sec. 443. (1) Before April 30, July 31, October 31, and January 31 of each year, each foreign insurer admitted to do insurance business in this state and subject to the tax prescribed in section 476a shall pay to the state treasurer, accompanied by forms prescribed by the revenue commissioner, quarterly installments of the insurer's total estimated tax for the current year. Failure of an insurer to make quarterly payments of at least 1/4 of either of the following shall subject the insurer to the penalty and interest prescribed in 1941 PA 122, MCL 205.1 to 205.31:

(a) If the preceding year's liability was $20,000.00 or less, the total tax liability of the insurer for the previous calendar year. For purposes of this subdivision, an insurer's tax liability for the previous calendar year shall be considered to be the amount of tax imposed that year under section 476a or under the former single business tax act, 1975 PA 228, or the Michigan business tax act, 2007 PA 36, MCL 208.1101 to 208.1601, whichever is greater.

(b) Eighty-five percent of the actual tax liability of the insurer for the current calendar year.

(2) Annually before March 1, each insurer described in subsection (1) shall make and file with the revenue commissioner its statement showing all of the data necessary for computation of its taxes under this chapter,

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upon forms and including information that the revenue commissioner prescribes, and shall pay any additional amount due for the preceding calendar year. The failure to file the statement with the revenue commissioner does not excuse or relieve an insurer from the payment of the tax that is justly due.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1959, Act 37, Eff. Mar. 19, 1960;—Am. 1971, Act 54, Imd. Eff. June 30, 1971;—Am. 1981, Act 110, Imd. Eff. July 17, 1981;—Am. 1987, Act 261, Imd. Eff. Dec. 28, 1987;—Am. 1990, Act 256, Imd. Eff. Oct. 15, 1990;—Am. 2007, Act 187, Imd. Eff. Dec. 21, 2007.

Popular name: Act 218

500.444 Collection of delinquent taxes with interest or penalty.

Sec. 444. The taxes prescribed in this code may be collected, in case of delinquency, together with any interest or penalty on those taxes, by the revenue commissioner, out of money or by the sale of securities, deposited with the state treasurer by the delinquent insurer or if securities or money are not deposited, by an action in a court of competent jurisdiction as for the collection of a debt to the state. In such an action the computation of the revenue commissioner duly sworn to is prima facie evidence of the amount of the computation.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1959, Act 37, Eff. Mar. 19, 1960;—Am. 1967, Act 111, Eff. Nov. 2, 1967;—Am. 1971, Act 54, Imd. Eff. June 30, 1971;—Am. 1990, Act 256, Imd. Eff. Oct. 15, 1990.

Popular name: Act 218

500.445 Delinquency as bar to granting certificate of authority.

Sec. 445. A certificate of authority shall not be granted to an insurer or to its agents if the insurer is delinquent in the payment of the taxes or penalties prescribed in this chapter.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1967, Act 111, Eff. Nov. 2, 1967;—Am. 1971, Act 54, Imd. Eff. June 30, 1971;—Am. 1981, Act 110, Imd. Eff. July 17, 1981;—Am. 1990, Act 256, Imd. Eff. Oct. 15, 1990.

Popular name: Act 218

500.446 Repealed. 1987, Act 261, Imd. Eff. Dec. 28, 1987.

Compiler's note: The repealed section pertained to premium tax on foreign reciprocal insurer.

Popular name: Act 218

500.448, 500.449 Repealed. 1975, Act 232, Eff. July 2, 1976.

Compiler's note: The repealed sections pertained to privilege fees of domestic insurers.

Popular name: Act 218

500.450 Repealed. 1987, Act 261, Imd. Eff. Dec. 28, 1987.

Compiler's note: The repealed section pertained to penalty for delinquency in payment of privilege fee.

Popular name: Act 218

500.451 Taxes on unauthorized insurers; regulatory fee; payment; delinquency.

Sec. 451. Any unauthorized insurer transacting insurance in this state shall be subject to a tax of 2% of premiums written in this state and to an additional regulatory fee of 0.5% on premiums written in this state. The tax required by this section shall be considered delinquent if not paid within 30 days after a copy of the computation of the tax by the commissioner is delivered to the insurer in the manner prescribed by law for the service of process.

History: Add. 1967, Act 111, Eff. Nov. 2, 1967;—Am. 1987, Act 261, Imd. Eff. Dec. 28, 1987;—Am. 1994, Act 228, Imd. Eff. June 30, 1994.

Popular name: Act 218

500.454 Name of insurer.

Sec. 454. (1) Except as otherwise provided in this section, the department shall not authorize an insurer to do business in this state if its name is the same as or closely resembles the name of another insurer organized under or authorized to do business under the laws of this state. However, the department may authorize an insurer to do business in this state if it adds to its corporate name a word, abbreviation, or other distinctive and distinguishing element.

(2) The department shall issue a certificate of authority to an insurer in the name applied for, and the insurer shall use that name in all its dealings with the department and in the conduct of its affairs in this state. An insurer shall identify the incorporated name of the insurer in any document used or advertising offered in this state.

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(3) The director may disapprove the use of a name of an insurer or health maintenance organization if the director determines that the name is deceptive or misleading.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1987, Act 168, Imd. Eff. Nov. 9, 1987;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.456 Legal process served on resident agent effective as personal service on company, association, or group; stipulation; filing copy of appointment; fee; duration of appointment; service of process.

Sec. 456. (1) Every insurance company, association, risk retention group, or purchasing group not organized under the statutes of this state shall file with the commissioner, as a condition precedent to doing business in this state, the name and address of a resident agent upon which any local process affecting the company, association, or group may be served. Service upon the resident agent designated under this section is service on the company, association, or group. This designation shall remain in force as long as any liability remains within this state.

(2) As a condition of doing business in this state, an unauthorized insurer who does not have a resident agent shall file with the commissioner an irrevocable written stipulation agreeing that any legal process affecting the company, association, or group that is served upon the commissioner or his or her designee has the same effect as if personally served upon the company, association, or group. A copy of the appointment shall be filed with the commissioner. Service upon the commissioner is service upon the company, association, or group and the fee for service is $10.00 payable at time of service. This appointment remains in force as long as any liability remains within this state.

(3) Every insurance company not organized under the statutes of this state that provides a surety bond required or permitted under the laws of the United States shall irrevocably appoint the commissioner or his or her designee as the company's agent to receive service of process in any action in United States district court on the surety bond. Service upon the commissioner is service upon the company, and the commissioner may establish a reasonable fee, payable at the time of service, for the acceptance of service. Upon receipt of service of process, the commissioner or his or her designee shall forward the service of process to the resident agent designated under subsection (1). Service of process on the commissioner under this subsection only applies for a bond provided within this state and is in addition to and not in place of any other method of service authorized by law or court rule.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1981, Act 1, Imd. Eff. Mar. 30, 1981;—Am. 1989, Act 214, Eff. Jan. 1, 1990;—Am. 2002, Act 26, Imd. Eff. Mar. 6, 2002;—Am. 2002, Act 664, Eff. Mar. 31, 2003.

Popular name: Act 218

500.457 Repealed. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Compiler's note: The repealed section pertained to service of process on insurance commissioner.

Popular name: Act 218

500.460 Insurance producer to write or place insurance policies.

Sec. 460. Except as otherwise provided in section 1202, an insurer authorized to transact business in this state shall not write, place, or cause to be written or placed an insurance policy or insurance contract in this state, except through an insurance producer.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1963, Act 37, Eff. Sept. 6, 1963;—Am. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.462 Signature of insurance producer on application for life or disability insurance.

Sec. 462. Except as otherwise provided in this section, an application for life or disability insurance must bear the signature of an insurance producer. This section does not apply to an application for insurance through the insurer's internet website if the website contains a statement that the applicant may use an insurance producer to assist with the application at no cost to the applicant.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.464 Additional deposits by domestic insurers.

Sec. 464. (1) Whenever a domestic insurer desiring to do business in any other state or in any foreign country is required to make or maintain a deposit of cash or securities or both in some state other than or in addition to the deposit required to be made with the state treasurer under this act, the other or additional

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deposit may be made and maintained with the treasurer of this state.

(2) Deposits by insurers with the state treasurer pursuant to this act or in compliance with the law of another state or a foreign country, shall be held for the purposes specified in the applicable law. Special deposits by insurers with the state treasurer shall be held for the purposes specified by the insurer in making the deposit.

(3) Securities deposited with the state treasurer shall be indorsed to bearer or to the state treasurer in the name of his office. The state treasurer shall not enforce, sell or assign securities except when necessary to fulfill the purposes of the deposit and except to return the securities to the depositing insurer when return is permitted.

(4) The insurer may collect and receive dividends and interest on the securities deposited with the state treasurer and may exchange securities for other acceptable securities.

(5) If the market value of securities held by the state treasurer becomes less than the required amount of the deposit, the commissioner may suspend or revoke the authority of the insurer to transact insurance in this state until the deficiency has been covered by the deposit of additional acceptable securities.

(6) Deposits required by this act may be released to the depositing insurer to the extent the insurer demonstrates to the satisfaction of the commissioner that the deposited securities are no longer necessary to cover the obligations of the insurer, if the insurer no longer is transacting business within the state. Other deposits or portions of other deposits may be released to the depositing insurer at any time to the extent that the insurer has demonstrated to the satisfaction of the commissioner that the deposited securities no longer are necessary to satisfy the purposes of the deposit.

History: Add. 1972, Act 360, Imd. Eff. Jan. 9, 1973.

Popular name: Act 218

500.470 Repealed. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Compiler's note: The repealed section pertained to deficiency in life insurer assets.

Popular name: Act 218

500.476 Repealed. 1987, Act 261, Imd. Eff. Dec. 28, 1987.

Compiler's note: The repealed section pertained to deposit of securities for protection of policyholders.

Popular name: Act 218

500.476a Alien or foreign insurers; deposit of securities or making certain payments; computation; revocation of certificate of authority; purpose of section; domestic insurer owned or controlled by alien or foreign insurer; domestic insurer as alien or foreign insurer; compliance; taxes subject to MCL 208.22d or MCL 208.1243; administration of tax; disclosure of tax return.

Sec. 476a. (1) Beginning August 3, 1987, whenever, by a law in force outside of this state or country, a domestic insurer or agent of a domestic insurer is required to make a deposit of securities for the protection of policyholders or otherwise, or to make payment for taxes, fines, penalties, certificates of authority, valuation of policies, or otherwise, or a special burden or other burden is imposed, greater in the aggregate than is required by the laws of this state for a similar alien or foreign insurer or agent of an alien or foreign insurer, the alien or foreign insurer of that state or country is required, as a condition precedent to its transacting business in this state, to make a like deposit for like purposes with the state treasurer of this state, and to pay to the revenue commissioner for taxes, fines, penalties, certificates of authority, valuation of policies, and otherwise an amount equal in the aggregate to the charges and payments imposed by the laws of the other state or country upon a similar domestic insurer and the agents of a domestic insurer, regardless of whether a domestic insurer or agent of a domestic insurer is actually transacting business in that state or country. For fire department or salvage corps taxes or other local taxes the amount shall be computed by the revenue commissioner by dividing the total of the payments made by domestic insurers in that state or country by the gross premium received by domestic insurers in that state or country less return premiums. The commissioner shall revoke the certificate of authority of an alien or foreign insurer refusing for 30 days to make payment of fees or taxes as required by this chapter. Except as provided in subsections (3) and (4), for purposes of this section, an insurer organized under the laws of a state or country other than these United States shall be considered an insurer of the state in which its general deposit for the benefit of its policyholders is made.

(2) The purpose of this section is to promote the interstate business of domestic insurers by deterring other states from enacting discriminatory or excessive taxes.

(3) Subsection (4) does not apply to a domestic insurer that is owned or controlled, directly or indirectly, by an alien or foreign insurer who prior to 1998 and with the commissioner's approval did not keep books,

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records, and files or true copies thereof in this state.

(4) For purposes of this section, the state treasurer, after consultation with the commissioner, shall determine that a domestic insurer is an alien or foreign insurer domiciled in a state or country determined by the state treasurer if the insurer does not comply with all of the following:

(a) Maintain its principal place of business in this state.

(b) Maintain in this state officers and personnel responsible for and knowledgeable of the company's operation, books, records, administration, and annual statement.

(c) Conduct in this state a substantial portion of its underwriting, sales, claims, legal, and, if applicable, medical operations relating to Michigan policyholders and certificate holders.

(d) Comply with section 5256(1)(a) and (2) through (6). The commissioner shall inform the state treasurer when a domestic insurer is not in compliance with section 5256(1)(a) or (2) through (6).

(5) Taxes collected pursuant to this section are subject to section 22d of the former single business tax act, 1975 PA 228, or section 243 of the Michigan business tax act, 2007 PA 36, MCL 208.1243.

(6) The state treasurer shall administer the tax prescribed by this section in the manner provided in 1941 PA 122, MCL 205.1 to 205.31.

(7) The requirements of section 28 of 1941 PA 122, MCL 205.28, that prohibit an employee or an authorized representative or former employee or authorized representative or anyone connected with the department of treasury from divulging any facts or information obtained in connection with the administration of taxes, do not apply to disclosure of the tax return prescribed in this act.

History: Add. 1987, Act 261, Imd. Eff. Dec. 28, 1987;—Am. 1990, Act 256, Imd. Eff. Oct. 15, 1990;—Am. 1998, Act 121, Imd. Eff. June 10, 1998;—Am. 2007, Act 187, Imd. Eff. Dec. 21, 2007.

Constitutionality: Neither Michigan's retaliatory tax nor the 1988 amendment to that tax violates the state or federal constitutions. The retaliatory tax, and the amendments of it, are rationally related to the legitimate governmental purpose of promoting Michigan insurers in other states. Because the tax and its amendments do not violate equal protection, they also do not violate the Michigan Constitution's Uniformity of Taxation Clause (Const. 1963, art 9, § 3). TIG Ins Co Inc v Treasury, 464 Mich 548; 629 NW2d 402 (2000).

Popular name: Act 218

500.476b Taxes to which authorized insurer subject.

Sec. 476b. Authorized insurers are subject to the tax as provided in section 476a if applicable or the former single business tax act, 1975 PA 228, or the Michigan business tax act, 2007 PA 36, MCL 208.1101 to 208.1601, whichever is greater.

History: Add. 1987, Act 261, Imd. Eff. Dec. 28, 1987;—Am. 2007, Act 187, Imd. Eff. Dec. 21, 2007.

Popular name: Act 218

500.476c Repealed. 1993, Act 200, Eff. Dec. 28, 1994.

Compiler's note: The repealed section pertained to payment of fee and legal status of accident fund.

Popular name: Act 218

500.478 NAIC report of activities.

Sec. 478. (1) On or before October 1 of each year, the NAIC shall file a report of its activities with the commissioner and the senate and house of representatives standing committees on insurance issues. The report shall include all of the following:

(a) A summary of the activities of the NAIC during the preceding year.

(b) A fiscal report, in accordance with generally accepted accounting principles and on a form approved by the commissioner, stating each category of personal, operating, and capital expenditures, and each category of revenue from all sources for the NAIC's preceding fiscal year, and anticipated expenses and revenues for the current and succeeding fiscal years. The fiscal report shall include for each fiscal year statements of expenditures by major program; an audit opinion of the association's fiscal report; the salaries and other compensation for the association's officers; the salaries and other compensation of the professional and managerial employees receiving the highest 5 salaries; the salary range and other compensation of all other professional and managerial employees; and other information as may be requested on or before August 1 of each year by the commissioner or the senate and house of representatives standing committees on insurance issues.

(c) A list of each proposed or required NAIC standard, identified by name and version, to be enacted, adopted, or followed in order for a state to receive or continue its status as an NAIC accredited state, including a detailed explanation of how each NAIC standard benefits the public interest and why alternative means, less restrictive of state sovereignty and innovation, would not accomplish an equal or greater benefit to the public interest.

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(d) A list of each NAIC standard adopted or proposed to be adopted during the preceding calendar year, identified by name and version, that is not required or proposed to be required for a state to receive or continue its status as an NAIC accredited state.

(e) A description of the policies and procedures in effect with the NAIC that are designed to ensure that a state's accreditation status is determined solely based on the merits of a state's regulatory effectiveness, a statement on whether the NAIC has complied with those policies and procedures, and a detailed explanation of any noncompliance with those policies and procedures.

(f) A description of the policies and procedures designed to ensure that the NAIC conducts its deliberations and makes its decisions in meetings that are open to the public and in a manner that provides fair notice and a fair opportunity for all affected persons to be heard; a statement on whether the NAIC has complied with those policies and procedures; and a detailed explanation of any noncompliance with those policies and procedures.

(2) On or before March 15 of each year, the senate and house of representatives standing committees on insurance issues shall review the NAIC report filed under subsection (1). The committees may provide an opportunity for consumers, the commissioner and other state regulators, insurers, and any other interested person to be heard on matters relating to the NAIC and any other matter relative to the efficient and effective regulation of insurers. The committees may explore the feasibility of conducting legislative oversight hearings together with the legislative committees of other states that have jurisdiction over insurance matters. The committees may transmit the record of their oversight review to the national conference of insurance legislators, the NAIC, and the commissioner on or before July 1 of each year.

History: Add. 1998, Act 279, Imd. Eff. July 27, 1998.

Popular name: Act 218

500.479 Imposition of fee by NAIC.

Sec. 479. (1) An insurer domiciled in this state and authorized to transact insurance in this state is not required and cannot be compelled to pay any fee imposed by the NAIC, unless the fee is authorized by an order of the commissioner pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(2) In determining whether to authorize the payment of a fee imposed by the NAIC, the commissioner shall consider the NAIC's annual report required under section 478, any legislative oversight reports, records, or findings transmitted by the senate and house of representatives standing committees on insurance issues under section 478, and the following factors:

(a) How the NAIC dedicates the use of the fees, including the degree to which any solvency-related revenue is improperly used to subsidize NAIC functions other than solvency oversight.

(b) The degree to which fees imposed by the NAIC are based on an insurer's annual amount of premium volume, rather than the cost of a service rendered by the NAIC.

(c) Whether the NAIC has exceeded its legal authority, as determined by an examination of the fiscal report required under section 478, as well as any other factors considered appropriate by the commissioner.

(d) The level of accountability shown by the NAIC to legislative and regulatory authorities.

(e) The effect of NAIC standards on state sovereignty and innovation.

(f) Whether the NAIC determines the state's accreditation status solely on the basis of its regulatory effectiveness.

(g) Whether NAIC proceedings and decision making are open and publicly accessible.

(3) An order issued under this section shall include a detailed explanation of the commissioner's findings concerning the factors listed in subsection (2).

(4) The commissioner may by an appropriate order authorize or prohibit, in whole or in part, the payment of a fee imposed by the NAIC. The commissioner may rescind or modify, in whole or in part, an order issued by the commissioner under this section as circumstances warrant.

History: Add. 1998, Act 279, Imd. Eff. July 27, 1998.

Popular name: Act 218

500.480 Definitions.

Sec. 480. As used in sections 478 and 479:

(a) "Fee" means financial data base fees, annual statement filing fees, securities valuation fees, user fees, and any other financial assessment or charge of any kind imposed directly or indirectly by the NAIC.

(b) "NAIC" means the national association of insurance commissioners.

(c) "NAIC standard" means a directive; financial annual statement requirement; model act; model regulation; issue paper; market conduct or financial examination report or requirement; accounting practice,

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procedure, or reporting standard; securities valuation requirement; or any report, action, or program of any kind promulgated by the NAIC, or a committee, task force, working group, or advisory committee of the NAIC.

(d) "Solvency oversight" means an activity directly related to regulating the financial condition of an insurer. Solvency oversight does not include an activity related to market conduct regulation, market regulatory support, or general regulatory support.

(e) "Solvency-related revenue" means only financial data base fees, annual statement fees, and securities valuation fees.

History: Add. 1998, Act 279, Imd. Eff. July 27, 1998.

Popular name: Act 218

CHAPTER 5
PRIVACY OF FINANCIAL INFORMATION

500.501 Scope of chapter.

Sec. 501. (1) This chapter applies to the treatment of nonpublic personal financial information about individuals who obtain or are claimants or beneficiaries of products or services primarily for personal, family, or household purposes from licensees whether through an individual or group plan. This chapter does not apply to information about companies or about individuals who obtain products or services for business, commercial, or agricultural purposes.

(2) This chapter does not modify, limit, or supersede any provision of section 1243.

(3) This chapter does not modify, limit, or supersede statute or rules governing the confidentiality or privacy of individually identifiable health and medical information, including, but not limited to, all of the following:

(a) Section 2157 of the revised judicature act of 1961, 1961 PA 236, MCL 600.2157.

(b) Section 1750 of the mental health code, 1974 PA 258, MCL 330.1750.

(c) The public health code, 1978 PA 368, MCL 333.1101 to 333.25211.

(d) Section 406 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1406.

(e) Sections 410 and 492A of the Michigan penal code, 1931 PA 328, MCL 750.410 and 750.492a.

(f) Section 13 of the freedom of information act, 1976 PA 442, MCL 15.243.

(g) Section 34 of the third party administrator act, 1984 PA 218, MCL 550.934.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.503 Definitions.

Sec. 503. As used in this chapter:

(a) "Affiliate" means any company that controls, is controlled by, or is under common control with another company.

(b) "Annual notice" means the privacy notice required in section 513.

(c) "Clear and conspicuous" means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice.

(d) "Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol, or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

(e) "Company" means any corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship, or similar organization.

(f) "Consumer" means an individual, or the individual's legal representative, who seeks to obtain, obtains, or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes. As used in this chapter:

(*i*) "Consumer" includes, but is not limited to, all of the following:

(A) An individual who provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment, or economic advisory services relating to an insurance product or service. An individual is a consumer under this subparagraph regardless of whether the licensee establishes an ongoing advisory relationship.

(B) An applicant for insurance prior to the inception of insurance coverage.

(C) An individual that a licensee discloses nonpublic, personal financial information about to a nonaffiliated third party other than as permitted under sections 535, 537, and 539, if the individual is any of the following:

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(I) A beneficiary of a life insurance policy underwritten by the licensee.

(II) A claimant under an insurance policy issued by the licensee.

(III) An insured under an insurance policy or an annuitant under an annuity issued by the licensee.

(IV) A mortgagor of a mortgage covered under a mortgage insurance policy.

(*ii*) So long as the licensee provides the initial, annual, and revised notices under this chapter to the plan sponsor, group or blanket insurance policyholders, and group annuity contract holder and does not disclose to a nonaffiliated third party nonpublic personal financial information other than as permitted under sections 535, 537, and 539, "consumer" does not include an individual solely because he or she meets 1 of the following:

(A) Is a participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer, or fiduciary.

(B) Is covered under a group or blanket insurance policy or group annuity contract issued by the licensee.

(*iii*) "Consumer" does not include an individual solely because he or she meets 1 of the following:

(A) Is a beneficiary of a trust for which the licensee is a trustee.

(B) Has designated the licensee as trustee for a trust.

(g) "Consumer reporting agency" has the same meaning as in section 603(f) of the federal fair credit reporting act, title VI of the consumer credit act, Public Law 90-321, 15 U.S.C. 1681a.

(h) "Customer" means a consumer who has a customer relationship with a licensee. However, customer does not include an individual solely because he or she meets 1 of the following:

(*i*) Is a participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer, or fiduciary.

(*ii*) Is covered under a group or blanket insurance policy or group annuity contract issued by the licensee.

(*iii*) Is a beneficiary or claimant under a policy of insurance.

(i) "Customer relationship" means a continuing relationship between a consumer and a licensee under which the licensee provides 1 or more insurance products or services to the consumer that are to be used primarily for personal, family, or household purposes.

(j) "Initial notice" means the privacy notice required in section 507.

(k) "Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of this state or pursuant to a federal insurance program. Insurance service includes a licensee's evaluation, brokerage, or distribution of information that the licensee collects in connection with a request or an application from a consumer for an insurance product or service.

(*l*) "Licensee" means a licensed insurer or producer, and other persons licensed or required to be licensed, authorized or required to be authorized, registered or required to be registered, or holding or required to hold a certificate of authority under this act. Licensee includes, except as otherwise provided, a nonprofit health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704, and a nonprofit dental care corporation operating pursuant to 1963 PA 125, MCL 550.351 to 550.373. Licensee includes an unauthorized insurer who places business through a licensed surplus line agent or broker in this state, but only for the surplus line placements placed under chapter 19. Licensee does not include any of the following:

(*i*) A nonprofit health care corporation for member personal data and information otherwise protected under section 406 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1406.

(*ii*) The Michigan life and health guaranty association and the property and casualty guaranty association.

(*iii*) The Michigan automobile insurance placement facility, the Michigan worker's compensation placement facility, and the assigned claims facility created under section 3171. However, servicing carriers for these facilities are licensees.

(m) "Nonaffiliated third party" means any person except a licensee's affiliate or a person employed jointly by a licensee and any company that is not the licensee's affiliate. Nonaffiliated third party includes the other company that jointly employs a person with a licensee. Nonaffiliated third party also includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in section 4(k)(4)(H) of the bank holding company act of 1956, chapter 240, 70 Stat. 135, 12 U.S.C. 1843, or insurance company investment activities of the type described in section 4(k)(4)(I) of the bank holding company act of 1956, chapter 240, 70 Stat. 135, 12 U.S.C. 1843.

(n) "Nonpublic personal financial information" means personally identifiable financial information and any list, description, or other grouping of consumers and publicly available information pertaining to them that is derived using any personally identifiable financial information that is not publicly available. Nonpublic personal financial information does not include any of the following:

(*i*) Health and medical information otherwise protected by state or federal law.

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(*ii*) Publicly available information.

(*iii*) Any list, description, or other grouping of consumers and publicly available information pertaining to them that is derived without using any personally identifiable financial information that is not publicly available.

(o) "Opt out" means a direction by the consumer that the licensee not disclose nonpublic personal financial information about that consumer to a nonaffiliated third party, other than as permitted by sections 535, 537, and 539.

(p) "Personally identifiable financial information" means any of the following:

(*i*) Information a consumer provides to a licensee to obtain an insurance product or service from the licensee.

(*ii*) Information about a consumer resulting from any transaction involving an insurance product or service between a licensee and a consumer.

(*iii*) Information the licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer.

(q) "Producer" means a person required to be licensed under this act to sell, solicit, or negotiate insurance.

(r) "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state, or local government records by wide distribution by the media or by disclosures to the general public that are required to be made by federal, state, or local law. A licensee has a reasonable basis to believe that information is lawfully made available to the general public if both of the following apply:

(*i*) The licensee has taken steps to determine that the information is of the type that is available to the general public.

(*ii*) If an individual can direct that the information not be made available to the general public, that the licensee's consumer has not directed that the information not be made available to the general public.

(s) "Revised notice" means the privacy notice required in section 525.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.505 Notice and opt out requirements.

Sec. 505. (1) A licensee is not required to provide the notice and opt out requirements for nonpublic personal financial information under this chapter if the licensee is an employee, agent, or other representative of a principal and all of the following are met:

(a) The principal is another licensee.

(b) The principal otherwise complies with and provides the notices required by this chapter.

(c) The licensee does not disclose any nonpublic personal information to any person other than the principal or its affiliates as provided in this chapter.

(2) A surplus lines broker or surplus lines insurer is considered to be in compliance with the notice and opt out requirements for nonpublic personal financial information under this chapter if all of the following are met:

(a) The broker or insurer does not disclose nonpublic personal information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing under section 535, except as permitted by section 537 or 539.

(b) The broker or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in 16-point type:

PRIVACY NOTICE

"Neither the U.S. brokers that handled this insurance nor the insurers that have underwritten this insurance will disclose nonpublic personal information concerning the buyer to nonaffiliates of the brokers or insurers except as permitted by law.".

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.507 Privacy policies and practices; notice.

Sec. 507. (1) Beginning July 1, 2001, a licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to all of the following:

(a) An individual who on or after July 1, 2001 becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in section 511.

(b) An individual who was the licensee's customer before July 1, 2001, either at the next regularly scheduled contact with that customer but not later than July 1, 2002, so long as the licensee does not disclose

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any nonpublic personal financial information about the customer to any nonaffiliated third party other than as authorized by sections 537 and 539 or annually in accordance with section 513 if the licensee provided a notice before July 1, 2001 and that notice was consistent with the requirements of this chapter.

(c) A consumer, before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes such a disclosure other than as authorized by sections 537 and 539.

(2) A licensee is not required to provide an initial notice to a consumer under subsection (1) if the licensee meets any of the following:

(a) The licensee does not disclose any nonpublic personal financial information about that consumer to any nonaffiliated third party, other than as authorized by sections 537 and 539, and the licensee does not have a customer relationship with the consumer.

(b) A notice has been provided to that consumer by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.509 Customer relationship; time of establishment; continuing relationship; revised privacy notice for new insurance product or service.

Sec. 509. (1) A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship. A continuing relationship includes, but is not limited to, all of the following:

(a) For an insurer, when the consumer receives the delivery of an insurance policy or contract.

(b) For a producer, when the consumer obtains insurance through that licensee.

(c) When the consumer agrees to obtain financial, economic, or investment advisory services relating to insurance products or services for a fee from the licensee.

(2) An individual does not have a continuing relationship with a licensee as follows:

(a) If the individual's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices and the licensee has not communicated with the individual about the policy for a period of 12 consecutive months, other than to provide annual privacy notices, material required by law or regulation, communication at the direction of a state or federal authority, or promotional materials.

(b) If the individual is an insured or an annuitant under an insurance policy or annuity, but is not the policyholder or owner of the insurance policy or annuity.

(c) If the individual's last known address according to the licensee's records is invalid. An address of record is considered invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current, valid address for the individual have been unsuccessful.

(3) Except as otherwise provided in this subsection, when an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes, the licensee shall provide a revised privacy notice that meets the requirements of section 525 and that covers the customer's new insurance product or service. If the initial, revised, or annual notice that the licensee most recently provided to that customer under this chapter is accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under this subsection.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.511 Initial notice; conditions; delivery.

Sec. 511. (1) A licensee may provide the initial notice within a reasonable time after the licensee establishes a customer relationship if establishing the customer relationship is not at the customer's election or providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

(2) When a licensee is required to deliver an initial notice under this section, the licensee shall deliver it according to section 527. If the licensee uses a short-form initial notice for noncustomers according to section 517, the licensee may deliver its privacy notice according to section 517(3).

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.513 Annual notice required; "annually" defined; exception.

Sec. 513. (1) Except as otherwise provided in subsection (2), a licensee shall provide a clear and

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conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. As used in this subsection, "annually" means at least once in any period of 12 consecutive months during which that customer relationship exists. A licensee may define the 12-consecutive-month period, but the licensee shall apply it to the customer on a consistent basis.

(2) A licensee is not required to provide an annual notice under subsection (1) if all of the following apply:

(a) The licensee only provides nonpublic personal information to a nonaffiliated third party under section 535, 537, or 539.

(b) The licensee's privacy policies and practices about disclosing nonpublic personal information have not changed from the previous notice the licensee provided to the customer under subsection (1) or section 511.

(3) A licensee is not required to provide an annual notice under subsection (1) to a former customer.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001;—Am. 2020, Act 90, Eff. Sept. 14, 2020.

Popular name: Act 218

500.515 Initial, annual, and revised notices; information required; disclosure of nonpublic personal financial information.

Sec. 515. (1) The initial, annual, and revised notices shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that apply to the licensee and to the consumers to whom the licensee sends its privacy notice:

(a) The categories of nonpublic personal financial information that the licensee collects.

(b) The categories of nonpublic personal financial information that the licensee discloses.

(c) The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under sections 537 and 539.

(d) The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under sections 537 and 539.

(e) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under section 535 and no other exception in section 537 or 539 applies to that disclosure, a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted.

(f) An explanation of the consumer's right under section 529 to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the method by which the consumer may exercise that right at that time.

(g) Any disclosures that the licensee makes under section 603(d)(2)(A)(*iii*) of the fair credit reporting act, title VI of the consumer credit protection act, Public Law 90-321, 15 U.S.C. 1681a.

(h) The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information.

(i) Any disclosure that the licensee makes under subsection (2).

(2) If a licensee discloses nonpublic personal financial information as authorized under sections 537 and 539, the licensee is not required to list those exceptions in the initial or annual notices. When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

(3) Instead of providing the information required under subsection (1) and if a licensee does not disclose and does not want to reserve the right to disclose nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under sections 537 and 539, the licensee may state that fact as part of a simplified notice so long as the licensee provides the information required under subsections (1)(a), (h), and (i) and (2).

(4) The licensee's initial notice may include categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future but does not currently disclose, and categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose but to whom the licensee does not currently disclose, nonpublic personal financial information.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.517 Initial notice requirements for consumer not a customer; short-form initial notice; delivery.

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Sec. 517. (1) A licensee may satisfy the initial notice requirements in sections 507 and 519(3) for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers an opt out notice as required in section 519.

(2) A short-form initial notice under subsection (1) shall be clear and conspicuous, state that the licensee's privacy notice is available upon request, and explain a reasonable means by which the consumer may obtain that notice.

(3) The licensee shall deliver its short-form initial notice according to section 527. The licensee is not required to deliver its privacy notice with its short-form initial notice and may provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to section 527.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.519 Opt out notice; requirements.

Sec. 519. (1) If a licensee is required to provide an opt out notice under section 529, it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under that section. The notice shall state all of the following:

(a) That the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party.

(b) That the consumer has the right to opt out of that disclosure.

(c) A reasonable means by which the consumer may exercise the opt out right.

(2) A licensee may provide the required opt out notice together with or on the same written or electronic form as the initial notice.

(3) If a licensee provides the opt out notice later than required for the initial notice, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.521 Opt out notice to joint consumers.

Sec. 521. (1) If 2 or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice. The licensee's opt out notice shall explain how the licensee will treat an opt out direction by a joint consumer and may either treat an opt out direction by a joint consumer as applying to all of the associated joint consumers or permit each joint consumer to opt out separately.

(2) If a licensee permits under subsection (1) each joint consumer to opt out separately, the licensee shall permit 1 of the joint consumers to opt out on behalf of all of the joint consumers. A licensee may not require all joint consumers to opt out before it implements any opt out direction.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.523 Consumer's opt out direction; compliance requirements.

Sec. 523. (1) A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it.

(2) A consumer may exercise the right to opt out at any time. A consumer's direction to opt out under this subsection is effective until the consumer revokes it in writing or, if the consumer agrees, revokes it electronically.

(3) If a customer relationship terminates, the customer's opt out direction shall continue to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.525 Disclosure of nonpublic personal financial information to nonaffiliated third party.

Sec. 525. Except as otherwise authorized in this chapter, a licensee shall not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice unless all of the following have been met:

(a) The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices.

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(b) The licensee has provided to the consumer a new opt out notice.

(c) The licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure, and the consumer does not opt out.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.527 Receipt of notice.

Sec. 527. (1) A licensee shall provide any notice required under this chapter so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically. A licensee may reasonably expect that a consumer will receive actual notice if the licensee does any of the following:

(a) Hand delivers a printed copy of the notice to the consumer.

(b) Mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing, or other written communication.

(c) For a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service.

(d) For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

(2) The following do not provide a reasonable expectation that a consumer will receive actual notice of a licensee's privacy policies and practices under subsection (1):

(a) The licensee only posts a sign in its office or generally publishes advertisements of its privacy policies and practices.

(b) The licensee sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

(3) A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual notice in either of the following cases:

(a) The customer uses the licensee's website to access insurance products and services electronically and agrees to receive notices at the website and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the website.

(b) The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

(4) A licensee shall not provide any notice required by this chapter solely by orally explaining the notice, either in person or over the telephone.

(5) For customers only, a licensee shall provide the initial annual and revised notices so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically. A licensee provides an initial, annual, or revised notice to the customer so that the customer can retain it or obtain it later if the licensee does any of the following:

(a) Hand delivers a printed copy of the notice to the customer.

(b) Mails a printed copy of the notice to the last known address of the customer.

(c) Makes the current initial, annual, or revised notice available on a website or a link to another website for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the website.

(6) A licensee may provide a joint notice from the licensee and 1 or more of its affiliates or other financial institutions, as identified in the notice, if the notice is accurate with respect to the licensee and the other institutions. A licensee may also provide a notice on behalf of another financial institution, as identified in the notice, if the notice is accurate with respect to the licensee and the other institution.

(7) If 2 or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual, and revised notice requirements by providing 1 notice to those consumers jointly.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.529 Disclosure of nonprofit personal financial information to nonaffiliated third party; reasonable opportunity; opt out notice.

Sec. 529. (1) Except as otherwise provided in this chapter, a licensee shall not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party

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unless all of the following are met:

(a) The licensee has provided to the consumer an initial notice.

(b) The licensee has provided to the consumer an opt out notice as required in section 519.

(c) The licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure and the consumer does not opt out.

(2) A licensee provides a consumer with a reasonable opportunity to opt out under subsection (1) in any of the following ways:

(a) If the licensee mails the notices required in subsection (1) to the consumer and allows the consumer to opt out by mailing a form, calling a toll-free telephone number, or any other reasonable means within 30 days from the date the licensee mailed the notices.

(b) A customer opens an on-line account with a licensee and agrees to receive the notices required in subsection (1) electronically, and the licensee allows the customer to opt out by any reasonable means within 30 days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account.

(c) For an isolated transaction such as providing the consumer with an insurance quote, if the licensee provides the notices required in subsection (1) at the time of the transaction and requests that the consumer decide, as a necessary part of the transaction, whether to opt out before completing the transaction.

(3) This section applies to a licensee whether or not the licensee and the consumer have established a customer relationship.

(4) Unless a licensee complies with this section, the licensee shall not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving the direction to opt out from the consumer.

(5) A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.531 Receipt of nonpublic personal financial information from nonaffiliated financial institution; limitation on disclosure.

Sec. 531. (1) If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in section 537 or 539, the licensee's disclosure and use of that information is limited as follows:

(a) The licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information.

(b) The licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information.

(c) The licensee may disclose and use the information pursuant to an exception in section 537 or 539 in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

(2) If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in section 537 or 539, the licensee may disclose the information only as follows:

(a) To the affiliates of the financial institution from which the licensee received the information.

(b) To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information.

(c) To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information.

(3) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in section 537 or 539, the third party may disclose and use that information only as follows:

(a) To the licensee's affiliates.

(b) To its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information.

(c) Pursuant to an exception in section 537 or 539 in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

(4) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in section 537 or 539, the third party may disclose the information only as follows:

(a) To the licensee's affiliates.

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(b) To the third party's affiliates, but the third party's affiliates may, in turn, disclose the information only to the extent the third party can disclose the information.

(c) To any other person, if the disclosure would be lawful if the licensee made it directly to that person.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.533 Disclosure of policy or account number.

Sec. 533. (1) A licensee shall not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy or account number or other access number or access code for a consumer's policy, credit card account, deposit account, or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail to the consumer.

(2) Subsection (1) does not apply if a licensee discloses a policy or account number or other access number or access code as follows:

(a) To the licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account.

(b) To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services.

(c) To a participant in an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program.

(3) Subsection (1) does not apply if the policy or account number, or other access number or access code, is in an encrypted form, as long as the licensee does not provide the recipient with a means to decode the number or code.

(4) As used in this section, "transaction account" means an account other than a deposit account or a credit card account. A transaction account does not include an account to which third parties cannot initiate charges.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.535 Applicability of opt out requirements in MCL 500.519 and 500.529; "joint agreement" defined.

Sec. 535. (1) The opt out requirements in sections 519 and 529 do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee does both of the following:

(a) Provides the initial notice.

(b) Enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in section 537 or 539 in the ordinary course of business to carry out those purposes.

(2) The services a nonaffiliated third party performs for a licensee under subsection (1) may include marketing of the licensee's own products or services or marketing of insurance products or services offered pursuant to joint agreements between the licensee and 1 or more financial institutions.

(3) As used in this section, "joint agreement" means a written contract pursuant to which a licensee and 1 or more financial institutions jointly offer, endorse, or sponsor a financial product or service.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.537 Applicability of MCL 500.507(1)(c), 500.519, 500.529, and 500.535; "necessary to effect, administer, or enforce a transaction" defined.

Sec. 537. (1) Sections 507(1)(c), 519, 529, and 535 do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer, or enforce a transaction that a consumer requests or authorizes, or in connection with any of the following:

(a) Servicing, adjusting, or processing an insurance product or service that a consumer requests or authorizes.

(b) Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of that entity.

(c) A proposed or actual securitization, secondary market sale including sales of servicing rights, or similar transaction related to a transaction of the consumer.

(d) Reinsurance or stop loss or excess loss insurance.

(e) Servicing or processing an insurance product or service on behalf of the Michigan automobile

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insurance placement facility, the Michigan worker's compensation placement facility, or the assigned claims facility created under section 3171.

(2) As used in subsection (1), "necessary to effect, administer, or enforce a transaction" means that the disclosure is either of the following:

(a) Required or is 1 of the lawful or appropriate methods to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service.

(b) Required or is a usual, appropriate, or acceptable method for any of the following:

(*i*) To carry out the transaction or the product or service business of which the transaction is a part, and record, service, or maintain the consumer's account in the ordinary course of providing the insurance product or service.

(*ii*) To administer, adjust, or service benefits or claims relating to the transaction or the product or service business of which it is a part.

(*iii*) To provide a confirmation, explanation, statement, or other record of the transaction, or information on the status or value of the insurance product or service to the consumer, the consumer's agent or broker, or a policyholder or the policyholder's agent or broker with respect to a claim asserted by, or paid to, a consumer under the policy.

(*iv*) To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party.

(*v*) To underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer's insurance or to an insurance policy under which the consumer is a claimant: account administration, reporting, investigating, or preventing fraud or material misrepresentation, processing premium payments, processing, adjusting, settling, or paying insurance claims, administering insurance benefits including utilization review activities, participating in research projects, or as otherwise required or specifically permitted by federal or state law.

(*vi*) In connection with any of the following:

(A) The authorization, settlement, billing, processing, clearing, transferring, reconciling, or collection of amounts charged, debited, or otherwise paid using a debit, credit, or other payment card, check, or account number, or by other payment means.

(B) The transfer or collection of debts, receivables, accounts, or interests in receivables or accounts.

(C) The audit of debit, credit, or other payment information.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.539 Applicability of MCL 500.507(1)(c), 500.519, 500.529, and 500.535.

Sec. 539. Sections 507(1)(c), 519, 529, and 535 do not apply when a licensee discloses nonpublic personal financial information as follows:

(a) With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction.

(b) To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product, or transaction.

(c) To protect against or prevent actual or potential fraud or unauthorized transactions.

(d) For required institutional risk control or for resolving consumer disputes or inquiries.

(e) To persons holding a legal or beneficial interest relating to the consumer.

(f) To persons acting in a fiduciary or representative capacity on behalf of the consumer.

(g) To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, or the licensee's attorneys, accountants, and auditors.

(h) To the extent specifically permitted or required under other provisions of law and in accordance with the right to privacy act of 1978, title XI of the financial institutions regulatory and interest rate control act of 1978, Public Law 95-630, 12 U.S.C. 3401 to 3420 and 3422, to law enforcement agencies including the federal reserve board, office of the comptroller of the currency, federal deposit insurance corporation, office of thrift supervision, national credit union administration, the securities and exchange commission, the secretary of the treasury, with respect to subchapter II of chapter 53 of subtitle IV of title 31 of the United States code, 31 U.S.C. 5311 and 5330, and sections 121 to 129 of chapter 2 of title I of Public Law 91-508, 12 U.S.C. 1951 to 1959, the federal trade commission, a state insurance authority, self-regulatory organizations, or for an investigation on a matter related to public safety.

(i) To a consumer reporting agency in accordance with the fair credit reporting act, title VI of the consumer credit protection act, Public Law 90-321, 15 U.S.C. 1681 to 1681u.

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(j) From a consumer report reported by a consumer reporting agency.

(k) In connection with a proposed or actual sale, merger, transfer, or exchange of all or a portion of a business or operating unit of the licensee if the disclosure of nonpublic personal financial information concerns solely consumers of that business or unit.

(*l*) To comply with federal, state, or local laws, rules, and other applicable legal requirements.

(m) To comply with a properly authorized civil, criminal, or regulatory investigation, subpoena, or summons by a federal, state, or local authority.

(n) To respond to judicial process or a government regulatory authority having jurisdiction over a licensee for examination, compliance, or other purposes as authorized by law.

(o) For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan, or worker's compensation plan to the extent necessary to effectuate the replacement.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.540 Use or disclosure of nonpublic personal financial information by certain associations or facilities.

Sec. 540. The Michigan life and health guaranty association, the property and casualty guaranty association, the Michigan automobile insurance placement facility, the Michigan worker's compensation placement facility, and the assigned claims facility created under section 3171 shall not disclose or use nonpublic personal financial information except as provided in section 537(1)(a) to (e) or section 539(a) to (o).

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.541 Operation of fair credit reporting act; construction of chapter.

Sec. 541. Nothing in this chapter shall be construed to modify, limit, or supersede the operation of the fair credit reporting act, title VI of the consumer credit protection act, Public Law 90-321, 15 U.S.C. 1681 to 1681u, and no inference shall be drawn on the basis of the provisions of this chapter regarding whether information is transaction or experience information under section 603 of the fair credit reporting act, title VI of the consumer credit protection act, Public Law 90-321, 15 U.S.C. 1681a.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.543 Consumer opting out from disclosure; discrimination prohibited.

Sec. 543. A licensee shall not unfairly discriminate against any consumer because that consumer has opted out or intends to opt out from the disclosure of his or her nonpublic personal financial information pursuant to the provisions of this chapter.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.545 Contract of licensee with nonaffiliated third party; effect of agreement entered before or on July 1, 2000.

Sec. 545. Until July 1, 2002, a contract that a licensee has entered into with a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf satisfies the provisions of section 535(1)(b), even if the contract does not include a requirement that the third party maintain the confidentiality of nonpublic personal financial information, as long as the licensee entered into the agreement on or before July 1, 2000.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.547 Protection of customer records and information; adoption of guidelines for administrative, technical, and physical safeguards.

Sec. 547. (1) The commissioner shall adopt guidelines for administrative, technical, and physical safeguards that protect the security, confidentiality, and integrity of customer information, pursuant to sections 501, 505(b), and 507 of the Gramm-Leach-Bliley act, Public Law 106-102, 113 Stat. 1338, 15 U.S.C. 6801, 6805, and 6807.

(2) Each licensee shall adopt policies and procedures for administrative, technical, and physical safeguards for the protection of customer records and information. The policies and procedures shall be based on the

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guidelines adopted under subsection (1) and shall be reasonably designed to do all of the following:

(a) Ensure the security and confidentiality of customer records and information.

(b) Protect against any anticipated threats or hazards to the security or integrity of customer records and information.

(c) Protect against unauthorized access to or use of customer records or information that could result in substantial harm or inconvenience to any customer.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

CHAPTER 5A
DATA SECURITY

500.550 Private cause of action not created; exclusive standards.

Sec. 550. This chapter does not create or imply a private cause of action for violation of its provisions and does not curtail a private cause of action that would otherwise exist in the absence of this chapter. Notwithstanding any other provision of law, this chapter establishes the exclusive standards, for this state, applicable to licensees for data security, the investigation of a cybersecurity event, and notification to the director.

History: Add. 2018, Act 690, Eff. Jan. 20, 2021.

Popular name: Act 218

500.553 Definitions.

Sec. 553. As used in this chapter:

(a) "Authorized individual" means an individual known to and screened by the licensee and determined to be necessary and appropriate to have access to the nonpublic information held by the licensee and its information systems.

(b) "Consumer" means an individual, including, but not limited to, an applicant, a policyholder, an insured, a beneficiary, a claimant, and a certificate holder, who is a resident of this state and whose nonpublic information is in a licensee's possession, custody, or control.

(c) "Cybersecurity event" means an event that results in unauthorized access to and acquisition of, or disruption or misuse of, an information system or nonpublic information stored on an information system. Cybersecurity event does not include either of the following:

(*i*) The unauthorized acquisition of encrypted nonpublic information if the encryption, process, or key is not also acquired, released, or used without authorization.

(*ii*) The unauthorized access to data by a person if the access meets both of the following criteria:

(A) The person acted in good faith in accessing the data.

(B) The access was related to activities of the person.

(d) "Encrypted" means the transformation of data into a form that results in a low probability of assigning meaning without the use of a protective process or key.

(e) "Information security program" means the administrative, technical, and physical safeguards that a licensee uses to access, collect, distribute, process, protect, store, use, transmit, dispose of, or otherwise handle nonpublic information.

(f) "Information system" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of electronic nonpublic information, as well as any specialized system such as an industrial or process controls system, a telephone switching and private branch exchange system, or an environmental control system.

(g) "Licensee" means a licensed insurer or producer, and other persons licensed or required to be licensed, authorized, or registered, or holding or required to hold a certificate of authority under this act. Licensee does not include a purchasing group or a risk retention group chartered and licensed in a state other than this state or a person that is acting as an assuming insurer that is domiciled in another state or jurisdiction.

(h) "Multi-factor authentication" means authentication through verification of at least 2 of the following types of authentication factors:

(*i*) Knowledge factors, such as a password.

(*ii*) Possession factors, such as a token or text message on a mobile phone.

(*iii*) Inherence factors, such as a biometric characteristic.

(i) "Nonpublic information" means electronic information that is not publicly available information and is any of the following:

(*i*) Business-related information of a licensee, the tampering with which, or unauthorized disclosure,

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access, or use of which, would cause a material adverse impact to the business, operations, or security of the licensee.

(*ii*) Any information concerning a consumer that because of name, number, personal mark, or other identifier can be used to identify the consumer, in combination with any 1 or more of the following data elements:

(A) Social Security number.

(B) Driver license number or nondriver identification card number.

(C) Financial account number, or credit or debit card number.

(D) Any security code, access code, or password that would permit access to a consumer's financial account.

(E) Biometric records.

(*iii*) Any information or data, except age or gender, in any form or medium created by or derived from a health care provider or a consumer, that can be used to identify a particular consumer, and that relates to any of the following:

(A) The past, present, or future physical, mental, or behavioral health or condition of any consumer or a member of the consumer's family.

(B) The provision of health care to any consumer.

(C) Payment for the provision of health care to any consumer.

(j) "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state, or local government records, by widely distributed media, or by disclosures to the general public that are required to be made by federal, state, or local law. A licensee has a reasonable basis to believe that information is lawfully made available to the general public if both of the following apply:

(*i*) The licensee has taken steps to determine that the information is of the type that is available to the general public.

(*ii*) If an individual can direct that the information not be made available to the general public, that the licensee's consumer has not directed that the information not be made available to the general public.

(k) "Risk assessment" means the risk assessment that each licensee is required to conduct under section 555(3).

(*l*) "Third-party service provider" means a person that is not a licensee and that contracts with a licensee to maintain, process, or store, or otherwise is permitted access to nonpublic information, through its provision of services to the licensee.

History: Add. 2018, Act 690, Eff. Jan. 20, 2021.

Popular name: Act 218

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500.555 Comprehensive written information security program; requirements; duties of licensee and board of directors; third-party service provider; incident response plan; certification of compliance.

Sec. 555. (1) Commensurate with the size and complexity of the licensee, the nature and scope of the licensee's activities, including its use of third-party service providers, and the sensitivity of the nonpublic information used by the licensee or in the licensee's possession, custody, or control, each licensee shall develop, implement, and maintain a comprehensive written information security program, based on the licensee's risk assessment, that contains administrative, technical, and physical safeguards for the protection of nonpublic information and the licensee's information system.

(2) A licensee's information security program must be designed to do all of the following:

(a) Protect the security and confidentiality of nonpublic information and the security of the information system.

(b) Protect against any threats or hazards to the security or integrity of nonpublic information and the information system.

(c) Protect against unauthorized access to or use of nonpublic information, and minimize the likelihood of harm to any consumer.

(d) Maintain policies and procedures for the secure disposal on a periodic basis of any nonpublic information that is no longer necessary for business operations or for other legitimate business purposes.

(3) A licensee shall do all of the following:

(a) Designate 1 or more employees, an affiliate, or an outside vendor to act on behalf of the licensee that is responsible for the information security program.

(b) Identify reasonably foreseeable internal or external threats that could result in unauthorized access, transmission, disclosure, misuse, alteration, or destruction of nonpublic information, including the security of

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information systems and nonpublic information that are accessible to, or held by, third-party service providers.

(c) Assess the likelihood and potential damage of these threats, taking into consideration the sensitivity of the nonpublic information.

(d) Assess the sufficiency of policies, procedures, information systems, and other safeguards in place to manage these threats, including consideration of threats in each relevant area of the licensee's operations, including all of the following:

(*i*) Employee training and management.

(*ii*) Information systems, including network and software design, as well as information classification, governance, processing, storage, transmission, and disposal.

(*iii*) Detecting, preventing, and responding to attacks, intrusions, or other systems failures.

(e) Implement information safeguards to manage the threats identified in its ongoing assessment, and, no less than annually, assess the effectiveness of the safeguards' key controls, systems, and procedures.

(4) Based on its risk assessment, a licensee shall do all of the following:

(a) Design its information security program to mitigate the identified risks, commensurate with the size and complexity of the licensee, the nature and scope of the licensee's activities, including its use of third-party service providers, and the sensitivity of the nonpublic information used by the licensee or in the licensee's possession, custody, or control.

(b) Determine which of the following security measures are appropriate and implement those appropriate security measures:

(*i*) Placing access controls on information systems, including controls to authenticate and permit access only to authorized individuals to protect against the unauthorized acquisition of nonpublic information.

(*ii*) Identifying and managing the data, personnel, devices, systems, and facilities that enable the organization to achieve business purposes in accordance with their relative importance to business objectives and the organization's risk strategy.

(*iii*) Restricting physical access to nonpublic information to authorized individuals only.

(*iv*) Protecting by encryption or other appropriate means all nonpublic information while being transmitted over an external network and all nonpublic information stored on a laptop computer or other portable computing or storage device or media.

(*v*) Adopting secure development practices for in-house developed applications utilized by the licensee.

(*vi*) Adding procedures for evaluating, assessing, or testing the security of externally developed applications used by the licensee.

(*vii*) Modifying the information system in accordance with the licensee's information security program.

(*viii*) Using effective controls, which may include multi-factor authentication procedures for employees accessing nonpublic information.

(*ix*) Regularly testing and monitoring systems and procedures to detect actual and attempted attacks on, or intrusions into, information systems.

(*x*) Including audit trails within the information security program designed to detect and respond to cybersecurity events and designed to reconstruct material financial transactions sufficient to support normal operations and obligations of the licensee.

(*xi*) Implementing measures to protect against destruction, loss, or damage of nonpublic information due to environmental hazards, such as fire and water damage or other catastrophes or technological failures.

(*xii*) Developing, implementing, and maintaining procedures for the secure disposal of nonpublic information in any format.

(c) Include cybersecurity risks in the licensee's enterprise risk management process.

(d) Stay informed regarding emerging threats or vulnerabilities and utilize reasonable security measures when sharing information relative to the character of the sharing and the type of information shared.

(e) Provide its personnel with cybersecurity awareness training that is updated as necessary to reflect risks identified by the licensee in the risk assessment.

(5) If a licensee has a board of directors, the board or an appropriate committee of the board shall, at a minimum, do all of the following:

(a) Require the licensee's executive management or its delegates to develop, implement, and maintain the licensee's information security program.

(b) Require the licensee's executive management or its delegates to report in writing, at least annually, all of the following information:

(*i*) The overall status of the information security program and the licensee's compliance with this chapter.

(*ii*) Material matters related to the information security program, addressing issues such as risk assessment, risk management and control decisions, results of testing, cybersecurity events or violations, and

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management's responses to the material matters described in this subparagraph, and recommendations for changes in the information security program.

(*iii*) If executive management delegates any of its responsibilities under this section, it shall oversee the development, implementation, and maintenance of the licensee's information security program prepared by a delegate and shall receive a report from the delegate complying with the requirements of the report to the board of directors.

(6) A licensee shall exercise due diligence in selecting its third-party service provider. A licensee shall require a third-party service provider to implement appropriate administrative, technical, and physical measures to protect and secure the information systems and nonpublic information that are accessible to, or held by, the third-party service provider.

(7) A licensee shall monitor, evaluate, and adjust, as appropriate, the information security program consistent with any relevant changes in technology, the sensitivity of its nonpublic information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements, and changes to information systems.

(8) As part of its information security program, each licensee shall establish a written incident response plan designed to promptly respond to, and recover from, any cybersecurity event that compromises the confidentiality, integrity, or availability of nonpublic information in its possession, the licensee's information systems, or the continuing functionality of any aspect of the licensee's business or operations. An incident response plan under this subsection must address all of the following areas:

(a) The internal process for responding to a cybersecurity event.

(b) The goals of the incident response plan.

(c) The definition of clear roles, responsibilities, and levels of decision-making authority.

(d) External and internal communications and information sharing.

(e) Identification of requirements for the remediation of any identified weaknesses in information systems and associated controls.

(f) Documentation and reporting regarding cybersecurity events and related incident response activities.

(g) The evaluation and revision as necessary of the incident response plan following a cybersecurity event.

(9) By February 15 of each year, each insurer domiciled in this state shall submit to the director a written statement, certifying that the insurer is in compliance with the requirements of this section. Each insurer shall maintain for examination by the department all records, schedules, and data supporting this certificate for 5 years. To the extent an insurer has identified areas, systems, or processes that require material improvement, updating, or redesign, the insurer shall document the identification and the remedial efforts planned and underway to address the areas, systems, or processes. The documentation described in this subsection must be available for inspection by the director.

History: Add. 2018, Act 690, Eff. Jan. 20, 2021.

Popular name: Act 218

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500.557 Occurrence of cybersecurity event; investigation; maintenance of records.

Sec. 557. (1) If the licensee learns that a cybersecurity event has or may have occurred, the licensee or an outside vendor or service provider, or both, designated to act on behalf of the licensee, shall conduct a prompt investigation.

(2) During the investigation under subsection (1), the licensee, or an outside vendor or service provider, or both, designated to act on behalf of the licensee, shall, at a minimum, do as much of the following as possible:

(a) Determine whether a cybersecurity event has occurred.

(b) Assess the nature and scope of the cybersecurity event.

(c) Identify any nonpublic information that may have been involved in the cybersecurity event.

(d) Perform or oversee reasonable measures to restore the security of the information systems compromised in the cybersecurity event to prevent further unauthorized acquisition, release, or use of nonpublic information in the licensee's possession, custody, or control.

(3) The licensee shall maintain records concerning all cybersecurity events for at least 5 years from the date of the cybersecurity event and shall produce those records on demand of the director.

History: Add. 2018, Act 690, Eff. Jan. 20, 2021.

Popular name: Act 218

500.559 Notification of cybersecurity event involving nonpublic information; duty to update and supplement notifications to director; contents; application to third-party service provider; duties of ceding insurers with direct contractual relationship.

Sec. 559. (1) Each licensee shall notify the director as promptly as possible but not later than 10 business

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days after a determination that a cybersecurity event involving nonpublic information that is in the possession of a licensee has occurred when either of the following criteria has been met:

(a) This state is the licensee's state of domicile, for an insurer, or this state is the licensee's home state, for an insurance producer as that term is defined in section 1201, and the cybersecurity event has a reasonable likelihood of materially harming either of the following:

(*i*) A consumer residing in this state.

(*ii*) Any material part of a normal operation of the licensee.

(b) The licensee reasonably believes that the nonpublic information involved is of 250 or more consumers residing in this state and is either of the following:

(*i*) A cybersecurity event impacting the licensee of which notice is required to be provided to any government body, self-regulatory agency, or other supervisory body under any state or federal law.

(*ii*) A cybersecurity event that has a reasonable likelihood of materially harming either of the following:

(A) Any consumer residing in this state.

(B) Any material part of the normal operation of the licensee.

(2) The licensee shall provide the information under this subsection in electronic form as directed by the director. The licensee has a continuing obligation to update and supplement initial and subsequent notifications to the director regarding material changes to previously provided information relating to the cybersecurity event. The licensee shall provide as much of the following information as possible:

(a) The date of the cybersecurity event.

(b) A description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of third-party service providers, if any.

(c) How the cybersecurity event was discovered.

(d) Whether any lost, stolen, or breached information has been recovered and, if so, how this was done.

(e) The identity of the source of the cybersecurity event.

(f) Whether the licensee has filed a police report or has notified any regulatory, government, or law enforcement agencies and, if so, when the notification was provided.

(g) A description of the specific types of information acquired without authorization. As used in this subdivision, "specific types of information" means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the consumer.

(h) The period during which the information system was compromised by the cybersecurity event.

(i) The number of total consumers in this state affected by the cybersecurity event. The licensee shall provide the best estimate in the initial report to the director and update this estimate with each subsequent report to the director under this section.

(j) The results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed.

(k) A description of efforts being undertaken to remediate the situation that permitted the cybersecurity event to occur.

(*l*) A copy of the licensee's privacy policy and a statement outlining the steps the licensee will take to investigate and notify consumers affected by the cybersecurity event.

(m) The name of a contact person who is both familiar with the cybersecurity event and authorized to act for the licensee.

(3) A licensee shall comply with this chapter, as applicable, and provide a copy of the notice sent to consumers under this chapter, if a licensee is required to notify the director under section 559.

(4) For a cybersecurity event in a system maintained by a third-party service provider, of which the licensee has become aware, the licensee shall treat the event as it would under this section. The computation of the licensee's deadlines begins on the day after the third-party service provider notifies the licensee of the cybersecurity event or the licensee otherwise has actual knowledge of the cybersecurity event, whichever is earlier. This chapter does not prevent or abrogate an agreement between a licensee and another licensee, a third-party service provider, or any other party to fulfill any of the investigation requirements imposed under section 557 or notice requirements imposed under this section.

(5) For a cybersecurity event involving nonpublic information that is used by the licensee that is acting as an assuming insurer or in the possession, custody, or control of a licensee that is acting as an assuming insurer and that does not have a direct contractual relationship with the affected consumers, the assuming insurer shall notify its affected ceding insurers and the director of its state of domicile within 10 business days after making the determination that a cybersecurity event has occurred. The ceding insurers that have a direct contractual relationship with affected consumers shall fulfill the consumer notification requirements imposed under this section. For a cybersecurity event involving nonpublic information that is in the possession,

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custody, or control of a third-party service provider of a licensee that is an assuming insurer, the assuming insurer shall notify its affected ceding insurers and the director of its state of domicile within 10 business days after receiving notice from its third-party service provider that a cybersecurity event has occurred. The ceding insurers that have a direct contractual relationship with affected consumers shall fulfill the consumer notification requirements imposed under this chapter.

(6) A licensee acting as an assuming insurer does not have other notice obligations relating to a cybersecurity event or other data breach under this section or any other law of this state.

(7) For a cybersecurity event involving nonpublic information that is in the possession, custody, or control of a licensee that is an insurer or its third-party service provider for which a consumer accessed the insurer's services through an independent insurance producer, and for which consumer notice is required under this chapter, the insurer shall notify the producers of record of all affected consumers of the cybersecurity event not later than the time at which notice is provided to the affected consumers. The insurer is excused from this obligation for any producer who is not authorized by law or contract to sell, solicit, or negotiate on behalf of the insurer, and in those instances in which the insurer does not have the current producer of record information for any individual consumer.

History: Add. 2018, Act 690, Eff. Jan. 20, 2021.

Popular name: Act 218

500.561 Notice of cybersecurity event to residents of this state; conditions and requirements; duties of licensee; substitute notice; notification to certain consumer reporting agencies; exception; compliance with health insurance portability and accountability act considered compliance with section; notice with intent to defraud; misdemeanor; penalty; failure to provide notice; civil fine; aggregate liability; applicability of section; definitions.

Sec. 561. (1) Unless the licensee determines that the cybersecurity event has not or is not likely to cause substantial loss or injury to, or result in identity theft with respect to, 1 or more residents of this state, a licensee that owns or licenses data that are included in a database that discovers a cybersecurity event, or receives notice of a cybersecurity event under subsection (2), shall provide a notice of the cybersecurity event to each resident of this state who meets 1 or more of the following:

(a) That resident's unencrypted and unredacted personal information was accessed and acquired by an unauthorized person.

(b) That resident's personal information was accessed and acquired in encrypted form by a licensee with unauthorized access to the encryption key.

(2) Unless the licensee determines that the cybersecurity event has not or is not likely to cause substantial loss or injury to, or result in identity theft with respect to, 1 or more residents of this state, a licensee that maintains a database that includes data that the licensee does not own or license that discovers a breach of the security of the database shall provide a notice to the owner or licensor of the information of the cybersecurity event.

(3) In determining whether a cybersecurity event is not likely to cause substantial loss or injury to, or result in identity theft with respect to, 1 or more residents of this state under subsection (1) or (2), a licensee shall act with the care an ordinarily prudent person or agency in like position would exercise under similar circumstances.

(4) A licensee shall provide any notice required under this section without unreasonable delay. A licensee may delay providing notice without violating this subsection if either of the following is met:

(a) A delay is necessary in order for the licensee to take any measures necessary to determine the scope of the cybersecurity event and restore the reasonable integrity of the database. However, the licensee shall provide the notice required under this subsection without unreasonable delay after the licensee completes the measures necessary to determine the scope of the cybersecurity event and restore the reasonable integrity of the database.

(b) A law enforcement agency determines and advises the licensee that providing a notice will impede a criminal or civil investigation or jeopardize homeland or national security. However, the licensee shall provide the notice required under this section without unreasonable delay after the law enforcement agency determines that providing the notice will no longer impede the investigation or jeopardize homeland or national security.

(5) A licensee shall provide any notice required under this section by providing 1 or more of the following to the recipient:

(a) Written notice sent to the recipient at the recipient's postal address in the records of the licensee.

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(b) Written notice sent electronically to the recipient if any of the following are met:

(*i*) The recipient has expressly consented to receive electronic notice.

(*ii*) The licensee has an existing business relationship with the recipient that includes periodic electronic mail communications and based on those communications the licensee reasonably believes that it has the recipient's current electronic mail address.

(*iii*) The licensee conducts its business primarily through internet account transactions or on the internet.

(c) If not otherwise prohibited by state or federal law, notice given by telephone by an individual who represents the licensee if all of the following are met:

(*i*) The notice is not given in whole or in part by use of a recorded message.

(*ii*) The recipient has expressly consented to receive notice by telephone, or if the recipient has not expressly consented to receive notice by telephone, the licensee also provides notice under subdivision (a) or (b) if the notice by telephone does not result in a live conversation between the individual representing the licensee and the recipient within 3 business days after the initial attempt to provide telephonic notice.

(d) Substitute notice, if the licensee demonstrates that the cost of providing notice under subdivision (a), (b), or (c) will exceed $250,000.00 or that the licensee has to provide notice to more than 500,000 residents of this state. A licensee provides substitute notice under this subdivision by doing all of the following:

(*i*) If the licensee has electronic mail addresses for any of the residents of this state who are entitled to receive the notice, providing electronic notice to those residents.

(*ii*) If the licensee maintains a website, conspicuously posting the notice on that website.

(*iii*) Notifying major statewide media. A notification under this subparagraph must include a telephone number or a website address that a person may use to obtain additional assistance and information.

(6) A notice under this section must do all of the following:

(a) For a notice provided under subsection (5)(a) or (b), be written in a clear and conspicuous manner and contain the content required under subdivisions (c) to (g).

(b) For a notice provided under subsection (5)(c), clearly communicate the content required under subdivisions (c) to (g) to the recipient of the telephone call.

(c) Describe the cybersecurity event in general terms.

(d) Describe the type of personal information that is the subject of the unauthorized access or use.

(e) If applicable, generally describe what the licensee providing the notice has done to protect data from further security breaches.

(f) Include a telephone number where a notice recipient may obtain assistance or additional information.

(g) Remind notice recipients of the need to remain vigilant for incidents of fraud and identity theft.

(7) A licensee may provide any notice required under this section under an agreement between the licensee and another licensee, if the notice provided under the agreement does not conflict with this section.

(8) Except as provided in this subsection, after a licensee provides a notice under this section, the licensee shall notify each consumer reporting agency that compiles and maintains files on consumers on a nationwide basis, as defined in 15 USC 1681a(p), of the cybersecurity event without unreasonable delay. A notification under this subsection must include the number of notices that the licensee provided to residents of this state and the timing of those notices. This subsection does not apply if either of the following is met:

(a) The licensee is required under this section to provide notice of a cybersecurity event to 1,000 or fewer residents of this state.

(b) The licensee is subject to 15 USC 6801 to 6809.

(9) A licensee that is subject to and complies with the health insurance portability and accountability act of 1996, Public Law 104-191, and with regulations promulgated under that act, 45 CFR parts 160 and 164, for the prevention of unauthorized access to customer information and customer notice is considered to be in compliance with this section.

(10) A person that provides notice of a cybersecurity event in the manner described in this section when a cybersecurity event has not occurred, with the intent to defraud, is guilty of a misdemeanor punishable as follows:

(a) Except as otherwise provided under subdivisions (b) and (c), by imprisonment for not more than 93 days or a fine of not more than $250.00 for each violation, or both.

(b) For a second violation, by imprisonment for not more than 93 days or a fine of not more than $500.00 for each violation, or both.

(c) For a third or subsequent violation, by imprisonment for not more than 93 days or a fine of not more than $750.00 for each violation, or both.

(11) Subject to subsection (12), a person that knowingly fails to provide a notice of a cybersecurity event required under this section may be ordered to pay a civil fine of not more than $250.00 for each failure to provide notice. The attorney general or a prosecuting attorney may bring an action to recover a civil fine

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under this section.

(12) The aggregate liability of a person for civil fines under subsection (11) for multiple violations of subsection (11) that arise from the same cybersecurity event must not exceed $750,000.00.

(13) Subsections (10) and (11) do not affect the availability of any civil remedy for a violation of state or federal law.

(14) This section applies to the discovery or notification of a breach of the security of a database that occurs after December 31, 2019.

(15) This section does not apply to the access or acquisition by a person or agency of federal, state, or local government records or documents lawfully made available to the general public.

(16) This section deals with subject matter that is of statewide concern, and any charter, ordinance, resolution, regulation, rule, or other action by a municipal corporation or other political subdivision of this state to regulate, directly or indirectly, any matter expressly set forth in this section is preempted.

(17) As used in this section:

(a) "Data" means computerized information.

(b) "Identity theft" means a person doing any of the following:

(*i*) With intent to defraud or violate the law, using or attempting to use the personal information of another person to do either of the following:

(A) Obtain credit, goods, services, money, property, a vital record, a confidential telephone record, medical records or information, or employment.

(B) Commit another unlawful act.

(*ii*) By concealing, withholding, or misrepresenting the person's identity, using or attempting to use the personal information of another person to do either of the following:

(A) Obtain credit, goods, services, money, property, a vital record, a confidential telephone record, medical records or information, or employment.

(B) Commit another unlawful act.

(c) "Personal information" means the first name or first initial and last name linked to 1 or more of the following data elements of a resident of this state:

(*i*) A Social Security number.

(*ii*) A driver license number or state personal identification card number.

(*iii*) A demand deposit or other financial account number, or credit card or debit card number, in combination with any required security code, access code, or password that would permit access to any of the resident's financial accounts.

History: Add. 2018, Act 690, Eff. Jan. 20, 2021.

Popular name: Act 218

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500.563 Confidentiality; use of documents, materials, or other information; duties of director.

Sec. 563. (1) Any documents, materials, or other information in the control or possession of the department that is furnished by a licensee or an employee or agent of the licensee acting on behalf of the licensee under section 555(9), section 559(2)(b), (c), (d), (e), (h), (i), and (j), or that is obtained by the director in an investigation or examination by the director is confidential by law and privileged, is not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, is not subject to subpoena, and is not subject to discovery or admissible in evidence in any private civil action. However, the director is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the director's duties. The director shall not otherwise make the documents, materials, or other information public.

(2) Neither the director nor any person that received documents, materials, or other information while acting under the authority of the director is permitted or required to testify in any private civil action concerning any confidential documents, materials, or information under subsection (1).

(3) To assist in the performance of the director's duties under this chapter, the director may do any of the following:

(a) Share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (1), with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates, or its subsidiaries, and with state, federal, and international law enforcement authorities, if the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information.

(b) Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners, its affiliates, or its subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic

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jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(c) Share documents, materials, or other information subject to subsection (1) with a third-party consultant or vendor if the consultant agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information.

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

(4) A waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information does not occur as a result of disclosure to the director under this section or as a result of sharing as authorized under subsection (3).

(5) This chapter does not prohibit the director from releasing final, adjudicated actions that are open to public inspection pursuant to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates, or its subsidiaries.

(6) Any documents, materials, or other information in the possession or control of the National Association of Insurance Commissioners or a third-party consultant or vendor under this chapter is confidential by law and privileged, is not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, is not subject to subpoena, and is not subject to discovery or admissible in evidence in any private civil action.

History: Add. 2018, Act 690, Eff. Jan. 20, 2021.

Popular name: Act 218

500.565 Exemption for certain licensees; timeline for implementation and compliance.

Sec. 565. (1) A licensee that has fewer than 25 employees, including any independent contractors, is exempt from section 555.

(2) A licensee subject to and in compliance with the health insurance portability and accountability act of 1996, Public Law 104–191, and with regulations promulgated under that act, is not required to comply with this chapter except for the requirements under sections 559 and 561.

(3) An employee, agent, representative, or designee of a licensee, who is also a licensee, is exempt from section 555 and does not need to develop its own information security program to the extent that the employee, agent, representative, or designee is covered by the information security program of the other licensee.

(4) If a licensee ceases to qualify for the exception under subsection (1), the licensee has 180 days to comply with this chapter.

(5) This chapter takes effect on January 20, 2021. A licensee shall implement section 555 by January 20, 2022. However, a licensee has until January 20, 2023 to implement section 555(6).

History: Add. 2018, Act 690, Eff. Jan. 20, 2021.

Popular name: Act 218

CHAPTER 6
KINDS OF INSURANCE; REINSURANCE; LIMIT OF RISK

500.600 Insurance; definitions applicable.

Sec. 600. The applicable definitions of the kinds of insurance set forth in this chapter shall apply to all insurers.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1970, Act 180, Imd. Eff. Aug. 3, 1970.

Popular name: Act 218

500.602 "Life" insurance, "transaction of life insurance," and "life insurance companies" defined.

Sec. 602. (1) "Life" insurance is insurance upon the lives and health of persons and every insurance pertaining thereto, and to grant, purchase, or dispose of annuities. Notwithstanding any other provision of law, life insurance includes insurance upon the lives of persons which insurance prepays the death benefit.

(2) Transaction of life insurance includes the issuance of policies of life and endowment insurance and contracts for the payment of annuities and pure endowments, and contracts supplemental to those that contain only those provisions relating to accident and sickness insurance as provide additional benefits for death or dismemberment or loss of sight by accident or as operate to safeguard those policies or contracts against lapse or to give a special surrender value or special benefit or an annuity if the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

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(3) All corporations, associations, partnerships, or individuals, doing business in this state under any charter, compact, agreement, or statute of this or any other state, involving an insurance, guaranty, contract, or pledge, for the payment of annuities or endowments, or for the payment of money to families, or representatives of policy or certificate holders or members, are considered life insurance companies within the meaning of the laws relating to life insurance within this state.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1989, Act 35, Imd. Eff. June 1, 1989;—Am. 2003, Act 208, Imd. Eff. Nov. 26, 2003

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Popular name: Act 218

500.603 Definitions; accelerated benefits; acknowledgment; disclosures; waiver of premium; qualifying event; powers of insurer; pro rata reduction in cash value; actuarial memorandum; policy reserves.

Sec. 603. (1) As used in this section:

(a) "Accelerated benefits" means benefits payable under a life insurance contract to a policyowner or certificateholder, during the lifetime of the insured, in anticipation of death or upon the occurrence of specified life-threatening or catastrophic conditions as defined by the policy or rider that reduce the death benefit otherwise payable under the life insurance contract and that are payable upon the occurrence of a single qualifying event that results in the payment of a benefit amount fixed at the time of acceleration. Accelerated benefits do not include benefits payable to an insured under a long-term care insurance policy.

(b) "Chronic illness" means a permanent medical condition that results in an individual being unable to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating. Chronic illness also includes a permanent severe cognitive impairment or a similar form of dementia.

(c) "Qualifying event" means 1 or more of the following:

(*i*) A medical condition that would result in a drastically limited life span as specified in the contract.

(*ii*) A medical condition that has required or requires extraordinary medical intervention including, but not limited to, major organ transplant or continuous artificial life support, without which the insured would die.

(*iii*) A condition that usually requires continuous confinement in an eligible institution as defined in the contract if the insured is expected to remain there for the rest of his or her life.

(*iv*) A medical condition that would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, but are not limited to, coronary artery disease resulting in an acute infarction or requiring surgery, permanent neurological deficit resulting from cerebral vascular accident, end stage renal failure, acquired immune deficiency syndrome, or other medical conditions that the director of the department of insurance and financial services has approved for any particular filing.

(*v*) A chronic illness.

(*vi*) Other qualifying events that the director of the department of insurance and financial services approves for a particular filing.

(2) An accelerated benefit rider and a life insurance policy with accelerated benefit provisions are primarily mortality risks rather than morbidity risks and are life insurance benefits subject to all of the following:

(a) Chapters 40 and 44.

(b) The rider or provisions must provide the option to take the benefit as a lump sum and not as an annuity contingent upon the life of the insured.

(c) The rider or provisions must have no restrictions on the use of the proceeds.

(d) If any death benefit remains after payment of an accelerated benefit, the rider or provisions must not affect the accidental death benefit provision, if any, by the payment of the accelerated benefit.

(e) The rider or provisions must include the terminology "accelerated benefit" in the descriptive title and not be described or marketed as long-term care insurance or as providing long-term care benefits. This subdivision does not apply to life insurance policies or riders that provide directly or supplement long-term care insurance as described in section 3901.

(3) Except as otherwise provided in this section, the insurer of an accelerated benefit rider or life insurance policy with accelerated benefit provisions is required to obtain from an assignee or irrevocable beneficiary a signed acknowledgment of concurrence for payout before the payment of the accelerated benefit. If the insurer making the accelerated benefit is itself the assignee under the policy, an acknowledgment is not required.

(4) An insurer of an accelerated benefit rider or life insurance policy with accelerated benefit provisions shall provide a disclosure statement at the time of application and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor. The disclosure statement must be prominently displayed on the first page

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of the policy or rider and any other related documents. If a policyowner or certificateholder of an accelerated benefit rider or life insurance policy with accelerated benefit provisions requests an acceleration, the insurer shall send a statement to the policyowner or certificateholder and irrevocable beneficiary showing any effect that the payment of the accelerated benefit will have on the policy's cash value, accumulation account, death benefit, premium, policy loans, and policy liens. The statement shall disclose that receipt of accelerated benefit payments may adversely affect the recipient's eligibility for medicaid or other government benefits or entitlements and may be taxable and that assistance should be sought from a personal tax advisor. If a previous disclosure statement becomes invalid as a result of an acceleration of the death benefit, the insurer shall send a revised disclosure statement to the policyowner or certificateholder and irrevocable beneficiary. If the insurer agrees to accelerate death benefits, the insurer shall issue an amended schedule page to the policyholder to reflect, or shall notify the certificateholder under a group policy of, any new, reduced in-force face amount of the contract.

(5) A written disclosure, including, but not necessarily limited to, a brief description of the accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefits shall be given to the applicant for an accelerated benefit rider or life insurance policy with accelerated benefit provisions. The description must include an explanation of any effect of the payment of a benefit on the policy's cash value, accumulation account, death benefit, premium, policy loans, and policy liens. For agent solicited insurance, the agent shall provide the disclosure form to the applicant before or concurrently with the application. Acknowledgment of the disclosure shall be signed by the applicant and writing agent. For a solicitation by direct response methods, the insurer shall provide the disclosure form to the applicant at the time the policy is delivered, with a notice that a full premium refund will be received if the policy is returned to the company within the free look period. For group insurance policies, the disclosure form must be contained as part of the certificate of coverage or any related document furnished by the insurer for the certificateholder.

(6) If there is a premium or cost of insurance charge, the insurer shall give the applicant for an accelerated benefit rider or life insurance policy with accelerated benefit provisions a generic illustration numerically demonstrating any effect of the payment of a benefit on the policy's cash value, accumulation account, death benefit, premium, policy loans, and policy liens. For agent solicited insurance, the agent shall provide the illustration to the applicant before or concurrently with the application. For a solicitation by direct response methods, the insurer shall provide the illustration to the applicant at the time the policy is delivered. For group insurance policies, the disclosure form must be contained as part of the certificate of coverage or any related document furnished by the insurer for the certificateholder.

(7) An insurer of an accelerated benefit rider or life insurance policy with accelerated benefit provisions with financing options other than as described in subsection (12)(b) shall disclose to the policyowner any premium or cost of insurance charge for the accelerated benefit. The insurer shall make a reasonable effort to assure that the certificateholder is aware of any additional premium or cost of insurance charge if the certificateholder is required to pay a charge. Upon request of the director of the department of insurance and financial services, an insurer shall furnish an actuarial demonstration disclosing the method of arriving at its cost for the accelerated benefit.

(8) The insurer of an accelerated benefit rider or life insurance policy with accelerated benefit provisions shall disclose to the policyowner any administrative expense charge. The insurer shall make a reasonable effort to assure that the certificateholder is aware of any administrative expense charge if the certificateholder is required to pay the charge.

(9) An accelerated benefit provision is effective as follows:

(a) On the effective date of the policy or rider for accidents.

(b) No more than 30 days after the effective date of the policy or rider for illness.

(10) The insurer of an accelerated benefit rider or life insurance policy with accelerated benefit provisions may offer a waiver of premium for the accelerated benefit provision if a regular waiver of premium provision is not in effect. At the time the benefit is claimed, the insurer shall explain any continuing premium requirement to keep the policy in force.

(11) An insurer of an accelerated benefit rider or life insurance policy with accelerated benefit provisions shall not unfairly discriminate among insureds with differing qualifying events covered under the policy or among insureds with similar qualifying events covered under the policy. An insurer shall not apply further conditions on the payment of the accelerated benefits other than those conditions specified in the policy or rider.

(12) The insurer of an accelerated benefit rider or life insurance policy with accelerated benefit provisions may do any of the following:

(a) Require a premium charge or cost of insurance charge for the accelerated benefit if based on sound actuarial principles. For group insurance, the additional cost may also be reflected in the experience rating.

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(b) Pay a present value of the face amount. The calculation shall be based on any applicable actuarial discount appropriate to the policy design. The interest rate or interest rate methodology used in the calculation shall be based on sound actuarial principles and disclosed in the contract or actuarial memorandum. The maximum interest rate used shall be no greater than the greater of the current yield on 90-day treasury bills or the current maximum statutory adjustable policy loan interest rate.

(c) Accrue an interest charge on the amount of the accelerated benefits. The interest rate or interest rate methodology used in the calculation shall be based on sound actuarial principles and disclosed in the contract or actuarial memorandum. The maximum interest rate used shall be no greater than the greater of the current yield on 90-day treasury bills or the current maximum statutory adjustable policy loan interest rate. The interest rate accrued on the portion of the lien that is equal in amount to the cash value of the contract at the time of the benefit acceleration shall be no more than the policy loan interest rate stated in the contract.

(13) Except as otherwise provided in this subsection, if an accelerated benefit on an accelerated benefit rider or life insurance policy with accelerated benefit provisions is payable, there shall be no more than a pro rata reduction in the cash value based on the percentage of death benefits accelerated to produce the accelerated benefit payment. Alternatively, the payment of accelerated benefits, any administrative expense charges, any future premiums, and any accrued interest may be considered a lien against the death benefit of the policy or rider and the access to the cash value may be restricted to any excess of the cash value over the sum of any other outstanding loans and the lien. Future access to additional policy loans may be limited to any excess of the cash value over the sum of the lien and any other outstanding policy loans.

(14) If payment of an accelerated benefit on an accelerated benefit rider or life insurance policy with accelerated benefit provisions results in a pro rata reduction in the cash value, the payment shall not be applied toward repaying an amount greater than a pro rata portion of any outstanding policy loans.

(15) For an accelerated benefit rider or life insurance policy with accelerated benefit provisions, a qualified actuary shall describe the accelerated benefits, the risks, the expected costs, and the calculation of statutory reserves in an actuarial memorandum. The insurer shall maintain in its files descriptions of the bases and procedures used to calculate benefits payable. These descriptions and the actuarial memorandum shall be made available for examination by the director of the department of insurance and financial services upon request.

(16) If benefits are provided through the acceleration of benefits under group or individual life policies or riders to an accelerated benefit rider or life insurance policy with accelerated benefit provisions, policy reserves shall be determined in accordance with section 834. All valuation assumptions used in constructing the reserves shall be determined as appropriate for statutory valuation purposes by a member in good standing of the American academy of actuaries. The actuary shall follow both actuarial standards and certification for good and sufficient reserves. Reserves in the aggregate should be sufficient to cover policies upon which no claim has yet arisen and policies upon which an accelerated claim has arisen. For policies and certificates that provide actuarially equivalent benefits, additional reserves do not need to be established. Policy liens and policy loans, including accrued interest, represent assets of the insurer for statutory reporting purposes. For a policy on which the policy lien exceeds the policy's statutory reserve liability, the excess shall be held as a nonadmitted asset.

History: Add. 2003, Act 208, Imd. Eff. Nov. 26, 2003;—Am. 2014, Act 142, Eff. Mar. 31, 2015.

Popular name: Act 218

500.606 Disability insurance; definition.

Sec. 606. (1) "Disability" insurance is insurance against bodily injury or death by accident, or against disability on account of sickness or accident. Unless specifically excluded in chapter 34, disability insurance includes health insurance issued to an individual, family, or group, subject to limitations that are prescribed with respect to the insurance.

(2) An insured under a disability insurance policy as described in this section may be an employee of a person that is not subject to the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941. If the person is not subject to the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, the liability may be limited to liability arising out of and in the course of the employee's employment and the premium may be paid by the employer under an agreement with the employee.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.607 Group disability insurance; definition.

Sec. 607. (1) As used in this act, "group disability insurance" means voluntary disability insurance that covers 2 or more employees or members, with or without their eligible dependents, written under a master

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policy issued to a governmental corporation, unit, agency, or department of a governmental entity, to a corporation, copartnership, or individual employer, or, on application of an executive officer or trustee of the association, to an association that has a constitution or bylaws and that is formed in good faith for purposes other than that of obtaining insurance, and under which officers, members, employees, or classes or departments of the association may be insured for their individual benefit.

(2) Notwithstanding subsection (1), a group disability insurance policy may be issued to a trust or trustees of a fund established by 2 or more employers to insure 1 or more employees of the employers.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.608 "Health" and "health insurance policy" defined.

Sec. 608. As used in this act:

(a) "Health" insurance is insurance provided under a health insurance policy.

(b) "Health insurance policy" means an expense-incurred hospital, medical, or surgical policy, certificate, or contract.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.610 Property insurance; definition.

Sec. 610. "Property" insurance is insurance on dwelling houses, stores, and all kinds of buildings, and upon household furniture, goods, wares and merchandise, and any other property, against loss or damage by fire, earthquake, lightning, wind and water; and also against bombardment and/or explosion, whether fire ensues or not, but not to include steam boiler or flywheel explosion; and by and with the consent of the commissioner, insurance against any other loss or damage to property or any interest therein not prohibited by the laws of this state nor exclusively delegated to any other class or kind of insurer, including loss or damage of any character, whether by reason of burglary and theft of personal property or otherwise, and whether situated at any given time at a place of residence, or in storage, transit, or upon the person of the insured or otherwise. Property insurance shall be deemed to include also marine insurance as defined in section 614, inland navigation and transportation insurance as defined in section 616, and automobile insurance (limited) as defined in section 620.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.614 Marine insurance; definition.

Sec. 614. "Marine" insurance is insurance against any and all kinds of loss of or damage to:

(1) Vessels, craft, aircraft, cars, automobiles and vehicles of every kind, as well as all goods, freights, cargoes, merchandise, effects, disbursements, profits, moneys, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests, and all other kinds of property and interests therein, in respect to, appertaining to, or in connection with any and all risks or perils of navigation, transit, or transportation, including war risks, on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed, or similarly prepared for shipment, or while awaiting the same, or during any delays, storage, transshipment, or reshipment incident thereto, including marine builders' risks and all personal property floater risks.

(2) Person or to property in connection with or appertaining to a marine, inland marine, transit, or transportation insurance, including liability for loss of or damage to either, arising out of or in connection with the construction, repair, operation, maintenance, or use of the subject matter of such insurance (but not including life insurance or surety bonds), but shall not mean insurances against loss by reason of bodily injury to the person arising out of the maintenance, operation or use of motor vehicles.

(3) Precious stones, jewels, jewelry, gold, silver, and other precious metals whether used in business or trade or otherwise and whether the same be in course of transportation or otherwise, which shall include jeweler's block insurance.

(4) Bridges, tunnels, and other instrumentalities of transportation and communication (excluding buildings, their furniture and furnishing, fixed contents, and supplies held in storage) unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and/or civil commotion are the only hazards to be covered. Piers, wharves, docks and slips, excluding the risks of fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and/or civil commotion. Other aids to navigation and transportation, including dry dock and marine railways, against all risks.

History: 1956, Act 218, Eff. Jan. 1, 1957.

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Popular name: Act 218

500.616 Inland navigation and transportation insurance; definition.

Sec. 616. "Inland navigation and transportation" insurance is insurance upon vessels, freights, goods, wares, merchandise and other property, against the risks of inland navigation and transportation.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.618 "Legal expense insurance" defined.

Sec. 618. "Legal expense insurance" is insurance which involves the assumption of a contractual obligation to reimburse the beneficiary against or pay on behalf of the beneficiary, all or a portion of his or her fees, costs, or expenses related to or arising out of services performed by or under the supervision of an attorney licensed to practice in the jurisdiction in which the services are performed. Legal expense insurance may also include provisions for basic legal services rendered to the beneficiary, by telephone or mail, by 1 or more attorneys licensed to practice in the jurisdiction in which the services are performed, none of whom are employees of or under the control of the insurer directly or indirectly. Legal expense insurance does not include the provision of or reimbursement for legal services incidental to other insurance coverages.

History: Add. 1982, Act 501, Imd. Eff. Dec. 31, 1982.

Popular name: Act 218

500.620 Automobile insurance (limited); definition.

Sec. 620. "Automobile insurance (limited)" is insurance upon automobiles, whether stationary or being operated under their own power, which shall include all or any of the hazards of fire, explosion, transportation, collision, loss by legal liability for damage to property resulting from the maintenance and use of automobiles, and loss by burglary or theft or both, but shall not include insurance against loss by reason of bodily injury to the person.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.624 "Casualty" defined; combination with property insurance.

Sec. 624. (1) "Casualty" insurance includes insurances as follows:

(a) Steam boiler and flywheel. Insurance against loss or damage to property of the insured, and loss or damage to the life, person or property of another for which the insured is liable, caused by the explosion of steam boilers or their connections or by the breakage or rupture of machinery or flywheels; and against loss of use and occupancy caused thereby;

(b) Liability, automobile, and workmen's compensation. Insurance of any person, partnership, or corporation against loss or damage on account of the bodily injury or death by accident of any person, or against damage caused by automobiles, vehicles or draft animals to property of another, for which loss or damage said person, partnership or corporation is responsible, or against accidental damage sustained by automobiles or vehicles, or against all of the said contingencies, inclusive of workmen's compensation insurance;

(c) Plate glass. Insurance against a breakage of plate glass, local or in transit;

(d) Sprinkler. Insurance of any goods or premises against loss or damage by water caused by the breakage or leakage of sprinklers, pumps, water pipes or plumbing and its fixtures, and against accidental injury from other causes than fire or lightning to such sprinklers, pumps, water pipes, plumbing and fixtures;

(e) Credit. The business commonly known as credit insurance or guaranty, either by agreeing to purchase uncollectible debts, or otherwise to insure against loss or damage from the failure of persons indebted to the insured to meet their liabilities;

(f) Burglary and theft. Insurance against loss or damage by burglary, theft, house breaking or forgery;

(g) Livestock. Insurance upon the lives of horses, cattle and other livestock or against loss by the theft of any of such property or both;

(h) Malpractice. Insurance of persons lawfully engaged in the practice of medicine, surgery, dentistry, or dispensing drugs or medicines, and partnerships or corporations lawfully engaged in the operation of hospitals or sanitariums, against loss resulting from all claims and suits alleging malpractice, error or mistake and based upon professional services rendered or which should have been rendered by insured and/or his or her assistants or employees, and to defend and indemnify insured against any loss resulting from all other suits for civil damages arising out of the practice by insured of his profession; except that indemnity under such insurance shall not extend to claims or suits based on criminal acts or on services rendered while under the

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influence of liquor or drugs;

(i) Miscellaneous. By and with the consent of the commissioner, insurance against any other hazards of a casualty nature not prohibited by the laws of this state nor exclusively delegated to any other class or kind of insurer.

(2) Any insurance carrier authorized under any section of this code to write any casualty insurance, shall have the right and authority to insure against any of the risks specified or referred to in any of the provisions of section 610 (property insurance defined), combined in a single policy. Nothing herein contained shall be construed to extend the lines permitted to be written by any class of insurer beyond those otherwise provided, except as to personal property floater policies.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1966, Act 221, Imd. Eff. July 11, 1966.

Popular name: Act 218

500.625 Automobile passenger and liability coverage; expense or disability coverage included.

Sec. 625. Any insurer authorized to write automobile bodily injury liability insurance policies may, by an endorsement attached to or as a part of such a policy, insure any person or in behalf of any person for expense or disability including death growing out of any accidental injury incurred while driving, riding in, entering, alighting from, or through being struck by, any motor vehicle. Such coverage shall not be subject to provisions of this code otherwise applicable to disability insurance.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.628 Surety and fidelity insurance; definition.

Sec. 628. "Surety and fidelity" insurance is to guarantee the fidelity of persons in positions of trust, private or public, and to act as surety on official bonds and for the performance of other obligations, and to indemnify banks, bankers, brokers, financial or moneyed associations, or financial or moneyed corporations, against the loss of any bills of exchange, notes, drafts, acceptances of drafts, bonds, securities, evidences of debt, deeds, mortgages, warehouse receipts, bills of lading, documents, currency, money, gold, platinum, silver and other precious metals refined or unrefined, and articles made therefrom, jewelry, watches, necklaces, bracelets, gems, precious and semi-precious stones, and also against loss, resulting from damage, except by fire, to the insured's premises, furnishings, fixtures, equipment, safes and vaults therein caused by burglary, robbery, holdup, theft or larceny, or attempt thereat. No such indemnity indemnifying against loss of any property as specified herein shall indemnify against the loss of any such property occurring while in the mail or in the custody or possession of a carrier for hire for the purpose of transportation, except for the purpose of transportation by an armored motor vehicle accompanied by 1 or more armed guards.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.632 Insurers; nonprofit dental care corporation; reinsurance; authorization.

Sec. 632. (1) An insurer may reinsure any risk authorized to be undertaken by it and grant reinsurance on any similar risk undertaken by any other insurer. A nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373, may reinsure any risk authorized to be undertaken by it and grant reinsurance on any similar risk undertaken by another legal entity.

(2) Subject to chapter 58, a mutual insurance company other than life may, by policy, treaty, or other agreement, cede to or accept from any insurance company or insurer reinsurance on the whole or any part of any risk, which reinsurance must be without contingent liability or participation or membership unless provided otherwise. Reinsurance must not be effected with any company or insurer disapproved by written order of the director filed in his or her office.

(3) An insurer authorized to transact multiple lines of insurance may, except with respect to policies of life and endowment insurance and contracts for the payment of annuities and pure endowments, reinsure risks of every kind or description.

(4) Reinsurance must not be ceded to or accepted by any insurer operating under the cooperative or assessment plan. Reinsurance of any insurer operating under the cooperative or assessment plan must be ceded only to insurers authorized under this act to transact a similar kind of insurance in this state and to accept reinsurance.

(5) An insurer may be specifically authorized to accept reinsurance for kinds of risks that it does not have authority to insure directly.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1962, Act 53, Eff. Mar. 28, 1963;—Am. 1966, Act 221, Imd. Eff. July 11, 1966;—

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Am. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.636 Repealed. 1994, Act 226, Imd. Eff. June 27, 1994.

Compiler's note: The repealed section pertained to reinsurance by domestic stock or mutual insurers.

Popular name: Act 218

500.640 Insurers; limitation of risk; exceptions; "title insurance" and "title insurer" defined.

Sec. 640. (1) Except as otherwise provided in subsections (2) to (5), an insurer transacting business in this state shall not expose itself to any loss on any 1 risk or hazard in an amount exceeding 10% of its paid-up capital and surplus. However, no portion of a risk or hazard that has been reinsured by an insurer licensed to do insurance business in this state shall be included in determining the limitation of risk prescribed in this subsection.

(2) An insurer transacting business in this state that has obtained a certificate of authority authorizing the transaction of title insurance in this state before the effective date of the amendatory act that added this subsection shall not expose itself to any loss on any 1 title insurance risk or hazard in an amount exceeding 50% of its paid-up capital and surplus. However, no portion of a title insurance risk or hazard that has been reinsured by an insurer licensed to do title insurance business in this state shall be included in determining the limitation of risk prescribed in this subsection.

(3) An insurer transacting business in this state that obtains a certificate of authority authorizing the transaction of title insurance in this state on or after the effective date of the amendatory act that added this subsection shall not expose itself to any loss on any 1 title insurance risk or hazard in an amount exceeding 10% of its paid-up capital and surplus unless the title insurer meets all of the following:

(a) Has a most recent A.M. best financial rating of at least an A- or has a comparable rating as assigned by a nationally recognized statistical rating organization approved by the commissioner.

(b) Has been licensed and operating in this or another state for at least 5 years and has reported a net income for at least 3 of the last 5 years.

(c) Has capital that exceeds 2 times the minimum paid-up capital and surplus requirements in Michigan.

(4) No portion of a title insurance risk or hazard that has been reinsured by an insurer licensed to do title insurance business in this state shall be included in determining the 10% limitation of risk prescribed in subsection (3). An insurer described in subsection (3)(a) to (c) shall not expose itself to any loss on any 1 title insurance risk or hazard in an amount exceeding 50% of its paid-up capital and surplus.

(5) Upon application by a title insurer, the commissioner may waive the 10% limitation of risk prescribed in subsection (3) for a particular risk or hazard for good cause shown and so long as the net retained liability for that particular risk or hazard does not exceed 50% of the insurer's paid-up capital and surplus.

(6) As used in this section, "title insurance" and "title insurer" mean those terms as defined in section 7301.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2010, Act 338, Imd. Eff. Dec. 21, 2010.

Popular name: Act 218

500.644 Life, disability, and loss of position insurers; limit of risk.

Sec. 644. For provisions as to limit of risk applicable to life, disability, and loss of position insurers operating on the cooperative or assessment plan see section 6446.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

CHAPTER 7
RESERVE STANDARDS FOR DISABILITY INSURANCE

500.701 Definitions.

Sec. 701. As used in this chapter:

(a) "Annual claim cost" means the net annual cost per unit of benefit before the addition of expenses, including claim settlement expenses, and a margin for profit or contingencies.

(b) "Accrued claims" means that portion of claims payable under a health insurance policy or certificate and incurred on or prior to the valuation date that result in liability of the insurer for the payment of benefits for medical services rendered on or prior to the valuation date and for the payment of benefits for days of hospitalization and days of disability that have occurred on or prior to the valuation date that the insurer has not paid as of the valuation date but for which it is liable and will have to pay after the valuation date.

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(c) "Date of disablement" means the earliest date the insured is considered as being disabled under the definition of disability in the health insurance policy or certificate based on a doctor's evaluation or other evidence.

(d) "Date of incurral" means the date a claim is determined to be a liability of the insurer.

(e) "Elimination period" means a specified number of days, weeks, or months starting at the beginning of each period of loss, during which benefits under a health insurance policy or certificate are not payable.

(f) "Gross premium" means the amount of premium charged by the insurer. Gross premium includes the net premium, based on claim-cost, for the risk together with any loading for expenses, profit, or contingencies.

(g) "Group insurance" means blanket insurance and franchise insurance and any other forms of group insurance.

(h) "Level premium" means a premium on a health insurance policy or certificate calculated to remain unchanged throughout either the lifetime of the policy or certificate or for some shorter projected period of years.

(i) "Long-term care insurance" means any insurance policy, certificate, or rider advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for 1 or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Long-term care insurance includes a policy, certificate, or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance does not include an insurance policy or certificate offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(j) "Modal premium" means the premium paid on a health insurance policy or certificate based on a premium term that could be annual, semiannual, quarterly, monthly, or weekly.

(k) "Preliminary term reserve method" means the method under which the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium or stream of changing valuation premiums becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

(*l*) "Reserve" means all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued. An insurer under its contracts promises benefits that result in either of the following:

(*i*) Claims that have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date. On these claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves.

(*ii*) Claims that are expected to be incurred after the valuation date. Any present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.

(m) "Unearned premium reserve" means that portion of the premium on a health insurance policy or certificate paid or due to the insurer that is applicable to the period of coverage extending beyond the valuation date.

(n) "Valuation net modal premium" means the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. For example, if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

500.702 Health insurance reserves; determination of adequacy; basis.

Sec. 702. The adequacy of an insurer's health insurance reserves shall be determined only on the combined basis of claim, premium, and contract reserves and not on any 1 or 2 of these categories alone.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

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Popular name: Act 218

500.703 Claim reserves and claim expense reserves required; conditions; testing for adequacy and reasonableness.

Sec. 703. (1) Claim reserves are required for all incurred but unpaid claims on all health insurance policies and certificates.

(2) Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but unpaid claims on health insurance policies and certificates.

(3) All claim reserves on health insurance policies and certificates for prior valuation years are to be tested for adequacy and reasonableness consistent with claim runoff schedules in accordance with the insurer's annual statutory financial statement including consideration of any residual unpaid liability.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

500.705 Disability income claim reserves; maximum interest rate; morbidity standards specified in rules; exception; group disability income claim reserves; duration from date of disablement 2 years or more but less than 5 years; basis; request for modification plan approval; elimination period; measurement of disablement duration.

Sec. 705. (1) The maximum interest rate for claim reserves related to disability income is that rate specified in section 733.

(2) Minimum standards with respect to morbidity are those specified in rules promulgated pursuant to this chapter except that, at the option of the insurer, for claims with a duration from date of disablement of less than 2 years, reserves may be based upon the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(3) For group disability income claims with a duration from date of disablement of 2 years or more but less than 5 years, reserves may, with the approval of the commissioner, be based on the insurer's experience for which the insurer maintains underwriting and claim administration control. The request for approval of a plan of modification to the reserve basis shall include all of the following:

(a) An analysis of the credibility of the experience.

(b) A description of how all of the insurer's experience is proposed to be used in setting reserves.

(c) A description and quantification of the margins to be included.

(d) A summary of the financial impact that the proposed plan of modification would have had on the insurer's last filed annual statement.

(e) A copy of the approval of the proposed plan of modification by the commissioner.

(f) Any other information considered necessary by the commissioner.

(4) For health insurance policies and certificates with an elimination period, the duration of disablement shall be measured as dating from the time that benefits would have begun to accrue if there had not been an elimination period.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

500.707 Health insurance benefits other than disability income; claim reserves maximum interest rate; basis of claim reserve.

Sec. 707. (1) The maximum interest rate for claim reserves related to health insurance benefits other than disability income is that rate specified in section 733.

(2) The claim reserve shall be based upon the insurer's experience if such experience is considered credible or upon other assumptions designed to place a sound value on the liabilities.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

500.709 Estimation of claim liabilities; methods.

Sec. 709. Except as otherwise provided in this chapter, any generally accepted or reasonable actuarial method or combination of methods may be used to estimate all claim liabilities. The methods used for estimating liabilities generally may be aggregate methods or various reserve items may be separately valued. Approximations based on groupings and averages may also be employed, provided, however, that the adequacy of the claim reserves shall be determined in the aggregate.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

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500.711 Unearned premium reserves; treatment of premiums due and unpaid; discount of certain gross premiums paid in advance.

Sec. 711. (1) Unearned premium reserves are required for all health insurance policies and certificates with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

(2) If premiums due and unpaid are carried as an asset, such premiums shall be treated as premiums in force, subject to unearned premium reserve determination. The value of unpaid commissions, premium taxes, and the cost of collection associated with due and unpaid premiums shall be carried as an offsetting liability.

(3) The gross premiums paid in advance for a period of coverage commencing after the next premium due date that follows the date of valuation may be appropriately discounted to the valuation date and shall be held either as a separate liability or as an addition to the unearned premium reserve that would otherwise be required as a minimum.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

500.713 Minimum unearned premium reserve; basis; sum of unearned premium and contract reserves; limitation.

Sec. 713. (1) The minimum unearned premium reserve with respect to any health insurance policy or certificate is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with such premium determined on the basis of either of the following:

(a) The valuation net modal premium on the contract reserve basis applying to the health insurance policy or certificate.

(b) The gross modal premium for the health insurance policy or certificate if no contract reserve applies.

(2) The sum of the unearned premium and contract reserves for all health insurance policies and certificates of the insurer subject to contract reserve requirements shall not be less than the gross modal unearned premium reserve on all such health insurance policies and certificates, as of the date of valuation. This reserve shall not be less than the expected claims for the period beyond the valuation date represented by the unearned premium reserve, to the extent not provided for under this chapter.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

500.715 Premium reserves; computation.

Sec. 715. The insurer may employ suitable approximations and estimates in computing premium reserves including, but not limited to, groupings, averages, and aggregate estimation. The insurer should test periodically the approximations or estimates to determine their continuing adequacy and reliability.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

500.717 Contract reserves; required for certain policies and certificates; exception; addition to claim and premium reserves; methods and procedures; date of incurral defined.

Sec. 717. (1) Except as otherwise provided for in subsection (2), contract reserves are required for both of the following:

(a) All health insurance policies and certificates that use level premiums.

(b) All health insurance policies and certificates with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. The values specified in this subdivision shall be determined in the manner provided for in section 719.

(2) Health insurance policies and certificates not requiring a contract reserve include the following:

(a) Policies and certificates that cannot be continued after 1 year from issue.

(b) Policies and certificates already in force on the effective date of this chapter for which a contract reserve was not required under standards in effect before the effective date of this chapter.

(3) The contract reserve is in addition to claim reserves and premium reserves.

(4) The methods and procedures for contract reserves shall be consistent with those methods and procedures for claim reserves for any health insurance policy or certificate, or else appropriate adjustment shall be made when necessary to assure provision for the aggregate liability. The definition of the date of incurral shall be the same in both determinations.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

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Popular name: Act 218

500.719 Morbidity standards; rules; structure of valuation net premiums; valuation of health insurance policies and certificates for which tabular morbidity standards not specified; maximum interest rate for contract reserves; termination rates; adjustment of morbidity standard on aggregate basis; minimum reserve; application of certain reserve adjustments; offset of negative reserves against positive reserves; total contract reserve not less than zero.

Sec. 719. (1) Minimum standards with respect to morbidity are those set forth in rules promulgated pursuant to this chapter. Valuation net premiums used under each health insurance policy or certificate shall have a structure consistent with the gross premium structure at the date of issuance of the policy or certificate as this relates to advancing age of the insured, contract duration, and period for which gross premiums have been calculated.

(2) Health insurance policies and certificates for which tabular morbidity standards are not specified in rules promulgated pursuant to this chapter shall be valued using tables established for reserve purposes by a qualified actuary and acceptable to the commissioner.

(3) The maximum interest rate for contract reserves is that rate specified in section 733.

(4) Termination rates used in the computation of reserves shall be on the basis of mortality as specified in section 735 except that under policies or certificates for which premium rates are not guaranteed, and where the effects of insurer underwriting are specifically used by policy or certificate duration in the valuation morbidity standard, or for return of premium or other deferred cash benefits, total termination rates may be used at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of the following:

(a) 80% of the total termination rate used in the calculation of the gross premiums.

(b) 8%.

(5) If a morbidity standard specified in rules promulgated pursuant to this chapter is on an aggregate basis, the morbidity standard may be adjusted to reflect the effect of insurer underwriting by policy or certificate duration. The adjustments shall be appropriate to the underwriting and be acceptable to the commissioner.

(6) For health insurance, except for long-term care insurance and return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated on the 2-year full preliminary term method where the terminal reserve is zero at the first and second year anniversary of the policy or certificate. For long-term care insurance, the minimum reserve is the reserve calculated on the 1-year full preliminary term method. For health insurance, except for return of premium or other deferred cash benefits, the preliminary term method may be applied only in relation to the date of issue of a policy or certificate. For return of premium or other deferred cash benefits issued on or after the effective date of this chapter, the minimum reserve is the reserve, calculated as of the date of issue of the return of premium or other deferred cash benefits, set forth as follows:

(a) On the 1-year preliminary term method if such benefits are provided at any time before the twentieth anniversary.

(b) On the 2-year preliminary term method if such benefits are only provided on or after the twentieth anniversary.

(7) Reserve adjustments made after issuance of the health insurance policy or certificate as a result of rate increases, revisions in assumptions, or for other reasons are to be applied immediately as of the effective date of adoption of the adjusted basis.

(8) Negative reserves on any benefit may be offset against positive reserves for other benefits in the same health insurance policy or certificate, but the total contract reserve with respect to all benefits combined shall not be less than zero.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

500.721 Application of alternative method or basis to contract reserve; assumptions; methods to determine sound value of liabilities.

Sec. 721. (1) If the contract reserve on all health insurance policies and certificates to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified in this chapter, an insurer may use any reasonable assumptions as to interest rates, termination, and mortality rates, and rates of morbidity or other contingency.

(2) Subject to subsection (1), the insurer may employ other methods in determining a sound value of its liabilities under health insurance policies and certificates, including, but not limited to, the following:

(a) The net level premium method.

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(b) The 1-year full preliminary term method.

(c) Prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses.

(d) The use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, and grouping of similar contract forms.

(e) The computation of the reserve for 1 contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued.

(f) The use of a composite annual claim cost for all or any combination of the benefits included in the policies or certificates valued.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

500.723 Tabular reserves; annual review; increments; restriction of future gross premiums; establishment of contract reserves for insufficiency in aggregate.

Sec. 723. (1) A review shall be made annually of the insurer's prospective contract liabilities on health insurance policies and certificates valued by tabular reserves, to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The insurer shall make appropriate increments to the tabular reserves if the tests indicate that the basis of the reserves is no longer adequate, subject to the minimum standards of section 719.

(2) If an insurer has a health insurance policy or certificate for which future gross premiums will be restricted by contract, insurance bureau regulations, or for other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the insurer shall establish contract reserves for the insufficiency in the aggregate.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

500.725 Reinsurance; determination of increases to, or credit against, reserves.

Sec. 725. Increases to, or credits against, reserves carried arising because of reinsurance assumed or reinsurance ceded, shall be determined in a manner consistent with minimum reserve standards described in this chapter and with all applicable provisions of the reinsurance contracts that affect the insurer's liabilities.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

500.729 Individual insurance policies; minimum morbidity standards for disability income benefits; basis of contract reserve standards for certain hospital, surgical, and maternity benefits; basis of contract reserve standards for certain cancer expense benefits and accidental death benefits.

Sec. 729. (1) The following minimum morbidity standards for disability income benefits for individual health insurance policies shall be used:

(a) For contract reserves for policies issued on or after the effective date of this chapter, the 1985 commissioners individual disability tables A (85 C.I.D.A.) or the 1985 commissioners individual disability tables B (85 C.I.D.B.) and for policies issued on or after January 1, 1965, and before the effective date of this chapter, the insurer may use either of those tables or the 1964 commissioners disability table (64 C.D.T.). Each insurer shall elect, with respect to all individual policies issued in any 1 annual statement year, whether it will use tables A or tables B as the minimum standard. The insurer may, however, elect to use the other tables with respect to any subsequent annual statement year.

(b) For claim reserves, the minimum morbidity standard in effect for contract reserves as of the date the claim is incurred.

(2) Contract reserve standards for hospital, surgical, and maternity benefits for scheduled or fixed-time period benefits for individual health insurance policies issued on or after January 1, 1955 and before January 1, 1982, shall be based on the 1956 intercompany hospital-surgical tables and for policies issued on or after January 1, 1982, the 1974 medical expense tables, table A,Transactions of the Society Actuaries, volume XXX, page 63.

(3) The contract reserve standards for scheduled or fixed-time period cancer expense benefits shall be based on the 1985 N.A.I.C. cancer claim cost tables for policies issued on or after January 1, 1986.

(4) Contract reserve standards for accidental death benefits shall be based on the 1959 accidental death benefits table for policies issued on or after January 1, 1965.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

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Popular name: Act 218

500.731 Disability benefits for group health insurance certificates; minimum morbidity standards.

Sec. 731. The following minimum morbidity standards for disability benefits for group health insurance certificates shall be used:

(a) For contract reserves for policies and certificates issued on or after the effective date of this chapter, the 1987 commissioners group disability income table (87 C.G.D.T.).

(b) For claim reserves for claims incurred prior to, on, or after the effective date of this chapter, the 1987 commissioners group disability income table (87 C.G.D.T.).

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

500.733 Maximum interest rates.

Sec. 733. (1) The maximum interest rate for contract reserves is the calendar year statutory valuation interest rate for life insurance specified in section 836 as of the date of issuance of the health insurance policy or certificate.

(2) The maximum interest rate for claim reserves on policies requiring contract reserves is the calendar year statutory valuation interest rate for life insurance specified in section 836 as of the date the claim is incurred.

(3) The maximum interest rate for claim reserves on policies not requiring contract reserves is the calendar year statutory valuation interest rate for single premium immediate annuities specified in section 836 as of the date the claim is incurred, reduced by 100 basis points.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

500.735 Mortality basis; use of other mortality tables; request for approval.

Sec. 735. (1) The mortality basis used shall be that specified in section 834 as of the date of issuance of the health insurance policy or certificate.

(2) Other mortality tables adopted by the national association of insurance commissioners and promulgated by the commissioner may be used in the calculation of the minimum reserves if appropriate for the type of benefits and if approved by the commissioner. The request for approval shall include the proposed mortality table and the reason that the standard specified in subsection (1) is inappropriate.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

500.737 Rules.

Sec. 737. The commissioner may promulgate rules pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, that he or she considers appropriate for the implementation of this chapter.

History: Add. 1994, Act 148, Imd. Eff. June 7, 1994.

Popular name: Act 218

CHAPTER 8
ASSETS AND LIABILITIES

500.808 Stock or mutual insurers; unearned premium reserves, pro rata basis, computation.

Sec. 808. Every insurer doing business in this state shall establish and maintain an unearned premium reserve on a pro rata basis on all unexpired policies and contracts except for those policies and contracts for which a different basis is specified in this act. A liability shall be set forth for the unearned pro rata portion of the aggregate premiums on all such unexpired risks as ascertained in a manner approved by the commissioner. In the case of perpetual risks or policies of fire insurance, the whole amount of the deposit or premium collected shall be included as unearned. On all unexpired trip risk insurance the entire premium received shall be included as unearned.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1961, Act 153, Eff. Sept. 8, 1961;—Am. 1962, Act 51, Eff. Mar. 28, 1963;—Am. 1969, Act 318, Eff. Mar. 20, 1970.

Popular name: Act 218

500.810 Reserves; computation; additional reserves; plan to restore compliance; effect of

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noncompliance; examination of reserve practices and investment incomes.

Sec. 810. (1) Each insurer transacting business in this state, at all times, shall maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses and claims incurred, whether reported, or unreported, which are unpaid and for which the insurer may be liable and to provide for the expenses of adjustment or settlement of losses and claims. The reserves shall be computed in accordance with rules promulgated by the commissioner, after due notice and hearing, based upon reasonable consideration of the ascertained experience and the character of those kinds of business, for the purpose of adequately protecting the insureds and securing the solvency of the insurer.

(2) If the loss and loss expense experience of the insurer or the anticipated loss expense experience of the insurer as determined by an actuarial evaluation shows the reserves, calculated in accordance with the rules, to be inadequate, the commissioner shall require the insurer to maintain additional reserves. Within 30 business days after notification by the commissioner that its reserves have been determined to be in noncompliance with the requirements of subsection (1), the insurer shall file a plan to restore compliance. The commissioner, upon written request by the insurer, may grant a period of time within which to restore compliance. The period of time may be granted only if the commissioner is satisfied the insurer is safe, reliable, and entitled to public confidence and the commissioner approves the plan filed by the insurer for restoring compliance within the time granted. If the plan is not approved by the commissioner, or if the plan is approved but at the end of 1 year the insurer is not in compliance with the requirements of this section, the commissioner may grant additional time to comply, or the commissioner may suspend, revoke, or limit the certificate of authority of the insurer pursuant to section 436.

(3) The commissioner shall annually examine the reserve practices and investment incomes of medical malpractice, products liability, and municipal liability insurers licensed to do business in this state.

History: Add. 1969, Act 318, Eff. Mar. 20, 1970;—Am. 1976, Act 307, Imd. Eff. Oct. 28, 1976;—Am. 1978, Act 506, Imd. Eff. Dec. 13, 1978;—Am. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

Administrative rules: R 500.1231 et seq. of the Michigan Administrative Code.

500.811 Repealed. 1994, Act 148, Imd. Eff. June 7, 1994.

Compiler's note: The repealed section pertained to outstanding disability policies and benefits reserves.

Popular name: Act 218

500.812 Repealed. 1969, Act 318, Eff. Mar. 20, 1970.

Compiler's note: The repealed section pertained to liability or workmen's compensation and automobile insurers' reserve for claims.

Popular name: Act 218

500.813 Repealed. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Compiler's note: The repealed section pertained to the annual report filed by the commissioner with the legislature.

Popular name: Act 218

500.814 Certification of loss reserves.

Sec. 814. The commissioner may require an insurer writing liability insurance, other than homeowners, farmowners, and commercial multiperil, to certify the loss reserves of the insurer by an actuary approved by the commissioner.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

500.814a Statement of actuarial opinion; filing requirements; confidentiality; Michigan automobile insurance placement facility not property and casualty insurer.

Sec. 814a. (1) Every property and casualty insurer doing business in this state, unless exempted by the commissioner, shall annually file with the commissioner the opinion of an appointed actuary which shall be entitled statement of actuarial opinion. This statement shall be filed pursuant to the same instructions issued by the commissioner for the filing of annual statements.

(2) Every property and casualty insurer domiciled in this state that is required to file a statement of actuarial opinion under subsection (1) shall annually file with the commissioner an actuarial opinion summary, written by the insurer's appointed actuary. This actuarial opinion summary shall be filed pursuant to the same instructions issued by the commissioner for the filing of annual statements and shall be considered as a document supporting the statement of actuarial opinion required in subsection (1).

(3) A property and casualty insurer not domiciled in this state that is required to file a statement of

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actuarial opinion under subsection (1) shall provide an actuarial opinion summary described in subsection (2) upon the commissioner's request.

(4) An actuarial report and underlying workpapers shall be prepared to support each statement of actuarial opinion. If the property and casualty insurer fails to provide this actuarial report or workpapers at the commissioner's request, the commissioner may engage a qualified actuary at the expense of the insurer to review the statement of actuarial opinion and the basis for the opinion and prepare the actuarial report or workpapers.

(5) The statement of actuarial opinion shall be filed with the annual statement in accordance with section 438 and shall be treated as a public document.

(6) Documents, materials, or other information in the possession or control of the office of financial and insurance regulation that are considered an actuarial report, workpapers, or actuarial opinion summary provided in support of the statement of actuarial opinion, and any other material provided by the insurer to the commissioner in connection with the actuarial report, workpapers, or actuarial opinion summary, is confidential and privileged and is not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, subpoena, or to discovery and is not admissible in evidence in any private civil action. This subsection does not do either of the following:

(a) Limit the commissioner's authority to release the documents for the purpose of professional disciplinary proceedings if the commissioner is satisfied that the confidentiality of the documents will be preserved.

(b) Limit the commissioner's authority to use the documents, materials, or other information in furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

(7) Neither the commissioner nor any person who received documents, materials, or other information while acting under the commissioner's authority shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (6).

(8) In order to assist in the performance of the commissioner's duties, the commissioner may do any of the following:

(a) Share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (6) with any other state, federal, or international regulatory agencies, with the national association of insurance commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information and has the legal authority to maintain confidentiality.

(b) Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the national association of insurance commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(9) Any applicable privilege or claim of confidentiality is not waived by the disclosing or sharing of documents, materials, or information as permitted by this section.

(10) For purposes of this section, the Michigan automobile insurance placement facility created under chapter 33 is not a property and casualty insurer.

History: Add. 2009, Act 198, Eff. Jan. 1, 2010.

Popular name: Act 218

500.815 Computation of unearned premium reserve on mortgage guaranty insurance.

Sec. 815. The unearned premium reserve on mortgage guaranty insurance shall be computed in accordance with section 808, except that on policies covering a risk period of more than 1 year the unearned premium reserve shall be computed in accordance with rules promulgated by the commissioner.

History: Add. 1972, Act 345, Imd. Eff. Jan. 9, 1973.

Popular name: Act 218

Administrative rules: R 500.1231 et seq. of the Michigan Administrative Code.

500.815a Establishment of contingency reserve by mortgage guaranty insurer.

Sec. 815a. In addition to the capital, surplus and reserves specified in sections 410, 810 and 815, a mortgage guaranty insurer shall establish a contingency reserve, which shall be reported as a liability in the insurer's financial statements. The amount of the reserve shall be computed in accordance with rules prescribed by the commissioner.

History: Add. 1972, Act 345, Imd. Eff. Jan. 9, 1973.

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Popular name: Act 218

Administrative rules: R 500.1231 et seq. of the Michigan Administrative Code.

500.816 Repealed. 1969, Act 318, Eff. Mar. 20, 1970.

Compiler's note: The repealed section pertained to liability or workmen's compensation and automobile insurers' reserve for claims.

Popular name: Act 218

500.817 Repealed. 1966, Act 221, Imd. Eff. July 11, 1966.

Compiler's note: The repealed section pertained to unearned premium reserve of title insurers.

Popular name: Act 218

500.818, 500.822 Repealed. 1969, Act 318, Eff. Mar. 20, 1970.

Compiler's note: The repealed sections pertained to unearned premium reserve of reciprocal and mutual insurers.

Popular name: Act 218

500.830 Life insurance policies and annuity and pure endowment contracts; life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts; annual valuation of reserves; limitation; valuation fee; adopting lower standard of valuation; valuation of business of foreign cooperative or assessment insurer; definitions.

Sec. 830. (1) The director shall annually value the reserve liabilities, hereinafter called reserves, for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurer doing business in this state issued before the operative date of the valuation manual, except that for an alien insurer, the valuation is limited to its United States' business. In calculating the reserves, the director may use group methods and approximate averages for fractions of a year or otherwise. Instead of the valuation of the reserves required in this section of any foreign or alien insurer, the director may accept any valuation made by the insurance supervisory official of any state or other jurisdiction, if the valuation complies with the minimum standard provided in this section.

(2) The director shall annually value the reserve liabilities hereinafter called reserves for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts of every company issued on or after the operative date of the valuation manual. On the election of a company, for a contract acquired by the company through a business acquisition or reinsurance transaction after the effective date of the amendatory act that added section 836a, regardless of when the contract was issued, the director shall annually value the reserves for the contract. Instead of the valuation of the reserves required of a foreign or alien company, the director may accept a valuation made by the insurance supervisory official of any state or other jurisdiction if the valuation complies with the minimum standard provided in this section.

(3) Except as otherwise provided in this subsection, the insurer shall pay to the director, as compensation for the valuation, 1 cent for each thousand dollars insured, under policies insuring residents of the United States, or issued by an insurer organized under the laws of this state. For annual valuations after December 31, 1987, the valuation fee imposed under this section does not apply to contracts of reinsurance. A valuation fee under this subsection does not apply to an annual valuation of a domestic insurer after December 31, 1987. For annual valuations for the 1994 calendar year, the valuation fee imposed under this subsection for alien insurers is .67 cent for each thousand dollars insured. After December 31, 1994, the valuation fee imposed under this subsection does not apply to alien insurers.

(4) An insurer that has adopted a standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided in this section may, with the approval of the director, adopt a lower standard of valuation, but not lower than the minimum provided in this section.

(5) A foreign cooperative or assessment insurer shall value its business and shall maintain reserves under the standards required of domestic insurers transacting similar insurance under this section.

(6) As used in this section:

(a) "Accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(b) "Company" means an entity that has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and has at least 1 life insurance, accident and health insurance, or deposit-type policy in force or on claim, or that has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is

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required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this state.

(c) "Deposit-type contract" means a contract that does not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

(d) "Life insurance" means a contract that incorporates mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(e) "NAIC" means the national association of insurance commissioners.

(f) "Valuation manual" means the manual of valuation instructions adopted by the NAIC as described in section 836b.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1961, Act 226, Eff. Sept. 8, 1961;—Am. 1987, Act 261, Imd. Eff. Dec. 28, 1987;—Am. 1992, Act 2, Imd. Eff. Jan. 31, 1992;—Am. 1994, Act 228, Imd. Eff. June 30, 1994;—Am. 2014, Act 571, Eff. Mar. 31, 2015.

Popular name: Act 218

500.830a Life insurance; actuarial opinion; form; submission to director; liability of actuary; "qualified actuary" defined; limitation; public hearing; company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts; actuarial opinion; requirements; definitions.

Sec. 830a. (1) A life insurance company doing business in this state shall annually submit to the director the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the director by rule are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The actuarial opinion required by this section must be submitted in a form prescribed by the director and may include any other items that the director considers necessary.

(2) A life insurance company, except as exempted by or under rule, shall also annually include in the opinion required by subsection (1) an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the director by rule, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts. By order, the director may provide for a transition period for establishing any higher reserves that the qualified actuary may consider necessary to render the opinion required by this subsection.

(3) All of the following apply to an opinion required by subsection (2):

(a) A memorandum must be prepared to support each actuarial opinion that is in form and substance acceptable to the director.

(b) If the insurance company does not provide a supporting memorandum within the period of time requested by the director or the director determines that the supporting memorandum provided by the insurer does not meet the standards prescribed by applicable laws or rules or is otherwise unacceptable to the director, the director may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare a supporting memorandum as is required by the director.

(4) All of the following apply to an opinion required by this section:

(a) The opinion must be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after December 31, 1994.

(b) The opinion applies to all business in force including individual and group disability insurance plans in form and substance acceptable to the director.

(c) The opinion must be based on standards as the director may prescribe by rule.

(d) For an opinion required to be submitted by a foreign or alien insurer, the director may accept the opinion filed by the foreign or alien insurer with the insurance supervisory official of another state if the director determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(e) A memorandum in support of the opinion, and any other material provided by the insurer to the director in connection with it, shall be kept confidential by the director, shall not be made public, and is not subject to subpoena, other than for the purpose of defending an action seeking damages from a person by reason of an action required by this section or by rules promulgated under this section. However, the director may release the memorandum or other material in any of the following instances:

(*i*) With the written consent of the insurer.

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(*ii*) To the American academy of actuaries if the memorandum or other material is required for the purpose of professional disciplinary proceedings and the request describes procedures satisfactory to the director for preserving the confidentiality of the memorandum or other material.

(*iii*) If any portion of the confidential memorandum is cited by the insurer in its marketing or is cited before any governmental agency other than a state insurance regulatory agency or is released by the insurer to the news media. A confidential memorandum cited as described under this subparagraph is not confidential.

(5) Except for fraud or willful misconduct, the qualified actuary is not liable for damages to a person other than the insurance company and the director for an act, error, omission, decision, or conduct with respect to the actuary's opinion. Disciplinary action by the director against the insurer or the qualified actuary shall be defined in rules by the director.

(6) For purposes of this section, "qualified actuary" means a member of either the american academy of actuaries or the society of actuaries who also meets any other criteria established by the director by rule.

(7) The director shall not accept as a qualified actuary or accept an actuarial opinion prepared in whole or in part by an individual who has done any of the following:

(a) Been convicted of fraud, bribery, a violation of 18 USC 1961 to 1968, or any dishonest conduct or practices under federal or state law.

(b) Violated the insurance laws of this state with respect to any previous reports submitted under this section.

(c) Did not detect or disclose material information in 1 or more previous reports filed under this section.

(8) The director may hold a public hearing under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to determine if an actuary is qualified. After considering the evidence presented, the director may find that the actuary is not qualified for purposes of expressing his or her opinion on reserves and related actuarial items as required by this section, and may require the insurer to replace the actuary with another actuary.

(9) Every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and subject to regulation by the director shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The valuation manual must provide the specifics of this opinion, including any items considered necessary to its scope.

(10) Every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and subject to regulation by the director, except as exempted in the valuation manual, shall also annually include in the opinion required by subsection (9) an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provisions for the company's obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts.

(11) Both of the following apply to an opinion required under subsection (10):

(a) A memorandum, in form and substance as specified in the valuation manual, and acceptable to the director, shall be prepared to support each actuarial opinion.

(b) If an insurance company does not provide a supporting memorandum at the request of the director within a period specified in the valuation manual or the director determines that the supporting memorandum provided by the insurance company does not meet the standards prescribed by the valuation manual or is otherwise unacceptable to the director, the director may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the director.

(12) All of the following apply to an opinion required under subsection (9) or (10):

(a) The opinion must be in form and substance as specified in the valuation manual and acceptable to the director.

(b) The opinion must be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after the operative date of the valuation manual.

(c) The opinion applies to all policies and contracts described in subsection (10), and to other actuarial liabilities as may be specified in the valuation manual.

(d) The opinion must be based on standards adopted from time to time by the actuarial standards board or its successor, and on such additional standards as may be prescribed in the valuation manual.

(e) For an opinion required to be submitted by a foreign or alien company, the director may accept the

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opinion filed by the foreign or alien company with the insurance supervisory official of another state if the director determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(f) Except for fraud or willful misconduct, the appointed actuary is not liable for damages to a person other than the insurance company and the director for an act, error, omission, or decision, or conduct, with respect to the appointed actuary's opinion.

(g) The director shall determine by regulation disciplinary action against the company or the appointed actuary.

(13) As used in this section:

(a) "Accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(b) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required under subsection (9) or (10).

(c) "Company" means an entity that has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and has at least 1 policy in force or on claim or that has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this state.

(d) "Deposit-type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

(e) "Life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(f) "NAIC" means the national association of insurance commissioners.

(g) "Qualified actuary" means an individual who is qualified to sign an applicable statement of actuarial opinion in accordance with the American academy of actuaries qualification standards for actuaries signing statements of actuarial opinion and who meets the requirements specified in the valuation manual.

(h) "Valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in section 836b.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 2014, Act 571, Eff. Mar. 31, 2015.

Popular name: Act 218

500.831 Domestic insurer's business in foreign country; variance of mortality standard.

Sec. 831. In case of insurance issued by a domestic insurer authorized to do business in a foreign country upon the lives of residents of that country, the commissioner may vary the mortality standard to a standard applicable to that country.

History: Add. 1961, Act 127, Eff. Sept. 8, 1961.

Popular name: Act 218

500.832 Valuation of life insurance policies and contracts issued before operative date of standard nonforfeiture law.

Sec. 832. (1) This section shall apply to only life insurance policies and contracts issued before the operative date of section 4060, the standard nonforfeiture law.

(2) Except as otherwise provided in section 835 for group annuity and pure endowment contracts issued before the operative date of section 4060, in valuing the policies to which this section applies, the rate of interest to be assumed shall, after and including the year 1896, be 4% per annum, and at the election of the insurer the rate of 4% shall be assumed any year before 1896, and the rate of mortality shall be that established by the "table of mortality based on American experience". Group life insurance policies may be valued on the basis of the American men ultimate table of mortality with interest at the rate of 3-1/2% per annum, except that the minimum standard for the valuation of annuities and pure endowments purchased under group annuity and pure endowment contracts shall be that provided in this section, but replacing the interest rates specified in this section by an interest rate of 5% per annum. However, at least 90 days before an insurer revalues reserves relative to annuities and pure endowments purchased under group annuity and pure endowment contracts in accordance with this subsection, the insurer shall give notice to the commissioner of its intent to do so in a form prescribed by the commissioner. The notice shall specify the amount of the reserves affected and the amount by which the reserves are proposed to be revalued. The notice shall also contain an actuarial certification that, after the proposed revaluation, the reserves will still be adequate to mature the obligations of the insurer on the policies and contracts for which the reserves were established.

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The certification shall be made by an actuary qualified to certify an annual statement described in section 438. Except as otherwise provided in section 834, all outstanding industrial life insurance policies issued on or after January 1, 1944 shall be valued on a basis of not less than the standard industrial table of mortality or the substandard industrial table of mortality with interest at the rate of 3-1/2% per annum. Upon written application of the insurer, the commissioner may vary the standards of mortality and interest required by this section. This section shall not permit the use of standards of mortality and interest or methods of producing aggregate reserves lower than those based upon the standard prescribed by this section. The policies shall be valued in accordance with the terms of the policy contracts. In each case in which the actual premium charged for an insurance is less than the net premium for the insurance, based upon the American experience table of mortality with interest at the rate of 4%, the insurer shall also be charged with the value of an annuity, the amount of which shall be equal to the difference between the premium charged and the net premium for the insurance based upon the American experience table with interest at the rate of 4% and the terms of which in years shall equal the number of future annual payments due on the insurance at the date of valuation.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1974, Act 302, Imd. Eff. Oct. 21, 1974;—Am. 1980, Act 58, Eff. Oct. 1, 1980.

Popular name: Act 218

500.834 Valuation of life insurance policies and contracts issued on and after operative date of standard nonforfeiture law; minimum standard; reserves; definitions.

Sec. 834. (1) Except as otherwise provided in sections 835, 835a, 836, and 837, the minimum standard for the valuation of policies and contracts described in subsection (8) is the commissioner's reserve valuation methods defined in subsections (2), (3), and (6), 5% interest for group annuity and pure endowment contracts if prior notice of any revaluation of reserves with respect to group annuity and pure endowment contracts is given to the director in the same manner as is required before a revaluation of reserves under section 832(2), and 3-1/2% interest for all other of those policies and contracts; or for policies and contracts, other than annuity and pure endowment contracts, issued after October 20, 1974, 4% interest for those policies issued before October 1, 1980, and 4-1/2% interest for those policies issued after September 30, 1980, or for life insurance contracts, other than annuity and pure endowment contracts, issued after December 31, 1994, 5-1/2% interest for single premium life insurance policies and 4-1/2% interest for all other policies, and the following tables:

(a) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in those policies: the Commissioner's 1941 Standard Ordinary Mortality Table, for policies issued before the operative date of paragraph 5 of section 4060(5); and the Commissioner's 1958 Standard Ordinary Mortality Table for policies issued on or after that operative date and before the operative date of paragraphs 9 to 18 of section 4060(5). For any category of those policies issued on female risks, all modified net premiums and present values referred to in this section may be calculated according to an age not more than 6 years younger than the actual age of the insured; and, for those policies issued on or after the operative date of paragraphs 9 to 18 of section 4060(5), the Commissioner's 1980 Standard Ordinary Mortality Table or, at the election of the company for any 1 or more specified plans of life insurance, the Commissioner's 1980 Standard Ordinary Mortality Table with 10-year select mortality factors or any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by a rule promulgated by the director for use in determining the minimum standard of valuation for those policies or the 2001 CSO mortality table under section 838.

(b) For all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in those policies: the 1941 Standard Industrial Mortality Table for those policies issued before the operative date of paragraph 7 of section 4060(5); and for those policies issued on or after that operative date, the Commissioner's 1961 Standard Industrial Mortality Table or any industrial mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by a rule promulgated by the director for use in determining the minimum standard of valuation for those policies.

(c) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in those policies: the 1937 Standard Annuity Mortality Table or, at the option of the company, the annuity mortality table for 1949, ultimate, or any modification of either of those tables approved by the director.

(d) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in those policies: the Group Annuity Mortality Table for 1951, any modification of that table approved by the director, or, at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

(e) For total and permanent disability benefits in or supplementary to ordinary policies or contracts: for policies or contracts issued after December 31, 1965, the tables of period 2 disablement rates and the 1930 to

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1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners that are approved by a rule promulgated by the director for use in determining the minimum standard of valuation for those policies; for policies or contracts issued after December 31, 1960, and before January 1, 1966, either those tables or, at the option of the company, the class (3) disability table, 1926; and for policies issued before January 1, 1961, the class (3) disability table, 1926. For active lives, a table must be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(f) For accidental death benefits in or supplementary to policies: for policies issued after December 31, 1965, the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the National Association of Insurance Commissioners that is approved by a rule promulgated by the director for use in determining the minimum standard of valuation for those policies; for policies issued after December 31, 1960, and before January 1, 1966, 1 of the above tables or at the option of the insurer the intercompany double indemnity mortality table. A table must be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(g) For group life insurance, life insurance issued on the substandard basis, and other special benefits: any table approved by the director.

(2) Except as otherwise provided in subsections (3) and (6), reserves according to the Commissioner's Reserve Valuation Method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, is the excess, if any, of the present value, at the date of valuation, of the future guaranteed benefits provided for by those policies over the then present value of any future modified net premiums for the policies. The modified net premiums for the policy is a uniform percentage of the respective contract premiums for the future guaranteed benefits so that the present value of all modified net premiums equals, at the date of issue of the policy, the sum of the then present value of these benefits provided for by the policy and the excess of subdivision (a) over subdivision (b), as follows:

(a) A net level annual premium equal to the present value, at the date of issue, of the future guaranteed benefits provided for after the first policy year divided by the present value, at the date of issue, of an annuity of 1 per annum payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium must not exceed the net level annual premium on the 19-year premium whole life plan for insurance of the same amount at an age 1 year higher than the age at issue of the policy.

(b) A net 1-year term premium for the future guaranteed benefits provided for in the first policy year.

However, for any life insurance policy issued after December 31, 1985 for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for that excess and that provides an endowment benefit or a cash surrender value or a combination of endowment benefit and cash surrender value in an amount greater than the excess premium, the reserve according to the Commissioner's Reserve Valuation Method as of any policy anniversary occurring on or before the assumed ending date, defined as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than the excess premium, is, except as otherwise provided in subsection (6), the greater of the reserve as of that policy anniversary calculated as described in paragraph 1 of this subsection and the reserve as of that policy anniversary calculated as described in that paragraph, but with the value defined in subdivision (a) being reduced by 15% of the amount of the excess first year premium; all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date; the policy being assumed to mature on that date as an endowment; and the cash surrender value provided on that date being considered as an endowment benefit. In making the above comparison, the mortality and interest bases stated in subsection (1) and section 836 must be used.

Reserves according to the Commissioner's Reserve Valuation Method for life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums; group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the internal revenue code of 1986, 26 USC 408; disability and accidental death benefits in all policies and contracts; and all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, must be calculated by a method consistent with the principles of this subsection.

(3) This subsection applies to all annuity and pure endowment contracts other than group annuity and pure

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endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the internal revenue code of 1986, 26 USC 408. Without action by the Michigan Legislature to adopt Actuarial Guideline 35, reserves according to the Commissioner's Annuity Reserve Method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in those contracts, must be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by those contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of the contract, that become payable before the end of that respective contract year. The future guaranteed benefits must be determined by using the mortality table, if any, and the interest rate specified in those contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of the contracts to determine nonforfeiture values.

(4) An insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, must not be less than the aggregate reserves calculated in accordance with the methods described in subsections (2), (3), (6), and (7), and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for the policies. The aggregate reserves for all policies, contracts, and benefits must not be less than the aggregate reserves determined by the appointed actuary to be necessary to render the opinion required by section 830a.

(5) Reserves for all policies and contracts issued before June 27, 1994 may be calculated, at the option of the insurer, according to any standards that produce greater aggregate reserves for all those policies and contracts than the minimum reserves required by the laws in effect immediately before June 27, 1994. Reserves for a category of policies, contracts, or benefits as established by the director, issued after June 26, 1994, may be calculated at the option of the insurer according to any standards that produce greater aggregate reserves than those calculated according to the minimum standard provided in this act. However, the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, must not be greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for in those policies and contracts. An insurer that had previously adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided in this section and sections 835 and 835a may, with the director's approval, adopt any lower standard of valuation, but not lower than the minimum standard provided by this section and sections 835 and 835a. However, for the purposes of this section, the holding of additional reserves previously determined by an appointed actuary to be necessary to render the opinion required by section 830a is not considered to be the adoption of a higher standard of valuation.

(6) If in any contract year the gross premium charged by an insurer on a policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve on the policy or contract, the insurer may use the minimum valuation standards of mortality, either at the time of issue or the time of valuation of the policy or contract and the minimum valuation rate of interest at time of issue or the time of valuation of the policy or contract, if the minimum reserve required for the policy or contract is the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for the policy or contract, or the reserve calculated by the method actually used for the policy or contract using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this subsection are those standards stated in subsection (1) and section 836. However, for any life insurance policy issued after December 31, 1985 for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for that excess and that provides an endowment benefit or a cash surrender value or a combination of endowment benefit and cash surrender value in an amount greater than the excess premium, this subsection applies as if the method actually used in calculating the reserve for that policy were the method described in subsection (2), ignoring paragraph 2 of that subsection. The minimum reserve at each policy anniversary of that policy must be the greater of the minimum reserve calculated in accordance with subsection (2), including paragraph 2 of that subsection, and the minimum reserve calculated in accordance with this subsection.

(7) For any plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or, for any plan of life insurance or annuity that the minimum reserves cannot be determined by the methods described in subsections (2), (3), and (6), the reserves that are held under those plans must be appropriate in relation to the

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benefits and the pattern of premiums for that plan and computed by a method that is consistent with the principles of this standard valuation law, as determined by rules promulgated by the director.

(8) This section applies to only life insurance policies and contracts issued on and after the operative date of section 4060, the standard nonforfeiture law, except as otherwise provided in sections 835 and 836 for group annuity and pure endowment contracts issued on or after the operative date of section 4060 and except as otherwise provided in section 837 for universal life contracts.

(9) As used in this section:

(a) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in section 830a(9).

(b) "NAIC" means the National Association of Insurance Commissioners.

(c) "Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing statements of actuarial opinions and who meets the requirements specified in the valuation manual.

(d) "Valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in section 836b.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1960, Act 153, Imd. Eff. May 23, 1960;—Am. 1961, Act 226, Eff. Sept. 8, 1961;—Am. 1963, Act 110, Eff. Sept. 6, 1963;—Am. 1974, Act 302, Imd. Eff. Oct. 21, 1974;—Am. 1980, Act 58, Eff. Oct. 1, 1980;—Am. 1982, Act 221, Imd. Eff. July 10, 1982;—Am. 1993, Act 349, Eff. Oct. 1, 1994;—Am. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 1994, Act 443, Imd. Eff. Jan. 10, 1995;—Am. 1995, Act 274, Imd. Eff. Jan. 8, 1996;—Am. 2000, Act 378, Imd. Eff. Jan. 2, 2001;—Am. 2004, Act 236, Imd. Eff. July 21, 2004;—Am. 2014, Act 571, Eff. Mar. 31, 2015;—Am. 2016, Act 558, Eff. Apr. 10, 2017.

Popular name: Act 218

500.835 Valuation of individual annuity and pure endowment contracts; minimum standard; notice of election to invoke section; failure to make election; definitions.

Sec. 835. (1) Except as provided in sections 835a and 836, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this section, as described in subsection (2), and for all annuities and pure endowments purchased on or after that operative date under group annuity and pure endowment contracts, must be the Commissioners Reserve Valuation Method described in section 834(2) and (3), and the following tables and interest rates:

(a) For individual annuity and pure endowment contracts issued before October 1, 1980, excluding any disability and accidental death benefits in these contracts, the standard must be the 1971 Individual Annuity Mortality Table, or a modification of this table approved by the director, and 6% interest for single premium immediate annuity contracts, and 4% interest for all other individual annuity and pure endowment contracts.

(b) Except as otherwise provided in this subdivision, for individual single premium immediate annuity contracts issued after September 30, 1980, excluding any disability and accidental death benefits in these contracts, the standard must be the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by a rule promulgated by the director for use in determining the minimum standard of valuation for the contracts, or a modification of these tables approved by the director, and 7-1/2% interest. At the election of the insurer, the following tables may be used as the standard for individual single premium immediate annuity contracts, as applicable:

(*i*) For contracts issued after December 31, 1985, the 1983 Table a.

(*ii*) For contracts issued after December 31, 1998, the Annuity 2000 Table.

(*iii*) For contracts issued after December 31, 2014, the 2012 IAR Table.

(c) Except as otherwise provided in this subdivision, for individual annuity and pure endowment contracts issued after September 30, 1980 and before January 1, 2015, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in the contracts, the standard must be the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by a rule promulgated by the director for use in determining the minimum standard of valuation for such contracts, or a modification of these tables approved by the director, and 5-1/2% interest for single premium deferred annuity and pure endowment contracts, and 4-1/2% interest for all other such individual annuity and pure endowment contracts. At the election of the insurer, the following tables may be used as the standard for individual annuity and pure endowment contracts, other than single premium immediate annuities, as applicable:

(*i*) For contracts issued after December 31, 1985, the 1983 Table a.

(*ii*) For contracts issued after December 31, 1998, the Annuity 2000 Table.

(*iii*) For contracts issued after December 31, 2014, the 2012 IAR Table.

(d) For all annuities and pure endowments purchased before October 1, 1980, under group annuity and

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pure endowment contracts, excluding any disability and accidental death benefits purchased under these contracts, the standard must be the 1971 Group Annuity Mortality Table, or a modification of these tables approved by the director, and 6% interest.

(e) Except as otherwise provided in this subdivision, For all annuities and pure endowments purchased after September 30, 1980 and before January 1, 2015, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under these contracts, the standard must be the 1971 Group Annuity Mortality Table or any group annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by a rule promulgated by the director for use in determining the minimum standard of valuation for such annuities and pure endowments, or a modification of these tables approved by the director, and 7-1/2% interest. At the election of the insurer, the following tables may be used as the standard for all annuities and pure endowments under group annuity and pure endowment contracts, as applicable:

(*i*) For annuities and pure endowments purchased after December 31, 1985, the 1983 GAM Table.

(*ii*) For annuities and pure endowments purchased after December 31, 1998, the 1994 GAR Table.

(2) After October 21, 1974, a company may file with the director a written notice of its election to invoke this section after a specified date before January 1, 1981, which must be the operative date of this section for the company. A company may elect a different operative date of this section for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If a company does not make an election, the operative date of this section for the company must be January 1, 1981.

(3) As used in this section:

(a) "Annuity 2000 Table" means that term as defined in section 835a.

(b) "1983 GAM Table" means that term as defined in section 835a.

(c) "1983 Table a" means that term as defined in section 835a.

(d) "1994 GAR Table" means that term as defined in section 835a.

(e) "2012 IAR Table" means that term as defined in section 835a.

History: Add. 1974, Act 302, Imd. Eff. Oct. 21, 1974;—Am. 1980, Act 58, Eff. Oct. 1, 1980;—Am. 1982, Act 221, Imd. Eff. July 10, 1982;—Am. 2016, Act 558, Eff. Apr. 10, 2017.

Popular name: Act 218

Administrative rules: R 500.1241 of the Michigan Administrative Code.

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500.835a Individual annuity and pure endowment contracts purchased after December 31, 2014; annuities and pure endowments purchased after December 31, 2014 under group annuity and pure endowment contracts; valuation; tables and interest rates; definitions.

Sec. 835a. (1) Except as otherwise provided in section 836, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued after December 31, 2014 and for all annuities and pure endowments purchased after December 31, 2014 under group annuity and pure endowment contracts must be the Commissioner's Reserve Valuation Method described in section 834(2) and (3), and the following tables and interest rates:

(a) For individual single premium immediate annuity contracts, excluding any disability and accidental death benefits in these contracts, the standard must be the 2012 IAR Table or any individual annuity mortality table adopted after 2015 by the National Association of Insurance Commissioners that is approved by a rule promulgated by the director for use in determining the minimum standard of valuation for such contracts, or a modification of these tables approved by the director, and an interest rate as determined by the methodology described in section 836.

(b) Except as otherwise provided in subdivision (d), for individual annuity and pure endowment contracts, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in the contracts, the standard must be the 2012 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 2017 by the National Association of Insurance Commissioners that is approved by a rule promulgated by the director for use in determining the minimum standard of valuation for such contracts, or a modification of these tables approved by the director, and an interest rate as determined by the methodology described in section 836 for single premium deferred annuity and pure endowment contracts, and an interest rate as determined by the methodology described in section 836 for all other such individual annuity and pure endowment contracts.

(c) For all annuities and pure endowments purchased under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under these contracts, the standard must be the 1994 GAR Table, or any group annuity mortality table adopted after 2017 by the National Association of Insurance Commissioners that is approved by a rule promulgated by the director for use in determining the

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minimum standard of valuation for such annuities and pure endowments, or a modification of these tables approved by the director, and an interest rate as determined by the methodology described in section 836.

(d) For individual annuity and pure endowment contracts, the standard must be the 1983 Table a without projection only if the contract is based on life contingencies and is issued to fund periodic benefits arising from either of the following:

(*i*) Settlements of various forms of claims pertaining to court settlements, out of court settlements from tort actions, or settlements involving similar actions such as worker's compensation claims.

(*ii*) Settlement of long-term disability claims if a temporary or life annuity has been used instead of continuing disability payments.

(2) As used in this section:

(a) "Annuity 2000 Table" means the mortality table developed by the Society of Actuaries Committee on Life Insurance Research and shown on page 240 of volume XLVII of the Transactions of the Society of Actuaries.

(b) "Generational Mortality Table" means a mortality table containing a set of mortality rates that decrease for a given age from 1 year to the next based on a combination of a period table and a projection scale containing rates of mortality improvement.

(c) "Period table" means a table of mortality rates applicable to a given calendar year.

(d) "Projection Scale G2" means the table of annual rates, G2X, of mortality improvement by age for projecting future mortality rates beyond calendar year 2012 developed by the Society of Actuaries Committee on Life Insurance Research.

(e) "1983 GAM Table" means that mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for annuities in December 1983 by the National Association of Insurance Commissioners.

(f) "1983 Table a" means the mortality table developed by the Society of Actuaries Committee to recommend a new mortality basis for individual annuity valuation and adopted as a recognized mortality table for annuities in June 1982 by the National Association of Insurance Commissioners.

(g) "1994 GAR Table" means the mortality table developed by the Society of Actuaries group annuity valuation table task force and published on pages 866-867 of volume XLVII of the Transactions of the Society of Actuaries, where the mortality rate for an individual of age x in year 1994+n, QX1994+N, is determined as follows:

$$Qx1994+N = Qx1994(1-AAX)N$$

where QX1994 is as specified in the 1994 GAR Table, n is the number of years that have elapsed since 1994, and AAX is as specified in the 1994 GAR Table.

(h) "2012 IAM Period Table" means the period table developed by the Society of Actuaries Committee on Life Insurance Research that contains loaded mortality rates for calendar year 2012.

(i) "2012 IAR Table" means the generational mortality table developed by the Society of Actuaries Committee on Life Insurance Research that contains rates derived from a combination of the 2012 IAM Period Table and Projection Scale G2, where mortality rates for an individual of age x in year 2012+n, QX2012+N, are determined as follows, and the results rounded to the nearest one-thousandth:

$$Qx2012+N = Qx2012(1-G2X)N$$

where QX2012 is as specified in the 2012 IAM Period Table, n is the number of years that have elapsed since 2012, and G2X is as specified in Projection Scale G2.

History: Add. 2016, Act 558, Eff. Apr. 10, 2017;—Am. 2017, Act 67, Imd. Eff. June 30, 2017.

Popular name: Act 218

500.836 Calendar year statutory valuation interest rates; use; determination; weighting factors; “reference interest rate” defined; alternative method for determination of reference interest rate; changes to policy or contract forms; computing reference interest rate for calendar year 1986.

Sec. 836. (1) The calendar year statutory valuation interest rates as defined in this section are the interest rates used in determining the minimum standard for the valuation of the following:

(a) All life insurance policies issued in a particular calendar year on or after the operative date of paragraphs 9 to 18 of section 4060(5).

(b) All individual annuity and pure endowment contracts issued in a calendar year after December 31, 1982.

(c) All annuities and pure endowments purchased in a calendar year after December 31, 1982 under group annuity and pure endowment contracts.

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(d) The net increase, if any, in a calendar year after January 1, 1983 in amounts held under guaranteed interest contracts.

(2) The calendar year statutory valuation interest rates, I, shall be determined as follows, and the results rounded to the nearer 0.25%:

(a) For life insurance,

$$I = .03 + W (R1 - .03) + \frac{W}{2} (R2 - .09).$$

where R is the reference interest rate defined in this section, R1 is the lesser of R and .09, R 2 is the greater of R and .09, and W is the weighting factor defined in this section.

(b) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options, I = .03 + W (R - .03) where R is the reference interest rate defined in this section, R1 is the lesser of R and .09, R 2 is the greater of R and .09, and W is the weighting factor defined in this section.

(c) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subdivision (b), the formula for life insurance stated in subdivision (a) applies to annuities and guaranteed interest contracts with guaranteed durations in excess of 10 years and the formula for single premium immediate annuities stated in subdivision (b) applies to annuities and guaranteed interest contracts with guaranteed duration of 10 years or less.

(d) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in subdivision (b) applies.

(e) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in subdivision (b) applies.

(3) However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than 0.5%, the calendar year statutory valuation interest rate for the life insurance policies must be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year must be determined for 1980 using the reference interest rate defined for 1979 and must be determined for each subsequent calendar year regardless of when paragraphs 9 to 18 of section 4060(5) become operative.

(4) The weighting factors referred to in the formulas in subsection (2) are given in the following tables:

(a) The weighting factors for life insurance are:

Guaranteed Duration (Years)	Weighting Factors
10 or less	.50
more than 10, but not more than 20	.45
more than 20	.35

For life insurance, the guaranteed duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values, or both, that are guaranteed in the original policy.

(b) The weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options is .80.

(c) The weighting factors for other annuities and for guaranteed interest contracts, except as stated in subdivision (b), are specified in subparagraphs (*i*), (*ii*), and (*iii*), according to the rules and definitions in subparagraphs (*iv*), (*v*), and (*vi*) as follows:

(*i*) For annuities and guaranteed interest contracts valued on an issue year basis:

Guaranteed Duration (Years)	Weighting Factor For Plan Type A	B	C
5 or less:	.80	.60	.50
more than 5, but not more than 10:	.75	.60	.50

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more than 10, but not more than 20:	.65	.50	.45
more than 20:	.45	.35	.35

	Plan Type		
	A	B	C
(*ii*) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in subparagraph (*i*) increased by:	.15	.25	.05

	Plan Type		
	A	B	C
(*iii*) For annuities and guaranteed interest contracts valued on an issue year basis, other than those with no cash settlement options, that do not guarantee interest on considerations received more than 1 year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis that do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors shown in subparagraph (*i*) or derived in subparagraph (*ii*) increased by:	.05	.05	.05

(*iv*) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guaranteed duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guaranteed duration in excess of 20 years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guaranteed duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(*v*) As used in subparagraphs (*i*) to (*iii*):

(A) "Plan Type A" means at any time the policyholder may withdraw funds only with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; without the adjustment but in installments over 5 years or more; as an immediate life annuity; or no withdrawal permitted.

(B) "Plan Type B" means before expiration of the interest rate guarantee, the policyholder may withdraw funds only with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; without the adjustment but in installments over 5 years or more; or no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without the adjustment in a single sum or installments over less than 5 years.

(C) "Plan Type C" means the policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than 5 years either without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company or subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(*vi*) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this section, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(5) As used in subsections (2) and (3), "the reference interest rate" means:

(a) For all life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, inc.

(b) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase or December 31 of the calendar year preceding the year of issue or year of purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, inc. An insurer shall use the same method of computing the reference interest rate under this subdivision in all of its contracts. An insurer shall not change its method of computing the reference interest rate under this subdivision unless the insurer has notified and received approval from the director.

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(c) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in subdivision (b), with guaranteed duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase or December 31 of the calendar year preceding the year of issue or year of purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, inc. An insurer shall use the same method of computing the reference interest rate under this subdivision in all of its contracts. An insurer shall not change its method of computing the reference interest rate under this subdivision unless the insurer has notified and received approval from the director.

(d) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in subdivision (b), with guaranteed duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase or December 31 of the calendar year preceding the year of issue or year of purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, inc. An insurer shall use the same method of computing the reference interest rate under this subdivision in all of its contracts. An insurer shall not change its method of computing the reference interest rate under this subdivision unless the insurer has notified and received approval from the director.

(e) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase or December 31 of the calendar year preceding the year of issue or year of purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, inc. An insurer shall use the same method of computing the reference interest rate under this subdivision in all of its contracts. An insurer shall not change its method of computing the reference interest rate under this subdivision unless the insurer has notified and received approval from the director.

(f) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in subdivision (b), the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund or December 31 of the calendar year preceding the year of the change in the fund, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, inc. An insurer shall use the same method of computing the reference interest rate under this subdivision in all of its contracts. An insurer shall not change its method of computing the reference interest rate under this subdivision unless the insurer has notified and received approval from the director.

(6) If Moody's corporate bond yield average - monthly average corporates is no longer published by Moody's investors service, inc. or if the national association of insurance commissioners determines that Moody's corporate bond yield average - monthly average corporates as published by Moody's investors service, inc. is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the national association of insurance commissioners and approved by a rule promulgated by the director, may be substituted.

(7) Any changes to policy or contract forms that are needed because of changes in valuation rates do not require refiling with, or approval by, the director.

(8) An insurer may use December 31, 1985 for purposes of computing the reference interest rate for the calendar year 1986 only.

History: Add. 1982, Act 221, Imd. Eff. July 10, 1982;—Am. 1986, Act 12, Imd. Eff. Mar. 3, 1986;—Am. 2014, Act 571, Eff. Mar. 31, 2015.

Popular name: Act 218

500.836a Valuation of disability plans and contracts issued before date of valuation manual; regulations; accidental and health insurance contracts; definitions.

Sec. 836a. (1) The director shall promulgate regulations containing the minimum standards applicable to the valuation of disability plans and contracts issued before the date of the valuation manual. For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under section 830(2).

(2) As used in this section, the following definitions apply on and after the operative date of the valuation manual:

(a) "Accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(b) "NAIC" means the national association of insurance commissioners.

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(c) "Valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in section 836b.

History: Add. 2014, Act 571, Eff. Mar. 31, 2015.

Popular name: Act 218

500.836b Valuation manual; establishment of reserves using principle-based valuation; duties of company; confidential information; definitions.

Sec. 836b. (1) All of the following apply to the valuation manual:

(a) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(*i*) The NAIC has adopted the valuation manual by a vote of at least 42 members, or 3/4 of the members voting, whichever is greater.

(*ii*) The standard valuation law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than 75% of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident, and health annual statements; health annual statements; or fraternal annual statements.

(*iii*) The standard valuation law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least 42 of the following 55 jurisdictions: the 50 states of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

(b) Unless a change in the valuation manual specifies a later effective date, a change to the valuation manual is effective on January 1 after the date the NAIC adopts the change to the valuation manual by a vote representing both of the following:

(*i*) At least 3/4 of the members of the NAIC, but not less than a majority of the total membership.

(*ii*) Members of the NAIC representing jurisdictions that amount to greater than 75% of the direct premiums written as reported in the following annual statements most recently available before the vote in subparagraph (*i*): life, accident, and health annual statements; health annual statements; or fraternal annual statements.

(c) The valuation manual must specify all of the following:

(*i*) Minimum valuation standards for and definitions of the policies or contracts subject to section 830(2). The minimum valuation standards are all of the following:

(A) The director's reserve valuation method for life insurance contracts, other than annuity contracts, subject to section 830(2).

(B) The director's annuity reserve valuation method for annuity contracts subject to section 830(2).

(C) Minimum reserves for all other policies or contracts subject to section 830(2).

(*ii*) The policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation under subsection (2) and the minimum valuation standards consistent with those requirements.

(*iii*) For policies and contracts subject to a principle-based valuation under subsection (2), all of the following apply:

(A) Requirements for the format of reports to the director under subsection (3)(c) and that must include information necessary to determine if the valuation is appropriate and in compliance with this section.

(B) Assumptions must be prescribed for risks over which the company does not have significant control or influence.

(C) Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of the procedures.

(*iv*) For policies that are not subject to a principle-based valuation under subsections (2), (3), and (4), the minimum valuation standard is 1 of the following:

(A) The standard is consistent with the minimum standard of valuation before the operative date of the valuation manual.

(B) The standard develops reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring.

(*v*) Other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules, and internal controls.

(*vi*) The data and form of the data required under subsection (5), to whom the data must be submitted, and

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may specify other requirements including data analyses and reporting of analyses.

(d) If there is not a specific valuation requirement or if the director determines that a specific valuation requirement in the valuation manual does not comply with this section, the company shall, with respect to the requirement, comply with minimum valuation standards prescribed by the director by rule.

(e) The director may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement of this section. The director may rely on the opinion, regarding this section, of a qualified actuary engaged by the commissioner of another state, district, or territory of the United States. As used in this subdivision, "engage" includes employment and contracting.

(f) The director may require a company to change any assumption or method that the director considers necessary to comply with the requirements of the valuation manual or this section, and the company shall adjust the reserves as required by the director.

(2) A company shall establish reserves using a principle-based valuation that meets all of the following conditions for policies or contracts as specified in the valuation manual:

(a) Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For polices or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk.

(b) Incorporate assumptions, risk analysis methods, financial models, and management techniques that are consistent with, but not necessarily identical to, those used within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods.

(c) Incorporate assumptions that are derived in 1 of the following manners:

(*i*) The assumption is prescribed in the valuation manual.

(*ii*) For assumptions that are not prescribed in the valuation manual, the assumptions must do the following, as applicable:

(A) Use the company's available experience, to the extent it is relevant and statistically credible.

(B) To the extent that company data are not available, relevant, or statistically credible, use other relevant and statistically credible experience.

(d) Provide margins for uncertainty, including adverse deviation and estimation error, such that the greater the uncertainty, the larger the margin and resulting reserve.

(3) A company that uses principle-based valuation for 1 or more policies or contracts subject to this section as specified in the valuation manual shall do all of the following:

(a) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.

(b) Provide to the director and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. The internal controls must be designed to assure that all material risks inherent in the liabilities and associated assets subject to the valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification must be based on the controls in place at the end of the preceding calendar year.

(c) Develop, and file with the director on request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

(4) A principle-based valuation may include a prescribed formulaic reserve component.

(5) A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

(6) Except as otherwise provided in this section, confidential information is confidential and privileged, is not subject to disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, is not subject to subpoena, and is not subject to discovery or admissible in evidence in a private civil action. However, the director may use the confidential information in the furtherance of any regulatory or legal action brought as a part of the director's official duties.

(7) The director or any person who received confidential information while acting under the authority of the director shall not testify in a private civil action concerning confidential information.

(8) The director may do all of the following:

(a) Except as otherwise provided in this subdivision, share confidential information with other state, federal, and international regulatory agencies and with the NAIC and its affiliates and subsidiaries. The director may also share confidential information described in subsection (14)(c)(*i*) and (*iv*) only with the actuarial board for counseling and discipline or its successor on request for the purpose of professional

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disciplinary proceedings and with state, federal, and international law enforcement officials. The director shall not share confidential information unless the recipient agrees in writing to maintain the confidentiality and privileged status of the confidential information and has verified in writing the legal authority to maintain confidentiality.

(b) Subject to this subdivision, receive documents, materials, data, or information from regulatory or law enforcement officials of other foreign or domestic jurisdictions, the actuarial board for counseling and discipline or its successor, and the NAIC and its affiliates and subsidiaries. The director shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(9) The director may enter into written agreements governing sharing and use of information provided under this section.

(10) The disclosure or sharing of confidential information to the director under this section is not a waiver of an applicable privilege or claim of confidentiality.

(11) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this section applies in any proceeding in, and in any court of, this state.

(12) As used in subsections (6) to (10), "regulatory agency", "law enforcement agency", and "NAIC" include, but are not limited to, their employees, agents, consultants, and contractors.

(13) Notwithstanding anything in this section to the contrary, any confidential information described in subsection (14)(c)(*i*) and (*iv*) is subject to all of the following:

(a) The confidential information is subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under section 830a or principle-based valuation report developed under subsection (3)(c) by reason of an action required by section 830a or subsection (3)(c) or by rules promulgated under this section.

(b) The director may release the confidential information with the written consent of the company.

(c) If any portion of a memorandum in support of an opinion submitted under section 830a or a principle-based valuation report developed under subsection (3)(c) is cited by the company in its marketing, is cited before a governmental agency other than a state insurance department, or is released by the company to the news media, the memorandum or report is not confidential.

(14) As used in this section:

(a) "Accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(b) "Company" means an entity that has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and has at least 1 policy in force or on claim or that has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this state.

(c) "Confidential information" means all of the following:

(*i*) A memorandum in support of an opinion submitted under section 830a and any other documents, materials, and other information, including, but not limited to, all working papers, and copies of working papers, created, produced, or obtained by or disclosed to the director or any other person in connection with the memorandum.

(*ii*) All documents, materials, and other information, including, but not limited to, all working papers, and copies of working papers, created, produced, or obtained by or disclosed to the director or any other person in the course of an examination made under subsection (1)(e) if an examination report or other material prepared in connection with an examination made under section 222 is not held as private and confidential information under section 222, an examination report or other material prepared in connection with an examination made under subsection (1)(e) is not "confidential information" to the same extent as if the examination report or other material had been prepared under section 222.

(*iii*) Any reports, documents, materials, and other information developed by a company in support of, or in connection with, an annual certification by the company under subsection (3)(b) evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials, and other information, including, but not limited to, all working papers, and copies of working papers, created, produced, or obtained by or disclosed to the director or any other person in connection with such reports, documents, materials, and other information.

(*iv*) Any principle-based valuation report developed under subsection (3)(c) and any other documents, materials, and other information, including, but not limited to, all working papers, and copies of working

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papers, created, produced, or obtained by or disclosed to the director or any other person in connection with the report.

(*v*) Any documents, materials, data, and other information submitted by a company under subsection (5), collectively, experience data, and any other documents, materials, data, and other information, including, but not limited to, all working papers, and copies of working papers, created or produced in connection with the experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the director, together with any experience data, the experience materials and any other documents, materials, data, and other information, including, but not limited to, all working papers, and copies of working papers, created, produced, or obtained by or disclosed to the director or any other person in connection with the experience materials.

(d) "Deposit-type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

(e) "Life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(f) "NAIC" means the National Association of Insurance Commissioners.

(g) "Policyholder behavior" means any action a policyholder, contract holder, or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this section, including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(h) "Principle-based valuation" means a reserve valuation that uses 1 or more methods or 1 or more assumptions determined by the insurer and is required to comply with this section as specified in the valuation manual.

(i) "Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

(j) "Tail risk" means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

(k) "Valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in this section.

History: Add. 2014, Act 571, Eff. Mar. 31, 2015;—Am. 2016, Act 558, Eff. Apr. 10, 2017;—Am. 2020, Act 15, Imd. Eff. Jan. 27, 2020.

Popular name: Act 218

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500.837 Definitions; valuation requirements for universal life insurance policies.

Sec. 837. (1) As used in this section:

(a) "A" means the present value of all future guaranteed benefits at the date of valuation.

(b) "B" means the quantity

$$\frac{PVFB_a}{a}$$

(c) "C" is the quantity

$$((g) - (h))(a_{\overline{a}})(r)$$

where (g) and (h) are the same as (g) and (h) as defined in section 834(2) for the plan of insurance defined at issue by the guaranteed maturity premiums and all guarantees contained in the policy or declared by the insurer.

(d) "D" is the sum of any additional quantities analogous to "C" that arise because of structural changes in the policy, with each such quantity being determined on a basis consistent with that of "C" using the maturity date in effect at the time of the change.

(e) "Guaranteed maturity fund at any duration" means that amount which, together with future guaranteed maturity premiums, will mature the policy based on all policy guarantees at issue.

(f) "Guaranteed maturity premium for fixed premium universal life insurance policies" shall be the premium defined in the policy that at issue provides the minimum policy guarantees.

(g) "Guaranteed maturity premium for flexible premium universal life insurance policies" means that level

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gross premium, paid at issue and periodically thereafter over the period during which premiums are allowed to be paid, which will mature the policy on the latest maturity date, if any, permitted under the policy for an amount that is in accordance with the policy structure. If there is no applicable latest maturity date, the highest age in the valuation mortality table shall be used.

(h) "Maturity amount" means the initial death benefit if the death benefit is level over the lifetime of the policy except for the existence of a minimum death benefit corridor, or means the specific amount if the death benefit equals a specified amount plus the policy value or cash surrender value except for the existence of a minimum death benefit corridor.

(i) "PVFB" means the present value of all benefits guaranteed at issue assuming future guaranteed maturity premiums are paid by the policyowner and taking into account all guarantees contained in the policy or declared by the insurer.

(j) "Structural changes" are those changes that are separate from the automatic workings of the policy. Such changes usually would be initiated by the policyholder and include changes in the guaranteed benefits, changes in latest maturity date, or changes in allowable premium payment period. For fixed premium universal life policies with redetermination of all credits and charges no more frequently than annually, on policy anniversaries, structural changes also include changes in guaranteed benefits, or in fixed premiums, unanticipated by the guaranteed maturity premium for such policies at the date of issue, even if such changes arise from automatic workings of the policy.

(k) The letter "r" is equal to 1, unless the policy is a flexible premium policy and the policy value is less than the guaranteed maturity fund, in which case "r" is the ratio of the policy value to the guaranteed maturity fund.

(*l*) The letter "t" means the duration of the policy.

(m) The letter "x" means the issue age.

(n) "a_x" and "a_{x+t}" are present values of an annuity of 1 per year payable on policy anniversaries beginning at ages x and x+t, respectively, and continuing until the highest attained age at which a premium may be paid under the policy.

(2) All of the following are valuation requirements for universal life insurance policies:

(a) The minimum valuation standard for universal life insurance policies shall be the commissioner's reserve valuation method as described in this section and the tables and interest rates as specified in this section.

(b) The terminal reserve for the basic policy and any benefits or riders for which premiums are not paid separately as of any policy anniversary shall be equal to the net level premium reserves less "C" and less "D", where net level premium reserves shall be equal to (A-B)(r).

(c) The guaranteed maturity premium is calculated at issue based on all policy guarantees at issue, excluding guarantees linked to an external referent. The guaranteed maturity premium for both flexible and fixed premium policies shall be adjusted for death benefit corridors provided by the policy. The guaranteed maturity premium may be less than the premium necessary to pay all charges.

(d) The guaranteed maturity premium, the guaranteed maturity fund, and "B" shall be recalculated to reflect any structural changes in the policy. This recalculation shall be done in a manner consistent with this section.

(e) The recomputation of "B", for fixed premium universal life structural changes, shall exclude from "PVFB", the present value of future guaranteed benefits, those guaranteed benefits that are funded by the excess of the insurer's declared guarantees of interest, mortality and expenses, over the guarantees contained in the policy at the date of issue.

(f) Future guaranteed benefits shall be determined by both of the following:

(*i*) Projecting the greater of the guaranteed maturity fund and the policy value, taking into account future guaranteed maturity premiums, if any, and using all guarantees of interest, mortality, expense deductions, etc., contained in the policy or declared by the insurer.

(*ii*) Taking into account any benefits guaranteed in the policy or by declaration that do not depend on the policy value.

(g) To the extent that the insurer declares guarantees more favorable than the contractual guarantees in the policy, the declared guarantees shall be applicable to the determination of future guaranteed benefits.

(h) All present values shall be determined using all of the following:

(*i*) An interest rate or rates specified in section 834(1) for policies issued in the same year.

(*ii*) The mortality rates specified in section 834(1) for policies issued in the same year or contained in such other table as may be approved by the commissioner for this purpose.

(*iii*) Any other tables needed to value supplementary benefits provided by a rider that is being valued together with the policy.

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(i) The mortality and interest bases for calculating present values are the minimum standards specified in section 834(1).

(j) If, in any policy year, the guaranteed maturity premium on any universal life insurance policy is less than the valuation net premium for the policy, calculated by the valuation method actually used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for the contract shall be the greater of the following:

(*i*) The reserve calculated according to the method, the mortality table, and the rate of interest actually used.

(*ii*) The reserve calculated according to the method actually used but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the guaranteed maturity premium in each policy year for which the valuation net premium exceeds the guaranteed maturity premium.

(k) For universal life insurance reserves on a net level premium basis, the valuation net premium is

$$\frac{PVFB}{a}$$

and for reserves on a commissioner's reserve valuation method, the valuation net premium is

$$\frac{PVFB}{a} + \frac{(g)-(h)}{a}.$$

History: Add. 1993, Act 349, Eff. Oct. 1, 1994.

Popular name: Act 218

500.838 Definitions; use of NAIC accounting practices and procedures manual; mortality table; separate rates for smokers and nonsmokers; determining minimum reserve liabilities, minimum cash surrender values, and amounts of paid-up nonforfeiture benefits; actuarial opinion; application of accounting practices and procedural manual; rates and charges based on gender; blended tables; basis as sex-distinct and sex-neutral.

Sec. 838. (1) As used in this section:

(a) "2001 CSO mortality table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American academy of actuaries CSO task force from the valuation basic mortality table developed by the society of actuaries individual life insurance valuation mortality task force and adopted by the NAIC in December 2002. Unless the context indicates otherwise, the 2001 CSO mortality table includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

(b) "2001 CSO mortality table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO mortality table.

(c) "2001 CSO mortality table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO mortality table.

(d) "Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

(e) "NAIC" means the national association of insurance commissioners.

(f) "Smoker and nonsmoker mortality tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.

(2) In addition to the other requirements of this act, a life insurer shall use appendix A-830 of the NAIC accounting practices and procedures manual for the valuation of life insurance policies. Any supplements, replacements, or changes to appendix A-830 of the NAIC accounting practices and procedures manual that are adopted by the NAIC only take effect if adopted by the director by rules promulgated under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. This section does not expand the applicability of appendix A-830 of the NAIC accounting practices and procedures manual to include life insurance policies otherwise exempt under appendix A-830 of the NAIC accounting practices and procedures manual.

(3) At the election of an insurer for each plan of insurance and subject to this section, the 2001 CSO mortality table may be used as the minimum standard for policies issued on or after July 1, 2004 and before January 1, 2009 to which sections 834(1)(a) and 4060(5)(f) and (g) are applicable. If an insurer elects to use the 2001 CSO mortality table, it shall do so for both valuation and nonforfeiture purposes. Subject to this section, the 2001 CSO mortality table must be used in determining minimum standards for policies issued on or after January 1, 2009 to which sections 834(1)(a) and 4060(5)(f) and (g) are applicable.

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(4) For plans of insurance without separate rates for smokers and nonsmokers, the composite mortality tables must be used. For each plan of insurance with separate rates for smokers and nonsmokers, an insurer may use any of the following:

(a) Composite mortality tables to determine minimum reserve liabilities, minimum cash surrender values, and amounts of paid-up nonforfeiture benefits.

(b) Smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by section 834 and composite mortality tables to determine the basic minimum reserve liabilities, minimum cash surrender values, and amounts of paid-up nonforfeiture benefits.

(c) Smoker and nonsmoker mortality tables to determine minimum reserve liabilities, minimum cash surrender values, and amounts of paid-up nonforfeiture benefits.

(5) An insurer may, at the option of the insurer for each plan of insurance, use the 2001 CSO mortality table in its ultimate or select and ultimate form for the purpose of determining minimum reserve liabilities, minimum cash surrender values, and amounts of paid-up nonforfeiture benefits for each plan of insurance.

(6) If the 2001 CSO mortality table is the minimum reserve standard for any plan for an insurer, the actuarial opinion in the annual statement filed with the director must be completed under section 830a. The director may exempt an insurer that does business in this state and in no other state from this subsection.

(7) In valuing life insurance policies pursuant to appendix A-830 of the NAIC accounting practices and procedures manual, all of the following apply:

(a) In determining the applicability to any universal life policy, the net level reserve premium for the secondary guarantee period is based on the ultimate mortality rates in the 2001 CSO mortality table.

(b) All calculations under the contract segmentation method are made using the 2001 CSO mortality rate, and, if elected, the optional minimum mortality standard for deficiency reserves. The value of "$q_{x+k+t-1}$" is the valuation mortality rate for deficiency reserves in policy year k+t, but using the unmodified select mortality rates if modified select mortality rates are used in the computation of deficiency reserves.

(c) For purposes of general calculation requirements for basic reserves and premium deficiency reserves, the 2001 CSO mortality table is the minimum standard for basic reserves.

(d) For purposes of general calculation requirements for basic reserves and premium deficiency reserves, the 2001 CSO mortality table is the minimum standard for deficiency reserves. If select mortality rates are used, they may be multiplied by X percent for durations in the first segment, subject to the conditions set forth in appendix A-830 of the NAIC accounting practices and procedures manual. In demonstrating compliance with those conditions, the demonstrations may not combine the results of tests that utilize the 1980 CSO mortality table with those tests that utilize the 2001 CSO mortality table, unless the combination is explicitly required by regulation or is necessary to be in compliance with relevant actuarial standards of practice.

(e) When determining minimum value for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits, other than universal life policies, the valuation mortality table used in determining the tabular cost of insurance is the ultimate mortality rates in the 2001 CSO mortality table.

(f) When determining the optional exemption for yearly renewable term reinsurance for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits, other than universal life policies, the calculations must use the maximum valuation interest rate and the ultimate mortality rates in the 2001 CSO mortality table.

(g) When determining the optional exemption for attained-age-based yearly renewable term life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits, other than universal life policies, the calculations must use the maximum valuation interest rate and the ultimate mortality rates in the 2001 CSO mortality table.

(h) When determining the exemption from unitary reserves for certain n-year renewable term life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits, other than universal life policies, the calculations must use the ultimate mortality rates in the 2001 CSO mortality table.

(i) For flexible premium and fixed premium universal life insurance policies that contain provisions resulting in the ability of a policyowner to keep a policy in force over a secondary guarantee period, the 1-year valuation premium for purposes of identifying policies with a secondary guarantee is calculated using the ultimate mortality rates in the 2001 CSO mortality table.

(8) For any ordinary life insurance policy delivered or issued for delivery in this state on or after July 1, 2004 that uses the same premium rates and charges for male and female lives or is issued in circumstances where applicable law does not permit distinctions on the basis of gender, a mortality table that is a blend of the 2001 CSO mortality table (M) and the 2001 CSO mortality table (F) may, at the option of the insurer for each plan of insurance, be substituted for the 2001 CSO mortality table for use in determining minimum cash surrender value and amounts of paid-up nonforfeiture benefits. No change in minimum valuation standards is implied by this subsection.

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(9) In determining minimum reserve liabilities and nonforfeiture benefits, an insurer may choose from among the blended tables developed by the American academy of actuaries CSO task force and adopted by the NAIC in December 2002.

(10) It is not, by itself, a violation of chapter 20 for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis.

History: Add. 2004, Act 236, Imd. Eff. July 21, 2004;—Am. 2014, Act 571, Eff. Mar. 31, 2015.

Compiler's note: Former MCL 500.838, which pertained to valuation of group life insurance policies, was repealed by Act 318 of 1969, Eff. Mar. 20, 1970.

Popular name: Act 218

500.838a Definitions; 2001 CSO preferred class structure mortality table.

Sec. 838a. (1) As used in this section:

(a) "2001 CSO mortality table" means that term as defined in section 838.

(b) "2001 CSO preferred class structure mortality table" means mortality tables with separate rates of mortality for super preferred nonsmokers, preferred nonsmokers, residual standard nonsmokers, preferred smokers, and residual standard smoker splits of the 2001 CSO nonsmoker and smoker tables as adopted by the NAIC at the September 2006 national meeting and published in the "NAIC Proceedings" (3rd Quarter 2006). Unless the context indicates otherwise, the "2001 CSO preferred class structure mortality table" includes both the ultimate form of that table and the select and ultimate form of that table. It includes both the smoker and nonsmoker mortality tables. It includes both the male and female mortality tables and the gender composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality table.

(c) "Director" means the director of the department of insurance and financial services.

(d) "NAIC" means the national association of insurance commissioners.

(e) "Smoker and nonsmoker mortality tables" means that term as defined in section 838.

(f) "Statistical agent" means an entity with proven systems for protecting the confidentiality of individual insured and insurer information; demonstrated resources for and history of ongoing electronic communications and data transfer ensuring data integrity with insurers that are its members or subscribers; and a history of and means for aggregation of data and accurate promulgation of the experience modifications in a timely manner.

(2) Subject to subsections (6) and (7), an insurer may substitute the 2001 CSO preferred class structure mortality table in place of the 2001 CSO smoker and nonsmoker mortality tables as the minimum valuation standard for policies issued after June 30, 2004 and before January 1, 2007. An insurer may, for each calendar year of issue for any 1 or more specified plans of insurance and subject to this section, substitute the 2001 CSO preferred class structure mortality table in place of the 2001 CSO smoker and nonsmoker mortality tables as the minimum valuation standard for policies issued on or after January 1, 2007. An insurer shall not elect the 2001 CSO preferred class structure mortality table until the insurer demonstrates that not less than 20% of the business valued on this table is in 1 or more of the preferred classes. A table from the 2001 CSO preferred class structure mortality table used in place of a 2001 CSO mortality table as provided in this section is treated as part of the 2001 CSO mortality table only for purposes of reserve valuation under section 838.

(3) For each plan of insurance with separate rates for preferred and standard nonsmoker lives, an insurer may use the super preferred nonsmoker, preferred nonsmoker, and residual standard nonsmoker tables to substitute for the nonsmoker mortality table found in the 2001 CSO mortality table to determine minimum reserves. At the time of election and annually thereafter, except for business valued under the residual standard nonsmoker table, the appointed actuary shall certify both of the following:

(a) That the present value of death benefits over the next 10 years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

(b) That the present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

(4) For each plan of insurance with separate rates for preferred and standard smoker lives, an insurer may use the preferred smoker and residual standard smoker tables to substitute for the smoker mortality table found in the 2001 CSO mortality table to determine minimum reserves. At the time of election and annually thereafter, for business valued under the preferred smoker table, the appointed actuary shall certify both of the

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following:

(a) That the present value of death benefits over the next 10 years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table corresponding to the valuation table being used for that class.

(b) That the present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table.

(5) Unless exempted by the director, every authorized insurer using the 2001 CSO preferred class structure mortality table shall file annually with the director, with the NAIC, or with a statistical agent designated by the NAIC and acceptable to the director statistical reports showing mortality and other information as the director considers necessary or expedient for the administration of this section. The director shall establish the form of the reports under this subsection.

(6) The use of the 2001 CSO preferred class structure mortality table as the minimum valuation standard for policies issued after June 30, 2004 and before January 1, 2007 is subject to both of the following:

(a) The consent of the director. In determining consent, the director may rely on whether consent for the use of the 2001 CSO preferred class structure mortality table was given to the insurer by the commissioner of the insurer's state of domicile.

(b) The use is not permitted if the insurer reports in any statutory financial statement for a coinsured policy or portion of a policy coinsured, either of the following:

(*i*) If the mode of payment of the reinsurance premium is less frequent than the mode of payment of the policy premium, a reserve credit that exceeds by more than the amount specified in this subdivision as "Y", the gross reserve calculated before reinsurance. "Y" is the amount of the gross reinsurance premium that provides coverage for the period from the next policy premium due date to the earlier of the end of the policy year and the next reinsurance premium due date, and would be refunded to the ceding entity upon the termination of the policy.

(*ii*) If the mode of payment of the reinsurance premium is more frequent than the mode of payment of the policy premium, a reserve credit that is less than the gross reserve, calculated before reinsurance, by an amount that is less than the amount specified in this subdivision as "Z". "Z" is the amount of the gross reinsurance premium that the ceding entity would need to pay the assuming company to provide reinsurance coverage from the period of the next reinsurance premium due date to the next policy premium due date minus any liability established for the proportionate amount not remitted to the reinsurer.

(7) For purposes of (6)(b), the reserve for the mean reserve method is the mean reserve minus the deferred premium asset, and the reserve for the midterminal reserve method includes the unearned premium reserve. To satisfy subsection (6)(b), an insurer may estimate and adjust its accounting on an aggregate basis.

History: Add. 2006, Act 671, Imd. Eff. Jan. 10, 2007;—Am. 2014, Act 392, Imd. Eff. Dec. 22, 2014.

Compiler's note: Enacting section 1(2) of Act 671 of 2006 provides:

"(2) Section 838a of the insurance code of 1956, 1956 PA 218, MCL 500.838a, as added by this amendatory act, applies on and after January 1, 2007."

Popular name: Act 218

500.839 Capital notes.

Sec. 839. (1) A domestic insurer may issue capital notes under this section.

(2) A capital note issued by a domestic insurer may provide for interest payments at fixed or adjustable rates, for sinking fund payments, and for payments and redemptions of principal under the terms of the capital note.

(3) The issuance of a capital note is not subject to the commissioner's prior approval.

(4) A capital note shall be treated as a liability in the computation of statutory surplus and shall be reported as a liability on the domestic insurer's annual statement filed with the commissioner under section 438.

(5) In a liquidation proceeding pursuant to chapter 81, a capital note is a similar obligation under section 8142(1)(h).

(6) A capital note may be included in a domestic insurer's total adjusted capital. For a capital note to be so included, the commissioner may require the capital note to contain other features as the commissioner determines are adequate and appropriate to ensure that the insurer continues to be safe, reliable, and entitled to public confidence.

(7) As used in this section:

(a) "Capital note" means a debt instrument that complies with this section.

(b) "Total adjusted capital" means the sum of an insurer's statutory capital and surplus as determined under

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the annual statement filed with the commissioner under section 438.

History: Add. 1998, Act 457, Imd. Eff. Jan. 4, 1999.

Compiler's note: Former MCL 500.839, which pertained to group life insurance premiums, rules, and regulations, was repealed by Act 318 of 1969, Eff. Mar. 20, 1970.

Popular name: Act 218

500.840 Repealed. 1969, Act 318, Eff. Mar. 20, 1970.

Compiler's note: The repealed section pertained to stock in federal financing agency.

Popular name: Act 218

500.841 Valuation of certain bonds or other evidences of debt.

Sec. 841. (1) Subject to subsection (2), all bonds or other evidences of debt having a fixed term and rate of interest held by an insurer, if amply secured and not in default as to principal or interest, may be valued as follows:

(a) If purchased at par, at the par value.

(b) If purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield in the meantime the effective rate of interest at which the purchase was made, or in lieu of such method, according to the accepted method of valuation as approved by the commissioner.

(2) The purchase price of a bond or evidence of debt under subsection (1) shall not be taken at a higher figure than the actual market value at the time of purchase, plus actual brokerage, transfer, postage, or express charges paid in the acquisition of the securities.

(3) The commissioner shall have full discretion in determining the method of calculating values under this section, but a method or valuation shall not be inconsistent with any applicable valuation or method used by insurers in general.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.842 Valuation of certain securities, stocks, or shares.

Sec. 842. (1) Securities, other than those referred to in section 841, held by an insurer shall be valued, in the commissioner's discretion, at their market value, at their appraised value, or at prices determined by the commissioner as representing their fair market value.

(2) Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value in lieu of market value, at the commissioner's discretion and in accordance with a method of valuation as the commissioner may approve.

(3) Stock of a subsidiary corporation of an insurer shall not be valued at an amount in excess of the net value of the stock as based upon only those assets of the subsidiary that would be eligible under sections 910 through 947 for the direct investment of the insurer's funds.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

CHAPTER 9
INVESTMENTS

500.900 Repealed. 1969, Act 318, Eff. Mar. 20, 1970.

Compiler's note: The repealed section pertained to investments by domestic insurer.

Popular name: Act 218

500.901 Asset requirements for insurers.

Sec. 901. (1) Each domestic insurer shall maintain assets in cash or as defined in this chapter in a total amount at least equal to the sum of its liabilities including its reserves as required by this act, plus an amount equal to the lesser of the following:

(a) The minimum capital and surplus required to be maintained by sections 408 and 410.

(b) One of the following:

(*i*) For a fraternal benefit society regulated under chapter 81a, $1,000,000.00.

(*ii*) $7,000,000.00.

(2) For purposes of meeting the assets required by subsection (1), the following apply:

(a) The value of all computers shall not exceed 2% of the assets required by subsection (1) and the value of

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each computer shall not exceed the original cost of the computer amortized over a period not to exceed 3 years. For purposes of this section, "computer" means an electronic data processing system, composed of 1 or more components, that utilizes storage and processing mechanization and has a direct automatic means of input and output, including, but not limited to, central processing units, data input/output channels, main storage or memory, and peripheral devices for systems control, data input, output, or temporary or permanent storage of information, and associated reusable media required by these devices and operating systems software.

(b) Title insurers may include their net investment in their title plant.

(c) Assets described in sections 946 and 947 that are encumbered with prior liens that affect the salability of the asset to a material extent shall not be used to satisfy the requirements of subsection (1). For purposes of this subdivision, liens that do not affect the salability of the asset to a material extent are real estate taxes or assessments that are not delinquent, liens against an asset for which an insurer is insured against loss by title insurance, and any other liens that in the aggregate are not in excess of 5% of the fair market value of the asset. Assets described in sections 946 and 947 shall not be used to satisfy more than 20% of the requirements of subsection (1). This subdivision does not apply to assets described in section 942.

(d) Amounts receivable from broker/dealers registered under the securities exchange act of 1934, chapter 404, 48 Stat. 881, or from the issuer of a security or asset in connection with the disposition of assets qualified to satisfy subsection (1) may be included, provided the amount is not more than 5 business days past the date of disposition.

(e) Assets not otherwise defined in this chapter may be used as qualified assets for purposes of subsection (1) if the assets are rated investment grade by a securities rating organization approved by the commissioner.

(f) No more than 20% of the assets required by subsection (1) shall be high-yield, high-risk obligations. As used in this subdivision, "high-yield, high-risk obligations" means obligations that are not in 1 of the top 2 numbered classifications of bonds reported in the insurer's annual financial statement on a form approved by the commissioner.

(3) The sum of the liabilities and reserves computed for purposes of this section may be reduced by 1 or more of the following:

(a) A reinsurance balance recoverable or other credit due from a reinsurer that complies with existing or other applicable rules or orders promulgated or issued by the commissioner, to the extent that the balance recoverable or other credit due may be used to offset a liability as authorized in an insurer's annual statement concerning its affairs filed pursuant to section 438.

(b) Policy loans secured by policies included in the liabilities and reserves but not in excess of the cash surrender value of the policies.

(c) Premium notes secured by letters of credit, security trust funds, or unearned premium reserves.

(d) The net amount of insurance premiums and annuity considerations booked but deferred and not yet due. Reduction under this subdivision shall not be allowed for credit life and credit accident and health premiums deferred and uncollected, whether individual or group, except as allowed pursuant to subdivision (e).

(e) Amounts receivable from an agent, agency, policyholder, or other person that does not have control of more than 10% of all the insurer's agents' balances, and that is not affiliated with the insurer on policies with an effective date not more than 1 month old to the extent that the amounts are offset by unearned premium reserves on the same policies.

(f) Amounts receivable from a person to the extent the amounts offset liabilities or amounts payable to that person. Receivables and payables with respect to reinsurance may be allowed so long as the reinsurance contract has a right of offset provision. A reduction under this subdivision shall not be allowed for agents' balances or uncollected premiums as defined by subdivision (e).

(4) Assets, liabilities, and reserves under subsection (1) shall exclude assets, liabilities, and reserves included in separate accounts established in accordance with section 925. The value of income due and accrued in respect to assets required by subsection (1) may be included in the total amount. The assets shall not be valued at more than the actual value as ascertained in a manner approved by the commissioner, except those assets described in sections 912, 914, 918, 934, 938, and 942 that have a fixed term and rate, if amply secured and not in default as to principal and interest which may be valued as follows: if purchased at par, the par value; if purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield in the meantime the effective rate of interest at which the purchase was made. The purchase price shall not be taken at a higher figure than the actual market value at the time of purchase.

(5) The commissioner may permit other assets not specifically described in this section to be used as qualified assets for purposes of subsection (1), as long as the assets are financially equivalent to those assets

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described in sections 910 to 947, are approved by the commissioner as adequate as to quality and liquidity to secure the liabilities they support, and are valued in a manner approved by the commissioner.

(6) No more than 5% of the assets required by subsection (1) shall be invested in, loaned to, receivable from, secured by, leased or rented to, or deposited with 1 person or 1 group of affiliated persons or invested in 1 parcel of real estate. In calculating this restriction, the following apply:

(a) For purposes of this section, each issue of mortgage-backed securities secured by residential mortgage pools and rated investment grade by a securities rating organization approved by the commissioner, and each issue of asset-backed security rated investment grade by a securities rating organization approved by the commissioner, shall be considered a separate person regardless of other obligations issued by the same or affiliated issuer.

(b) This restriction does not apply to mortgage-related securities issued by the federal home loan mortgage corporation or the federal national mortgage association.

(c) This restriction does not apply to the extent that the principal and interest are fully guaranteed by the United States or any state.

(d) This restriction does not apply to assets invested in, loaned to, receivable from, secured by, leased or rented to, or deposited with an affiliate of the insurer that is authorized to transact insurance in any state or Canada.

(e) For an alien insurer that is an insurer authorized to transact the business of life insurance, for purposes of this subsection the 5% restriction applies to the total assets of the insurer, excluding assets included in separate accounts, as reported in the total business annual statement filed by the insurer with its domiciliary authority.

(f) This restriction does not apply to the value of a noninsurance affiliate that is owned solely by the insurer as described in subsection (7)(c).

(g) This restriction does not apply to the value of a noninsurance affiliate that is not owned solely by the insurer if the value of the noninsurance affiliate is determined in accordance with procedures approved by the commissioner and if the investment in the noninsurance affiliate is approved by the commissioner as adequate in quality and liquidity to secure the liabilities of the insurer.

(7) The assets referred to in subsection (1) shall not include assets invested in, loaned to, receivable from, secured by, leased or rented to, or deposited with a person that is, directly or indirectly, owned or controlled by the insurer or that, directly or indirectly, owns, controls, or is affiliated with the insurer as control is defined in section 115, except as follows:

(a) Amounts receivable from, secured by, leased or rented to, or deposited with an insurer affiliated with the insurer may be included if the amount receivable is not more than 90 days past due and its affiliated insurer complies with this section.

(b) Amounts invested in an affiliated publicly traded investment company that is registered and regulated under the investment company act of 1940, title I of chapter 686, 54 Stat. 789, 15 U.S.C. 80a-1 to 80a-3 and 80a-4 to 80a-64, may be included.

(c) The value of a noninsurance affiliate that is owned solely by the insurer may be included. The value of the noninsurance affiliate shall be the value of all assets qualifying under this section in excess of the assets required by this section, but shall not exceed the value determined by the securities valuation office of the national association of insurance commissioners. In support of the noninsurance affiliate's value, the insurer shall submit to the commissioner an audited financial statement for the noninsurance affiliate supplemented with a list of qualifying assets and associated values.

(d) Amounts invested in a noninsurance affiliate that is not owned solely by the insurer may be included if the investment in the noninsurance affiliate is approved by the commissioner as adequate in quality and liquidity to secure the liabilities of the insurer. The value of the noninsurance affiliate shall be the value determined in accordance with procedures adopted by the commissioner.

(e) The assets required by subsection (1) may include the value of amounts invested in or loaned to an affiliate authorized to transact insurance in any state or in Canada in an amount equal to the assets that would qualify for compliance with this section that are held by the affiliate and are in excess of the amount of assets that would be required for the affiliate by this section, prorated to reflect the extent of the insurer's investment in or loans to the affiliate. Qualified assets for purposes of subsection (1) include loans, other than surplus notes, to an affiliate authorized to transact insurance in any state or in Canada provided that the affiliate has assets in excess of the amount of assets that are required for the affiliate under subsection (1). With the commissioner's approval, surplus notes may be treated as an investment for purposes of this section.

(f) Amounts loaned to a noninsurance affiliate may be included if the loans are rated investment grade by a securities rating organization approved by the commissioner. The insurer shall submit documentation satisfactory to the commissioner in support of the investment grade rating.

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(8) An insurer may comply with this section if the insurer elects to provide alternative security to Michigan policyholders and claimants satisfactory to the commissioner or elects to deposit funds or securities of the kind described in section 912, or other securities acceptable to the commissioner, registered in the name of the state treasurer of Michigan, designated as exclusively held and deposited for the sole benefit of Michigan policyholders, claimants, and creditors pursuant to section 8141a, in an amount, at market value, considered adequate by the commissioner to secure Michigan policyholders, but not less than the greater of the aggregate sum of 100% of Michigan direct unpaid losses and unpaid loss adjustment expense plus 100% of Michigan direct unearned premiums and policy and contract reserves or the direct premiums written in Michigan during the most recent 12 months available in filed statements. Direct unpaid losses and unpaid loss adjustment expenses shall include a provision for incurred but not reported losses and associated loss adjustment expense. The deposit shall be a special deposit and shall be subject to special deposit claims for the benefit of Michigan policyholders and claimants pursuant to section 8141a. The deposit of funds required by this subsection shall be increased by adjustment each quarter. A decrease to the deposited fund may be made annually only upon a satisfactory showing by the insurer to the commissioner that a decrease in the deposit is justified. The commissioner may require the special deposits set forth in this subsection as a condition for any insurer to transact insurance in this state if the commissioner finds that a special deposit is necessary for the protection of Michigan policyholders and claimants.

(9) Compliance with subsection (1) is the obligation of each insurer, fund, or fraternal benefit society authorized to transact the business of insurance in this state. Failure to comply shall limit the insurer, fund, or fraternal benefit society under the remainder of this act. If, at any time following compliance with the requirements of this section, an insurer, fund, or fraternal benefit society fails to maintain compliance, the commissioner shall notify the insurer, fund, or fraternal benefit society that it has failed to maintain compliance with this section. Within 30 business days after notification by the commissioner of noncompliance with the provisions of this section, an insurer shall file a plan to restore compliance with this section. Failure of the insurer to file a plan shall create a presumption that the insurer is not safe, reliable, and entitled to public confidence. The commissioner, upon written request by the insurer, may grant a period of time within which to restore compliance. The period of time may be granted only if the commissioner is satisfied the insurer is safe, reliable, and entitled to public confidence; is satisfied the insurer would suffer a material financial loss from an immediate forced conversion of its assets; and approves the plan filed by the insurer for restoring compliance within the time granted. If the plan is not approved by the commissioner, or if the plan is approved, and, at the end of 1 year the insurer still does not comply with the requirements of this section, the commissioner may grant additional time to comply, or the commissioner may suspend, revoke, or limit the certificate of authority of the insurer pursuant to section 436.

(10) The requirements of this section constitute a discrete determination of financial solidity and liquidity and are not intended to apply to other provisions of this act with respect to financial condition or to the accounting practices and procedures governing the preparation of financial statements pursuant to section 438.

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History: Add. 1969, Act 318, Eff. Mar. 20, 1970;—Am. 1970, Act 125, Imd. Eff. July 23, 1970;—Am. 1980, Act 370, Imd. Eff. Dec. 30, 1980;—Am. 1982, Act 338, Imd. Eff. Dec. 17, 1982;—Am. 1984, Act 90, Imd. Eff. Apr. 19, 1984;—Am. 1986, Act 321, Imd. Eff. Dec. 26, 1986;—Am. 1988, Act 340, Imd. Eff. Oct. 18, 1988;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1992, Act 2, Imd. Eff. Jan. 31, 1992;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 226, Eff. Dec. 31, 1993;—Am. 2002, Act 462, Imd. Eff. June 21, 2002.

Compiler's note: Enacting section 2(1) of Act No. 226 of the Public Acts of 1994 provides: “Section 901 as amended by this amendatory act is retroactively effective and applies on and after December 31, 1993.”

Popular name: Act 218

Administrative rules: R 500.402 et seq. of the Michigan Administrative Code.

500.902 Investments by domestic insurer; amount in qualified asset required; definition.

Sec. 902. (1) Except as otherwise provided in sections 942(7), (10), and (11), 943(2), and 946(4), this chapter does not prohibit the investment of a domestic insurer's capital and surplus in any asset otherwise permitted to be held by any other person or corporation under the laws of this state, provided the domestic insurer maintains qualified assets as described in this chapter in the amounts specified in section 901.

(2) As used in this section, "qualified assets" means cash and those assets described in sections 910 to 947.

History: Add. 2002, Act 462, Imd. Eff. June 21, 2002.

Compiler's note: Former MCL 500.902, which pertained to authorized investments by domestic insurers, was repealed by Act 318 of 1969, Eff. Mar. 20, 1970.

Popular name: Act 218

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500.904 Repealed. 1957, Act 91, Eff. Sept. 27, 1957.

Compiler's note: The repealed section pertained to investment limitations of domestic mutual insurer.

Popular name: Act 218

500.906, 500.908 Repealed. 1969, Act 318, Eff. Mar. 20, 1970.

Compiler's note: The repealed sections pertained to assets and limitations on investments.

Popular name: Act 218

500.910 Certificates of deposit or depository receipts; construction as deposits of cash.

Sec. 910. Certificates of deposit or depository receipts issued by a bank, trust company or savings and loan association insured by the federal deposit insurance corporation or federal savings and loan insurance corporation to an insurer and not otherwise negotiable, transferable, encumbered or pledged, maturing not more than 1 year from date of issue, shall be construed as deposits of cash by the insurer.

History: Add. 1969, Act 318, Eff. Mar. 20, 1970.

Popular name: Act 218

500.912 Qualified assets; description; limitation on governmental securities.

Sec. 912. (1) Qualified assets for purposes of section 901 include all of the following:

(a) In the bonds or other evidences of indebtedness of the United States or Canada, or any state, province, territory, or public instrumentality of the United States or Canada, or in the valid public debt, bonds, or other evidence of indebtedness of any city, county, township, village, school district, or any other political subdivision having the power to levy taxes or of any state or territory of the United States or province of Canada, if the state, province, municipality, or other political subdivision has not, in the 3 years preceding the time of the investment, failed to pay its debt or any part of its debt, the interest due on the debt, or any part of the interest due on the debt. Delay, not exceeding 6 months, in the payment of any installment of principal or interest is not considered failure to pay.

(b) In the bonds or other evidences of indebtedness of any political subdivision of the United States, any state or county in the United States, any agency, public instrumentality, or authority created by the United States, or any state or county in the United States or any political subdivision of the state or county, if, by statutory or other legal requirements, those obligations are payable, as to both principal and interest, from adequate special revenues pledged or otherwise appropriated or by law required to be provided for the purpose of payment.

(c) In governmental bonds or governmental securities of this or any foreign government, or governmental subdivisions or authorities or instrumentalities, not otherwise provided for in this section subject to the limitations in subdivisions (a) and (b) prescribed for other governmental securities.

(2) A domestic insurer's investment in governmental securities is subject to the limitations in section 901(2)(f).

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1969, Act 318, Eff. Mar. 20, 1970;—Am. 2002, Act 462, Imd. Eff. June 21, 2002;—Am. 2014, Act 141, Eff. Mar. 31, 2015.

Popular name: Act 218

500.914 Qualified assets as guaranteed interest bonds.

Sec. 914. Qualified assets for purposes of section 901 include bonds or other securities, the interest of which is guaranteed by the United States government pursuant to any act of congress enacted before, on, or after January 1, 1957.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2002, Act 462, Imd. Eff. June 21, 2002.

Popular name: Act 218

500.916 Qualified assets as federal financing agency stock.

Sec. 916. If any agency or corporation is established by the federal government with authority to purchase, discount, or loan money upon the security of real estate mortgages but requiring membership or ownership of capital stock in that federal agency or corporation for any insurer organized under the laws of this state to avail itself of the full privileges of selling, rediscounting, or borrowing money upon those mortgages, then qualified assets for purposes of section 901 include the amount of capital stock that is required by the federal law or the rules of the governing body of the federal agency or corporation.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957;—Am. 1969, Act 318, Eff. Mar. 20, 1970;—Am. 2002, Act 462, Imd. Eff. June 21, 2002.

Popular name: Act 218

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500.917 Mortgage-backed securities; certain securities described in secondary mortgage market enhancement act of 1984 subject to limitations; definition.

Sec. 917. (1) Qualified assets for purposes of section 901 include mortgage-backed securities backed by pools of residential mortgages and rated investment grade by a securities rating organization approved by the commissioner. Any securities described in section 106 of title I of the secondary mortgage market enhancement act of 1984, Public Law 98-440, 15 U.S.C. 77r-1, shall be subject to all the limitations prescribed by this chapter for investments not guaranteed by the full faith and credit of the United States.

(2) As used in this section, "mortgage-backed securities" means securities representing an ownership interest in, or as to which payments are secured directly or indirectly by, a pool of mortgages or by the cash flows generated by a pool of mortgages and shall include, but are not limited to, mortgage pass-through securities and collateralized mortgage obligations.

History: Add. 1991, Act 106, Imd. Eff. Oct. 3, 1991;—Am. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 2002, Act 462, Imd. Eff. June 21, 2002.

Popular name: Act 218

500.917a Definitions; asset-backed securities.

Sec. 917a. (1) As used in this section:

(a) "Asset-backed securities" means securities, other than those governed by section 917, representing loans to, participations in loans to, or equity interests in a person that has as its primary activity the acquisition and holding of assets, directly or through a trustee, for the benefit of its debt or equity holders and includes, but is not limited to, structured securities, pass-through certificates, and other securitized obligations.

(b) "Assets" means pools of assets consisting of either interest bearing obligations or contractual obligations representing the right to receive payment from the assets.

(c) "Structured securities" means asset-backed securities that have been divided into 2 or more classes where the payment of interest on or principal of any class of the securities has been allocated in a manner that may not be directly proportional to interest or principal received by the issuer of the securities on the underlying assets.

(d) "Pass-through certificate" means an asset-backed security, whether or not mortgage-related, where the payment of interest or principal on the security is directly proportional to interest or principal received by the issuer of the security on the underlying assets.

(2) Qualified assets for purposes of section 901 include asset-backed securities that are rated investment grade by a securities rating organization approved by the commissioner. Asset-backed securities that are secured by or represent an undivided interest in a single asset or pool of assets or in the cash flows generated by those assets, including without limitation, structured securities and pass-through certificates, are subject to all the limitations prescribed by this chapter for investments not guaranteed by the full faith and credit of the United States.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 2002, Act 462, Imd. Eff. June 21, 2002.

Popular name: Act 218

500.918 Qualified assets by solvent institution; authorization; mortgage loans; equipment trust certificates; fixed interest bearing obligations.

Sec. 918. Qualified assets for purposes of section 901 include lawfully authorized obligations issued, assumed, or guaranteed by any solvent institution created or existing under the laws of the United States or of any state, district, or territory of the United States, or of Canada or any province of Canada, that are not in default as to principal or interest and that are qualified under any of the following clauses:

(a) Obligations secured by the mortgage of property or the pledge of adequate collateral if, during any 3, including the last 2, of the 5 fiscal years next preceding the time of investment, the net earnings of the issuing, assuming, or guaranteeing institution available for fixed charges, as determined in accordance with standard accounting practice, have been not less than the total of its fixed charges for such year on an overall basis nor less than 1-1/2 times its fixed charges for such year on a priority basis after excluding interest requirements on obligations junior to such issue as to security.

(b) In equipment trust certificates of railroad companies organized under the laws of any state of the United States or of Canada or of any province of Canada, payable within 20 years from their date of issue, in annual or semiannual installments, beginning not later than the fifth year after such date, and which certificates are a first lien on the specific equipment pledged as security for the payment which are either the direct obligations of the railroad companies or guaranteed by them, or are executed by trustees holding title to the equipment.

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(c) Fixed interest bearing obligations other than those described in subdivisions (a) and (b), if the net earnings of the issuing, assuming, or guaranteeing institution available for fixed charges during each of any 3, including the last 2, of the 5 fiscal years next preceding the time of investment, shall have been not less than 1-1/2 times the total of its fixed charges for such year.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2002, Act 462, Imd. Eff. June 21, 2002.

Popular name: Act 218

500.920 Net earnings available for fixed charges; definition.

Sec. 920. For the purposes of this chapter, the term "net earnings available for fixed charges" means net income after deducting operating and maintenance expenses, taxes other than federal and state income taxes, depreciation and depletion, but excluding extraordinary nonrecurring items of income and expenses appearing in the regular financial statements of the issuing company.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.922 Qualified assets in stocks, bonds, or evidences of corporate indebtedness; authorization.

Sec. 922. Qualified assets for purposes of section 901 include stocks, bonds, and other evidence of indebtedness of solvent corporations as approved by its board of directors or a committee of the board entrusted with the investment of the company's funds. The insurer may hold the stocks, bonds, and other evidences of indebtedness as an investment.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957;—Am. 1969, Act 318, Eff. Mar. 20, 1970;—Am. 1991, Act 79, Imd. Eff. July 18, 1991;—Am. 2002, Act 462, Imd. Eff. June 21, 2002.

Popular name: Act 218

500.924 Qualified assets in preferred stock; conditions.

Sec. 924. Qualified assets for purposes of section 901 include preferred stocks of any company organized under the laws of the United States, a state of the United States, the District of Columbia, Canada, or a province or territory of Canada, if the company has continuously and regularly paid the dividends provided for by the preferred stock during the 5 years preceding the investment; except that with respect to preferred stocks issued within the 5-year period, the dividend payments requirement applies only from the date of issuance, and in those cases the net earnings of the company and its subsidiaries available for fixed charges of the company and its subsidiaries and the net earnings of any predecessor organizations and their subsidiaries, if any, available for fixed charges of the predecessor organizations and their subsidiaries, must have averaged an amount per annum for the 5 fiscal years preceding the making of the investment at least equal to 2 times the total of the annual interest charges, including amortization of debt discount and expense, and dividends guaranteed, if any, and the preferred dividend requirement on a pro forma basis.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1969, Act 318, Eff. Mar. 20, 1970;—Am. 2002, Act 462, Imd. Eff. June 21, 2002;—Am. 2014, Act 141, Eff. Mar. 31, 2015.

Popular name: Act 218

500.925 Application of amounts paid life insurer to purchase of retirement benefits; income, gains, or losses on accounts; limitations on charges and deductions; investment or amounts allocated; standards; “contract on a variable basis” defined; compliance with investment company act of 1940; identification of investments and liabilities; “investment company act of 1940” defined; rules.

Sec. 925. (1) A life insurer, after adoption of a resolution by its board of directors and certification thereof to the commissioner, may allocate to 1 or more separate accounts, in accordance with the terms of a written agreement or a contract on a variable basis, amounts which are paid to the insurer, in connection with a pension, retirement or profit-sharing plan, or in connection with a contract on a variable basis, whether on an individual or group basis, and which amounts are to be applied to purchase retirement benefits in fixed or in variable dollar amounts, or both, or to provide benefits in accordance with a contract on a variable basis.

The income, if any, and gains or losses realized or unrealized on each such account may be credited to or charged against the amount allocated to such account in accordance with such agreement, without regard to the other income, gains or losses of the insurer. The commissioner may prescribe reasonable limitations on charges against and permissible deductions from the investment experience credited to life insurance contracts on a variable basis. Notwithstanding any other provision in the insurer's articles of incorporation or in this act, the amounts allocated to such accounts and accumulations thereon may be invested and reinvested in any

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class of loans and investments specified in such agreement, or, with respect to life insurance contracts on a variable basis, as prescribed by the commissioner, and such loans and investments shall not be considered in applying any limitation in this chapter. The commissioner may, with respect to separate accounts for life insurance on a variable basis, establish reasonable standards for procedures to be used in changing investment policy and provisions to safeguard the rights of insured persons and beneficiaries.

(2) "Contract on a variable basis" means a contract issued by an insurer providing for the dollar amount of benefits or other contractual payments or values thereunder to vary so as to reflect investment results of a segregated portfolio of investments or of a designated account in which amounts received in connection with such a contract have been placed and such other contracts as may be approved by the commissioner.

(3) Notwithstanding any other provision of law, a life insurer, if necessary to comply with the investment company act of 1940, with respect to any such account or any portion thereof may:

(a) Exercise the voting rights of the stock or shares or interest in accordance with instructions from the persons having the beneficial interests in such account ratably according to their respective interests in the account.

(b) Establish a committee for the account, the members of which may be directors or officers or other employees of the insurer, or persons having no such relationship to the insurer, or any combination thereof, who may be elected to membership by the vote of the persons having the beneficial interests in the account ratably according to their respective interests in the account. The committee may alone, in conjunction with others, or by delegation to the insurer or any other person, as investment manager or investment adviser, authorize purchases and sales of investments for the account if, as long as the life insurer or any subsidiary or affiliate of the life insurer is the investment manager or investment adviser of the account, the investments of the account are eligible under this section. If compliance with the investment company act of 1940 involves only a portion of the account, the insurer may establish a committee for only that portion, and its members may be elected by the vote of the persons having the beneficial interests in the portion. A committee for only a portion of the account may be given the further power to require the subdivision of the account into 2 accounts so that the portion of the account with respect to which the committee is acting shall constitute a separate account. If the committee so requires, the insurer shall segregate from the account being so subdivided a portion of each asset held with respect to the reserve liabilities of the account. That portion shall be in the same proportion to the total of the asset as the reserve liability for the portion of the account with respect to which the committee is acting bears to the total reserve liability of the account; and notwithstanding any other provision of law, the assets so segregated shall be transferred to a separate account with respect to which the committee shall act.

(4) The investments and liabilities of the account shall at all times be clearly identifiable and distinguishable from the other investments and liabilities of the insurer. A sale, transfer, or exchange of investments shall not be made between any of the separate accounts or between any other investment account of the company and 1 or more of the separate accounts, except for the purpose of (i) conducting the business of the account in accordance with provisions of a "contract on a variable basis", or (ii) making adjustments necessitated by the contract for mortality experience adjustment, and then only if the transfers are made by a transfer of cash or by a transfer of securities having a valuation which can readily be determined in the market place. The commissioner may require for domestic life insurers that a transfer of cash or investments from a separate account or accounts to the company be approved in advance of the transfer. The commissioner may prescribe reasonable limitations on charges against and permissible deductions from separate accounts for life insurance contracts on a variable basis.

(5) As used in this section, "investment company act of 1940" means the act of congress approved August 22, 1940 entitled "investment company act of 1940" as amended from time to time, or any similar statute enacted in substitution therefor.

(6) The commissioner may promulgate rules pursuant to Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.315 of the Michigan Compiled Laws, as may be necessary to carry out this section.

History: Add. 1963, Act 48, Eff. Sept. 6, 1963;—Am. 1966, Act 344, Imd. Eff. Oct. 26, 1966;—Am. 1969, Act 318, Eff. Mar. 20, 1970;—Am. 1974, Act 225, Eff. Nov. 1, 1974.

Popular name: Act 218

Administrative rules: R 500.402 et seq. and R 500.841 et seq. of the Michigan Administrative Code.

500.926-500.931 Repealed. 1969, Act 318, Eff. Mar. 20, 1970.

Compiler's note: The repealed sections pertained to investments by insurers.

Popular name: Act 218

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500.932 Qualified assets in shares of savings and loan associations.

Sec. 932. Qualified assets for purposes of section 901 include shares of any building and loan association or savings and loan association, either state chartered or federally chartered.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1969, Act 318, Eff. Mar. 20, 1970;—Am. 2002, Act 462, Imd. Eff. June 21, 2002.

Popular name: Act 218

500.933 Repealed. 1969, Act 318, Eff. Mar. 20, 1970.

Compiler's note: The repealed section pertained to investments by insurers.

Popular name: Act 218

500.934 Qualified assets in farm loan bonds, intermediate credit bank loans, central bank for cooperatives, home loan banks, federal savings and loan insurance corporation obligations; authorization.

Sec. 934. Qualified assets for purposes of section 901 include farm loan bonds, consolidated or otherwise, issued by the federal land banks pursuant to the federal farm loan act, as amended; in collateral trust debentures or other similar obligations, consolidated or otherwise, issued by federal intermediate credit banks pursuant to the federal farm loan act, as amended; in debentures, consolidated or otherwise, issued by the central bank for cooperatives or banks for cooperatives pursuant to the farm credit act of 1933, as amended; in obligations issued pursuant to the provisions of the federal home loan bank act, approved July 22, 1932, as amended; and in interest-bearing obligations of the federal savings and loan insurance corporation issued pursuant to title 4 of the national housing act, approved June 27, 1934, as amended.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1958, Act 118, Eff. Sept. 13, 1958;—Am. 2002, Act 462, Imd. Eff. June 21, 2002.

Popular name: Act 218

500.938 Qualified assets.

Sec. 938. Qualified assets for purposes of section 901 include all of the following:

(a) Any negotiable paper or other evidence of indebtedness secured by any of the classes of securities in which insurance companies may lawfully invest funds pursuant to sections 912 and 918.

(b) Negotiable notes secured by pledge of stock of national or state banks, which have a surplus equal in amount to 25% of the paid in capital stock provided those loans do not exceed 85% of the market value of the stock and the total amount of the loan on bank secured collateral does not exceed 15% of the capital and surplus of the insurance company.

(c) For other than a life insurer, loans secured as collateral by corporate stocks and securities eligible for investment under section 922 but no loan shall be made of more than 50% of the fair market value of those stocks and securities.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957;—Am. 2002, Act 462, Imd. Eff. June 21, 2002.

Popular name: Act 218

500.942 Qualified assets in real estate loans; purchase of loan or certificate of participation.

Sec. 942. (1) Qualified assets for purposes of section 901 include real estate loans secured by first liens upon improved or income bearing real estate, including also improved farmland and improved business and residential properties, or that are secured by first mortgages or deeds of trust on leasehold estates having an unexpired term equivalent to the term of the mortgage, inclusive of the term or terms that may be provided by enforceable options of renewal. Vacant property, at least 60% of which is under contract of sale and the contract or contracts in connection therewith trusteed or pledged as additional collateral, is income bearing real estate within the meaning of this section.

(2) Real estate is not encumbered within the meaning of this section because it is subject to lease in whole or in part and rents or profits are reserved to the owner or because it is subject to an easement for a right of way.

(3) A loan secured by real estate shall be in the form of obligations secured by mortgage, trust deed, or other such instrument upon real estate, and an insurer may purchase an obligation so secured when the entire amount of the obligation is sold to the insurer, except that an insurer may purchase a part of an obligation if the investment of each participant is not less than $50,000.00 at the time of the insurer's investment, if all other participants are insurers, banks, savings and loan associations, or any other financial institution as that term is defined in the Gramm-Leach-Bliley act, public law 106-102, 113 Stat. 1338, 12 U.S.C. 1811, and if the entire indebtedness of which participation is a part would qualify under the provisions of this section, and either the insurer holds a senior participation, giving it substantially the rights of a first mortgagee, or each

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participation is of equal rank.

(4) Except as otherwise provided in this subsection, any portion of a loan that exceeds 66-2/3% of the appraised value, at the time of the loan, of the real estate constituting or offered as security and any loan the term of which exceeds 5 years is not a qualified asset for purposes of section 901. However, the following loans are qualified assets for the purposes of section 901:

(a) A loan on land improved with permanent buildings used for agriculture or pasture in an amount not to exceed 75% of the appraised value, at the time of the loan, of the real estate constituting or offered as security if the loan is secured by an amortized mortgage, deed of trust, or other instrument under the terms of which the installment payments are sufficient to amortize on not to exceed an annual basis of 40% or more of the principal of the loan within a period of not more than 10 years.

(b) A loan on single family residential property in an amount not to exceed 80% of the appraised value, at the time of the loan, of the real estate offered as security, if the loan is secured by a mortgage, deed of trust, or other instrument for a term of not more than 35 years.

(c) Subject to subsection (6), a loan on multifamily residential property in an amount not to exceed 85% of the appraised value, at the time of the loan, of the real estate offered as security, if the loan is secured by a mortgage, deed of trust, or other instrument for a term of not more than 35 years.

(d) A loan in an amount not to exceed 75% of the appraised value of the real estate offered as security and for a term not longer than 35 years, if the real estate is improved if it is not used for agriculture or pasture, and if the loan is secured by a mortgage, deed of trust, or other instrument for a term of not more than 35 years.

(5) The limitations and restrictions in subsection (4) do not apply to real estate loans that are insured under the provisions of title II of the national housing act, chapter 847, 48 Stat. 1247, 12 U.S.C. 1707 to 1709, 1710 to 1715g, 1715k to 1715r, and 1715t to 1715z-1, by the federal housing administration, to loans insured under the Canadian national housing act of 1954 by the central mortgage and housing corporation, or to real estate loans that are guaranteed as to principal by the United States government or Canadian government or an agency or instrumentality of the United States or Canadian government.

(6) If the total amount of multifamily residential loans that exceed 75% of the appraised value of the real estate offered as security for those loans is greater than 20% of an insurer's mortgage portfolio, the portion of those loans that exceed 75% of the appraised value shall not be treated as a qualified asset for purposes of section 901.

(7) An insurer shall not make any such loan unless an appraisal has been made in writing by a competent appraiser appointed or employed by the insurer and filed with the investment committee authorized to approve the loan.

(8) Qualified assets for the purposes of section 901 include a loan or certificate of participation secured by a loan made on a single-family residential property in an amount not to exceed 95% of the appraised value, at the time of the loan, of the real estate offered as security, if the loan is secured by a mortgage, deed of trust, or other instrument for a term of not more than 35 years, and the loan is insured by a private mortgage insurer approved by the federal home loan mortgage corporation and the federal national mortgage association and is licensed to do business in the state of Michigan.

(9) Qualified assets for the purposes of section 901 include real estate loans that do not qualify as first mortgages as described in subsections (1) and (3). Total investments that may be treated as qualified assets under this subsection shall not exceed 25% of the insurer's total investments in real estate loans as described in subsections (1) and (3).

(10) A domestic insurer shall not invest more than 10% of its surplus in real estate loans that exceed the appraised value limitations under subsection (4), (6), or (8) unless the real estate loan is the result of a restructuring of an existing real estate loan and the insurer provides written notice to the commissioner on or before the date of the restructuring. The commissioner may increase the 10% investment limit of this section to 20% for an insurer who demonstrates to the commissioner's satisfaction the soundness of a particular investment or investment strategy that would cause the insurer to exceed the lower limit. If the loans under this subsection exceed 5% of an insurer's assets within any 12-month period, no other loans may be made pursuant to this subsection except with the commissioner's prior approval.

(11) A domestic insurer shall not invest more than 20% of its mortgage portfolio in multifamily residential mortgages that exceed 75% of the appraised value, at the time of the loan, of the real estate offered as security.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957;—Am. 1961, Act 128, Eff. Sept. 8, 1961;—Am. 1969, Act 318, Eff. Mar. 20, 1970;—Am. 1974, Act 330, Imd. Eff. Dec. 17, 1974;—Am. 1982, Act 338, Imd. Eff. Dec. 17, 1982;—Am. 1984, Act 90, Imd. Eff. Apr. 19, 1984;—Am. 2002, Act 462, Imd. Eff. June 21, 2002.

Popular name: Act 218

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500.943 Qualified assets; derivative instruments and transactions.

Sec. 943. (1) Qualified assets for purposes of section 901 include derivative instruments only if the insurer is able to demonstrate to the commissioner through cash flow testing or other appropriate analyses both the intended hedging characteristics and the ongoing effectiveness of the derivative transaction or combination of transactions.

(2) Before engaging in a derivative transaction and with board of director approval, a domestic insurer shall do all of the following:

(a) Establish written guidelines to be used for effecting or maintaining derivative transactions. The guidelines shall be available to the commissioner on request and shall meet all of the following:

(*i*) Address investment or, if applicable, underwriting objectives and risk constraints, such as credit risk limits.

(*ii*) Address permissible derivative transactions and the relationship of those transactions to its operations.

(*iii*) Require compliance with internal control procedures.

(b) Have a system for determining whether a derivative instrument used in a hedging or replication transaction is effective.

(c) Have a credit risk management system for over-the-counter derivative transactions that measures credit risk exposure using counter party exposure amount.

(d) Determine whether the insurer has adequate professional personnel, technical expertise, and systems to implement investment practices involving derivatives.

(e) Determine that the derivative program is prudent and that the level of risk is appropriate for the insurer given the level of capitalization and expertise available to the insurer.

(3) Except as provided in section 222(7), written guidelines prepared pursuant to subsection (2), if furnished to the commissioner, are confidential and privileged, are not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, are not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action.

(4) The commissioner may promulgate rules pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to implement this section, including, but not limited to, the establishment of all of the following:

(a) Financial solvency standards.

(b) Valuation standards.

(c) Reporting requirements.

(5) An insurer shall include all counter party exposure amounts in determining compliance with the limitations in section 901(6).

(6) In measuring the net amount of credit risk exposure using counter party exposure amount, all of the following apply:

(a) The net amount of credit risk equals the market value of the over-the-counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer or zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurer.

(b) If over-the-counter derivative instruments are entered into pursuant to a written master agreement that provides for netting of payments owed by the respective parties, and the domiciliary jurisdiction of the counter party is either within the United States or, if not within the United States, within a foreign jurisdiction approved as eligible for netting, the net amount of credit risk is the greater of zero or the net sum of the market value of the over-the-counter derivative instruments entered into pursuant to the agreement, the liquidation of which would result in a final cash payment to the insurer and the market value of the over-the-counter derivative instruments entered into pursuant to the agreement, the liquidation of which would result in a final cash payment by the insurer to the business entity.

(7) As used in subsection (6), market value shall be determined for open transactions at the end of the most recent quarter of the insurer's fiscal year and shall be reduced by the market value of acceptable collateral held by the insurer or placed in escrow by 1 or both parties.

(8) As used in this section:

(a) "Cap" means an agreement obligating the seller to make payments to the buyer with each payment based on the amount by which a reference price or level or the performance or value of 1 or more underlying interests exceeds a predetermined number, sometimes called the strike rate or strike price.

(b) "Collar" means an agreement to receive payments as the buyer of an option, cap, or floor, and to make payments as the seller of a different option, cap, or floor.

(c) "Collateralized mortgage obligation" means an asset-backed security that has cash flows originating directly or indirectly from underlying mortgage assets.

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(d) "Counter party exposure amount" means the net amount of credit risk attributable to a derivative instrument entered into with a business entity other than through a qualified exchange or qualified foreign exchange or cleared through a qualified clearinghouse such as an over-the-counter derivative instrument.

(e) "Derivative instrument" means any agreement, option, or instrument, or any series or combinations of an agreement, option, or instrument to make or take delivery of, or assume or relinquish, a specified amount of 1 or more underlying interests, or to make a cash settlement in lieu of 1 or more underlying interests, or that has a price, performance, value, or cash flow based primarily upon the actual or expected price, yield, level, performance, value, or cash flow of 1 or more underlying interests. Derivative instruments include options, warrants, caps, floors, collars, swaps, swaptions, forwards, futures, and any other substantially similar agreements, options, or instruments, or any series or combinations and any further agreements, options, or instruments included under rules promulgated by the commissioner. Derivative instruments do not include collateralized mortgage obligations, other asset-backed securities, principal-protected structured securities, or instruments that an insurer is otherwise permitted to invest in or receive under this chapter other than under this section. The sale or purchase of a derivative instrument by an insurer in connection with a written investment policy that insulates the purchaser from the risk of default of an underlying financial instrument shall be treated as a derivative and not as insurance for purposes of this act.

(f) "Derivative transaction" means a transaction involving the use of 1 or more derivative instruments. For purposes of this section, dollar roll transactions, repurchase transactions, reverse repurchase transactions, and securities lending transactions are not derivative transactions.

(g) "Floor" means an agreement obligating the seller to make payments to the buyer in which each payment is based on the amount by which a predetermined number, sometimes called the floor rate or price, exceeds a reference price, level, performance, or value of 1 or more underlying interests.

(h) "Forward" means an agreement, other than a future, to make or take delivery in the future of 1 or more underlying interests, or effect a cash settlement, based on the actual or expected price, level, performance, or value of the underlying interests. Forward includes spot transactions effected within customary settlement periods, when-issued purchases, or other similar cash market transactions.

(i) "Future" means an agreement traded on a futures exchange, to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance, or value of 1 or more underlying interests.

(j) "Hedging transaction" means a derivative transaction that is entered into and maintained to manage the risk of a change in the value, yield, price, cash flow, or quantity of assets or liabilities that the insurer has acquired or incurred or anticipates acquiring or incurring or the currency exchange rate risk related to assets or liabilities that an insurer has acquired or incurred or anticipates acquiring or incurring.

(k) "Option" means an agreement giving the buyer the right to buy or receive, known as a call option, sell or deliver, known as a put option, enter into, extend, or terminate or effect a cash settlement based on the actual or expected price, spread, level, performance, or value of 1 or more underlying interests.

(*l*) "Replication transaction" means a derivative transaction or combination of derivative transactions effected either separately or in conjunction with cash market investments included in the insurer's investment portfolio in order to replicate the risks and returns of another authorized transaction, investment, or instrument or to operate as a substitute for cash market transactions. A derivative transaction entered into by the insurer as a hedging transaction is not a replication transaction.

(m) "Structured security" means an obligation whose principal or interest payments are determined partially or entirely by reference to an index, market, event, or asset unrelated to the issuer's ability to pay.

(n) "Swap" means an agreement to exchange or to net payments at 1 or more times based on the actual or expected price, yield, level, performance, or value of 1 or more underlying interests.

(o) "Swaption" means an option to purchase or sell a swap at a given price and time or at a series of prices and times. A swaption does not mean a swap with an embedded option.

(p) "Underlying interest" means the assets, liabilities, other interests, or a combination of assets, liabilities, or other interests underlying a derivative instrument such as any 1 or more securities, currencies, rates, indices, commodities, or derivative instruments.

(q) "Warrant" means an instrument that gives the holder the right to purchase or sell the underlying interest at a given price and time or at a series of prices and times outlined in the warrant agreement.

(9) The amendatory act that added this subsection does not affect the validity of any derivative transaction entered into or derivative instrument acquired by an insurer before the effective date of the amendatory act that added this subsection.

History: Add. 1987, Act 24, Imd. Eff. Apr. 24, 1987;—Am. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 2002, Act 462, Imd. Eff. June 21, 2002.

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Popular name: Act 218

500.944 Accounts receivable; includable as qualified assets.

Sec. 944. Qualified assets for purposes of section 901 include the value of any amounts receivable from insurers authorized to transact insurance in this state.

History: Add. 1969, Act 318, Eff. Mar. 20, 1970;—Am. 2002, Act 462, Imd. Eff. June 21, 2002.

Popular name: Act 218

500.945 Repealed. 1994, Act 226, Imd. Eff. June 27, 1994.

Compiler's note: The repealed section pertained to investments or loans meeting trusted depository requirements.

Popular name: Act 218

500.946 Home office, lands, and buildings; includable as qualified assets.

Sec. 946. (1) Subject to the limitations in section 901, qualified assets for purposes of section 901 include a home office, lands, and buildings as follows:

(a) A building in which the insurer has its principal home office and the land upon which the building stands.

(b) Real estate requisite for its accommodation in the convenient transaction of its business.

(c) Other real estate requisite or desirable for the protection or enhancement of the value of real estate described under subdivisions (a) and (b).

(2) Any parcel of real estate acquired under this section may include excess space for rental to others or if the excess is reasonably required in order to have a building that would be an economic unit.

(3) Real estate under this section may be subject to a mortgage.

(4) Any real estate investment under this section that would result in a total real estate investment in excess of 10% of a domestic insurer's capital and surplus shall not be made until a certificate of permission for the purchase or construction of the property is granted by the commissioner. The commissioner may require an appraisal of the property considered for investment by 3 qualified appraisers, appointed by the commissioner for the purpose of the appraisal, and their certification to the commissioner of a valuation of the property at least equal to the amount that is proposed to be invested in the property by the insurer.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957;—Am. 1969, Act 318, Eff. Mar. 20, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 2002, Act 462, Imd. Eff. June 21, 2002.

Popular name: Act 218

500.947 Income producing real estate and housing projects; includable as qualified assets.

Sec. 947. (1) Subject to the limitations in section 901, qualified assets for purposes of section 901 include real estate or any interest in real estate, acquired by the insurer for the purpose, under its franchise, of construction, development, maintenance, operation, or lease as an investment for the production of income, or for the purpose, under its franchise, of constructing, maintaining, or operating housing projects including incidental retail and service facilities.

(2) Subject to the limitations in section 901, qualified assets for purposes of section 901 include real estate conveyed or mortgaged in good faith, by way of security for debts or in satisfaction for debts, or purchased at sales on judgments, decrees, or mortgages in favor of the insurer or acquired in the process of settling claims asserted under its policies.

History: Add. 1969, Act 318, Eff. Mar. 20, 1970;—Am. 2002, Act 462, Imd. Eff. June 21, 2002.

Popular name: Act 218

500.948 Repealed. 1969, Act 318, Eff. Mar. 20, 1970.

Compiler's note: The repealed section pertained to investments by insurers.

Popular name: Act 218

500.950, 500.951 Repealed. 1969, Act 318, Eff. Mar. 20, 1970.

Compiler's note: The repealed sections pertained to investments by insurers.

Popular name: Act 218

500.960 Repealed. 1969, Act 318, Eff. Mar. 20, 1970.

Compiler's note: The repealed section pertained to investments by insurers.

Popular name: Act 218

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500.1001 Definitions.

Sec. 1001. As used in this chapter:

(a) "Audited financial report" means the report required in section 1005 and furnished under section 1007.

(b) "Audit committee" means a committee or equivalent body established by the board of directors of an entity to oversee the accounting and financial reporting processes of an insurer or group of insurers, the internal audit function of an insurer or group of insurers, if applicable, and the external audits of the financial statements of an insurer or group of insurers. The audit committee of an entity that controls a group of insurers may be the audit committee for 1 or more of these controlled insurers solely for the purposes of compliance with this chapter at the election of the controlling person as permitted in section 1027(7). If an audit committee is not designated by an insurer, the insurer's entire board of directors will constitute the audit committee.

(c) "Group of insurers" means those licensed insurers included in the reporting requirements of chapter 13, or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

(d) "Indemnification agreement" means an agreement of indemnity or a release from liability as to which the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives.

(e) "Independent board member" has the same meaning as described in section 1027(5).

(f) "Independent public accountant" means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants and in good standing in all states in which the accountant or accounting firm is licensed to practice. For Canadian and British companies, "independent public accountant" means a Canadian-chartered or British-chartered accountant.

(g) "Insurer" means that term as defined in section 106 and includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

(h) "Internal audit function" means a person or persons that provide independent, objective, and reasonable assurance designed to add value and improve an organization's operations and accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

(i) "Internal control over financial reporting" means a process effected by an entity's board of directors, management, and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements filed with the director, and includes the following:

(*i*) Policies and procedures pertaining to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets.

(*ii*) Policies and procedures providing reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements filed with the director and that receipts and expenditures are being made only in accordance with authorizations of management and directors.

(*iii*) Policies and procedures providing reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of assets that could have a material effect on the financial statements filed with the director.

(j) "SEC" means the United States Securities and Exchange Commission.

(k) "Section 404" means section 404 of the Sarbanes-Oxley act of 2002, 15 USC 7262, and the SEC's rules and regulations promulgated under that section.

(*l*) "Section 404 report" means management's report on "internal control over financial reporting" as defined by the SEC and the related attestation report of the independent certified public accountant.

(m) "SOX compliant entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley act of 2002 and the regulations promulgated under that act:

(*i*) The preapproval requirements of section 201, section 10A(i) of the securities exchange act of 1934, 15 USC 78j-1.

(*ii*) The audit committee independence requirements of section 301, section 10A(m)(3) of the securities exchange act of 1934, 15 USC 78j-1.

(*iii*) The internal control over financial reporting requirements of section 404, 15 USC 7262, as prescribed by item 308 of SEC regulation S-K, 17 CFR 229.308.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2008, Act 342, Imd. Eff. Dec. 23, 2008;—Am. 2016, Act 276, Imd. Eff. July 1, 2016;—Am. 2020, Act 17, Imd. Eff. Jan. 27, 2020.

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Popular name: Act 218

500.1003 Nonapplicability of chapter.

Sec. 1003. (1) This chapter does not apply to any of the following:

(a) Insurers having direct premiums written in this state of less than $1,000,000.00 in any year and having less than 1,000 policyholders in this state at the end of any year unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out the responsibilities of this act.

(b) Domestic insurers transacting insurance only in this state that have direct premiums written of less than $10,000,000.00 in any year, write or assume reinsurance for only property-based coverage, and are not part of an insurance holding company system whose members have total direct written premiums of more than $10,000,000.00 in any year, unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out the responsibilities of this act.

(c) Insurers filing audited financial reports in another state, pursuant to the other state's requirement of audited financial reports that have been found by the commissioner to be substantially similar to the requirements of this chapter, if a copy of the audited financial report and the evaluation of accounting procedures and systems of internal control report that are filed with the other state are filed with the commissioner in accordance with the filing dates specified in sections 1005 and 1017 or, if a Canadian insurer, a copy of the independent public accountants' reports that are filed with the Canadian Dominion department of insurance, and a copy of any notification of adverse financial condition report filed with the other state is filed with the commissioner within the time specified in section 1015.

(2) This chapter does not prohibit, preclude, or in any way limit the commissioner from ordering, conducting, and performing examinations of insurers under this act.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1005 Insurer; annual audit; filing date; extensions; designation of audit committee.

Sec. 1005. (1) Each insurer authorized to do business in this state shall have an annual audit by an independent public accountant and shall file an audited financial report with the commissioner on or before June 1 for the immediately preceding calendar year. With 90 days' advance notice to the insurer, the commissioner may require an insurer to file an audited financial report earlier than June 1.

(2) Extensions of the June 1 filing date under subsection (1) may be granted by the commissioner for 30-day periods upon a showing by the insurer and its independent public accountant of the reasons for requesting the extension and upon a determination by the commissioner of good cause for an extension. The extension request shall be submitted in writing not less than 10 days prior to the due date and in sufficient detail to permit the commissioner to make an informed decision on the requested extension. An extension granted under this subsection shall include a 30-day extension to the filing of management's report of internal control over financial reporting.

(3) Each insurer required to file an annual audited financial report under this chapter shall designate a group of individuals as constituting its audit committee. The audit committee of an entity that controls an insurer may be the insurer's audit committee for purposes of this chapter at the election of the controlling person.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2008, Act 342, Imd. Eff. Dec. 23, 2008.

Popular name: Act 218

500.1007 Annual audited financial report; contents; form; conduct of examination by independent public accountant.

Sec. 1007. (1) The annual audited financial report shall report the insurer's financial condition as of the end of the most recent calendar year and the results of its operations, cash flows, and changes in capital and surplus for the year then ended in conformity with accounting practices prescribed, or otherwise permitted, by the commissioner and shall include all of the following:

(a) The report of an independent public accountant.

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

(c) A statement of operations.

(d) A statement of cash flows.

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

(f) Notes to financial statements. These notes shall be those required by the commissioner's annual statement instructions and accounting practices prescribed by the commissioner. The notes shall include a reconciliation of differences, if any, between the audited financial statements and the annual statement filed

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pursuant to section 438 with a written description of the nature of these differences.

(2) The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the insurer's annual statement filed with the commissioner, may be rounded to the nearest thousand dollars, may combine insignificant amounts, and, except for the first year the insurer is required to file an audited financial report, shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31.

(3) The independent public accountant shall conduct the examination in accordance with generally accepted auditing standards. Consideration shall be given, as the independent public accountant considers necessary, to the procedures illustrated in the "Financial Conditions Examiners Handbook" prepared by the national association of insurance commissioners.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2008, Act 342, Imd. Eff. Dec. 23, 2008.

Popular name: Act 218

500.1009 Insurer required to file annual audited report; registration of insurer's independent public accountant; letter required; dismissal or resignation of independent public accountant; notice; report of disagreement; responsive letter.

Sec. 1009. (1) Each insurer required by this chapter to file an annual audited financial report shall register with the commissioner in writing, within 60 days after becoming subject to this requirement, the name and address of the independent public accountant or accounting firm retained to conduct the annual audit under this chapter. Insurers not retaining an independent public accountant on the effective date of this chapter shall register the name and address of their retained independent public accountant not less than 6 months before the date when the first audited financial report is to be filed.

(2) The insurer shall obtain a letter from the insurer's independent public accountant and shall file a copy with the commissioner stating that the independent public accountant is aware of the insurance code's provisions and the rules and regulations of the state of domicile's insurance department that relate to accounting and financial matters and affirming that he or she will express his or her opinion on the financial statements as to whether they conform to the accounting practices prescribed or otherwise permitted by that department, specifying the exceptions as he or she believes appropriate.

(3) If the independent public accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall notify the commissioner within 5 business days of this event. The insurer shall also furnish the commissioner with a separate letter within 10 business days of the above notification stating whether in the 24 months preceding the event there were any disagreements with the former independent public accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, which disagreements, if not resolved to the satisfaction of the former independent public accountant, would have caused the former independent public accountant to refer to the subject matter of the disagreement in connection with his or her opinion. The disagreements required to be reported in response to this section include both those resolved to the former independent public accountant's satisfaction and those not resolved to the former independent public accountant's satisfaction. Disagreements contemplated by this section are those that occur at the decision-making level between personnel of the insurer responsible for presentation of its financial statements and personnel of the independent public accounting firm responsible for rendering its report. The insurer shall also request in writing the former independent public accountant to furnish a letter addressed to the insurer stating whether the independent public accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which he or she does not agree. The insurer shall furnish this responsive letter from the former independent public accountant to the commissioner together with its own.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Compiler's note: Act 143 of 1993, which amended this act, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

Popular name: Act 218

500.1010 Recognition of person or firm as independent public accountant; mediation or arbitration of disputes; limitation on period of service; relief from rotation requirement; restrictions; hearing; ruling by commissioner; exemption from subsection (7); nonaudit

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services; preapproval; waiver; independent public accountant not recognized as qualified; condition; relief from subsection (14).

Sec. 1010. (1) The commissioner shall not recognize a person or firm as an independent public accountant unless that person or firm meets both of the following:

(a) Is in good standing with the American institute of certified public accountants and in good standing in all states in which the independent public accountant is licensed to practice, or, for a Canadian or British company, unless that person or firm is a chartered accountant.

(b) Has not either directly or indirectly entered into an indemnification agreement, whether an agreement of indemnity or release from liability, with respect to the insurer's audit.

(2) Except as otherwise provided, a certified public accountant shall be recognized as independent as long as he or she conforms to the standards of his or her profession, as contained in the code of professional ethics of the American institute of certified public accountants, its rules and regulations, and this state's board of accountancy's code of ethics and rules of professional conduct.

(3) A qualified independent accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, if a delinquency proceeding is commenced against the insurer under chapter 81, the mediation or arbitration provision shall operate at the option of the statutory successor.

(4) An individual independent public accountant or a lead partner having primary responsibility for an annual audit or other person responsible for rendering a report by an independent public accounting firm retained to conduct an annual audit under this chapter shall not act in that capacity for the same insurer for more than 5 consecutive years. Following such a 5-year period of service, the individual independent public accountant or partner or other responsible person for the accounting firm shall not conduct an annual audit under this chapter for the same insurer or its insurance subsidiaries or affiliates for a period of 5 years. An insurer may apply for relief from the commissioner from this rotation requirement on the basis of unusual circumstances. This application shall be made at least 30 days before the end of the calendar year. The commissioner may consider the following factors in determining if relief should be granted:

(a) Number of partners, expertise of the partners, or the number of insurance clients in the independent public accounting firm.

(b) The insurer's premium volume.

(c) Number of jurisdictions in which the insurer transacts business.

(5) An approval for relief granted under subsection (4) shall be filed by the insurer with its annual statement filing with the states that it is licensed in or doing business in and with the national association of insurance commissioners. If the nondomestic state accepts electronic filing with the national association of insurance commissioners, the insurer shall file the approval in an electronic format acceptable to the national association of insurance commissioners.

(6) The commissioner shall not recognize as a qualified independent public accountant, or accept an annual audited financial report, prepared in whole or in part by an individual who has done any of the following:

(a) Been convicted of fraud, bribery, a violation of chapter 96 of title 18 of the United States Code, 18 USC 1961 to 1968, or any dishonest conduct or practices under federal or state law.

(b) Been found to have violated the insurance laws of this state with respect to any previous reports submitted under this chapter.

(c) Has failed to detect or disclose material information in 1 or more previous reports filed under this chapter.

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

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

(b) Financial information systems design and implementation.

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

(d) Actuarially oriented advisory services involving the determination of amounts recorded in the financial statements. The accountants may assist an insurer in understanding the methods, assumptions, and inputs used in the determination of amounts recorded in the financial statements only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification on an insurer's reserves if all of the following conditions have been met:

(*i*) Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions.

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

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

(e) Internal audit outsourcing services.

(f) Management functions or human resources.

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

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

(i) Any other services that the commissioner determines, by order or regulation, are impermissible.

(8) To be a qualified independent public accountant, the accountant shall not function in the role of management, shall not audit his or her own work, and shall not serve in an advocacy role for the insurer.

(9) The commissioner may hold a public hearing pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to determine whether a certified public accountant is qualified. After considering the evidence presented, the commissioner may rule that the accountant is not qualified for purposes of expressing his or her opinion on the financial statements in the annual audited financial report made pursuant to this chapter and may require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this chapter.

(10) Insurers having direct written and assumed premiums of less than $100,000,000.00 in any calendar year may request an exemption from subsection (7). An insurer requesting an exemption shall file with the commissioner a written statement discussing the reasons why the insurer should be exempt. The commissioner shall grant the exemption if after review of the statement the commissioner finds that compliance with subsection (7) would constitute a financial or organizational hardship upon the insurer.

(11) A qualified independent public accountant who performs an audit under this chapter may engage in other nonaudit services, including tax services, that are not described in subsection (7) and that do not conflict with subsection (8), only if the activity is approved in advance by the audit committee as provided in subsection (12).

(12) All auditing services and nonaudit services provided to an insurer by a qualified independent public accountant of the insurer shall be preapproved by the audit committee. The preapproval requirement is waived with respect to nonaudit services in either of the following cases:

(a) If the insurer is a SOX compliant entity or a direct or indirect wholly-owned subsidiary of a SOX compliant entity.

(b) If the aggregate amount of all such nonaudit services provided to the insurer constitutes not more than 5% of the total amount of fees paid by the insurer to its qualified independent public accountant during the fiscal year in which the nonaudit services are provided, the services were not recognized by the insurer at the time of the engagement to be nonaudit services, and the services are promptly brought to the attention of the audit committee and approved prior to the completion of the audit by the audit committee or by 1 or more members of the audit committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the audit committee.

(13) The audit committee may delegate to 1 or more designated members of the audit committee the authority to grant the preapprovals required by subsection (12). The decisions of any member to whom this authority is delegated shall be presented to the full audit committee at each of its scheduled meetings.

(14) The commissioner shall not recognize an independent public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer was employed by the independent public accountant and participated in the audit of that insurer during the 1-year period preceding the date that the most current statutory opinion is due. This subsection only applies to partners and senior managers involved in the audit. An insurer may request relief from this subsection by filing a request with the commissioner 30 days prior to the end of the calendar year for the audit in a manner prescribed by the commissioner showing the unusual circumstances that support the need for relief from this subsection. An approval for relief granted by the commissioner under this subsection shall be filed by the insurer with its annual statement filing with the states that it is licensed in or doing business in and with the national association of insurance commissioners. If the nondomestic state accepts electronic filing with the national association of insurance commissioners, the insurer shall file the approval in an electronic format acceptable to the national association of insurance commissioners.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2008, Act 342, Imd. Eff. Dec. 23, 2008.

Popular name: Act 218

500.1011 Audited consolidated or combined financial statements; application for filing; work

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sheet.

Sec. 1011. An insurer may make written application to the commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of affiliates that uses a pooling or 100% reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer cedes all of its direct and assumed business to the pool. If approval is given, a columnar consolidating or combining work sheet shall be filed with the report, as follows:

(a) Amounts shown on the consolidated or combined audited financial report shall be shown on the work sheet.

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

(c) Noninsurance operations may be shown on the work sheet on a combined or individual basis.

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

(e) Any differences between the amounts shown in the individual insurer columns of the work sheet and comparable amounts shown on the annual statements of the insurers shall be reconciled.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1015 Independent public accountant; reporting determination that insurer materially misstated financial condition or does not meet requirements of MCL 500.408 or MCL 500.410; liability; action to be taken after date of audited financial report.

Sec. 1015. (1) An insurer required to furnish the annual audited financial report shall require the independent public accountant to report in writing within 5 business days to the board of directors or its audit committee any determination by that independent public accountant that the insurer has materially misstated its financial condition as reported to the commissioner as of the balance sheet date currently under examination or that the insurer does not meet the requirements of section 408 or 410 as of that date. The insurer shall furnish a copy of this report to the commissioner within 5 business days of receipt of the report and shall provide the independent public accountant making the report with evidence of the report being furnished to the commissioner. If the independent public accountant fails to receive the evidence within the required 5-business day period, the independent public accountant shall furnish a copy of its report to the commissioner within the next 5 business days.

(2) An independent public accountant is not liable to any person for a statement or report made in connection with this section if the statement or report is made in good faith in compliance with subsection (1).

(3) If after the date of the audited financial report filed pursuant to this chapter the accountant becomes aware of facts that might have affected his or her report, the accountant shall take action as prescribed by the professional standards of the American institute of certified public accountants.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2008, Act 342, Imd. Eff. Dec. 23, 2008.

Popular name: Act 218

500.1017 Independent public accountant; communicating unremediated material weaknesses; description.

Sec. 1017. (1) In addition to the annual audited financial report, each insurer shall furnish the commissioner with a written communication as to any unremediated material weaknesses in the insurer's internal controls over financial reporting noted during the audit. This communication shall be prepared by the accountant within 60 days after the filing of the annual audited financial report and shall contain a description of any unremediated material weaknesses, as of the December 31 immediately preceding, in the insurer's internal control over financial reporting noted by the accountant during the course of his or her audit of the financial statements. The communication shall also state if no unremediated material weaknesses were noted.

(2) The insurer shall provide to the commissioner a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions taken or proposed are not described in the accountant's communication.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2008, Act 342, Imd. Eff. Dec. 23, 2008.

Popular name: Act 218

500.1019 Independent public accountant; filing letter with annual audited financial report; contents.

Sec. 1019. The independent public accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual audited financial report, a letter stating all of the following:

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(a) That the independent public accountant is independent of the insurer and conforms to the standards of his or her profession.

(b) The general background and experience and the experience in insurer audits of the staff assigned to the annual audited financial report and whether each is an independent public accountant. Nothing within this chapter shall be construed as prohibiting the independent public accountant from using the staff he or she considers appropriate if the use is consistent with the standards prescribed by generally accepted auditing standards.

(c) That the independent public accountant understands the annual audited financial report, and his or her opinion on the report, will be filed in compliance with this chapter, and that the commissioner will be relying on this information in the monitoring and regulation of the financial position of the insurer.

(d) That the independent public accountant consents to the requirements of section 1021 and that the independent public accountant consents and agrees to make available for review by the commissioner, his or her designee, or his or her appointed agent, the work papers described in section 1021.

(e) A representation that the independent public accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the American institute of certified public accountants.

(f) A representation that the independent public accountant is in compliance with the requirements of section 1010.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1021 Work papers; availability; retention; review as investigation; use.

Sec. 1021. (1) Work papers are the records kept by the independent public accountant of the procedures followed, tests performed, information obtained, and conclusions reached pertinent to his or her examination of the insurer's financial statements. Work papers may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents, and schedules or commentaries prepared or obtained by the independent public accountant in the course of his or her examination of the insurer's financial statements and that support his or her opinion.

(2) Each insurer required to file an audited financial report pursuant to this chapter shall require the independent public accountant to make available for review by the commissioner the work papers prepared in the conduct of his or her examination and any communications between the independent public accountant and the insurer related to the audit at the commissioner's offices or at any other reasonable place designated by the commissioner. The insurer shall require that the independent public accountant retain the audit work papers and communications for a period of not less than 5 years after the period reported on.

(3) In a review by the commissioner under subsection (2), it shall be agreed that photocopies of pertinent audit work papers may be made and retained by the commissioner. A review by the commissioner under subsection (2) shall be considered an investigation and all working papers and communications obtained during the course of the investigation shall be confidential.

(4) In the examination or other investigation or determination of the financial condition of an insurer pursuant to this act, the commissioner shall utilize the audit work papers and other documents prepared by the independent public accountant and shall avoid duplication of the work of the independent public accountant unless the commissioner in the reasonable exercise of his or her discretion finds that additional examination is necessary in order to determine whether an insurer is safe, reliable, and entitled to public confidence.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1023 Compliance with chapter; exemption; filing reports on other than calendar year basis; compliance by domestic insurers; schedule; compliance by foreign insurers.

Sec. 1023. (1) Upon an insurer's written application, the commissioner may grant an exemption from compliance with this chapter if the commissioner finds, upon review of the application, that compliance with this chapter would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within 10 days from a denial of an insurer's written request for an exemption from this chapter, the insurer may request in writing a hearing on its application for an exemption. The hearing shall be held in accordance with the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws.

(2) Upon an insurer's written application, the commissioner, for a specified period or periods, may permit an insurer to file annual audited financial reports on some basis other than a calendar year basis. Within 10 days from a denial of such a written request, the insurer may request in writing a hearing on its application.

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The hearing shall be held in accordance with Act No. 306 of the Public Acts of 1969.

(3) Domestic insurers retaining a certified public accountant on the effective date of this chapter who qualifies as independent shall comply with this chapter for the year ending December 31, 1992 and each year thereafter unless the commissioner permits otherwise.

(4) Domestic insurers not retaining a certified public accountant on the effective date of this chapter who qualifies as independent shall meet the following schedule for compliance unless the commissioner permits otherwise:

(a) As of December 31, 1992, file with the commissioner all of the following:

(*i*) Report of independent public accountant.

(*ii*) Audited balance sheet.

(*iii*) Notes to audited balance sheet.

(b) For the year ending December 31, 1993 and each year thereafter, file with the commissioner all reports required by this chapter.

(5) Foreign insurers shall comply with this chapter for the year ending December 31, 1993 and each year thereafter, unless the commissioner permits otherwise.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1025 Canadian and British insurers; annual audited financial report; contents of independent public accountant's letter.

Sec. 1025. (1) For Canadian and British insurers, the annual audited financial report is the annual statement of total business, on the form filed by those companies with their domiciliary supervision authority, and duly audited by an independent chartered accountant.

(2) For insurers listed in subsection (1), the independent public accountant's letter required in section 1009 shall state that the independent public accountant is aware of the requirements relating to the annual audited statement filed with the commissioner pursuant to section 1005 and shall affirm that the opinion expressed is in conformity with those requirements.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1027 Applicability of section to domestic insurer not SOX compliant entity; duties of audit committee; member of audit committee as independent; election of controlling person; report by accountant; reports provided on aggregate basis; structure of audit committee; waiver from section based on hardship; effective date of section; "direct written and assumed premiums" defined.

Sec. 1027. (1) This section applies to a domestic insurer that is not a SOX compliant entity. A domestic insurer that is a direct or indirect subsidiary of a SOX compliant entity is considered to be a SOX compliant entity for purposes of this section.

(2) The audit committee is directly responsible for the appointment, compensation, and oversight of the work of any accountant, including resolution of disagreements between management and the accountant regarding financial reporting, for the purpose of preparing or issuing the audited financial report or related work under this chapter. Each accountant shall report directly to the audit committee.

(3) The audit committee of an insurer or group of insurers is responsible for overseeing the insurer's internal audit function and granting the person and persons performing the function suitable authority and resources to fulfill their responsibilities if required under section 1028.

(4) Each member of the audit committee must be a member of the board of directors of the insurer or a member of the board of directors of an entity elected under subsection (7).

(5) To be considered independent for purposes of this section, a member of the audit committee must not, other than in his or her capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory, or other compensatory fee from the entity audited or be an affiliated person of the entity or subsidiary audited, unless the individual serves on the board to meet another statutory requirement related to the composition of the board. However, the independent audit committee member must not be an officer or employee of the insurer or 1 of its affiliates.

(6) If a member of the audit committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the state, may remain an audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or 1 year from the occurrence of the event that caused the member to be no longer independent.

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(7) To exercise the election of the controlling person to designate the audit committee for purposes of this section, the ultimate controlling person shall provide written notice to the director. Notification must be made timely before the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the director by the insurer, which must include a description of the basis for the change. The election must remain in effect until rescinded.

(8) The audit committee shall require the accountant that performs for an insurer any audit required by this chapter to timely report to the audit committee in accordance with the requirements of SAS 61, communication with audit committees, or a substantially similar replacement publication as required by the director, including all of the following:

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

(b) All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant.

(c) Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

(9) If an insurer is a member of an insurance holding company system, the reports required by subsection (8) may be provided to the audit committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the audit committee.

(10) All insurers are encouraged to structure their audit committees with at least a supermajority of independent committee members. An insurer with $300,000,000.01 or less of direct written and assumed premiums in the prior calendar year is not required to have independent audit committee members. An insurer with over $300,000,000.01 but less than $500,000,000.00 of direct written and assumed premiums in the prior calendar year must have 50% or more of its audit committee members be independent. An insurer with over $500,000,000.00 of direct written and assumed premiums in the prior calendar year must have 75% or more of its audit committee members be independent.

(11) The director may require an entity's board to enact improvements to the independence of the audit committee membership if the insurer is in a risk-based capital action level event, meets 1 or more of the standards listed in chapter 4 of an insurer considered to be in hazardous financial condition, or otherwise exhibits signs of a troubled insurer.

(12) An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program, of less than $500,000,000.00 may apply to the director for a waiver from this section based on hardship. The insurer shall file, with its annual statement filing, the approval for relief from this section granted by the commissioner with the states that it is licensed in or doing business in and with the National Association of Insurance Commissioners. If the nondomestic state accepts electronic filing with the National Association of Insurance Commissioners, the insurer shall file the approval in an electronic format acceptable to the National Association of Insurance Commissioners.

(13) This section takes effect January 1, 2010. An insurer or group of insurers that is not required to have independent audit committee members or only 50% independent audit committee members because the total written and assumed premium is below the required threshold in subsection (10) and subsequently becomes subject to 1 of the independence requirements due to changes in premium, whether through business combination or not, has 1 year after the year the threshold is exceeded to comply with the independence requirements of subsection (10).

(14) As used in this section, "direct written and assumed premiums" is the combined total of direct premiums and assumed premiums from nonaffiliates for the reporting entities.

History: Add. 2008, Act 342, Eff. Jan. 1, 2010;—Am. 2020, Act 17, Imd. Eff. Jan. 27, 2020.

Popular name: Act 218

500.1028 Internal audit function; exemption; confidentiality; report to audit committee.

Sec. 1028. (1) An insurer is exempt from the requirements of this section if the insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program less than $500,000,000.00 and if the insurer is a member of a group of insurers that has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program less than $1,000,000,000.00.

(2) An insurer or group of insurers not exempt under subsection (1) shall establish an internal audit function providing independent, objective, and reasonable assurance to the audit committee and management

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regarding the insurer's governance, risk management, and internal controls. This assurance must be provided by performing general and specific audits, reviews and tests, and by employing other techniques considered necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations.

(3) General and specific audits performed under this section are not considered an insurance compliance self-evaluative audit under section 221. Documents prepared or produced as a result of or in connection with audits performed under this section must be disclosed to the director on written request. Except as otherwise provided in this subsection, the director shall withhold from public inspection all information and documents submitted to the department under this section and these items are confidential, are not subject to subpoena, are not subject to disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, and must not be divulged to any person. However, the director may divulge the information and documents described in this subsection to a relevant state or federal agency, or to the National Association of Insurance Commissioners, if the director receives assurances that the information and documents will be kept confidential. The director shall not use the information and documents submitted under this section to form the sole basis for an examination under section 222.

(4) To ensure that internal auditors remain objective, the internal audit function must be organizationally independent. Specifically, the internal audit function must not defer ultimate judgment on audit matters to others, and must appoint an individual to head the internal audit function who will have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual-reporting relationships.

(5) The head of internal audit function shall report to the audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the internal audit function's independence or effectiveness, material findings from completed audits, and the appropriateness of corrective actions implemented by management as a result of audit findings.

(6) If an insurer is a member of an insurance holding company system or included in a group of insurers, the insurer may satisfy the internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level.

(7) An insurer that meets the premium thresholds under this section must have an internal audit function and must have the function in place by no later than January 1, 2021. If an insurer or group of insurers that is exempt no longer qualifies for the exemption, it has 1 year after the year the threshold is exceeded to comply with the requirement.

History: Add. 2020, Act 17, Imd. Eff. Jan. 27, 2020.

Popular name: Act 218

500.1029 Director or officer of insurer; prohibited conduct.

Sec. 1029. (1) A director or officer of an insurer shall not directly or indirectly do either of the following:

(a) Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review, or communication required under this chapter.

(b) Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review, or communication required under this chapter.

(2) A director or officer of an insurer, or any other person acting under the direction thereof, shall not directly or indirectly take any action to coerce, manipulate, mislead, or fraudulently influence any accountant engaged in the performance of an audit under this chapter if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading. Actions that, if successful, could result in rendering the insurer's financial statements materially misleading include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead, or fraudulently influence an accountant to do any of the following:

(a) To issue or reissue a report on an insurer's financial statements that is not warranted under the circumstances due to material violations of statutory accounting principles prescribed by the commissioner, generally accepted auditing standards, or other professional or regulatory standards.

(b) Not to perform audit, review, or other procedures required by generally accepted auditing standards or other professional standards.

(c) Not to withdraw an issued report.

(d) Not to communicate matters to an insurer's audit committee.

History: Add. 2008, Act 342, Imd. Eff. Dec. 23, 2008.

Popular name: Act 218

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500.1031 Report of insurer's or group of insurers' internal control over financial reporting; requirements.

Sec. 1031. (1) Every insurer required to file an audited financial report pursuant to this chapter that has annual direct written and assumed premiums, excluding premiums reinsured with the federal crop insurance corporation and federal flood program, of $500,000,000.00 or more shall prepare a report of the insurer's or group of insurers' internal control over financial reporting, which shall be as of the immediately preceding December 31. The report shall be filed with the commissioner along with the communication of internal control related matters noted in an audit described under section 1017.

(2) Notwithstanding the premium threshold in subsection (1), the commissioner may require an insurer to file a report of internal control over financial reporting if the insurer is in a risk-based capital level event or meets 1 or more of the standards listed in chapter 4 of an insurer considered to be in hazardous financial condition, or otherwise exhibits signs of a troubled insurer.

(3) An insurer or a group of insurers that is directly subject to section 404, part of a holding company system whose parent is directly subject to section 404, not directly subject to section 404 but is a SOX compliant entity, or a member of a holding company system whose parent is not directly subject to section 404 but is a SOX compliant entity may file its or its parent's section 404 report and an addendum in satisfaction of the requirements of this section provided that those internal controls of the insurer or group of insurers having a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements as required in section 1007 were included in the scope of the section 404 report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements as required in section 1007 excluded from the section 404 report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the section 404 report, the insurer or group of insurers may either file a report as specified in subsection (1), or the section 404 report and a report as specified in subsection (1) for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the section 404 report.

(4) The report of internal control over financial reporting shall include all of the following:

(a) A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting.

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

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

(d) A statement that briefly describes the scope of work that is included and whether any internal controls were excluded.

(e) Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of the immediately preceding December 31. Management shall not conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is 1 or more unremediated material weaknesses in its internal control over financial reporting.

(f) A statement regarding the inherent limitations of internal control systems.

(g) Signatures of the chief executive officer and the chief financial officer or his or her equivalent.

(5) Management shall document and make available upon financial condition examination the basis upon which its assertions, required in subsection (4), are made. Management may base its assertions, in part, upon its review, monitoring, and testing of internal controls undertaken in the normal course of its activities. Management has discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost-effective manner and, as such, may include assembly of or reference to existing documentation.

(6) The office of financial and insurance regulation shall keep confidential the report on internal control over financial reporting, required by subsection (1), and any documentation provided in support thereof during the course of a financial condition examination.

(7) This section takes effect beginning with the reporting period that ends December 31, 2010. An insurer or group of insurers that is not required to file a report because the total written premium is below the required

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threshold and subsequently becomes subject to the reporting requirement, whether through business combination or not, shall have 2 years after the year the threshold is exceeded to comply with this section's reporting requirements.

History: Add. 2008, Act 342, Imd. Eff. Dec. 23, 2008.

Popular name: Act 218

500.1033 Exemption from any or all provisions of chapter.

Sec. 1033. Upon written application of any insurer, the commissioner may grant an exemption from compliance with any or all provisions of this chapter if the commissioner finds, upon review of the application, that compliance with this chapter would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. An exemption granted under this section shall be filed by the insurer with the states that it is licensed in or doing business in and with the national association of insurance commissioners. If the nondomestic state accepts electronic filing with the national association of insurance commissioners, the insurer shall file the approval in an electronic format acceptable to the national association of insurance commissioners. Within 10 days from a denial of an insurer's written request for an exemption from this chapter, the insurer may request in writing a hearing on its application for an exemption. The hearing shall be held pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

History: Add. 2008, Act 342, Imd. Eff. Dec. 23, 2008.

Popular name: Act 218

CHAPTER 11
REINSURANCE

500.1101 "Qualified United States financial institution" defined.

Sec. 1101. For purposes of this chapter, a "qualified United States financial institution" means an institution that meets either subdivision (a) or (b):

(a) Is organized, or in the case of a United States office of a foreign banking organization, is licensed, under the laws of the United States or any state in the United States, is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies, and has been determined by the commissioner to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(b) For those institutions that are eligible to act as a fiduciary of a trust, is organized, or in the case of a United States branch or agency office of a foreign banking organization, is licensed, under the laws of the United States or any state in the United States, has been granted authority to operate with fiduciary powers, and is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 2000, Act 283, Imd. Eff. July 10, 2000.

Compiler's note: Enacting section 1 of Act 283 of 2000 provides:

"Enacting section 1. The legislature declares that the provisions of this amendatory act are fundamental to the business of insurance as provided in sections 1 and 2 of chapter 20, popularly known as the McCarran-Ferguson act, 59 Stat. 33 and 34, 15 U.S.C. 1011 and 1012. It is the intent of this amendatory act that upon the insolvency of an alien insurer or reinsurer that provides security to fund its United States obligations under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, the assets representing the security shall be maintained in the United States and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets shall be distributed under the insurance laws of the state where the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies."

Popular name: Act 218

500.1103 Credit for reinsurance as asset or reduction from liability; accredited reinsurer; trust fund; requirements; report to director; certified reinsurer requirements; obligation to arbitrate; trust agreement; list of reciprocal jurisdictions; suspension or revocation; hearing; recoverable assets; diversification; member of catastrophic claims association; definitions.

Sec. 1103. (1) A ceding insurer is allowed credit for reinsurance as either an asset or a reduction from liability on account of reinsurance ceded only if the reinsurance is ceded to an assuming insurer that is authorized to transact insurance or reinsurance in this state or that meets the requirements of subsection (2), (3), (4), (5), (6), or (7). In addition, credit for reinsurance is allowed under this section only to the extent that it is consistent with any rules promulgated by the director under section 1106 regarding the valuation of

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reserve credits or assets, the amount and forms of security supporting reinsurance agreements, or the circumstances under which credit will be reduced or eliminated. For an assuming insurer that is licensed to transact insurance or reinsurance in this state or that meets the requirements of subsection (2), credit is allowed only for cessions of those kinds or classes of business that the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, for a United States branch of an alien insurer, in the state through which it is entered and is licensed to transact insurance or reinsurance.

(2) A ceding insurer is allowed credit for reinsurance ceded as either an asset or a reduction from liability on account of reinsurance ceded if the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state. An accredited reinsurer under this subsection is a reinsurer that meets all of the following requirements:

(a) Files with the director evidence of the reinsurer's submission to this state's jurisdiction.

(b) Submits to this state's authority to examine its books and records and bears the expense of the examination.

(c) Is licensed to transact insurance or reinsurance in at least 1 state or for a United States branch of an alien assuming insurer is entered through and licensed to transact insurance or reinsurance in at least 1 state.

(d) Files annually with the director a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement.

(e) Demonstrates to the satisfaction of the director that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer meets the requirement of this subdivision as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than $20,000,000.00 and its accreditation has not been denied by the director within 90 days after submission of its application.

(3) A ceding insurer is allowed credit for reinsurance as either an asset or a reduction from liability on account of reinsurance ceded if the reinsurance is ceded to an assuming insurer that is domiciled in, or for a United States branch of an alien assuming insurer is entered through, a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this chapter and the assuming insurer or United States branch of an alien assuming insurer meets both of the following requirements:

(a) Except for reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system, maintains a surplus as regards policyholders in an amount not less than $20,000,000.00.

(b) Submits to this state's authority to examine its books and records and bears the expense of the examination.

(4) Subject to subsection (19), a ceding insurer is allowed credit for reinsurance ceded as either an asset or a reduction from liability on account of reinsurance ceded if the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution for the payment of the valid claims of its United States ceding insurers, their assigns, and successors in interest, the trust agreement complies with subsection (21), and the assuming insurer submits to the director's authority to examine its books and records and bears the expense of the examination. The assuming insurer shall report annually to the director information substantially the same as an authorized insurer is required to report under section 438 to enable the director to determine the sufficiency of the trust fund. The trust fund must meet all of the following requirements:

(a) For a single assuming insurer, all of the following apply:

(*i*) The trust must consist of a trusteed account representing the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers and, in addition, the assuming insurer shall maintain a trusteed surplus of an amount sufficient in the opinion of the director to maintain compliance with section 403 as respects reinsurance ceded by United States ceding insurers but not less than $20,000,000.00.

(*ii*) Except as otherwise provided in this subparagraph and subparagraph (*iii*), after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least 3 full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus. The commissioner with principal regulatory oversight of the trust shall not authorize a reduction in the required trusteed surplus unless the commissioner with principal regulatory oversight of the trust determines, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and must consider all material risk factors, including, when applicable, the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency.

(*iii*) The minimum required trusteed surplus must not be reduced to an amount less than 30% of the

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assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

(b) For a group including incorporated and individual unincorporated underwriters, all of the following apply:

(*i*) For reinsurance ceded under reinsurance agreements with an inception date, amendment, or renewal date on or after January 1, 1993, the trust must consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by United States domiciled ceding insurers to any underwriter of the group.

(*ii*) For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding this section, the trust must consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States.

(*iii*) In addition to subparagraphs (*i*) and (*ii*), the group shall maintain a trusteed surplus of which an amount sufficient in the opinion of the director to maintain compliance with section 403 as respects reinsurance ceded by United States domiciled ceding insurers but not less than $100,000,000.00 must be held jointly for the benefit of United States domiciled ceding insurers of any member of the group for all years of account. The incorporated members of the group shall not engage in any business other than underwriting as a member of the group and are subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members. Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide the director with an annual certification of the solvency of each underwriter member by the group's domiciliary regulator or if certification is unavailable, financial statements prepared by independent public accountants for each underwriter group member.

(c) For a group of incorporated underwriters under common administration, all of the following apply:

(*i*) The group must have continuously transacted an insurance business outside the United States for at least 3 years immediately before applying for accreditation.

(*ii*) The group must maintain an aggregate policyholders' surplus of not less than $10,000,000,000.00.

(*iii*) The group must maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group.

(*iv*) In addition to subparagraph (*iii*), the group must maintain a joint trusteed surplus of which $100,000,000.00 is held jointly for the benefit of United States domiciled ceding insurers of any member of the group as additional security for those liabilities.

(*v*) Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the director an annual certification of each underwriter member's solvency by the member's domiciliary regulator and financial statements of each underwriter member of the group prepared by its independent public accountant.

(d) The trust and any amendments to the trust must be established in a form approved by the commissioner of the state where the trust is domiciled or the commissioner of another state who under the trust instrument terms has accepted principal regulatory oversight of the trust. The trust instrument must provide that contested claims are valid and enforceable on the final order of a court of competent jurisdiction in the United States. The trust must vest legal title to its assets in the trustees of the trust for its United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the director, and the assuming insurer shall bear the expense of the examination. The trust must remain in effect while the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(e) No later than February 28 of each year, the trustees of the trust shall report to the director in writing the balance of the trust and listing the trust's investments at the preceding year end and shall certify the date of termination of the trust, if a termination is planned, or certify that the trust does not expire before the following December 31.

(5) A ceding insurer is allowed credit for reinsurance ceded as either an asset or a reduction from liability on account of reinsurance ceded if reinsurance is ceded to an assuming insurer that does not meet the requirements of this section but only for the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

(6) A ceding insurer is allowed credit for reinsurance ceded as either an asset or a reduction from liability on account of reinsurance if the reinsurance is ceded to an assuming insurer that has been certified by the director as a certified reinsurer in this state and secures its obligations as required under this subsection. Certification requirements include all of the following:

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(a) The director shall not certify an assuming insurer as a certified reinsurer unless the assuming insurer meets all of the following requirements:

(*i*) The assuming insurer is domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the director under subdivision (c).

(*ii*) The assuming insurer maintains minimum capital and surplus, or its equivalent, in an amount determined by the director pursuant to rule.

(*iii*) The assuming insurer maintains financial strength ratings from 2 or more rating agencies considered acceptable by the director pursuant to rule.

(*iv*) The assuming insurer agrees to submit to the jurisdiction of this state.

(*v*) The assuming insurer agrees to appoint the director as its agent for service of process in this state.

(*vi*) The assuming insurer agrees to provide security for 100% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment.

(*vii*) The assuming insurer agrees to meet applicable information filing requirements as determined by the director, both with respect to an initial application for certification and on an ongoing basis.

(*viii*) The assuming insurer satisfies any other requirements for certification that the director considers relevant.

(b) The director may certify an association including incorporated and individual unincorporated underwriters as a certified reinsurer if the association meets all of the following requirements:

(*i*) The association meets the requirements of subdivision (a).

(*ii*) The association satisfies its minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and its members, that include a joint central fund that may be applied to an unsatisfied obligation of the association or any of its members, in an amount determined by the director to provide adequate protection.

(*iii*) The incorporated members of the association are not engaged in any business other than underwriting as a member of the association. The incorporated members are subject to the same level of regulation and solvency control by the association's domiciliary regulator as the unincorporated members.

(*iv*) Within 90 days after its financial statements are due to be filed with the association's domiciliary regulator, the association provides to the director an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

(c) The director shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in a qualified jurisdiction is eligible to be considered for certification by the director as a certified reinsurer. All of the following apply to the list of qualified jurisdictions:

(*i*) To determine if the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the director shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits, and extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction shall agree to share information and cooperate with the director with respect to all certified reinsurers domiciled within that jurisdiction. The director shall not recognize a jurisdiction as a qualified jurisdiction if the director determines that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. The director may consider additional factors to determine if the domiciliary is eligible to be recognized as a qualified jurisdiction.

(*ii*) In determining whether a jurisdiction is a qualified jurisdiction, the director shall consider a list of qualified jurisdictions published by the NAIC committee process. If the director approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the director shall provide thoroughly documented justification to the NAIC in accordance with criteria required pursuant to rules.

(*iii*) The director shall recognize a United States jurisdiction that meets the requirement for accreditation under the NAIC financial standards and accreditation program as a qualified jurisdiction.

(*iv*) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the director may suspend the reinsurer's certification indefinitely, instead of revoking it.

(d) The director shall assign a rating to each certified reinsurer, giving consideration to the financial strength ratings that have been assigned by rating agencies considered acceptable to the director pursuant to rule. The director shall publish a list of all certified reinsurers and their ratings.

(e) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subsection at a level consistent with its rating, as specified in rules promulgated by the director. All of the following apply to a certified reinsurer securing its obligations:

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(*i*) Except as otherwise provided in this subsection, a domestic ceding insurer does not qualify for full financial statement credit for reinsurance ceded to a certified reinsurer unless the certified reinsurer maintains security in a form acceptable to the director and consistent with section 1105, or in a multibeneficiary trust in accordance with subsection (4).

(*ii*) If a certified reinsurer maintains a trust to fully secure its obligations described in subsection (4), and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security provided under this subsection or comparable laws of other United States jurisdictions and for its obligations described under subsection (4). The director shall not certify a reinsurer under this subsection unless the reinsurer binds itself, by the language of the trust and agreement with the commissioner with principal regulatory oversight of each trust account, to fund, on termination of a trust account, out of the remaining surplus of the trust any deficiency of any other trust account.

(*iii*) The minimum trusteed surplus requirements provided in subsection (4) are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection, except that the trust must maintain a minimum trusteed surplus of $10,000,000.00.

(*iv*) With respect to obligations incurred by a certified reinsurer under this subsection, if the security is insufficient, the director shall reduce the allowable credit by an amount proportionate to the deficiency, and may impose further reductions in allowable credit on finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(*v*) For purposes of this subsection, a certified reinsurer whose certification has been terminated for any reason is considered a certified reinsurer required to secure 100% of its obligations. If the director continues to assign a higher rating under this section, the requirement under this subparagraph does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended. As used in this subparagraph, "terminated" means revoked, suspended, voluntarily surrendered, or placed in inactive status.

(f) If an applicant for certification has been certified as a reinsurer in an NAIC-accredited jurisdiction, the director may defer to that jurisdiction's certification, and may defer to the rating assigned by that jurisdiction, and the applicant is considered a certified reinsurer in this state.

(g) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this subsection, and the director shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

(7) A ceding insurer is allowed credit when the reinsurance is ceded to an assuming insurer that meets all of the following conditions:

(a) The assuming insurer must have its head office or be domiciled in, as applicable, and be licensed in a reciprocal jurisdiction.

(b) The assuming insurer must have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be set forth in rule. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, minimum capital and surplus equivalents, net of liabilities, calculated according to the methodology applicable in its domiciliary jurisdiction, and a central fund containing a balance in amounts to be set forth in rule.

(c) The assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ratio, as applicable, that will be set forth in rule. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and is also licensed.

(d) The assuming insurer must agree and provide adequate assurance to the director, in a form specified by the director pursuant to rule, as follows:

(*i*) The assuming insurer must provide prompt written notice and explanation to the director if it falls below the minimum requirements under subdivision (b) or (c), or if any regulatory action is taken against it for serious noncompliance with applicable law.

(*ii*) The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the director as agent for service of process. The director may require that consent for service of process be provided to the director and included in each reinsurance agreement. This subparagraph does not limit or alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent the agreements are unenforceable under applicable insolvency or

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delinquency laws.

(*iii*) The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained.

(*iv*) Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to the agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate.

(*v*) The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement that involves this state's ceding insurers, and agree to notify the ceding insurer and the director and to provide security in an amount equal to 100% of the assuming insurer's liabilities to the ceding insurer, if the assuming insurer enters into a solvent scheme of arrangement described in this subparagraph. The security must be in a form consistent with subsection (6) and section 1105 and as specified by the director in rule.

(e) The assuming insurer or its legal successor must provide, if requested by the director, on behalf of itself and any legal predecessors, certain documentation to the director, as specified by the director in rule.

(f) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth in rule.

(g) The assuming insurer's supervisory authority must confirm to the director on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements under subdivisions (b) and (c).

(h) This subsection does not preclude an assuming insurer from providing the director with information on a voluntary basis.

(8) The director shall timely create and publish a list of reciprocal jurisdictions that is published through the NAIC committee process. Both of the following apply to the director's list published under this subsection:

(a) The director's list must include a reciprocal jurisdiction that meets the conditions under subsection (27)(b)(*i*) and (*ii*) and must consider any other reciprocal jurisdiction included on the NAIC list. The director may approve a jurisdiction that does not appear on the NAIC list of reciprocal jurisdictions in accordance with criteria to be developed under rules promulgated by the director.

(b) The director may remove a jurisdiction from the list of reciprocal jurisdictions on a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set forth in rules promulgated by the director, except that the director shall not remove from the list a reciprocal jurisdiction that meets the conditions under subsection (27)(b)(*i*) and (*ii*). On removal of a reciprocal jurisdiction from this list, a ceding insurer is allowed credit for reinsurance ceded to an assuming insurer that has its home office or is domiciled in that jurisdiction if otherwise allowed under this section, section 1105, or section 1106.

(9) The director shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in subsection (7) and to which cessions must be granted credit in accordance with subsection (7). The director may add an assuming insurer to the list if an NAIC accredited jurisdiction has added the assuming insurer to a list of assuming insurers or if, on initial eligibility, the assuming insurer submits the information to the director as required under subsection (7)(d) and complies with any additional requirements that the director may impose by rule, except to the extent that they conflict with an applicable covered agreement.

(10) If the director determines that an assuming insurer no longer meets 1 or more of the requirements under subsection (7), the director may revoke or suspend the eligibility of the assuming insurer for recognition under subsection (7) in accordance with procedures set forth in rule.

(11) While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with section 1105.

(12) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into before the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the director and consistent with section 1105.

(13) If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded

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liabilities.

(14) Subsection (7) does not limit or alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited under this section, section 1105, or section 1106 or other applicable law or rule.

(15) Credit may be taken under subsection (7) only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the amendatory act that added this subsection, and only with respect to losses incurred and reserves reported on or after the later of the following:

(a) The date on which the assuming insurer has met all eligibility requirements under subsection (7).

(b) The effective date of the new reinsurance agreement, amendment, or renewal.

(16) Subsection (15) does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under subsection (7), if the reinsurance qualifies for credit under any other applicable provision under this section, section 1105, or section 1106.

(17) Subsection (7) does not authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement.

(18) Subsection (7) does not limit or alter the capacity of parties to any reinsurance agreement to renegotiate the agreement.

(19) If the assuming insurer is not licensed, accredited, or certified to transact insurance or reinsurance in this state, the credit under subsection (4) is not allowed unless the assuming insurer agrees in the reinsurance agreements to both of the following:

(a) That if the assuming insurer fails to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, will submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction, and will abide by the final decision of the court or any appellate court if there is an appeal.

(b) To designate the director or a designated attorney as its true and lawful attorney on whom may be served any lawful process in an action, suit, or proceeding instituted by or on behalf of the ceding insurer.

(20) Subsection (19) is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if the obligation is created in the agreement.

(21) The credit under subsection (4), (6), or (7) is not allowed unless the assuming insurer agrees in the trust agreement to all of the following:

(a) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by subsection (4) or (6), or if the trust grantor has been declared or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee will comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund.

(b) The assets will be distributed by and claims will be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

(c) If the commissioner with regulatory oversight determines that the trust fund assets or any part of the trust fund assets is not necessary to satisfy the claims of the United States ceding insurers of the trust grantor, the trust fund assets or any part of the trust fund assets will be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement.

(d) The trust grantor waives any right otherwise available under United States laws inconsistent with subdivisions (a) to (c).

(22) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the director may suspend or revoke the reinsurer's accreditation or certification. The director shall give the reinsurer notice and opportunity for hearing. The suspension or revocation must not take effect until after the director's order on hearing, unless 1 of the following occurs:

(a) The reinsurer waives its right to hearing.

(b) The director's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under subsection (6)(f).

(c) The director finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the director's action.

(23) While a reinsurer's accreditation or certification is suspended, a reinsurance contract issued or renewed after the effective date of the suspension does not qualify for credit except to the extent that the reinsurer's obligations under the contract are secured under section 1105. If a reinsurer's accreditation or

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certification is revoked, credit for reinsurance may not be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured under subsection (6)(e) or section 1105.

(24) A ceding insurer shall take steps to manage its reinsurance recoverable assets proportionate to its own book of business. A domestic ceding insurer shall notify the director within 30 days after reinsurance recoverable assets from any single assuming insurer, or group of affiliated assuming insurers, exceeds 50% of the domestic ceding insurer's last reported surplus to policyholders, or after it has determined that reinsurance recoverable assets from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification must demonstrate that the exposure is safely managed by the domestic ceding insurer.

(25) A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the director within 30 days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than 20% of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification must demonstrate that the exposure is safely managed by the domestic ceding insurer.

(26) A ceding insurer that is a member of the catastrophic claims association created under section 3104 is exempt from subsections (24) and (25) for purposes of cessions to the catastrophic claims association.

(27) As used in this section:

(a) "NAIC" means the National Association of Insurance Commissioners.

(b) "Reciprocal jurisdiction" is a jurisdiction that meets 1 of the following conditions:

(*i*) A non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority or, for a covered agreement between the United States and European Union, is a member state of the European Union. As used in this subparagraph, "covered agreement" means an agreement entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 USC 313 and 314, that is currently in effect, or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.

(*ii*) A United States jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program.

(*iii*) A qualified jurisdiction, as determined by the director under subsection (6)(c), that is not otherwise described in subparagraph (*i*) or (*ii*) and that meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the director in rule.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 1994, Act 443, Imd. Eff. Jan. 10, 1995;—Am. 2000, Act 283, Imd. Eff. July 10, 2000;—Am. 2018, Act 91, Eff. June 24, 2018;—Am. 2020, Act 328, Eff. Mar. 24, 2021.

Compiler's note: Enacting section 1 of Act 283 of 2000 provides:

"Enacting section 1. The legislature declares that the provisions of this amendatory act are fundamental to the business of insurance as provided in sections 1 and 2 of chapter 20, popularly known as the McCarran-Ferguson act, 59 Stat. 33 and 34, 15 U.S.C. 1011 and 1012. It is the intent of this amendatory act that upon the insolvency of an alien insurer or reinsurer that provides security to fund its United States obligations under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, the assets representing the security shall be maintained in the United States and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets shall be distributed under the insurance laws of the state where the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies."

Popular name: Act 218

500.1105 Reduction from liability by ceding insurer to assuming insurer not meeting requirements of MCL 500.1103; security.

Sec. 1105. An asset or a reduction from liability for the reinsurance ceded by a ceding insurer to an assuming insurer that does not meet the requirements of section 1103 is allowed in an amount not to exceed the liabilities carried by the ceding insurer. In addition, any asset or reduction from liability for reinsurance ceded is allowed under this section only to the extent that it is consistent with any rules promulgated by the director under section 1106 regarding the valuation of reserve credits or assets, the amount and forms of security supporting reinsurance agreements, or the circumstances under which credit will be reduced or eliminated. The reduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations under the reinsurance contract, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer and, for a trust, held in a qualified United States financial institution. This security may be in the form of any of the following:

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(a) Cash.

(b) Securities that may be valued by the director under sections 841 and 842 and are approved for investment by insurers under chapter 9, including those considered exempt from filing as defined by the purposes and procedures manual of the Securities Valuation Office of the National Association of Insurance Commissioners.

(c) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution no later than December 31 of the year for which filing is being made, and in the possession of the ceding insurer on or before the filing date of its annual statement. Letters of credit that meet applicable standards of issuer acceptability on the date the letters of credit are issued or confirmed are, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever occurs first.

(d) Any other form of security acceptable to the director.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 2000, Act 283, Imd. Eff. July 10, 2000;—Am. 2018, Act 91, Eff. June 24, 2018.

Compiler's note: Enacting section 1 of Act 283 of 2000 provides:

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Popular name: Act 218

500.1106 Rules.

Sec. 1106. (1) Subject to subsections (2) and (3), the director may promulgate rules pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, with regard to reinsurance agreements concerning any of the following:

(a) Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits, if the reinsurance treaty meets either of the following criteria:

(*i*) Contains policies issued after December 31, 2014.

(*ii*) Contains policies issued before January 1, 2015, if the risk pertaining to the policies is ceded, in whole or in part, in connection with the treaty, after December 31, 2014.

(b) Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period, if the reinsurance treaty meets either of the following criteria:

(*i*) Contains policies issued after December 31, 2014.

(*ii*) Contains policies issued before January 1, 2015, if the risk pertaining to the policies is ceded, in whole or in part, in connection with the treaty, after December 31, 2014.

(c) Variable annuities with guaranteed death or living benefits.

(d) Long-term care insurance policies.

(e) Other life and health insurance and annuity products as the director considers necessary for the administration of sections 1103 and 1105.

(2) A rule promulgated under subsection (1) may require a ceding insurer to use the valuation manual adopted by the NAIC under section 11b(1) of the NAIC standard valuation law when calculating amounts or forms of security required to be held under law.

(3) A rule promulgated pursuant to subsection (1) does not apply to cessions to an assuming insurer that meets any of the following criteria:

(a) The assuming insurer meets the conditions under section 1103(7).

(b) The assuming insurer is certified as a reinsurer in this state.

(c) The assuming insurer maintains at least $250,000,000.00 in capital and surplus when determined in accordance with the NAIC accounting practices and procedures manual and meets either of the following criteria:

(*i*) The assuming insurer is licensed to transact insurance or reinsurance in at least 26 states.

(*ii*) The assuming insurer is licensed to transact insurance or reinsurance in at least 10 states, and is licensed to transact insurance or reinsurance or accredited as a reinsurer in a total of at least 35 states.

(4) As used in this section, "NAIC" means the National Association of Insurance Commissioners.

History: Add. 2018, Act 91, Eff. June 24, 2018;—Am. 2020, Act 328, Eff. Mar. 24, 2021.

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Compiler's note: Former MCL 500.1106, which pertained to administration of deposits, was repealed by Act 360 of 1972, Imd. Eff. Jan. 9, 1973.

Popular name: Act 218

500.1108-500.1120 Repealed. 1972, Act 360, Imd. Eff. Jan. 9, 1973.

Compiler's note: The repealed sections pertained to administration of deposits.

Popular name: Act 218

500.1121 Applicability of MCL 500.1123 to 500.1127 to certain insurers.

Sec. 1121. The provisions of sections 1123 through 1127 apply to all life and disability insurers and also apply to licensed property and casualty insurers with respect to their disability insurance business. Sections 1123 through 1127 do not apply to assumption reinsurance, yearly renewable term reinsurance, or certain nonproportional reinsurance such as excess or catastrophe reinsurance.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1123 Reinsurance agreement; conditions prohibiting reduction in liability or establishment of asset; approval of commissioner; filing agreements.

Sec. 1123. (1) For reinsurance ceded an insurer subject to this section shall not reduce any liability or establish any asset in any financial agreement filed with the commissioner if, by the terms of the reinsurance agreement, in substance or effect, any of the following conditions exist:

(a) Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period are not sufficient to cover anticipated allowable renewal expenses of the ceding insurer on the portion of the business reinsured, unless a liability is established for the present value of the shortfall, using assumptions equal to the applicable statutory reserve basis on the business reinsured. Those expenses include commissions, premium taxes, and direct expenses including, but not limited to, billing, valuation, claims, and maintenance expected by the company at the time the business is reinsured.

(b) The ceding insurer can be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld, and tax reimbursements, shall not be considered to be such a deprivation of surplus or assets.

(c) The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in-force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions that allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding insurer to prematurely terminate the reinsurance treaty.

(d) The ceding insurer must, at specific points in time scheduled in the agreement, terminate or automatically recapture all or part of the reinsurance ceded.

(e) The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. For example, a ceding insurer may not pay reinsurance premiums or other fees or charges to a reinsurer that are greater than the direct premiums collected by the ceding insurer.

(f) The treaty does not transfer all of the significant risk inherent in the business being reinsured. The following table identifies for a representative sampling of products or type of business the risks that are considered to be significant. For products not specifically included, the risks determined to be significant shall be consistent with this table.

Risk Categories:

(*i*) Morbidity.

(*ii*) Mortality.

(*iii*) Lapse. This is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy.

(*iv*) Credit quality (C1). This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that the assets will default or that there will be a decrease in earning power. It

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excludes market value declines due to changes in interest rate.

(*v*) Reinvestment (C2). This is the risk that interest rates will fall and funds reinvested, such as coupon payments or money received upon asset maturity or call, will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase.

(*vi*) Disintermediation (C3). This is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.

Risk Category

	(*i*)	(*ii*)	(*iii*)	(*iv*)	(*v*)	(*vi*)
Health insurance - other than LTC/LTD*	+	0	+	0	0	0
Health insurance - LTC/LTD*	+	0	+	+	+	0
Immediate annuities	0	+	0	+	+	0
Single premium deferred annuities	0	0	+	+	+	+
Flexible premium deferred annuities	0	0	+	+	+	+
Guaranteed interest contracts	0	0	0	+	+	+
Other annuity deposit business	0	0	+	+	+	+
Single premium whole life	0	+	+	+	+	+
Traditional nonpar permanent	0	+	+	+	+	+
Traditional nonpar term	0	+	+	0	0	0
Traditional par permanent	0	+	+	+	+	+
Traditional par term	0	+	+	0	0	0
Adjustable premium permanent	0	+	+	+	+	+
Indeterminate premium permanent	0	+	+	+	+	+
Universal life flexible premium	0	+	+	+	+	+
Universal life fixed premium	0	+	+	+	+	+
Universal life fixed premium Dump-in premiums allowed	0	+	+	+	+	+

+ = Significant
0 = Insignificant
*LTC = Long term care insurance
LTD = Long term disability insurance

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(g) The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and, other than for the classes of business excepted in subdivision (h), the ceding insurer does not either transfer the underlying assets to the reinsurer or legally segregate such assets in a trust or escrow account or otherwise establish a mechanism satisfactory to the commissioner that legally segregates, by contract or contract provision, the underlying assets.

(h) Notwithstanding the requirements of subsection (g), the assets supporting the reserves for the following classes of business and any classes of business that do not have a significant credit quality, reinvestment, or disintermediation risk may be held by the ceding insurer without segregation of such assets:

(*i*) Health insurance - LTC/LTD.

(*ii*) Traditional nonparticipating permanent life.

(*iii*) Traditional participating permanent life.

(*iv*) Adjustable premium permanent life.

(*v*) Indeterminate premium permanent life.

(*vi*) Universal life fixed premium.

The associated formula for determining the reserve interest rate adjustment must use a formula that reflects the ceding insurer's investment earnings and incorporates all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

$$RATE = \frac{2(I + CG)}{X+Y-I-CG}$$

WHERE: I is the net investment income
CG is capital gains less capital losses
X is the current year cash and invested assets plus investment income due and accrued less borrowed money

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Y is the same as X but for the prior year

(i) Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within 90 days of the settlement date.

(j) The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured.

(k) The ceding insurer is required to make representations or warranties about future performance of the business or liabilities being reinsured.

(*l*) The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

(2) Notwithstanding subsection (1), an insurer subject to this section and sections 1125 and 1127 may, with the prior approval of the commissioner, take such reserve credit or establish such asset as the commissioner may consider consistent with this act.

(3) Agreements entered into after the effective date of this chapter that involve the reinsurance of business, excluding annually renewable reinsurance treaties and agreements, issued prior to the effective date of the agreements, along with any subsequent amendments thereto, shall be filed by the ceding insurer with the commissioner within 30 days from its date of execution. Each filing shall include data detailing the financial impact of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this section and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with the commissioner. The actuary should maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that the work conforms to this section. A foreign insurer is not required to file the agreements with the commissioner as required by this subsection if it is subject to filing requirements adopted by statute or regulation in its state of domicile that the commissioner has determined are substantially similar to those required under this subsection. Any increase in surplus net of federal income tax resulting from arrangements described in this subsection shall be identified separately on the insurer's statutory financial statement as a surplus item under aggregate write-ins for gains and losses in surplus in the capital and surplus account, and recognition of the surplus increase as income shall be reflected on a net of tax basis and identified as "reinsurance ceded" in the annual financial statement as earnings emerge from the business reinsured.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1124 Repealed. 1972, Act 360, Imd. Eff. Jan. 9, 1973.

Compiler's note: The repealed section pertained to administration of deposits.

Popular name: Act 218

500.1125 Reinsurance agreement; use; execution; “reasonable period of time” defined; provisions; assumption of obligations by life and health insurance guaranty association.

Sec. 1125. (1) Neither a reinsurance agreement nor any amendment to that agreement shall be used to reduce any liability or to establish any asset in any financial statement filed with the commissioner unless the agreement, amendment, or a binding letter of intent has been duly executed by the appropriate party no later than the filing date of the financial statement.

(2) A letter of intent, a reinsurance agreement, or an amendment to a reinsurance agreement shall be executed within a reasonable period of time in order for credit to be granted for the reinsurance ceded. As used in this subsection, "reasonable period of time" means that period of time as provided by the national association of insurance commissioners accounting practices and procedures manual and as approved by the commissioner.

(3) Except for facultative certificates duly executed by a property and casualty reinsurer or its duly appointed agent, a reinsurance agreement shall contain both of the following:

(a) That the agreement constitutes the entire agreement between the parties with respect to the business being reinsured thereunder and that there are no understandings between the parties other than as expressed in the agreement.

(b) That any change or modification to the agreement is null and void unless made by amendment to the agreement and signed by both parties.

(4) A ceding insurer shall not be allowed credit for reinsurance ceded as either an asset or a reduction from liability on account of reinsurance ceded, unless the reinsurance contract provides, in substance, that if the

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ceding insurer becomes insolvent, the reinsurance shall be payable pursuant to the terms of the reinsurance contract by the assuming insurer on the basis of reported claims allowed by the liquidation court, except as provided in subsection (6), without diminution because of the insolvency of the ceding insurer. The payments shall be made directly to the ceding insurer or its domiciliary liquidator unless the reinsurance contract requires or an endorsement signed by the reinsurer to the policies reinsured requires the reinsurer to make payment to the payees under the policies reinsured if the ceding insurer becomes insolvent.

(5) The reinsurance agreement may provide that the domiciliary liquidator of an insolvent ceding insurer shall give written notice to the assuming insurer of the pendency of a claim against the ceding insurer on the contract reinsured within a reasonable time after the claim is filed in the liquidation proceeding.

(6) If a life and health insurance guaranty association or its designated successor life or health insurer has assumed policy obligations as direct obligations of the insolvent ceding insurer and has succeeded to the rights of the insolvent insurer under the contract of reinsurance, then the reinsurer's liability shall continue under the contract of reinsurance and shall be payable pursuant to the direction of the guaranty association or its designated successor. As a condition to succeeding to the insolvent insurer's rights under the contract, the guaranty association or successor life or health insurer shall be responsible for premiums payable under the reinsurance contract for periods after the date of liquidation.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 2000, Act 283, Imd. Eff. July 10, 2000;—Am. 2008, Act 342, Imd. Eff. Dec. 23, 2008.

Compiler's note: Enacting section 1 of Act 283 of 2000 provides:

"Enacting section 1. The legislature declares that the provisions of this amendatory act are fundamental to the business of insurance as provided in sections 1 and 2 of chapter 20, popularly known as the McCarran-Ferguson act, 59 Stat. 33 and 34, 15 U.S.C. 1011 and 1012. It is the intent of this amendatory act that upon the insolvency of an alien insurer or reinsurer that provides security to fund its United States obligations under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, the assets representing the security shall be maintained in the United States and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets shall be distributed under the insurance laws of the state where the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies."

Popular name: Act 218

500.1127 Reinsurance agreements; reduction to zero of certain reserve credits or assets.

Sec. 1127. Insurers subject to sections 1121 through 1125 shall reduce to zero by December 31, 1994 any reserve credits or assets established with respect to reinsurance agreements entered into prior to the effective date of this chapter that, under the provisions of this chapter, would not be entitled to recognition as reserve credits or assets, so long as those reinsurance agreements were in compliance with laws or regulations in effect immediately preceding the effective date of this chapter.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

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CHAPTER 11A
REINSURANCE INTERMEDIARIES

500.1151 Definitions.

Sec. 1151. As used in this chapter:

(a) "Actuary" means a person who is a member in good standing of the American academy of actuaries, the society of actuaries, or the casualty actuarial society.

(b) "Qualified United States Financial institution" means an institution that meets either subparagraph (*i*) or (*ii*):

(*i*) Is organized, or in the case of a United States office of a foreign banking organization, is licensed, under federal or state law, is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies, and has been determined by the commissioner to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(*ii*) For those institutions that are eligible to act as a fiduciary of a trust, is organized, or in the case of a United States branch or agency office of a foreign banking organization, is licensed, under federal or state law, has been granted authority to operate with fiduciary powers, and is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

(c) "Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager.

(d) "Reinsurance intermediary-broker" means any person, other than an officer or employee of the ceding insurer, who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer

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without the authority or power to bind reinsurance on behalf of that insurer.

(e) "Reinsurance intermediary-manager" means any person who has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department, or underwriting office, and acts as an agent for the reinsurer whether known as a reinsurance intermediary-manager, manager, or other similar term. Notwithstanding the above, the following persons are not considered a reinsurance intermediary-manager, with respect to a reinsurer, for the purposes of this chapter:

(*i*) An employee of the reinsurer.

(*ii*) A United States manager of the United States branch of an alien reinsurer.

(*iii*) An underwriting manager that, pursuant to contract, manages all the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to chapter 13, and whose compensation is not based on the volume of premiums written.

(*iv*) The manager of a group, association, pool, or organization of insurers that engage in joint underwriting or joint reinsurance and who are subject to examination by the commissioner of the state where the manager's principal office is located.

(f) "Reinsurer" means any person duly authorized in this state pursuant to the applicable provisions of this act as an insurer with the authority to assume reinsurance.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1153 Person acting as reinsurance intermediary-broker; bond; license; nonresident; service of process; refusal to issue license.

Sec. 1153. (1) A person shall not act as a reinsurance intermediary-broker in this state if the reinsurance intermediary-broker, either directly or as a member or employee of a firm or association, or as an officer, director, or employee of a corporation, does either of the following:

(a) Maintains an office in this state, unless the person is licensed as an agent or a reinsurance intermediary-broker in this state.

(b) Maintains an office in another state, unless the person is licensed as an agent or a reinsurance intermediary-broker in this state or another state having a law substantially similar to this law or such reinsurance intermediary-broker is licensed in this state as a nonresident reinsurance intermediary.

(2) A person shall not act as a reinsurance intermediary-manager in any of the following cases:

(a) For a reinsurer domiciled in this state, unless such person is licensed as an agent or a reinsurance intermediary-manager in this state.

(b) In this state, if the person maintains an office either directly or as a member of a firm or association, or an officer, director, or employee of a corporation in this state, unless such person is licensed as an agent or a reinsurance intermediary-manager in this state.

(c) In another state for a nondomestic insurer, unless the person is licensed as an agent or a reinsurance intermediary-manager in this state or another state having a law substantially similar to this law or the person is licensed in this state as a nonresident reinsurance intermediary.

(3) The commissioner may require a reinsurance intermediary-manager subject to subsection (2) to file a bond in an amount acceptable to the commissioner from an insurer acceptable to the commissioner for the protection of the reinsurer, and maintain an errors and omissions policy in an amount acceptable to the commissioner.

(4) The commissioner may issue a reinsurance intermediary license to any person who has complied with the requirements of this chapter. Any license issued to a firm or association shall authorize all the members of the firm or association and any designated employees to act as reinsurance intermediaries under the license, and all such persons shall be named in the application and any supplements thereto. Any license issued to a corporation shall authorize all of the officers and any designated employees and directors to act as reinsurance intermediaries on behalf of the corporation, and all such persons shall be named in the application and any supplements thereto.

(5) If the applicant for a reinsurance intermediary license is a nonresident, the applicant, as a condition precedent to receiving or holding a license, shall designate the commissioner as agent for service of process in the manner, and with the same legal effect, provided for by this act for designation of service of process upon unauthorized insurers, and shall also furnish the commissioner with the name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting the nonresident reinsurance intermediary may be served. The licensee shall promptly notify the commissioner in writing of every change in its designated agent for service of process.

(6) The commissioner may refuse to issue a reinsurance intermediary license if, in his or her judgment, the

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applicant, anyone named on the application, or any member, principal, officer, or director of the applicant, is not trustworthy, if any controlling person of the applicant is not trustworthy to act as a reinsurance intermediary, or if any of the foregoing has given cause for revocation or suspension of license or has failed to comply with any prerequisite for issuance of a license. Upon written request, the commissioner shall furnish a summary of the basis for refusal to issue a license, which document shall be confidential and shall not be divulged to any person except as provided in this section.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1155 Transactions between reinsurance intermediary-broker and insurer; authorization.

Sec. 1155. Transactions between a reinsurance intermediary-broker and the insurer it represents in such capacity shall be entered into only pursuant to a written authorization, specifying the responsibilities of each party. The authorization shall, at a minimum, provide for all of the following:

(a) That the insurer may terminate the reinsurance intermediary-broker's authority at any time.

(b) That the reinsurance intermediary-broker will render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to, the reinsurance intermediary-broker, and remit all funds due to the insurer within 30 days of receipt.

(c) That all funds collected for the insurer's account will be held by the reinsurance intermediary-broker in a fiduciary capacity in a bank that is a qualified United States financial institution.

(d) That the reinsurance intermediary-broker will comply with the record-keeping requirements of section 1157.

(e) That the insurer will have access and the right to copy and audit all accounts and records maintained by the reinsurance intermediary-broker related to its business in a form usable by the insurer.

(f) That the reinsurance intermediary-broker will comply with the written standards established by the insurer for the cession or retrocession of all risks.

(g) That the reinsurance intermediary-broker will disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1157 Record of transaction.

Sec. 1157. For at least 10 years after expiration of each contract of reinsurance transacted by a reinsurance intermediary, the reinsurance intermediary will keep a complete record for each transaction showing all of the following:

(a) The type of contract, limits, underwriting restrictions, classes or risks, and territory.

(b) Period of coverage, including effective and expiration dates, cancellation provisions, and notice required of cancellation.

(c) Reporting and settlement requirements of balances.

(d) Rate used to compute the reinsurance premium.

(e) Names and addresses of assuming reinsurers.

(f) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary.

(g) Related correspondence and memoranda.

(h) Proof of placement.

(i) Details regarding retrocessions handled by the reinsurance intermediary including the identity of retrocessionaires and percentage of each contract assumed or ceded.

(j) Financial records, including, but not limited to, premium and loss accounts.

(k) When the reinsurance intermediary procures a reinsurance contract on behalf of a licensed ceding insurer as follows:

(*i*) If directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk.

(*ii*) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1159 Person acting as reinsurance-broker; license required; employment of individual

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employed by reinsurance intermediary-broker; annual copy of statements of financial condition.

Sec. 1159. (1) An insurer shall not engage the services of any person to act as a reinsurance intermediary-broker on its behalf unless the person is licensed as required by section 1153.

(2) An insurer may not employ an individual who is employed by a reinsurance intermediary-broker with which it transacts business, unless the reinsurance intermediary-broker is under common control with the insurer and subject to chapter 13.

(3) The insurer shall obtain annually a copy of statements of the financial condition of each reinsurance intermediary-broker with which it transacts business.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1161 Transactions between reinsurance intermediary-manager and reinsurer; contract.

Sec. 1161. Transactions between a reinsurance intermediary-manager and the reinsurer it represents in such capacity shall only be entered into pursuant to a written contract, specifying the responsibilities of each party, which shall be approved by the reinsurer's board of directors. At least 30 days before the reinsurer assumes or cedes business through such person, a true copy of the approved contract shall be filed with the commissioner for approval. The contract shall, at a minimum, provide for all of the following:

(a) That the reinsurer may terminate the contract for cause upon written notice to the reinsurance intermediary-manager. The reinsurer may immediately suspend the authority of the reinsurance intermediary-manager to assume or cede business during the pendency of any dispute regarding the cause for termination.

(b) That the reinsurance intermediary-manager will render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to the reinsurance intermediary-manager, and remit all funds due under the contract to the reinsurer on not less than a monthly basis.

(c) That all funds collected for the reinsurer's account will be held by the reinsurance intermediary-manager in a fiduciary capacity in a bank that is a qualified United States financial institution. The reinsurance intermediary-manager may retain no more than 3 months' estimated claims payments and allocated loss adjustment expenses. The reinsurance intermediary-manager shall maintain a separate bank account for each reinsurer that it represents.

(d) That the reinsurance intermediary-manager will comply with the record-keeping requirements of section 1157. In addition to all the records required by section 1157, the reinsurance intermediary-manager will keep a complete record of all outstanding reserves on covered risks.

(e) That the reinsurer will have access and the right to copy all accounts and records maintained by the reinsurance intermediary-manager related to its business in a form usable by the reinsurer.

(f) That the contract cannot be assigned in whole or in part by the reinsurance intermediary-manager.

(g) That the reinsurance intermediary-manager will comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks.

(h) That the rates, terms, and purposes of commissions, charges, and other fees that the reinsurance intermediary-manager may levy against the reinsurer are set forth.

(i) That if the contract permits the reinsurance intermediary-manager to settle claims on behalf of the reinsurer, then all of the following are required:

(*i*) That all claims will be reported to the reinsurer in a timely manner.

(*ii*) That a copy of the claim file will be sent to the reinsurer at its request or as soon as it becomes known that the claim meets any of the following:

(A) Has the potential to exceed the lesser of an amount determined by the commissioner or the limit set by the reinsurer.

(B) Involves a coverage dispute.

(C) May exceed the reinsurance intermediary-manager's claims settlement authority.

(D) Is open for more than 6 months.

(E) Is closed by payment of the lesser of an amount set by the commissioner or an amount set by the reinsurer.

(*iii*) That all claim files will be the joint property of the reinsurer and the reinsurance intermediary-manager. However, upon an order of liquidation of the reinsurer, the files shall become the sole property of the reinsurer or its estate. The reinsurance intermediary-manager shall have reasonable access to and the right to copy the files on a timely basis.

(*iv*) That any settlement authority granted to the reinsurance intermediary-manager may be terminated for

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cause upon the reinsurer's written notice to the reinsurance intermediary-manager or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of any dispute regarding the cause of termination.

(j) That if the contract provides for a sharing of interim profits by the reinsurance intermediary-manager, that such interim profits will not be paid until 1 year after the end of each underwriting period for policies providing property coverages and 5 years after the end of each underwriting period for policies providing casualty coverages, and in any event, not until the adequacy of reserves on remaining claims has been verified pursuant to section 1165.

(k) That the reinsurance intermediary-manager will provide the reinsurer annually with a statement of its financial condition prepared by an independent certified accountant.

(*l*) That the reinsurer shall periodically, but at least semiannually, conduct an on-site review of the underwriting and claims processing operations of the reinsurance intermediary-manager.

(m) That the reinsurance intermediary-manager will disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with the insurer pursuant to this contract.

(n) That within the scope of its actual or apparent authority the acts of the reinsurance intermediary-manager shall be considered to be the acts of the reinsurer on whose behalf it is acting.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1163 Reinsurance intermediary-manager; prohibited conduct.

Sec. 1163. A reinsurance intermediary-manager shall not do any of the following:

(a) Cede retrocessions on behalf of the reinsurer, except that the reinsurance intermediary-manager may cede facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for such retrocessions. These guidelines shall include a list of reinsurers with which the automatic agreements are in effect, and for each reinsurer, the coverages and amounts or percentages that may be reinsured and commission schedules.

(b) Commit the reinsurer to participate in reinsurance syndicates.

(c) Appoint any agent without assuring that the agent is lawfully licensed to transact the type of reinsurance for which he or she is appointed.

(d) Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or 1% of the reinsurer's policyholder's surplus as of December 31 of the preceding calendar year.

(e) Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer.

(f) Jointly employ an individual who is employed by the reinsurer unless the reinsurance intermediary-manager is under common control with the reinsurer subject to chapter 13.

(g) Appoint a subreinsurance intermediary-manager.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1165 Reinsurance intermediary-manager; license required; obtaining annual copy of statement of financial condition and opinion of actuary; authority for retrocessional contracts or participation in reinsurance syndicates; termination of contract; appointment to board of directors.

Sec. 1165. (1) A reinsurer shall not engage the services of any person to act as a reinsurance intermediary-manager on its behalf unless the person is licensed as required by section 1153.

(2) The reinsurer shall obtain annually a copy of statements of the financial condition of each reinsurance intermediary-manager that the reinsurer has engaged. The statements shall be prepared by an independent certified accountant and shall be in a form acceptable to the commissioner.

(3) If a reinsurance intermediary-manager establishes loss reserves, the reinsurer shall obtain annually the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the reinsurance intermediary-manager. This opinion shall be in addition to any other required loss reserve certification.

(4) Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the reinsurance intermediary-manager.

(5) Within 30 days of termination of a contract with a reinsurance intermediary-manager, the reinsurer shall provide written notification of the termination to the commissioner.

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(6) A reinsurer shall not appoint to its board of directors any officer, director, employee, controlling shareholder, or subproducer of its reinsurance intermediary-manager. This subsection shall not apply to relationships governed by chapter 13 or, if applicable, chapter 14a.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1167 Reinsurance intermediary and reinsurance intermediary-manager; examination of books, bank accounts, and records.

Sec. 1167. (1) A reinsurance intermediary shall be subject to examination by the commissioner. The commissioner shall have access to all books, bank accounts, and records of the reinsurance intermediary in a form usable to the commissioner.

(2) A reinsurance intermediary-manager may be examined as if it were the reinsurer.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1169 Violation; penalties.

Sec. 1169. (1) A reinsurance intermediary, insurer, or reinsurer found by the commissioner to be in violation of any of the provisions of this chapter, after a hearing held pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, is subject to all of the following penalties:

(a) For each separate violation, payment of a civil fine of not more than $5,000.00.

(b) The suspension, limitation, or revocation of its license.

(c) If a violation was committed by the reinsurance intermediary, the reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator, or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to the violation.

(2) This section does not preclude the commissioner from imposing any other penalties provided in this act.

(3) This chapter shall not in any manner confer any rights upon or limit or restrict the rights of policyholders, claimants, creditors, or other third parties.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1171 Reinsurance intermediary; use of services.

Sec. 1171. Neither an insurer nor a reinsurer shall continue to use the services of a reinsurance intermediary on or after December 31, 1994 except in compliance with this chapter.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

CHAPTER 12
AGENTS, SOLICITORS, ADJUSTERS, AND COUNSELORS

500.1200 “Good moral character” defined.

Sec. 1200. As used in this chapter, "good moral character" means good moral character as defined and determined under Act No. 381 of the Public Acts of 1974, as amended, being sections 338.41 to 338.47 of the Michigan Compiled Laws.

History: Add. 1980, Act 390, Imd. Eff. Jan. 7, 1981.

Popular name: Act 218

500.1201 Definitions.

Sec. 1201. As used in this chapter:

(a) "Agent" except as provided in section 1243 means an insurance producer.

(b) "Agent of the insured" means an insurance producer who is not an appointed insurance producer of the insurer with which the insurance policy is placed. An agent of the insured is treated as representing the insured or the insured's beneficiary and not the insurer.

(c) "Agent of the insurer" means an insurance producer who sells, solicits, or negotiates an application for insurance as a representative of the insurer and not the insured or the insured's beneficiary.

(d) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

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(e) "Home state", except as provided in section 1224, means the District of Columbia or any state or territory of the United States in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer.

(f) "Insurance" means any of the lines of authority in chapter 6.

(g) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(h) "License" means a document issued by the director authorizing a person to act as an insurance producer for the qualifications specified in the document. The license itself does not create any actual, apparent, or inherent authority in the holder to represent or commit an insurer.

(i) "Limited line credit insurance" includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation that the director determines should be designated a form of limited line credit insurance.

(j) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates 1 or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.

(k) "Limited lines insurance" means any of the following:

(*i*) Marine insurance as defined in section 614.

(*ii*) Credit insurance as described in section 624(1)(e).

(*iii*) Surety and fidelity insurance as defined in section 628.

(*iv*) Legal expense insurance as defined in section 618.

(*v*) Livestock insurance as described in section 624(1)(g).

(*vi*) Malpractice insurance as described in section 624(1)(h).

(*vii*) Plate glass insurance as described in section 624(1)(c).

(*viii*) Any other miscellaneous insurance described in section 624(1)(i).

(*ix*) Any other line of insurance that the director considers necessary to recognize to comply with section 1206a(5).

(*l*) "Limited lines producer" means a person authorized by the director to sell, solicit, or negotiate limited lines insurance.

(m) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, if the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(n) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(o) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

(p) "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 1980, Act 340, Imd. Eff. Dec. 23, 1980;—Am. 2001, Act 228, Eff. Mar. 1, 2002;—Am. 2012, Act 462, Imd. Eff. Dec. 27, 2012;—Am. 2018, Act 449, Imd. Eff. Dec. 21, 2018.

Popular name: Act 218

500.1201a Sale, solicitation, or negotiation of insurance; license required; applicability to excess and surplus lines agents and brokers.

Sec. 1201a. (1) A person shall not sell, solicit, or negotiate insurance in this state for any line of insurance unless the person is licensed for that qualification in accordance with this chapter.

(2) This chapter does not apply to excess and surplus lines agents and brokers licensed under chapter 19 except as provided in sections 1204e and 1206a.

History: Add. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

500.1202 Insurance producer license; definitions.

Sec. 1202. (1) This chapter does not require an insurer to obtain an insurance producer license. As used in this section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries, or affiliates.

(2) A license as an insurance producer is not required of any of the following:

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(a) An officer, director, or employee of an insurer or of an insurance producer, if the officer, director, or employee does not receive any commission on policies written or sold to insure risks residing, located, or to be performed in this state and meets 1 or more of the following:

(*i*) The officer's, director's, or employee's activities are executive, administrative, managerial, clerical, or a combination of these, and are only indirectly related to the sale, solicitation, or negotiation of insurance.

(*ii*) The officer's, director's, or employee's function relates to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance.

(*iii*) The officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers if the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation, or negotiation of insurance.

(b) A person who performs and receives no commission for any of the following services:

(*i*) Securing and furnishing information for the purpose of group life insurance, group property and casualty insurance, group annuities, or group or blanket accident and health insurance.

(*ii*) Securing and furnishing information for the purpose of enrolling individuals under plans, issuing certificates under plans, or otherwise assisting in administering plans.

(*iii*) Performing administrative services related to mass marketed property and casualty insurance.

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

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

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

(f) A person who is not a resident of this state who sells, solicits, or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than 1 state insured under that contract, if the person is otherwise licensed as an insurance producer to sell, solicit, or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state.

(g) A salaried full-time employee who counsels or advises his or her employer concerning the insurance interests of the employer or of the subsidiaries or business affiliates of the employer, if the employee does not sell or solicit insurance or receive a commission.

(h) A person whose only sale of insurance is for travel or auto-related insurance sold in connection with and incidental to the rental of a motor vehicle under a rental agreement for a period not to exceed 90 days.

(i) A person whose only sale of insurance is for portable electronics insurance sold in connection with and incidental to the sale of a portable electronic device if written disclosure material is provided to the customer at the time of solicitation and the written material includes all of the following:

(*i*) A disclosure that portable electronics insurance may duplicate coverage already provided by the customer's homeowners, renters, or other insurance policies.

(*ii*) A statement that the enrollment by the customer in a portable electronics insurance program is not required to purchase or lease a portable electronic device or services for the device.

(*iii*) A summary of the material terms of the portable electronics insurance coverage, including all of the following:

(A) The identity of the insurer.

(B) The amount of any applicable deductible and how it is to be paid.

(C) The benefits of the coverage.

(D) Key terms and conditions of the coverage, such as whether the portable electronics may be repaired or replaced with a similar make and model or reconditioned or nonoriginal manufacturer parts or equipment.

(*iv*) A summary of the process for filing a claim, including a description of how to return a portable electronic device and the maximum fee applicable if the customer fails to comply with equipment return requirements.

(*v*) A statement that the customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and that the person paying the premium will receive a refund of or credit for any

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unearned premium.

(j) A person whose only sale of insurance is for travel insurance sold in conjunction with and incidental to planned travel.

(k) A person whose only sale of insurance is stored property insurance sold in connection with and incidental to the rental of storage space in a self-service storage facility under a rental agreement for a period not to exceed 1 year if written disclosure material is provided to the customer at the time of solicitation and the written material includes all of the following:

(*i*) A disclosure that the stored property insurance may duplicate coverage already provided by the customer's homeowners, renters, or other insurance policies.

(*ii*) A summary of the material terms of the stored property insurance coverage, including all of the following:

(A) The identity of the insurer.

(B) The benefits of the coverage.

(C) The key terms and conditions of the coverage.

(*iii*) A summary of the process for filing a claim.

(3) As used in this section:

(a) "Motor vehicle" means a motorized vehicle designed for transporting passengers or goods.

(b) "Self-service storage facility" means that term as defined in section 2 of the self-service storage facility act, 1985 PA 148, MCL 570.522.

(c) "Stored property insurance" means insurance that provides coverage for the loss of, or damage to, tangible personal property with an insured value not exceeding $10,000.00 contained in a storage space located on a self-service storage facility or in transit during the term of a self-service storage facility rental agreement and that is provided under a group or master policy issued to a self-service storage facility for the provision of insurance to its customers.

(d) "Travel insurance" means, subject to subdivision (e), a limited lines insurance coverage under section 1201(k) for personal risk incident to planned travel, including 1 or more of the following:

(*i*) Interruption or cancellation of a trip or event.

(*ii*) Loss of baggage or personal effects.

(*iii*) Damages to accommodations or rental vehicles.

(*iv*) Sickness, accident, disability, or death occurring during travel.

(*v*) Emergency evacuation.

(*vi*) Repatriation of remains.

(*vii*) Any other contractual obligations to indemnify or pay a specified amount to the traveler on determinable contingencies related to travel as approved by the director.

(e) "Travel insurance" does not include either of the following:

(*i*) Major medical plans, which provide comprehensive medical protection for travelers with trips lasting longer than 6 months, including, for example, those working or residing overseas as an expatriate, or military personnel being deployed.

(*ii*) A product that requires a specific insurance producer's license.

(*iii*) A prearranged funeral agreement by a funeral service provider.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 1980, Act 340, Imd. Eff. Dec. 23, 1980;—Am. 2001, Act 228, Eff. Mar. 1, 2002;—Am. 2002, Act 737, Imd. Eff. Dec. 30, 2002;—Am. 2012, Act 552, Imd. Eff. Jan. 2, 2013;—Am. 2014, Act 150, Imd. Eff. June 11, 2014;—Am. 2016, Act 114, Eff. Aug. 8, 2016;—Am. 2020, Act 266, Imd. Eff. Dec. 29, 2020.

Popular name: Act 218

500.1203 Authority of insurance producer for fraternal benefit society; authority of attorney-in-fact of reciprocal or inter-insurance exchange.

Sec. 1203. (1) A person may act as an insurance producer only for a fraternal benefit society authorized to transact insurance in this state without being licensed as an insurance producer if less than 50% of his or her time is devoted to the solicitation and procurement of insurance contracts for the society. A person who in the preceding calendar year solicits or procures life insurance contracts on behalf of any society in an amount of insurance in excess of $50,000.00, or, in case of any other kind of insurance that the society might write, on the persons of more than 25 individuals and who has received a commission or other compensation for the sale of that insurance is conclusively presumed to be devoting 50% of his or her time to the solicitation or procurement of insurance contracts for the society. An insurance producer for a fraternal benefit society authorized to transact insurance in this state before March 1, 2002 may, upon application to the commissioner before March 1, 2003, be licensed as an insurance producer to represent that fraternal benefit society without written examination.

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(2) An attorney-in-fact of a reciprocal or of an inter-insurance exchange may act as an insurance producer for the reciprocal or exchange.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

500.1204 Applicant for insurance producer license; examination; registered program of study; waiver of examination or program of study requirements; administration of examinations; fee; reapplication.

Sec. 1204. (1) A resident individual applying for an insurance producer license shall pass a written examination unless exempt pursuant to section 1206b.

(2) Within a reasonable time after receipt of a properly completed application for examination, the commissioner shall subject the applicant to a written examination. An applicant shall not be given an examination unless the applicant has completed a program of study registered with the commissioner pursuant to section 1204a. An applicant shall file a certificate of completion of the registered program of study with the commissioner on a form prescribed by the commissioner indicating that the course of study was completed by the applicant not more than 12 months before the application for examination is received by the commissioner. The commissioner may waive the applicable examination or program of study requirements of this section for a person who meets any of the following:

(a) Applies for a limited license as designated by the commissioner.

(b) Has been a licensed insurance producer within the preceding 12 months.

(c) Has obtained the chartered property and casualty underwriter designation, the chartered life underwriter designation, certified insurance counselor designation, accredited advisor in insurance designation, the chartered financial consultant designation, the certified employee benefit specialist designation, the certified financial planner designation, the fellow life management institute designation, the life underwriting training council fellow designation, the registered health underwriter designation, the registered employee benefits consultant designation, the health insurance associate designation, or the associate in risk management designation.

(d) Has an associate's, bachelor's, or master's degree with a concentration in insurance from an institution approved by the commissioner.

(3) The examination shall be entry level and shall test the knowledge of the individual concerning the qualifications for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws and regulations of this state. Examinations required by this section shall be developed and conducted as prescribed by the commissioner.

(4) The commissioner may make arrangements, including contracting with an outside testing service, for administering examinations under this section and collecting the nonrefundable fee in section 240(1)(h) or (4).

(5) Each individual applying for an examination under this section shall remit a nonrefundable fee as prescribed in section 240(1)(h) or (4).

(6) An individual who fails to appear for the examination required under this section as scheduled or fails to pass the examination shall reapply for an examination and remit all required examination fees and forms to be rescheduled for another examination.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 1972, Act 207, Eff. Aug. 1, 1972;—Am. 1980, Act 390, Imd. Eff. Jan. 7, 1981;—Am. 1981, Act 1, Imd. Eff. Mar. 30, 1981;—Am. 1986, Act 173, Imd. Eff. July 7, 1986;—Am. 2001, Act 228, Eff. Mar. 1, 2002;—Am. 2008, Act 576, Eff. July 16, 2009.

Popular name: Act 218

500.1204a Qualification as registered insurance producer program of study; criteria; conducting portion of minimum number of classroom hours of instruction; rules; recommendations for improvements in course materials; failure to maintain reasonable standards; refusal by director to approve insurance education instructor; probation, suspension, or revocation of approval.

Sec. 1204a. (1) To qualify as a registered insurance producer program of study, the program of study must meet all of the following criteria:

(a) Be conducted through an educational institution offering home study courses that has been in existence for not less than 5 years, by an insurance trade association, by an authorized insurer as provided in subsection (2), or by an educational institution listed in the state board of education directory of institutions of higher learning.

(b) Except as provided in subsection (2), provide for a minimum number of hours of classroom instruction

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or its equivalent in home study or online courses as follows:

(*i*) For a program of study for health insurance producers, 20 hours of instruction.

(*ii*) For a program of study for life insurance producers, 20 hours of instruction.

(*iii*) For a combined program of study for life and health insurance producers, 40 hours of instruction.

(*iv*) For a program of study for property insurance producers and solicitors, 20 hours of instruction.

(*v*) For a program of study for casualty insurance producers and solicitors, 20 hours of instruction.

(*vi*) For a program of study for personal lines producers, 20 hours of instruction.

(*vii*) For a program of study for property and casualty producers and solicitors, 40 hours of instruction. A program of study completed under this subparagraph satisfies the program of study requirements for personal lines producers and solicitors.

(c) Include instruction in ethical practices in the marketing and selling of insurance.

(d) Subject to subsection (5), instruction must be given only by individuals who meet the qualifications required by the director. The director shall promulgate rules prescribing the criteria that must be met by a person to render instruction in a registered insurance producer program of study.

(2) An authorized insurer may conduct that portion of the minimum number of hours of instruction under subsection (1) as the director considers appropriate. Any combination of classroom, online, or self-study hours may be used in satisfying the minimum number of hours of instruction under subsection (1).

(3) The director shall promulgate rules prescribing the subject matter that a program of study must possess to qualify for registration under this section.

(4) The director may recommend improvements in course materials as considered necessary by the director. The director may, after notice and opportunity for a hearing, withdraw the registration of a program of study that does not maintain reasonable standards as determined by the director for the protection of the public.

(5) For a registered insurance producer program of study under this section, the director may refuse to approve an insurance education instructor, and the director may place an approved insurance education instructor on probation or suspend or revoke approval of an approved insurance education instructor, or take any combination of these actions, if 1 or more of the following apply:

(a) The insurance education instructor violates an insurance law or violates a rule, subpoena, or order of the director or of another state's insurance commissioner.

(b) The insurance education instructor uses fraudulent, coercive, or dishonest practices or demonstrates incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this state or outside this state.

(c) The insurance education instructor's insurance producer license or its equivalent is revoked in conjunction with a disciplinary action in any state, province, district, or territory.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986;—Am. 1987, Act 64, Imd. Eff. June 25, 1987;—Am. 2006, Act 442, Imd. Eff. Oct. 19, 2006;—Am. 2008, Act 575, Eff. July 16, 2009;—Am. 2017, Act 67, Imd. Eff. June 30, 2017.

Popular name: Act 218

500.1204b Repealed. 2017, Act 67, Imd. Eff. June 30, 2017.

Compiler's note: The repealed section pertained to creation of insurance education advisory council.

Popular name: Act 218

500.1204c Insurance producer's hours of study; review; continuing education requirements; program of study; approval; fee; hearing; revocation; filing certificate of attendance or instruction; waiver; reciprocal agreements; fees; grace period; sale of business and failure to meet continuing education requirements; cancellation of license; review date of applicable 2-year period; access to classroom; refusal to approve education instructor; probation, suspension, or revocation of approval; definitions.

Sec. 1204c. (1) An insurance producer's hours of study accrued under this section must be reviewed for license continuance every 2 years under a schedule established by the director. The director may establish a schedule for license continuation that staggers license continuation dates to apportion the continuation dates throughout the calendar year. If the system of staggered continuation is adopted, the director may extend the licensure period for some licensees.

(2) Except as provided in subsections (9) to (12), and subject to subsection (13), before the review date of each applicable 2-year period provided for under subsection (1), an insurance producer wishing to renew his or her license shall renew his or her license by attending or instructing not less than 24 hours of continuing education classes approved by the director or 24 hours of home study or online training if evidenced by

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successful completion of coursework approved by the director. Of the 24 hours of continuing education required, not less than 3 hours must be in ethics in insurance classes or coursework.

(3) The director shall approve a registered insurance producer program of study if the director determines that the program increases knowledge of insurance and related subjects as follows:

(a) For a life-health agent program of study, the program offers instruction in 1 or more of the following:

(*i*) The fundamental considerations and major principles of life insurance.

(*ii*) The fundamental considerations and major principles of health insurance.

(*iii*) Estate planning and taxation as related to insurance.

(*iv*) Industry and legal standards concerning ethics in insurance.

(*v*) Legal, legislative, and regulatory matters concerning insurance, the insurance code, and the insurance industry.

(*vi*) Principal provisions used in life insurance contracts, health insurance contracts, or annuity contracts and differences in types of coverages.

(*vii*) Accounting and actuarial considerations in insurance.

(*viii*) Principles of agency management, excluding telemarketing or other marketing instruction.

(*ix*) The fundamental considerations, major principles, and statutory requirements of long-term care insurance.

(b) For a property-casualty agent program of study, the program offers instructions in 1 or more of the following:

(*i*) The fundamental considerations and major principles of property insurance.

(*ii*) The fundamental considerations and major principles of casualty insurance.

(*iii*) Basic principles of risk management.

(*iv*) Industry and legal standards concerning ethics in insurance.

(*v*) Legal, legislative, and regulatory matters concerning insurance, the insurance code, and the insurance industry.

(*vi*) Principal provisions used in casualty insurance contracts, no-fault insurance contracts, or property insurance contracts and differences in types of coverages.

(*vii*) Accounting and actuarial considerations in insurance.

(*viii*) Principles of agency management, excluding telemarketing or other marketing instruction.

(4) A provider of a program of study for insurance producers applying for approval or reapproval from the director under this section shall file, on a form provided by the director, a description of the course of study including a description of the subject matter and course materials, hours of instruction, location of classroom, qualifications of instructors, and maximum student-instructor ratio and shall pay a nonrefundable $25.00 filing fee. Any material change in a program of study requires the reapproval of the director. If the information in an application for approval or reapproval is insufficient for the director to determine whether the program of study meets the requirements under subsection (3), the director shall give written notice to the provider, within 15 days after the provider's filing of the application for approval or reapproval, of the additional information needed by the director. An application for approval or reapproval is considered approved unless disapproved by the director within 90 days after the application for approval or reapproval is filed, or within 90 days after the receipt of additional information if the information was requested by the director, whichever is later.

(5) A provider of a program of study approved by the director under this section shall pay a provider authorization fee of $500.00 for the first year the provider's program of study is approved under this section and a $100.00 provider renewal fee for each subsequent year that the provider offers the approved program of study.

(6) A person dissatisfied with an approved program of study may petition the director for a hearing on the program or the director on his or her own initiative may request a hearing on a program of study. If the director finds that the petition was submitted in good faith, that the petition if true shows that the program of study does not satisfy the criteria in subsection (3), or that the petition otherwise justifies holding a hearing, the director shall hold a hearing under chapter 4 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.271 to 24.287, within 30 days after receipt of the petition and on not less than 10 days' written notice to the petitioner and the provider of the program of study. If the director requests a hearing on a program of study on his or her own initiative, the director shall hold a hearing under chapter 4 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.271 to 24.287, on not less than 10 days' written notice to the provider of the program of study.

(7) If after a hearing under subsection (6) the director finds that the program of study does not satisfy the requirements under subsection (3), the director shall state, in a written order mailed first-class to the petitioner and provider of the program of study, his or her findings and the date on which the director will revoke

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approval of the program of study, which date must be within a reasonable time of the issuance of the order.

(8) A certificate of attendance or instruction in an approved program of study or a certificate of successful completion of coursework must be filed as directed by the director on a form prescribed by the director and must indicate the name and number of the course of study, the number of hours, dates of completion, and the name and number of schools attended or taught by the insurance producer or the evidence of successful completion of coursework. A representative of the approved program of study shall file the form and a fee of $1.00 per hour for course credit for each insurance producer license renewal as directed by the director within 30 days after the insurance producer completes the program. A copy of the form must also be mailed first-class to the insurance producer who attended, taught, or successfully completed the program of study. The director may enter into contracts to provide for the administrative functions of this subsection.

(9) The director shall waive the continuing education requirements of this section for an insurance producer if the producer is unable to comply with the continuing education requirements of this section because of military service or if the director determines that enforcement of the requirements would cause a severe hardship. The director shall waive the continuing education requirements of this section for the following insurance producers:

(a) An insurance producer who is licensed to write only travel or baggage insurance policies and whose employment is for a purpose other than the sale of those policies.

(b) An insurance producer who is licensed to write only limited line credit insurance.

(10) The director may enter into reciprocal continuing education agreements with insurance commissioners from other states.

(11) If an insurance producer has not met his or her continuing education requirements by the expiration date of his or her license, the insurance producer has a 90-day grace period in which to meet the continuing education requirements of this section. During the 90-day grace period, the insurance producer shall not solicit or sell new policies of insurance, bind coverage, or otherwise act as an insurance producer, except that the insurance producer may continue to service policies previously sold and may receive commissions on policies previously sold. If the insurance producer has not met his or her continuing education requirements by the expiration of the 90-day grace period, the director shall cancel the insurance producer's license. An insurance producer whose license has been canceled under this section may reapply for a license to act as an insurance producer under section 1204.

(12) An insurance producer who has sold his or her insurance business and who has not met the continuing education requirements of this section shall not solicit or sell new policies of insurance, bind coverage, or otherwise act as an insurance producer, except that the insurance producer may continue to service policies previously sold and may receive commissions on policies previously sold as well as receive partial commissions on policies of insurance sold by a purchasing insurance producer. An insurance producer who is in the process of selling his or her insurance business and who has not met the continuing education requirements of this section shall not solicit or sell new policies of insurance, bind coverage, or otherwise act as an insurance producer, except that the insurance producer may continue to service policies previously sold and may receive commissions on policies previously sold as well as receive partial commissions on policies of insurance sold by a purchasing insurance producer, for a period not to exceed 12 months after the selling insurance producer's license review date under subsection (1). An insurance producer whose license has been canceled and who wishes to resume soliciting or selling new policies of insurance, bind coverage, or otherwise act as an insurance producer and who has not met the continuing education requirements within the immediately preceding 12 months may reapply for a license to act as an insurance producer under section 1204.

(13) After 1 year after the effective date of the amendatory act that added subsection (14), for a review date of an applicable 2-year period under subsection (1), all of the following apply:

(a) Subject to subdivisions (b) and (c), if an insurance producer completes more than 24 hours of continuing education in an applicable 2-year period, the insurance producer may, for purposes of subsection (2), apply each hour more than 24 hours to the next 2-year period. However, no more than 12 hours may be applied to the next applicable 2-year period under this subdivision.

(b) An insurance producer may not apply any hours in ethics in insurance classes or coursework to the next applicable 2-year period under subdivision (a).

(c) If an insurance producer completes the same continuing education class or coursework under subsection (2) in an applicable 2-year period, an hour associated with a duplicative class or coursework may not be applied to the next applicable 2-year period under subdivision (a).

(14) The director or his or her designee may access any classroom while instruction for a program of study under section 1204a or this section is in progress to monitor the classroom instruction.

(15) For an insurance producer program of study under this section, the director may refuse to approve an

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insurance education instructor, and the director may place an approved insurance education instructor on probation or suspend or revoke approval of an approved insurance education instructor, or take any combination of these actions, if 1 or more of the following apply:

(a) The insurance education instructor violates an insurance law or violates a rule, subpoena, or order of the director or of another state's insurance commissioner.

(b) The insurance education instructor uses fraudulent, coercive, or dishonest practices or demonstrates incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this state or outside this state.

(c) The insurance education instructor's insurance producer license or its equivalent is revoked in conjunction with a disciplinary action in any state, province, district, or territory.

(16) As used in this section:

(a) "Hour" means a period of time of not less than 50 minutes.

(b) "Insurance producer" means a life-health agent or property-casualty agent.

(c) "Life-health agent" means a resident or nonresident individual insurance producer licensed for life, limited life, mortgage redemption, or accident and health or a combination of life, limited life, mortgage redemption, or accident and health.

(d) "Property-casualty agent" means a resident or nonresident individual insurance producer or solicitor licensed for automobile, fire, multiple lines, or any limited or minor property and casualty lines or a combination of automobile, fire, multiple lines, or limited or minor property and casualty lines.

History: Add. 1992, Act 1, Eff. Jan. 1, 1993;—Am. 1992, Act 84, Eff. Jan. 1, 1993;—Am. 1994, Act 48, Imd. Eff. Mar. 25, 1994;—Am. 1996, Act 466, Eff. Mar. 31, 1997;—Am. 1998, Act 540, Imd. Eff. Jan. 20, 1999;—Am. 2001, Act 228, Eff. Mar. 1, 2002;—Am. 2005, Act 247, Eff. Feb. 1, 2006;—Am. 2006, Act 109, Imd. Eff. Apr. 7, 2006;—Am. 2006, Act 442, Imd. Eff. Oct. 19, 2006;—Am. 2008, Act 574, Eff. Jan. 1, 2010;—Am. 2017, Act 67, Imd. Eff. June 30, 2017.

Popular name: Act 218

500.1204d Continuing education fund; creation; administration; disposition and reversion of funds; funding of shortfall.

Sec. 1204d. (1) The continuing education fund is created as a separate, self-supporting fund and shall be administered by the commissioner. Money in the continuing education fund shall be used for the administration of the continuing education requirements in section 1204c.

(2) Money received pursuant to section 1204c shall be deposited in the continuing education fund.

(3) Money in the continuing education fund shall not revert to the general fund at the close of the fiscal year but shall remain in the continuing education fund.

(4) Notwithstanding section 240(3), if money in the continuing education fund is not sufficient to provide for the administration of the continuing education requirements in section 1204c, the shortfall shall be funded from the agent's appointment fees required by section 240(1)(c).

History: Add. 1992, Act 1, Eff. Jan. 1, 1993.

Popular name: Act 218

500.1204e Nonresident license applicant; requirements.

Sec. 1204e. (1) The commissioner shall waive any requirements for a nonresident license applicant with a valid license from his or her home state, except the requirements under section 1206a, if the applicant's home state awards nonresident licenses to residents of this state on the same basis.

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

History: Add. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

500.1204f Long-term care insurance; requirements for sale, solicitation, or negotiation by individual; delivery or issuance by insurer; 1-time training course; requirements.

Sec. 1204f. (1) An individual shall not sell, solicit, or negotiate long-term care insurance unless the individual meets all of the following requirements:

(a) The individual is licensed as an insurance producer for accident and health or life.

(b) The individual has completed a 1-time long-term care training course as described in this section.

(c) The individual completes ongoing training as described in this section for every 2-year continuing education compliance period after the completion of the 1-time long-term care training course.

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(2) An insurer that delivers or issues for delivery long-term care insurance in this state shall do both of the following:

(a) Obtain verification that an insurance producer has received the training described in this section before permitting the insurance producer to sell, solicit, or negotiate the insurer's long-term care insurance products.

(b) Make the verification obtained under subdivision (a) available to the director on the director's request.

(3) An insurance producer selling, soliciting, or negotiating long-term care insurance on the effective date of the amendatory act that added chapter 39A shall not continue to sell, solicit, or negotiate long-term care insurance unless the insurance producer has completed the 1-time training course described in this section within 1 year after the effective date of the amendatory act that added chapter 39A.

(4) The 1-time long-term care training course and ongoing training required under this section may be provided in conjunction with other insurance producer training or separately. To satisfy subsection (2), an insurance producer may document to an insurer that he or she has obtained training as described in subsections (5) and (6) from a program of study approved under section 1204c.

(5) The 1-time long-term care training course required under this section must not be less than 8 hours, and the ongoing training required under this section must not be less than 4 hours for every 2-year continuing education compliance period after the completion of the 1-time long-term care training course.

(6) The 1-time long-term care training course and ongoing training required under this section must consist of topics related to long-term care insurance, long-term care services, and, if applicable, qualified state long-term care insurance partnership programs, including, but not limited to, all of the following:

(a) State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including Medicaid.

(b) Available long-term care services and providers.

(c) Changes or improvements in long-term care services or providers.

(d) Alternatives to the purchase of private long-term care insurance.

(e) The effect of inflation in eroding the value of benefits and the importance of inflation protection.

(f) Consumer suitability standards and guidelines.

(7) The 1-time long-term care training course and ongoing training required under this section must not include any training that is solely oriented to the sales or marketing of an insurer-specific long-term care product.

(8) Satisfying the training requirements of this section in any state satisfies the training requirements in this state.

History: Add. 2006, Act 442, Imd. Eff. Oct. 19, 2006;—Am. 2015, Act 198, Eff. Feb. 22, 2016.

Popular name: Act 218

500.1205 Resident insurance producer license; filing; application; statement; requirements; business entity; verification of information; limited line credit insurance.

Sec. 1205. (1) A person applying for a resident insurance producer license shall file with the director the uniform application required by the director and shall declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. The director shall not approve an application for a resident insurer producer license unless the director finds that the individual meets all of the following conditions:

(a) Is at least 18 years of age.

(b) Has not committed any act listed in section 1239(1).

(c) As required under section 1204(2), has completed a prelicensing course of study for the qualifications for which the person has applied.

(d) Has paid the fees applicable to the individual under section 240.

(e) Has successfully passed the examination required for each qualification for which the person has applied.

(2) A business entity acting as an insurance producer shall obtain an insurance producer license. A business entity applying for an insurance producer license shall file with the director the uniform business entity application required by the director. The director shall not approve an application for an insurance producer license under this subsection unless the director finds all of the following:

(a) The business entity has paid the fees under section 240(1)(d).

(b) The business entity has designated an individual licensed producer responsible for the business entity's compliance with this state's insurance laws, rules, and regulations.

(c) The business entity has not committed any act listed in section 1239(1).

(3) The director may require the production of any documents reasonably necessary to verify the

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information contained in an application.

(4) An insurer that sells, solicits, or negotiates any form of limited line credit insurance shall provide to each individual whose duties will include selling, soliciting, or negotiating limited line credit insurance a program of instruction that may be approved by the director.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 2001, Act 228, Eff. Mar. 1, 2002;—Am. 2008, Act 422, Imd. Eff. Jan. 6, 2009;—Am. 2019, Act 124, Eff. May 21, 2020.

Popular name: Act 218

500.1206 Insurance producer license; issuance; qualification in line of insurance; duration; reinstatement; contents of license; change of name or address; ministerial functions.

Sec. 1206. (1) Unless denied licensure under section 1239, persons who have met the requirements of sections 1204 and 1205 shall be issued an insurance producer license. An individual insurance producer may receive a license for a qualification in 1 or more of the following lines of insurance:

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

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

(c) Property--insurance coverage for the direct or consequential loss or damage to property of every kind.

(d) Casualty--insurance coverage against legal liability, including that for death, injury, or disability or damage to real or personal property.

(e) Variable life and variable annuity products--insurance coverage provided under variable life insurance contracts and variable annuities.

(f) Personal lines--property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes.

(g) Credit--limited line credit insurance.

(h) Any other line of insurance permitted under state laws or rules.

(2) An insurance producer license shall remain in effect unless revoked or suspended as long as education requirements for resident individual producers are met by the due date.

(3) An individual insurance producer who allows his or her license to lapse for a reason other than not meeting the requirements of section 1204c may reinstate the same license without the necessity of passing a written examination if he or she does so not later than 12 months after the date of the lapse.

(4) A license under subsection (1) shall contain the licensee's name, address, personal identification number, and the date of issuance, the qualifications, the expiration date, and any other information the commissioner considers necessary.

(5) Licensees shall inform the commissioner by any means acceptable to the commissioner of a change of legal name or address within 30 days of the change.

(6) The commissioner may contract with nongovernmental entities to perform any ministerial functions, including the collection of fees, related to producer licensing that the commissioner considers appropriate.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 1982, Act 501, Imd. Eff. Dec. 31, 1982;—Am. 1989, Act 68, Imd. Eff. June 16, 1989;—Am. 1992, Act 1, Eff. Jan. 1, 1993;—Am. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

500.1206a Nonresident insurance producer license; requirements; verification of status; change of address; nonresident surplus lines insurance producer license; nonresident limited lines insurance producer.

Sec. 1206a. (1) Unless denied licensure under section 1239, a nonresident person shall receive a nonresident insurance producer license if he or she meets all of the following:

(a) Is currently licensed as a resident and in good standing in his or her home state.

(b) Has submitted the proper request for licensure and has paid the applicable fees required by section 240.

(c) Has submitted or transmitted to the commissioner the application for licensure that the person submitted to his or her home state or a completed uniform application as required by the commissioner.

(d) The person's home state awards nonresident producer licenses to residents of this state on the same basis.

(2) The commissioner may verify the insurance producer's licensing status through the producer database maintained by the national association of insurance commissioners or its affiliates or subsidiaries.

(3) A nonresident insurance producer who moves from 1 state to another state or a resident insurance producer who moves from this state to another state shall file a change of address and provide certification from the new resident state within 30 days of the change of legal residence. No fee or license application is

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required.

(4) Notwithstanding any other provision of this chapter, a person licensed as a surplus lines insurance producer in his or her home state shall receive a nonresident surplus lines insurance producer license pursuant to subsection (1). Except as otherwise provided in subsection (1), this section does not otherwise amend or supersede any provision of chapter 19.

(5) Notwithstanding any other provision of this chapter, a person licensed as a limited line credit insurance or other type of limited lines insurance producer in his or her home state shall receive a nonresident limited lines insurance producer license, pursuant to subsection (1), granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this subsection, limited lines insurance is any authority granted by the home state that restricts the authority of the license to less than the total authority prescribed in the associated major lines under section 1206(1)(a) to (f).

History: Add. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

500.1206b Nonresident insurance producer license; prelicensing education or examination; exemption; application as resident licensee.

Sec. 1206b. (1) An individual who applies for an insurance producer license in this state who was previously licensed for the same qualifications in another state is not required to complete any prelicensing education or examination. This exemption is only available if the person is currently licensed in that state or if the application is received within 90 days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's producer database records, maintained by the national association of insurance commissioners, its affiliates, or its subsidiaries, indicate that the producer is or was licensed in good standing for the qualification requested.

(2) A person licensed as an insurance producer in another state who moves to this state shall apply within 90 days after establishing legal residence to become a resident licensee pursuant to section 1205. Prelicensing education or examination is not required of that person to obtain any qualification previously held in the prior state except where the commissioner determines otherwise by rule.

History: Add. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

500.1206c Life and health insurance producer examinations; summary of statistical information; report.

Sec. 1206c. By not later than 6 months after the effective date of this section and by April 30 of each year thereafter, the commissioner or a designee of the commissioner shall prepare and publish a report that summarizes statistical information relating to life and health insurance producer examinations administered during the preceding calendar year. The report shall include, but is not limited to, all of the following information:

(a) The total number of examinees.

(b) The percentage and number of examinees who passed the examination.

(c) The mean scaled scores on the examination.

(d) The standard deviation of scaled scores on the examination.

(e) The correct answer rate and correlation for each test question and each test form.

History: Add. 2008, Act 494, Imd. Eff. Jan. 13, 2009.

500.1207 Agent as fiduciary; separate accounts; examination of records; remuneration of person acting as agent; placing refused coverage; use of intimidation, threats, or unlawful inducements; agent as party to contract.

Sec. 1207. (1) An agent is a fiduciary for all money received or held by the agent in the agent's capacity as an agent.

(2) An agent shall treat all premiums and return premiums as fiduciary money and segregate the premiums from the agent's own money. Except as otherwise provided in this subsection, an agent shall not commingle premiums or return premiums with any other money of the agent. An agent may make an initial deposit from the agent's own money to establish the separate account. An agent may make additional deposits from the agent's own money into the separate account solely for the purpose of paying or avoiding financial institution charges or fees, or both, required to maintain the separate account. Any of the agent's own money deposited into the separate account under this subsection must be separately accounted for and identifiable in the agent's books and records.

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(3) The separate account under subsection (2) must be established and maintained in any state or federally chartered financial institution that is federally insured. The separate account may be interest-bearing.

(4) An agent may hold returned premiums in the separate account for the purpose of paying future premiums on behalf of an insured with the insured's written authorization.

(5) An agent shall use reasonable accounting methods to record money received in the agent's fiduciary capacity, including the receipt and distribution of premiums due each of the agent's insurers.

(6) An agent who receives fiduciary money must document the receipt of the fiduciary money in sufficient detail to determine, at a minimum, the date received, the name of the payee, the amount received, and a description of the money.

(7) An agent shall record return premiums received by or credited to the agent that are due an insured on policies reduced or canceled or that are due a prospective purchaser of insurance as a result of a rejected or declined application.

(8) Failure by an agent in a timely manner to turn over the money that the agent holds in a fiduciary capacity to the persons to whom it is owed is prima facie evidence of violation of the agent's fiduciary responsibility.

(9) An agent shall not accept payment of a premium for a Medicare supplemental policy or certificate in the form of a check or money order made payable to the agent instead of the insurer. On receiving payment of a premium for a Medicare supplemental policy or certificate, an agent shall immediately provide a written receipt to the insured.

(10) Records required by this section must be open to examination by the director.

(11) Except as provided in sections 1211 and 1212 and subsection (12), an agent shall not reward or remunerate any person for procuring or inducing business in this state, furnishing leads or prospects, or acting in any other manner as an agent.

(12) If an agent is unable to immediately provide, through the agent's insurers that are authorized to underwrite the coverage, all or a part of the coverage requested on a risk, the agent may obtain the part of the coverage refused by the agent's insurers through another licensed agent or through a risk sharing plan permitted by state law. An agent who attempts to place the refused part of the coverage through another licensed agent shall advise the buyer in writing that the refused part of the coverage is not in effect until the buyer receives written evidence of insurance.

(13) A person shall not sell or attempt to sell insurance by means of intimidation or threats, whether express or implied. Except as provided in section 2077(4), a person may not induce the purchase of insurance through a particular agent or from a particular insurer by means of a promise to sell goods, lend money, or provide services, or by a threat to refuse to sell goods, lend money, or provide services.

(14) After January 1, 1973, an insurer or an agent may not be a party to a contract under which the agent assumes any responsibility or obligation for payment, from the agent's commission or any allocation of premium to the agent by the insurer, of any losses on insurance policies sold by the agent unless the claim adjusting is done by insurance company adjusters or licensed independent adjusters.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 1990, Act 170, Imd. Eff. July 2, 1990;—Am. 1993, Act 200, Eff. Dec. 28, 1994;—Am. 2018, Act 449, Imd. Eff. Dec. 21, 2018;—Am. 2023, Act 181, Eff. May 5, 2024.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.1208 Insurance effected by agent on certain risks; limitation.

Sec. 1208. An agent, during any 12-month period, may not effect insurance upon his own property, life or other risk and the property, life or other risk of his employees, employer or business associates, in excess of 15% of the total premium which he effected during that period.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973.

Popular name: Act 218

500.1208a Appointment of producer as agent; notice of appointment; filing; verification of eligibility; fee.

Sec. 1208a. (1) An insurance producer shall not act as the agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of the insurer is not required to become appointed.

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(2) An insurance producer shall not bind coverage for an insurer unless the insurance producer is appointed by the insurer.

(3) To appoint a producer as its agent, the appointing insurer shall file, in a format approved by the director, a notice of appointment for the qualifications held by that insurance producer within 15 days from the date the agency contract is executed or the first insurance application is submitted. An insurer may also elect to appoint an insurance producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request.

(4) On receipt of the notice of appointment, the director shall verify within a reasonable time not to exceed 30 days that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the director shall notify the insurer within 5 days of that determination.

(5) An insurer shall pay an appointment fee and a renewal appointment fee as provided under section 240(1)(c) for each insurance producer appointed or renewed by the insurer.

History: Add. 2001, Act 228, Eff. Mar. 1, 2002;—Am. 2018, Act 449, Imd. Eff. Dec. 21, 2018.

Popular name: Act 218

500.1208b Termination of business relationship with insurance producer; notice to commissioner; format; liability for disclosure of information or statement.

Sec. 1208b. (1) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract, or other insurance business relationship with an insurance producer shall notify the commissioner using a format prescribed by the commissioner of the termination within 30 days following the effective date of the termination if the reason for termination is 1 of the reasons listed in section 1239 or the insurer has knowledge the producer was found by a court, government body, or self-regulatory organization authorized by law to have engaged in any of the activities listed in section 1239. Upon the written request of the commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the producer.

(2) An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with a producer for any reason not listed in section 1239 shall notify the commissioner using a format prescribed by the commissioner of the termination within 30 days following the effective date of the termination. Upon written request of the commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination.

(3) The insurer or the authorized representative of the insurer shall promptly notify the commissioner in a format acceptable to the commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the commissioner in accordance with subsection (1) had the insurer then known of its existence.

(4) Not later than 15 days after making the notification required by subsection (1), (2), or (3), the insurer shall mail a copy of the notification to the producer at his or her last known address. If the producer is terminated for cause for any of the reasons listed in section 1239, the insurer shall provide a copy of the notification to the producer at his or her last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier. Within 30 days after the insurance producer has received the original or additional notification, the insurance producer may file written comments concerning the substance of the notification with the commissioner. The insurance producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the commissioner's file and accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under section 1246.

(5) In the absence of actual malice, an insurer, the authorized representative of the insurer, an insurance producer, the commissioner, or an organization of which the commissioner is a member and that compiles the information and makes it available to other commissioners or regulatory or law enforcement agencies is not subject to civil liability for making this information available, and a civil cause of action of any nature shall not arise against these entities or their respective representatives or employees, as a result of reporting or providing any statement or information required by or provided pursuant to this section or any information relating to any statement that may be requested in writing by the commissioner, from an insurer or insurance producer; or a statement by a terminating insurer or insurance producer to an insurer or insurance producer limited solely and exclusively to whether a termination for cause under subsection (1) was reported to the commissioner, provided that the propriety of any termination for cause under subsection (1) is certified in writing by an officer or authorized representative of the insurer or insurance producer terminating the relationship. In any action brought against a person that may have immunity under this subsection for making any statement required by this section or providing any information relating to any statement that may be requested by the commissioner, the party bringing the action shall plead specifically in any allegation that the

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immunity permitted under this subsection does not apply because the person making the statement or providing the information did so with actual malice. This subsection does not abrogate or modify any existing statutory or common law privileges or immunities.

History: Add. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

500.1209 Termination of insurance producer's authority to represent insurer; responsibility and authority of insurance producer following notice of termination; exceptions; condition of insurer's authority to transact business in state; construction of subsection (2); "automobile insurance" and "home insurance" defined.

Sec. 1209. (1) If an insurance producer's authority to represent an insurer is terminated, the responsibility of an insurance producer having property rights in the renewal shall continue until the existing policies of insurance are canceled, replaced, or have expired. The insurance producer's authority during the period following notice of termination shall be governed by the written agreement between the insurance producer and the insurer. An insurer shall not cancel or refuse to renew the policy of an insured because of the termination of an insurance producer's contract. If the written agreement does not cover the insurance producer's authority during this period, the insurance producer may continue to represent the insurer in servicing existing policies, but the insurance producer shall not bind a new risk, renew a policy, nor increase the obligation of the insurer under the policy without the approval of the insurer. This subsection does not apply to a life insurer, an insurance producer of a life insurer, an insurance producer who is an employee of an insurer, or to an insurance producer who by contractual agreement represents only 1 insurer or group of affiliated insurers, if the property rights in the renewal are owned by the insurer or group of affiliated insurers and the alteration of the insurance producer's contract does not result in the cancellation or nonrenewal of any insurance policy.

(2) As a condition of maintaining its authority to transact insurance in this state, an insurer transacting automobile insurance or home insurance in this state shall not cancel an insurance producer's contract or otherwise terminate an insurance producer's authority to represent the insurer with respect to automobile insurance or home insurance, except for 1 or more of the following reasons:

(a) Malfeasance.

(b) Breach of fiduciary duty or trust.

(c) A violation of this act.

(d) Failure to perform as provided by the contract between the parties.

(e) Submission of less than 25 applications for home insurance and automobile insurance within the immediately preceding 12-month period.

(3) Subsection (2) shall not be construed as permitting a termination of an insurance producer's authority based primarily upon any of the following:

(a) The geographic location of the insurance producer's home insurance or automobile insurance business.

(b) The actual or expected loss experience of the insurance producer's automobile or home insurance business, related in whole or in part to the geographical location of that business.

(c) The performance of the insurance producer's obligations under chapter 21.

(4) Subsection (2) and the written notice requirement under section 1208b(4) do not apply with respect to an insurance producer who is an employee of an insurer or to an insurance producer who by contractual agreement represents only 1 insurer or group of affiliated insurers, if the property rights in the renewal are owned by the insurer or group of affiliated insurers and the cancellation or termination of the insurance producer's contract does not result in the cancellation or nonrenewal of any home or automobile insurance policy.

(5) As used in this section, "automobile insurance" and "home insurance" mean those terms as defined in chapter 21.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 1978, Act 217, Imd. Eff. June 5, 1978;—Am. 1979, Act 145, Imd. Eff. Nov. 13, 1979;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

500.1210 Accident and health insurance agent as health benefit agent.

Sec. 1210. An accident and health insurance agent who is a health benefit agent pursuant to the health benefit agent act shall be subject to the health benefit agent act when selling health benefits. As used in this section, "health benefits" and "health benefit agent" means those terms as defined in the health benefit agent act.

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History: Add. 1986, Act 253, Eff. Mar. 31, 1987.

Popular name: Act 218

500.1211 Solicitation and collection on behalf of licensed insurance producer; authorization; contract; agent of the insured; agent of the insurer.

Sec. 1211. (1) A natural person may solicit applications for insurance and collect premiums on behalf of a licensed insurance producer resident in this state if he or she is so authorized to act by a written contract with the insurance producer, and the contract specifies the extent of his or her authority to act, he or she is licensed to act as a solicitor in accordance with this chapter, and the insurance producer has notified the director of the contract.

(2) An agent of the insured may obtain coverage for a consumer through an agent of the insurer if all of the following apply:

(a) The agent of the insured is licensed to act as an insurance producer in accordance with this chapter.

(b) The agent of the insured has a relationship with the agent of the insurer under a written contract. The written contract under this subdivision must specify the extent of the agent of the insured's authority to act and require the maintenance of an amount of professional liability insurance, commonly known as errors and omissions insurance.

(c) The coverage being obtained is not a health insurance policy or a health maintenance contract.

History: Add. 2001, Act 228, Eff. Mar. 1, 2002;—Am. 2018, Act 449, Imd. Eff. Dec. 21, 2018.

Popular name: Act 218

500.1211a Assumed name; use.

Sec. 1211a. An insurance producer doing business under any name other than the producer's legal name shall notify the commissioner prior to using the assumed name.

History: Add. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

500.1211b Temporary license.

Sec. 1211b. (1) The commissioner may issue a temporary insurance producer license for a period not to exceed 180 days without requiring an examination if the commissioner considers that the temporary license is necessary for the servicing of an insurance business in the following cases:

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

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

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

(d) In any other circumstance where the commissioner considers that the public interest will best be served by the issuance of this license.

(2) The commissioner may by order limit the authority of any temporary licensee if he or she considers it necessary to protect insureds and the public. The commissioner may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee and may impose other similar requirements designed to protect insureds and the public. The commissioner may by order revoke a temporary license if the interest of insureds or the public is endangered. A temporary license may not continue after the owner or the personal representative disposes of the business.

History: Add. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

500.1212 Persons acting as solicitors; contract with agent; license; notice of appointment.

Sec. 1212. (1) An agent may not appoint, employ or in any manner receive the benefit of business done or services rendered in this state by a person acting as a solicitor unless that person is so authorized to act by a written contract with the agent, he is licensed as a solicitor in accordance with this chapter, and the agent has notified the commissioner in writing of the appointment.

(2) A person who is licensed as a solicitor, within the lines of insurance permitted by the license, may act on behalf of a licensed agent if the agent has properly notified the commissioner of the appointment of that

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person as his solicitor.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973.

Popular name: Act 218

500.1214 Solicitor; application for license and notice of appointment; forms; examination required; program of study as condition to examination; waiver of examination or program of study; investigations and interrogatories; decision; issuance of license; qualifications; disclosures; acting on behalf of sponsoring agent; contents of license; person licensed as solicitor for casualty insurance permitted to act as solicitor for legal expense insurance; duration and surrender of license; reexamination; notice.

Sec. 1214. (1) An application for a license to act as a solicitor shall be made to the commissioner and shall be accompanied by a notice of appointment from the sponsoring licensed insurance producer. The application and the notice of appointment shall be on forms prescribed by the commissioner.

(2) Within a reasonable time after receipt of a properly completed application and notice of appointment forms, the commissioner shall subject the applicant to a written examination. The examination shall be given only after the applicant has completed a program of study registered with the commissioner as provided in section 1204a. A certificate of completion of the registered program of study shall be filed with the commissioner on a form prescribed by the commissioner and shall indicate that the course of study was completed by the applicant not more than 6 months before the application is received by the commissioner. An applicant who has failed to pass the examination may take subsequent examinations as determined by rules promulgated by the commissioner. The commissioner may waive the examination or program of study requirements of this section for a person who applies for a limited lines license as designated by the commissioner or for a person who has been licensed as an insurance producer or solicitor within the preceding 12 months. The commissioner may conduct investigations and propound interrogatories concerning the applicant's qualifications, residence, business affiliations that are relevant to the applicant's qualifications as a solicitor, and any other matter the commissioner considers necessary or advisable to determine compliance with this chapter, or for protection of the public. The commissioner shall make a decision on the application within 60 days after the applicant passes the examination or within 60 days after receipt of a properly completed application and notice of appointment forms.

(3) After examination, investigation, and interrogatories, the commissioner shall license an applicant if the commissioner determines that the applicant meets all of the following:

(a) Is authorized by written contract to act on behalf of a licensed insurance producer.

(b) Possesses reasonable understanding of the provisions, terms, and conditions of the insurance the applicant will be licensed to solicit.

(c) Possesses reasonable understanding of the insurance laws of this state.

(d) Intends in good faith to act as a solicitor.

(e) Is honest and trustworthy.

(f) Possesses a good business reputation.

(g) Possesses good moral character to act as a solicitor.

(4) The commissioner may require an applicant or a licensed solicitor to disclose fully the identity of his or her employers, partners, and employees, may propound reasonable interrogatories, and may refuse to issue or to continue a license if the commissioner is satisfied that any employer, partner, or employee who can materially influence the applicant or the solicitor is not a fit and proper person under the standards of this chapter and that the action reasonably is necessary to protect the public.

(5) An applicant may act on behalf of the applicant's sponsoring insurance producer after receipt of a license from the commissioner.

(6) The license shall set forth the name of the solicitor and the lines of insurance permitted by the license. A person who is licensed to act as a solicitor for casualty insurance is permitted to act as a solicitor for legal expense insurance without obtaining additional authorization or licensure from the commissioner.

(7) The license shall continue in effect until suspended or revoked by the commissioner or voluntarily surrendered by the licensee. The commissioner shall demand that the licensee surrender the license when the commissioner's records indicate that the licensee is without authority from any insurance producer to act as a solicitor.

(8) The commissioner may reexamine a licensed solicitor at any time upon written notice with stated reasons.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 1980, Act 390, Imd. Eff. Jan. 7, 1981;—Am. 1981, Act 1, Imd. Eff. Mar. 30, 1981;—Am. 1982, Act 501, Imd. Eff. Dec. 31, 1982;—Am. 1986, Act 173, Imd. Eff. July 7, 1986;—Am. 2001, Act 228, Eff. Mar. 1,

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2002.

Popular name: Act 218

500.1216 Solicitor as fiduciary; accounting methods; examination of records; remuneration of person acting as agent or solicitor.

Sec. 1216. (1) A solicitor shall be a fiduciary for all moneys received or held by him in his capacity as a solicitor. Failure by a solicitor in a timely manner to turn over the moneys which he holds in a fiduciary capacity to the persons to whom they are owed is prima facie evidence of violation of the solicitor's fiduciary responsibility.

(2) A solicitor shall use reasonable accounting methods to record funds received in his fiduciary capacity. The records required by this section shall be open to examination by the commissioner.

(3) A solicitor shall not reward or remunerate a person for procuring or inducing business in this state, furnishing leads or prospects or acting in any other manner as an agent or solicitor.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973.

Popular name: Act 218

500.1218 Termination of solicitor's authority to represent agent; notice; disclosure; liability of agent.

Sec. 1218. An agent shall immediately notify the commissioner of the termination of a solicitor's authority to represent the agent. The notice shall include full disclosure, with supporting evidence, of acts or omissions by the solicitor which reasonably may be construed to be a violation of this act or of any other statute and any act or omissions that may reflect on his qualification as a solicitor or which adversely affect the public interest. There shall not be any liability on the part of, and a cause of action of any nature shall not arise against, an agent for any statements or evidence provided in compliance with this section.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973.

Popular name: Act 218

500.1222 Adjuster's license required; exemptions.

Sec. 1222. (1) A person shall not adjust loss or damage under a policy of insurance or advertise, solicit business, or hold himself or herself out to the public as an adjuster unless he or she is licensed as an adjuster.

(2) The following are exempt from licensure under subsection (1):

(a) A person admitted to the practice of law in this state.

(b) A marine average adjuster.

(c) An employee or manager of an authorized insurer adjusting loss or damage under a policy issued by the insurer.

(d) A licensed insurance producer to whom claim authority has been granted by an insurer.

(e) An individual who collects claim information from, or furnishes claim information to, insureds or claimants, and who conducts data entry including entering data into an automated claims adjudication system, if the individual is under the supervision of 1 or more licensed independent adjusters or an individual who is exempt from licensure under subdivision (c). As used in this subdivision, "automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and final resolution of portable consumer electronic insurance claims.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 2012, Act 462, Imd. Eff. Dec. 27, 2012.

Popular name: Act 218

500.1224 Adjuster; application for license; forms; examination; investigations and interrogatories; waiver; decision; issuance of license; qualifications; additional restrictions; licenses to certain persons prohibited; "home state" defined.

Sec. 1224. (1) An application for a license to act as an adjuster shall be made to the commissioner on forms prescribed by the commissioner.

(2) Within a reasonable time after receipt of a properly completed application form under subsection (1), the commissioner may subject the applicant to a written examination, and may conduct investigations and propound interrogatories concerning the applicant's qualifications, residence, business affiliations, and any other matter that the commissioner considers necessary or advisable to determine compliance with this chapter, or for the protection of the public. The commissioner may waive the examination requirements of this subsection for a person who has been licensed as an adjuster within the preceding 12 months. The commissioner shall make a decision on the application within 60 days after receipt of a properly completed application form.

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(3) After examination, investigation, and interrogatories, the commissioner shall issue a license to act as an adjuster to an applicant if the commissioner determines that the applicant possesses reasonable understanding of the provisions, terms, and conditions of the insurance with which the applicant will deal, possesses reasonable understanding of the insurance laws of this state, intends in good faith to act as an adjuster, possesses a good business reputation, and possesses good moral character to act as an adjuster. Persons currently licensed and new licenses issued are subject to any additional restrictions under which a resident of this state would be licensed in the jurisdiction in which the applicant resides. Any such restriction shall be imposed by the commissioner upon the date set for payment of the license fee. The commissioner shall not issue a new license or accept an annual license fee continuing a current license to either of the following:

(a) A person residing in a state that denies a comparable license to a resident of this state solely because of residency.

(b) A person who is employed either directly or indirectly by an adjuster that is a resident of a state, or by an adjuster's business that has a majority of shareholders, members, officers, directors, or owners that are residents of a state, that denies a comparable license to a resident of this state solely because of residency. An affidavit from an applicant establishing compliance with this subdivision may be relied on by the commissioner to show compliance with this subdivision.

(4) The commissioner shall not issue a license to act as an adjuster to a person who is employed by, owns stock in, is an officer or director of, or in any other manner is connected with, a fire repair contractor.

(5) The commissioner shall not issue a nonresident license to act as an adjuster to an individual who is a resident of Canada unless the individual has received a resident license to act as an adjuster from another state or declared another state his or her home state.

(6) As used in this section:

(a) "Home state" means either of the following:

(*i*) The state in which the adjuster maintains his or her principal place of residence or business and is licensed to act as a resident adjuster.

(*ii*) If the state of the adjuster's principal place of residence or business does not license adjusters, the state in which the adjuster is licensed and in good standing and that is designated by the adjuster as the adjuster's home state.

(b) "State" means that term as defined in section 3o of 1846 RS 1, MCL 8.3o.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 1978, Act 86, Imd. Eff. Mar. 29, 1978;—Am. 1980, Act 390, Imd. Eff. Jan. 7, 1981;—Am. 1981, Act 1, Imd. Eff. Mar. 30, 1981;—Am. 2000, Act 35, Imd. Eff. Mar. 17, 2000;—Am. 2001, Act 228, Eff. Mar. 1, 2002;—Am. 2012, Act 462, Imd. Eff. Dec. 27, 2012.

Popular name: Act 218

500.1226 Persons aiding adjuster; representation by adjuster; procedure for soliciting loss; schedule of rates; limitation on charges; contract.

Sec. 1226. (1) An adjuster for an insured shall not employ a person to aid, directly or indirectly, in soliciting or adjusting a loss and shall not offer or pay a fee, commission, or other valuable consideration to a person to aid, directly or indirectly, in soliciting or adjusting a loss unless the adjuster regularly employs that person to so act for him or her and that person is licensed to act as an adjuster by the commissioner.

(2) An adjuster for the insured shall not represent that he or she is an adjuster for or a representative of an insurer, that he or she is a fire investigator, or that he or she is connected with a fire department. When soliciting a loss, an adjuster shall orally identify himself or herself to the prospective client as an adjuster for the insured, and leave with the prospective client a business card or other document which clearly indicates that he or she is an adjuster for the insured and the rates which the adjuster charges for his or her services.

(3) An adjuster for the insured shall not charge a rate for his or her services which exceeds 10% of the amount paid by the insurer in settlement of the loss.

(4) An adjuster for an insured shall not provide his or her services to a client until the adjuster has contracted in writing, on a form approved by the commissioner, with the insured or his or her authorized representative. A contract which is executed within 48 hours after conclusion of the loss-producing occurrence shall be voidable at the option of the insured for 10 days after execution of the contract. The written contract shall constitute the entire agreement between the adjuster for the insured and the insured. A copy of the contract shall be given to the insured when the contract is executed.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 1984, Act 7, Imd. Eff. Feb. 1, 1984.

Popular name: Act 218

500.1227 Conduct of adjuster; prohibitions.

Sec. 1227. (1) An adjuster for an insured shall not solicit or attempt to solicit a loss during progress of a

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loss-producing occurrence nor while the fire department or its representatives are engaged at the damaged premises.

(2) An adjuster for an insured shall not collect or attempt to collect a fee or charge from a repair contractor for obtaining repair work for the contractor.

(3) An adjuster for an insured shall not advance money or any other valuable thing to an insured pending adjustment of a claim.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973.

Popular name: Act 218

500.1228 Records of adjuster.

Sec. 1228. (1) An adjuster for an insured shall maintain a complete record of each of his transactions as an adjuster for the insured. The record shall include: (a) the name of the insured, (b) the date, location and amount of the loss, (c) a copy of the contract between the adjuster for the insured and the insured, (d) the name of the insurer and the amount, expiration date and number of each policy carried with respect to the loss, (e) an itemized statement of the recoveries by the insured from the sources known to the adjuster for the insured, (f) the name of each person soliciting the adjustment for the insured and the date and time when solicited, and (g) the total compensation received for the adjustment and the amount of commission, salary or other compensation paid to each representative of the adjuster for the insured in connection with the transaction.

(2) Records shall be maintained for at least 6 years after the termination of the transaction with an insured, and shall be open to examination by the commissioner.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973.

Popular name: Act 218

500.1232 Insurance counselor; license required; use of designation "certified insurance counselor" or "fraternal insurance counselor"; exceptions.

Sec. 1232. A person shall not audit or abstract policies of insurance or annuities, provide advice, counsel, or opinion with respect to benefits promised, coverage afforded, terms, value, effect, advantages, or disadvantages of a policy of insurance or annuity, nor advertise, solicit business, or hold himself or herself out to the public as an insurance counselor unless he or she is licensed as an insurance counselor. A person other than a licensed counselor shall not use terms such as consultant, consulting services, or any other language in a way which implies that he or she is a licensed insurance counselor. However, this section does not prohibit the use of the copyrighted designation "certified insurance counselor" if the designation is conferred upon a person by the society of certified insurance counselors or the copyrighted designation "accredited advisor in insurance" if the designation is conferred upon a person by the insurance institute of America. The person using the designation "certified insurance counselor" in each instance of usage, shall capitalize the initial letter of each of the 3 words. A person shall not employ the words certified insurance counselor generically so as to reasonably lead the public to believe that the person is licensed as an insurance counselor pursuant to section 1234, if the person is not so licensed. In addition, this section does not prohibit the use of the designation "fraternal insurance counselor" if such designation has been conferred upon the person by the fraternal field managers association. A person who acts as an insurance agent on behalf of a fraternal benefit society and who is also authorized to represent an insurer other than a fraternal benefit society but who is not licensed as an insurance counselor shall not, in connection with the solicitation or procurement of insurance contracts on behalf of that insurer, hold himself or herself out to the public as a licensed insurance counselor. This section does not prohibit the customary advice offered by a licensed insurance agent nor does this section apply to a person admitted to the practice of law in this state.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 1984, Act 7, Imd. Eff. Feb. 1, 1984;—Am. 1987, Act 38, Imd. Eff. May 27, 1987.

Popular name: Act 218

500.1234 Insurance counselor; application for license; forms; examination; investigations and interrogatories; decision; issuance of license; qualifications.

Sec. 1234. (1) An application for a license to act as an insurance counselor shall be made to the commissioner on forms prescribed by the commissioner.

(2) Within a reasonable time after receipt of a properly completed application form, the commissioner shall subject the applicant to a written examination, and may conduct investigations and propound interrogatories concerning the applicant's qualifications, residence, business affiliations, and any other matter that the commissioner considers necessary or advisable to determine compliance with this chapter, or for the

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protection of the public. The commissioner may waive the examination requirements of this subsection for a person who has been licensed as an insurance counselor within the preceding 12 months. The commissioner shall make a decision on the application within 60 days after receipt of a properly completed application form.

(3) After examination, investigation, and interrogatories, the commissioner shall issue a license to an applicant if the commissioner determines that the applicant possesses reasonable understanding of the provisions, terms, and conditions of the insurance concerning that the applicant will counsel, possesses reasonable understanding of the insurance laws of this state, intends in good faith to act as an insurance counselor, possesses a good business reputation, and possesses good moral character to act as an insurance counselor.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 1980, Act 390, Imd. Eff. Jan. 7, 1981;—Am. 1981, Act 1, Imd. Eff. Mar. 30, 1981;—Am. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

500.1236 Written agreement between insurance counselor and client.

Sec. 1236. In advance of rendering any service set forth in section 1232, a written agreement shall be prepared by a counselor, and shall be signed by both the counselor and the client. The agreement shall outline the nature of the work to be performed by the counselor and shall state his fee for the work. The agreement shall clearly state that the counselor's fee may not be waived under any circumstances and disclose that the counselor will receive a commission from the insurer on any insurance placed by the counselor acting as insurance agent. The counselor shall retain a copy of the agreement for not less than 2 years after completion of the services. The copy shall be available to the insurance commissioner.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973.

Popular name: Act 218

500.1238 Reporting mailing and electronic mail address of agent, solicitor, counselor, or adjuster; notice of change in address; maintaining address on file; mailing of notice of hearing or process.

Sec. 1238. (1) When applying for a license to act as an agent, solicitor, counselor, or adjuster, the applicant shall report his or her mailing and electronic mail address to the commissioner. An agent, solicitor, counselor, or adjuster shall notify the commissioner of any change in his or her mailing or electronic mail address within 30 days after the change. The commissioner shall maintain the mailing and electronic mail address of each agent, solicitor, counselor, or adjuster on file.

(2) A notice of hearing or service of process may be served upon an agent, solicitor, counselor, or adjuster in any action or proceeding for a violation of this act by mailing the notice or process by first class mail to the agent's, solicitor's, counselor's, or adjuster's mailing address reported to the commissioner under subsection (1).

History: Add. 1984, Act 5, Imd. Eff. Feb. 1, 1984;—Am. 2012, Act 453, Imd. Eff. Dec. 27, 2012.

Popular name: Act 218

500.1239 Probation, suspension, or revocation of insurance producer's license; refusal to issue or reissue; causes; civil fine; notice of license denial; hearing; license of business entity; penalties and remedies.

Sec. 1239. (1) In addition to any other powers under this act, the director may place on probation, suspend, or revoke an insurance producer's license or may levy a civil fine under section 1244 or any combination of actions, and the director shall not issue a license under section 1205 or 1206a, for any 1 or more of the following causes:

(a) Obtaining or attempting to obtain a license through misrepresentation or fraud.

(b) Improperly withholding, misappropriating, or converting any money or property received in the course of doing insurance business.

(c) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance.

(d) Having been convicted of a felony within 10 years before the uniform application was filed.

(e) Regardless of the date of conviction, having been convicted of a felony involving any of the following:

(*i*) Violence or threat of violence against an individual, including, but not limited to, domestic violence.

(*ii*) Criminal sexual conduct.

(*iii*) A felony of a fiduciary nature or financial nature such as fraud, embezzlement, bribery, or extortion.

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

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

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

(i) Knowingly accepting insurance business from an individual who is not licensed.

(2) In addition to any other powers under this act, the director may place on probation, suspend, or revoke an insurance producer's license or may levy a civil fine under section 1244 or any combination of actions, and the director may refuse to issue a license under section 1205 or 1206a, for any 1 or more of the following causes:

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

(b) Having been convicted of a felony other than a felony described in subsection (1)(e).

(c) Having an insurance producer license or its equivalent denied, suspended, or revoked in any other state, province, district, or territory.

(d) Improperly using notes or any other reference material to complete an examination for an insurance license.

(e) Violating any insurance laws or violating any regulation, subpoena, or order of the director or of another state's insurance commissioner.

(f) Failing to comply with an administrative or court order imposing a child support obligation.

(g) Failing to pay the single business tax or the Michigan business tax or comply with any administrative or court order directing payment of the single business tax or the Michigan business tax.

(3) Subject to subsection (2), after examination, investigation, and interrogatories, the director shall issue a license under section 1205 or 1206a to an applicant if the director determines the applicant possesses good moral character to act as an insurance producer.

(4) Before the director denies an application for a license under section 1205 or 1206a, the director shall notify in writing the applicant or licensee of the denial and of the reason for the denial. Not later than 30 days after this written denial, the applicant or licensee may make written demand on the director for a hearing before the director to determine the reasonableness of the director's action. A hearing under this subsection must be held under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(5) The license of a business entity may be suspended, revoked, or refused if the director finds, after hearing, that an individual licensee's violation was known or should have been known by 1 or more of the partners, officers, or managers acting on behalf of the partnership or corporation and the violation was not reported to the director and corrective action was not taken.

(6) In addition to or instead of any applicable denial, suspension, or revocation of a license, a person may, after hearing, be subject to a civil fine under section 1244.

(7) In addition to the penalties under this section, the director may enforce the provisions of and impose any penalty or remedy authorized by this act against a person that is under investigation for or charged with a violation of this act even if the person's license or registration has been surrendered or has lapsed by operation of law.

History: Add. 2001, Act 228, Eff. Mar. 1, 2002;—Am. 2007, Act 187, Imd. Eff. Dec. 21, 2007;—Am. 2008, Act 423, Imd. Eff. Jan. 6, 2009;—Am. 2019, Act 124, Eff. May 21, 2020.

Popular name: Act 218

500.1240 Payment or acceptance of commission, service fee, or valuable consideration.

Sec. 1240. (1) An insurer or insurance producer shall not pay a commission, service fee, or other valuable consideration to a person for selling, soliciting, or negotiating insurance in this state if that person is required to be licensed under this chapter and is not so licensed.

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

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

(4) An insurer or insurance producer may pay or assign commissions, service fees, or other valuable consideration to an insurance agency or to persons who do not sell, solicit, or negotiate insurance in this state, unless the payment would violate section 2024.

History: Add. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

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500.1242 Refusal, suspension, or revocation of license; notice; hearings; summary suspension; subpoenas.

Sec. 1242. (1) The commissioner shall refuse to grant a license to act as a solicitor, an insurance counselor, or an adjuster to an applicant who fails to meet the requirements of this chapter. Notice of the refusal shall be in writing and shall set forth the basis for the refusal. If the applicant submits a written request within 30 days after mailing of the notice of refusal, the commissioner shall promptly conduct a hearing in which the applicant shall be given an opportunity to show compliance with the requirements of this chapter.

(2) The commissioner, after notice and opportunity for a hearing, may suspend or revoke the license of a solicitor, insurance counselor, or adjuster who fails to maintain the standards required for initial licensing or who violates any provision of this act.

(3) After notice and opportunity for a hearing, the commissioner may refuse to grant or renew a license to act as a solicitor, adjuster, or insurance counselor if he or she determines by a preponderance of the evidence, that it is probable that the business or primary occupation of the applicant will give rise to coercion, indirect rebating of commissions, or other practices in the sale of insurance that are prohibited by law.

(4) Without prior hearing, the commissioner may order summary suspension of a license if he or she finds that protection of the public requires emergency action and incorporates this finding in his or her order. The suspension shall be effective on the date specified in the order or upon service of a certified copy of the order on the licensee, whichever is later. If requested, the commissioner shall conduct a hearing on the suspension within a reasonable time but not later than 20 days after the effective date of the summary suspension unless the person whose license is suspended requests a later date. At the hearing, the commissioner shall determine if the suspension should be continued or if the suspension should be withdrawn, and, if proper notice is given, may determine if the license should be revoked. The commissioner shall announce his or her decision within 30 days after conclusion of the hearing. The suspension shall continue until the decision is announced.

(5) The commissioner, or his or her designated deputy, may issue subpoenas to require the attendance and testimony of witnesses and the production of documents necessary to the conduct of the hearing and may designate an office of financial and insurance services employee to make service. The subpoenas issued by the commissioner, or his or her designated deputy, may be enforced upon petition to the circuit court of Ingham county to show cause why a contempt order should not be issued, as provided by law.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 2001, Act 228, Eff. Mar. 1, 2002;—Am. 2002, Act 32, Imd. Eff. Mar. 7, 2002.

Popular name: Act 218

500.1243 Definitions; sale of insurance by lender.

Sec. 1243. (1) As used in this section:

(a) "Act" means the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(b) "Affiliate" means a person that directly or indirectly or through 1 or more intermediaries, controls or is controlled by another or is under common control with another. An affiliate includes a person who for any 12-month period makes a monthly average of 10 or more referrals to lenders for the purpose of procuring a loan and the person receives consideration for making those referrals.

(c) "Agent" means an individual licensed as an insurance producer, broker, solicitor, or insurance counselor under this act.

(d) "Agency" means an insurance agency licensed under this act.

(e) "Control" means control as defined in section 115.

(f) "Insurance product" means any product or service regulated, in whole or in part, by the commissioner.

(g) "Lender" means a person or entity who directly or indirectly, in the ordinary course of business regularly makes, arranges, offers to make, or purchases and services a loan as defined by subdivision (h). A lender includes a mortgage broker. If a person purchases an interest in but does not service a loan, that person is not a lender under this section for the purposes of that loan.

(h) "Loan" means an agreement to lend money or to finance goods or services. Loan does not include any of the following:

(*i*) The financing of insurance premiums.

(*ii*) A loan from the cash value of an insurance policy.

(*iii*) A home improvement charge agreement or a home improvement installment contract made under the home improvement finance act, 1965 PA 332, MCL 445.1101 to 445.1431.

(*iv*) A retail installment contract of $10,000.00 or less or a retail charge agreement made under the retail installment sales act, 1966 PA 224, MCL 445.851 to 445.873.

(i) "Loan representative" means an employee or representative of a lender that deals directly with loan

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applicants in accepting loan applications or approving or closing a loan.

(j) "Person" means an individual, corporation, partnership, association, or any other legal entity.

(k) "Required insurance" means any insurance product that a borrower is required to obtain as a condition of closing a loan.

(2) The commissioner shall issue an insurance agency license to an affiliate of a lender or an agent license to an individual who is an employee of the affiliate if the commissioner determines that the affiliate or employee has met the prerequisites for licensure under this act and that the affiliate and the lender will conduct the sale of insurance in compliance with this section. If a lender acquires ownership in or becomes affiliated with an agency with an existing license under this act, an application for a new license is not required. The commissioner may issue an insurance agency or agent license directly to a lender or an employee of the lender who is not an employee of an affiliated agency if the commissioner determines that the lender or employee has met the prerequisites for licensure and will conduct the sale of insurance in substantial compliance with this section.

(3) This section applies to all of the following:

(a) A lender that has been affiliated with a licensed agency or has employed a licensed agent before March 30, 1995 and that affiliation or employment continues or is renewed on and after March 30, 1995.

(b) A lender, affiliate, or employee of a lender that has been licensed as an agency or agent before March 30, 1995 and maintains that licensure on and after March 30, 1995, to the extent that the provisions of this section apply.

(c) A person affiliated with a lender that receives an agency license or an individual employed by the lender who receives an agent license.

(d) A lender that is licensed as an agency, to the extent that the provisions of this section apply.

(e) A lender that acquires ownership in an agency or otherwise becomes affiliated with a licensed insurance agency.

(f) A lender that employs a licensed insurance agent.

(4) A lender, an agency affiliated with a lender, or an agent employed by a lender may be licensed to sell any insurance product.

(5) A lender may own an insurance agency in whole or in part and shall provide notice to the commissioner and the commissioner of the financial institutions bureau of any acquisition, in whole or in part, of an insurance agency.

(6) Applications for insurance agency or agent licenses under this act shall be promptly reviewed by the commissioner. An application shall be considered approved by the commissioner if the commissioner has not denied the application for good cause within 60 days after the date the application is filed. The commissioner shall issue the insurance agency or agent license within 10 days of approval.

(7) Interrogatories propounded by the commissioner regarding the proposed business conduct between a lender and an affiliated insurance agency shall be limited to questions pertaining to compliance with this section.

(8) There is no limit on the percentage of insurance business sold to customers of a lender through an insurance agency affiliated with the lender or agent employed by the lender if sold in compliance with this act.

(9) A lender shall not do either of the following:

(a) Require a borrower to purchase any policy or contract of insurance through a particular agency or agent or with a particular insurer or fix or vary the terms or conditions of a loan as an inducement to purchase insurance. This subdivision does not prohibit a lender from requiring a borrower to purchase a required insurance policy that conforms to the requirements, if any, of the loan.

(b) Except as otherwise provided by law, require a person to purchase any insurance product from the lender or an affiliate as a condition of making a loan.

(10) The board of directors of an insurance agency affiliated with a lender shall act separately from the board of directors of the lender. A director of a lender may also serve as a director of an affiliated agency, except that a majority of directors of the affiliated agency shall not be directors of the lender. This subsection does not apply to a lender that is also the licensed agency.

(11) An officer or employee of a lender may be an officer or employee of an affiliated agency. However, except as otherwise provided by this section, for purposes of soliciting or selling insurance products, such officer or employee shall not use or disclose information that the lender may not disclose to the affiliated agency.

(12) An officer or employee of a lender shall not directly or indirectly delay or impede the completion of a loan transaction for the purpose of influencing a consumer's selection or purchase of insurance products from an agent, solicitor, agency, or insurer that is not affiliated with the lender.

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(13) A loan representative may not act as an agent or solicitor for the sale or provision of required insurance related to an application, approval, commitment, or closing of a loan if the loan representative participated in the application, approval, commitment, or closing of that loan.

(14) A lender or its employees shall not knowingly initiate a discussion concerning the availability of insurance products from the lender or an affiliated agency to or with a person in response to an inquiry about credit made by the person or to a loan applicant prior to the loan applicant being notified of the disposition of a loan application. This subsection does not prohibit a lender or its employees from discussing with the person making the inquiry or loan applicant that certain required insurance must be maintained as a condition of obtaining a loan.

(15) If asked about the availability of insurance products by a person inquiring about a loan or a loan applicant, the lender may indicate that insurance products are available from the lender or an affiliated agency and may provide instruction about how to obtain further information concerning the agency or agent and available insurance products.

(16) If insurance is required as a condition of obtaining a loan, and if the required insurance is available through the lender or an affiliate of the lender, the lender shall disclose to the applicant all of the following:

(a) That the lender will not require the borrower to purchase any policy or contract of insurance through a particular agent, agency, or with a particular insurer.

(b) Except as otherwise provided by law, that the lender will not require the borrower to purchase any insurance product from the lender or an affiliate as a condition of the loan.

(c) That the purchase of any insurance product from the lender or its affiliated agency is optional and will not in any way affect current or future credit decisions.

(17) The disclosure required by subsection (16) shall be made to a loan applicant at the time the loan applicant inquires about the availability of required insurance or at such time as the lender advises the loan applicant that the required insurance is available through the lender or an affiliate of the lender, whichever is earlier. The disclosure shall be confirmed in writing, dated, and signed by the applicant no later than the closing of the loan.

(18) If insurance is required as a condition of obtaining a loan, the credit and insurance transactions shall be completed independently and through separate documents. A loan for premiums on required insurance shall not be included in the primary credit without the written consent of the customer.

(19) The offering of a loan by a lender and the sale or provision of insurance products by the lender or an affiliated agency shall be made in different areas that are clearly and conspicuously signed and separated so as to preclude confusion on the part of customers. However, in the limited situation where physical or employee considerations prevent lending and the sale of insurance products from being conducted in different areas, the lender shall take appropriate measures to minimize customer confusion. In unique circumstances to accommodate the needs of or for the convenience of particular customers, this subsection does not prohibit on an irregular basis, taking applications for loans, extensions of loans, and the sale of insurance products at the same location.

(20) Signs and other informational material concerning the availability of insurance products from the lender or an affiliated agency shall not be displayed in an area when loan applications are being taken and when loans are being closed in that area.

(21) A lender, its employees, or its representatives may advise the general public and its customers, through mailings or otherwise, that insurance products are available from the lender or affiliated agency and may advise the general public and its customers how to obtain more information about those insurance products, so long as:

(a) The information is not provided because of a submission of any loan application until after the loan applicant has been notified of the disposition of the application, or in response to any inquiry about the availability, terms, and conditions of any loan.

(b) The timing of the communications is not based on the maturity or expiration date of a policy of required insurance or an insurance policy in the lender's possession.

(c) No information concerning customers that is prohibited for use in the solicitation or sale of insurance products under subsections (23) and (25) is used to determine which customers should receive the information.

(22) A lender may provide the names, addresses, telephone numbers, and information related to account relationships with customers to an affiliated agency or an agent employed by the lender so long as the lender does not disclose account balances or maturity dates of certificates of deposit and does not disclose account relationships to an affiliated agency or an agent employed by the lender in a manner that account balances or maturity dates of certificates of deposit may be determined by the agency or agent. This section does not prohibit disclosure of minimum required balances, terms, or conditions of an account.

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(23) A lender shall not directly or indirectly provide to an affiliated agency or an agent employed by the lender the following information if obtained from an insurance policy or preauthorized payment agreement that is in the possession of the lender:

(a) The expiration date of the insurance policy.

(b) The name of the insurance company that issued the policy.

(c) The amount of the premium.

(d) Scheduled coverages and policy limits contained in the policy.

(e) Any deductibles contained in the policy.

(f) Any information contained on the declaration sheet of the policy.

(g) Cash or surrender values.

(24) A lender may disclose to an affiliated agency or an agent employed by the lender information obtained from a policy of required insurance that the borrower has failed to keep in force, if the information is necessary to obtain the required insurance through the affiliated agency, employee, or elsewhere. If a customer has failed to keep required insurance in force, this section does not prohibit a lender from obtaining the required insurance in accordance with the terms of the loan or from obtaining insurance limited to repayment of the outstanding balance due in the event of loss or damage to property used as collateral on the loan.

(25) A lender shall not directly or indirectly provide to an affiliated agency or agent employed by the lender the following customer documents or information:

(a) Loan applications, except that a lender may provide to an affiliated agency or agent employed by the lender the name, address, telephone number, and account relationship concerning a loan applicant after the applicant has been notified of the disposition of the application.

(b) Financial statements regarding assets, liabilities, net worth, income, and expenses.

(c) Budgets or proposed budgets.

(d) Business plans.

(e) Contracts.

(f) Credit reports.

(g) Inventory records.

(h) Collateral offered as security for loans.

(i) Appraisals.

(j) Personal guarantees and related information.

(k) Insurance policy, certificate, or binder.

(26) This section does not require the lender to remove the name, address, or other information concerning the customer from the customer list if information concerning a customer of a lender is on a customer list by reason of other account relationships with the lender and the lender is otherwise authorized to disclose the list to an affiliate agency or an agent employed by the lender.

(27) This section does not prohibit a lender from providing information about the customers of the lender to an affiliated agency or an agent employed by the lender if that information is otherwise available from a public record.

(28) This section does not prohibit a lender from releasing customer information in its possession to any person if the customer authorizes the release of that information. The release shall be in writing, dated, and signed by the customer. A lender shall not knowingly ask a loan applicant to release such information prior to the applicant being notified of the disposition of the application unless the applicant has asked about the availability of insurance products as provided under subsection (15). A lender shall not require the release as a condition of applying for the loan.

(29) The use or disclosure of information allowed under this section is not a violation of the use or disclosure of information under section 2077.

(30) Except as provided in subsection (31), an insurance agency or agent shall not reward or remunerate an affiliated lender for procuring or inducing insurance product business for the agency or agent or for furnishing leads and prospects or acting in any other manner as an agent. This subsection does not preclude an affiliated agency from compensating its employees, who may also be employees of the lender, or reimbursing its affiliated lender at fair market value for any goods, services, or facilities that the lender may provide to the agency or for expense incurred by the lender in advising its customers and the general public of the agency's services.

(31) An insurance agency may pay dividends and make other distributions of assets to the agency's shareholders, including an affiliated lender, as a return on the capital invested and risks assumed by the shareholders or in conjunction with a merger, liquidation, or other corporate transaction.

(32) This section does not prohibit a lender, or a manufacturer or an affiliate of a manufacturer acting as a

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lender, from soliciting or selling insurance products to a closed dealership, designated family member, new motor vehicle dealer, or proposed new motor vehicle dealer. This subsection shall not be construed to include customers of motor vehicle dealers.

(33) As used in subsection (32):

(a) "Closed dealership" means a closed dealership as defined in section 2 of 1981 PA 118, MCL 445.1562.

(b) "Designated family member" means a designated family member as defined in section 2 of 1981 PA 118, MCL 445.1562.

(c) "Manufacturer" means a manufacturer as defined in section 4 of 1981 PA 118, MCL 445.1564.

(d) "New motor vehicle dealer" means a new motor vehicle dealer as defined in section 5 of 1981 PA 118, MCL 445.1565.

(e) "Proposed new motor vehicle dealer" means a proposed new motor vehicle dealer as defined in section 5 of 1981 PA 118, MCL 445.1565.

(34) This section does not apply to insurance products offered under the credit insurance act, 1958 PA 173, MCL 550.601 to 550.624.

(35) This section does not apply to the offering of life insurance by a lender under section 4418.

(36) Notwithstanding section 4418, payment by an insurer of consideration to an agency or agent licensed under this act for an individual policy of insurance on the life of the borrower issued in connection with a loan on a dwelling or mobile home made or serviced by an affiliated lender is not considered a monetary or financial benefit to the lender as a result of the insurance.

(37) If after an opportunity for a hearing pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the commissioner finds that a person has violated this section, the commissioner shall reduce the findings and decision to writing and serve upon the person charged with the violation a copy of the decision and an order requiring the person to cease and desist from the violation. In addition, the commissioner may order any of the following:

(a) For all violations committed in a 6-month period, the payment of a civil fine of not more than $1,000.00 for each violation but not to exceed an aggregate civil penalty of $30,000.00, unless the person knew or reasonably should have known the person was in violation of this section, in which case the civil fine shall not be more than $5,000.00 for each violation and shall not exceed an aggregate civil fine of $150,000.00. A fine collected under this subdivision shall be turned over to the state treasurer and credited to the general fund of the state.

(b) That restitution be made to the insured or any other person, including a customer claimant, to cover actual damages directly attributable to the acts that are found to be in violation of this section by a person that knew or reasonably should have known the acts were in violation of this section.

(c) The suspension or revocation of the person's license under this act.

(38) If a person knowingly violates a cease and desist order under this section and has been given notice and an opportunity for a hearing as provided by this section, the commissioner may order a civil fine of not more than $25,000.00 for each violation, or a suspension or revocation of the person's license under this act, or both. However, an order issued by the commissioner pursuant to this subsection shall not require the payment of civil fines exceeding $250,000.00. A fine collected under this subsection shall be turned over to the state treasurer and credited to the general fund of the state.

(39) The commissioner may apply to the circuit court of Ingham county for an order of the court enjoining a violation of this section.

(40) An action under this section shall not be brought more than 5 years after the occurrence of the violation that is the basis of the action.

History: Add. 1994, Act 409, Eff. Mar. 30, 1995;—Am. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

500.1244 Violation of chapter; hearing; serving copy of findings and cease and desist order; additional orders; reopening, altering, modifying, or setting aside order; violation of cease and desist order; notice and hearing; civil fine; suspension or revocation of license; disposition of fine; court of claims.

Sec. 1244. (1) If the director finds that a person has violated this chapter, after an opportunity for a hearing under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director shall reduce the findings and decision to writing and shall issue and cause to be served on the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from the violation. In addition, the director may order any of the following:

(a) Payment of a civil fine of not more than $1,000.00 for each violation. However, if the person knew or

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reasonably should have known that he or she was in violation of this chapter, the director may order the payment of a civil fine of not more than $5,000.00 for each violation. An order of the director under this subsection must not require the payment of civil fines exceeding $50,000.00. A fine collected under this subdivision must be turned over to the state treasurer and credited to the general fund of this state.

(b) A refund of any overcharges.

(c) That restitution be made to the insured or other claimant to cover incurred losses, damages, or other harm attributable to the acts of the person found to be in violation of this chapter.

(d) The suspension or revocation of the person's license.

(2) The director may by order, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued under this section, if in the opinion of the director conditions of fact or of law have changed to require that action, or if the public interest requires that action.

(3) If a person knowingly violates a cease and desist order under this chapter and has been given notice and an opportunity for a hearing held under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director may order a civil fine of not more than $20,000.00 for each violation, a suspension or revocation of the person's license, or both. An order issued by the director under this subsection must not require the payment of civil fines exceeding $100,000.00. A fine collected under this subsection must be turned over to the state treasurer and credited to the general fund of this state.

(4) The director may apply to the court of claims for an order of the court enjoining a violation of this chapter.

History: Add. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 1984, Act 7, Imd. Eff. Feb. 1, 1984;—Am. 2001, Act 228, Eff. Mar. 1, 2002;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.1246 Confidentiality; use of documents, materials, or other information.

Sec. 1246. (1) Any documents, materials, or other information in the control or possession of the office of financial and insurance services that is furnished by an insurer, an insurance producer, or an employee or representative acting on behalf of the insurer or insurance producer, or obtained by the commissioner in an investigation pursuant to this section is confidential by law and privileged, is not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, is not subject to subpoena, and is not subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's duties.

(2) Neither the commissioner nor any person who received documents, materials, or other information while acting under the commissioner's authority is permitted or required to testify in any private civil action concerning any confidential documents, materials, or information under subsection (1).

(3) In order to assist in the performance of the commissioner's duties under this chapter, the commissioner may do any of the following:

(a) Share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (1), with other state, federal, and international regulatory agencies, with the national association of insurance commissioners, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information.

(b) Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the national association of insurance commissioners, its affiliates or subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

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

(4) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under section 1208b or this section, or as a result of sharing as authorized under subsection (3).

(5) This chapter does not prohibit the commissioner from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, to a database or other clearinghouse service maintained by the national association of insurance commissioners or its affiliates or subsidiaries.

(6) An insurer, the authorized representative of the insurer, or an insurance producer that fails to report as required under section 1208b or this section or that is found to have reported with actual malice by a court of

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competent jurisdiction may, after notice and hearing, have its license or certificate of authority suspended or revoked and may be fined under section 1244.

History: Add. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

500.1247 Report of administrative action.

Sec. 1247. (1) An insurance producer shall report to the commissioner any administrative action taken against the insurance producer in another jurisdiction or by another governmental agency in this state within 30 days after the final disposition of the matter. This report shall include a copy of the order, consent to order, or other relevant legal documents.

(2) Within 30 days after the initial pretrial hearing date, an insurance producer shall report to the commissioner any criminal prosecution of the insurance producer taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

History: Add. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

CHAPTER 12A

500.1261 Definitions.

Sec. 1261. As used in this chapter:

(a) "Affordable care act" means the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(b) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(c) "Certificate" means a document issued by the director authorizing a person to act as a navigator or certified application counselor for the qualifications specified in the document. The certificate itself does not create any actual, apparent, or inherent authority in the certificate holder to represent or commit an insurer.

(d) "Certificate holder" means a person issued a certificate under this chapter.

(e) "Certified application counselor" means an individual who is certified as a certified application counselor under this chapter and is authorized by the United States department of health and human services to perform the duties described in 45 CFR 155.225.

(f) "Certified navigator" means a person that is certified as a navigator under this chapter.

(g) "Exchange" means an American health benefits exchange established or operating under the affordable care act.

(h) "Insurance" means any of the kinds of insurance described in chapter 6.

(i) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(j) "Navigator" means a person that receives any funding from an exchange or the federal government and is designated or selected by an exchange or the federal government to perform any of the duties described in 42 USC 18031(i)(3).

(k) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(*l*) "Qualified health plan" means that term as defined in section 1301 of the affordable care act.

(m) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(n) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

History: Add. 2014, Act 566, Imd. Eff. Jan. 15, 2015.

Compiler's note: Enacting section 1 of Act 566 of 2014 provides:

"Enacting section 1. (1) This amendatory act shall not be construed to do any of the following:

(a) Authorize this state or an agency of this state to conduct or oversee state-level governmental consumer assistance functions for an American health benefit exchange established or operating in this state under the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(b) Convey any administrative, statutory, rule-making, or other power to this state or an agency of this state to authorize, establish, or operate an American health benefit exchange in this state that did not exist before the effective date of this amendatory act.

(2) It is the intent of this legislature that any consumer assistance functions by or overseen by this state or an agency of this state with regard to an American health benefit exchange shall be conducted in a manner that utilizes and highlights Michigan-based resources,

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including insurance producers, in order to best serve the residents of this state and to ensure appropriate health care decisions."

Enacting section 2 of Act 566 of 2014 provides:

"Enacting section 2. This amendatory act applies to policies, certificates, or contracts delivered, issued for delivery, or renewed in this state on and after the effective date of this amendatory act."

Popular name: Act 218

500.1262 Navigator; certification; application; funding from exchange prohibited; duties; determination by director that program to certify and train navigators protects personally identifiable information.

Sec. 1262. (1) Beginning June 30, 2015, an individual shall not act as a navigator unless he or she has filed an application under section 1263(1) and is certified with this state as a navigator.

(2) Unless certified as a navigator, an individual shall not receive funding from an exchange.

(3) Subject to the affordable care act, a certified navigator shall do all of the following:

(a) Conduct public education activities to raise awareness of the availability of qualified health plans.

(b) Distribute fair and impartial information concerning enrollment in all qualified health plans offered within the exchange and the availability of the premium tax credits under section 36B of the internal revenue code of 1986, 26 USC 36B, and cost-sharing reduction under section 1402 of the affordable care act.

(c) Facilitate selection of a qualified health plan.

(d) Provide referrals to appropriate state agencies for an enrollee with a grievance, complaint, or question regarding the enrollee's health plan, coverage, or a determination under such plan coverage.

(e) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population served by the exchange.

(4) A certified navigator shall not do any of the following:

(a) Sell, solicit, or negotiate health insurance.

(b) Recommend a particular health benefit plan.

(c) Provide any information or services related to insurance regulated under this act other than health benefit plans or other products offered in the exchange.

(5) If an exchange is operational in this state, the director shall determine whether a program to certify and train navigators protects the privacy and security of personally identifiable information of the residents of this state under the laws of this state. If the director determines that the program does not protect the residents of this state under this subsection, the director shall do all of the following:

(a) Establish a certification and training program that must include, but is not limited to, all of the following:

(*i*) A criminal history check using the department of state police's internet criminal history access tool (ICHAT).

(*ii*) Training on privacy and security of personal identifying information, training on ethics, training on provisions of the affordable care act relating to navigators and certified application counselors and any necessary state-specific training as determined by the director.

(b) Develop an application and disclosure form by which an applicant for a certificate shall disclose any potential conflicts of interest, as well as any other information required by the director.

(c) Submit an annual report to the standing committees of the senate and house of representatives with jurisdiction over health policy. The report must include all of the following:

(*i*) The director's assessment of any federal program to certify and train navigators and certified application counselors.

(*ii*) Any changes implemented by the department as a result of a federal program to train navigators and certified application counselors.

History: Add. 2014, Act 566, Imd. Eff. Jan. 15, 2015.

Compiler's note: Enacting section 1 of Act 566 of 2014 provides:

"Enacting section 1. (1) This amendatory act shall not be construed to do any of the following:

(a) Authorize this state or an agency of this state to conduct or oversee state-level governmental consumer assistance functions for an American health benefit exchange established or operating in this state under the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(b) Convey any administrative, statutory, rule-making, or other power to this state or an agency of this state to authorize, establish, or operate an American health benefit exchange in this state that did not exist before the effective date of this amendatory act.

(2) It is the intent of this legislature that any consumer assistance functions by or overseen by this state or an agency of this state with regard to an American health benefit exchange shall be conducted in a manner that utilizes and highlights Michigan-based resources, including insurance producers, in order to best serve the residents of this state and to ensure appropriate health care decisions."

Enacting section 2 of Act 566 of 2014 provides:

"Enacting section 2. This amendatory act applies to policies, certificates, or contracts delivered, issued for delivery, or renewed in this state on and after the effective date of this amendatory act."

Popular name: Act 218

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500.1262a Certified application counselor; certification; application; funding from exchange prohibited; powers; prohibited conduct; disclosure of potential conflict of interest.

Sec. 1262a. (1) An individual shall not act as a certified application counselor unless he or she has filed an application under section 1263(2) and is certified with this state as a certified application counselor.

(2) Unless certified as a certified application counselor, an individual shall not receive funding from an exchange.

(3) Subject to the affordable care act, a certified application counselor may do all of the following:

(a) Conduct public education activities to raise awareness of the availability of qualified health plans.

(b) Distribute fair and impartial information about all qualified health plans offered within the exchange and the availability of the premium tax credits under section 36B of the internal revenue code of 1986, 26 USC 36B, and cost-sharing reduction under section 1402 of the affordable care act.

(c) Assist individuals applying for coverage in a qualified health plan.

(d) Facilitate selection of eligible individuals in a qualified health plan.

(e) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population served by the exchange.

(f) Refer an individual with limited English proficiency to a navigator, insurance producer, or other source of assistance.

(4) A certified application counselor shall not do any of the following:

(a) Sell, solicit, or negotiate health insurance.

(b) Recommend a particular qualified health benefit plan.

(c) Provide any information or services related to insurance regulated under this act other than qualified health benefit plans or other products offered in the exchange.

(5) Before providing services to or acting for an individual under subsection (3), a certified application counselor shall disclose any potential conflict of interest to the individual.

History: Add. 2014, Act 566, Imd. Eff. Jan. 15, 2015.

Compiler's note: Enacting section 1 of Act 566 of 2014 provides:

"Enacting section 1. (1) This amendatory act shall not be construed to do any of the following:

(a) Authorize this state or an agency of this state to conduct or oversee state-level governmental consumer assistance functions for an American health benefit exchange established or operating in this state under the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(b) Convey any administrative, statutory, rule-making, or other power to this state or an agency of this state to authorize, establish, or operate an American health benefit exchange in this state that did not exist before the effective date of this amendatory act.

(2) It is the intent of this legislature that any consumer assistance functions by or overseen by this state or an agency of this state with regard to an American health benefit exchange shall be conducted in a manner that utilizes and highlights Michigan-based resources, including insurance producers, in order to best serve the residents of this state and to ensure appropriate health care decisions."

Enacting section 2 of Act 566 of 2014 provides:

"Enacting section 2. This amendatory act applies to policies, certificates, or contracts delivered, issued for delivery, or renewed in this state on and after the effective date of this amendatory act."

Popular name: Act 218

500.1263 Navigator certificate or certified application counselor certificate; application; statement; approval; criteria; training and testing program; business entity acting as navigator or certified application counselor; certificate required; verification of information; document production.

Sec. 1263. (1) An individual applying for a navigator certificate shall file with the director the uniform application required by the director and shall declare under penalty of refusal, suspension, or revocation of the navigator certificate that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. An application for a navigator certificate shall not be approved unless the director finds that the individual meets all of the following criteria:

(a) Is at least 18 years of age.

(b) Has not committed an act listed that would be a ground for denial, suspension, or revocation of an insurance producer's license in section 1239(1).

(c) Has completed all required training courses under section 1262.

(d) Has paid the fees required by the director.

(e) Has successfully passed any required examination.

(f) Has successfully completed a criminal history check under section 1262.

(2) An individual applying for a certified application counselor certificate shall file with the director the uniform application required by the director and shall declare under penalty of refusal, suspension, or revocation of the certified application counselor certificate that the statements made in the application are

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true, correct, and complete to the best of the individual's knowledge and belief. An application for a certified application counselor certificate shall not be approved unless the director finds that the individual meets all of the following criteria:

(a) Is at least 18 years of age.

(b) Has not committed an act listed that would be a ground for denial, suspension, or revocation of an insurance producer's license in section 1239(1).

(c) Has completed the entire United States department of health and human services training for certified application counselors, has successfully completed all testing, and has received certification as a certified application counselor from the federal government.

(d) Has paid the fees required by the director.

(e) Has successfully completed a criminal history check using the department of state police's internet criminal history access tool (ICHAT).

(3) If the United States department of health and human services discontinues the training and testing program for certified application counselors, the director shall create a training and testing program for certified application counselors regarding qualified health plan options, insurance affordability programs, eligibility, and benefit rules, and regulations governing all insurance affordability programs operated in this state.

(4) A business entity acting as a navigator or certified application counselor shall obtain a certificate. A business entity applying for a certificate shall file with the director the uniform business entity application required by the director. An application for a certificate under this subsection shall not be approved unless the director finds that the business entity meets all of the following:

(a) The business entity has paid the fees required by the director.

(b) The business entity has designated an individual certificate holder responsible for the business entity's compliance with this chapter.

(c) The business entity has not committed an act listed in section 1239(1).

(5) The director may require the production of any documents reasonably necessary to verify the information contained in an application.

History: Add. 2014, Act 566, Imd. Eff. Jan. 15, 2015.

Compiler's note: Enacting section 1 of Act 566 of 2014 provides:

"Enacting section 1. (1) This amendatory act shall not be construed to do any of the following:

(a) Authorize this state or an agency of this state to conduct or oversee state-level governmental consumer assistance functions for an American health benefit exchange established or operating in this state under the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(b) Convey any administrative, statutory, rule-making, or other power to this state or an agency of this state to authorize, establish, or operate an American health benefit exchange in this state that did not exist before the effective date of this amendatory act.

(2) It is the intent of this legislature that any consumer assistance functions by or overseen by this state or an agency of this state with regard to an American health benefit exchange shall be conducted in a manner that utilizes and highlights Michigan-based resources, including insurance producers, in order to best serve the residents of this state and to ensure appropriate health care decisions."

Enacting section 2 of Act 566 of 2014 provides:

"Enacting section 2. This amendatory act applies to policies, certificates, or contracts delivered, issued for delivery, or renewed in this state on and after the effective date of this amendatory act."

Popular name: Act 218

500.1264 Probation, suspension, revocation, or denial of certificate; refusal to issue; civil fine; examination of books and records.

Sec. 1264. (1) In addition to any other powers under this act, the director may place on probation, suspend, or revoke a certificate or may levy a civil fine under section 1270 or any combination of actions, and the director shall refuse to issue a certificate under section 1263, for any 1 or more causes that would be a ground for refusal, suspension, or revocation of an insurance producer's license under section 1239. The director may revoke a certificate of a person or refuse to issue a certificate for a person that receives financial compensation, including monetary and in-kind compensation, gifts, or any compensation related to enrollment from an insurer offering qualified health benefits through an exchange operating in this state. The director may deny, suspend, approve, renew, or revoke a certificate if the director considers it necessary to protect insureds and the public.

(2) The certificate of a business entity may be suspended, revoked, or refused if the director finds, after hearing, that an individual certificate holder's violation was known or should have been known by 1 or more of the partners, officers, or managers acting on behalf of the business entity and the violation was neither reported to the director nor corrective action taken.

(3) The director may examine the books and records of a certificate holder to determine whether the certificate holder is conducting its business in accordance with this chapter. For the purpose of facilitating the

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examination, the certificate holder shall allow the director free access, at reasonable times, to all of the certificate holder's books and records relating to transactions to which this chapter applies.

History: Add. 2014, Act 566, Imd. Eff. Jan. 15, 2015.

Compiler's note: Enacting section 1 of Act 566 of 2014 provides:

"Enacting section 1. (1) This amendatory act shall not be construed to do any of the following:

(a) Authorize this state or an agency of this state to conduct or oversee state-level governmental consumer assistance functions for an American health benefit exchange established or operating in this state under the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(b) Convey any administrative, statutory, rule-making, or other power to this state or an agency of this state to authorize, establish, or operate an American health benefit exchange in this state that did not exist before the effective date of this amendatory act.

(2) It is the intent of this legislature that any consumer assistance functions by or overseen by this state or an agency of this state with regard to an American health benefit exchange shall be conducted in a manner that utilizes and highlights Michigan-based resources, including insurance producers, in order to best serve the residents of this state and to ensure appropriate health care decisions."

Enacting section 2 of Act 566 of 2014 provides:

"Enacting section 2. This amendatory act applies to policies, certificates, or contracts delivered, issued for delivery, or renewed in this state on and after the effective date of this amendatory act."

Popular name: Act 218

500.1265 List of individual certificate holders.

Sec. 1265. A business entity issued a certificate shall, in a manner prescribed by the director, make available a list of all individual certificate holders that the business entity employs or supervises or with which the business entity is otherwise affiliated.

History: Add. 2014, Act 566, Imd. Eff. Jan. 15, 2015.

Compiler's note: Enacting section 1 of Act 566 of 2014 provides:

"Enacting section 1. (1) This amendatory act shall not be construed to do any of the following:

(a) Authorize this state or an agency of this state to conduct or oversee state-level governmental consumer assistance functions for an American health benefit exchange established or operating in this state under the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(b) Convey any administrative, statutory, rule-making, or other power to this state or an agency of this state to authorize, establish, or operate an American health benefit exchange in this state that did not exist before the effective date of this amendatory act.

(2) It is the intent of this legislature that any consumer assistance functions by or overseen by this state or an agency of this state with regard to an American health benefit exchange shall be conducted in a manner that utilizes and highlights Michigan-based resources, including insurance producers, in order to best serve the residents of this state and to ensure appropriate health care decisions."

Enacting section 2 of Act 566 of 2014 provides:

"Enacting section 2. This amendatory act applies to policies, certificates, or contracts delivered, issued for delivery, or renewed in this state on and after the effective date of this amendatory act."

Popular name: Act 218

500.1266 Termination of relationship with individual certificate holder by business entity; notice to director.

Sec. 1266. A business entity that terminates the employment, engagement, affiliation, or other relationship with an individual certificate holder shall notify the director using a format prescribed by the director of the termination within 30 days following the effective date of the termination if the reason for termination is 1 of the reasons listed in section 1239(1) or the business entity has knowledge the individual was found by a court or government body to have engaged in any of the activities listed in section 1239(1).

History: Add. 2014, Act 566, Imd. Eff. Jan. 15, 2015.

Compiler's note: Enacting section 1 of Act 566 of 2014 provides:

"Enacting section 1. (1) This amendatory act shall not be construed to do any of the following:

(a) Authorize this state or an agency of this state to conduct or oversee state-level governmental consumer assistance functions for an American health benefit exchange established or operating in this state under the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(b) Convey any administrative, statutory, rule-making, or other power to this state or an agency of this state to authorize, establish, or operate an American health benefit exchange in this state that did not exist before the effective date of this amendatory act.

(2) It is the intent of this legislature that any consumer assistance functions by or overseen by this state or an agency of this state with regard to an American health benefit exchange shall be conducted in a manner that utilizes and highlights Michigan-based resources, including insurance producers, in order to best serve the residents of this state and to ensure appropriate health care decisions."

Enacting section 2 of Act 566 of 2014 provides:

"Enacting section 2. This amendatory act applies to policies, certificates, or contracts delivered, issued for delivery, or renewed in this state on and after the effective date of this amendatory act."

Popular name: Act 218

500.1268 Mailing and electronic mail address; mailing of notice or process.

Sec. 1268. (1) When applying for a certificate, the applicant shall report his or her mailing and electronic mail address to the director. A certificate holder shall notify the director of a change in his or her mailing or electronic mail address within 30 days after the change. The director shall maintain the mailing and electronic

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mail address of each certificate holder on file.

(2) A notice of hearing or service of process may be served upon a certificate holder in an action or proceeding for a violation of this act by mailing the notice or process by first-class mail to the certificate holder's mailing address reported to the director under subsection (1).

History: Add. 2014, Act 566, Imd. Eff. Jan. 15, 2015.

Compiler's note: Enacting section 1 of Act 566 of 2014 provides:

"Enacting section 1. (1) This amendatory act shall not be construed to do any of the following:

(a) Authorize this state or an agency of this state to conduct or oversee state-level governmental consumer assistance functions for an American health benefit exchange established or operating in this state under the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(b) Convey any administrative, statutory, rule-making, or other power to this state or an agency of this state to authorize, establish, or operate an American health benefit exchange in this state that did not exist before the effective date of this amendatory act.

(2) It is the intent of this legislature that any consumer assistance functions by or overseen by this state or an agency of this state with regard to an American health benefit exchange shall be conducted in a manner that utilizes and highlights Michigan-based resources, including insurance producers, in order to best serve the residents of this state and to ensure appropriate health care decisions."

Enacting section 2 of Act 566 of 2014 provides:

"Enacting section 2. This amendatory act applies to policies, certificates, or contracts delivered, issued for delivery, or renewed in this state on and after the effective date of this amendatory act."

Popular name: Act 218

500.1269 Refusal of director to grant certificate; notice; hearing; suspension or revocation of certificate; summary suspension; witness and production of documents; subpoenas.

Sec. 1269. (1) The director shall refuse to grant a certificate to an applicant who fails to meet the requirements of this chapter. Notice of the refusal shall be in writing and shall set forth the basis for the refusal. If the applicant submits a written request within 30 days after mailing of the notice of refusal, the director shall promptly conduct a hearing in which the applicant shall be given an opportunity to show compliance with the requirements of this chapter.

(2) The director, after notice of and opportunity for a hearing, may suspend or revoke a certificate of a certificate holder who fails to maintain the standards required for initial certification or who violates this act.

(3) Without prior hearing, the director may order summary suspension of a certificate if he or she finds that protection of the public requires emergency action and incorporates this finding in his or her order. The suspension shall be effective on the date specified in the order or upon service of a certified copy of the order on the certificate holder, whichever is later. If requested, the director shall conduct a hearing on the suspension within a reasonable time but not later than 20 days after the effective date of the summary suspension unless the person whose certificate is suspended requests a later date. At the hearing, the director shall determine if the suspension should be continued or if the suspension should be withdrawn, and, if proper notice is given, may determine if the certificate should be revoked. The director shall announce his or her decision within 30 days after conclusion of the hearing. The suspension shall continue until the decision is announced.

(4) The director, or his or her designated deputy, may issue subpoenas to require the attendance and testimony of witnesses and the production of documents necessary to the conduct of the hearing and may designate a department employee to make service. The subpoenas issued by the director, or his or her designated deputy, may be enforced upon petition to the circuit court of Ingham county to show cause why a contempt order should not be issued, as provided by law.

History: Add. 2014, Act 566, Imd. Eff. Jan. 15, 2015.

Compiler's note: Enacting section 1 of Act 566 of 2014 provides:

"Enacting section 1. (1) This amendatory act shall not be construed to do any of the following:

(a) Authorize this state or an agency of this state to conduct or oversee state-level governmental consumer assistance functions for an American health benefit exchange established or operating in this state under the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(b) Convey any administrative, statutory, rule-making, or other power to this state or an agency of this state to authorize, establish, or operate an American health benefit exchange in this state that did not exist before the effective date of this amendatory act.

(2) It is the intent of this legislature that any consumer assistance functions by or overseen by this state or an agency of this state with regard to an American health benefit exchange shall be conducted in a manner that utilizes and highlights Michigan-based resources, including insurance producers, in order to best serve the residents of this state and to ensure appropriate health care decisions."

Enacting section 2 of Act 566 of 2014 provides:

"Enacting section 2. This amendatory act applies to policies, certificates, or contracts delivered, issued for delivery, or renewed in this state on and after the effective date of this amendatory act."

Popular name: Act 218

500.1270 Violation of chapter; findings and decision; order; violation of cease and desist order; civil fine; injunction.

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Sec. 1270. (1) If the director finds that a person has violated this chapter, after an opportunity for a hearing under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director shall reduce the findings and decision to writing and shall issue and cause to be served upon the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from the violation. In addition, the director may order any of the following:

(a) Payment of a civil fine of not more than $500.00 for each violation. However, if the person knew or reasonably should have known that he or she was in violation of this chapter, the director may order the payment of a civil fine of not more than $2,500.00 for each violation. An order of the director under this subsection shall not require the payment of civil fines exceeding $25,000.00. A fine collected under this subdivision shall be turned over to the state treasurer and credited to the general fund of this state.

(b) The suspension or revocation of the certificate.

(2) The director may by order, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued under this section, if in the opinion of the director conditions of fact or of law have changed to require that action, or if the public interest requires that action.

(3) If a person knowingly violates a cease and desist order under this chapter and has been given notice and an opportunity for a hearing held under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director may order a civil fine of not more than $10,000.00 for each violation, or a suspension or revocation of the certificate, or both. An order issued by the director under this subsection shall not require the payment of civil fines exceeding $50,000.00. A fine collected under this subsection shall be turned over to the state treasurer and credited to the general fund of this state.

(4) The director may apply to the circuit court of Ingham county for an order of the court enjoining a violation of this chapter.

History: Add. 2014, Act 566, Imd. Eff. Jan. 15, 2015.

Compiler's note: Enacting section 1 of Act 566 of 2014 provides:

"Enacting section 1. (1) This amendatory act shall not be construed to do any of the following:

(a) Authorize this state or an agency of this state to conduct or oversee state-level governmental consumer assistance functions for an American health benefit exchange established or operating in this state under the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(b) Convey any administrative, statutory, rule-making, or other power to this state or an agency of this state to authorize, establish, or operate an American health benefit exchange in this state that did not exist before the effective date of this amendatory act.

(2) It is the intent of this legislature that any consumer assistance functions by or overseen by this state or an agency of this state with regard to an American health benefit exchange shall be conducted in a manner that utilizes and highlights Michigan-based resources, including insurance producers, in order to best serve the residents of this state and to ensure appropriate health care decisions."

Enacting section 2 of Act 566 of 2014 provides:

"Enacting section 2. This amendatory act applies to policies, certificates, or contracts delivered, issued for delivery, or renewed in this state on and after the effective date of this amendatory act."

Popular name: Act 218

500.1271 Citizen complaints; report.

Sec. 1271. The director shall develop and implement a process for receipt, investigation, and referral to a federal exchange of citizen complaints regarding navigators and certified application counselors. The director shall submit an annual report that describes this process to the standing committees of the senate and house of representatives with jurisdiction of health policy.

History: Add. 2014, Act 566, Imd. Eff. Jan. 15, 2015.

Compiler's note: Enacting section 1 of Act 566 of 2014 provides:

"Enacting section 1. (1) This amendatory act shall not be construed to do any of the following:

(a) Authorize this state or an agency of this state to conduct or oversee state-level governmental consumer assistance functions for an American health benefit exchange established or operating in this state under the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(b) Convey any administrative, statutory, rule-making, or other power to this state or an agency of this state to authorize, establish, or operate an American health benefit exchange in this state that did not exist before the effective date of this amendatory act.

(2) It is the intent of this legislature that any consumer assistance functions by or overseen by this state or an agency of this state with regard to an American health benefit exchange shall be conducted in a manner that utilizes and highlights Michigan-based resources, including insurance producers, in order to best serve the residents of this state and to ensure appropriate health care decisions."

Enacting section 2 of Act 566 of 2014 provides:

"Enacting section 2. This amendatory act applies to policies, certificates, or contracts delivered, issued for delivery, or renewed in this state on and after the effective date of this amendatory act."

Popular name: Act 218

500.1272 Construction of chapter.

Sec. 1272. This chapter does not authorize or shall not be construed to authorize the establishment or operation of an American health benefit exchange in this state under the affordable care act.

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History: Add. 2014, Act 566, Imd. Eff. Jan. 15, 2015.

Compiler's note: Enacting section 1 of Act 566 of 2014 provides:

"Enacting section 1. (1) This amendatory act shall not be construed to do any of the following:

(a) Authorize this state or an agency of this state to conduct or oversee state-level governmental consumer assistance functions for an American health benefit exchange established or operating in this state under the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(b) Convey any administrative, statutory, rule-making, or other power to this state or an agency of this state to authorize, establish, or operate an American health benefit exchange in this state that did not exist before the effective date of this amendatory act.

(2) It is the intent of this legislature that any consumer assistance functions by or overseen by this state or an agency of this state with regard to an American health benefit exchange shall be conducted in a manner that utilizes and highlights Michigan-based resources, including insurance producers, in order to best serve the residents of this state and to ensure appropriate health care decisions."

Enacting section 2 of Act 566 of 2014 provides:

"Enacting section 2. This amendatory act applies to policies, certificates, or contracts delivered, issued for delivery, or renewed in this state on and after the effective date of this amendatory act."

Popular name: Act 218

CHAPTER 12B
TRAVEL INSURANCE

500.1281 Scope of chapter.

Sec. 1281. This chapter applies to travel insurance that covers a resident of this state and is sold, solicited, negotiated, or offered in this state and for which policies and certificates are delivered or issued for delivery in this state. Except as otherwise provided in this chapter, this chapter does not apply to cancellation fee waivers and travel assistance services.

History: Add. 2020, Act 266, Imd. Eff. Dec. 29, 2020.

Popular name: Act 218

500.1283 Definitions.

Sec. 1283. As used in this chapter:

(a) "Aggregator site" means a website that provides access to information regarding insurance products from more than 1 insurer, including product and insurer information, for use in comparison shopping.

(b) "Blanket travel insurance" means a policy of travel insurance issued to any eligible group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the eligible group without a separate charge to individual members of the eligible group.

(c) "Cancellation fee waiver" means a contractual agreement between a supplier of travel services and its customer to waive some or all of the nonrefundable cancellation fee provisions of the supplier's underlying travel contract with or without regard to the reason for the cancellation or form of reimbursement. A cancellation fee waiver is not insurance.

(d) "Eligible group" means 2 or more persons that are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship, including, but not limited to, any of the following:

(*i*) Persons engaged in the business of providing travel or travel services, including, but not limited to, tour operators, lodging providers, vacation property owners, hotels and resorts, travel clubs, travel agencies, property managers, cultural exchange programs, and common carriers or the operators, owners, or lessors of a means of transportation of passengers, including, but not limited to, airlines, cruise lines, railroads, steamship companies, and public bus carriers, in which, with regard to any particular travel or type of travel or travelers, all members or customers of the group must have a common exposure to risk attendant to the travel.

(*ii*) Colleges, schools, or other institutions of learning covering students, teachers or employees, or volunteers.

(*iii*) Employers covering a group of employees, volunteers, contractors, board of directors, dependents, or guests.

(*iv*) Sports teams, camps, or sponsors of sports teams or camps covering participants, members, campers, employees, officials, supervisors, or volunteers.

(*v*) Religious, charitable, recreational, educational, or civic organizations or branches of religious, charitable, recreational, educational, or civic organizations covering any group of members, participants, or volunteers.

(*vi*) Financial institutions or financial institution vendors, or parent holding company, trustee, or agent of or designated by 1 or more financial institutions or financial institution vendors, including account holders, credit card holders, debtors, guarantors, or purchasers.

(*vii*) Incorporated or unincorporated associations, including labor unions, having a common interest, constitution, and bylaws, and organized and maintained in good faith for purposes other than obtaining insurance for members or participants of the association covering its members.

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(*viii*) A trust or the trustees of a fund established, created, or maintained for the benefit of and covering members, employees, or customers, subject to the director's permitting the use of a trust and the premium tax under section 1285, of 1 or more associations described in subparagraph (*vii*).

(*ix*) Entertainment production companies covering a group of participants, volunteers, audience members, contestants, or workers.

(*x*) Volunteer fire departments, ambulance, rescue, police, or court, or any first aid, civil defense, or other volunteer groups.

(*xi*) Preschools, daycare institutions for children or adults, and senior citizen clubs.

(*xii*) Automobile or truck rental or leasing companies covering a group of individuals who may become renters, lessees, or passengers defined by their travel status on the rented or leased vehicles. The common carrier, the operator, owner, or lessor of a means of transportation, or the automobile or truck rental or leasing company is the policyholder under a policy to which this subparagraph applies.

(*xiii*) Any other group as to which the director has determined that the members are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship, and that issuance of the policy would not be contrary to the public interest.

(e) "Fulfillment materials" means documentation sent to the purchaser of a travel protection plan confirming the purchase and providing the travel protection plan's coverage and assistance details.

(f) "Group travel insurance" means travel insurance issued to any eligible group.

(g) "Primary certificate holder" means an individual who elects and purchases travel insurance under a group policy.

(h) "Primary policyholder" means an individual who elects and purchases individual travel insurance.

(i) "Travel assistance services" means noninsurance services for which the consumer is not indemnified based on a fortuitous event, and as to which providing the service does not result in the transfer or shifting of risk that would constitute the business of insurance. Travel assistance services include, but are not limited to, security advisories, destination information, vaccination and immunization information services, travel reservation services, entertainment, activity and event planning, translation assistance, emergency messaging, international legal and medical referrals, medical case monitoring, coordination of transportation arrangements, emergency cash transfer assistance, medical prescription replacement assistance, passport and travel document replacement assistance, lost luggage assistance, concierge services, and any other service that is furnished in connection with planned travel. Travel assistance services are not insurance and not related to insurance.

(j) "Travel insurance" means that term as defined in section 1202.

(k) "Travel protection plans" means plans that provide 1 or more of the following:

(*i*) Travel insurance.

(*ii*) Travel assistance services.

(*iii*) Cancellation fee waivers.

History: Add. 2020, Act 266, Imd. Eff. Dec. 29, 2020.

Popular name: Act 218

500.1285 Payment of premium tax on travel insurance premiums; travel insurer duties.

Sec. 1285. (1) A travel insurer shall pay a premium tax, as provided in section 635 of the income tax act of 1967, 1967 PA 281, MCL 206.635, on travel insurance premiums paid by any of the following:

(a) An individual primary policyholder who is a resident of this state.

(b) A primary certificate holder who is a resident of this state who elects coverage under a group travel insurance policy.

(c) A blanket travel insurance policyholder that is a resident in, or has its principal place of business or the principal place of business of an affiliate or subsidiary that has purchased blanket travel insurance in, this state for eligible blanket group members, subject to any apportionment rules that apply to the insurer across multiple taxing jurisdictions or that permits the insurer to allocate premium on an apportioned basis in a reasonable and equitable manner in those jurisdictions.

(2) A travel insurer shall do both of the following:

(a) Document the state of residence or principal place of business of the policyholder or certificate holder, as required in subsection (1).

(b) Report as premium only the amount allocable to travel insurance and not any amounts received for travel assistance services or cancellation fee waivers.

History: Add. 2020, Act 266, Imd. Eff. Dec. 29, 2020.

Popular name: Act 218

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500.1287 Travel protection plans; requirements.

Sec. 1287. Travel protection plans may be offered for 1 price for the combined features that the travel protection plan offers in this state if both of the following conditions are met:

(a) The travel protection plan clearly discloses to the consumer at or before the time of purchase that it includes travel insurance, travel assistance services, and cancellation fee waivers, as applicable, and provides information and an opportunity at or before the time of purchase for the consumer to obtain additional information regarding the features and pricing of each.

(b) The fulfillment materials do both of the following:

(*i*) Describe and delineate the travel insurance, travel assistance services, and cancellation fee waivers in the travel protection plan.

(*ii*) Include the travel insurance disclosures and the contact information for persons providing travel assistance services and cancellation fee waivers, as applicable.

History: Add. 2020, Act 266, Imd. Eff. Dec. 29, 2020.

Popular name: Act 218

500.1289 Offering or selling travel insurance; subject to unfair and prohibited trade practices and frauds; fulfillment materials; cancellation policy.

Sec. 1289. (1) Except as otherwise provided in this section, a person that offers travel insurance to residents of this state is subject to chapter 20. If there is a conflict between this chapter and other provisions of this act regarding the sale and marketing of travel insurance and travel protection plans, this chapter controls.

(2) Offering or selling a travel insurance policy that could never result in payment of any claims for an insured under the policy is an unfair trade practice under chapter 20.

(3) All documents provided to consumers before the purchase of travel insurance, including, but not limited to, sales materials, advertising materials, and marketing materials, must be consistent with the travel insurance policy, including, but not limited to, forms, endorsements, policies, rate filings, and certificates of insurance.

(4) For travel insurance policies or certificates that contain preexisting condition exclusions, information and an opportunity to learn more about the preexisting condition exclusions must be provided any time before the time of purchase, and in the coverage's fulfillment materials.

(5) The fulfillment materials must be provided to a policyholder or certificate holder as soon as practicable following the purchase of a travel protection plan. Unless the insured has either started a covered trip or filed a claim under the travel insurance coverage, a policyholder or certificate holder may cancel a policy or certificate for a full refund of the travel protection plan price from the date of purchase of the travel protection plan until at least either of the following:

(a) Fifteen days following the date of delivery of the travel protection plan's fulfillment materials by postal mail.

(b) Ten days following the date of delivery of the travel protection plan's fulfillment materials by means other than postal mail.

(6) A company shall disclose in the policy documentation and fulfillment materials whether the travel insurance is primary or secondary to other applicable coverage.

(7) If travel insurance is marketed directly to a consumer through an insurer's website or by others through an aggregator site, it is not an unfair trade practice or other violation of law if both of the following apply:

(a) An accurate summary or short description of coverage is provided on the webpage.

(b) If the consumer has access to the full provisions of the policy through electronic means.

(8) A person that offers, solicits, or negotiates travel insurance or travel protection plans on an individual or group basis shall not use a negative option or opt-out, that would require a consumer to take an affirmative action to deselect coverage, such as unchecking a box on an electronic form when the consumer purchases a trip.

(9) If a consumer's destination jurisdiction requires insurance coverage, it is not an unfair trade practice to require that a consumer choose between any of the following options as a condition of purchasing a trip or travel package:

(a) Purchasing the coverage required by the destination jurisdiction through the travel insurance producer supplying the trip or travel package.

(b) Agreeing to obtain and provide proof of coverage that meets the destination jurisdiction's requirements before departure.

(10) As used in this section, "delivery" means handing fulfillment materials to the policyholder or certificate holder or sending fulfillment materials by postal mail or electronic means to the policyholder or

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certificate holder.

History: Add. 2020, Act 266, Imd. Eff. Dec. 29, 2020.

Popular name: Act 218

500.1291 Classification of travel insurance; inland marine line of insurance; eligibility and underwriting standards.

Sec. 1291. (1) Notwithstanding any other provision of this act, travel insurance is classified and must be filed for purposes of rates and forms under an inland marine line of insurance. However, travel insurance that provides coverage for sickness, accident, disability, or death occurring during travel, either exclusively or in conjunction with related coverages of emergency evacuation or repatriation of remains, or incidental limited property and casualty benefits such as baggage or trip cancellation, may be filed by an authorized insurer under either an accident and health line of insurance or an inland marine line of insurance.

(2) Travel insurance may be in the form of an individual, group, or blanket policy.

(3) Eligibility and underwriting standards for travel insurance may be developed and provided based on travel protection plans designed for individual or identified marketing or distribution channels, if those standards also meet this state's underwriting standards for inland marine.

History: Add. 2020, Act 266, Imd. Eff. Dec. 29, 2020.

Popular name: Act 218

CHAPTER 13
HOLDING COMPANIES

500.1301 Insurance holding companies; definitions.

Sec. 1301. As used in this chapter:

(a) "Enterprise risk" means an activity, circumstance, event, or series of events involving 1 or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect on the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer to be hazardous to policyholders, creditors, and the public.

(b) "Group-wide supervisor" means the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the director under section 1359 to have sufficient contacts with the internationally active insurance group.

(c) "Insurer" means that term as defined in section 106 and includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373. Insurer does not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the commonwealth of Puerto Rico, the District of Columbia or a state or political subdivision of a state, fraternal benefit societies, or nonprofit health care corporations.

(d) "Internationally active insurance group" means an insurance holding company system to which both of the following apply:

(*i*) The insurance holding company system includes an insurer registered under section 1324.

(*ii*) The insurance holding company system meets all of the following criteria:

(A) The insurance holding company system has premiums written in at least 3 countries.

(B) The percentage of gross premiums written outside the United States is at least 10% of the insurance holding company system's total gross written premiums.

(C) Based on a 3-year rolling average, the total assets of the insurance holding company system are at least $50,000,000,000.00 or the total gross written premiums of the insurance holding company system are at least $10,000,000,000.00.

(e) "Lead state commissioner" means the insurance commissioner of the state in which an insurer member of an insurance holding company system is domiciled and that is determined to be the lead state under the procedures in the Financial Analysis Handbook, as adopted by the director.

(f) "NAIC" means the National Association of Insurance Commissioners.

(g) "NAIC Liquidity Stress Test Framework" means a separate NAIC publication that includes all of the following components:

(*i*) A history of the NAIC's development of regulatory liquidity stress testing.

(*ii*) The liquidity stress test instructions and reporting templates and scope criteria for a specified data year, which are adopted by the NAIC and amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(h) "Person" means that term as defined in section 114, except that it does not include a securities broker

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that does not perform more than the usual and customary broker's function, so long as the securities broker holds less than 10% of the voting securities of an insurer or of any person that controls an insurer.

(i) "Scope criteria" means, as detailed in the NAIC Liquidity Stress Test Framework, the designated exposure bases and their minimum magnitudes for a specified data year that are used to establish a preliminary list of insurers considered scoped into the NAIC Liquidity Stress Test Framework for that data year.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2015, Act 244, Imd. Eff. Dec. 22, 2015;—Am. 2020, Act 16, Imd. Eff. Jan. 27, 2020;—Am. 2022, Act 258, Eff. Mar. 29, 2023.

Popular name: Act 218

500.1305 Domestic insurers; organization or acquisition of subsidiaries; book of business; value; admitted asset; limitation; amortization; annual test; definition; authority of commissioner.

Sec. 1305. (1) A domestic insurer, either by itself or in cooperation with 1 or more persons, may organize or acquire 1 or more subsidiaries if consistent with other provisions of this act. These subsidiaries may conduct any kind of business and their authority to do so shall not be limited by reason of the fact that they are subsidiaries of a domestic insurer. This provision shall not be construed to provide authority for conduct or activities by these subsidiaries that would otherwise be inconsistent with other provisions of this act.

(2) Except as otherwise provided in subsection (3), if a domestic insurer acquires through a business acquisition or a reinsurance transaction a book of business that includes life insurance or other business written by a life insurance company, and the book of business has a readily determinable market value represented by the present value of the future after-tax profits that will be earned on the book of business in force at the date of the acquisition, the value of the book of business acquired, above any amount previously recognized as an admitted asset under this section or that may be permitted under accounting practices and procedures designated by the commissioner under section 438, may be recognized with the prior approval of the commissioner as an admitted asset in the annual statement filed pursuant to section 438. The commissioner shall make a determination regarding the admissibility of this asset within 60 days after receiving a filing with supporting documentation, in a form satisfactory to the commissioner, from the domestic insurer requesting such approval.

(3) Notwithstanding subsection (2), a domestic insurer may recognize as an admitted asset in the annual statement filed pursuant to section 438 the value of a book of business described in subsection (2) without the prior approval of the commissioner, if the domestic insurer files a written notice with the commissioner of its intent to record the value of the book of business acquired as an admitted asset and provides a certification by an officer of the domestic insurer that, as of the date of the notice, the domestic insurer meets all of the following criteria:

(a) The insurer's most recent a.m. best financial rating is at least an "A".

(b) The insurer has at least 1 additional rating of at least an "A" or its equivalent, as assigned by a rating organization included on the national association of insurance commissioners' list of nationally recognized statistical organizations and approved by the commissioner.

(c) Following the acquisition or reinsurance transaction, the insurer will possess a minimum capital and surplus of at least $1,000,000,000.00, excluding from the insurer's capital and surplus the pro forma effect of the total value of the book of business to be recognized as an admitted asset by the domestic insurer.

(d) The insurer's total adjusted risk based capital exceeds 5 times the company's authorized control level risk based capital.

(e) The insurer's certificate of authority has not been suspended, revoked, or limited under section 436 at any time during the 5-year period immediately preceding the acquisition or reinsurance transaction.

(f) The insurer is not subject to an analyst team system level A or B designation by the national association of insurance commissioners for the year immediately preceding the acquisition or reinsurance transaction.

(g) Following the acquisition or reinsurance transaction, the insurer will meet the asset requirement under section 901.

(4) The value of the book of business acquired as described in subsection (2) that a domestic insurer may recognize as an admitted asset shall not exceed the lesser of 50% of capital and surplus or the following:

(a) Twenty percent of that adjusted capital and surplus that is less than or equal to 500% of authorized control level risk based capital, plus

(b) Eighty-five percent of that adjusted capital and surplus that is greater than 500%, but less than or equal to 600%, of authorized control level risk based capital, plus

(c) Ninety-five percent of that adjusted capital and surplus that is greater than 600%, but less than or equal to 700%, of authorized control level risk based capital, plus

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(d) One hundred percent of that adjusted capital and surplus that is greater than 700% of authorized control level risk based capital.

(5) The value of the book of business acquired as described in subsection (2) shall be amortized pursuant to accounting practices and procedures designated by the commissioner under section 438. The value of the book of business acquired in excess of the amount allowable under this section shall not be an admitted asset in the annual statement filed pursuant to section 438.

(6) A domestic insurer that recognizes as an admitted asset in the annual statement filed pursuant to section 438 any value of business acquired shall annually test the value of the asset for impairment as part of the asset adequacy testing and shall reference this testing in the opinion filed under section 830a.

(7) As used in subsection (4), "adjusted capital and surplus" means capital and surplus as of December 31 of the immediately preceding year, adjusted to exclude any net positive goodwill exclusive of any component of the goodwill relating to the existing value of the book of business acquired, electronic data processing equipment, operating system software, and net deferred tax assets.

(8) Nothing in this section shall be construed to limit the commissioner's authority under sections 436 and 436a.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2006, Act 55, Imd. Eff. Mar. 9, 2006.

Popular name: Act 218

500.1311 Merging with or acquiring control of domestic insurer; statement; filing confidential notice of proposed divestiture; notice by person proposing to merge or acquire control of domestic insurer; "domestic insurer" explained.

Sec. 1311. (1) A person other than the issuer shall not make a tender offer for or a request or invitation for tenders of, or enter into an agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, a voting security of a domestic insurer if, after the consummation thereof, the person directly or indirectly, or by conversion or by exercise of a right to acquire, would be in control of the insurer. A person shall not enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time an offer, request, or invitation is made or an agreement is entered into, or before the acquisition of the securities if no offer or agreement is involved, the person has filed with the director and has sent to the insurer, which has sent to its shareholders, a statement containing the information required by this chapter and the offer, request, invitation, agreement, or acquisition has been approved by the director in the manner prescribed in this chapter.

(2) If a person has not filed a statement under subsection (1), a controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the director, with a copy to the insurer, a confidential notice of its proposed divestiture at least 30 days before the cessation of control. The director shall determine those instances in which the person or persons seeking to divest or to acquire a controlling interest in an insurer are required to file to obtain approval of the transaction. The information must remain confidential until the conclusion of the transaction unless the director determines that confidential treatment will interfere with enforcement of this section.

(3) The person who proposes to enter into an agreement to merge with or otherwise acquire control of a domestic insurer shall file a notice with the director, in a form and containing the information prescribed by applicable rule promulgated or order issued by the director.

(4) For purposes of this section and sections 1312 to 1319, a domestic insurer includes a person controlling a domestic insurer and any foreign insurer whose written insurance premium in this state for each of the most recent 3 years exceeds the premiums written in its state of domicile and whose written premium in this state was 20% or more of its total written premium in each of the most recent 3 years.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1990, Act 85, Imd. Eff. May 29, 1990;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 227, Imd. Eff. June 27, 1994;—Am. 2010, Act 61, Imd. Eff. Apr. 30, 2010;—Am. 2015, Act 244, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1312 Statement filed with director; contents; duties.

Sec. 1312. (1) The statement filed with the director under section 1311(1) shall be made under oath or affirmation and must contain all of the following information:

(a) The name and address of each person by whom or on whose behalf the merger or other acquisition of control described in section 1311 will be effected, hereinafter referred to in this section and section 1315 as the acquiring party. If the person is an individual, his or her principal occupation, all offices and positions held during the past 5 years, any civil judgments against the person for $25,000.00 or more in civil fines or

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penalties or injunctive or other equitable relief, and any conviction of crimes other than minor traffic violations during the past 10 years. If the person is not an individual, a report of the nature of its business operations during the past 5 years or for a lesser period in which the person and any predecessors of the person have been in existence, an informative description of the business intended to be done by the person and the person's subsidiaries, and a list of all individuals who are or who have been selected to become directors or executive officers of the person or who perform or will perform functions appropriate to those positions. The list must include for each individual the individual's principal occupation, all offices and positions held during the past 5 years, any civil judgments against the person for $25,000.00 or more in civil fines or penalties or injunctive or other equitable relief, and any conviction of crimes other than minor traffic violations during the past 10 years.

(b) The source, nature, and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction in which funds were or are to be obtained for the merger or other acquisition, including any pledge of the insurer's stock, or the stock of any of its subsidiaries or controlling affiliates, and the identity of persons furnishing the consideration. If a source of the consideration is a loan made in the lender's ordinary course of business, the identity of the lender must be disclosed but remain confidential if the person filing the statement so requests.

(c) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding 5 fiscal years or for a lesser period in which the acquiring party and any predecessors of the acquiring party have been in existence and similar unaudited information as of a date not earlier than 90 days before the filing of the statement.

(d) Any plans or proposals that each acquiring party may have under consideration concerning the insurer's business operations, including, but not limited to, plans or proposals to liquidate the insurer, to sell its assets, to merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management.

(e) The number of shares of any security described in section 1311 that each acquiring party proposes to acquire, the terms of the offer, request, invitation, agreement, or acquisition described in section 1311, and a statement as to how the proposal's fairness was arrived at.

(f) The amount of each class of a security described in section 1311 that is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party.

(g) A full description of a contract, arrangement, or understanding concerning a security described in section 1311 in which an acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description must identify the persons with whom the contracts, arrangements, or understandings have been entered into.

(h) A description of the purchase of a security described in section 1311 during the 12 calendar months preceding the filing of the statement, by an acquiring party, including the dates of purchase, names of the purchasers, and consideration paid or agreed to be paid for the security.

(i) A description of a recommendation to purchase a security described in section 1311 made during the 12 calendar months preceding the filing of the statement, by an acquiring party or by another person based upon interviews or at the suggestion of the acquiring party.

(j) Copies of all tender offers for, requests or invitations for tenders of, exchange offers for, and agreements to acquire or exchange a security described in section 1311 and additional related distributed soliciting material.

(k) The terms of an agreement, contract, or understanding made with or proposed to be made with a broker-dealer as to solicitation of securities described in section 1311 for tender, and the amount of a fee, commission, or other compensation to be paid to a broker-dealer.

(*l*) Additional information that the director prescribes by order or rule as necessary or appropriate for the protection of the insurer's policyholders and securityholders or in the public interest.

(2) A person required to file the statement described in section 1311 shall do all of the following:

(a) File the annual enterprise risk report under section 1325a, for as long as control exists.

(b) Provide, and ensure that all subsidiaries within its control in the insurance holding company system will provide, information to the director on request as necessary to evaluate enterprise risk to the insurer.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2015, Act 244, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1313 Partnership, syndicate or other group; statement filed with commissioner,

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amendment.

Sec. 1313. (1) If the person required to file the statement referred to in section 1311 is a partnership, limited partnership, syndicate or other group, the commissioner may require that the information required by section 1312 shall be given with respect to each partner of the partnership or limited partnership, each member of the syndicate or group and each person who controls a partner or member. If any partner, member or person is a corporation or the person required to file the statement referred to in section 1311 is a corporation, the commissioner may require that the information required by section 1312 shall be given with respect to the corporation, each officer and director of the corporation and each person who is directly or indirectly the beneficial owner of more than 10% of the outstanding voting securities of the corporation.

(2) If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer pursuant to section 1311, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the commissioner and sent to the insurer within 2 business days after the person learns of the change. The insurer shall send the amendment to its shareholders.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970.

Popular name: Act 218

500.1314 Alternative filing materials.

Sec. 1314. If any offer, request, invitation, agreement or acquisition referred to in section 1311 is proposed to be made by means of a registration statement under the securities act of 1933 or in circumstances requiring the disclosure of similar information under the securities exchange act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in section 1311 may utilize such documents in furnishing the information called for by that statement.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970.

Popular name: Act 218

500.1315 Merger or acquisition of control; approval by director; public hearing; determination; contested case hearing.

Sec. 1315. (1) The director shall approve a merger or other acquisition of control described in section 1311 of a domestic insurer unless the director determines from information furnished to the director on the merger or other acquisition of control 1 or more of the following:

(a) After the change of control, the domestic insurer described in section 1311 would not be able to satisfy the requirements for the issuance of a certificate of authority to write the types of insurance for which it is presently authorized.

(b) The merger or other acquisition of control would substantially lessen competition in insurance in this state or tend to create a monopoly in this state.

(c) The financial condition of an acquiring party might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders or the interests of a remaining securityholder who is unaffiliated with the acquiring party.

(d) The terms of the offer, request, invitation, agreement, or acquisition described in section 1311 are unfair and unreasonable to the insurer's policyholders or securityholders.

(e) The acquiring party's plan or proposal to liquidate the insurer, sell its assets, consolidate or merge the insurer with a person, or to make any other material change in its business or corporate structure or management, is unfair and unreasonable to the insurer's policyholders, and not in the public interest.

(f) The competence, experience, and integrity of the persons who would control the operation of the insurer are such that it would not be in the interest of the insurer's policyholders or the general public to permit the merger or other acquisition of control.

(g) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

(2) The director may hold a public hearing to receive evidence and to hear parties affected by the merger or acquisition. A hearing under this subsection must be held within 30 days after the filing of a statement under section 1311. The director shall provide notice of the hearing to the person filing the statement at least 20 days before the hearing. Not less than 7 days' notice of the public hearing shall be given by the person filing the statement to the insurer and to any other persons designated by the director. If the proposed acquisition of control will require the approval of more than 1 insurance commissioner, the public hearing may be held on a consolidated basis on request of the person filing the statement or as determined by the director. The director may opt out of a consolidated hearing and shall provide notice to the person who filed the statement under section 1311 of the opt-out within 10 days after the receipt of the statement required by section 1311. A hearing conducted on a consolidated basis must be held within the United States before the commissioners of

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the states in which the insurers are domiciled.

(3) In connection with a change of control of a domestic insurer, a determination by the director that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by this act shall be made not later than 60 days after the date of notification of the change of control submitted under section 1311.

(4) A person aggrieved by the director's order under this section is entitled to a contested case hearing before the director under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. The director shall make a final decision within 30 days after the conclusion of the hearing.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2015, Act 244, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1316 Information to shareholders; expense; bond; examination or investigation.

Sec. 1316. All statements, amendments, or other material filed pursuant to section 1311 or 1312 and all notices of hearings held pursuant to section 1315, shall be mailed by the insurer to its shareholders within 5 business days after the insurer has received them. The expenses of mailing shall be borne by the person making the filing. As security for the payment of the expenses, the person shall file with the commissioner an acceptable bond or other deposit in an amount to be determined by the commissioner. At the acquiring party's expense, the commissioner may conduct such examination or investigation as the commissioner is empowered to do under section 224.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1317 Exemptions.

Sec. 1317. The provisions of sections 1311 to 1319 do not apply to:

(a) Any transaction subject to the provisions of chapter 76.

(b) Any offer, request, invitation, agreement, or acquisition that the commissioner by order exempts as not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer or as otherwise not comprehended within the purposes of sections 1311 to 1319.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1318 Violations.

Sec. 1318. The following are violations of sections 1311 to 1319:

(a) Failure to file any statement, amendment or other material required to be filed pursuant to sections 1311 or 1312.

(b) The effectuation or any attempt to effectuate an acquisition of control of, or merger with, a domestic insurer unless the commissioner has given his approval.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970.

Popular name: Act 218

500.1319 Jurisdiction of actions arising out of violations; consent to process.

Sec. 1319. The courts of this state have jurisdiction over every person not resident, domiciled, or authorized to do business in this state who files or fails to file a statement with the commissioner as required by this chapter and over all actions involving the person arising out of violations of sections 1311 to 1318. Each such person shall be considered to have performed acts equivalent to and constituting an appointment by him or her of the commissioner to be his or her true and lawful attorney upon whom may be served all lawful process in any action, suit, or proceeding arising out of violations of this section. Copies of all lawful process shall be served on the commissioner and transmitted by registered or certified mail by the commissioner to the person at his or her last known address.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1324 Insurers subject to registration; time.

Sec. 1324. An insurer that is a member of an insurance holding company system and is authorized to do business in this state shall register with the commissioner. A foreign insurer is not required to register if it is subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained in this section and sections 1325 to 1343 and that

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exempt insurers domiciled in this state from the requirements of registration or that permit insurers domiciled in this state to satisfy the registration requirement by filing copies of materials required to be filed under this chapter. An insurer subject to registration under this chapter shall register by May 1 of each year for the immediately preceding calendar year unless the commissioner for good cause shown extends the time for registration. The commissioner may require an authorized insurer that is a member of a holding company system not subject to registration under this section to furnish a copy of the registration statement or other information filed by the insurer with the insurance regulatory authority of domiciliary jurisdiction.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1990, Act 85, Imd. Eff. May 29, 1990;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1325 Registration statement; form; contents; other reports or information required.

Sec. 1325. (1) An insurer subject to registration under section 1324 shall file a registration statement on a form provided by the director containing the following current information:

(a) The capital structure, comprehensive financial condition, ownership, and management of the insurer and a person controlling the insurer.

(b) The identity and relationship of every member of the insurance holding company system.

(c) The following agreements in force, relationships subsisting, and transactions currently outstanding or that have occurred during the last calendar year between the insurer and its affiliates:

(*i*) Loans, other investments or purchases, sales, or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates.

(*ii*) Purchases, sales, or exchanges of assets.

(*iii*) Transactions not in the ordinary course of business.

(*iv*) Guarantees or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business.

(*v*) All management and service contracts and all cost sharing arrangements.

(*vi*) Reinsurance agreements.

(*vii*) Dividends and other distributions to shareholders.

(*viii*) Consolidated tax allocation agreements.

(d) A pledge of the insurer's stock, including stock of a subsidiary or controlling affiliate for a loan made to a member of the insurance holding system.

(e) A summary outlining all items in the current registration statement representing changes from the prior registration statement.

(f) Other matters concerning transactions between registered insurers and any affiliates as included in any registration forms adopted or approved by the director.

(g) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers and senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures.

(2) If a person ultimately controlling the insurer or intermediately controlling the insurer is registered on a national stock exchange or is otherwise required to make periodic reports to the United States Securities and Exchange Commission or other instrumentality of a state or the government of the United States or of a foreign nation or jurisdiction regulating the financial conduct of that person, the insurer shall file the reports with the director in addition to other information required by the director. If requested by the director, the insurer must include financial statements of or within an insurance holding company system, including all affiliates. The insurer may satisfy the request by providing the director the most recently filed parent corporation financial statements that have been filed with the United States Securities and Exchange Commission.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 227, Imd. Eff. June 27, 1994;—Am. 2015, Act 244, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1325a Annual enterprise risk report.

Sec. 1325a. (1) Except as otherwise provided in subsection (2), the ultimate controlling person of an insurer subject to registration under section 1324 shall file an annual enterprise risk report with the director or a jurisdiction designated by the director. The report must be appropriate to the nature, scale, and complexity of the operations of the insurance holding company system and must, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that

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could pose enterprise risk to the insurer. The ultimate controlling person of an insurer subject to registration under section 1324 may request an exemption from this section. The ultimate controlling person of the insurer shall file with the director a written statement discussing the reasons why the ultimate controlling person of the insurer should be exempt. The director may grant the exemption if after review of the statement the director finds that compliance with this section would create an undue financial or organizational hardship on the ultimate controlling person.

(2) The ultimate controlling person of an insurance holding company system subject to registration under section 1324 that meets the requirements of this subsection before December 23, 2015 is not required to file an annual enterprise risk report under subsection (1) if all of the following requirements are met:

(a) The ultimate controlling person is exempt from taxation under section 501(c)(5) of the internal revenue code of 1986, 26 USC 501.

(b) The ultimate controlling person was organized under the laws of this state before January 1, 1921.

(c) The director has not approved the controlling person's petition for disclaimer of affiliation or has disallowed a disclaimer of affiliation under section 1332.

(d) The insurer in which the ultimate controlling person owns a controlling interest meets both of the following requirements:

(*i*) Is registered under section 1324.

(*ii*) Is a wholly domestic insurer with not more than 10% of its written premium covering risks outside of this state and has not issued policies directly insuring any risk located outside of this state.

History: Add. 2015, Act 244, Imd. Eff. Dec. 22, 2015;—Am. 2022, Act 260, Eff. Mar. 29, 2023.

Popular name: Act 218

500.1325b Annual group capital calculation; filing; exemption.

Sec. 1325b. (1) Except as otherwise provided in this section, the ultimate controlling person of an insurer subject to registration under section 1324 shall concurrently file with the registration an annual group capital calculation as directed by the lead state commissioner.

(2) The annual group capital calculation must meet all of the following requirements:

(a) Be completed in accordance with the group capital calculation instructions, which may permit the lead state commissioner to allow a controlling person that is not the ultimate controlling person to file the group capital calculation.

(b) Be filed with the lead state commissioner.

(3) The following insurance holding company systems are exempt from filing the annual group capital calculation under subsection (1):

(a) An insurance holding company system that meets all of the following requirements:

(*i*) Has only 1 insurer within its holding company structure.

(*ii*) Writes only business.

(*iii*) Is licensed only in its domestic state.

(*iv*) Does not assume business from any other insurer.

(b) An insurance holding company system that is required to perform a group capital calculation specified by the Federal Reserve Board, if the lead state commissioner requests the calculation from the Federal Reserve Board under the terms of any information sharing agreement in effect and the Federal Reserve Board shares the calculation with the lead state commissioner.

(c) Except as otherwise provided in subsection (4), an insurance holding company system whose non-United States group-wide supervisor is located within a reciprocal jurisdiction, as described in section 1103, that recognizes the United States state's regulatory approach to group supervision and group capital.

(d) Except as otherwise provided in subsection (4), an insurance holding company system that meets both of the following requirements:

(*i*) The system provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly, through the group-wide supervisor who has determined that the information is satisfactory to allow the lead state to comply with the NAIC group supervision approach, as detailed in the NAIC Financial Analysis Handbook.

(*ii*) The system's non-United States group-wide supervisor is not in a reciprocal jurisdiction, as described in section 1103, and recognizes and accepts, as specified by the director, the group capital calculation as the world-wide group capital assessment for United States insurance groups that operate in that jurisdiction.

(4) The lead state commissioner shall require the group capital calculation for United States operations of any non-United States based insurance holding company system if, after any necessary consultation with other supervisors or officials, it is considered appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace.

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(5) The lead state commissioner may exempt the ultimate controlling person from filing the annual group capital calculation or accept a limited group capital filing or report in accordance with criteria specified by the director.

(6) If the lead state commissioner determines that an insurance holding company system no longer qualifies as 1 or more of the systems exempted under subsection (3), the insurance holding company system must file the group capital calculation at the next annual filing date unless given an extension by the lead state commissioner based on reasonable grounds shown.

(7) As used in this section, "group capital calculation instructions" means the group calculation instructions that are adopted by the NAIC and amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

History: Add. 2022, Act 262, Eff. Mar. 29, 2023.

Popular name: Act 218

500.1325c Liquidity stress test framework; results; filing; compliance with NAIC.

Sec. 1325c. (1) Except as otherwise provided in this section, the ultimate controlling person of every insurer that is subject to registration under section 1324 and that is scoped into the NAIC liquidity stress test framework for the specified data year shall file with the lead state commissioner the results of that year's liquidity stress test.

(2) A change to the NAIC liquidity stress test framework or to the data year for which the scope criteria are to be measured must be effective on January 1 of the year following the calendar year when the change is adopted by NAIC.

(3) An insurer that meets at least 1 threshold of the scope criteria is considered scoped into the NAIC liquidity stress test framework for the specified data year, unless the lead state commissioner, in consultation with the NAIC financial stability task force or its successor, determines that the insurer should not be scoped into the framework for the specified data year.

(4) An insurer that does not meet at least 1 threshold of the scope criteria is considered scoped out of the NAIC liquidity stress test framework for the specified data year, unless the lead state commissioner, in consultation with the NAIC financial stability task force or its successor, determines the insurer should be scoped into the NAIC liquidity stress test framework for the specified data year.

(5) As part of a determination made under subsection (3) or (4), the lead state commissioner, in consultation with the NAIC financial stability task force or its successor, shall consider that regulators wish to avoid having insurers scoped in and out of the NAIC liquidity stress test framework on a frequent basis.

(6) The performance of, and filing of the results from, a specified year's liquidity stress test must comply with the NAIC liquidity stress test framework's instructions and reporting templates for that year and any lead state commissioner determination, in conjunction with the NAIC financial stability task force or its successor, provided within the NAIC liquidity stress test framework.

History: Add. 2022, Act 263, Eff. Mar. 29, 2023.

Popular name: Act 218

500.1326 Registration statement; nonmaterial information not disclosed.

Sec. 1326. (1) Information does not need to be disclosed on a registration statement filed under section 1325 if the information is not material for the purposes of sections 1324 to 1325a and 1327 to 1343.

(2) Unless the director by rule or order provides otherwise, a sale, purchase, exchange, loan, extension of credit, or investment involving 1/2 of 1% or less of an insurer's admitted assets on the preceding December 31 is not material for purposes of sections 1324 to 1325a and 1327 to 1343.

(3) A sale, purchase, exchange, loan, extension of credit, or investment involving 1/2 of 1% or less of an insurer's admitted assets on the preceding December 31 is not material for purposes of an annual group capital calculation under section 1325b or an NAIC liquidity stress test under section 1325c.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 2022, Act 259, Eff. Mar. 29, 2023.

Popular name: Act 218

500.1327 Registration statement; reporting material changes or additions and distributions to shareholders.

Sec. 1327. Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within 15 days after the end of the month in which it learns of each change or addition. Subject to section 1343, each registered insurer shall report all dividends and other distributions to shareholders within 2 business days following the declaration.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

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Popular name: Act 218

500.1328 Registration; termination.

Sec. 1328. The commissioner shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970.

Popular name: Act 218

500.1329 Consolidated registration statements.

Sec. 1329. The commissioner may require or allow 2 or more affiliated insurers subject to registration to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970.

Popular name: Act 218

500.1330 Registration on behalf of affiliated insurer.

Sec. 1330. The commissioner may allow an insurer authorized to do business in this state which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under section 1324 and to file all information and material required to be filed under this chapter.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970.

Popular name: Act 218

500.1331 Exemptions.

Sec. 1331. The provisions of sections 1324 to 1333 shall not apply to any insurer, information or transaction if and to the extent that the commissioner by rule or order exempts the insurer.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970.

Popular name: Act 218

500.1332 Petition for disclaimer of affiliation; filing; contents; effect; disallowance.

Sec. 1332. Any person may file with the commissioner a petition for disclaimer of affiliation with an authorized insurer or an insurer or any member of an insurance holding company system may file such a petition for disclaimer. The petition for disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation and shall be subject to approval by the commissioner. The burden of proof for establishing that an affiliation does not exist shall rest with the petitioner. After a petition for disclaimer is filed with and approved by the commissioner, the insurer is relieved of any duty to register or report under this chapter that may arise out of the insurer's relationship with the person unless the commissioner subsequently disallows the disclaimer. The commissioner may disallow a disclaimer that has been previously approved only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support the disallowance.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1994, Act 227, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1333 Registration statement; failure to file.

Sec. 1333. The failure to file a registration statement, an amendment to or summary of the registration statement, or an enterprise risk report required by sections 1324 to 1332 within the time specified for the filing is a violation of this chapter.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 2015, Act 244, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1334 Person subject to registration; providing information to insurer.

Sec. 1334. A person within an insurance holding company system subject to registration is required to provide complete and accurate information to an insurer if the information is reasonably necessary to enable the insurer to comply with the provisions of this chapter.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1341 Transactions within holding company system; certain insurers as party; standards; prior approval; transactions entered into by domestic insurers; notification; separate

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transactions; review by director; total investment exceeding 10% of corporation's voting securities.

Sec. 1341. (1) Transactions within a holding company system to which an insurer domiciled in this state or a foreign insurer whose written insurance premium in this state for each of the most recent 3 years exceeds the premiums written in its state of domicile and whose written premium in this state was 20% or more of its total written premium in each of the most recent 3 years is a party or with respect to which the assets or liabilities of these insurers are affected are subject to all of the following standards:

(a) The terms must be fair and reasonable.

(b) The charges or fees for services performed must be reasonable.

(c) The expenses incurred and payment received must be allocated to the insurer in conformity with customary insurance accounting practices consistently applied.

(d) The books, accounts, and records of each party must be maintained to clearly and accurately disclose the precise nature and details of the transactions including necessary accounting information to support the reasonableness of the charges or fees to the respective parties.

(e) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates must be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs so that the insurer continues to comply with section 403.

(2) The director's prior approval is required for sales, purchases, exchanges, loans, extensions of credit, or investments, involving 5% or more of the insurer's assets at the immediately preceding year's end, between a domestic controlled insurer and a person in its holding company system.

(3) A domestic insurer and a person in its holding company system shall not enter into the following transactions with each other, or modify an existing transaction, unless the insurer notifies the director in writing of its intention to enter into the transaction, or its reason to modify an existing transaction and the modification's financial impact on the insurer, at least 30 days, or a shorter period as the director allows, before entering into or modifying the transaction and the director has not disapproved it within that period:

(a) A sale, purchase, exchange, loan, extension of credit, or investment, if the transaction is equal to or greater than the lesser of 3% of the insurer's assets or 25% of capital and surplus as of December 31 of the immediately preceding year.

(b) A loan or extension of credit to a person who is not an affiliate, if the insurer makes the loan or extends the credit with the agreement or understanding that the proceeds of the transaction, in whole or in substantial part, will be used to make a loan or extend credit to, to purchase an asset of, or to invest in, an affiliate of the insurer making the loan or extending credit if the transaction is equal to or greater than the lesser of 3% of the insurer's assets or 25% of capital and surplus as of December 31 of the immediately preceding year.

(c) A guarantee that is quantifiable and exceeds the lesser of 0.5% of the insurer's admitted assets or 10% of surplus as of December 31 of the immediately preceding year. A guarantee that is not quantifiable under this subdivision is subject to prior approval of the director.

(d) A direct or indirect acquisition of, or investment in, a person that controls the insurer or that controls an affiliate of the insurer, if the amount of the transaction plus the insurer's present holdings in investment exceeds 2.5% of surplus. This subdivision does not apply to a direct or indirect acquisition of, or investments in, a subsidiary acquired under section 1305 or any other section of this chapter, or a nonsubsidiary insurance affiliate that is subject to this act.

(e) A reinsurance treaty or agreement.

(f) Rendering of services on a regular systematic basis.

(g) A tax allocation agreement.

(h) A cost-sharing agreement.

(i) A material transaction, specified by regulation, that the director determines may adversely affect the interests of the insurer's policyholders.

(4) An insurer shall informally notify the director of a termination of transaction under subsection (3) no later than 30 days after the transaction terminates.

(5) Subsection (3) does not authorize or permit a transaction that, for an insurer that is not a member of the same holding company system, would be otherwise contrary to law.

(6) A domestic insurer shall not enter into transactions that are part of a plan or series of like transactions with persons within the holding company system if the purpose of those separate transactions is to avoid the threshold amount under this chapter and thus avoid the review that would otherwise occur. If the director determines that the separate transactions were entered into over any relevant period for that purpose, he or she may exercise his or her authority under section 1371.

(7) In reviewing a transaction under subsection (2), the director shall consider whether the transaction

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complies with the standards described in subsection (1) and whether it may otherwise adversely affect the interests of policyholders, creditors, or the public.

(8) A domestic insurer shall notify the director within 30 days of the domestic insurer's investment in any 1 corporation if the insurance holding company system's total investment in the corporation exceeds 10% of the corporation's voting securities.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 227, Imd. Eff. June 27, 1994;—Am. 1994, Act 443, Imd. Eff. Jan. 10, 1995;—Am. 2015, Act 244, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1341a Domestic insurer investments; limitations.

Sec. 1341a. (1) In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted under this chapter, and except as otherwise provided in this section, a domestic insurer may invest in common stock, preferred stock, debt obligations, and other securities of 1 or more subsidiaries, amounts that do not exceed the lesser of 10% of the insurer's assets or 50% of the insurer's surplus with regard to policyholders, if after the investments, the insurer's surplus with regard to policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs.

(2) In calculating the amount described in subsection (1), any investment in domestic or foreign insurance subsidiaries, licensed third-party administrators, and domestic health maintenance organizations must be excluded from the calculation and both of the following must be included in the calculation:

(a) Total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities.

(b) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities, and all contributions to the capital or surplus of a subsidiary subsequent to its acquisition or formation.

(3) With the approval of the director, an insurer may invest a greater amount than prescribed by subsection (1) in common stock, preferred stock, debt obligations, or other securities of 1 or more subsidiaries, if after the investment the insurer's surplus with regard to policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(4) All existing investments held on or before the effective date of the amendatory act that added this section comply with this section and do not count toward the limits prescribed by subsection (1) if held by an insurer that writes only premium in this state or that is a nonprofit insurer statutorily prohibited from converting to a mutual holding company under chapter 60. Any additional amounts expended in the investments are subject to the requirements of this section except for any additional amounts expended by or in existing investments held by any nonprofit insurer that is statutorily prohibited from converting to a mutual holding company under chapter 60. An investment in new subsidiaries after the effective date of the amendatory act that added this section by a nonprofit insurer statutorily prohibited from converting to a mutual holding company that exceeds the thresholds prescribed by subsection (1) is subject to the approval of the director.

History: Add. 2022, Act 264, Eff. Mar. 29, 2023.

Popular name: Act 218

500.1342 Application of MCL 500.436a.

Sec. 1342. In determining whether an insurer remains safe, reliable, and entitled to public confidence for the purposes of sections 1324 to 1343, the commissioner shall apply the standards of section 436a.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1343 Ordinary shareholder dividends paid by domestic insurers; review by director; determination of reasonableness; factors; limiting or disallowing payment of shareholder dividends; declaration or payment from earned surplus; declaration of shareholder dividend by domestic insurer as member of insurance holding company system; extraordinary dividend or distribution to shareholders; hearing.

Sec. 1343. (1) Each year the director shall review the ordinary shareholder dividends paid by domestic insurers to determine whether each insurer's surplus following those dividends is reasonable in relation to the insurer's outstanding liabilities and adequate to its needs so that it continues to comply with section 403. In conducting the review and making the determination, the director shall consider all of the following factors in

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addition to factors listed in section 436a:

(a) The adequacy of the level of surplus as regards policyholders remaining after the dividend payment or payments.

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

(c) The quality and liquidity of investments in subsidiaries. The director may discount any of those investments or refuse to consider the investment as an asset for purposes of determining the adequacy of surplus as regards policyholders if the investment so warrants.

(2) If the director determines that an insurer's surplus as regards policyholders is not reasonable in relation to the insurer's outstanding liabilities and is not adequate to its financial needs so that the insurer will not continue to comply with section 403, the director shall limit or disallow the payment of shareholder dividends.

(3) Shareholder dividends shall be declared or paid only from earned surplus, unless the director approves the dividend before payment. The director shall consider whether the dividend will be paid from the insurer's net gain from operations if the insurer is a life insurer, or the insurer's net income if the insurer is not a life insurer, for the 12-month period ending December 31 of the immediately preceding year. For purposes of this subsection, earned surplus excludes surplus arising from unrealized capital gains or a revaluation of assets.

(4) A domestic insurer that is a member of an insurance holding company system and declares a shareholder dividend shall report the dividend to the director within 5 business days after declaring the dividend. The insurer shall not pay the dividend until 10 days after the director receives a report under this subsection.

(5) An insurer subject to registration under section 1324 shall not pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until 30 days after the director has received notice of the declaration and has not disapproved or has approved the payment within that period. If the director, applying the criteria in subsection (1), determines that the insurer's surplus as regards policyholders is not reasonable in relation to the insurer's outstanding liabilities and is not adequate to its financial needs so that the insurer will not continue to comply with section 403, the director may, before the expiration of the 30-day period described in this subsection, enter an order prohibiting the payment of the dividend.

(6) An extraordinary dividend or distribution includes a dividend or distribution of cash or other property, whose fair market value plus the fair market value of other dividends or distributions made within the preceding 12 months exceeds the greater of 10% of the insurer's surplus as regards policyholders as of December 31 of the immediately preceding year, or the net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the 12-month period ending December 31 of the immediately preceding year, but shall not include pro rata distributions of any class of the insurer's own securities.

(7) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution that is conditional on the director's approval. The declaration does not confer rights on shareholders until the director has approved or has not disapproved the payment of the dividend or distribution within the 30-day period described in subsection (5).

(8) Notwithstanding subsections (5) through (7), a dividend shall not be declared and paid by an insurer to an affiliate if after the payment the insurer could not satisfy the standards described in section 403.

(9) An insurer aggrieved by the director's determination or order under this section is entitled to a contested case hearing under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. A hearing under this subsection must be held no later than 10 days after receipt of the insurer's request. The director's determination or order shall remain in effect except as modified by the director during the pendency of the hearing and until a final decision by the director. The director shall render a final decision within 30 days after the conclusion of the hearing.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 227, Imd. Eff. June 27, 1994;—Am. 1994, Act 443, Imd. Eff. Jan. 10, 1995;—Am. 1995, Act 219, Imd. Eff. Dec. 1, 1995;—Am. 2015, Act 244, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1344 Officers and directors; obligation or liability; common management or cooperative or joint use of personnel, property, or services.

Sec. 1344. (1) Notwithstanding the control of a domestic insurer by any person, the insurer's officers and directors shall not be relieved of any obligation or liability to which they would otherwise be subject by law and the insurer shall be managed so as to assure its separate operating identity consistent with this act.

(2) Nothing in this section shall preclude a domestic insurer from having or sharing a common

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management or cooperative or joint use of personnel, property, or services with 1 or more other persons under arrangements meeting the standards of this act.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1351 Examination of insurer or affiliates; information; experts; expenses.

Sec. 1351. (1) Subject to the limitation in this section and in addition to the powers that the director has under chapters 2 and 4 relating to the examination of insurers, the director may order an insurer registered under section 1324 to produce records, books, or other information papers in the possession of the insurer or its affiliates as are necessary to determine the insurer's financial condition, including enterprise risk to the insurer by the ultimate controlling party, or by combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis, or legality of conduct. If the insurer fails to comply with the order, the director may examine the affiliates to obtain the information. The director may order an insurer registered under section 1324 to produce information not in the possession of the insurer if the insurer can obtain access to the information under a contractual relationship, statutory obligation, or other method. If the insurer cannot obtain the information requested by the director, the insurer shall provide the director with a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of information. If the director determines the detailed explanation is without merit, the director may require, after notice and hearing, the insurer to pay a civil fine of $1,000.00 for each day's delay or may suspend or revoke the insurer's license.

(2) The director may retain at the registered insurer's expense attorneys, actuaries, accountants, and other experts not otherwise a part of the director's staff as are reasonably necessary to assist in the conduct of the examination under subsection (1). The expense of the attorneys, actuaries, accountants, and other experts shall be certified by the director and paid as provided in sections 216 and 224. The person retained is under the direction and control of the director and shall act in a purely advisory capacity.

(3) Each registered insurer producing for examination records, books, and papers under subsection (1) is liable for and shall pay the expense of the examination under sections 216 and 224.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2015, Act 244, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1355 Examination of insurer or affiliates; privilege and confidentiality of information; use of materials; written consent; disclosure; notice; publication in interest of public; sharing documents; written agreement; responsibility of director; group capital calculation.

Sec. 1355. (1) Except as otherwise provided in this section, documents, materials, and other information in the possession or control of the department that are obtained by or disclosed to the director or any other person in the course of an examination or investigation made under section 1351, and all information reported or provided to the department under sections 1312(2), 1324 to 1333, 1341 to 1344, and 1359, are proprietary and contain trade secrets, are confidential and privileged, are not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, are not subject to subpoena, and are not subject to discovery or admissible in evidence in a private civil or administrative action.

(2) Except as otherwise provided in subsections (5) and (6), the director may use the documents, materials, or information described in subsection (1) in furtherance of a regulatory or legal action brought as part of the director's official duties.

(3) Except as otherwise provided in subsections (2), (4), and (5), the director shall not publicly disclose the documents, materials, or information described in subsection (1) without the prior written consent of the insurer to which it pertains.

(4) Except as otherwise provided in subsections (2) and (5), the director may, after giving the insurer and its affiliates that would be affected by the disclosure notice and opportunity to be heard, disclose all or part of any document, material, or information described in subsection (1) if the director determines that the interests of policyholders, shareholders, or the public will be served by the publication of the document, material, or information.

(5) The director shall not disclose any of the following information:

(a) All of the following information reported and provided to the department under section 1325b:

(*i*) The group capital calculation.

(*ii*) The group capital ratio produced within the group capital calculation.

(*iii*) Any group capital information received from an insurance holding company supervised by the Federal Reserve Board or any United States group-wide supervisor.

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(b) All of the following information reported and provided to the department under section 1325c:

(*i*) The liquidity stress test results.

(*ii*) Any supporting disclosures to the liquidity stress test results.

(*iii*) Any liquidity stress test information received from an insurance holding company supervised by the Federal Reserve Board and non-United States group-wide supervisors.

(6) The director or a person who received documents, materials, or other information while acting under the authority of the director or with whom the documents, materials, or other information is shared under this chapter shall not testify in a private civil or administrative action concerning documents, materials, or information described in subsections (1) to (5).

(7) Except as otherwise provided in subsection (8), the director may share documents, materials, or other information, including documents, materials, and information that are confidential, privileged, proprietary, and constitute trade secrets under subsection (1), with any of the following entities if the entity agrees in writing to maintain the confidentiality and privileged status of the document, material, or information and has verified in writing the legal authority to maintain the confidentiality:

(a) A state, federal, or international regulatory agency.

(b) The NAIC.

(c) A third-party consultant designated by the director.

(d) A state, federal, or international law enforcement authority, including a member of a supervisory college under section 1357.

(8) The director may only share confidential and privileged documents, material, or information that are reported under section 1325a with commissioners of states having statutes or regulations substantially similar to subsections (1) to (5) and who have agreed in writing to not disclose the documents, materials, or information.

(9) The director may receive documents, materials, or information, including documents, materials, or information that are confidential, privileged, or proprietary or that constitute trade secrets under subsection (1), from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(10) The disclosure of documents, materials, or other information to the director or another person under this section or the sharing of documents, materials, or other information under this section is not a waiver of an applicable privilege or claim of confidentiality.

(11) Documents, materials, or other information in the possession or control of the NAIC or a third-party consultant designated by the director under this chapter are confidential and privileged, are not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, are not subject to subpoena, and are not subject to discovery or admissible as evidence in a private civil or administrative action.

(12) The director shall enter into written agreements with the NAIC and any third-party consultant designated by the director governing sharing and use of information provided under this chapter. The written agreement must meet all of the following requirements:

(a) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant designated by the director under this chapter, including procedures and protocols for sharing by the NAIC with other state, federal, or international regulators. The procedures and protocols must require the recipient of the shared documents, materials, or information to agree in writing to maintain the confidentiality and privileged status of the documents, materials, and information and verify in writing the legal authority to maintain the confidentiality.

(b) Specify that the director owns the information shared with the NAIC or a third-party consultant designated by the director under this chapter and that the NAIC's or the third-party consultant's use of the information is subject to the direction of the director.

(c) Prohibit the NAIC or a third-party consultant designated by the director from storing information shared under this chapter in a permanent database after the underlying analysis is completed. This subdivision does not apply to documents, materials, or other information reported under 1325c.

(d) Require prompt notice to be given to an insurer whose confidential information in possession of the NAIC or a third-party consultant designated by the director under this chapter is subject to a request or subpoena to the NAIC or a third-party consultant designated by the director for disclosure or production.

(e) Require the NAIC or a third-party consultant designated by the director to consent to intervention by an insurer in a judicial or administrative action in which the NAIC or the third-party consultant designated by the director may be required to disclose confidential information about the insurer shared under this chapter with the NAIC or third-party consultant designated by the director.

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(13) In addition to any requirement for an agreement set forth in subsection (12), if a third-party consultant designated by the director is a party to the agreement, with regard to documents, materials, or information reported under section 1325c, the agreement must provide for notification of the identity of the third-party consultant to the applicable insurer.

(14) The group capital calculation and resulting group capital ratio required under section 1325b and the NAIC liquidity stress test and its results and supporting disclosures required under section 1325c are regulatory tools for assessing group risk and capital adequacy and group liquidity risks, respectively, and are not intended as a means to rank insurers or insurance holding company systems.

(15) Except as otherwise provided under this chapter, a person shall not, directly or indirectly, make, publish, disseminate, circulate, or place before the public, in a newspaper, magazine, or other publication, in the form of a notice, circular, pamphlet, letter, or poster, over any radio or television station, by any electronic means of communication available to the public, or in any other way as an advertisement, announcement, or statement containing a representation or statement with regard to the group capital calculation or group capital ratio under section 1325b, or the liquidity stress test results or supporting disclosures for the liquidity stress tests under section 1325c, of any insurer or any insurer group, or of any component derived in the calculation by any insurer group, or of any component derived in the calculation by any insurer, broker, or other person engaged in any manner in the insurance business, that would be misleading.

(16) If any materially false statement with respect to the group capital calculation, resulting group capital ratio, an inappropriate comparison of any amount to an insurer's or insurance group's group capital calculation, resulting group capital ratio under section 1325b or liquidity stress test result, supporting disclosures for the liquidity stress test, or an inappropriate comparison of any amount to an insurer's or insurance group's liquidity stress test result or supporting disclosures under section 1325c is published in any written publication and the insurer is able to demonstrate to the director with substantial proof the falsity of the statement or its inappropriateness, the insurer may publish announcements in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(17) The sharing of information by the director under this chapter is not a delegation of regulatory authority or rule-making, and the director is solely responsible for the administration, execution, and enforcement of this chapter.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 2015, Act 244, Imd. Eff. Dec. 22, 2015;—Am. 2022, Act 261, Eff. Mar. 29, 2023.

Popular name: Act 218

500.1357 Participation of director in supervisory college.

Sec. 1357. (1) The director may participate in a supervisory college for a domestic insurer that is part of an insurance holding company system with international operations to determine the insurer's financial condition, business strategy, risk management, risk exposures, governance processes, regulatory position, or legality of conduct. The director may participate in a supervisory college with other regulators including state, federal, and international regulatory agencies, charged with the supervision of the insurer or its affiliates. The authority of the director under this section includes, but is not limited to, initiating a supervisory college, clarifying membership and participation of other supervisors in the supervisory college, clarifying the functions of the supervisory college and roles of other regulators including establishing a groupwide supervisor, coordinating ongoing activities of the supervisory college, and establishing a crisis management plan.

(2) The insurer is liable for and shall pay the reasonable expenses for the director to participate in the supervisory college, including reasonable travel expenses, if the director considers it appropriate to require the insurer to pay these costs.

(3) The director may enter into agreements under section 1355 providing the basis for cooperation and sharing of confidential information with state, federal, and international regulatory agencies that regulate the domestic insurer or affiliates within the insurance holding company system. This section does not delegate to the supervisory college the authority of the director to regulate or supervise the domestic insurer or its affiliates within its jurisdiction.

History: Add. 2015, Act 245, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1359 Internationally active insurance group; group-wide supervisor; determination factors; duties.

Sec. 1359. (1) The director may act as the group-wide supervisor for any internationally active insurance group in accordance with this section. However, the director may otherwise acknowledge another regulatory

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official as the group-wide supervisor if any of the following apply to the internationally active insurance group:

(a) The internationally active insurance group does not have substantial insurance operations in the United States.

(b) The internationally active insurance group has substantial insurance operations in the United States, but not in this state.

(c) The internationally active insurance group has substantial insurance operations in the United States and this state, but the director has determined under the factors set forth in subsections (3), (4), and (8) that the other regulatory official is the appropriate group-wide supervisor.

(2) An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the director make a determination or acknowledgement as to a group-wide supervisor under this section.

(3) Subject to subsection (4), in cooperation with other state, federal, and international regulatory agencies, the director shall identify a single group-wide supervisor for an internationally active insurance group. The director may determine that the director is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. However, the director may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The director shall consider all of the following factors when making a determination or acknowledgement under this subsection:

(a) The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's written premiums, assets, or liabilities.

(b) The place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the internationally active insurance group.

(c) The location of the executive offices or largest operational offices of the internationally active insurance group.

(d) Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the director determines to be either of the following:

(*i*) Substantially similar to the system of regulation provided under the laws of this state.

(*ii*) Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials.

(e) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the director with reasonably reciprocal recognition and cooperation.

(4) A commissioner identified under this section as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgement of the group-wide supervisor must be made in consideration of the factors under subsection (3), and must be made in cooperation with and subject to the acknowledgement of other regulatory officials involved with supervision of members of the internationally active insurance group, and in consultation with the internationally active insurance group.

(5) Notwithstanding any other provision of law, if another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the director shall acknowledge that regulatory official as the group-wide supervisor. However, the director shall make a determination or acknowledgement as to the appropriate group-wide supervisor for the internationally active insurance group under subsection (3) in the event of a material change in the internationally active insurance group that results in either of the following:

(a) The internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets, or liabilities.

(b) This state being the place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the internationally active insurance group.

(6) Pursuant to section 1351, the director may collect from an insurer registered under section 1324 all information necessary to determine whether the director may act as the group-wide supervisor of an internationally active insurance group or if the director may acknowledge another regulatory official to act as the group-wide supervisor. Before issuing a determination that an internationally active insurance group is subject to group-wide supervision by the director, the director shall notify the insurer registered under section 1324 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group has at least 30 days to provide the director with additional information pertinent to the pending determination. The director shall publish on its website the identity of internationally active insurance groups that the director has determined are subject to group-wide supervision by the director.

(7) If the director is the group-wide supervisor for the internationally active insurance group, the director may engage in any of the following group-wide supervision activities:

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(a) Assess the enterprise risks within the internationally active insurance group to ensure both of the following:

(*i*) That the material financial condition and liquidity risk to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management.

(*ii*) That reasonable and effective mitigation measures are in place.

(b) Request, from any member of the internationally active insurance group subject to the director's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the internationally active insurance group regarding any of the following:

(*i*) Governance, risk assessment, and management.

(*ii*) Capital adequacy.

(*iii*) Material intercompany transactions.

(c) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of the internationally active insurance group that are engaged in the business of insurance.

(d) Communicate with other state, federal, and international regulatory agencies for members within the internationally active insurance group and share relevant information, subject to the confidentiality provisions of section 1355, through supervisory colleges as provided in section 1357 or otherwise.

(e) Enter into agreements with or obtain documentation from any insurer registered under section 1324, any member of the internationally active insurance group, and any other state, federal, and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the director's role as group-wide supervisor, including provisions for resolving disputes with the other regulatory officials. The agreements or documentation described in this subdivision must not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state.

(f) Other group-wide supervision activities, consistent with the authorities and purposes provided in this subsection, as considered necessary by the director.

(8) If the director acknowledges that another regulatory official from a jurisdiction that is not accredited by the NAIC is the group-wide supervisor, the director may reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor if both of the following apply:

(a) The director's cooperation is in compliance with the laws of this state.

(b) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the director's activities as a group-wide supervisor for other internationally active insurance groups where applicable. If recognition and cooperation described in this subdivision is not reasonably reciprocal, the director may refuse recognition and cooperation.

(9) The director may enter into agreements with or obtain documentation from any insurer registered under section 1324, any affiliate of the insurer, and other state, federal, and international regulatory agencies for members of the internationally active insurance group, that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

(10) A registered insurer subject to this section is liable for and shall pay the reasonable expenses of the director's participation in the administration of this section, including the engagement of attorneys, actuaries, and any other professionals and all reasonable travel expenses.

History: Add. 2020, Act 16, Imd. Eff. Jan. 27, 2020.

Popular name: Act 218

500.1361 Issuance of rules and orders.

Sec. 1361. Upon notice and opportunity for all interested persons to be heard, the commissioner may promulgate rules and issue orders as are necessary to carry out the provisions of this chapter.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

Administrative rules: R 500.701 et seq. of the Michigan Administrative Code.

500.1365 Injunctions; violation of chapter, rule or order.

Sec. 1365. When it appears to the commissioner that any insurer or any director, officer, employee or agent thereof has committed or is about to commit a violation of this chapter or of any rule or order issued by the

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commissioner, he may apply to the circuit court for the county in which the principal office of the insurer is located or if the insurer has no such office in this state then to the circuit court for Ingham county for an order enjoining the insurer or the director, officer, employee or agent thereof from violating or continuing to violate this chapter, rule or order and for such other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors and shareholders or the public may require.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970.

Popular name: Act 218

500.1367 Voting certain securities prohibited; injunction.

Sec. 1367. A security that is the subject of any agreement or arrangement regarding acquisition, or that is acquired or to be acquired, in contravention of this chapter or of any rule or order issued by the commissioner, shall not be voted at any shareholders' meeting or counted for quorum purposes and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding. An action taken at the meeting shall not be invalidated by the voting of the securities, unless the action would materially affect control of the insurer or unless so ordered by the court. If an insurer or the commissioner has reason to believe that any security of the insurer has been or is about to be acquired in contravention of this chapter or of any rule or order issued by the commissioner, the insurer or the commissioner may apply to the Ingham county circuit court or to the circuit court for the county in which the insurer has its principal place of business to enjoin any offer, request, invitation, agreement, or acquisition made in contravention of sections 1311 to 1319 or any rule or order issued by the commissioner to enjoin the voting of any security so acquired, to void any vote of the security already cast at any meeting of shareholders and for other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors, and shareholders or the public may require.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1368 Voting securities in violation of chapter; sequestration of securities.

Sec. 1368. When a person has acquired or is proposing to acquire any voting securities in violation of this chapter or any rule or order issued by the commissioner, the circuit court for Ingham county or the circuit court for the county in which the insurer has its principal place of business, on such notice as the court deems appropriate, upon the application of the insurer or the commissioner, may seize or sequester any voting securities of the insurer owned directly or indirectly by such person and issue such orders with respect thereto as may be appropriate. Notwithstanding any other provisions of law, for the purposes of this chapter the situs of the ownership of the securities of domestic insurers is deemed to be in this state.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970.

Popular name: Act 218

500.1371 Violation of chapter; action by director; criminal proceeding; penalty; disapproval of dividends or distributions.

Sec. 1371. (1) An insurer that does not, without just cause, file a registration statement required under this chapter shall, after notice and hearing, pay a civil fine of $1,000.00 for each day's delay, up to a maximum of $50,000.00, to be recovered by the director and paid into the general fund. The director may reduce the penalty if the insurer demonstrates to the director that the civil fine would cause financial hardship to the insurer.

(2) Every director or officer of an insurance holding company system who knowingly violates, knowingly participates in or assents to, or with actual knowledge permits any of the officers or agents of the insurer to engage in material acts, omissions, or transactions or make investments that have not been properly reported or submitted under section 1324, 1341, or 1343, that, with respect to material transactions, violate this chapter, or that result in material false or misleading statements to the director with respect to the financial condition of the insurer or any of its affiliates shall pay, in their individual capacity, a civil forfeiture of not more than $10,000.00 per violation, after notice and hearing before the director. In determining the amount of the civil forfeiture, the director shall take into account the appropriateness of the forfeiture with respect to the gravity of the violation, the history of previous violations, and other matters as justice requires. In addition, a violation of this subsection is grounds for removal of a director or officer from a position of trust or responsibility in an insurer domiciled in this state in accordance with the procedures established in section 250.

(3) If it appears to the director that an insurer subject to this chapter or an insurer's director, officer, employee, or agent has engaged in a transaction or entered into a contract that is subject to section 1341 or

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1344 and that would not have been approved had approval been requested, the director may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing, the director may also order the insurer to void the contract, transaction, or distribution, and restore the status quo if that action is in the best interest of the policyholders, creditors, or the public.

(4) If it appears to the director that an insurer or an insurer's director, officer, employee, or agent has committed a willful violation of this chapter, the director may institute criminal proceedings in the circuit court for the county in which the principal office of the insurer is located or, if the insurer does not have a principal office in this state, in the Ingham county circuit court against the insurer or the insurer's responsible director, officer, employee, or agent. An insurer that willfully violates this chapter may be fined not more than $50,000.00. An individual who willfully violates this chapter may be fined not more than $10,000.00 or, if the willful violation involves the deliberate perpetration of a fraud upon the director, imprisoned not more than 2 years, or both.

(5) An officer, director, or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made a false statement, false report, or false filing with the intent to deceive the director in the performance of his or her duties under this chapter, shall be imprisoned for not more than 2 years, or fined $10,000.00, or both. The officer, director, or employee shall pay a fine in his or her individual capacity.

(6) If the director determines that a person violated section 1311 and the violation prevents the full understanding of the enterprise risk of the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision under chapter 81.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2015, Act 244, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1375 Violation of chapter; receivership.

Sec. 1375. If it appears to the commissioner that a person has committed a violation of this chapter that so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders, or the public, the commissioner may proceed as provided in chapter 81 to take possession of the property of the domestic insurer and conduct the insurer's business.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1377 Liquidation or rehabilitation; recovery of certain distributions or payments.

Sec. 1377. (1) If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer both of the following:

(a) From any parent corporation, holding company, or person who otherwise controls the insurer, the amount of distributions, other than distributions of shares of the same class of stock, paid by the insurer on its capital stock if made at any time during the 3 years preceding the petition for liquidation, conservation, or rehabilitation.

(b) Any payment in the form of an extraordinary bonus, termination settlement, or lump sum salary adjustment made by the insurer or its subsidiary to a director, officer, or employee if made at any time during the 3 years preceding the petition for liquidation, conservation, or rehabilitation.

(2) A distribution or payment shall not be recoverable under this section if the parent or affiliate or the director, officer, or employee shows that when paid the distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known that the distribution or payment might adversely affect the ability of the insurer to fulfill its contractual obligations. If payments were made to more than 1 director, officer, or employee, this subsection shall apply to the aggregate of those payments.

(3) A person who was a parent corporation, holding company, or a person who otherwise controlled the insurer or affiliate at the time the distribution was paid shall be liable up to the amount of distributions or payments under subsection (1) that the person received. A person who otherwise controlled the insurer at the time the distribution was declared shall be liable up to the amount of distributions he or she would have received if they had been paid immediately. If 2 or more persons are liable with respect to the same distribution, they are jointly and severally liable.

(4) The maximum amount recoverable under this section shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

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(5) To the extent that any person liable under subsection (3) is insolvent or otherwise fails to pay claims due from it pursuant to subsection (3), its parent corporation, holding company, or person who otherwise controlled it at the time the distribution was paid, is jointly and severally liable for any resulting deficiency in the amount recovered from that person.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1378 Failure by commissioner to act or make determination; petition for writ of superintending control.

Sec. 1378. A person aggrieved by failure of the commissioner to act or make a determination required by this chapter may petition the Ingham county circuit court for a writ of superintending control.

History: Add. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.1379 Violation of chapter; suspension, revocation or refusal to renew license.

Sec. 1379. When it appears to the commissioner that any person has committed a violation of this chapter which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the commissioner, after giving notice and an opportunity to be heard, may determine to suspend, revoke or refuse to renew the insurer's license or authority to do business in this state for such period as he finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusion of law.

History: Add. 1970, Act 136, Imd. Eff. July 29, 1970.

Popular name: Act 218

CHAPTER 14
MANAGING GENERAL AGENTS

500.1400 Repealed. 1972, Act 133, Eff. Mar. 30, 1973.

Compiler's note: The repealed section pertained to application of chapter as to agents, solicitors, adjustors, and counselors.

Popular name: Act 218

500.1401 Definitions.

Sec. 1401. As used in this chapter:

(a) "Actuary" means a person who is a member in good standing of the American academy of actuaries.

(b) "Managing general agent" or "MGA" means a person who is not listed under section 1403 and meets both of the following:

(*i*) 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.

(*ii*) Acts as an agent for such insurer whether known as a managing general agent or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium of not less than 5% of the policyholder surplus as reported in the last annual statement of the insurer in any 1 quarter or year and adjusts or pays claims in excess of an amount determined by the commissioner or negotiates reinsurance on behalf of the insurer.

(c) "Guaranty association" means the property and casualty guaranty association created in chapter 79 and the life and health insurance guaranty association created in chapter 77.

(d) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

History: Add. 1990, Act 350, Eff. June 1, 1991.

Popular name: Act 218

500.1402 Repealed. 1972, Act 133, Eff. Mar. 30, 1973.

Compiler's note: The repealed section pertained to definition of general, district, state, or special agent.

Popular name: Act 218

500.1403 Persons not considered managing general agents.

Sec. 1403. For the purposes of the chapter, the following persons are not considered managing general agents:

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(a) An employee of the insurer.

(b) A United States manager of the United States branch of an alien insurer.

(c) An underwriting manager who pursuant to contract manages all the insurer's insurance operations, is under common control with the insurer, is subject to chapter 13, and whose compensation is not based on the volume of premiums written.

(d) An attorney-in-fact for a reciprocal or inter-insurance exchange.

History: Add. 1990, Act 350, Eff. June 1, 1991;—Am. 1991, Act 57, Imd. Eff. June 27, 1991.

Popular name: Act 218

500.1404 Repealed. 1972, Act 133, Eff. Mar. 30, 1973.

Compiler's note: The repealed section pertained to resident agents, definition, and licenses.

Popular name: Act 218

500.1405 Licensing.

Sec. 1405. (1) A person shall not act in the capacity of a managing general agent with respect to risks located in this state for an insurer authorized in this state unless that person is licensed as an agent in this state.

(2) A person shall not act in the capacity of a managing general agent representing an insurer domiciled in this state with respect to risks located outside this state unless that person is licensed as an agent in this state pursuant to the provisions of this chapter.

History: Add. 1990, Act 350, Eff. June 1, 1991.

Popular name: Act 218

500.1407 Bond; errors and omissions policy.

Sec. 1407. The commissioner may require a managing general agent to do both of the following:

(a) Maintain a bond in an amount acceptable to the commissioner for the protection of the insurer.

(b) Maintain an errors and omissions policy.

History: Add. 1990, Act 350, Eff. June 1, 1991.

Popular name: Act 218

500.1408 Repealed. 1972, Act 133, Eff. Mar. 30, 1973.

Compiler's note: The repealed section pertained to definition of solicitor.

Popular name: Act 218

500.1409 Contract between managing general agent and insurer; required provisions.

Sec. 1409. No person acting in the capacity of a managing general agent shall place business with an insurer unless there is a written contract between the parties that sets forth the responsibilities of each party, and if both parties share responsibility for a particular function, specifies the division of the responsibilities, and that contains the following provisions:

(a) That the insurer may terminate the contract upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination.

(b) That the managing general agent shall render accounts to the insurer detailing all transactions and shall remit all funds due to the insurer on not less than a monthly basis.

(c) That funds collected for the account of the insurer shall be held by the managing general agent in a fiduciary capacity in a federally insured financial institution. This account shall be used for all payments on behalf of the insurer. The managing general agent may retain no more than 3 months' estimated claims payments and allocated loss adjustment expenses.

(d) That separate records of business written by the managing general agent shall be maintained by the managing general agent for the period between each examination of the insurer and until 1 year after each examination of the insurer by the commissioner or licensing authority. The insurer shall have access to and the right to copy all books, accounts, and records related to its business in a form usable by the insurer and the commissioner shall have access to and the right to copy all books, accounts, and records of the managing general agent in a form usable to the commissioner.

(e) That the contract shall not be assigned in whole or in part by the managing general agent.

(f) That the managing general agent is subject to appropriate underwriting guidelines that include, but are not limited to, the following:

(*i*) The maximum annual premium volume.

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(*ii*) The basis of the rates to be charged.

(*iii*) The types of risks that may be written.

(*iv*) Maximum limits of liability.

(*v*) Applicable exclusions.

(*vi*) Territorial limitations.

(*vii*) Policy cancellation provisions.

(*viii*) The maximum policy period.

(g) If the contract permits the managing general agent to settle claims on behalf of the insurer, all of the following apply:

(*i*) All claims must be reported to the insurer in a timely manner.

(*ii*) A copy of the claim file shall be sent to the insurer at its request or as soon as it becomes known that the claim meets any of the following:

(A) Has the potential to exceed an amount determined by the commissioner or exceeds the limit set by the insurer, whichever is less.

(B) Involves a coverage dispute.

(C) May exceed the managing general agent's claims settlement authority.

(D) Is open for more than 6 months.

(E) Is closed by payment of an amount set by the commissioner or an amount set by the insurer, whichever is less.

(*iii*) All claims files are the joint property of the insurer and the managing general agent.

(*iv*) Any settlement authority granted to the managing general agent may be terminated upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend any settlement authority granted to the managing general agent during the pendency of any dispute regarding the cause for termination.

(h) If the contract provides for a sharing of interim profits by the managing general agent and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves, controlling claim payments, or in any other manner, that interim profits shall not be paid to the managing general agent until 1 year after they are earned for property insurance business and 5 years after they are earned for casualty insurance business and not until section 1411(a) and (b) has been met.

(i) That the managing general agent shall not do any of the following:

(*i*) Bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(*ii*) Commit the insurer to participate in insurance or reinsurance syndicates.

(*iii*) Appoint any agent without assuring that the agent is lawfully licensed to transact the type of insurance for which he or she is appointed.

(*iv*) Without prior approval of the insurer pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, that shall not exceed 1% of the insurer's policyholder's surplus as of December 31 of the last completed calendar year.

(*v*) Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer, without prior approval of the insurer. If prior approval is given, a report shall be promptly forwarded to the insurer.

(*vi*) Permit its agent to serve on the insurer's board of directors.

(*vii*) Jointly employ an individual who is employed with the insurer.

(*viii*) Appoint another managing general agent to perform its duties under this chapter.

History: Add. 1990, Act 350, Eff. June 1, 1991.

Popular name: Act 218

500.1411 Insurer; duties.

Sec. 1411. An insurer shall comply with all of the following:

(a) Have on file an independent financial examination, in a form acceptable to the commissioner, of each managing general agent with which it has done business.

(b) If a managing general agent establishes loss reserves for the insurer, annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent. This subdivision is in addition to any other required loss reserve certification.

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(c) Periodically, and not less than semiannually, conduct an on-site review of the underwriting and claims processing operations of the managing general agent.

(d) Provide that binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates rests with an officer of the insurer who is not affiliated with the managing general agent.

(e) Within 30 days of entering into or terminating a contract with a managing general agent, provide written notification of the appointment or termination to the commissioner. Notices of appointment of a managing general agent shall include a statement of duties that the applicant is a licensed agent, is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other information the commissioner may request.

(f) Review each quarter its books and records to determine if an agent has become a managing general agent. If the insurer determines that an agent has become a managing general agent, the insurer shall promptly notify the agent and the commissioner of this determination and the insurer and agent shall fully comply with the provisions of this chapter within 30 days.

(g) Except as to relationships governed by chapter 13, shall not appoint to the board of directors an officer, director, employee, agent, or controlling shareholder of the insurer's managing general agents.

History: Add. 1990, Act 350, Eff. June 1, 1991.

Popular name: Act 218

500.1412 Repealed. 1972, Act 133, Eff. Mar. 30, 1973.

Compiler's note: The repealed section pertained to license requirement and employment of insurance agent.

Popular name: Act 218

500.1413 Acts of managing general agent deemed acts of insurer; examination.

Sec. 1413. The acts of the managing general agent are considered to be the acts of the insurer on whose behalf it is acting. A managing general agent may be examined as if it were the insurer.

History: Add. 1990, Act 350, Eff. June 1, 1991.

Compiler's note: Former MCL 500.1413, which pertained to action by unlicensed agent, was repealed by Act 133 of 1972, Eff. Mar. 30, 1973.

Popular name: Act 218

500.1414 Repealed. 1972, Act 133, Eff. Mar. 30, 1973.

Compiler's note: The repealed section pertained to license requirement of clerical help.

Popular name: Act 218

500.1415 Violation; penalties; judicial review; rights of policyholders, claimants, and auditors.

Sec. 1415. (1) If the commissioner finds after a hearing conducted in accordance with the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, that any person has violated any provision of this chapter, the commissioner may order the following:

(a) For each separate violation, a civil fine in an amount that does not exceed $25,000.00.

(b) Revocation or suspension of the agent's license.

(c) Restitution by the managing general agent to reimburse the insurer, the rehabilitator, liquidator of the insurer, or the guaranty associations for any losses incurred by the insurer or the guaranty associations because of a violation of this chapter.

(2) The decision, determination, or order of the commissioner pursuant to subsection (1) shall be subject to judicial review pursuant to Act No. 306 of the Public Acts of 1969.

(3) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in this act.

(4) Nothing contained in this chapter is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, and auditors.

History: Add. 1990, Act 350, Eff. June 1, 1991.

Popular name: Act 218

500.1416 Repealed. 1972, Act 133, Eff. Mar. 30, 1973.

Compiler's note: The repealed section pertained to requisition of agent's license by insurer.

Popular name: Act 218

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500.1417 Rules and regulations.

Sec. 1417. The commissioner may adopt reasonable rules and regulations for the implementation and administration of the provisions of this chapter.

History: Add. 1990, Act 350, Eff. June 1, 1991.

Compiler's note: Former MCL 500.1417, which pertained to license, application, form, and examination fee, was repealed by Act 133 of 1972, Eff. Mar. 30, 1973.

Popular name: Act 218

500.1419 Effective date of chapter.

Sec. 1419. This chapter shall take effect on June 1, 1991. An insurer shall not use the services of a managing general agent on and after June 1, 1991, unless such use is in compliance with this chapter.

History: Add. 1990, Act 350, Eff. June 1, 1991.

Popular name: Act 218

500.1420-500.1450 Repealed. 1972, Act 133, Eff. Mar. 30, 1973.

Compiler's note: The repealed sections pertained to agents and solicitors.

Popular name: Act 218

CHAPTER 14a
PRODUCER CONTROLLED INSURERS

500.1451 "Producer" defined.

Sec. 1451. As used in this chapter, "producer" means an insurance agent or any other person, firm, association, or corporation, when, for any compensation, commission, or other thing of value, the person, firm, association, or corporation acts or aids in any manner in soliciting, negotiating, or procuring the making of an insurance contract on behalf of an insured other than the person, firm, association, or corporation.

History: Add. 1994, Act 227, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1452 Repealed. 1972, Act 133, Eff. Mar. 30, 1973.

Compiler's note: The repealed section, formerly compiled in Chapter 14 of this act, pertained to reward prohibited for procurement of business by unlicensed person.

Popular name: Act 218

500.1453 Exceptions to provisions of chapter.

Sec. 1453. The provisions of this chapter do not apply to the following:

(a) Risk retention groups as defined in section 1801.

(b) Captive insurers owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, owned by the insureds whose exclusive purpose is to insure risks of member organizations or group members and their affiliates.

History: Add. 1994, Act 227, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1454 Repealed. 1972, Act 133, Eff. Mar. 30, 1973.

Compiler's note: The repealed section, formerly compiled in Chapter 14 of this act, pertained to penalty for violations and suspension of license.

Popular name: Act 218

500.1455 Applicability of section; contract between controlling producer and insurer required for doing business; minimum provisions; audit committee; reports; applicability of section 60 days after effective date of chapter.

Sec. 1455. (1) Except as provided in subsection (2), this section applies if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling producer is equal to or greater than 5% of the admitted assets of the controlled insurer, as reported in the controlled insurer's quarterly financial statement filed as of September 30 of the prior year.

(2) This section does not apply if the controlling producer places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate, or subsidiary and receives no compensation based upon the amount of premiums written in connection with such insurance and accepts insurance

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placements only from nonaffiliated subproducers, and not directly from insureds; and the controlled insurer, except for insurance business written through a residual market facility, accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer.

(3) A controlled insurer shall not accept business from a controlling producer and a controlling producer shall not place business with a controlled insurer unless there is a written contract between the controlling producer and the insurer specifying the responsibilities of each party, which contract has been approved by the board of directors of the insurer and contains the following minimum provisions:

(a) That the controlled insurer may terminate the contract for cause, upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination.

(b) That the controlling producer shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to, the controlled producer.

(c) That the controlling producer shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that the premiums or installments collected shall be remitted no later than 90 days after the effective date of any policy placed with the controlled insurer under this contract.

(d) That all funds collected for the controlled insurer's account shall be held by the controlling producer in a fiduciary capacity, in 1 or more appropriately identified bank accounts in banks that are members of the federal reserve system, in accordance with the provisions of the applicable insurance law.

(e) That the controlling producer shall maintain separately identifiable records of business written for the controlled insurer.

(f) That the contract shall not be assigned in whole or in part by the controlling producer.

(g) That the controlled insurer shall provide the controlling producer with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates, and conditions. The standards, rules, procedures, rates, and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer.

(h) That the rates and terms of the controlling producer's commissions, charges, or other fees and the purposes for those charges or fees shall be specified. The rates of the commissions, charges, and other fees shall be no greater than those applicable to comparable business placed with the controlled insurer by producers other than controlling producers. For purposes of this subdivision and subdivision (g), examples of comparable business include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business.

(i) That if the contract provides that the controlling producer, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then such compensation shall not be determined and paid until at least 5 years after the premiums on policies that include liability insurance are earned and at least 1 year after the premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified as required by subsection (5).

(j) A limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings shall be set. The insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and shall not accept business from the controlling producer if the limit is reached. The controlling producer shall not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached.

(k) That the controlling producer may negotiate but shall not bind reinsurance on behalf of the controlled insurer on business the controlling producer places with the controlled insurer, except that the controlling producer may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(4) Every controlled insurer shall have an audit committee of the board of directors composed of independent directors. The audit committee shall meet annually with management, the insurer's independent public accountants as defined in section 1001, and an independent casualty actuary or other independent loss reserve specialist acceptable to the commissioner to review the adequacy of the insurer's loss reserves.

(5) Every controlled insurer shall file the following reports:

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(a) In addition to any other required loss reserve certification, the controlled insurer shall file with the commissioner on April 1 of each year an opinion of an independent casualty actuary or such other independent loss reserve specialist acceptable to the commissioner reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end, including provisions for incurred but not reported losses, on business placed by the controlling producer.

(b) The controlled insurer shall annually report to the commissioner the amount of commissions paid to the controlling producer, the percentage such amount represents of the net premiums written, and comparable amounts and percentage paid to noncontrolling producers for placements of the same kinds of insurance.

(6) A foreign controlled insurer is not required to file the reports with the commissioner required by subsection (5) if the insurer is subject to reporting requirements adopted by statute or regulation in its state of domicile that the commissioner has determined are substantially similar to those required under this chapter.

(7) This section applies 60 days after the effective date of this chapter.

History: Add. 1994, Act 227, Imd. Eff. June 27, 1994.

Compiler's note: Former MCL 500.1455, which was compiled in Chapter 14 of this act and pertained to insurance agents, accounts, and records, was repealed by Act 133 of 1972 , Eff. Mar. 30, 1973.

Popular name: Act 218

500.1456 Repealed. 1972, Act 133, Eff. Mar. 30, 1973.

Compiler's note: The repealed section, formerly compiled in Chapter 14 of this act, pertained to agent, solicitor, or broker as fiduciary and intent to embezzle.

Popular name: Act 218

500.1457 Notice of relationship between producer and controlled insurer; exception; applicability of section to policies written or renewed 60 days after effective date of chapter.

Sec. 1457. (1) The controlling producer, prior to the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the producer and the controlled insurer, except that if the business is placed through a subproducer who is not a controlling producer, the controlling producer shall retain a record of a signed commitment from the subproducer that the subproducer is aware of the relationship between the insurer and the producer and that the subproducer has or will notify the insured.

(2) This section applies to all policies written or renewed on or after 60 days after the effective date of this chapter.

History: Add. 1994, Act 227, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1458 Repealed. 1972, Act 133, Eff. Mar. 30, 1973.

Compiler's note: The repealed section, formerly compiled in Chapter 14 of this act, pertained to insurers' adjuster, license, and licensed agents for fire insurers.

Popular name: Act 218

500.1459 Noncompliance with chapter, regulation, or order; authority of commissioner; civil action for recovery of damages for benefit of insurer; other penalties; rights of third parties not affected or altered.

Sec. 1459. (1) If the commissioner believes that the controlling producer or any other person has not materially complied with this chapter or any regulation or order promulgated under this act, the commissioner may, after notice and opportunity to be heard, do either or all of the following:

(a) Order the controlling producer to cease placing business with the controlled insurer.

(b) If it was found that because of such material noncompliance that the controlled insurer or any policyholder of the insurer has suffered any loss or damage, maintain a civil action or intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages for the benefit of the insurer or policyholder or other appropriate relief.

(2) If an order for liquidation or rehabilitation of the controlled insurer has been entered pursuant to chapter 81, and the receiver appointed under that order believes that the controlling producer or any other person has not materially complied with this chapter or any regulation or order promulgated under this act and the insurer suffered any loss or damage as a result, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

(3) This section shall not affect the right of the commissioner to impose any other penalties provided for in

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this act.

(4) This section is not intended to or shall in any manner alter or affect the rights of policyholders, claimants, creditors, or other third parties.

History: Add. 1994, Act 227, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1460-500.1474 Repealed. 1972, Act 133, Eff. Mar. 30, 1973.

Compiler's note: The repealed sections, formerly compiled in Chapter 14 of this act, pertained to adjusters, counselors, and licensing.

Popular name: Act 218

CHAPTER 15
INSURANCE PREMIUM FINANCE COMPANIES

500.1501 Inapplicability of chapter.

Sec. 1501. This chapter shall not apply with respect to:

(a) An insurance company authorized to do business in the state or a subsidiary of an authorized insurer admitted in this state or a corporation under substantially the same management or control as an admitted authorized insurer or group of insurers, which subsidiary, managed or controlled company is engaged in the business of financing insurance premiums on policies issued only by its parent insurer or affiliated group of insurers, subject to section 1508(3).

(b) A bank, industrial bank, trust company, safe and collateral deposit company, small loan company, credit union, building and loan association, finance company, or cooperative savings association authorized to do business in the state.

(c) The inclusion of a charge for insurance in connection with an installment sale of a motor vehicle made in accordance with Act No. 27 of the Public Acts of the Extra Session of 1950, as amended, being sections 492.101 to 492.138 of the Michigan Compiled Laws.

(d) The financing of insurance premiums in accordance with Act No. 326 of the Public Acts of 1966, as amended, being sections 438.31 to 438.33 of the Michigan Compiled Laws, relating to legal interest rate.

(e) Any insurance agent or agency, or any wholly owned premium finance company of an insurance agent or agency, financing only insurance premiums on business produced by the agent or agency.

History: Add. 1968, Act 352, Eff. Nov. 15, 1968;—Am. 1976, Act 273, Eff. Apr. 1, 1977.

Popular name: Act 218

500.1501a Financial institutions; application of chapter.

Sec. 1501a. Nothing in this chapter shall limit or interfere with any bank, company or association described in subsection (b) of section 1501 as to any business which it is otherwise authorized to conduct, including the financing of insurance premiums. Nothing in this chapter shall prevent any such bank, company or association, if otherwise permitted by law and regulation, from qualifying under this chapter as an insurance premium finance company.

History: Add. 1968, Act 352, Eff. Nov. 15, 1968.

Popular name: Act 218

500.1502 Insurance premium finance companies; definitions.

Sec. 1502. As used in this chapter:

(a) "Insurance premium finance agreement" means an agreement by which an insured or prospective insured promises to pay to a premium finance company the amount advanced or to be advanced under the agreement to an insurer or to an insurance agent in payment of premiums on an insurance contract together with a service charge as authorized and limited by this chapter.

(b) "Insurance premium finance company" means a person engaged in the business of entering into insurance premium finance agreements.

(c) "Licensee" means a premium finance company holding a license issued by the commissioner under this chapter.

History: Add. 1968, Act 352, Eff. Nov. 15, 1968.

Popular name: Act 218

500.1503 License requirements; violation, penalty; fees, renewal, application.

Sec. 1503. (1) No person, except those excluded by section 1501, shall engage in the business of financing

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insurance premiums in this state without first having obtained a license as a premium finance company from the commissioner. Any person who shall engage in the business of financing insurance premiums in this state without obtaining a license, upon conviction as provided in section 230, shall be subject to a fine of not more than $200.00.

(2) The annual license fee shall be $200.00. Licenses may be renewed from year to year as of April 1 of each year upon payment of the fee of $200.00. The fee for the license shall be paid through the commissioner to the state treasury.

(3) Each applicant shall file sworn answers, subject to the penalties of perjury, to such interrogatories as the commissioner may require. The commissioner at any time may require the applicant fully to disclose the identity of all stockholders, partners, officers and employees and he may refuse to issue or renew a license in the name of any firm, partnership or corporation if he is not satisfied that any officer, employee, stockholder or partner thereof who may materially influence the applicant's conduct meets the standards of this chapter.

History: Add. 1968, Act 352, Eff. Nov. 15, 1968.

Popular name: Act 218

500.1504 License investigation of applicant; issuance, grounds, hearing, bond.

Sec. 1504. (1) Upon the filing of an application and the payment of the license fee the commissioner shall make an investigation of each applicant and shall issue a license if the applicant is qualified in accordance with this chapter. If the commissioner does not so find, he shall, within 30 days after he has received the application, at the request of the applicant, give the applicant a full hearing.

(2) The commissioner shall issue or renew a license as may be applied for when he is satisfied that the applicant is competent and trustworthy, has a good business reputation and has had experience, training or education in the business for which the license is applied, if a corporation, is a corporation incorporated under the laws of this state or admitted to do business in this state, and has proven in form satisfactory to the commissioner, that he has paid-up capital and surplus of $50,000.00, if a corporation, or net worth if an individual or copartnership of $50,000.00 which shall be maintained, and that allowing the applicant to engage in the business will promote the convenience and advantage of the community in which the business of the applicant is to be conducted. A $10,000.00 cash or corporate surety bond shall be deposited with the state treasurer for the benefit of any or all borrowers, who may become creditors of the premium finance company.

History: Add. 1968, Act 352, Eff. Nov. 15, 1968.

Popular name: Act 218

500.1505 Premium finance company; license; revocation or suspension; grounds; hearing; penalty; appeal; remuneration; applicability of subsection (4).

Sec. 1505. (1) The commissioner may revoke or suspend the license of a premium finance company if after investigation it appears to the commissioner that any of the following has occurred:

(a) Any license issued to the company was obtained by fraud.

(b) There was any misrepresentation in the application for the license.

(c) The holder of the license has otherwise shown himself or herself untrustworthy or incompetent to act as a premium finance company.

(d) The company has violated any of the provisions of this chapter or the rules and regulations promulgated under this chapter.

(e) Except as otherwise provided in subsection (4), the company has remunerated any insurance producer or any employee of an insurance producer or any other person as an inducement to the financing of any insurance policy with the premium finance company. Except, that if the insurance producer prepares the premium finance agreement, the premium finance company may pay him or her a service fee not to exceed $2.00.

(2) Before the commissioner revokes, suspends, or refuses to renew the license of a premium finance company, he or she shall give to the person an opportunity to be fully heard and to introduce evidence on its behalf. Instead of revoking or suspending the license for any of the reasons listed in subsection (1), after a hearing, the commissioner may subject the company to a penalty of not more than $200.00 for each offense with a total not to exceed $1,000.00 when in his or her judgment the commissioner finds that the public interest would not be harmed by the continued operation of the company. The amount of any penalty shall be paid by the company through the office of financial and insurance regulation to the state treasury. At any hearing provided by this section, the commissioner shall have authority to administer oaths to witnesses. Anyone testifying falsely, after having been administered an oath, is subject to the penalty of perjury.

(3) If the commissioner refuses to issue or renew a license or if an applicant or licensee is aggrieved by any

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action of the commissioner, the applicant or licensee shall have the right to a hearing and court proceeding as provided for in section 244.

(4) Subsection (1)(e) does not prohibit a premium finance company that is majority owned by insurance producers from remunerating any of its insurance producer owners. This subsection does not apply to a premium finance company that is involved in any manner in financing life insurance or annuity policies or contracts.

History: Add. 1968, Act 352, Eff. Nov. 15, 1968;—Am. 2011, Act 75, Imd. Eff. July 12, 2011.

Popular name: Act 218

500.1506 Premium finance transaction records; examination; preservation.

Sec. 1506. (1) A licensee shall maintain records of its premium finance transactions and the records shall be open to examination and investigation by the commissioner. The commissioner may at any time require a licensee to bring records as the commissioner may direct to the commissioner's office for examination.

(2) A licensee shall preserve its records of premium finance transactions, including cards used in a card system, for at least 3 years after making the final entry in respect to a premium finance agreement. The preservation of records in the form of reproductions pursuant to the records media act constitutes compliance with this requirement, except that a record shall not be reduced to such form until at least 2 years after the final entry is made in the record.

History: Add. 1968, Act 352, Eff. Nov. 15, 1968;—Am. 1992, Act 200, Imd. Eff. Oct. 5, 1992.

Popular name: Act 218

500.1507 Insurance commissioner; regulatory powers.

Sec. 1507. The commissioner may make and enforce such reasonable rules and regulations as may be necessary in making effective the provisions of this chapter, but such rules and regulations shall not be contrary to nor inconsistent with the provisions of this chapter. The rules shall be promulgated in accordance with the provisions of Act No. 88 of the Public Acts of 1943, as amended, being sections 24.71 to 24.80 of the Compiled Laws of 1948, and subject to Act No. 197 of the Public Acts of 1952, as amended, being sections 24.101 to 24.110 of the Compiled Laws of 1948.

History: Add. 1968, Act 352, Eff. Nov. 15, 1968.

Popular name: Act 218

500.1508 Premium finance agreement; requirements; specifications; items; subsidiary companies.

Sec. 1508. (1) A premium finance agreement shall:

(a) Be dated, signed by or on behalf of the insured, and the printed portion thereof shall be in at least 8-point type.

(b) Contain the name and place of business of the insurance agent negotiating the related insurance contract, the name and residence or the place of business of the insured as specified by him, the name and place of business of the premium finance company to which payments are to be made, a description of the insurance contracts involved and the amount of the premium therefor.

(c) Set forth the following items where applicable:

(*i*) The total amount of the premiums,

(*ii*) The amount of the down payment,

(*iii*) The balance of premiums due, the difference between items (*i*) and (*ii*),

(*iv*) The amount of the service charge, or other charges for each installment to be paid pursuant to the terms of the contract and the total charges to be paid for the duration of the contract,

(*v*) The balance payable by the insured, sum of items (*iii*) and (*iv*),

(*vi*) The number of installments required, the amount of each installment expressed in dollars, and the due date or period thereof.

(2) The items set out in subdivision (c) of subsection (1) need not be stated in the sequence or order in which they appear in the clause, and additional items may be included to explain the computations made in determining the amount to be paid by the insured.

(3) A subsidiary of an authorized insurer or a corporation under substantially the same management or control as an authorized insurer or group of authorized insurers may finance insurance premiums on insurance policies issued on business produced by such authorized insurer or group of insurers under an open-end, revolving credit plan wherein credit is advanced for the payment of insurance premiums from time to time, without being required to comply with the provisions of paragraphs (1) and (2) of this section if the service charge made under such premium finance agreement shall not exceed the service charge permitted under

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section 1509.

History: Add. 1968, Act 352, Eff. Nov. 15, 1968.

Popular name: Act 218

500.1509 Premium finance company; authorized charges; service charge; amending original contract where balance of premium due changed.

Sec. 1509. (1) A premium finance company shall not charge, contract for, receive, or collect any charge other than as permitted by this chapter.

(2) The service charge shall be computed on the balance of the premiums due, after subracting the down payment made by the insured in accordance with the premium finance agreement, from the effective date of the insurance coverage, for which the premiums are being advanced, to and including the date when the final installment of the premium finance agreement is payable.

(3) Except as provided in subsection (4), the service charge shall be a maximum of $12.00 per $100.00 per year plus an additional charge of $18.00 per premium finance agreement. The $18.00 need not be refunded upon cancellation or prepayment. Notwithstanding the provisions of any premium finance agreement to the contrary, any insured may pay the agreement in full at any time before the maturity of the final installment of the balance thereof and shall receive a refund of the unearned service charge which shall represent at least as great a proportion of the service charge after first deducting therefrom an acquisition cost of not more than $18.00 as:

(a) The sum of the monthly balances under the schedule of payments in the finance agreement beginning as of the date after the prepayment which is the next succeeding monthly anniversary date of the due date of the first installment under the agreement, or, if the prepayment is prior to the due date of the first installment under the agreement, then as of the date after the prepayment which is the next succeeding monthly anniversary date of the date of the agreement, bears to;

(b) The sum of all the monthly balances under the schedule of installment payments in the agreement. Where the amount of refund is less than $3.00, a refund need not be made.

(4) When the balance of premiums due is less than $100.00 and is:

(a) To be paid in 3 monthly installments or less, the maximum service charge shall be $15.00.

(b) To be paid in 4 or 5 monthly installments, the maximum service charge shall be $17.00.

(5) The service charge shall be computed at the time of making the contract of insurance.

(6) If the balance of premium due is changed, an amendment shall be added to the original contract setting forth the items required in section 1508(1)(c).

History: Add. 1968, Act 352, Eff. Nov. 15, 1968;—Am. 1982, Act 143, Imd. Eff. Apr. 28, 1982.

Compiler's note: In subsection (2) of this section, the word "subracting" evidently should read "subtracting".

Popular name: Act 218

500.1510 Insurance premium finance agreement; delinquency charge; cancellation charge.

Sec. 1510. (1) An insurance premium finance agreement may provide for the payment by the insured of a delinquency charge of $1.00 to a maximum of 5% of the amount of the delinquent installment payment on any installment payment that is in default for a period of 10 days or more. However, an insurance premium finance agreement shall not provide for the payment by the insured of a delinquency charge that exceeds $5.00 on any installment that is in default for a period of 10 days or more for either of the following:

(a) An insurance premium finance agreement that finances an insurance contract primarily for a personal, family, or household purpose.

(b) An insurance premium finance agreement, the annual premium of which does not exceed $10,000.00, that is issued to a nonprofit organization exempt from taxation under section 501 of the internal revenue code of 1986, 26 U.S.C. 501.

(2) If a default under subsection (1) results in the cancellation of any insurance contract listed in the agreement, the agreement may provide for the payment by the insured of a cancellation charge equal to the difference between any delinquency charge imposed in respect to the installment in default and $5.00.

History: Add. 1968, Act 352, Eff. Nov. 15, 1968;—Am. 1994, Act 6, Imd. Eff. Feb. 24, 1994.

Popular name: Act 218

500.1511 Premium finance agreement; cancellation of insurance, procedure, notice, refund.

Sec. 1511. (1) When a premium finance agreement empowers the premium finance company to cancel any insurance contract or contracts listed in the agreement, the insurance contract or contracts shall not be canceled by the premium finance company unless such cancellation is effectuated in accordance with this section.

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(2) Not less than 10 days' written notice shall be mailed to the insured of the intent of the premium finance company to cancel the insurance contract unless the default is cured within the 10-day period.

(3) After expiration of the 10-day period, the premium finance company may request cancellation of the insurance contract by mailing to the insurer a notice of cancellation, and the insurance contract shall be cancelled by the insurer without requiring the return of the insurance contract. The premium finance company shall also mail a notice of cancellation to the insured at his last known address at the same time the premium finance company requests cancellation of the insurance contract.

(4) All statutory, regulatory and contractual restrictions providing that the insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee or other third party shall apply where cancellation is effected under the provisions of this section. The insurer shall give the prescribed notice in behalf of itself or the insured to any governmental agency, mortgagee or other third party on or before the second business day after the day it receives the notice of cancellation from the premium finance company and shall determine the effective date of cancellation taking into consideration the number of days' notice required to complete the cancellation.

(5) Whenever a financed contract is canceled, the insurer shall return whatever gross unearned premiums are due under the insurance contract to the premium finance company for the account of the insured.

(6) If the crediting of return premiums to the account of the insured results in a surplus over the amount due from the insured, the premium finance company shall refund the excess to the insured, but no refund shall be required if it amounts to less than $1.00.

History: Add. 1968, Act 352, Eff. Nov. 15, 1968.

Popular name: Act 218

500.1512 Premium finance agreement; filing not required.

Sec. 1512. No filing of the premium finance agreement shall be necessary to perfect the validity of such agreement as a secured transaction as against creditors, subsequent purchasers, pledgees, encumbrances, successors or assigns.

History: Add. 1968, Act 352, Eff. Nov. 15, 1968.

Popular name: Act 218

500.1513 Existing companies; license, fee.

Sec. 1513. Any person who has been engaged in the business as a premium finance company in this state which premium finance company has paid-up capital and surplus of at least $20,000.00 and whose fiscal solvency, general operation and financial condition has been investigated or audited and approved by the commissioner on written request and payment of the annual license fee made within 60 days of the effective date of this chapter shall be entitled to a license notwithstanding any other provisions of this chapter. Any premium finance company licensed pursuant to this section, the capital and surplus of which is less than $50,000.00 shall increase its capital and surplus to at least $50,000.00 within 2 years of the date of issuance of its first license hereunder and upon failure to do so such license shall not be further renewed. Nothing in this section shall prevent such company thereafter from being licensed under this act.

History: Add. 1968, Act 352, Eff. Nov. 15, 1968.

Popular name: Act 218

500.1514 Insurance commissioner and employees; statement of expenses and charges, payment; employment of expert personnel.

Sec. 1514. (1) All actual and necessary expenses incurred by the commissioner, his deputies, assistants, and employees, or the commissioner himself, in connection with the regulation, examination, or investigation of any licensed premium finance company pursuant to this code shall be certified by the commissioner, together with an appropriate statement of the time spent by such persons, upon such regulation, examination, or investigation, to the accounting division of the department of administration, who, if correct, shall approve it and the expenses shall be paid to the persons by whom they were incurred, upon the warrant of the state treasurer.

(2) The insurance commissioner shall prepare and present to the premium finance company so regulated, examined, or investigated, the statement of such expenses and charges sufficient to defray all of the costs to the state of each person engaged in such regulation, examination, or investigation and that of any administrative or supervisory personnel utilized in connection therewith, and the applicant or licensed premium finance company, upon receiving such statement shall pay to the commissioner the amount stated therein. The commissioner shall deposit the funds so received with the state treasurer to be credited by him to the general fund.

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(3) The commissioner may employ such expert personnel as may be necessary for other than routine regulation; examination, or investigation of any applicant for license or licensed premium finance company, and the compensation and expenses of such expert personnel shall be that charged by the expert personnel. Charges hereunder shall be accounted, charged, and paid in the same manner as provided in subsections (1) and (2) above.

History: Add. 1968, Act 352, Eff. Nov. 15, 1968.

Popular name: Act 218

CHAPTER 16.
Creditor-Placed Insurance

500.1601 Insurer or producer transacting creditor-placed insurance; scope.

Sec. 1601. (1) This chapter applies to an insurer or producer transacting creditor-placed insurance as defined in this chapter.

(2) All creditor-placed insurance written in connection with credit transactions for personal, family, or household purposes is subject to the provisions of this chapter, except for the following:

(a) Transactions involving extensions of credit primarily for business or commercial purposes.

(b) Insurance on collateralized real property.

(c) Insurance offered by the creditor and elected by the debtor at the debtor's option.

(d) Insurance for which no specific charge is made to the debtor or the debtor's account.

(e) Blanket insurance, whether paid for by the debtor or the creditor.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

500.1603 Private cause of action not created.

Sec. 1603. This chapter does not create or imply a private cause of action for violation of this chapter and does not extinguish any debtor rights available under common law or other state statute.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

500.1605 Definitions.

Sec. 1605. As used in this chapter:

(a) "Actual cash value" means the cost of replacing damaged or destroyed property with comparable new property, minus depreciation and obsolescence.

(b) "Blanket insurance" means insurance that provides coverage on collateral as defined in a policy issued to a creditor, without specifically listing the collateral covered.

(c) "Collateral" means personal property that is pledged as security for the satisfaction of a debt.

(d) "Credit agreement" means the written document that sets forth the terms of the credit transaction and includes the security agreement.

(e) "Credit transaction" means a transaction by the terms of which the repayment of money loaned or credit commitment made, or payment of goods, services, or properties sold or leased, is to be made at a future date or dates.

(f) "Creditor" means the lender of money or vendor or lessor of goods, services, property, rights, or privileges for which payment is arranged through a credit transaction, or any successor to the right, title, or interest of a lender, vendor, or lessor.

(g) "Creditor-placed insurance" means insurance that is purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss, expense, or damage to collateralized personal property as a result of fire, theft, collision, or other risks of loss that would either impair a creditor's interest or adversely affect the value of collateral covered by limited dual interest insurance. Creditor-placed insurance is purchased according to the terms of the credit agreement as a result of the debtor's failure to provide required physical damage insurance, with the cost of the coverage being charged to the debtor. It is either single interest insurance or limited dual interest insurance.

(h) "Debtor" means the borrower of money or a purchaser or lessee of goods, services, property, rights, or privileges, for which payment is arranged through a credit transaction.

(i) "Insurance tracking" means monitoring evidence of insurance on collateralized credit transactions to determine whether insurance required by the credit agreement has lapsed, and communicating with debtors concerning the status of insurance coverage.

(j) "Lapse" means that the insurance coverage required by the credit agreement is not in force.

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(k) "Limited dual interest insurance" means insurance purchased by the creditor to insure its interest in the collateral securing the debtor's credit transaction. Limited dual interest insurance waives the 3 conditions for loss payment under single interest insurance and extends coverage on the collateral while in the possession of the debtor.

(*l*) "Loss ratio" means the ratio of incurred losses to earned premium.

(m) "Net debt" means the amount necessary to liquidate the remaining debt in a single lump-sum payment, excluding all unearned interest and other unearned charges.

(n) "Producer" means a person who receives a commission for insurance placed or written or who, on behalf of an insurer or creditor, solicits, negotiates, effects, procures, delivers, renews, continues, or binds policies of insurance to which this chapter applies, but does not include the following:

(*i*) A regular salaried officer, employee, or other representative of an insurer who devotes substantially all working time to activities other than those specified in this subdivision and who receives no compensation that is directly dependent on the amount of insurance business written.

(*ii*) A regular salaried officer or employee of a creditor who receives no compensation that is directly dependent on the amount of insurance effected or procured.

(o) "Single interest insurance" means insurance purchased by the creditor to insure its interest in the collateral securing a debtor's credit transaction where the following 3 conditions must be met for payment of loss under the policy:

(*i*) The debtor has defaulted in payment.

(*ii*) The creditor has legally repossessed the collateral, unless collateral has been stolen from the debtor.

(*iii*) The creditor has suffered an impairment of interest.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

500.1607 Dates on which insurance effective or terminated.

Sec. 1607. (1) Creditor-placed insurance shall become effective on the latest of the following dates:

(a) The date of the credit transaction.

(b) The date prior coverage, including prior creditor-placed insurance coverage, lapsed.

(c) One year before the date on which the related insurance charge is made to the debtor's account.

(d) A later date provided for in the agreement between the creditor and insurer.

(2) Creditor-placed insurance shall terminate on the earliest of the following dates:

(a) The date other acceptable insurance becomes effective, subject to the debtor providing acceptable evidence of the other insurance to the creditor.

(b) The date the collateralized personal property is repossessed, unless the property is returned to the debtor within 10 days of the repossession.

(c) The date the collateralized personal property is determined by the insurer to be a total loss.

(d) The date the debt is completely extinguished.

(e) An earlier date specified in the individual policy or certificate of insurance.

(3) An insurance charge shall not be made to a debtor for a term longer than the scheduled term of the creditor-placed insurance when it becomes effective, and an insurance charge shall not be made to the debtor for creditor-placed insurance before the effective date of the insurance.

(4) If a charge is made to a debtor for creditor-placed insurance coverage that exceeds a term of 1 year, the debtor shall be notified at least annually that the insurance will be canceled and a refund or credit of unearned charges made if evidence of acceptable insurance secured by the debtor is provided.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

500.1609 Premiums; calculation; limitation; charges creating balloon payment prohibited.

Sec. 1609. (1) Premiums for creditor-placed insurance coverage may be calculated based on an amount not exceeding the net debt even though the coverage may limit the insurer's liability to the net debt, actual cash value, or cost of repair, or other premium calculation methods that more closely reflect the exposure of each item insured and approximate the premium calculation method of the coverage required by the credit agreement.

(2) An insurer shall not write creditor-placed insurance for which the premium rate differs from that determined by the schedules of the insurer on file with the commissioner. The premium or amount charged to the debtor for creditor-placed insurance shall not exceed the premiums charged by the insurer, computed at the time the charge to the debtor is determined.

(3) A method of billing insurance charges to the debtor on closed-end credit transactions that creates a

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balloon payment at the end of the credit transaction or extends the credit transaction's maturity date is prohibited, unless specifically disclosed at the time of the origination of the credit agreement and specifically agreed to by the debtor at the time the charge is added to the outstanding credit balance.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

500.1611 Exclusions.

Sec. 1611. (1) Creditor-placed insurance coverage does not include any of the following:

(a) Coverage for the cost of repossession.

(b) Skip, confiscation, and conversion coverage.

(c) Coverage for payment of mechanics' or other liens that do not arise from a covered loss occurrence.

(d) Coverage that requires a debtor's insurance deductible to be less than $250.00.

(e) Coverage that is broader than the insurance coverages that meet the minimum insurance requirements of the credit agreement.

(2) This section does not prohibit the issuance of a separate policy or endorsement providing the coverages listed in subsection (1). However, no charge shall be passed along to the debtor for these coverages.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

500.1613 Evidence of insurance coverage.

Sec. 1613. Creditor-placed insurance shall be set forth in an individual policy or certificate of insurance. A copy of the individual policy, certificate of insurance coverage, or other evidence of insurance coverage shall be mailed, first-class mail, or delivered in person to the last known address of the debtor.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

500.1615 Policy forms and certificates of insurance; filing; schedule of premium rates; withdrawal of approval.

Sec. 1615. (1) All policy forms and certificates of insurance to be delivered or issued for delivery in this state and the schedules of premium rates pertaining to them shall be filed with the commissioner.

(2) Within 30 days after the filing of the policy forms and certificates of insurance, the commissioner shall disapprove a form that does not conform to this act. Within 30 days of filing, the commissioner shall disapprove a schedule of premium rates pertaining to the form if it does not conform to the standard set forth in subsection (5).

(3) If the commissioner disapproves a form or schedule of premium rates, the commissioner shall promptly notify the insurer in writing of the disapproval, and the insurer shall not issue or use the form or schedule. The commissioner shall specify the reasons for disapproval in the notice and state that a hearing will be granted upon request pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(4) Unless the commissioner disapproves the form or schedule of premium rates as provided in this section or gives written approval of the form or schedule within 30 days after the filing, the form or schedule is considered approved 31 days after the filing.

(5) A schedule of premium rates shall provide for premiums that are not unreasonable in relation to the benefits provided by the form to which the schedule applies. A premium rate or schedule of premium rates is reasonable for purposes of this section if the rate or schedule of rates produces or may reasonably be expected to produce a loss ratio of 60% or greater. This subsection does not prohibit the commissioner from approving other loss ratios he or she finds reasonable.

(6) The commissioner may withdraw approval of an approved form or schedule of premium rates when the commissioner would be required to disapprove the form or schedule of premium rates if it were filed at the time of the withdrawal. The withdrawal shall be in writing and shall specify the reasons for withdrawal and the effective date of the withdrawal. An insurer adversely affected by a withdrawal may, within 30 days after receiving the written notification of the withdrawal, request a hearing pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to determine whether the withdrawal should be annulled, modified, or confirmed. Unless the commissioner grants an extension in writing in the withdrawal or subsequently grants an extension, the withdrawal, in the absence of a request for hearing, shall become effective prospectively and not retroactively, 91 days after delivery of the notice of withdrawal and, if the request for hearing is filed, 91 days after delivery of written notice of the commissioner's determination.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

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500.1617 Refund of unearned premium or other charges; statement of refund; amount.

Sec. 1617. (1) Not later than 60 days after the termination of creditor-placed insurance coverage, and in accordance with sections 2833(1)(h) and 3020(1)(c), an insurer shall refund any unearned premium or other identifiable charges.

(2) Not later than 60 days after the termination date of creditor-placed insurance coverage, the insurer shall provide to the debtor a statement of refund disclosing the effective date, the termination date, the amount of premium being refunded, and the amount of premium charged for the coverage provided.

(3) If coverage under this chapter is not provided, the entire amount of premiums, minimum premiums, fees, or charges of any kind shall be refunded.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

500.1619 Loss incurred; payment; reduced net debt or actual cash value amounts; subrogation; written statement; towing and storage charges.

Sec. 1619. (1) If a loss is incurred under a creditor-placed insurance policy, the insurer shall pay, at a minimum, the lesser of the following, determined as of the date of loss:

(a) The cost to repair the collateral less any applicable deductible.

(b) The actual cash value of the collateral, less any applicable deductible.

(c) The net debt, less any applicable deductible. The method of calculation of net debt payable pursuant to this subdivision shall be identical to the method of calculation of net debt for payment of premiums pursuant to section 1609(1).

(d) If single interest insurance is provided, the amount by which the creditor's interest is impaired.

(2) The net debt or actual cash value amounts in subsection (1) may be reduced by the value of salvage if the insurer does not take possession of the insured property.

(3) In the event of a loss, no subrogation shall run against the debtor from the insurer.

(4) Whenever a claim is made on a creditor-placed insurance policy, the insurer shall furnish to the claimant a written statement of the loss explaining the settlement amount and the method of settlement.

(5) A creditor or insurer shall not abandon salvage to a towing or storage facility in lieu of payment of storage fees without the consent of the facility and the claimant. The insurer shall be responsible for the payment of towing and storage charges for a covered loss occurrence from the time the claim is reported to the insurer in accordance with the terms of the policy to the time the claim is paid. The insurer shall give written notice to the claimant when the claim is paid that the claimant may incur storage charges after the date the claim is paid.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

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500.1621 Insurance on collateral; conditions.

Sec. 1621. (1) For a creditor to place insurance on collateral pledged by the debtor and pass the cost of the insurance on to the debtor, all of the following must be met:

(a) The creditor must have a security interest in the collateral.

(b) The credit agreement must require the debtor to maintain insurance on the collateral to protect the creditor's interest.

(c) The credit agreement must authorize the creditor to place the insurance if the debtor fails to provide evidence of the insurance.

(d) The requirements listed in subdivisions (a) to (c) must be clearly disclosed to the debtor at the inception of the credit transaction.

(2) A debtor has the right to provide required insurance through existing policies of insurance owned or controlled by the debtor or of procuring and furnishing the required coverage through an insurer authorized to transact insurance within this state. However, a creditor may establish maximum acceptable deductibles, insurer solidity standards, and other reasonable conditions with respect to the required insurance.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

500.1623 Rebates or inducements; prohibitions.

Sec. 1623. (1) The entire amount of the premium due from a creditor shall be remitted to the insurer or its producer in accordance with the insurer's requirements. No commissions may be paid to, or retained by, a person or entity except a licensed and appointed producer.

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(2) A creditor shall not retain unearned premiums upon cancellation of the insurance without crediting to the debtor's account the amount of unearned insurance charges.

(3) Rebates to the creditor of a portion of the premium charged to the debtor are prohibited as are other inducements provided to the creditor by an insurer or producer. All of the following activities are prohibited rebates or inducements:

(a) Allowing insurers or producers to purchase certificates of deposit from the creditor or to maintain accounts with the creditor at less than the market interest rates and charges that the creditor applies to other customers for deposit accounts of similar amounts and duration.

(b) Paying a commission to a person, including a creditor, who is not appropriately licensed as a producer in this state.

(c) Purchasing or offering to purchase certificates of deposit from, or maintaining or offering to maintain deposit accounts or investment accounts with a creditor as part of a creditor-placed insurance solicitation.

(d) Any other activity identified by the commissioner and prohibited by rule, regulation, or order.

(4) Prohibited rebates or inducements do not include any of the following:

(a) The paying of commissions and other compensation to a duly licensed and appointed producer, whether or not affiliated with the creditor.

(b) The paying to the creditor policyholder of group experience rated refunds or policy dividends.

(c) The providing of insurance tracking and other services incidental to the creditor-placed insurance program.

(d) The paying to the creditor of amounts intended to reimburse the creditor for its expenses incurred incidental to the creditor-placed insurance program, such as costs of data processing, mail processing, telephone service, insurance tracking, billing, collection, and related activities, provided that these payments are approved in a manner consistent with the procedures in section 1615 and are calculated in a manner that does not exceed an amount reasonably estimated to equal the expenses incurred by the creditor.

(5) An insurer that pays commissions to producers for creditor-placed insurance that are greater than 20% of the net written premium shall demonstrate to the commissioner that the commissions are not unreasonably high in relation to the value of the services rendered.

(6) This section does not prohibit or restrict an insurer or producer from maintaining a demand, premium deposit, or other account or accounts with a creditor for which the insurer or producer provides insurance if the accounts pay the market interest rate and charges that the creditor applies to other customers for deposit accounts of similar amounts and duration.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

500.1625 Adequate disclosure of requirement to maintain insurance; notice; final notice; noncompliance.

Sec. 1625. (1) A creditor shall not impose charges, including premium costs and related interest and finance charges, on a debtor for creditor-placed insurance coverage unless adequate disclosure of the requirement to maintain insurance has been made to the debtor. Adequate disclosure is accomplished if all of the following occur:

(a) The credit agreement sets forth the requirement that the debtor must maintain insurance on the collateral as provided for in section 1621.

(b) The creditor makes reasonable efforts to notify the debtor of the requirement to maintain insurance and allows a reasonable time for compliance with this requirement.

(c) A final notice as required by this chapter is sent to the debtor.

(d) If creditor-placed insurance coverage is issued, a copy of the policy or certificate is sent to the debtor as provided for in section 1613.

(2) After adequate disclosure of the request to maintain insurance has been made to the debtor as required by this section, a creditor may proceed to impose charges for creditor-placed insurance if the debtor fails to provide evidence of insurance. A creditor may impose charges no earlier than 10 days after sending the final notice.

(3) Reasonable efforts to notify the debtor under subsection (1)(b) are accomplished if the creditor does all of the following:

(a) Mails a notice by first-class mail to the debtor's last known address as contained in the creditor's records, stating that the creditor intends to charge the debtor for creditor-placed insurance coverage on the collateral if the debtor fails to provide evidence of the property insurance to the creditor.

(b) Allows the debtor at least 20 days to respond to the notice and provide evidence of acceptable insurance coverage before sending a final notice.

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(c) Sends a final notice in compliance with this section by first-class mail to the debtor's last known address as contained in the creditor's records at least 10 days before the cost of insurance is charged to the debtor by the creditor. Proof of the mailing of the final notice shall be retained for at least 3 years following the expiration or termination of the coverage or as otherwise required by law.

(4) The initial notice under this section shall be in a form determined by the creditor to remind the debtor of the requirement to maintain insurance on the collateral. The final notice under this section shall be as complete as the following notice, printed in not less than 12-point type, and modified where necessary to fit the nature of the credit transaction:

FINAL NOTICE

Your credit agreement with us requires you to have property insurance on the collateral until you pay off your loan. You have not given us proof you have insurance on the property. You can ask your insurance company or agent to give us proof of insurance or you can send us proof you have property insurance within 10 calendar days after the date this letter was postmarked. If you do not, we will buy the insurance and charge the cost to you.

You must pay for the property insurance we buy. It may cost more than insurance you can buy on your own. The cost of the insurance we buy may be added to your loan balance and we may charge you interest on it. If we do, you will pay interest at the same rate you pay on your loan.

The insurance we buy will pay claims to us (the creditor) for physical damage to your property. It will not pay any claims made against you [and it may not pay you for any claims you make (delete if limited dual interest coverage)]. The insurance we buy will not give you any liability insurance coverage and will not meet the requirements of a state's financial responsibility law.

We may receive compensation for placing this insurance, which is included in the cost of coverage charged to you.

The property coverage we buy will start on the date shown in the policy or certificate, which may go back to the date of the loan or the date your prior coverage stopped. We will cancel the insurance we bought for you and give you a refund or credit of unearned charges if you give us proof you have bought property insurance somewhere else or if you have paid off the loan.

(5) All creditor-placed insurance shall be set forth in an individual policy or certificate of insurance. Not earlier than the sending of the final notice nor 25 days after a charge is made to the debtor for creditor-placed insurance coverage, the creditor shall cause a copy of the individual policy, certificate, or other evidence of insurance coverage evidencing the creditor-placed insurance coverage to be sent, first-class mail, to the debtor's last known address.

(6) A creditor's compliance with or failure to comply with this chapter shall not be construed to require the creditor to purchase insurance coverage on the collateral, and the creditor is not liable to the debtor or a third party as a result of its failure to purchase the insurance.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

500.1627 Investigations or examinations; enforcement; hearing; consent agreement; injunctive relief.

Sec. 1627. (1) In addition to other powers under this act, the commissioner may conduct investigations or examinations of insurers and producers to ensure compliance with and enforcement of the provisions of this chapter.

(2) Upon finding that an insurer or producer has violated a provision of this chapter or a regulation promulgated under this chapter, the commissioner may issue an order directing that the insurer or producer cease and desist from committing the violations, impose a civil penalty for the violations, provide an equitable remedy for past violations, or any combination of these.

(3) Upon the issuance of an order under subsection (2), the insurer or producer may request a hearing. At the hearing, the burden shall be on the insurer or producer to show cause why an order issued pursuant to subsection (2) should be annulled, modified, or confirmed. Pending the hearing and the decision by the commissioner, the commissioner shall suspend the effective date of the order. Not more than 60 days after the hearing, the commissioner shall enter an order of final determination that shall specify all relevant findings of fact, conclusions of law, and orders. With the agreement of each affected insurer or producer, and in lieu of a hearing, the commissioner may enter into a consent agreement disposing of the matters that would be the subject of the hearing and order.

(4) The commissioner may bring an action in the circuit court for Ingham county for an injunction or other appropriate relief to enjoin threatened or existing violations of this chapter or of the commissioner's orders or regulations or for restitution on behalf of persons aggrieved by a violation of this chapter or of the

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commissioner's orders or regulations.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

500.1629 Judicial review; court order.

Sec. 1629. (1) A person aggrieved by a final order, decision, finding, ruling, action, or inaction provided for under this chapter may seek judicial review as provided in section 244.

(2) To the extent that the order or final determination of the commissioner is affirmed, the court shall issue its own order commanding obedience to the terms of the commissioner's order or final determination. If either party applies to the court for leave to produce additional evidence, and shows to the satisfaction of the court that the additional evidence is material and that there were reasonable grounds for the failure to produce the evidence in the proceeding before the commissioner, the court may order the additional evidence to be taken before the commissioner and to be produced in a hearing in the manner and upon the terms and conditions the court considers proper. The commissioner may modify the findings of fact or make new findings by reason of the additional evidence taken and shall file the modified or new findings with a recommendation, if any, for the modification or setting aside of the original order or final determination, with the return of the additional evidence.

(3) An order issued by the commissioner under section 1627 shall become final upon the expiration of the time allowed for filing a petition for review if no petition has been duly filed within that time, except that the commissioner may thereafter modify or set aside the order to the extent provided in section 1627 or upon the final decision of the court if the court directs that the order of the commissioner be affirmed or the petition for review dismissed.

(4) An order of the commissioner under this chapter or an enforcement order of a court does not relieve or absolve any person affected by the order from liability under any other laws of this state.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

500.1631 Violation of order of commission; penalty.

Sec. 1631. An insurer that violates an order of the commissioner under this chapter shall be afforded a hearing before the commissioner under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. If the commissioner finds a violation has occurred, the commissioner may order either or both of the following:

(a) Payment of a monetary penalty of not more than $1,000.00 for each violation, but not to exceed an aggregate penalty of $100,000.00, unless the violation was committed in a conscious and flagrant disregard of this chapter, in which case the commissioner may order the payment of a monetary penalty of not more than $25,000.00 for each violation, but not to exceed an aggregate penalty of $250,000.00.

(b) Suspension or revocation of the insurer's license.

History: Add. 2002, Act 655, Eff. Mar. 23, 2003.

Popular name: Act 218

CHAPTER 17

RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT

500.1701 Definitions.

Sec. 1701. As used in this chapter:

(a) "Insurance group" means, for the purpose of conducting an ORSA, insurers and affiliates included within an insurance holding company system.

(b) "Insurer" means that term as defined in section 106. Insurer also includes a fraternal benefit society as that term is defined in section 8164 and a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373. Insurer does not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(c) "NAIC" means the National Association of Insurance Commissioners.

(d) "Own risk and solvency assessment" or "ORSA" means a confidential internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by the insurer or insurance group, of the material and relevant risks associated with the insurer or insurance group's current business plan, and the sufficiency of capital resources to support those risks.

(e) "ORSA guidance manual" means the own risk and solvency assessment guidance manual as adopted

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and prescribed by the director. A change in the ORSA guidance manual is effective on the January 1 following the calendar year in which the changes have been adopted and prescribed by the director.

(f) "ORSA summary report" means a confidential high-level summary of an insurer or insurance group's ORSA.

History: Add. 2015, Act 245, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1703 Risk management framework.

Sec. 1703. An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing, and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

History: Add. 2015, Act 245, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1705 ORSA; conduct.

Sec. 1705. Subject to section 1709, an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with a process comparable to the ORSA guidance manual. The ORSA shall be conducted no less than annually but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

History: Add. 2015, Act 245, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1707 ORSA summary report.

Sec. 1707. (1) An insurer shall annually submit to the director an ORSA summary report, or any combination of reports that together contain the information as described in the ORSA guidance manual, applicable to the insurer, the insurance group of which it is a member, or both. Within 90 days after the effective date of the amendatory act that added this section, the insurer shall submit to the director the calendar date the insurer will annually submit the ORSA summary report required under this section. The insurer shall file the first report required under this subsection no later than the insurer's submitted calendar date in 2018. If the insurer is a member of an insurance group and if the director is the lead state regulator of the insurance group as determined under the procedures within the National Association of Insurance Commissioners Financial Analysis Handbook, as adopted by the director, the insurer shall submit a report required by this subsection.

(2) A report required under subsection (1) must include a signature of the insurer or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process attesting to the best of his or her belief and knowledge that the insurer applies the enterprise risk management process described in the ORSA summary report and that a copy of the report has been provided to the insurer's board of directors or appropriate committee of the insurer's board of directors.

(3) An insurer may comply with subsection (1) by providing the most recent and substantially similar report provided by the insurer or another member of an insurance group of which the insurer is a member to a commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if the report provides information that is comparable to the information described in the ORSA guidance manual. A report in a language other than English must be accompanied by a translation of the report into the English language.

History: Add. 2015, Act 245, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1709 Exemptions; waiver; requirement to maintain risk management framework, conduct ORSA, and file ORSA summary report; compliance by insurer no longer qualifying for exemption.

Sec. 1709. (1) Except as otherwise provided in subsection (5), an insurer is exempt from the requirements of this chapter, if both of the following apply:

(a) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and federal flood program, less than $500,000,000.00.

(b) The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and federal flood program, less than $1,000,000,000.00.

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(2) If an insurer qualifies for exemption under subsection (1)(a) but the insurance group of which the insurer is a member does not qualify for exemption under subsection (1)(b), the ORSA summary report that may be required under section 1707 must include every insurer within the insurance group. This requirement may be satisfied by the submission of more than 1 ORSA summary report for any combination of insurers if the combination of reports includes every insurer within the insurance group.

(3) If an insurer does not qualify for exemption under subsection (1)(a) but the insurance group of which it is a member qualifies for exemption under subsection (1)(b), the only ORSA summary report that may be required under section 1707 is the report applicable to the insurer.

(4) Subject to subsection (5), an insurer that does not qualify for exemption under subsection (1) may apply to the director for a waiver from the requirements of this chapter based on unique circumstances. In deciding whether to grant the insurer's request for a waiver, the director may consider the type and volume of business written, ownership and organizational structure, and any other factor the director considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than 1 state, the director shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

(5) Notwithstanding the exemption provided in subsection (1), the director may require 1 or more of the following:

(a) The director may require that an insurer maintain a risk management framework, conduct an ORSA, and file an ORSA summary report based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests.

(b) The director may require that an insurer maintain a risk management framework, conduct an ORSA, and file an ORSA summary report if the director determines 1 or more of the following:

(*i*) The insurer has risk-based capital for a company action level event.

(*ii*) The insurer meets 1 or more of the conditions described in section 436.

(*iii*) The operation of the insurer is hazardous to policyholders, creditors, or the public under section 436a.

(*iv*) The insurer exhibits qualities of a troubled insurer.

(6) If an insurer that qualifies for an exemption under subsection (1) subsequently no longer qualifies for that exemption because of an increase in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer has 1 year following the year the premium exceeded the limitation provided in subsection (1) to comply with this chapter.

History: Add. 2015, Act 245, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1711 ORSA summary report; preparation; maintenance and availability; review by director.

Sec. 1711. (1) Subject to subsection (2), an insurer shall prepare an ORSA summary report under section 1707 consistent with the ORSA guidance manual prescribed by the director. The insurer shall maintain and make available to the director documentation and supporting information relating to the ORSA summary report.

(2) The director shall review an ORSA summary report and any additional requests for information using similar procedures used in the analysis and examination of multistate or global insurers and insurance groups.

History: Add. 2015, Act 245, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1713 Documents, materials, or other information; confidentiality; sharing and use of information; written agreement with NAIC or third-party consultant; administration, execution, and enforcement of chapter by director; inadmissibility as evidence.

Sec. 1713. (1) Documents, materials, or other information, including the ORSA summary report, in the possession or control of the director that are obtained by, created by, or disclosed to the director or any other person under this chapter are considered proprietary and to contain trade secrets. The documents, materials, or other information are confidential and privileged, are not subject to disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, are not subject to subpoena, and are not subject to discovery or admissible in evidence in a private civil action. However, the director may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the director's official duties. The director shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer to which it pertains.

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(2) The director or any person who received documents, materials, or other ORSA-related information, through examination or otherwise, while acting under the authority of the director or with whom the documents, materials, or other information are shared under this act shall not testify in a private civil action concerning confidential documents, materials, or information described in subsection (1).

(3) The director may do all of the following:

(a) Except as otherwise provided in this subdivision, on request, share documents, materials, or other ORSA-related information, including the confidential and privileged documents, materials, or information described in subsection (1), including proprietary and trade secret documents and materials with other state, federal, and international financial regulatory agencies, including members of a supervisory college, with the NAIC and with any third-party consultants designated by the director. The director shall not share documents, materials, or other ORSA-related information described in this subdivision unless the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality.

(b) Subject to this subdivision, receive documents, materials, or other ORSA-related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of a supervisory college, and from the NAIC. The director shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(4) The director shall enter into a written agreement with the NAIC or a third-party consultant governing sharing and use of information provided under this chapter. The written agreement must do all of the following:

(a) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant under this chapter, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers.

(b) Contain a statement that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality.

(c) Specify that the director owns the information shared with the NAIC or a third-party consultant under this chapter and that the NAIC's or third-party consultant's use of the information is subject to the direction of the director.

(d) Prohibit the NAIC or third-party consultant from storing the information shared under this chapter in a permanent database after the underlying analysis is completed.

(e) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or third-party consultant under this chapter is subject to a request or subpoena to the NAIC or third-party consultant for disclosure or production.

(f) Require the NAIC or third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or third-party consultant under this chapter.

(g) For an agreement involving a third-party consultant, provide for the insurer's written consent.

(5) The sharing of information and documents by the director under this chapter is not a delegation of regulatory authority or rule-making, and the director is solely responsible for the administration, execution, and enforcement of this chapter.

(6) The disclosure or sharing of documents, proprietary and trade-secret materials, or other ORSA-related information to the director or other person under this chapter is not a waiver of an applicable privilege or claim of confidentiality.

(7) Documents, materials, or other information in the possession or control of the NAIC or third-party consultants under this chapter is confidential and privileged, is not subject to disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, is not subject to subpoena, and is not subject to discovery or admissible in evidence in a private civil action.

(8) Documents, materials, or other information in the possession of an insurer created by the insurer to comply with this chapter is confidential and privileged, is not subject to subpoena or to discovery, and is not admissible in evidence in a private civil action.

History: Add. 2015, Act 245, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

500.1715 Failure to file timely ORSA summary report; penalty.

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Sec. 1715. An insurer that does not, without just cause, timely file an ORSA summary report as required in this chapter shall pay a civil fine of $1,000.00 for each day's delay, to be recovered by the director and paid into the general fund. The maximum civil fine under this section is $75,000.00. The director may reduce the penalty if the insurer demonstrates to the director that the penalty would cause a financial hardship to the insurer.

History: Add. 2015, Act 245, Imd. Eff. Dec. 22, 2015.

Popular name: Act 218

CHAPTER 17A
CORPORATE GOVERNANCE ANNUAL DISCLOSURE

500.1751 Limitation of chapter in accordance with other applicable state laws; exception.

Sec. 1751. This chapter does not prescribe or impose corporate governance standards and internal procedures beyond that which is required under applicable state corporate law. However, this chapter does not limit the director's authority, or the rights or obligations of third parties, under chapter 2.

History: Add. 2018, Act 520, Eff. Jan. 1, 2020.

Popular name: Act 218

500.1753 Applicability of chapter.

Sec. 1753. This chapter applies to all insurers domiciled in this state.

History: Add. 2018, Act 520, Eff. Jan. 1, 2020.

Popular name: Act 218

500.1755 Definitions.

Sec. 1755. As used in this chapter:

(a) "Corporate governance annual disclosure" or "CGAD" means a confidential report filed by the insurer or insurance group made in accordance with the requirements of this chapter.

(b) "Insurance group" means insurers and affiliates included within an insurance holding company system.

(c) "Insurer" means that term as defined in section 1701.

(d) "NAIC" means that term as defined in section 1701.

(e) "ORSA Summary Report" means that term as defined in section 1701.

History: Add. 2018, Act 520, Eff. Jan. 1, 2020.

Popular name: Act 218

500.1757 Corporate governance annual disclosure; requirements; reporting at separate levels; exception for substantially similar documents.

Sec. 1757. (1) An insurer, or the insurance group of which the insurer is a member, shall, no later than June 1, 2020 and each June 1 after that date, submit to the director a corporate governance annual disclosure as prescribed by the director. Notwithstanding any request from the director made under subsection (3), if the insurer is a member of an insurance group, the insurer shall submit the report required by this section to the commissioner of the lead state for the insurance group, in accordance with the laws and requirements of the lead state.

(2) The CGAD required under subsection (1) must include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee of the insurer's board of directors.

(3) An insurer not required to submit a CGAD under this section shall submit a CGAD on the director's request.

(4) For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level, or any 1 or more of those levels, depending on how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors is coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on the criteria described in this subsection, the insurer

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or insurance group shall indicate which of the 3 criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

(5) The review of the CGAD and any additional requests for information must be made through the lead state in accordance with the laws and requirements of the lead state.

(6) An insurer or insurance group that provides information substantially similar to the information required by this chapter in other documents provided to the director, including proxy statements filed in conjunction with Form B requirements, or other state or federal filings provided to the department is not required to duplicate that information in the CGAD and is only required to cross-reference the document in which the information is included.

History: Add. 2018, Act 520, Eff. Jan. 1, 2020.

Popular name: Act 218

500.1759 Corporate governance policies; information made available to director.

Sec. 1759. (1) The insurer or insurance group has discretion over the responses to the CGAD inquiries if the CGAD contains the material information necessary to permit the director to gain an understanding of the insurer's or group's corporate governance structure, policies, and practices. The director may request additional information that he or she considers material and necessary to provide the director with a clear understanding of the corporate governance policies, the reporting or information system, or the controls implementing those policies.

(2) Notwithstanding subsection (1), the CGAD must be prepared as prescribed by the director. Documentation and supporting information related to the CGAD must be maintained and made available on examination or on request of the director.

History: Add. 2018, Act 520, Eff. Jan. 1, 2020.

Popular name: Act 218

500.1761 Proprietary information; confidentiality; disclosure; exemption from freedom of information act; testimony in civil action; duties of director.

Sec. 1761. (1) Documents, materials, or other information, including the CGAD, in the possession or control of the director that are obtained by, created by, or disclosed to the director or any other person under this chapter are considered proprietary and to contain trade secrets. The documents, materials, or other information are confidential and privileged, are not subject to disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, are not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action. However, the director may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the director's official duties. The director shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer or insurance group. This section does not require written consent of the insurer or insurance group before the director may share or receive confidential documents, materials, or other CGAD-related information under subsection (3) to assist in the performance of the director's regular duties.

(2) The director or any person who received documents, materials, or other CGAD-related information, through examination or otherwise, while acting under the authority of the director, or with whom the documents, materials, or other information are shared under this act shall not testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (1).

(3) The director may do any of the following:

(a) Except as otherwise provided in this subdivision, on request, share documents, materials, or other CGAD-related information, including the confidential and privileged documents, materials, or information described in subsection (1), including proprietary and trade secret documents and materials with other state, federal, and international financial regulatory agencies, including members of any supervisory college under chapter 13, with the NAIC, and with third-party consultants retained by the director under section 1763. The director shall not share documents, materials, or other CGAD-related information unless the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality.

(b) Except as otherwise provided in this subdivision, receive documents, materials, or other CGAD-related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade-secret information or documents, from regulatory officials of other state, federal, and international financial regulatory agencies, including members of any supervisory college under chapter 13, and from the NAIC. The director shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

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(4) The sharing of information and documents by the director under this chapter is not a delegation of regulatory authority or rule-making, and the director is solely responsible for the administration, execution, and enforcement of this chapter.

(5) The disclosure or sharing of documents, proprietary and trade-secret materials, or other CGAD-related information to the director under this chapter is not a waiver of an applicable privilege or claim of confidentiality.

History: Add. 2018, Act 520, Eff. Jan. 1, 2020.

Popular name: Act 218

500.1763 Third-party consultants and National Association of Insurance Commissioners (NAIC); confidentiality; written agreement.

Sec. 1763. (1) The director may retain, at the insurer's or insurance group's expense, third-party consultants, including attorneys, actuaries, accountants, and other experts not otherwise a part of the director's staff as may be reasonably necessary to assist the director in reviewing the CGAD and related information or the insurer's or insurance group's compliance with this chapter.

(2) A person retained under subsection (1) is under the direction and control of the director and shall act in a purely advisory capacity.

(3) The NAIC and third-party consultants are subject to the same confidentiality standards and requirements as the director.

(4) As part of the retention process, a third-party consultant shall verify to the director, with written notice to the insurer or insurance group, that it is free of any conflict of interest and that it has internal procedures in place to identify and monitor compliance with any conflict that may arise after engagement and to comply with the confidentiality standards and requirements of this chapter.

(5) A written agreement with the NAIC or a third-party consultant, or both, under subsection (4) governing sharing and use of information provided under this chapter must contain all of the following provisions and expressly require the written consent of the insurer or insurance group before making public information provided under this chapter:

(a) Specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information shared with the NAIC or a third-party consultant under this chapter.

(b) Procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurer or insurance group has domiciled insurers. The agreement must provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality.

(c) A provision specifying that ownership of the CGAD-related information shared with the NAIC or a third-party consultant remains with the department and the NAIC's or third-party consultant's use of the information is subject to the direction of the director with written notice to the insurer or insurance group.

(d) A provision that prohibits the NAIC or a third-party consultant from storing the information shared under this chapter in a permanent database after the underlying analysis is completed and that requires the NAIC or third-party consultant to promptly return or destroy all CGAD-related information provided by the insurer or insurance group.

(e) A provision requiring the NAIC or third-party consultant to provide prompt written notice to the director and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information.

(f) A requirement that the NAIC or a third-party consultant consent to intervention by an insurer or insurance group in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant under this chapter.

History: Add. 2018, Act 520, Eff. Jan. 1, 2020.

Popular name: Act 218

500.1765 Failure to file corporate governance annual disclosure; civil fine; waiver.

Sec. 1765. (1) An insurer or insurance group that does not, without just cause, timely file the CGAD as required in this chapter, after written notice and hearing, shall pay a civil fine of $1,000.00 for each day's delay, to be recovered by the director and paid into the general fund of this state. The maximum civil fine under this section is $75,000.00. The director may reduce or waive the penalty if the insurer demonstrates to the director that either of the following applies:

(a) The penalty would cause a financial hardship to the insurer.

(b) There is just cause for the delayed filing.

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(2) On written request, the director may grant a 90-day extension for filing the CGAD.

History: Add. 2018, Act 520, Eff. Jan. 1, 2020.

Popular name: Act 218

500.1767 Severability.

Sec. 1767. If in a final decision a court holds section 1761 of this chapter to be invalid, that section is not severable, and the entire chapter is void as of the date of the court decision.

History: Add. 2018, Act 520, Eff. Jan. 1, 2020.

Popular name: Act 218

CHAPTER 18

500.1801 Definitions.

Sec. 1801. As used in this chapter:

(a) "Chartered" means a risk retention group licensed and authorized to engage in business as a liability insurance company in a state.

(b) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able to meet obligations to policyholders with respect to known claims and reasonably anticipated claims or to pay other obligations in the normal course of business.

(c) "Liability" means legal liability for damages including costs of defense, legal costs and fees, and other claims expenses because of personal injuries, property damage, or other damage or loss, to another person resulting from or arising out of a profit or nonprofit business, trade, product, service, including professional service, a premises or operation, or an activity of a state or local government or an agency or political subdivision of a state or local government. Liability does not include personal risk liability or an employer's liability with respect to its employees other than legal liability under chapter 149, 35 Stat. 65, 45 U.S.C. 51 to 60.

(d) "Liability risk retention act of 1986" means the liability risk retention act of 1986, Public Law 97-45, 15 U.S.C. 3901 to 3906.

(e) "Personal risk liability" means liability for damages because of personal injury, property damage, or other loss or damage, to any person resulting from a personal, family, or household responsibility or activity, and not from responsibilities or activities described under subdivision (c).

(f) "Plan of operation" or "feasibility study" means an analysis which presents the expected activities and results of a risk retention group including all of the following:

(*i*) Information sufficient to verify that a risk retention group's members are engaged in businesses or activities similar or related with respect to the liability to which the members are exposed by virtue of a related, similar, or common business, trade, product, service, premises, or operation.

(*ii*) For each state in which a risk retention group intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer.

(*iii*) Historical and expected loss experience of the proposed risk retention group members and national experience of similar exposures if this experience is reasonably available.

(*iv*) Financial statements for the 3 years immediately preceding the submission of the plan of operation or feasibility study under section 1807 or if financial statements are not available because the risk retention group has not been in existence for 3 years, any previous years' financial statements together with pro forma financial statements and projections for the upcoming 3-year period.

(*v*) Appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required of the risk retention group to commence operations and to prevent a hazardous financial condition.

(*vi*) Identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies, and reinsurance agreements of the risk retention group.

(*vii*) Identification of each state in which the risk retention group has obtained, or sought to obtain, a charter, and a description of its status in those states.

(*viii*) Other matters as may be prescribed by the commissioner of the state in which the risk retention group is chartered.

(g) "Purchasing group" means a group which meets all of the following:

(*i*) Has as 1 of its purposes the purchase of liability insurance on a group basis.

(*ii*) Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of a related, similar, or common business, trade, product,

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service, premises, or operation.

(*iii*) Purchases insurance only for its group members and only to cover their similar or related liability exposure, as described in subparagraph (*ii*).

(*iv*) Is domiciled in a state.

(h) "Risk retention group" means a corporation or other limited liability association which meets all of the following criteria:

(*i*) Is either of the following:

(A) Chartered in a state.

(B) Before January 1, 1985 was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and before January 1, 1985 had certified to the insurance commissioner of at least 1 state that it satisfied the capitalization requirements of that state, except that the group shall be considered to be a risk retention group only if it has been engaged in business continuously since January 1, 1985 and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability as those terms were defined before the October 27, 1986 amendments to the liability risk retention act of 1986.

(*ii*) Does not exclude a person from membership solely to provide members of the group with a competitive advantage over that person.

(*iii*) Has either of the following:

(A) As its owners only persons who comprise the membership of the risk retention group and who are provided insurance by the group.

(B) As its sole member and sole owner an organization which is owned by persons who are provided insurance by the risk retention group.

(*iv*) Its members are engaged in businesses or activities similar or related with respect to the liability of which members are exposed by virtue of a related, similar, or common business trade, product, service, premises, or operation.

(*v*) Is organized for, and whose activities are limited to, the provision of either or both of the following:

(A) Liability insurance for assuming and spreading all or a portion of the liability of its group members.

(B) Reinsurance with respect to the liability of another risk retention group, or any members of that other group, which is engaged in businesses or activities enabling the group or member to meet the requirement under subparagraph (*iv*) for membership in the risk retention group which provides the reinsurance.

(*vi*) The name of the group includes the phrase "risk retention group".

(i) "State" means any state of the United States or the District of Columbia.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

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500.1803 Risk retention group chartered in state; certificate of authority; license; compliance.

Sec. 1803. (1) To be chartered in this state, a risk retention group shall obtain a certificate of authority from the commissioner and be licensed as a domestic stock or mutual casualty insurer.

(2) Except as otherwise provided in this chapter, a risk retention group chartered in this state shall comply with all statutes, rules, regulations, and requirements applicable to domestic stock or mutual casualty insurers.

(3) A certificate of authority issued to a risk retention group chartered in this state shall be limited to the business of insurance for liability.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

500.1804 Repealed. 1980, Act 341, Eff. June 23, 1981.

Compiler's note: The repealed section pertained to void contracts of fire insurance.

Popular name: Act 218

500.1805 Risk retention group chartered in state; summary form of required information.

Sec. 1805. To be chartered in this state, a risk retention group shall provide to the commissioner in summary form, at the time of its application for a certificate of authority, all of the following:

(a) The identity of the initial members of the risk retention group.

(b) The identity of those individuals who organized the risk retention group or who will provide administrative services or otherwise influence or control the activities of the group.

(c) The amount and nature of initial capitalization.

(d) The coverages to be afforded.

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(e) The states in which the risk retention group intends to operate.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Compiler's note: Former MCL 500.1805, which provided a penalty for fire insurance with unauthorized insurer, was repealed by Act 341 of 1980, Eff. June 23, 1981.

Popular name: Act 218

500.1806 Repealed. 1980, Act 341, Eff. June 23, 1981.

Compiler's note: The repealed section provided penalty for agents' solicitation of fire insurance with unauthorized insurer.

Popular name: Act 218

500.1807 Risk retention group chartered in state; plan of operation or feasibility study.

Sec. 1807. Before it may offer insurance in this state, a risk retention group chartered in this state shall submit to the commissioner for approval a plan of operation or feasibility study and, within 10 days of a change, shall submit an appropriate revision if a subsequent material change in an item of the plan of operation or feasibility study occurs. The risk retention group shall not offer any additional kinds of liability insurance until a revision of the plan of operation or feasibility study is approved by the commissioner.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

500.1809 Risk retention group chartered in state; name.

Sec. 1809. The name under which a risk retention group chartered in this state may be authorized as a domestic casualty insurer shall be a brief description of the risk retention group's membership followed by the phrase "risk retention group".

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

500.1810 Repealed. 1980, Act 341, Eff. June 23, 1981.

Compiler's note: The repealed section provided penalty for life insurance with unauthorized insurer.

Popular name: Act 218

500.1811 Risk retention group not chartered in state; submission of information to commissioner.

Sec. 1811. A risk retention group not chartered in this state shall submit to the commissioner all of the following:

(a) Before offering insurance in this state, a statement identifying any state in which the risk retention group is chartered as a liability insurance company, the date on which it was chartered, and its principal place of business.

(b) Before offering insurance in this state, a copy of the risk retention group's plan of operation or feasibility study and revisions of the plan or study submitted to the state in which the risk retention group is chartered. However, the submission of a plan of operation or feasibility study shall not apply with respect to any line or classification of liability insurance which was defined in the liability risk retention act of 1986 before the October 27, 1986 amendments to that act and was offered before October 27, 1986 by a risk retention group which had been chartered and operating for not less than 3 years before October 27, 1986. A revision to the risk retention group's plan of operation or feasibility study submitted under this subdivision shall be submitted at the same time the revision is submitted to the commissioner of the risk retention group's chartering state.

(c) Before offering insurance in this state and by March 1 of each year thereafter, a copy of the risk retention group's financial statement submitted to the state in which the risk retention group is chartered. The financial statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist.

(d) A copy of the most recent examination of the risk retention group and upon request by the commissioner, any examination of the risk retention group, as certified by the commissioner or public official conducting the examination.

(e) Upon request by the commissioner, a copy of any audit performed with respect to the risk retention group and other information as considered necessary by the commissioner in order to determine the risk retention group's financial condition.

(f) Before offering insurance in this state, a $25.00 registration fee and, on a form prescribed by the

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commissioner, a statement of registration which designates the commissioner as its agent for the purpose of receiving service of legal documents or process.

(g) Other information as may be required to verify the risk retention group's continuing qualification as a risk retention group.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

500.1812 Repealed. 1980, Act 341, Eff. June 23, 1981.

Compiler's note: The repealed section provided penalty for disability, casualty, title, or surety insurance with unauthorized insurer.

Popular name: Act 218

500.1813 Risk retention group without certificate of authority issued by commissioner; tax; regulatory fee; report.

Sec. 1813. A risk retention group that does not have a certificate of authority issued by the commissioner shall be liable for the payment of a tax of 2% on direct business for a risk resident or located within this state and, instead of the costs and expenses that may be imposed by the commissioner pursuant to this chapter, an additional regulatory fee of 0.5% on direct business for a risk resident or located within this state and shall report to the commissioner the net direct premiums written for that business.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990;—Am. 1994, Act 228, Imd. Eff. June 30, 1994.

Popular name: Act 218

500.1815 Risk retention group not chartered in state and doing business in state; compliance required; examination of financial condition.

Sec. 1815. (1) A risk retention group, not chartered in this state and doing business in this state, and the risk retention group's agents and representatives, shall comply with chapter 20.

(2) A risk retention group not chartered in this state and doing business in this state shall submit to an examination by the commissioner to determine its financial condition if the commissioner of the charter state has not initiated an examination or does not initiate an examination within 60 days after a request by the commissioner of this state. An examination under this subsection should be coordinated with examination requests in other states to avoid unjustified repetition and conducted in an expeditious manner in accordance with generally accepted auditing standards.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

500.1817 Risk retention group not chartered in state and doing business in state; voluntary dissolution or delinquency proceeding.

Sec. 1817. A risk retention group not chartered in this state and doing business in this state shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by the commissioner if there has been a finding of financial impairment after an examination performed under section 1815(2).

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

500.1819 Notice required on application form and front and declaration pages of policy.

Sec. 1819. An application form for insurance from a risk retention group chartered or doing business in this state, as well as the front and declaration pages of a policy issued by a risk retention group, shall contain in 10-point type the following notice:

"NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group."

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

500.1820 Repealed. 1980, Act 341, Eff. June 23, 1981.

Compiler's note: The repealed section contained a short title.

Popular name: Act 218

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500.1821 Risk retention group chartered or doing business in state; prohibited conduct.

Sec. 1821. A risk retention group chartered or doing business in this state shall not do any of the following:

(a) Solicit or sell insurance to a person who is not eligible for membership in the group.

(b) Solicit or sell insurance if the risk retention group is in a hazardous financial condition or is financially impaired.

(c) Have as a member or owner, whether directly or indirectly, an insurance company, unless all members of the risk retention group are insurance companies.

(d) Issue an insurance policy with terms which provide, or could be construed to provide, coverage prohibited generally by law or declared unlawful by a final and binding decision of an appellate court that has considered the matter.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Compiler's note: Former MCL 500.1821, which pertained to substituted service of process, was repealed by Act 341 of 1980, Eff. June 23, 1981.

Popular name: Act 218

500.1822 Repealed. 1980, Act 341, Eff. June 23, 1981.

Compiler's note: The repealed section pertained to acts constituting appointment of commissioner as attorney for service of process.

Popular name: Act 218

500.1823 Violation; fines and penalties; compliance.

Sec. 1823. A risk retention group that violates a provision of this chapter shall be subject to fines and penalties applicable to licensed insurers, including revocation of the right to do business in this state. A risk retention group operating in this state prior to January 1, 1990 shall comply with section 1811 by February 1, 1990.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

500.1825 Purchasing group; information required before doing business in state.

Sec. 1825. (1) Before doing business in this state, a purchasing group shall provide the commissioner with all of the following:

(a) The identity of the name of the purchasing group through which it is purchasing liability insurance.

(b) The identity of the state in which the purchasing group is domiciled.

(c) The identity of all other states in which the purchasing group intends to do business or is doing business.

(d) The identity of the specific types and classifications of liability insurance which the purchasing group intends to purchase.

(e) The identity of any insurance company from which the group intends to purchase its insurance and the domicile of those companies.

(f) The method by which, and if applicable, the person through whom, insurance will be offered to the purchasing group's members whose risks are resident or located in this state.

(g) The identity of the officer or person responsible for the purchasing group.

(h) Other information as may be required by the commissioner to verify that the purchasing group is qualified under this chapter.

(2) A purchasing group shall notify the commissioner of any changes in any of the items set forth in subsection (1) within 10 days of the change.

(3) A purchasing group shall notify the commissioner annually of its intention to continue doing business in this state.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Compiler's note: Former MCL 500.1825, which pertained to service of process on insurance commissioner or secretary of state, was repealed by Act 341 of 1980, Eff. June 23, 1981.

Popular name: Act 218

500.1827 Purchasing group and insurer thereof; registration fee; statement of registration; applicability of subsection (1); information to be furnished.

Sec. 1827. (1) The purchasing group and any insurer of the purchasing group which has not submitted a registration fee shall submit a $25.00 registration fee and, on a form prescribed by the commissioner, a statement of registration which designates the commissioner as its agent for the purpose of receiving service of legal documents or process.

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(2) Subsection (1) shall not apply to a purchasing group which meets all of the following:

(a) Was a purchasing group under the requirements of the liability risk retention act of 1986 before October 27, 1986.

(b) Only purchases insurance that was authorized under the liability risk retention act of 1986 before October 27, 1986.

(c) Was domiciled in a state before April 1, 1986 and is domiciled in a state on and after September 25, 1981.

(d) Before September 25, 1981 purchased insurance from an insurance carrier licensed in a state and since September 25, 1981, purchased its insurance from an insurance carrier licensed in a state.

(3) A purchasing group under subsection (1) shall furnish information as requested by the commissioner that does all of the following:

(a) Verifies that the entity qualifies as a purchasing group.

(b) Determines where the purchasing group members are located.

(c) Determines appropriate tax treatment.

(4) A purchasing group which was doing business in this state prior to January 1, 1990 shall provide the information required by section 1825 to the commissioner by February 1, 1990.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

500.1828 Repealed. 1980, Act 341, Eff. June 23, 1981.

Compiler's note: The repealed section pertained to defense of action against unauthorized foreign or alien insurer.

Popular name: Act 218

500.1829 Purchase of insurance by purchasing group; written information to members; deductible or self-insured retention.

Sec. 1829. (1) A purchasing group doing business in this state may purchase insurance for risks resident or located in this state only from a risk retention group chartered in a state, from an insurer authorized in this state, or from an eligible unauthorized insurer pursuant to chapter 19.

(2) A purchasing group which obtains liability insurance from an insurer not authorized in this state or a risk retention group shall inform in writing each of the members of the group which have a risk resident or located in this state that the risk is not protected by an insurance insolvency guaranty fund in this state and that the risk retention group or the insurer may not be subject to all insurance laws and regulations of this state.

(3) A purchasing group shall not purchase insurance providing for a deductible or self-insured retention, unless the deductible or self-insured retention is the sole responsibility of each individual member of the purchasing group.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

500.1830 Repealed. 1980, Act 341, Eff. June 23, 1981.

Compiler's note: The repealed section pertained to refusal to defend action against unauthorized foreign or alien insurer.

Popular name: Act 218

500.1831 Premium taxes and other taxes.

Sec. 1831. Premium taxes and other taxes paid for coverage of risks resident or located in this state by a purchasing group or any members of the purchasing group shall be imposed at the same rate and subject to the same interest, fines, and penalties as that applicable to premium taxes and other taxes paid for similar coverage from a similar insurance source by other insureds.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

500.1832 Repealed. 1980, Act 341, Eff. June 23, 1981.

Compiler's note: The repealed section pertained to applicability of unauthorized insurers process act.

Popular name: Act 218

500.1833 Prohibitions regarding property and casualty guaranty association or similar association; risks covered by property and casualty guaranty association; participating member in Michigan automobile insurance placement facility; submission of information

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by risk retention group; apportioning proportionate share of losses and expenses.

Sec. 1833. (1) A risk retention group chartered or doing business in this state shall not join or contribute financially to the property and casualty guaranty association created under chapter 79 or other similar association or mechanism in this state. A risk retention group, its insureds, or claimants against its insureds, shall not receive any benefit from the property and casualty guaranty association or other similar association or mechanism for claims arising under the insurance policies issued by the risk retention group.

(2) A purchasing group obtaining insurance covering its members' risks from an insurer not authorized in this state or a risk retention group shall not be covered by the property and casualty guaranty association or similar association or mechanism in this state.

(3) If a purchasing group obtains insurance covering its members' risks from an insurer authorized in this state, only risks resident or located in this state shall be covered by the property and casualty guaranty association under chapter 79.

(4) A risk retention group chartered or doing business in this state which offers coverage for the security required under chapter 31 shall be a participating member in the Michigan automobile insurance placement facility established under chapter 33 for the purpose of sharing in the equitable apportionment among insurers of liability insurance losses and expenses incurred on policies written through that facility. The risk retention group shall submit sufficient information to the commissioner, or to whomever the commissioner may designate, to enable the apportionment on a nondiscriminatory basis of the risk retention group's proportionate share of the losses and expenses.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

500.1835 Licensing as condition to soliciting, negotiating, or procuring liability insurance; residency requirement for agent or broker; licensure of nonresident.

Sec. 1835. (1) A person, firm, association, or corporation shall not act or aid in any manner in soliciting, negotiating, or procuring liability insurance in this state from a risk retention group unless the person, firm, association, or corporation is licensed under chapter 12 or chapter 19.

(2) A person, firm, association, or corporation shall not act or aid in any manner in soliciting, negotiating, or procuring liability insurance in this state for a purchasing group from an authorized insurer or a risk retention group chartered in this state unless the person, firm, association, or corporation is licensed under chapter 12.

(3) A person, firm, association, or corporation shall not 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 doing business in this state unless the person, firm, association, or corporation is licensed under chapter 19.

(4) For the purpose of acting as an agent or broker for a risk retention group or purchasing group under subsections (1) and (2), the requirement of residence in this state shall not apply. However, licensure of a nonresident under chapter 19 shall be for the limited purpose of soliciting, negotiating, or procuring liability insurance from a risk retention group not chartered in this state.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

500.1837 Enforcement.

Sec. 1837. The commissioner may use any of the powers established under this act to enforce the laws of this state so long as those powers have not been specifically preempted by the liability risk retention act of 1986. For risk retention groups, the commissioner's injunctive authority is restricted by the requirement that an injunction be issued by a court of competent jurisdiction.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

500.1839 Financial responsibility.

Sec. 1839. If a law of this state or any political subdivision of this state requires a demonstration of financial responsibility as a condition for obtaining a license or permit to undertake specified activities, and the requirement may not be satisfied by obtaining insurance coverage from an insurer not authorized to do business in this state, the requirement shall not be satisfied by purchasing insurance from a risk retention group not chartered and authorized in this state.

History: Add. 1989, Act 214, Eff. Jan. 1, 1990.

Popular name: Act 218

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500.1840 Repealed. 1980, Act 341, Eff. June 23, 1981.

Compiler's note: The repealed section pertained to procurement of additional indemnity.

Popular name: Act 218

500.1841 Repealed. 2000, Act 486, Imd. Eff. Jan. 11, 2001.

Compiler's note: The repealed section pertained to promulgation of rules.

Popular name: Act 218

500.1843-500.1864 Repealed. 1980, Act 341, Eff. June 23, 1981.

Compiler's note: The repealed sections pertained to surplus lines insurers and agents.

Popular name: Act 218

CHAPTER 19

500.1901 Short title.

Sec. 1901. This chapter shall be known and may be cited as the "surplus lines insurance act".

History: Add. 1980, Act 341, Eff. June 23, 1981.

Compiler's note: Act 341 of 1980 did not provide a subject-matter heading for Chapter 19.

Popular name: Act 218

500.1902 Liberal construction and application.

Sec. 1902. This chapter shall be liberally construed and applied to promote its underlying purposes which include:

(a) Protecting persons seeking insurance in this state.

(b) Permitting stable and reputable insurers to write surplus lines insurance in this state.

(c) Establishing a system of regulation which will permit an orderly access to surplus lines insurance in this state.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

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500.1903 Definitions; conflicting provisions.

Sec. 1903. (1) As used in this chapter:

(a) "Eligible unauthorized insurer" means an insurer not authorized to transact insurance in this state but eligible to write insurance business under this chapter.

(b) "Association" means an association registered under section 1930.

(c) "Licensee" means a person licensed under this chapter.

(d) "Surplus lines insurance" means insurance in this state procured from or continued or renewed with an unauthorized insurer and includes all of the following, whether effected by mail or otherwise:

(*i*) Insurance for which applications are solicited from persons resident or located in this state.

(*ii*) Insurance for which contracts of insurance are issued or delivered to persons resident or located in this state.

(*iii*) Insurance that is procured through negotiations or by an application occurring in whole or in part in this state or made within or from within this state.

(*iv*) Insurance for which premiums, in whole or in part, are remitted directly or indirectly within or from within this state.

(2) The definitions contained in subsection (1), unless the context otherwise requires, shall apply to the use of the defined terms in this chapter and shall control in the interpretation of this chapter.

(3) The definitions contained in other chapters of this act shall apply to the terms used in this chapter unless otherwise specifically provided in this chapter.

(4) Nothing contained in this section shall supersede the provisions of section 402b and in the event of conflict between the provision herein and section 402b, the latter shall govern.

History: Add. 1980, Act 341, Eff. June 23, 1981;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.1903a Contract of insurance.

Sec. 1903a. For purposes of this chapter, a written contract or similar device which offers benefits substantially similar to benefits offered under policies of insurance, whether or not the benefits are identified or described as insurance, shall constitute a contract of insurance.

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History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

500.1904 Rates and forms used by unauthorized insurers.

Sec. 1904. (1) Rates used by unauthorized insurers shall not be subject to this code, except that a rate shall not be unfairly discriminatory.

(2) Forms used by unauthorized insurers pursuant to this chapter shall not be subject to this code, except that a policy shall not contain language which misrepresents the true nature of the policy or class of policies.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

500.1905 License required to act as agent or broker in transaction of surplus lines insurance; compliance; requirements for obtaining surplus lines license; permissible acts of surplus lines licensee; conditions to placement of insurance with eligible unauthorized insurer.

Sec. 1905. (1) A person shall not solicit insurance, bind coverage, or in any other manner act as an agent or broker in the transaction of surplus lines insurance unless licensed under this chapter and section 1206a.

(2) A person shall not offer, solicit, make a quotation on, sell, or issue a policy of insurance, binder, or any other evidence of insurance with an unauthorized insurer except in compliance with this chapter.

(3) To obtain a surplus lines license under subsection (1), a person shall do all of the following:

(a) File an application in the form and with the information as the commissioner may reasonably require to determine the ability of the applicant to satisfactorily act in accordance with this chapter.

(b) Complete an examination testing the applicant's understanding of this chapter, the surplus lines insurance business, and other chapters of this act, if required by the commissioner. The commissioner may waive the examination requirements for a person who has been licensed as a surplus lines licensee within the preceding 12 months.

(c) Comply with sections 1204 to 1206.

(d) Agree to file with the commissioner, not later than February 15 and August 15 annually, a sworn statement of the charges for insurance procured or placed, and the amounts returned on the insurance canceled, under the license, for the preceding 6-month period ending December 31 and June 30, respectively; and at the time of filing the statement, paying to the commissioner the 2% tax on premiums written and, instead of the costs and expenses that may be imposed by the commissioner pursuant to this chapter, a 0.5% regulatory fee on premiums written as required by section 451.

(4) A surplus lines licensee may do any or all of the following:

(a) Place insurance on risks in this state with eligible unauthorized insurers.

(b) Act in the capacity of an agent or broker, as determined by the contractual relationship with the eligible unauthorized insurer or that insurer's legal representative.

(c) Place insurance on risks in this state, with unauthorized insurers that are not eligible unauthorized insurers, in strict compliance with section 1950. If the insurance is provided through the participation of several insurers and the licensee has reason to believe that a substantial portion of the insurance would be assumed by authorized or eligible unauthorized insurers, then, with respect to the unauthorized insurers not eligible, the insured or the insured's representative shall be informed as provided in section 1950(a).

(d) Engage in any other acts expressly and implicitly authorized by this chapter and this act.

(5) Before placement of insurance with an eligible unauthorized insurer, a licensee shall inform an insured or the insured's representative that coverage is being placed with an insurer not licensed in this state and that payment of loss may not be guaranteed in the event of insolvency of the eligible unauthorized insurer.

History: Add. 1980, Act 341, Eff. June 23, 1981;—Am. 1987, Act 261, Imd. Eff. Dec. 28, 1987;—Am. 1989, Act 214, Eff. Jan. 1, 1990;—Am. 1994, Act 228, Imd. Eff. June 30, 1994;—Am. 1996, Act 548, Imd. Eff. Jan. 15, 1997;—Am. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

500.1906 Books and records of surplus lines licensee; examination; access.

Sec. 1906. If the commissioner considers it necessary, he or she may examine the books and records of a surplus lines licensee to determine whether the licensee is conducting its business in accordance with this chapter. For the purpose of facilitating the examination, the licensee shall allow the commissioner free access, at reasonable times, to all of the licensee's books and records relating to transactions to which this chapter applies.

History: Add. 1980, Act 341, Eff. June 23, 1981.

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Popular name: Act 218

500.1910 Prohibited placement of insurance with unauthorized insurer; rebuttable presumption as to availability of coverages; list of unavailable lines of insurance; additions to or deletions from list; publication, revision, and availability of list.

Sec. 1910. (1) Insurance shall not be placed by a licensee with an unauthorized insurer if coverage is available from an authorized insurer.

(2) There is a rebuttable presumption that the following coverages are available from an authorized insurer:

(a) No-fault automobile insurance, as required by section 3101, which is not written for a person who is self-insuring motor vehicles under section 3101d.

(b) Private passenger automobile physical damage coverage.

(c) Homeowners and property insurance on owner-occupied dwellings, the value of which is less than the maximum limits of coverage that are available for the property under the general rules of the Michigan basic property insurance association.

(d) Any coverage readily available from 3 or more authorized insurers, unless the authorized insurers quote a premium and terms not competitive with the premium and terms quoted by an unauthorized insurer.

(e) Worker's compensation insurance that is not written for an employer that is partially self-insured under section 611 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.611.

(3) There is a rebuttable presumption that the following coverages are unavailable from an authorized insurer:

(a) Coverages with respect to which 1 portion of the risk is acceptable to authorized insurers, but another portion of the same risk is not acceptable. The entire coverage may be placed with eligible unauthorized insurers if it can be shown that eligible unauthorized insurers will accept the entire coverage but not the rejected portion alone.

(b) Any coverage that the licensee is unable to procure after diligent search among authorized insurers.

(4) The commissioner shall maintain, on a current basis, a list of those lines of insurance for which coverages are determined by the commissioner to be generally unavailable in the authorized insurance market. Any person may request in writing that the commissioner add or remove a coverage from the current list. The commissioner shall grant or deny a request within 30 days after receiving the written request. The commissioner shall encourage dissemination of information regarding the availability of coverages for which the public interest necessitates additions to or deletions from the list. The list shall be published at least quarterly and shall be revised as required. The commissioner shall make the list available to all licensees and other members of the public, upon request.

History: Add. 1980, Act 341, Eff. June 23, 1981;—Am. 2012, Act 204, Eff. Jan. 1, 2013.

Popular name: Act 218

500.1911 Issuing evidence of placement of insurance with eligible unauthorized insurer; conditions; identification of entities directly assuming risk of loss; specifying obligation as joint or several; specifying proportion of obligation assumed.

Sec. 1911. (1) Only a licensee shall issue evidence of placement of insurance with an eligible unauthorized insurer. A licensee shall not issue that evidence, cause or purport to cause any risk to be insured by an eligible unauthorized insurer, or advise any insured or applicant for insurance or the representative of the insured or applicant that insurance has been or will be obtained from an eligible unauthorized insurer unless at least 1 of the following conditions is met:

(a) The licensee has prior written authority from the eligible unauthorized insurer to cause the risk to be insured.

(b) The licensee has received a written or oral communication 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 eligible unauthorized insurer and has been delivered to the insured or the insured's representative.

(2) A prior written authority, a communication showing that insurance has been obtained, or a policy of insurance prescribed in subsection (1) shall identify entities directly assuming any risk of loss. If there is more than 1 insurer, any document issued or certified by the licensee pursuant to section 1912 shall specify whether the obligation is joint or several, and if the obligation is several, the proportion of the obligation assumed by those insurers, if known.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

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500.1912 Delivery of written evidence of insurance to insured or insured's representative; time; conditions.

Sec. 1912. If the surplus lines licensee acts in reliance on prior written authority from an eligible unauthorized insurer in accordance with section 1911(1)(a), or on a written or oral communication received in accordance with section 1911(1)(b), the licensee, within 30 days after the date on which the risk was bound or the insured or applicant was advised that coverage has been or will be obtained, shall deliver a policy, a written binder, a certificate, or other written evidence of the insurance, to the insured or the insured's representative.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

500.1913 Separate account of each transaction; filing certified evidence of transactions.

Sec. 1913. Each surplus lines licensee shall keep a separate account of each transaction entered into pursuant to section 1905. Certified evidence of these transactions in the form and manner prescribed by the commissioner shall be filed periodically with the commissioner, or if designated by the commissioner, with an association.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

500.1915 Charging fees; conditions; excessive or discriminatory fee prohibited; documentation and evidence of disclosure of fees; exclusion of fees in computation of premium taxes.

Sec. 1915. (1) A licensee may charge a fee as follows:

(a) For a surplus lines insurance policy, a fee in addition to a commission only if the fee is not included in the premium and the fee is reasonable to cover underwriting and other expenses that are unique to surplus lines.

(b) For a personal lines insurance policy, a fee not to exceed the greater of $100.00 or 10% of the personal lines insurance policy premium.

(2) All of the following apply to a fee charged under subsection (1):

(a) The fee must not be excessive or discriminatory. The licensee shall maintain complete documentation of all fees charged and evidence of the disclosure required under subdivision (b).

(b) The fee must be fully disclosed in detail to the insured, whether directly or through another licensed insurance producer, in writing before the sale. The fee must be separately itemized on any of the following:

(*i*) The policy declarations page.

(*ii*) The billing statement.

(*iii*) Other documentation provided to the purchaser setting forth the cost of the policy.

(c) The fee must not be included as a part of the policy premium in the computation of premium taxes.

History: Add. 1980, Act 341, Eff. June 23, 1981;—Am. 2006, Act 644, Imd. Eff. Jan. 5, 2007;—Am. 2020, Act 62, Imd. Eff. Mar. 17, 2020.

Popular name: Act 218

500.1916 Compensation of licensee and licensed resident agent; collection of premiums; effect of premium payment made to agent.

Sec. 1916. A licensee may be compensated by an unauthorized insurer and the licensee may compensate a licensed resident agent in this state for obtaining surplus lines insurance business. The licensed resident agent authorized by the licensee may collect a premium on behalf of a surplus lines licensee and, as between the insured and the licensee, the licensee shall be considered to have received the premium if the premium payment has been made to the agent.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

500.1917 Liability if risk assumed and premium received by licensee.

Sec. 1917. If an unauthorized insurer has assumed a risk and if the premium for that risk has been received by the licensee who placed the insurance, then as between the insurer and the insured, the insurer shall be considered to have received the premium due to it for the coverage, and shall be liable to the insured for any loss covered by the insurance and for the unearned premium, upon cancellation of the insurance, regardless of whether the licensee is indebted to the insurer.

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History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

500.1920 Recognition as eligible surplus lines insurer; application; recommendations; conditions; information; examination; removal of insurer from list.

Sec. 1920. (1) A licensee shall offer surplus lines insurance only to insurers that are in a stable and unimpaired financial condition. An insurer recognized by the commissioner as an eligible surplus lines insurer pursuant to subsection (2) shall be considered to meet the requirements of this subsection. Recognition as an eligible surplus lines insurer shall be conditioned upon the insurer's continued compliance with this chapter and rules promulgated under this chapter.

(2) An unauthorized insurer may apply for recognition as an eligible surplus lines insurer by filing an application in the form and with the information as reasonably required by the commissioner regarding the insurer's financial stability, reputation, and integrity. The commissioner may delegate to an association the power to process and to make recommendations on applications for recognition as an eligible surplus lines insurer. Notwithstanding a delegation by the commissioner, an applicant may file an application for recognition directly with the commissioner.

(3) The commissioner shall recognize an insurer making an application in accordance with subsection (2) as an eligible surplus lines insurer if he or she is satisfied that the insurer is in a stable and unimpaired financial condition and that the insurer is qualified to provide coverage in compliance with this chapter. If filed with full supporting documentation before July 1 of any year, an application submitted under subsection (2) shall be acted upon by the commissioner before December 31 of the year of submission.

(4) The commissioner shall not recognize an insurer as an eligible surplus lines insurer unless the insurer continuously maintains capital and surplus of at least $1,500,000.00, and is safe, reliable, and entitled to public confidence. This subsection shall not be construed to require an alien insurer to file financial statements in the form required of authorized insurers under section 438. However, each alien applicant shall have current financial data filed with the national association of insurance commissioners.

(5) If the commissioner considers it necessary, he or she may request information about or examine the affairs of any eligible unauthorized insurer, at the expense of the insurer except as provided in sections 1905 and 1951, to determine whether the insurer should continue to remain on the list of eligible surplus lines insurers. If the commissioner finds that it is in the public interest to remove an insurer from the list because the insurer no longer meets the requirements of this chapter or is no longer qualified to provide coverage under this chapter, the commissioner shall do so without the necessity of a hearing.

History: Add. 1980, Act 341, Eff. June 23, 1981;—Am. 1994, Act 228, Imd. Eff. June 30, 1994.

Popular name: Act 218

500.1921 Recognition as eligible unauthorized insurer; deposit; trust fund, marketable securities, or equivalent instruments; provisions inapplicable to certain unincorporated, alien insurers; commissioner as resident agent for service of process.

Sec. 1921. (1) In addition to other requirements of this chapter, to gain recognition as an eligible unauthorized insurer in this state, an unauthorized insurer shall deposit with this state in cash, marketable securities, or other comparable instruments, at least $75,000.00 solely for the benefit of policyholders and beneficiaries in this state, or shall maintain a trust fund in the United States in cash, marketable securities, or other substantially equivalent instruments of at least $1,000,000.00 with a United States bank which is a member of the federal reserve system or which is regulated by the financial institutions bureau, or which is on deposit with regulatory authorities in the state of domicile of the insurer for the benefit of all United States policyholders and beneficiaries. A trust fund required under this subsection shall not have an expiration date which is at any time less than 5 years in the future, on a continuing basis. If the commissioner considers it necessary to protect the interests of policyholders and beneficiaries in this state, he or she may require an additional deposit or a larger trust fund from an insurer.

(2) Subsection (1) and section 1920(4) shall not apply to unincorporated, individual alien insurers which, in place of the requirements prescribed in subsection (1) and section 1920(4), hold in trust for all policyholders and beneficiaries in the United States not less than $50,000,000.00, in the aggregate.

(3) Each eligible unauthorized insurer shall appoint the commissioner as its resident agent, for purposes of service of process.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

500.1922 Notice on face of instrument evidencing surplus lines insurance.

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Sec. 1922. Each policy, cover note, or other instrument evidencing surplus lines insurance which is to be delivered to an insured or a representative of an insured shall have printed, typed, or stamped in red ink upon its face, in not less than 10-point type, the following notice: "This insurance has been placed with an insurer that is not licensed by the state of Michigan. In case of insolvency, payment of claims may not be guaranteed." This notice shall not be covered over or concealed in any manner.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

500.1930 Association of licensees; registration; purposes; required filings by association; reasons for refusal to register association; reasons for suspension or revocation of registration; denial of membership.

Sec. 1930. (1) Licensees may associate and the commissioner may register an association for 1 or more of the following purposes:

(a) Advising the commissioner as to the availability of surplus lines coverage and market practices and standards for surplus lines insurers and licensees.

(b) Collecting and furnishing records, statistics, and accounts.

(c) Submitting recommendations regarding administration of this chapter.

(2) Each association shall file with the commissioner, for approval, all of the following:

(a) A copy of the association's constitution and articles of agreement or association, or the association's certificate of incorporation and bylaws, and any rules or regulations governing the association's activities.

(b) An agreement that, as a condition of continued registration under subsection (1), the commissioner may examine the association.

(3) Each association shall file with the commissioner and keep current all of the following:

(a) A list of members.

(b) The name and address of a resident of this state upon whom notices or orders of the commissioner or process issued by the commissioner may be served.

(4) The commissioner may refuse to register, or may suspend or revoke the registration of, an association for any of the following reasons:

(a) It reasonably appears that the association will not be able to carry out the purposes of this chapter.

(b) The association fails to maintain and enforce rules which can reasonably be anticipated to assure that members of the association and persons associated with those members comply with this chapter, other applicable chapters of this code, and rules promulgated under either.

(c) The rules of the association do not assure a fair representation of its members in the selection of directors and in the administration of its affairs.

(d) The rules of the association do not provide for an equitable allocation of reasonable dues, fees, and other charges among members.

(e) The rules of the association impose a burden on competition not necessary or appropriate to the purposes of this chapter.

(f) The association fails to meet other applicable requirements prescribed in this chapter.

(5) An association shall deny membership to any person who is not a licensee.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

500.1932 Servicing facility; establishment; reimbursement for expenses and payments; functions; approval; member licensee as servicing facility.

Sec. 1932. (1) In accordance with its bylaws, an association may establish an independent office as a servicing facility. Each servicing facility shall be reimbursed by the association for expenses incurred and for any payments made on behalf of the association. Each servicing facility may perform any of the functions of the association that officers of the association may lawfully delegate to it. In performing functions delegated to it, the facility shall act on behalf of, and in the name of, the association.

(2) Designation of servicing facilities shall be subject to the approval of a commissioner. A member licensee may serve as the servicing facility.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

500.1933 Suits by or against association; assertion or defense of rights.

Sec. 1933. An association, in its own name or through servicing facilities, may sue or be sued and may use the courts to assert or defend any rights the association may have by virtue of this chapter which are

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reasonably necessary to fully implement this chapter.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

500.1934 Filing certified audit of books, records, and trust funds.

Sec. 1934. Each association shall file annually with the commissioner a certified audit of the books and records of the association and its trust funds.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

500.1940 Reports and recommendations regarding financial condition of eligible unauthorized insurer; reports and recommendations not considered public documents; liability for statements.

Sec. 1940. The association may submit reports and make recommendations to the commissioner regarding the financial condition of any eligible unauthorized insurer. These reports and recommendations shall not be considered to be public documents. There shall not be liability on the part of, and a cause of action of any nature shall not arise against, eligible unauthorized insurers, the association or its agents or employees, the directors, or the commissioner or authorized representatives of the commissioner, for statements made by them in any reports or recommendations made under this section.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

500.1946 Repealed. 2000, Act 486, Imd. Eff. Jan. 11, 2001.

Compiler's note: The repealed section pertained to promulgation of rules regulating conduct of licensees.

Popular name: Act 218

500.1950 Placement of insurance with insurer which is neither an authorized insurer nor an eligible unauthorized insurer; duties of licensee.

Sec. 1950. Notwithstanding section 1920(1), a resident of this state may obtain insurance from an unauthorized insurer in this state through a licensee under this chapter. Unless the resident insists that the insurance be placed with an unauthorized insurer which is not recognized by the commissioner as eligible, the licensee shall first attempt to place the insurance with authorized insurers or, if that is not possible, with eligible unauthorized insurers before placing the insurance with an unauthorized insurer not recognized as eligible, and shall certify to the commissioner on a form prescribed by the commissioner that these attempts were made. If the insurance is placed with an insurer which is neither an authorized insurer nor an eligible unauthorized insurer, upon obtaining coverage, the licensee shall do all of the following:

(a) Mail or deliver to the resident the following notice: "This insurance has been placed with an insurer not licensed by the state of Michigan nor recognized by the insurance commissioner as an eligible unauthorized insurer. In case of any dispute relative to the terms or conditions of the policy or the practices of the insurer, the insurance commissioner may not be able to assist in the dispute. In case of insolvency, payment of claims is not guaranteed." A copy of the notice shall be filed with the commissioner.

(b) Collect from the resident insured appropriate premium taxes and report the transaction to the commissioner on a form prescribed by the commissioner. If the resident insured fails to pay the taxes when due, the insured shall be subject to a civil fine of not more than $1,000.00, plus accrued interest from the inception of the insurance.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

500.1951 Procuring, continuing, or renewing insurance with unauthorized insurer; report; tax on premiums; regulatory fee.

Sec. 1951. An insured in this state who, on behalf of himself or herself, or an employee in this state who, on behalf of his or her employer, procures, causes to be procured, or continues or renews insurance with an unauthorized insurer, or a self-insurer in this state who procures or continues excess loss, catastrophe, or other insurance with an unauthorized insurer, upon a subject of insurance resident, located, or to be performed within this state, other than insurance procured pursuant to section 1905 or 1950, within 30 days after the date the insurance was procured, continued, or renewed, shall file a written report regarding the insurance with the commissioner on forms prescribed by the commissioner and furnished to the insured upon request. The report shall be accompanied by a 2% tax on premiums written and, instead of the costs and expenses that may be

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imposed by the commissioner pursuant to this chapter, a 0.5% regulatory fee on premiums written. The report shall show all of the following:

(a) The name and address of the insured or insureds.

(b) The name and address of the insurer.

(c) The subject of the insurance.

(d) A general description of the coverage.

(e) The amount of premium currently charged for the insurance.

(f) Any additional pertinent information, reasonably requested by the commissioner.

History: Add. 1980, Act 341, Eff. June 23, 1981;—Am. 1987, Act 261, Imd. Eff. Dec. 28, 1987;—Am. 1989, Act 214, Eff. Jan. 1, 1990;—Am. 1994, Act 228, Imd. Eff. June 30, 1994.

Popular name: Act 218

500.1952 Violation as misdemeanor; penalty.

Sec. 1952. A person who knowingly and wilfully violates or aids or abets directly or indirectly in a violation of this chapter is guilty of a misdemeanor, punishable by imprisonment for not more than 1 year, or a fine of not more than $1,000.00, or both.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

500.1955 Rules implementing chapter; declaratory rulings.

Sec. 1955. The commissioner may promulgate rules to implement this chapter pursuant to Act No. 306 of the Public Acts of 1969, as amended. The commissioner may issue declaratory rulings regarding implementation of this chapter.

History: Add. 1980, Act 341, Eff. June 23, 1981.

Popular name: Act 218

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CHAPTER 20
UNFAIR AND PROHIBITED TRADE PRACTICES AND FRAUDS

500.2001 Short title.

Sec. 2001. Sections 2001 to 2050 shall be known and may be cited as "the uniform trade practices act".

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1976, Act 273, Eff. Apr. 1, 1977.

Popular name: Act 218

500.2002 Purpose of act.

Sec. 2002. The purpose of this uniform trade practices act is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the act of congress of March 9, 1945 (Public Law 15, 79th Congress as amended), by defining, or by providing for the determination of (under standards or procedures herein prescribed), all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices, and by prohibiting the trade practices so defined or determined.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2003 Prohibited trade practices; "person" defined.

Sec. 2003. (1) A person shall not engage in a trade practice that is defined or described in this chapter or is determined under this chapter to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

(2) Except as otherwise provided in this subsection, "person" means that term as defined in section 114 and includes an insurance producer, solicitor, counselor, adjuster, or nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373. Person does not include the property and casualty guaranty association.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1976, Act 273, Eff. Apr. 1, 1977;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.2005 Misrepresentations.

Sec. 2005. An unfair method of competition and an unfair or deceptive act or practice in the business of insurance means the making, issuing, circulating, or causing to be made, issued, or circulated, an estimate,

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illustration, circular, statement, sales presentation, or comparison which by omission of a material fact or incorrect statement of a material fact does any of the following:

(a) Misrepresents the terms, benefits, advantages, or conditions of an insurance policy.

(b) Misrepresents the dividends or share of the surplus to be received on an insurance policy.

(c) Makes a false or misleading statement as to the dividends or share of surplus previously paid on an insurance policy.

(d) Makes a misleading statement or misrepresentation as to the financial condition of a person engaged in the business of insurance, or as to the legal reserve system upon which a life insurer operates.

(e) Uses a name or title of an insurance policy or class of insurance policies misrepresenting the true nature of that insurance policy or class of insurance policies. A policy approved by the commissioner shall be conclusively presumed not to misrepresent the true nature of that policy.

(f) Makes a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of an insurance policy.

(g) Makes a misrepresentation for the purpose of effecting a pledge or assignment of or a loan against an insurance policy.

(h) Misrepresents an insurance policy as being a security. This subdivision shall not apply to an insurance policy which must be registered as a security pursuant to the law of this state or of the United States.

(i) Misrepresents the nature or extent of coverage afforded an insurance policy or annuity contract by the Michigan life and health insurance guaranty association or the property and casualty guaranty association.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1976, Act 273, Eff. Apr. 1, 1977;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.2005a Unfair method of competition; unfair or deceptive act or practice.

Sec. 2005a. An unfair method of competition and an unfair or deceptive act or practice in the business of insurance includes all of the following:

(a) Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies, certificates, or contracts of insurers, health care corporations, or health maintenance organizations for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy, certificate, or contract or to take out a policy, certificate, or contract with another insurer, health care corporation, or health maintenance organization.

(b) Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, or threat, whether explicit or implied, or undue pressure.

(c) Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.2006 Payment of benefits on timely basis; payment of interest in alternative; failure to pay claims or interest as unfair trade practice; liability for claim pursuant to judgment; proof of loss; inability to pay claim; interest requirements; failure of reinsurer to pay benefits on timely basis; effect of inconsistency with certain acts; exceptions; processing and payment procedures; notices; payment of 1 or more services listed on claim; violations; fines; definitions; section applicable to nonprofit dental care corporation.

Sec. 2006. (1) A person must pay on a timely basis to its insured, a person directly entitled to benefits under its insured's insurance contract, or a third party tort claimant the benefits provided under the terms of its policy, or, in the alternative, the person must pay to its insured, a person directly entitled to benefits under its insured's insurance contract, or a third party tort claimant 12% interest, as provided in subsection (4), on claims not paid on a timely basis. Failure to pay claims on a timely basis or to pay interest on claims as provided in subsection (4) is an unfair trade practice unless the claim is reasonably in dispute.

(2) A person shall not be found to have committed an unfair trade practice under this section if the person is found liable for a claim pursuant to a judgment rendered by a court of law, and the person pays to its insured, the person directly entitled to benefits under its insured's insurance contract, or the third party tort claimant interest as provided in subsection (4).

(3) An insurer shall specify in writing the materials that constitute a satisfactory proof of loss not later than 30 days after receipt of a claim unless the claim is settled within the 30 days. If proof of loss is not supplied as

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to the entire claim, the amount supported by proof of loss is considered paid on a timely basis if paid within 60 days after receipt of proof of loss by the insurer. Any part of the remainder of the claim that is later supported by proof of loss is considered paid on a timely basis if paid within 60 days after receipt of the proof of loss by the insurer. If the proof of loss provided by the claimant contains facts that clearly indicate the need for additional medical information by the insurer in order to determine its liability under a policy of life insurance, the claim is considered paid on a timely basis if paid within 60 days after receipt of necessary medical information by the insurer. Payment of a claim is not untimely during any period in which the insurer is unable to pay the claim if there is no recipient who is legally able to give a valid release for the payment, or if the insurer is unable to determine who is entitled to receive the payment, if the insurer has promptly notified the claimant of that inability and has offered in good faith to promptly pay the claim on determination of who is entitled to receive the payment.

(4) If benefits are not paid on a timely basis, the benefits paid bear simple interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum, if the claimant is the insured or a person directly entitled to benefits under the insured's insurance contract. If the claimant is a third party tort claimant, the benefits paid bear interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum if the liability of the insurer for the claim is not reasonably in dispute, the insurer has refused payment in bad faith, and the bad faith was determined by a court of law. The interest must be paid in addition to and at the time of payment of the loss. If the loss exceeds the limits of insurance coverage available, interest is payable based on the limits of insurance coverage rather than the amount of the loss. If payment is offered by the insurer but is rejected by the claimant, and the claimant does not subsequently recover an amount in excess of the amount offered, interest is not due. Interest paid as provided in this section must be offset by any award of interest that is payable by the insurer as provided in the award.

(5) If a person contracts to provide benefits and reinsures all or a portion of the risk, the person contracting to provide benefits is liable for interest due to an insured, a person directly entitled to benefits under its insured's insurance contract, or a third party tort claimant under this section if a reinsurer fails to pay benefits on a timely basis.

(6) If there is any specific inconsistency between this section and chapter 31 or the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, the provisions of this section do not apply. Subsections (7) to (14) do not apply to a person regulated under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941. Subsections (7) to (14) do not apply to the processing and paying of Medicaid claims that are covered under section 111i of the social welfare act, 1939 PA 280, MCL 400.111i.

(7) Subsections (1) to (6) do not apply and subsections (8) to (14) do apply to health plans when paying claims to health professionals, health facilities, home health care providers, and durable medical equipment providers, that are not pharmacies and that do not involve claims arising out of chapter 31 or the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941. This section does not affect a health plan's ability to prescribe the terms and conditions of its contracts, other than as provided in this section for timely payment.

(8) Each health professional, health facility, home health care provider, and durable medical equipment provider in billing for services rendered and each health plan in processing and paying claims for services rendered shall use the following timely processing and payment procedures:

(a) A clean claim must be paid within 45 days after receipt of the claim by the health plan. A clean claim that is not paid within 45 days bears simple interest at a rate of 12% per annum.

(b) A health plan shall notify the health professional, health facility, home health care provider, or durable medical equipment provider within 30 days after receipt of the claim by the health plan of all known reasons that prevent the claim from being a clean claim.

(c) A health professional, health facility, home health care provider, or durable medical equipment provider has 45 days, and any additional time the health plan permits, after receipt of a notice under subdivision (b) to correct all known defects. The 45-day time period in subdivision (a) is tolled from the date of receipt of a notice to a health professional, health facility, home health care provider, or durable medical equipment provider under subdivision (b) to the date of the health plan's receipt of a response from the health professional, health facility, home health care provider, or durable medical equipment provider.

(d) If a health professional's, health facility's, home health care provider's, or durable medical equipment provider's response under subdivision (c) makes the claim a clean claim, the health plan shall pay the health professional, health facility, home health care provider, or durable medical equipment provider within the 45-day time period under subdivision (a), excluding any time period tolled under subdivision (c).

(e) If a health professional's, health facility's, home health care provider's, or durable medical equipment

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provider's response under subdivision (c) does not make the claim a clean claim, the health plan shall notify the health professional, health facility, home health care provider, or durable medical equipment provider of an adverse claim determination and of the reasons for the adverse claim determination within the 45-day time period under subdivision (a), excluding any time period tolled under subdivision (c).

(f) A health professional, health facility, home health care provider, or durable medical equipment provider must bill a health plan within 1 year after the date of service or the date of discharge from the health facility in order for a claim to be a clean claim.

(g) A health professional, health facility, home health care provider, or durable medical equipment provider shall not resubmit the same claim to the health plan unless the time period under subdivision (a) has passed or as provided in subdivision (c).

(h) A health plan that is a qualified health plan for the purposes of 45 CFR 156.270 and that, as required in 45 CFR 156.270(d), provides a 3-month grace period to an enrollee who is receiving advance payments of the premium tax credit and who has paid 1 full month's premium may pend claims for services rendered to the enrollee in the second and third months of the grace period. A claim during the second and third months of the grace period is not a clean claim under this section, and interest is not payable under subdivision (a) on that claim if the health plan has complied with the notice requirements of 45 CFR 155.430 and 45 CFR 156.270.

(9) Notices required under subsection (8) must be made in writing or electronically.

(10) If a health plan determines that 1 or more services listed on a claim are payable, the health plan shall pay for those services and shall not deny the entire claim because 1 or more other services listed on the claim are defective. This subsection does not apply if a health plan and health professional, health facility, home health care provider, or durable medical equipment provider have an overriding contractual reimbursement arrangement.

(11) A health plan shall not terminate the affiliation status or the participation of a health professional, health facility, home health care provider, or durable medical equipment provider with a health maintenance organization provider panel or otherwise discriminate against a health professional, health facility, home health care provider, or durable medical equipment provider because the health professional, health facility, home health care provider, or durable medical equipment provider claims that a health plan has violated subsections (7) to (10).

(12) A health professional, health facility, home health care provider, durable medical equipment provider, or health plan alleging that a timely processing or payment procedure under subsections (7) to (11) has been violated may file a complaint with the director on a form approved by the director and has a right to a determination of the matter by the director or his or her designee. This subsection does not prohibit a health professional, health facility, home health care provider, durable medical equipment provider, or health plan from seeking court action.

(13) In addition to any other penalty provided for by law, the director may impose a civil fine of not more than $1,000.00 for each violation of subsections (7) to (11) not to exceed $10,000.00 in the aggregate for multiple violations.

(14) As used in subsections (7) to (13):

(a) "Clean claim" means a claim that does all of the following:

(*i*) Identifies the health professional, health facility, home health care provider, or durable medical equipment provider that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.

(*ii*) Sufficiently identifies the patient and health plan subscriber.

(*iii*) Lists the date and place of service.

(*iv*) Is a claim for covered services for an eligible individual.

(*v*) If necessary, substantiates the medical necessity and appropriateness of the service provided.

(*vi*) If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained.

(*vii*) Identifies the service rendered using a generally accepted system of procedure or service coding.

(*viii*) Includes additional documentation based on services rendered as reasonably required by the health plan.

(b) "Health facility" means a health facility or agency licensed under article 17 of the public health code, 1978 PA 368, MCL 333.20101 to 333.22260.

(c) "Health plan" means all of the following:

(*i*) An insurer providing benefits under a health insurance policy, including a policy, certificate, or contract that provides coverage for specific diseases or accidents only, an expense-incurred vision or dental policy, or a hospital indemnity, Medicare supplement, long-term care, or 1-time limited duration policy or certificate, but not to payments made to an administrative services only or cost-plus arrangement.

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(*ii*) A MEWA regulated under chapter 70 that provides hospital, medical, surgical, vision, dental, and sick care benefits.

(d) "Health professional" means an individual licensed, registered, or otherwise authorized to engage in a health profession under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(15) After December 31, 2017, this section applies to a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

History: Add. 1976, Act 273, Eff. Apr. 1, 1977;—Am. 2002, Act 316, Eff. Oct. 1, 2002;—Am. 2004, Act 28, Eff. Sept. 16, 2004;—Am. 2016, Act 276, Imd. Eff. July 1, 2016;—Am. 2017, Act 223, Imd. Eff. Dec. 20, 2017.

Compiler's note: Enacting section 1 of Act 316 of 2002 provides:

"Enacting section 1. This amendatory act takes effect on October 1, 2002 and applies to all health care claims with dates of service on and after October 1, 2002."

Popular name: Act 218

500.2007 Unfair methods of competition or deception; false, deceptive or misleading advertising.

Sec. 2007. The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

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

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2008 Audit of insured's payroll expenditures; purpose; request; failure to complete payroll audit or final audit as unfair or deceptive act or practice; failure to pay premium adjustment or dividend on timely basis as unfair or deceptive act or practice; "timely basis" defined; interest; applicability of section.

Sec. 2008. (1) Upon the written request of an insured, an insurer shall audit or cause to be audited an insured's payroll expenditures for the purpose of determining the proper worker's compensation insurance premiums. The written request of the insured shall include a statement that the insured has reason to believe that there has been not less than a 20% change in payroll expenditures and the reasons for that belief. The audit shall be completed within 120 days of the receipt of the written request, if all required information to complete the audit has been made available. Only 1 audit per calendar year conducted at the request of the insured is required under this subsection.

(2) Except for a final audit, it is an unfair or deceptive act or practice in the business of insurance for an insurer to fail to complete a payroll audit which is required pursuant to the terms of a policy within 120 days after the date specified in the policy for the commencement of an audit, if all required information to complete the audit has been made available. It is an unfair or deceptive act or practice in the business of insurance if a final audit is not completed by an insurer within 120 days after the date of termination of the policy, if all required information to complete the audit has been made available.

(3) An insurer shall pay on a timely basis to its insured any adjustment in a premium, any dividend, a retrospective premium adjustment, or any similar amount which is due. It is an unfair or deceptive act or practice in the business of insurance for an insurer to not pay these amounts on a timely basis. As used in this section, "timely basis" means the following, as applicable:

(a) If the amount is due pursuant to a payroll audit, within 60 days after the completion of that audit.

(b) If the policy specifies a date on which an amount is due, on or before that date.

(c) If the date the amount is due is not specified in the policy, within 60 days after the expiration of the policy.

(d) In the case of a retrospective premium adjustment, as specified in the policy, or 9 months after expiration of the policy.

(e) In the case of a dividend, within 60 days after determination of the specific amount due.

(4) When an adjustment in a premium, a dividend, a retrospective premium adjustment, or a similar amount due an insured is not paid on a timely basis, the amount due shall bear simple interest from the applicable date specified in subsection (3) at the rate of 12% per annum. This interest shall be paid in addition to and at the time of payment of the amount due.

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(5) This section only applies to worker's compensation insurance.

History: Add. 1982, Act 7, Eff. Jan. 1, 1983.

Popular name: Act 218

500.2009 False, maliciously critical, or derogatory statement as to financial condition.

Sec. 2009. Unfair methods of competition and unfair or deceptive acts or practices in the business of insurance include the making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of an oral or written statement or a pamphlet, circular, article, or literature which is false, or maliciously critical of, or derogatory to the financial condition of a person engaged in the business of insurance, and which is calculated to injure a person engaged in the business of insurance.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1976, Act 273, Eff. Apr. 1, 1977.

Popular name: Act 218

500.2010 Unfair method of competition; unfair or deceptive act or practice.

Sec. 2010. It is an unfair method of competition and an unfair or deceptive act or practice in the business of insurance for a malpractice insurer to refuse to offer insurance to a health care provider or hospital on the grounds that the health care provider or hospital has entered or intends to enter into valid written agreements with patients or prospective patients for the arbitration of cases or controversies arising out of the professional or business relationships between a patient and the health care provider or hospital.

History: Add. 1993, Act 349, Eff. Oct. 1, 1994.

Popular name: Act 218

500.2011 Unfair methods of competition; unfair or deceptive acts or practices.

Sec. 2011. (1) An unfair method of competition and an unfair or deceptive act or practice in the business of insurance includes an insurer providing a commission or other compensation to the insurer's representative or agent for the sale or service of a disability policy or rider issued to an individual eligible for medicare, unless the amount of the commission or compensation paid in the first year of the policy is not more than the amount of the commission or compensation that the insurer's representative or agent receives for the policy in each of the 2 subsequent, consecutive annual renewal periods.

(2) An unfair method of competition and an unfair or deceptive act or practice in the business of insurance includes an insurer issuing a disability policy or rider to an individual eligible for medicare that provides for a new preexisting condition limitation waiting period if coverage is converted to or replaced by a new or other form of similar coverage with the same insurer or any of the insurer's affiliates. If the preexisting condition limitation waiting period in the original or replaced policy has not expired, the replacing policy may include the remaining term of the preexisting condition limitation waiting period of the replaced policy. This subsection does not apply to an increase in benefits voluntarily selected by the individual.

History: Add. 1989, Act 131, Eff. Nov. 1, 1989.

Popular name: Act 218

500.2012 Unfair methods of competition or deception; combinations in restraint of trade.

Sec. 2012. The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of the business of insurance.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2013 Violation of chapter or rule; effect.

Sec. 2013. A violation of chapter 5 or a rule promulgated under chapter 5 is an unfair method of competition and an unfair or deceptive act or practice in the business of insurance.

History: Add. 2001, Act 24, Imd. Eff. June 18, 2001.

Popular name: Act 218

500.2013a Failure to comply with MCL 500.3107e; unfair practice; applicability to other rights.

Sec. 2013a. (1) The failure of an insurer to materially comply with section 3107e is an unfair method of competition and an unfair or deceptive act or practice in the business of insurance.

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(2) This section does not affect any other right of a person under this chapter.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.2014 False material statement of financial condition; false entry or omission of true entry in book, report, or statement.

Sec. 2014. Unfair methods of competition and unfair or deceptive acts or practices in the business of insurance include:

(a) Filing with a supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to a person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, or delivered to a person, or placed before the public, a false material statement of financial condition of a person engaged in the business of insurance.

(b) Making a false entry of a material fact in a book, report, or statement of a person engaged in the business of insurance or omitting to make a true entry of a material fact pertaining to the business of the person in a book, report, or statement of the person.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1976, Act 273, Eff. Apr. 1, 1977.

Popular name: Act 218

500.2015 Repealed. 1976, Act 273, Eff. Apr. 1, 1977.

Compiler's note: The repealed section pertained to false or incomplete records and reports.

Popular name: Act 218

500.2016 Unfair methods of competition and unfair and deceptive acts or practices in business of insurance; applicability of section.

Sec. 2016. (1) In addition to other provisions of law, the following practices as applied to worker's compensation insurance including worker's compensation coverage provided through a self-insurer's group are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(a) As a condition of receiving a dividend for the current or a previous year, requiring an insured to renew or maintain worker's compensation insurance with the insurer beyond the current policy's expiration date or requiring a member to continue participation with a worker's compensation self-insurer group.

(b) As a condition of obtaining worker's compensation insurance, requiring a premium deposit greater than 25% of the total projected annual premium or $2,500.00, whichever is greater.

(c) As a condition of obtaining worker's compensation insurance, requiring the purchase of any other form of insurance from the same insurer.

(d) As the result of a payroll audit or examination, requiring the payment of an increased premium increment within 30 days of written notification of the increase in premium.

(2) This section does not apply if the insured was guilty of misrepresentation, fraud, or other acts of bad faith.

(3) This section also applies to worker's compensation self-insurers' groups.

History: Add. 1982, Act 7, Eff. Jan. 1, 1983;—Am. 1998, Act 457, Imd. Eff. Jan. 4, 1999.

Popular name: Act 218

500.2017 Unfair methods of competition or deception; illegal inducements.

Sec. 2017. The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2018 False or fraudulent statements or representations as to application for insurance policy.

Sec. 2018. An unfair method of competition and an unfair or deceptive act or practice in the business of insurance include making false or fraudulent statements or representations on or relative to an application for an insurance policy for the purpose of obtaining a fee, commission, money, or other benefit from an insurer,

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agent, broker, or individual.

History: Add. 1976, Act 273, Eff. Apr. 1, 1977.

Popular name: Act 218

500.2019 Unfair methods of competition or deception; unfair discrimination in life insurance.

Sec. 2019. The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2020 Unfair methods of competition or deception; unfair discrimination in accident or health insurance.

Sec. 2020. The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

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

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2021 Failure to furnish insured rate information upon request; unfair method of competition and unfair or deceptive act or practice in business of insurance; exception.

Sec. 2021. An unfair method of competition and an unfair or deceptive act or practice in the business of insurance includes failure by a rating organization and an insurer that makes its own rates, within a reasonable time after receiving written request for the information and on payment of a reasonable charge, to furnish to an insured affected by a rate made by it, or to the insured authorized representative, all pertinent information to the rate. Pertinent information under this section does not include information that is a trade secret as determined by the director under section 2108(5) or 2406(6).

History: Add. 1982, Act 7, Eff. Jan. 1, 1983;—Am. 2015, Act 141, Eff. Jan. 11, 2016.

Popular name: Act 218

500.2022 Repealed. 1976, Act 273, Eff. Apr. 1, 1977.

Compiler's note: The repealed section pertained to refusal to pay claims and to compelling acceptance of less than amount due.

Popular name: Act 218

500.2023 Automatic insurance on debtor contracting credit.

Sec. 2023. It is an unfair method of competition and an unfair or deceptive act or practice in the business of insurance for an insurer, unless required by law or statutory administrative rule or unless provided for by contract, to automatically write insurance on a debtor who has contracted credit based on the principle that the insurance is applicable unless specifically rejected by the debtor, unless the premium or such other identifiable charge as may be applicable is paid in full by the creditor.

History: Add. 1968, Act 240, Imd. Eff. June 26, 1968;—Am. 1976, Act 273, Eff. Apr. 1, 1977.

Popular name: Act 218

500.2024 Unfair methods of competition or deception; rebates and special inducements.

Sec. 2024. The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

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

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therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2024a Giving merchandise to applicants for life insurance.

Sec. 2024a. Beginning January 1, 1986, sections 2024, 2066, and 2070 shall not be construed to prohibit a life insurer or life insurance agent from giving to each applicant for a life insurance policy an article of merchandise having an invoice value of $5.00 or less.

History: Add. 1989, Act 68, Imd. Eff. June 16, 1989.

Popular name: Act 218

500.2024b Construction of MCL 500.2024, 500.2066, and 500.2070.

Sec. 2024b. Sections 2024, 2066, and 2070 do not prohibit a property-casualty insurer or property-casualty insurance producer from giving an applicant for or an insured under a property-casualty insurance policy an article of merchandise with a cost to the insurer of $50.00 or less per calendar year.

History: Add. 2005, Act 260, Imd. Eff. Dec. 16, 2005;—Am. 2018, Act 542, Imd. Eff. Dec. 28, 2018.

Popular name: Act 218

500.2025 Unfair methods of competition or deception; exclusions from discrimination, rebates.

Sec. 2025. Nothing in sections 2017 through 2024 shall be construed as including within the definition of discrimination or rebates any of the following practices:

(1) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from non-participating insurance: Provided, That any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interest of the company and its policyholders;

(2) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense;

(3) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2026 Course of conduct indicating persistent tendency to engage in that type of conduct.

Sec. 2026. (1) Unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, other than isolated incidents, are a course of conduct indicating a persistent tendency to engage in that type of conduct and include:

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

(b) Failing to acknowledge promptly or to act reasonably and 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 the available information.

(e) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

(f) Failing to attempt 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 due the insureds.

(h) Attempting to settle a claim for less than the amount to which a reasonable person would believe the claimant was entitled, by reference to written or printed advertising material accompanying or made part of an application.

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(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 a claims payment to a policyholder or beneficiary omitting the coverage under which each payment is 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 subsequent submission of formal proof of loss forms, seeking solely the duplication of a verification.

(m) Failing to promptly settle claims where liability has become reasonably clear under 1 portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy.

(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.

(2) The failure of a person to maintain a complete record of all the complaints of its insureds which it has received since the date of the last examination is an unfair method of competition and unfair or deceptive act or practice in the business of insurance. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition thereof, and the time it took to process each complaint. For purposes of this subsection, "complaint" means a written communication primarily expressing an allegation of acts which would constitute violation of this chapter. If a complaint relating to an insurer is received by an agent of the insurer, the agent shall promptly forward the complaint to the insurer unless the agent resolves the complaint to the satisfaction of the insured within a reasonable time. An insurer shall not be deemed to have engaged in an unfair method of competition or an unfair or deceptive act or practice in the business of insurance in violation of this chapter because of the failure of an agent who is not also an employee to forward a written complaint as required by this subsection.

History: Add. 1976, Act 273, Eff. Apr. 1, 1977.

Popular name: Act 218

500.2027 Unfair methods of competition and unfair or deceptive acts or practices; prohibited conduct.

Sec. 2027. Unfair methods of competition and unfair or deceptive acts or practices in the business of insurance include:

(a) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual or risk because of any of the following:

(*i*) Race, color, creed, marital status, sex, national origin, gender, gender identity or expression, or sexual orientation, except that marital status may be used to classify individuals or risks for the purpose of insuring family units.

(*ii*) The residence, age, disability, or lawful occupation of the individual or the location of the risk, unless there is a reasonable relationship between the residence, age, disability, or lawful occupation of the individual or the location of the risk and the extent of the risk or the coverage issued or to be issued, but subject to subparagraph (*iii*). This section does not prohibit an insurer from specializing in or limiting its transactions of insurance to certain occupational groups, types, or risks as approved by the director. The director shall approve the specialization for an insurer licensed to do business in this state and whose articles of incorporation contained a provision on July 1, 1976, requiring that specialization.

(*iii*) For property insurance, the location of the risk, unless there is a statistically significant relationship between the location of the risk and a risk of loss due to fire within the area in which the insured property is located. As used in this subparagraph, "area" means a single zip code number under the zoning improvement plan of the United States Postal Service.

(b) Refusing to insure or refusing to continue to insure an individual or risk solely because the insured or applicant was previously denied insurance coverage by an insurer.

(c) Charging a different rate for the same coverage based on race, color, creed, marital status, sex, national origin, gender, gender identity or expression, sexual orientation, age, residence, location of risk, disability, or lawful occupation of the risk unless the rate differential is based on sound actuarial principles and a reasonable classification system, and is related to the actual and credible loss statistics or, for new coverages, reasonably anticipated experience. This subdivision does not apply if the rate has previously been approved by the director.

History: Add. 1976, Act 273, Eff. Apr. 1, 1977;—Am. 1998, Act 26, Imd. Eff. Mar. 12, 1998;—Am. 2023, Act 156, Eff. Feb. 13, 2024.

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Popular name: Act 218

500.2028 Examination; investigation.

Sec. 2028. Upon probable cause, the commissioner shall have power to examine and investigate into the affairs of a person engaged in the business of insurance in this state to determine whether the person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by sections 2001 to 2050.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1976, Act 273, Eff. Apr. 1, 1977.

Popular name: Act 218

500.2029 Notice of hearing; opportunity to confer; summary disposition.

Sec. 2029. When the commissioner has probable cause to believe that a person engaged in the business of insurance has been engaged or is engaging in this state in an unfair method of competition, or an unfair or deceptive act or practice in the conduct of his business, as prohibited by sections 2001 to 2050, and that a hearing by the commissioner in respect thereto would be in the interest of the public, he shall first give notice in writing, pursuant to Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.315 of the Michigan Compiled Laws, to the person involved, setting forth the general nature of the complaint against him and the proceedings contemplated pursuant to sections 2001 to 2050. Before the issuance of a notice of hearing, the staff of the bureau of insurance responsible for the matters which would be at issue in the hearing shall give the person an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or his representative and the matter may be disposed of summarily upon agreement of the parties.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1976, Act 273, Eff. Apr. 1, 1977.

Popular name: Act 218

500.2030 Hearing; procedure; intervention; burden of proof; commissioner or designate to preside; independent hearing officer; peremptory dismissal.

Sec. 2030. (1) At the time and place fixed for the hearing referred to in section 2029, the person shall have an opportunity to be heard, to be represented by counsel and to show cause why an order should not be made by the commissioner requiring the person to cease and desist from the acts, methods, or practices complained of. Upon showing by any person that he has an interest likely to be affected adversely, the commissioner shall permit that person to intervene, appear and be heard at the hearing by counsel or in person.

(2) The burden of proof at the hearing shall be upon the agency or upon an intervenor who intervened in opposition to the person who is the subject of the proceeding.

(3) The commissioner or his designate shall preside over the hearing, except that an independent hearing officer shall be designated by the commissioner if requested by the person who is the subject of the proceedings. The independent hearing officer shall be selected by the commissioner from a list of individuals submitted by the American arbitration association qualified to conduct hearings on behalf of the commissioner. A list of the individuals shall be maintained by the commissioner and shall be compiled pursuant to rules promulgated by the commissioner. The rules shall set forth the qualifications, criteria, and procedures to be utilized in the compilation of the list of independent hearing officers. The person subject to the proceedings may exercise 1 peremptory dismissal of the hearing officer selected, if exercised within 20 days after notification.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1976, Act 273, Eff. Apr. 1, 1977.

Popular name: Act 218

Administrative rules: R 500.1051 et seq. of the Michigan Administrative Code.

500.2032 Unfair methods of competition or deception; hearing; oaths; witnesses; evidence; subpoenas; contempt of court; stenographic record; statement of evidence.

Sec. 2032. (1) The commissioner, upon the hearing referred to in section 2030, may administer oaths, examine and cross examine witnesses, and receive oral and documentary evidence. Any party to the cause shall have the power to compel the subpoena of witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which he deems relevant to the inquiry. In case of a refusal of any person to comply with any subpoena issued hereunder or to testify with respect to any matter concerning which he may be lawfully interrogated, the circuit court of Ingham county or the county where such party resides, on application of any party to the cause, may issue an order requiring such person to comply with such subpoena and to testify; and any failure to obey any such order of the court may be punished by the court as a contempt thereof.

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(2) The commissioner, upon such hearing, may, and upon the request of any party to the cause shall, cause to be made a stenographic record of all the evidence and all the proceedings had at such hearing. If no stenographic record is made and if a judicial review is sought, the commissioner shall prepare a statement of the evidence and proceeding for use on review.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2033 Hearing; directing witness to give testimony or produce evidence; immunity; perjury; waiver of immunity or privilege.

Sec. 2033. If any natural person shall ask to be excused from attending and testifying or from producing any books, papers, records, correspondence or other documents at any hearing on the ground that the testimony or evidence required of him or her may tend to incriminate him or her or subject him or her to a penalty or forfeiture, and shall notwithstanding be directed to give testimony or produce evidence, he or she must nonetheless comply with the directions, but he or she shall not be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter or thing concerning which he or she may testify or produce evidence pursuant to this section, and no testimony given or evidence produced shall be received against him or her upon any criminal action, investigation or proceeding. No individual testifying shall be exempt under this section from prosecution or punishment for any perjury committed by him or her while so testifying and the testimony or evidence given or produced shall be admissible against him or her upon any criminal action, investigation or proceeding concerning the perjury, nor shall he or she be exempt from the refusal, revocation or suspension of any license, permission or authority conferred, or to be conferred, pursuant to the insurance code. Any individual may execute, acknowledge and file in the office of the commissioner a statement expressly waiving immunity or privilege in respect to any transaction, matter or thing specified in the statement and the testimony of the person or evidence in relation to the transaction, matter or thing may be received or produced before any judge, court, tribunal, grand jury or otherwise, and if so received or produced the individual shall not be entitled to any immunity or privilege on account of any testimony he or she may give or evidence produced.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1991, Act 141, Imd. Eff. Nov. 25, 1991.

Popular name: Act 218

500.2034 Unfair methods of competition or deception; service of notices, process and other papers, return.

Sec. 2034. Statements of charges, notices, orders, subpoenas and other processes of the commissioner under this uniform trade practices act may be served by anyone duly authorized by the commissioner, either in the manner provided by law for service of process in civil actions, or by registering and mailing a copy thereof to the person affected by such statement, notice, order, or other process at his or its residence or principal office or place of business. The verified return by the person so serving such statement, notice, order, or other process, setting forth the manner of such service, shall be proof of the same, and the return postcard receipt for such statement, notice, order, or other process, registered and mailed as aforesaid, shall be proof of the service of the same.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2038 Findings and decision to be in writing; cease and desist order; other orders; stay; modification or setting aside of order.

Sec. 2038. (1) If, after opportunity for a hearing held under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director determines that the person complained of has engaged in methods of competition or unfair or deceptive acts or practices prohibited by sections 2001 to 2050, the director shall reduce his or her findings and decision to writing and shall issue and cause to be served on the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from engaging in that method of competition, act, or practice. The director may also order any of the following:

(a) Payment of a monetary penalty of not more than $1,000.00 for each violation but not to exceed an aggregate penalty of $10,000.00, unless the person knew or reasonably should have known he was in violation of this chapter, in which case the penalty must not be more than $5,000.00 for each violation and must not exceed an aggregate penalty of $50,000.00 for all violations committed in a 6-month period.

(b) Suspension or revocation of the person's license or certificate of authority if the person knowingly and persistently violated a provision of this chapter.

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(c) Refund of any overcharges.

(2) The filing of a petition for review does not stay enforcement of action under this section, but the director may grant, or the appropriate court may order, a stay on appropriate terms.

(3) If a petition for review has not been filed within the time allowed under section 244, until the time for filing the petition expires or, if a petition for review has been filed within that time, until the transcript of the record in the proceeding has been filed in the circuit court, as provided in this chapter, the director, on notice and in a manner as he or she considers proper, may modify or set aside in whole or in part an order issued under this section.

(4) After the expiration of the time allowed for filing a petition for review, if a petition has not been filed within that time, the director may at any time, by order, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued under this section, if in the director's opinion conditions of fact or of law have so changed as to require that action or if required by the public interest.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1976, Act 273, Eff. Apr. 1, 1977;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.2039 Finality of order.

Sec. 2039. An order issued by the commissioner pursuant to this chapter shall become final:

(a) Upon the expiration of the time allowed for filing a petition for review if a petition has not been duly filed within that time, except that the commissioner may thereafter modify or set aside his order to the extent provided in section 2038(2).

(b) Upon the final decision of the court if the court directs that the order of the commissioner be affirmed or the petition for review dismissed.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1976, Act 273, Eff. Apr. 1, 1977.

Popular name: Act 218

500.2040 Violation of cease and desist order; penalty; stay; contents of cease and desist order.

Sec. 2040. (1) A person who violates a cease and desist order of the director under this chapter while the order is in effect, after notice and an opportunity for a hearing and on order of the director, may be subject to any of the following:

(a) A monetary penalty of not more than $20,000.00 for each violation.

(b) Suspension or revocation of the person's license or certificate of authority.

(2) The filing of a petition for review does not stay enforcement under this section, but the director may grant, or the appropriate court may order, a stay on appropriate terms.

(3) A cease and desist order issued by the director under section 2043 must not contain fines or other penalties applicable to acts or omissions that occur before the date of the cease and desist order.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1976, Act 273, Eff. Apr. 1, 1977;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.2041 Unfair methods of competition or deception; court review of orders, findings of fact conclusive, modification; additional evidence.

Sec. 2041. (1) Any order or decision of the commissioner under this uniform trade practices act shall be subject to review as provided in section 244. The findings of fact of the commissioner, and any modification thereof as provided for in subsection (2) of this section, if supported by the preponderance of the evidence, shall be conclusive.

(2) To the extent that the order of the commissioner is affirmed, the court shall thereupon issue its own order commanding obedience to the terms of such order of the commissioner. If either party shall apply to the court for leave to adduce additional evidence, and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the commissioner, the court may order such additional evidence to be taken before the commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper. The commissioner may modify his findings of fact, or make new findings by reason of the additional evidence so taken, and he shall file such modified or new findings, which, if supported by the preponderance of the evidence, shall be conclusive, and his recommendation, if any, for the modification or setting aside of his original order, with the return of such additional evidence.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

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500.2043 Unfair methods of competition or deception; procedure to enjoin, jurisdiction of circuit court; filing petition; additional evidence; modification of findings; issuance of injunction; preliminary notice; application for trade conference.

Sec. 2043. (1) Whenever the commissioner has probable cause to believe that any person engaged in the business of insurance is engaging in this state in any method of competition or in any act or practice in the conduct of such business which is not defined in sections 2005 through 2025, that such method of competition is unfair or that such act or practice is unfair or deceptive and that a proceeding by him in respect thereto would be in the interest of the public, the commissioner may issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than 15 days after the date of the service thereof. Each such hearing shall be conducted in the same manner as the hearings provided for in section 2029. The commissioner shall, after such hearing, state in writing his findings of fact, his decision, and his order if any; and he shall serve a copy thereof upon all parties of record to the proceeding.

(2) If such finding and decision charges a violation of this uniform trade practices act and if such method of competition, act or practice has not been discontinued, the commissioner may, through the attorney general of this state, at any time after 15 days after the service of such finding and decision cause a petition to be filed in the circuit court of Ingham county to enjoin and restrain such person from engaging in such method, act or practice. The court shall have jurisdiction of the proceeding and shall have power to make and enter appropriate orders in connection therewith and to issue such writs as are ancillary to its jurisdiction or are necessary in its judgment to prevent injury to the public pendente lite.

(3) A transcript of the proceedings before the commissioner including all evidence taken and the findings and decision shall be filed with such petition. If any party of record shall apply to the court for leave to adduce additional evidence and shall show, to the satisfaction of the court, that such additional evidence is material and there were reasonable grounds for the failure to adduce such evidence in the proceeding before the commissioner the court may order such additional evidence to be taken before the commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper. The commissioner may modify his findings of fact and decision or make new findings and decision by reason of the additional evidence so taken, and he shall file such modified or new findings and decision with the return of such additional evidence.

(4) If the court finds that the method of competition complained of is unfair or that the act or practice complained of is unfair or deceptive, that the proceeding by the commissioner with respect thereto is in the interest of the public and that the findings of the commissioner are supported by the weight of the evidence, it shall issue its order enjoining and restraining the continuance of such method of competition, act or practice.

(5) The commissioner shall not proceed with any formal statement of charges or notice of hearing under subsection (1) of this section until he shall first have provided such person sought to be charged, within 10 days' preliminary notice of the commissioner's proposed statement of charges or intention to call a hearing. Such preliminary proceedings shall be deemed to be privileged and shall not be subject to public inspection or announcement. Such person sought to be charged, may within 10 days after receipt of such notice make application for a trade conference as provided for in section 2047 unless the practice complained of has been previously defined as an unfair trade practice by published rule, regulation or standard as provided in section 2047. If such application is made by such person, it shall be the duty of the commissioner to call such a trade conference as provided in section 2047 to discuss the method of competition, act or practice which is the subject matter of the proposed charge; and the commissioner shall not proceed to any action under subsection (1) of this section until after such trade conference shall have been held.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2045 Unfair methods of competition or deception; court review on petition of intervenor.

Sec. 2045. If the finding and decision of the commissioner referred to in section 2043 does not charge a violation of this uniform trade practices act, then any intervenor in the proceedings, as defined in section 2030, may within 15 days after the service of such report, cause a petition to be filed in the circuit court of Ingham county for a review of such finding and decision. Upon such review, the court shall have authority to issue appropriate orders and decrees in connection therewith, including, if the court finds that it is in the interest of the public, orders enjoining and restraining the continuance of any method of competition, act or practice which it finds, notwithstanding such finding and decision of the commissioner, constitutes a violation of this chapter.

History: 1956, Act 218, Eff. Jan. 1, 1957.

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Popular name: Act 218

500.2047 Trade practice conferences; authorization by insurance commissioner; purpose; notice; scope; recommendation; rules, regulations, or standards; construction of section.

Sec. 2047. (1) Trade practice conferences for the purpose of dealing with such trade practices as are within the purview of this uniform trade practices act and not defined in sections 2005 through 2025, or for the purpose of establishing supplementary regulations and rules relating to trade practices defined in sections 2005 through 2025, may be authorized by the commissioner upon his own motion, or upon written application therefor by any insurer or person to whom rulings arising therefrom may be directly applicable, whenever such a conference may appear to the commissioner to be in the interest of the public.

(2) The commissioner shall give reasonable notice to such persons as he shall deem directly affected, or to their representatives, of the time and place of any such conference. Such notice shall set forth briefly the subject matter for consideration. Each such conference shall be presided over by the commissioner or a member of his staff designated by him. Any such trade practice conference may submit to the commissioner its recommendations as to rules, regulations or standards defining certain methods of competition, acts or practices as being fair or unfair, deceptive or not deceptive within the meaning of this act. The scope of such trade conference shall be limited to the phase of the insurance business directly represented by those persons or insurers notified by the commissioner or attending such conference upon notice from the commissioner.

(3) The commissioner shall give due consideration to the recommendations, or conclusions of any such trade practice conference which has acted under the authority of this section; and if he shall find that the same is in the public interest and does not, in his opinion, sanction, aid or abet a practice contrary to law, he may accept such recommendations, or conclusions and promulgate them in the form of a rule, regulation or standard, enforceable under the provisions of this act, applicable thereto, until modified or rescinded as herein provided. Before any such rule, regulation or standard shall be promulgated, the commissioner shall advise all persons or insurers who would be directly affected thereby and shall give 30 days' notice in writing to such persons or insurers to file their objections, if any. Any rule, regulation or standard so arrived at shall be filed and shall become effective in accordance with the statutes of Michigan governing rules of administrative agencies.

(4) Trade practice rules, regulations or standards promulgated under this section may be amended or rescinded by the commissioner upon his own motion, or upon motion of any directly affected person or insurer, after the commissioner shall have given reasonable notice to the persons or insurers directly affected thereby, and after there has been a hearing, if requested by such affected persons or insurers, concerning such amendment or rescission: Provided, That such request is made in writing within 30 days after notice is given.

(5) This section shall not be construed as limiting any other provision of the insurance code.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

Administrative rules: R 500.402 et seq. of the Michigan Administrative Code.

500.2049 Unfair methods of competition or deception; liability under other state laws.

Sec. 2049. No order of the commissioner under this uniform trade practices act or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2050 Construction of chapter.

Sec. 2050. The enumeration in this uniform trade practices act of powers vested in the commissioner or of specific unfair methods of competition and unfair or deceptive acts and practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the commissioner or any court of review but the provisions of such act are in all respects cumulative of and supplemental to the insurance code and all other applicable Michigan statutes or common law.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2055 Misrepresentation of insurer's financial condition as misdemeanor; penalty; civil liability of officers and agents; forfeiture of chartered privileges; publication of true statement; other violations as misdemeanor; penalty.

Sec. 2055. (1) If any insurance corporation organized or operating within this state shall, by means of any

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advertisement, circular, notice or statement, printed or written, published, posted or circulated through and by the agency of any officer, agent or other person, or by any other means, falsely represent or hold out to the public that the capital stock of such company is greater than its actual amount, or that the accumulation of such insurer is greater than its actual cash or market value, or shall represent the financial condition to be other than it actually is or was at the time of making such statement, every director or officer of such insurer guilty of any participation therein shall be deemed guilty of a misdemeanor and on conviction thereof shall be punished by a fine not exceeding $100.00, or by imprisonment in the county jail not exceeding 3 months, or by both such fine and imprisonment, in the discretion of the court.

(2) If any such insurer, after such false advertisement, circular, notice or statement shall have been published, posted or circulated, shall receive any money, note or obligation for the payment of money, from any person, as a consideration for any insurance made or policy issued or to be issued by such insurer, such money, note or obligation shall be deemed and taken to have been received without consideration; and the directors of such insurer, and any officer or agent receiving the same, shall be jointly and severally liable in an action of assumpsit for the repayment thereof, and shall also, in like manner, be liable to the person insured for the amount of the insurance.

(3) Any such false advertisement, circular, notice or statement shall be sufficient ground for proceedings in any court of competent jurisdiction to forfeit the chartered privileges of such insurer, or for an order prohibiting the further transaction of business by it within this state: Provided, That no such forfeiture shall be declared on that ground solely, if it shall appear either that the publication was by mistake, or that the directors, officers or agents making the same have been dismissed from the service of such insurer, and that the insurer has published such true statement of its affairs as may have been directed by the commissioner, or such court.

(4) Any officer or agent guilty of any intentional violation of this section, or who aids or abets others in any such violation, shall be deemed guilty of a misdemeanor and upon conviction thereof shall be punished by a fine not exceeding $1,000.00, or by imprisonment not exceeding 6 months, or by both such fine and imprisonment, in the discretion of the court.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2057 Misrepresentation of insurer's identity prohibited; advertising by fire insurer not limited; violation as misdemeanor; penalty.

Sec. 2057. (1) No insurer or department or general agency of an insurer, doing business in this state, or its officers or agents, shall issue any false or misleading advertisement through newspapers or other periodicals, or any false or misleading representations by signs, cards, letterheads, or other stationery, tending to conceal or misrepresent the true identity of the issuer or insurer which is carrying the liability under any policy issued in this state. Nor shall any insurer or department or general agency of an insurer, doing business in this state, issue any advertisement or representation of any character, giving the appearance of a separate or independent insuring organization on the part of any department or general agency, and the type or lettering used in any advertisement or representation shall set forth the name of the company or organization assuming the risk more conspicuously than that of any department or general agency.

(2) Nothing herein contained shall be construed as limiting the right of any representative of a fire insurance company to advertise his own individual business.

(3) Any violation of this section shall be punished by a fine not exceeding $500.00, as a misdemeanor.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2059 Maintaining or operating office for transaction of insurance business; using name of insurer in conducting or advertising business not related to business of insurance.

Sec. 2059. (1) Except as otherwise provided in this act, a person shall not maintain or operate an office in this state for the transaction of the business of insurance or use the name of an insurer, fictitious or otherwise, in conducting or advertising a business that is not related or connected with the business of insurance as regulated in this act.

(2) Subsection (1) does not prohibit an insurance producer from marketing or transacting any of the following:

(a) Subject to the health benefit agent act, 1986 PA 252, MCL 550.1001 to 550.1020, health care coverage provided by a health maintenance organization.

(b) Subject to the health benefit agent act, 1986 PA 252, MCL 550.1001 to 550.1020, dental care coverage provided by a dental care corporation regulated under 1963 PA 125, MCL 550.351 to 550.373.

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(c) Administrative services of a third party administrator regulated under the third party administrator act, 1984 PA 218, MCL 550.901 to 550.960.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1986, Act 253, Eff. Mar. 31, 1987;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.2060 Repealed. 1986, Act 253, Eff. Dec. 31, 1987.

Compiler's note: The repealed section pertained to marketing or transacting health care coverage.

Popular name: Act 218

500.2062 False reports; forfeiture of franchise or right to do business; violation by officers or agents as misdemeanor; penalty.

Sec. 2062. (1) It shall be unlawful for any person in any report required by law to be made by any insurance corporation, organized or authorized to do business in this state, to make any such statement or report as to fraudulently conceal the real facts, and if intentionally so made shall, if the insurer is organized under the laws of this state, be cause of forfeiture of the corporate franchise, and if the insurer is organized under the laws of any other state or government, be cause for revocation of such insurer's authority to do business in this state by the commissioner, after hearing granted.

(2) Any officer or agent guilty of any such fraudulent statement or of any intentional violation of this section, or who aids or abets others in any such violation, shall be deemed guilty of a misdemeanor and upon conviction thereof shall be punished by a fine not exceeding $1,000.00, or by imprisonment not exceeding 6 months, or by both such fine and imprisonment, in the discretion of the court.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2064 Misrepresentation of terms of policy; future benefits or dividends prohibited; illegal inducements; violation; revocation of certificate or license; penalties.

Sec. 2064. (1) No insurer, or any officer, director, agent or solicitor thereof shall issue, circulate or use or cause or permit to be issued, circulated or used, any written or oral statement or circular misrepresenting the terms of any policy issued or to be issued by such insurer, or misrepresenting the benefits or privileges promised under any such policy, or estimating the future dividends payable under any such policy.

(2) No insurer, officer, director, agent or solicitor, or any person, firm, association or corporation, shall make any misrepresentation or incomplete comparison of policies, oral, written or otherwise, to any person insured in any insurer for the purpose of inducing or tending to induce such person to take out a policy of insurance or for the purpose of inducing or tending to induce a policyholder in any insurer to lapse, forfeit or surrender his insurance therein, and to take out a policy of insurance in another like insurer.

(3) Upon satisfactory evidence of any violation of the provisions of this section by any insurer, its officers, solicitors or agents, or any insurance broker, the commissioner shall forthwith revoke the certificate of authority or license of such insurer, its officers, solicitors or agents, after following the procedures provided for in section 2068, and no certificate of authority or license shall be issued to such insurer, officers, agents or solicitors, within 1 year from the date of such revocation.

(4) Violations of this section shall also be subject to the penalties provided for in section 2069.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2066 Rebates and illegal inducements prohibited; violation; revocation of license or certificate; penalties.

Sec. 2066. (1) No insurer, by itself or any other party, and no insurance agent or solicitor, personally or by any other party, transacting any kind of insurance business shall offer, promise, allow, give, set off or pay, directly or indirectly, any rebate of, or part of, the premium payable on the policy or on any policy, or agent's commission thereon, or earnings, profit, dividends or other benefit founded, arising, accruing or to accrue thereon, or therefrom, or any other valuable consideration or inducement to or for insurance, on any risk in this state now or hereafter to be written, which is not specified in the contract of insurance; nor shall any such insurer, agent or solicitor, personally or otherwise, offer, promise, give, sell, or purchase any stocks, bonds, securities or any dividend or profits accruing or to accrue thereon, or other thing of value whatsoever as inducement to insurance or in connection therewith which is not specified in the policy contract.

(2) Upon satisfactory evidence of the violation of this section by any insurer, its officers, solicitors or agents, or any insurance broker, the commissioner shall revoke the license or certificate of authority of such offending insurer, its officers, solicitors or agents, after following the procedures provided for in section 2068;

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and no license or certificate of authority shall be issued to such insurer, officers, agents, solicitors or brokers, within 1 year from the date of such revocation.

(3) Violations of this section shall also be subject to the penalties provided for in section 2069.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2068 Revocation of license or certificate; notice; hearing; order; review by supreme court.

Sec. 2068. (1) Before any such license or certificate is revoked, as provided in sections 2064 and 2066 hereof, the commissioner shall notify the holder thereof in writing of the complaint against him, and require such person on a date named, not less than 15 days after service of said notice, to appear for a hearing before him at the insurance department, and such certificate shall not be revoked until after a full hearing or an opportunity therefor has been granted as herein provided; and no such revocation shall take effect until 10 days after such order has been made by the commissioner and the holder thereof notified in writing of such action.

(2) Any such order may be reviewed by the supreme court if the appeal for such review is taken within the 10 days immediately following the giving of the notice of the making of said order, and pending such appeal for review, such license or certificate of authority shall be deemed to be in full force and effect and until the final determination of such appeal, but in case the order of revocation by the commissioner is sustained the period of such revocation shall date from the time such appeal is determined.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2069 Violation of MCL 500.2064 or 500.2066 as misdemeanor; penalty.

Sec. 2069. An insurer, agent, solicitor, or other person that violates section 2064 or 2066 is guilty of a misdemeanor. On conviction of violating section 2066, the offender must be sentenced to pay a fine of not more than $100.00 for each violation, or in the discretion of the court, to imprisonment in the county jail of the county in which the offense is committed. On conviction of violating section 2064, the offender must be sentenced to pay a fine of not more than $2,000.00 for each violation, or in the discretion of the court, to imprisonment in the county jail of the county in which the offense is committed.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1989, Act 306, Imd. Eff. Jan. 3, 1990;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.2070 Acceptance of rebate or illegal inducement prohibited; reduction of insurance; penalty.

Sec. 2070. (1) No insured person or party shall receive or accept, directly or indirectly, any rebate of premium or part thereof, or agent's, solicitor's or broker's commission thereon, payable on the policy, or on any policy of insurance, or any favor or advantage or share in the dividend or other benefit to accrue thereon, or any valuable consideration or inducement, not specified in the policy contract of insurance.

(2) The amount of the insurance whereon the insured has knowingly received or accepted, either directly or indirectly any rebate of the premium or agent's, solicitor's or broker's commission thereon, shall be reduced in such proportion as the amount or value of such rebate, commission, dividend, or other consideration so received by the insured bears to the total premium on such policy, and any person insured, in addition to having the insurance reduced, shall be guilty of a misdemeanor, and upon conviction thereof shall be sentenced to pay a fine of not more than $100.00.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2074 Repealed. 2000, Act 486, Imd. Eff. Jan. 11, 2001.

Compiler's note: The repealed section pertained to political contributions by insurers.

Popular name: Act 218

500.2075 Fire, marine or inland insurer's contract in restraint of competition prohibited; acts by agent prohibited; other prohibitions.

Sec. 2075. (1) No fire, fire and marine, or marine and inland insurance insurer not organized under the laws of this state, but doing business therein, shall either directly or indirectly enter into any contract, agreement, arrangement, or undertaking of any nature or kind whatever with any other insurer, the object or effect of which is to prevent open and free competition between it and said insurer, or between the agents of

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their respective insurers in the business transacted in this state, or in any part thereof.

(2) It shall not be lawful for the agent of any fire, fire and marine, or marine and inland insurance insurer not organized under the laws of this state, but doing business therein, to enter into any contract, agreement, arrangement, or undertaking of any nature or kind whatever with the agent of any other such insurer, the object or effect of which is to prevent free and open competition between the insurers represented by said agents in the business transacted in this state, or in any part thereof.

(3) No person or persons as agent, solicitor, broker, surveyor, or in any other capacity, shall transact or aid in any manner, directly or indirectly, in transacting or soliciting within this state, business for any fire, fire and marine or marine and inland insurance company or association not incorporated by the laws of this state, or in any other capacity to procure or assist to procure a fire or inland marine policy or policies of insurance in any company or association which is violating the provisions of this section, or whose agent or agents are violating the provisions of subsection (2) hereof.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2077 Creditors; favoritism of insurer prohibited; construction of section, violation, penalty.

Sec. 2077. (1) No person shall require, as a condition precedent to the lending of money or extension of credit, or any renewal thereof, that the person, to whom such money or credit is extended or whose obligation the creditor is to acquire or finance, negotiate any policy or contract of insurance through a particular insurance agent or with a particular insurer. No person engaged in the business of financing real or personal property other than motor vehicles or of lending money or extending credit, shall directly or indirectly require that the borrower pay a consideration of any kind to substitute the insurance policy of 1 insurer for that of another.

(2) If an instrument requires that a purchaser, mortgagor or borrower furnish insurance of any kind on real property being conveyed or which is collateral security to a loan, the vendor, mortgagee or lender shall refrain from using or disclosing any such information to his own advantage or to the detriment of the purchaser, mortgagor, borrower, insurance company or agency complying with such requirement.

(3) This section shall not be construed as forbidding the vendor or creditor from exercising a reasonable right to approve or disapprove the insurance selected by the debtor for protection of the property securing the credit or lien, but the vendor or creditor shall not disapprove a policy which contains coverages in excess of the basic coverage required by the vendor or creditor.

(4) Nothing in this section shall forbid any insurer from requiring as a condition precedent for the lending of its own funds that the debtor insure his own life for a reasonable amount with such insurer.

(5) Each violation of this section shall be a misdemeanor, punishable by a fine of not more than $100.00.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1961, Act 153, Eff. Sept. 8, 1961;—Am. 1962, Act 89, Eff. Mar. 28, 1963.

Popular name: Act 218

500.2078 Agreements as to placements of insurance; regulations.

Sec. 2078. Except as contained in the policy and the usual agreement for other insurance, no insurance company, insurer, corporation, partnership, or individual shall make any contract or agreement with any person insured or to be insured that the whole or any part of any insurance which is subject to the provisions of chapter 26 of this code (fire and inland marine rates), shall be placed by any particular corporation, partnership, or individual, or be written by any particular company, insurer, agent or any group of companies, insurers or agents. Any contracts made in contravention of this section, shall be null and void.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2080 Life insurance company, accident insurance company, sick or funeral benefit company; prohibited conduct with regard to funeral establishment, cemetery, or seller as limited life insurance producer; authorization to sell associated life insurance policies or annuity contracts; sale of cemetery goods or services or funeral goods or services; advising customers; application form; list; statement; sufficiency of death benefit; designation of certain beneficiaries prohibited; money payments required; medical, surgical, or hospital service; conditions and criteria regarding predeath assignment of proceeds of life insurance policy or annuity contract; false or misleading statements; false, misleading, deceptive, or unfair advertising; rules; protection against certain

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solicitations; signed statement authorizing release of assignment proceeds; failure to sign authorization statement; conditions to sale or solicitation of sale of life insurance policy or annuity contract with intention of having purchaser assign proceeds; action to enforce compliance; damages; violation as misdemeanor; separate offenses; penalties; creation, administration, and use of funeral consumers education and advocacy fund; definitions.

Sec. 2080. (1) A life or accident insurer authorized to do business in this state shall not own, manage, supervise, operate, or maintain a funeral establishment or permit its officers, agents, or employees to own or maintain a funeral establishment.

(2) Except as otherwise provided in subsection (6), a life insurance company, a sick or funeral benefit company, or a company, corporation, or association engaged in a similar business shall not contract or agree with a funeral director, undertaker, or mortuary to the effect that the funeral director, undertaker, or mortuary conducts the funeral of a person insured by the company, corporation, or association.

(3) A funeral establishment, cemetery, or seller must not be licensed as an insurance producer under chapter 12 other than as a limited licensee under this subsection and chapter 12. A funeral establishment, cemetery, or seller must not be a limited life insurance producer unless the funeral establishment, cemetery, or seller provides a written assurance to the director at the time of application for the limited licensure and with each license renewal that he or she has read and understands the conditions contained in subsection (9) and agrees to comply with those conditions. A person licensed as a limited life insurance producer under this subsection and chapter 12 is authorized and licensed to sell only an associated life insurance policy or annuity contract and is not authorized or licensed to sell any other type of insurance policy or annuity contract. A person licensed as a limited life insurance producer under this subsection and chapter 12 to sell associated life insurance policies or annuity contracts shall not sell cemetery goods or services or funeral goods or services unless all of the conditions provided in subsection (9) are met. A person licensed as a life insurance producer, other than a limited life insurance producer, shall not sell cemetery goods or services or funeral goods or services or be associated with a funeral establishment, cemetery, or seller. Notwithstanding any other provision in this act, a funeral establishment, cemetery, or seller may advise customers or potential customers of the availability of life insurance, the proceeds of which may be assigned under subsection (6), and may provide application forms and other information regarding that life insurance. If an application form is provided, the funeral establishment, cemetery, or seller shall also provide to the person a list annually prepared by the director that lists the life insurance companies that offer Michigan associated life insurance policies or annuity contracts. The list must include the name, address, and telephone number of a producer for each of the life insurance companies listed. The list also must include a statement that a person who is insured under any life insurance policy or annuity contract may assign all or a portion of the proceeds, not to exceed the amount provided in subsection (6)(g), of the existing life insurance policy or annuity contract for the payment of funeral services or goods or cemetery services or goods to any funeral establishment, cemetery, or seller that has accepted any other assignment of an associated life insurance policy or annuity contract during that calendar year. The funeral establishment, cemetery, or seller shall accept an assignment of the proceeds from any associated or nonassociated life insurance policy or annuity contract under subsection (6), and this requirement on the funeral establishment, cemetery, or seller must be set forth in the statement prepared by the director. The assignor or the person or persons legally entitled to make funeral arrangements for the person whose life was insured may contract with the funeral establishment, cemetery, or seller of his or her choice for the rendering of the funeral goods or services or cemetery goods or services. Except as otherwise provided in this subsection, each associated life insurance policy or annuity contract delivered or issued for delivery in this state must have a death benefit that is sufficient to cover the initial contract price of the cemetery goods or services or funeral goods or services. However, a life insurer may provide an associated life insurance policy or annuity contract with a limited death benefit to an insured who does not meet insurance requirements for a policy that provides immediate full coverage or who chooses not to answer medical questions required for a policy that provides immediate full coverage. An associated life insurance policy or annuity contract with a limited death benefit must disclose in boldfaced type that the death benefit will not be sufficient to cover the initial contract price for the cemetery goods and services or funeral goods and services for a period of up to 2 years if the premium is not paid in full and that during this period the price for those goods and services may increase at a rate higher than the increase in the Consumer Price Index for this period.

(4) A person must not be designated as the beneficiary in any policy of life or accident insurance under which the beneficiary, directly or indirectly, must, in return for all or a part of the proceeds of the policy of insurance, furnish cemetery services or goods or funeral services or goods in connection with the policy.

(5) Except as otherwise provided in subsection (6), a life or accident or sick or funeral benefit company, or

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any other person, shall not offer or furnish goods or services or anything but money to its insureds or the insured's heirs, representatives, attorneys, relatives, associates, or assigns in connection with, or by way of encumbrance, assignment, payment, settlement, satisfaction, discharge, or release of, an insurance policy. However, this subsection does not prohibit a company, corporation, or association from furnishing medical, surgical, or hospital service.

(6) Notwithstanding any other provision in this act, a life insurer may write a life insurance policy or annuity contract that is subject to an assignment of the proceeds of the insurance policy or annuity contract as payment for cemetery services or goods or funeral services or goods as provided in this subsection regardless of the relationship between the life insurer and the assignee. An assignment of the proceeds of the insurance policy or annuity contract under this subsection must be in writing on a form approved by the director. A predeath assignment of the proceeds of a life insurance policy or annuity contract as payment for cemetery services or goods or funeral services or goods is void unless all of the following conditions and criteria are met:

(a) The assignment is an inseparable part of the contract for the cemetery services or goods or funeral services or goods for which the assigned proceeds serve as payment.

(b) The assignment is revocable by the assignor, the assignor's successor, or if the assignor is the insured, the representative of the insured's estate before the cemetery services or goods or funeral services or goods are provided.

(c) The contract for funeral services or goods or cemetery services or goods and the assignment provide that on revocation of the assignment, the contract for the cemetery services or goods or funeral services or goods is revoked and cemetery services or goods or funeral services or goods may be obtained from any cemetery, funeral establishment, or seller.

(d) The assignment contains the following disclosure in boldfaced type:

"This assignment may be revoked by the assignor or assignor's successor or, if the assignor is also the insured and deceased, by the representative of the insured's estate before the cemetery services or goods or funeral services or goods are provided. If the assignment is revoked, the death benefit under the life insurance policy or annuity contract will be paid in accordance with the beneficiary designation under the insurance policy or annuity contract."

(e) The assignment provides for all of the following:

(*i*) That the actual price of the cemetery services or goods or funeral services or goods delivered at the time of death may be more than or less than the price set forth in the assignment.

(*ii*) For the assignment of an associated life insurance policy or annuity contract, that any increase in the price of the cemetery services or goods or funeral services or goods will not exceed the ultimate death benefit under the life insurance policy or annuity contract. This requirement does not apply to an insurance policy or annuity contract with a limited death benefit during the period that the limited death benefit is in effect. During this period, the beneficiary and the seller are not obligated to fulfill the terms of the contract for the cemetery services or goods or funeral services or goods for which the assigned proceeds serve as payment and the assignment of the associated life insurance policy or annuity contract may be revoked.

(*iii*) For the assignment of a nonassociated life insurance policy or annuity contract, that any increase in the price of the cemetery services or goods or the funeral services or goods must not exceed the Consumer Price Index or the retail price list in effect when the death occurs, whichever is less.

(*iv*) That if the ultimate death benefit under the life insurance policy or annuity contract exceeds the price of the cemetery services or goods or funeral services or goods at the time of performance, the excess amount must be distributed to the beneficiary designated under the life insurance policy or annuity contract or the insured's estate.

(*v*) That any addition to or modification of the contract for cemetery services or goods or funeral services or goods does not revoke the assignment or the contract for the cemetery services or goods or funeral services or goods that are not affected by the addition or modification for which the assigned proceeds are payment unless the assignment is revoked.

(f) The assignment is limited to that portion of the proceeds of the life insurance policy or annuity contract that is needed to pay for the cemetery services or goods or funeral services or goods for which the assignor has contracted.

(g) For an associated life insurance policy or annuity contract, the death benefit of the life insurance policy or annuity contract subject to the assignment does not exceed $12,720.00 when the first premium payment is made on the life insurance policy or annuity contract. For a nonassociated life insurance policy or annuity contract, the initial amount of proceeds assigned does not exceed $12,720.00. The maximum amounts in this subdivision must be adjusted annually in accordance with the Consumer Price Index.

(h) The assignment must contain the dispute resolution rights in subsection (8). After the death of the

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insured but before the cemetery services or goods or funeral services or goods are provided, the funeral establishment, cemetery, or seller shall provide to a representative of the insured's estate a separate document entitled, "dispute resolution disclosure statement," that must clearly set forth the dispute resolution rights in subsection (8). The dispute resolution disclosure statement must be filed with the director and is considered approved unless disapproved within 30 days after the submission. The language used to set forth the dispute resolution rights in subsection (8) must be written in a manner that is understood by a person of ordinary intelligence.

(i) The assignor and not the assignee is responsible for making the premium payments due on the life insurance policy or annuity contract. This subdivision does not apply to an insurance producer when acting as a fiduciary under section 1207.

(j) After the death of the insured but before the cemetery services or goods or funeral services or goods are provided, the representative of the insured's estate is provided with a current price list for the cemetery services or goods or funeral services or goods provided under the assignment.

(k) At the time the assignment is made, the assignee complies with the price disclosure rules of the Federal Trade Commission prescribed in 16 CFR part 453 whether or not the rules by their own terms apply to the offering.

(*l*) At the time the assignment is made, the assignor certifies that the insured does not have in effect other life insurance policies or annuity contracts that have been assigned as payment for cemetery goods or services or funeral goods or services that together with the additional assignment would have an aggregate face value in excess of the limitation provided in subdivision (g).

(m) For the assignment of a nonassociated life insurance policy or annuity contract, the assignment complies with both of the following:

(*i*) The assignment is sufficient to cover the initial contract price of the cemetery goods or services or funeral goods or services.

(*ii*) The assignment provides that any increase in the price of the cemetery services or goods or the funeral services or goods must not exceed the Consumer Price Index or the retail price list in effect when the death occurs, whichever is less.

(7) An insurer or an insurance producer shall not make a false or misleading statement, oral or written, regarding an assignment subject to subsection (6) or regarding the rights or obligations of any party or prospective party to the assignment. An insurer or an insurance producer shall not advertise or promote an assignment subject to subsection (6) in a manner that is false, misleading, deceptive, or unfair. The director shall promulgate rules regulating the solicitation of plans promoting assignments subject to subsection (6) to protect against solicitations that are intimidating, vexatious, fraudulent, or misleading, or which take unfair advantage of a person's ignorance or emotional vulnerability.

(8) After cemetery services or goods or funeral services or goods that are subject to an assignment under this section are provided, the funeral establishment, cemetery, or seller shall provide to a representative of the insured's estate a statement to be signed by the representative of the insured's estate authorizing the release of the assignment proceeds for the payment of the cemetery services or goods or funeral services or goods. The insurer shall release to the funeral establishment, cemetery, or seller the assignment proceeds on receipt of the authorization statement signed by a representative of the insured's estate. If a representative of the insured's estate fails to sign the authorization statement, all of the following apply:

(a) The funeral establishment, cemetery, or seller shall provide the representative of the insured's estate with a dispute resolution notice, a copy of which is to be sent to the insurer and the director that states all of the following:

(*i*) That the funeral establishment, cemetery, or seller has provided the cemetery services or goods or funeral services or goods.

(*ii*) That a representative of the insured's estate has refused to authorize the insurer to release the assignment proceeds for the payment of the cemetery services or goods or funeral services or goods.

(*iii*) That a representative of the insured's estate may seek arbitration to resolve the payment dispute.

(b) On the receipt of the dispute resolution notice described in subdivision (a), the insurer shall retain the assignment proceeds for 30 days. The insurer shall release the assignment proceeds to the funeral establishment, cemetery, or seller if after the expiration of the 30 days the insurer is not informed that arbitration proceedings have been commenced, or pursuant to the award of the arbitrator.

(c) The funeral establishment, cemetery, seller, or a representative of the insured's estate may commence arbitration proceedings to determine the disposition of the assignment proceeds. Arbitration must be conducted under the rules and procedures of the American Arbitration Association. Expenses of the arbitration must be shared equally by the insured's estate and the assignee unless otherwise ordered by the arbitrator.

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(d) This subsection does not limit the right of any party involved in the payment dispute to seek other recourse permitted by law.

(9) A life insurance producer shall not sell or solicit the sale of a life insurance policy or annuity contract with the intention of having the purchaser assign the proceeds of the policy or contract to a funeral establishment, cemetery, or seller with which the producer is associated unless all of the following conditions are met:

(a) The producer discloses in writing to the purchaser the nature of his or her association with the funeral establishment, cemetery, or seller and that both the funeral establishment, cemetery, or seller and the producer will or may profit from the transaction, if that is the case.

(b) A funeral establishment, cemetery, or seller that accepts assignments under subsection (6) also offers to sell or provide cemetery goods or services or funeral goods or funeral services under prepaid funeral contracts as provided in the prepaid funeral and cemetery sales act, 1986 PA 255, MCL 328.211 to 328.235, or under the trust provisions of the cemetery regulation act, 1968 PA 251, MCL 456.521 to 456.543.

(c) If the contemplated assignment is to be made to pay the cost of cemetery goods or services or funeral goods or funeral services, the producer discloses in writing to the purchaser that the cemetery goods or services or funeral goods or services may also be purchased before death by making payment directly to a funeral establishment, cemetery, or seller who will hold funds in escrow for the benefit of the purchaser under the prepaid funeral and cemetery sales act, 1986 PA 255, MCL 328.211 to 328.235, or in trust under the cemetery regulation act, 1968 PA 251, MCL 456.521 to 456.543. The written disclosure must also state that on cancellation of the prepaid funeral contract, the purchaser is entitled to a refund of at least 90% of the principal and income earned.

(d) The sale of cemetery goods or services or funeral goods or services is not conditioned on the purchaser buying or agreeing to buy a life insurance policy or annuity contract or on the assignment of the proceeds of the policy or contract to the funeral establishment, cemetery, or seller.

(e) The sale of a life insurance policy or annuity contract is not conditioned on the purchaser buying or agreeing to buy cemetery goods or services or funeral goods or services from the funeral establishment, cemetery, or seller with which the producer is associated or on the assignment of the proceeds of the policy or contract to the funeral establishment, cemetery, or seller.

(f) A discount from the current price of cemetery goods or services or funeral goods or services is not offered as an inducement to purchase or assign a life insurance policy or annuity contract.

(g) If the life insurance policy or annuity contract sold by the producer is canceled by the purchaser within 10 days after the receipt of the policy or annuity contract, a full refund of all premiums is paid to the purchaser.

(h) The producer discloses in writing to the purchaser that the funeral establishment, cemetery, or seller with which the producer is associated will accept assignments of life insurance policies or annuity contracts sold by any other licensed producer.

(10) The director or any other person, in order to force compliance with subsection (6) or (7), may bring an action in a circuit court in any county in which the assignee or insurance producer or any other person has solicited or sold a life insurance policy or annuity contract that is assigned under subsection (6), whether or not that person has purchased the life insurance policy or annuity contract or is personally aggrieved by a violation of this section. The court may award damages and issue equitable orders in accordance with the Michigan court rules to restrain conduct in violation of this section.

(11) A person that violates this section is guilty of a misdemeanor, punishable on conviction by a fine of not more than $1,000.00 or by imprisonment for not more than 6 months, or both, within the discretion of the courts. Each violation is a separate offense.

(12) In addition to the penalty provided in subsection (11), if, after a hearing conducted under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director determines a person has violated this section, the director may order the person to pay a civil fine of not more than $10,000.00 for each violation and may also impose other sanctions provided under chapter 12. The money collected under this subsection must be deposited in the funeral consumers education and advocacy fund. The funeral consumers education and advocacy fund is created within the department. The director shall administer the fund. The money in the fund must be used to do both of the following:

(a) To promote the education of consumers concerning the prearrangement and purchase of cemetery or funeral services or goods through the purchase and assignment of life insurance or annuity contracts.

(b) To provide legal assistance to persons who were injured as a result of a violation of this section.

(13) For purposes of this section, a life insurance producer is associated with a funeral establishment, cemetery, or seller if any of the following apply:

(a) The producer is a funeral establishment, cemetery, or seller.

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(b) The producer owns an interest, directly or indirectly, in a corporation or other entity that holds an interest in a funeral establishment, cemetery, or seller.

(c) The producer is an officer, employee, or agent of a funeral establishment, cemetery, or seller.

(d) The producer is an officer, employee, or agent of a corporation or other entity that holds an interest, either directly or indirectly, in a funeral establishment, cemetery, or seller, or in a corporation or other entity that holds an interest, directly or indirectly, in a corporation or other entity that holds an interest in a funeral establishment, cemetery, or seller.

(14) As used in this section:

(a) "Associated life insurance policy or annuity contract" means a life insurance policy or annuity contract that is marketed, designed, and intended to be assigned as payment for cemetery goods or services or funeral goods or services.

(b) "Casket" means any box or container consisting of 1 or more parts in which a dead human body is placed before interment, entombment, or cremation that may or may not be permanently interred, entombed, or cremated with the dead human body. Casket includes a permanent interment or entombment receptacle designed or intended for use without a cemetery burial vault or other outside container.

(c) "Catafalque" means an ornamental or decorative object or structure placed beneath, over, or around a casket, vault, or a dead human body before final disposition of the dead human body.

(d) "Cemetery" means that term as defined in section 2 of the cemetery regulation act, 1968 PA 251, MCL 456.522, regardless of whether the cemetery is regulated under the cemetery regulation act, 1968 PA 251, MCL 456.521 to 456.543, or an officer, agent, or employee of a cemetery.

(e) "Cemetery burial vault or other outside container" means a box or container used solely at the place of interment to permanently surround or enclose a casket and to support the earth above the casket after burial.

(f) "Cemetery goods" means land or interests in land, crypts, lawn crypts, mausoleum crypts, or niches that are sold by a cemetery. Cemetery goods also include cemetery burial vaults or other outside containers, markers, monuments, urns, and merchandise items used for the purpose of memorializing a decedent and placed on or in proximity to a place of interment or entombment of a casket, catafalque, or vault or to a place of inurnment that are sold by a cemetery.

(g) "Cemetery services" means those services customarily performed by a cemetery.

(h) "Combination unit" means any product consisting of a unit or a series of units designed or intended to be used together as both a casket and as a permanent burial receptacle.

(i) "Consumer Price Index" means the annual average percentage increase in the Detroit Consumer Price Index for all items for the prior 12-month period as reported by the United States Department of Labor and as certified by the director.

(j) "Funeral establishment" means a funeral establishment or a person that is engaged in the practice of mortuary science as those terms are defined in section 1801 of the occupational code, 1980 PA 299, MCL 339.1801, or an officer, agent, or employee of the funeral establishment or person.

(k) "Funeral goods" means items of merchandise that will be used in connection with a funeral or an alternative to a funeral or final disposition of human remains including, but not limited to, caskets, other burial containers, combination units, and catafalques. Funeral goods does not include cemetery goods.

(*l*) "Funeral services" means services customarily performed by a person who is licensed under article 18 of the occupational code, 1980 PA 299, MCL 339.1801 to 339.1812. Funeral services includes, but is not limited to, care of human remains, embalming, preparation of human remains for final disposition, professional services relating to a funeral or an alternative to a funeral or final disposition of human remains, transportation of human remains, limousine services, use of facilities or equipment for viewing human remains, visitation, memorial services, or services used in connection with a funeral or alternative to a funeral, coordinating or conducting funeral rites or ceremonies, and other services provided in connection with a funeral, alternative to a funeral, or final disposition of human remains.

(m) "Limited death benefit" means the sum payable on the insured's death during not more than the first 2 years that an associated life insurance policy or annuity contract is in effect that is less than the amount necessary to cover the initial contract price of cemetery goods and services or funeral goods and services, but that provides for a minimum benefit as follows:

(*i*) During the first year of the contract, not less than 25% of the initial contract price of cemetery goods and services or funeral goods and services.

(*ii*) During the second year of the contract, not less than 50% of the initial contract price of cemetery goods and services or funeral goods and services.

(n) "Nonassociated life insurance policy or annuity contract" means a life insurance policy or annuity contract that is not marketed to be assigned, designed to be assigned, or intended to be assigned as payment for cemetery goods or services or funeral goods or services.

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(o) "Representative of the insured's estate" means the person or persons legally entitled to make the funeral arrangements for the person whose life was insured.

(p) "Seller" means a person that offers to sell cemetery goods or services or funeral goods or services or an agent, officer, or employee of the person.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1986, Act 318, Eff. June 1, 1987;—Am. 2008, Act 513, Imd. Eff. Jan. 13, 2009;—Am. 2023, Act 167, Imd. Eff. Oct. 19, 2023.

Popular name: Act 218

500.2082 Racial discrimination by life insurers prohibited; violation; penalty.

Sec. 2082. (1) No life insurer doing business in this state shall make any distinction or discrimination between white persons and colored persons, wholly or partially of African descent, as to the premiums or rates charged for policies upon the lives of such persons, or in any other manner whatever; nor shall any such insurer demand or require a greater premium from such colored persons than is at that time required by such insurer from white persons of the same age, sex, general condition of health and prospect of longevity; nor make or require any rebate, diminution or discount upon the amount to be paid on such policy in case of death of such colored person insured; nor insert in the policy any condition, nor make any stipulation whereby such person insured shall bind himself or his heirs, executors, administrators and assigns to accept any sum less than the full amount or value of such policy in case of a claim accruing thereon by reason of the death of such person insured, other than such as are imposed on white persons in similar cases; and any such stipulations or conditions so made or inserted shall be void.

(2) Any insurer which violates any of the provisions of this section shall forfeit to the state the sum of $500.00 for each violation, to be recovered by the attorney general by appropriate action in any court of competent jurisdiction, and any judgment therefor may be collected in the same manner as is herein provided for collecting judgments rendered in favor of policyholders. And any officer or agent who violates any of the provisions of this section shall be deemed guilty of a misdemeanor, and upon conviction thereof shall be punished by imprisonment in the county jail not exceeding 1 year, or by a fine of not less than $50.00, and not exceeding $500.00, or by both such fine and imprisonment, in the discretion of the court.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2086 False report by physician as to life or casualty insurance applicant; penalty, civil liability to insurer.

Sec. 2086. Any physician who, as medical examiner for any life or casualty insurer, or as the reference of, or medical examiner for any person seeking insurance therein, shall knowingly make any false statement or report to the insurer, or any officer thereof, concerning the bodily health or condition of any applicant for insurance, or concerning any other matter or thing which might affect the propriety or prudence of granting such insurance, shall be deemed guilty of a misdemeanor, and on conviction thereof, shall be liable to a fine not exceeding $1,000.00, or to imprisonment in the county jail not exceeding 3 months, in the discretion of the court. And such physician shall also be liable to the insurer in an action on the case for the full amount of any insurance obtained from such insurer by means or through the assistance of such false statement or report.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2088 False report by physician; claim for death, sickness or disability benefits, penalty.

Sec. 2088. Any agent, collector, physician, insured or other person who shall make, present or cause to be presented to any insurer any false, dishonest or fraudulent certificate or report of death, sickness or disability of any kind or nature, or any false, dishonest or fraudulent claim for any death, sickness or disability benefit, or claim for payment to or against any such insurer, shall be deemed guilty of a misdemeanor, and on conviction thereof, shall be liable to a fine not exceeding $1,000.00, or to imprisonment in the county jail not exceeding 3 months, in the discretion of the court.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2091 Unlawful advertising; notice to supervisory official.

Sec. 2091. No unauthorized foreign or alien insurer shall make, issue, circulate or cause to be made, issued or circulated to residents of this state any estimate, illustration, circular, pamphlet or letter, or cause to be made in any newspaper, magazine or other publication, or over any radio or television station, any announcement or statement to such residents misrepresenting its financial condition or the terms of any

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contracts issued or to be issued or the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon in violation of sections 2001 to 2050 of this act, and whenever the commissioner has reason to believe that any such insurer is engaging in unlawful advertising, he shall give notice of such fact by certified mail to the insurer and to the insurance supervisory official of the domiciliary state of the insurer. For the purpose of this section, the domiciliary state of an alien insurer is the state of entry or the state of the principal office in the United States.

History: Add. 1961, Act 20, Eff. Sept. 8, 1961.

Popular name: Act 218

500.2092 Unlawful advertising; failure to cease and desist, procedure.

Sec. 2092. If after 30 days following the giving of the notice mentioned in section 2091 the insurer has failed to cease making, issuing or circulating such false misrepresentations or causing the same to be made, issued or circulated in this state, and if the commissioner has reason to believe that a proceeding by him in respect to such matters would be to the interest of the public, and that the insurer is issuing or delivering contracts of insurance to residents of this state or collecting premiums on such contracts or doing any of the acts enumerated in section 2093, he shall take action against the insurer under the provisions of sections 2001 to 2050 of this act.

History: Add. 1961, Act 20, Eff. Sept. 8, 1961.

Popular name: Act 218

500.2093 Enforcement of act against foreign or alien insurer; procedure.

Sec. 2093. (a) Any of the following acts in this state, effected by mail or otherwise, by any unauthorized foreign or alien insurer: (1) the issuance or delivery of contracts or insurance to residents of this state, (2) the solicitation of applications for such contracts, (3) the collection of premiums, membership fees, assessments or other considerations for such contracts, or (4) any other transaction of insurance business, is equivalent to and shall constitute an appointment by the insurer of the commissioner to be its true and lawful attorney, upon whom may be served all statements of charges, notices and lawful process in any proceeding instituted in respect to the misrepresentations set forth in section 2091 under the provisions of sections 2001 to 2050, or in any action, suit or proceeding for the recovery of any penalty therein provided, and any such act shall be signification of its agreement that such service of statement of charges, notices or process is of the same legal force and validity as personal service of the statement of charges, notices or process in this state, upon the insurer.

(b) Service of a statement of charges and notices under sections 2001 to 2050 shall be made by any deputy or employee of the department delivering to and leaving with the commissioner, or some person in apparent charge of his office, 2 copies thereof. Service of process issued by any court in any action, suit or proceeding to collect any penalty provided under sections 2001 to 2050, shall be made by delivering and leaving with the commissioner, or some person in apparent charge of his office, 2 copies thereof. The commissioner shall forthwith cause to be mailed by certified mail 1 of the copies of the statement of charges, notices or process to the defendant at its last known principal place of business, and shall keep a record of all statement of charges, notices and process so served. The service of statement of charges, notices or process shall be sufficient if they have been so mailed and the defendant's receipt, or receipt issued by the post office with which the letter is certified, or showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the person mailing the letter showing a compliance herewith are filed with the commissioner in the case of any statement of charges or notices, or with the clerk of the court in which the action is pending in the case of any process, on or before the date the defendant is required to appear or within such further time as may be allowed.

(c) Service of statement of charges, notices and process in any such proceeding, action or suit shall in addition to the manner provided in subsection (b) of this section be valid if served upon any person within this state who on behalf of such insurer is:

(1) Soliciting insurance, or

(2) Making, issuing or delivering any contract of insurance, or

(3) Collecting or receiving in this state any premium for insurance; and a copy of such statement of charges, notices or process is sent within 10 days thereafter by certified mail by or on behalf of the commissioner to the defendant at the last known principal place of business of the defendant, and the defendant's receipt, or the receipt issued by the post office with which the letter is certified, showing the name of the sender of the letter, the name and address of the person to whom the letter is addressed, and the affidavit of the person mailing the same showing a compliance herewith, are filed with the commissioner in the case of any statement of charges or notices, or with the clerk of the court in which such action is pending

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in the case of any process, on or before the date the defendant is required to appear or within such further time as the court may allow.

(d) No cease or desist order or judgment by default or a judgment pro confesso under this section shall be entered until the expiration of 30 days from the date of the filing of the affidavit of compliance.

(e) Service of process and notice under the provisions of this act shall be in addition to all other methods of service provided by law, and nothing in this section shall limit or prohibit the right to serve any statement of charges, notices or process upon any insurer in any other manner now or hereafter permitted by law.

History: Add. 1961, Act 20, Eff. Sept. 8, 1961.

Popular name: Act 218

CHAPTER 21

500.2101 Meanings of words and phrases.

Sec. 2101. For purposes of this chapter, the words and phrases defined in sections 2102 to 2104 have the meanings ascribed to them in those sections.

History: Add. 1979, Act 145, Eff. Jan. 1, 1980.

Compiler's note: Act 145 of 1979 did not provide a subject-matter heading for Chapter 21.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2102 Definitions; A to D.

Sec. 2102. (1) "Affiliate of", or an insurer "affiliated with" an insurer, means an insurer that directly, or indirectly through 1 or more intermediaries, controls, or is controlled by, or is under common control with the insurer specified.

(2) "Automobile insurance" means insurance for private passenger nonfleet automobiles which provides any of the following:

(a) Security required pursuant to section 3101.

(b) Personal protection, property protection, and residual liability insurance for amounts in excess of the amounts required under chapter 31.

(c) Insurance coverages customarily known as comprehensive and collision.

(d) Other insurance coverages for a private passenger nonfleet automobile as prescribed by rule promulgated by the commissioner pursuant to Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.315 of the Michigan Compiled Laws. A rule proposed for promulgation by the commissioner pursuant to this section shall be transmitted in advance to each member of the standing committee in the house and in the senate which has jurisdiction over insurance.

(3) "Automobile insurance package policy" means a policy which includes more than 1 of the automobile insurance coverages described in section 2102(2)(a), (b), (c), or (d), in any combination.

(4) "Declination" means any of the following:

(a) Refusal by an agent to submit an application on behalf of an applicant to any of the insurers represented by the agent.

(b) Refusal by an insurer to issue insurance to a person upon receipt of an application for insurance.

(c) Offering insurance at higher rates with a different insurer than that requested by a person.

(d) Offering coverage with less favorable terms or conditions than those requested by a person.

History: Add. 1979, Act 145, Eff. Jan. 1, 1980.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2103 Definitions; E to I.

Sec. 2103. (1) "Eligible person", for automobile insurance, means a person who is an owner or registrant of an automobile registered or to be registered in this state or who holds a valid license to operate a motor vehicle issued by this state, but does not include any of the following:

(a) A person who is not required to maintain security under section 3101, unless the person intends to reside in this state for 30 days or more and makes a written statement of that intention on a form approved by the director.

(b) A person whose license to operate a vehicle is under suspension or revocation.

(c) A person who has been convicted within the immediately preceding 5-year period of fraud or intent to

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defraud involving an insurance claim or an application for insurance; or an individual who has been successfully denied, within the immediately preceding 5-year period, payment by an insurer of a claim in excess of $1,000.00 under an automobile insurance policy, if there is evidence of fraud or intent to defraud involving an insurance claim or application.

(d) A person who, during the immediately preceding 3-year period, has been convicted under, or who has been subject to an order of disposition of the family division of circuit court for a violation of, any of the following:

(*i*) Section 601d of the Michigan vehicle code, 1949 PA 300, MCL 257.601d, or any other law of this state the violation of which constitutes a felony resulting from the operation of a motor vehicle.

(*ii*) Section 625 of the Michigan vehicle code, 1949 PA 300, MCL 257.625.

(*iii*) Section 617, 617a, 618, or 619 of the Michigan vehicle code, 1949 PA 300, MCL 257.617, 257.617a, 257.618, and 257.619.

(*iv*) Section 626 of the Michigan vehicle code, 1949 PA 300, MCL 257.626; or a similar violation under the laws of any other state or a municipality in or outside of this state.

(e) A person whose vehicle insured or to be insured under the policy fails to meet the motor vehicle safety requirements of sections 683 to 711 of the Michigan vehicle code, 1949 PA 300, MCL 257.683 to 257.711.

(f) A person whose policy of automobile insurance has been canceled because of nonpayment of premium or financed premium within the immediately preceding 2-year period, unless the premium due on a policy for which application has been made is paid in full before issuance or renewal of the policy.

(g) A person who fails to obtain or maintain membership in a club, group, or organization, if membership is a uniform requirement of the insurer as a condition of providing insurance, and if the dues, charges, or other conditions for membership are applied uniformly throughout this state, are not expressed as a percentage of premium, and do not vary with respect to the rating classification of the member except for the purpose of offering a membership fee to family units. Membership fees may vary in accordance with the amount or type of coverage if the purchase of additional coverage, either as to type or amount, is not a condition for reduction of dues or fees.

(h) A person whose driving record for the 3-year period immediately preceding application for or renewal of a policy, has, under section 2119a, an accumulation of more than 6 insurance eligibility points.

(2) "Eligible person", for home insurance, means a person who is the owner-occupant or tenant of a dwelling of any of the following types: a house, a condominium unit, a cooperative unit, a room, or an apartment; or a person who is the owner-occupant of a multiple unit dwelling of not more than 4 residential units. Eligible person does not include any of the following:

(a) A person who has been convicted, in the immediately preceding 5-year period, of 1 or more of the following:

(*i*) Arson, or conspiracy to commit arson.

(*ii*) A crime under sections 72 to 77, 112, 211a, 377a, 377b, or 380 of the Michigan penal code, 1931 PA 328, MCL 750.72 to 750.77, 750.112, 750.211a, 750.377a, 750.377b, and 750.380.

(*iii*) A crime under section 92, 151, 157b, or 218 of the Michigan penal code, 1931 PA 328, MCL 750.92, 750.151, 750.157b, and 750.218, based on a crime described in subparagraph (*ii*) committed by or on behalf of the person.

(b) A person who has been successfully denied, within the immediately preceding 5-year period, payment by an insurer of a claim under a home insurance policy based on evidence of arson, conspiracy to commit arson, fraud, or conspiracy to commit fraud, committed by or on behalf of the person.

(c) A person who insures or seeks to insure a dwelling that is being used for an illegal or demonstrably hazardous purpose.

(d) A person who refuses to purchase an amount of insurance equal to at least 80% of the replacement cost of the property insured or to be insured under a replacement cost policy.

(e) A person who refuses to purchase an amount of insurance equal to at least 100% of the market value of the property insured or to be insured under a repair cost policy.

(f) A person who refuses to purchase an amount of insurance equal to at least 100% of the actual cash value of the property insured or to be insured under a tenant or renter's home insurance policy.

(g) A person whose policy of home insurance has been canceled because of nonpayment of premium within the immediately preceding 2-year period, unless the premium due on the policy is paid in full before issuance or renewal of the policy.

(h) A person who insures or seeks to insure a dwelling, if the insured value is not any of the following:

(*i*) For a repair cost policy, at least $15,000.00.

(*ii*) For a replacement policy, at least $35,000.00 or another amount established by the director. The director may establish an amount under this subparagraph biennially by a rule promulgated under the

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administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, and based on changes in applicable construction cost indices.

(i) A person who insures or seeks to insure a dwelling that has physical conditions that clearly present an extreme likelihood of a significant loss under a home insurance policy.

(j) A person whose real property taxes with respect to the dwelling insured or to be insured have been and are delinquent for 2 or more years at the time of renewal of, or application for, home insurance.

(k) A person who has failed to procure or maintain membership in a club, group, or organization, if membership is a uniform requirement of the insurer, and if the dues, charges, or other conditions for membership are applied uniformly throughout this state, are not expressed as a percentage of premium, and do not vary with respect to the rating classification of the member except for the purpose of offering a membership fee to family units. Membership fees may vary in accordance with the amount or type of coverage if the purchase of additional coverage, either as to type or amount, is not a condition for reduction of dues or fees.

(3) "Home insurance" means any of the following, but does not include insurance intended to insure commercial, industrial, professional, or business property, obligations, or liabilities:

(a) Fire insurance for an insured's dwelling of a type described in subsection (2).

(b) If contained in or indorsed to a fire insurance policy providing insurance for the insured's residence, other insurance intended primarily to insure nonbusiness property, obligations, and liabilities.

(c) Other insurance coverages for an insured's residence as prescribed by rule promulgated by the director under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. The director shall transmit a rule proposed for promulgation under this section in advance to each member of the standing committees in the house of representatives and the senate that have jurisdiction over insurance.

(4) "Insurance eligibility points" means all of the following:

(a) Points calculated, according to the following schedule, for convictions, determinations of responsibility for civil infractions, or findings of responsibility in probate court:

(*i*) For a violation of any lawful speed limit by more than 15 miles per hour, or careless driving, 4 points.

(*ii*) For a violation of any lawful speed limit by more than 10 miles per hour but less than 16 miles per hour, 3 points.

(*iii*) For a violation of any lawful speed limit by more than 5 miles per hour but less than 11 miles per hour, 2 points.

(*iv*) For a violation of any speed limit by more than 5 miles per hour but less than 16 miles per hour on a roadway that had a lawfully posted maximum speed of 70 miles per hour or greater as of January 1, 1974, 2 points.

(*v*) For a violation of a speed limit by less than 6 miles per hour, 1 point.

(*vi*) For all other moving violations pertaining to the operation of motor vehicles, 2 points.

(b) Points calculated, according to the following schedule, for determinations that the person was substantially at-fault:

(*i*) For the first substantially at-fault accident, 3 points.

(*ii*) For the second and each subsequent substantially at-fault accident, 4 points.

(5) "Insurer" means an insurer authorized to transact in this state the kind or combination of kinds of insurance constituting automobile insurance or home insurance.

History: Add. 1979, Act 145, Eff. Jan. 1, 1980;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990;—Am. 2001, Act 147, Eff. Feb. 1, 2002;—Am. 2002, Act 492, Eff. Mar. 31, 2003;—Am. 2016, Act 449, Eff. Jan. 5, 2018.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2104 Definitions; P to U.

Sec. 2104. (1) "Private passenger nonfleet automobile" means a motorized land vehicle designed for transporting passengers or goods, subject to specific contemporary definitions for insurance purposes pursuant to section 3303.

(2) "Repair cost policy" means a home insurance policy for which the amount of coverage under the policy is based substantially on the market value of the property, and which provides for payment for repair, rebuilding, or replacement of losses or damages to real property with materials of like kind and quality, without depreciation, pursuant to section 2826, or with conventional materials and construction methods, pursuant to the standards of section 2827.

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(3) "Replacement cost policy" means a home insurance policy for which the amount of coverage under the policy is based substantially on the replacement cost of the property, which provides for settlement of losses to real property pursuant to the standards prescribed in section 2826.

(4) "Substantially at-fault" means a person's action or inaction was more than 50% of the cause of an accident.

(5) "Termination" means a refusal to continue to insure, for reasons other than nonpayment of premium, and includes both of the following:

(a) The transfer of coverage for an insured between affiliated insurers, when the transfer results in higher rates or less coverage, unless the transfer was requested by the insured.

(b) The offering of coverage with less favorable terms or conditions than those previously provided, unless so requested by the insured, or unless the terms or conditions of coverage previously provided are no longer available from the insurer anywhere in this state.

(6) "Underwriting rules" means the written statements, guidelines, or criteria of an insurer, phrased in terms understandable to a person of ordinary intelligence, which describe the standards under which the insurer issues, refuses to issue, renews, refuses to renew, or limits coverage for automobile insurance or home insurance to persons within this state.

History: Add. 1979, Act 145, Eff. Jan. 1, 1980;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2105 Automobile insurance or home insurance to conform with chapter; exceptions; group plan requirements; group discounts; applicability to certain insurers; effective date.

Sec. 2105. (1) A policy of automobile insurance or home insurance must not be offered, bound, made, issued, delivered or renewed in this state unless the policy conforms to this chapter.

(2) Except as otherwise expressly provided in subsection (4) and this chapter, this chapter does not apply to insurance written on a group, franchise, blanket policy, or similar basis that offers home insurance or automobile insurance to all members of the group, franchise plan, or blanket coverage who are eligible persons.

(3) For purposes of this section, a group plan includes a franchise plan, and, except as provided in subsection (4), is exempt from this chapter if the group meets all of the following criteria:

(a) Individuals in the group share a common enterprise or an economic or social affinity or relationship.

(b) The group was not created for the purposes of obtaining insurance.

(c) Membership in the group is not conditioned on the purchase of insurance.

(d) The individual members of the group can be specifically identified.

(e) Any other criteria as prescribed by a rule promulgated by the director under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(4) An insurer, including, but not limited to, an insurer that writes insurance as described in subsection (2), shall not establish or maintain rates or rating classifications for automobile insurance based on a factor that is not allowed, or that is prohibited, under section 2111. This subsection does not prohibit a group discount offered to a group based on the losses or expenses, or both, of the group but does prohibit group membership based on home ownership or postal zone.

(5) The amendments to this chapter made by the amendatory act that added this subsection apply to an insurer exempted from any of the requirements of this chapter under section 2129.

(6) The amendments to this chapter made by the amendatory act that added this subsection apply beginning July 1, 2020.

History: Add. 1979, Act 145, Eff. Jan. 1, 1980;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2106 Applicability of chapters 24 and 26; file, approval, and use of rates; inconsistent provisions.

Sec. 2106. (1) Except as specifically provided in this chapter, chapter 24 and chapter 26 do not apply to automobile insurance and home insurance.

(2) Subject to section 2108(6), an insurer shall file rates with the department for approval in compliance with this act.

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(3) An insurer may use rates for home insurance as soon as those rates are filed.

(4) To the extent that other provisions of this act are inconsistent with this chapter, this chapter governs with respect to automobile insurance and home insurance.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2107 Filings; review; disputes; approval; order of disapproval; revised filing.

Sec. 2107. (1) On or before September 1, 1980, each insurer subject to this chapter shall make filings in accordance with this chapter for automobile insurance, home insurance, or both, to be effective not later than January 1, 1981 nor earlier than November 1, 1980.

(2) With regard to a filing submitted under subsection (1), the commissioner shall conduct a review of the filing on an informal basis, and a dispute with regard to that filing shall not be considered a contested case under Act No. 306 of the Public Acts of 1969, as amended. A filing not disapproved within 60 days after its submission shall be considered approved.

(3) A filing approved or considered approved under subsection (2) shall be exempt from any further proceedings whatsoever under this chapter until July 1, 1981.

(4) If a filing is disapproved under subsection (2), the insurer, within 30 days of the order of disapproval, shall make a revised filing with the commissioner. The revised filing shall take effect on January 1, 1981 and shall be subject to review under this chapter on or after January 1, 1981 in the same manner as subsequent filings made under this chapter.

History: Add. 1979, Act 145, Eff. Jan. 1, 1980.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2108 Filing of manual or plan; statement of character and extent of coverage; maintaining rates in effect for eligible persons; insurer as member of or subscriber to rating organization; deviations; certification, contents, and public inspection of filing; trade secret; contract or policy to be in accordance with filings; automobile insurance compliance with chapter 24; redlining practices prohibited.

Sec. 2108. (1) On the effective date of a manual of classification, manual of rules and rates, rating plan, or modification of a manual of classification, manual of rules and rates, or rating plan that an insurer proposes to use for home insurance, the insurer shall file the manual or plan with the director. For automobile insurance, an insurer shall file a manual or plan described in this subsection in accordance with subsection (6). Each filing under this subsection must state the character and extent of the coverage contemplated. An insurer that is subject to this chapter and that maintains rates in any part of this state shall at all times maintain rates in effect for all eligible persons meeting the underwriting criteria of the insurer.

(2) An insurer may satisfy its obligation to make filings under subsection (1) by becoming a member of, or a subscriber to, a rating organization licensed under chapter 24 or chapter 26 that makes the filings, and by filing with the director a copy of its authorization of the rating organization to make the filings on its behalf. This chapter does not require an insurer to become a member of or a subscriber to a rating organization. An insurer may file and use deviations from filings made on its behalf. The deviations are subject to this chapter.

(3) A filing under this section must be accompanied by a certification by or on behalf of the insurer that, to the best of the insurer's information and belief, the filing conforms to the requirements of this chapter.

(4) A filing under this section must include information that supports the filing with respect to the requirements of section 2109. The information may include 1 or more of the following:

(a) The experience or judgment of the insurer or rating organization making the filing.

(b) The interpretation of the insurer or rating organization of any statistical data it relies on.

(c) The experience of other insurers or rating organizations.

(d) Any other relevant information.

(5) Except as otherwise provided in this subsection, the department shall make a filing under this section and any accompanying information open to public inspection on filing. An insurer or a rating organization filing on the insurer's behalf may designate information included in the filing or any accompanying information as a trade secret. The insurer or the rating organization filing on behalf of the insurer shall demonstrate to the director that the designated information is a trade secret. If the director determines that the

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information is a trade secret, the information is not subject to public inspection and is exempt from disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246. As used in this subsection, "trade secret" means that term as defined in section 2 of the uniform trade secrets act, 1998 PA 448, MCL 445.1902. However, trade secret does not include filings and information accompanying filings under this section that were subject to public inspection before January 11, 2016.

(6) For automobile insurance, an insurer shall file a manual or plan in accordance with chapter 24, except that the manual or plan must remain on file for a waiting period of 90 days before it becomes effective, which period may not be extended by the director, and the waiting period applies regardless of whether supporting information is required by the director under section 2406(1). Upon written application by the insurer, the director may authorize a filing that he or she has reviewed to become effective before expiration of the waiting period.

(7) An insurer shall not make, issue, or renew a contract or policy except in accordance with filings that are in effect for the insurer under this chapter.

(8) A filing under this chapter must specify that the insurer will not refuse to insure, refuse to continue to insure, or limit the amount of coverage available because of the location of the risk, and that the insurer recognizes those practices to constitute redlining. An insurer shall not engage in redlining as described in this subsection.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 2015, Act 141, Eff. Jan. 11, 2016;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2109 Rates for automobile insurance and home insurance; requirements; determining existence of reasonable degree of competition.

Sec. 2109. (1) All rates for automobile insurance and home insurance shall be made in accordance with the following provisions:

(a) Rates shall not be excessive, inadequate, or unfairly discriminatory. A rate shall not be held to be excessive unless the rate is unreasonably high for the insurance coverage provided and a reasonable degree of competition does not exist for the insurance to which the rate is applicable.

(b) A rate shall not be held to be inadequate unless the rate is unreasonably low for the insurance coverage provided and the continued use of the rate endangers the solvency of the insurer; or unless the rate is unreasonably low for the insurance provided and the use of the rate has or will have the effect of destroying competition among insurers, creating a monopoly, or causing a kind of insurance to be unavailable to a significant number of applicants who are in good faith entitled to procure that insurance through ordinary methods.

(c) A rate for a coverage is unfairly discriminatory in relation to another rate for the same coverage if the differential between the rates is not reasonably justified by differences in losses, expenses, or both, or by differences in the uncertainty of loss, for the individuals or risks to which the rates apply. A reasonable justification shall be supported by a reasonable classification system; by sound actuarial principles when applicable; and by actual and credible loss and expense statistics or, in the case of new coverages and classifications, by reasonably anticipated loss and expense experience. A rate is not unfairly discriminatory because it reflects differences in expenses for individuals or risks with similar anticipated losses, or because it reflects differences in losses for individuals or risks with similar expenses.

(2) A determination concerning the existence of a reasonable degree of competition with respect to subsection (1)(a) shall take into account a reasonable spectrum of relevant economic tests, including the number of insurers actively engaged in writing the insurance in question, the present availability of such insurance compared to its availability in comparable past periods, the underwriting return of that insurance over a period of time sufficient to assure reliability in relation to the risk associated with that insurance, and the difficulty encountered by new insurers in entering the market in order to compete for the writing of that insurance.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2110 Development and evaluation of rates; considerations; systems of expense

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provisions; grouping risks by classifications.

Sec. 2110. (1) In developing and evaluating rates pursuant to the standards prescribed in section 2109, due consideration shall be given to past and prospective loss experience within and outside this state, to catastrophe hazards, if any; to a reasonable margin for underwriting profit and contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; to past and prospective expenses, both countrywide and those specially applicable to this state exclusive of assessments under this code; to assessments under this code; to underwriting practice and judgment; and to all other relevant factors within and outside this state.

(2) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

(3) Risks may be grouped by classifications for the establishment of rates and minimum premiums. The classifications may measure differences in losses, expenses, or both.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2110a Premium discount plan.

Sec. 2110a. If uniformly applied to all its insureds, an insurer may use factors in addition to those permitted by section 2111 for insurance if the plan is consistent with the purposes of this act and reflects reasonably anticipated reductions or increases in losses or expenses. This section does not affect benefits or obligations required under chapter 31. This section does not authorize an insurer to offer or prohibit an insurer from offering premium discount plans concerning any of the following:

(a) Health care services, health care providers, or health care facilities.

(b) Automobile repair providers.

(c) Materials used in the repair of an automobile.

History: Add. 1996, Act 514, Imd. Eff. Jan. 13, 1997;—Am. 2012, Act 441, Imd. Eff. Dec. 27, 2012.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2110b Use of automobile repair or automobile glass repair or replacement service; unreasonable restriction prohibited; disclosure; notice to consumers; development of plan.

Sec. 2110b. (1) An automobile insurance policy and an automobile insurer and its employees, agents, and adjusters shall not unreasonably restrict an insured from using a particular person, place, shop, or entity for the providing of any automobile repair or automobile glass repair or replacement service or product covered by the policy.

(2) An automobile insurer shall disclose, prior to or at the time a claim is filed with the insurer, whether the insurer has an agreement with any repair or replacement facility to provide a repair or replacement service or product to an insured and shall inform an insured that he or she is under no obligation to use a particular repair or replacement facility.

(3) The office of financial and insurance services shall develop a plan whereby the office informs consumers of their rights regarding insurance coverage of automobile repairs, that the insurer is not required to pay more than a reasonable amount for repairs and parts, and of the insured's ability to report violations of their rights to the office of financial and insurance services through the office's toll-free telephone number or website. The plan shall be developed and submitted to the senate and house of representatives standing committees on insurance issues not later than 6 months after the effective date of this section.

History: Add. 2004, Act 190, Imd. Eff. July 8, 2004.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

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500.2111 Classifications and territorial base rates for automobile insurance or home insurance; conformity with applicable requirements; additional factors.

Sec. 2111. (1) Notwithstanding any provision of this act or this chapter to the contrary, classifications and territorial base rates used by an insurer in this state with respect to automobile insurance or home insurance must conform to the applicable requirements of this section.

(2) Classifications established under this section for automobile insurance must be based only on 1 or more of the following factors, which must be applied by an insurer on a uniform basis throughout this state:

(a) With respect to all automobile insurance coverages:

(*i*) Either the age of the driver; the length of driving experience; or the number of years licensed to operate a motor vehicle.

(*ii*) Driver primacy, based on the proportionate use of each vehicle insured under the policy by individual drivers insured or to be insured under the policy.

(*iii*) Average miles driven weekly, annually, or both.

(*iv*) Type of use, such as business, farm, or pleasure use.

(*v*) Vehicle characteristics, features, and options, such as engine displacement, ability of the vehicle and its equipment to protect passengers from injury, and other similar items, including vehicle make and model.

(*vi*) Daily or weekly commuting mileage.

(*vii*) Number of cars insured by the insurer or number of licensed operators in the household. However, number of licensed operators must not be used as an indirect measure of marital status.

(*viii*) Amount of insurance.

(b) In addition to the factors prescribed in subdivision (a), with respect to personal protection insurance coverage:

(*i*) Earned income.

(*ii*) Number of dependents of income earners insured under the policy.

(*iii*) Coordination of benefits.

(*iv*) Use of a safety belt.

(c) In addition to the factors prescribed in subdivision (a), with respect to collision and comprehensive coverages:

(*i*) The anticipated cost of vehicle repairs or replacement, which may be measured by age, price, cost new, or value of the insured automobile, and other factors directly relating to that anticipated cost.

(*ii*) Vehicle make and model.

(*iii*) Vehicle design characteristics related to vehicle damageability.

(*iv*) Vehicle characteristics relating to automobile theft prevention devices.

(d) With respect to all automobile insurance coverage other than comprehensive, successful completion by the individual driver or drivers insured under the policy of an accident prevention education course that meets the following criteria:

(*i*) The course must include a minimum of 8 hours of classroom instruction.

(*ii*) The course must include, but not be limited to, a review of all of the following:

(A) The effects of aging on driving behavior.

(B) The shapes, colors, and types of road signs.

(C) The effects of alcohol and medication on driving.

(D) The laws relating to the proper use of a motor vehicle.

(E) Accident prevention measures.

(F) The benefits of safety belts and child restraints.

(G) Major driving hazards.

(H) Interaction with other highway users, such as motorcyclists, bicyclists, and pedestrians.

(3) Each insurer shall establish a secondary or merit rating plan for automobile insurance, other than comprehensive coverage. A secondary or merit rating plan required under this subsection must provide for premium surcharges for all coverages for automobile insurance, other than comprehensive coverage, based on any of the following, when that information becomes available to the insurer:

(a) Substantially at-fault accidents.

(b) Convictions for, determinations of responsibility for civil infractions for, or findings of responsibility in probate court for civil infractions for violations under chapter VI of the Michigan vehicle code, 1949 PA 300, MCL 257.601 to 257.750. However, an insured must not be merit rated for a civil infraction under chapter VI of the Michigan vehicle code, 1949 PA 300, MCL 257.601 to 257.750, for a period of time longer than that which the secretary of state's office carries points for that infraction on the insured's motor vehicle record.

(4) An insurer shall not establish or maintain rates or rating classifications for automobile insurance based

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on any of the following:

(a) Sex.

(b) Marital status.

(c) Home ownership.

(d) Educational level attained.

(e) Occupation.

(f) The postal zone in which the insured resides.

(g) Credit score as provided in section 2162.

(5) Notwithstanding other provisions of this chapter, automobile insurance risks may be grouped by territory.

(6) This section does not limit insurers or rating organizations from establishing and maintaining statistical reporting territories. This section does not prohibit an insurer from establishing or maintaining, for automobile insurance, a premium discount plan for senior citizens in this state who are 65 years of age or older, if the plan is uniformly applied by the insurer throughout this state. If an insurer has not established and maintained a premium discount plan for senior citizens, the insurer shall offer reduced premium rates to senior citizens in this state who are 65 years of age or older and who drive less than 3,000 miles per year, regardless of statistical data.

(7) Classifications established under this section for home insurance other than inland marine insurance provided by policy floaters or endorsements must be based only on 1 or more of the following factors:

(a) Amount and types of coverage.

(b) Security and safety devices, including locks, smoke detectors, and similar, related devices.

(c) Repairable structural defects reasonably related to risk.

(d) Fire protection class.

(e) Construction of structure, based on structure size, building material components, and number of units.

(f) Loss experience of the insured, based on prior claims attributable to factors under the control of the insured that have been paid by an insurer. An insured's failure, after written notice from the insurer, to correct a physical condition that presents a risk of repeated loss is a factor under the control of the insured for purposes of this subdivision.

(g) Use of smoking materials within the structure.

(h) Distance of the structure from a fire hydrant.

(i) Availability of law enforcement or crime prevention services.

(8) Notwithstanding other provisions of this chapter, home insurance risks may be grouped by territory.

(9) An insurer may use factors in addition to those permitted by this section for insurance if the plan is consistent with the purposes of this act and reflects reasonably anticipated reductions or increases in losses or expenses.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 1986, Act 10, Imd. Eff. Feb. 28, 1986;—Am. 1987, Act 150, Imd. Eff. Oct. 26, 1987;—Am. 1990, Act 88, Eff. Mar. 28, 1991;—Am. 1991, Act 24, Imd. Eff. May 20, 1991;—Am. 1991, Act 191, Eff. Jan. 1, 1992;—Am. 1996, Act 98, Imd. Eff. Feb. 28, 1996;—Am. 2002, Act 492, Eff. Mar. 31, 2003;—Am. 2012, Act 441, Imd. Eff. Dec. 27, 2012;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2111a Completion of traffic accident prevention course; premium discount to insureds 50 years of age and older; provisions.

Sec. 2111a. (1) Notwithstanding section 2111, an automobile insurer may offer a premium discount to insureds 50 years of age and older who successfully complete a traffic accident prevention course that an automobile insurer determines meets all of the criteria listed in subsection (3).

(2) An automobile insurer may provide the discount under subsection (1) for 3 years after successful completion of an initial or refresher traffic accident prevention course.

(3) A traffic accident prevention course shall provide for all of the following:

(a) For an initial traffic accident prevention course, includes not less than 8 hours of classroom instruction taught by an instructor certified by the entity offering the course. For a refresher traffic accident prevention course, includes not less than 4 hours of classroom instruction taught by an instructor certified by the entity offering the course.

(b) Includes, but is not limited to, instruction in all of the following areas:

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(*i*) The effects of aging on driving behavior.

(*ii*) The shapes, colors, and types of road signs.

(*iii*) The effects of alcohol and other drugs, including medications, on older drivers.

(*iv*) Laws relating to the proper use of a motor vehicle and safe driving behavior.

(*v*) Traffic crash avoidance and prevention measures.

(*vi*) The benefits and proper use of motor vehicle occupant protection systems.

(*vii*) Major driving hazards and risk factors associated with traffic crash prevention.

(*viii*) Interaction with other highway users such as emergency vehicles, trucks, motorcyclists, bicyclists, and pedestrians.

(c) Provides, upon successful completion of the course, a certificate of completion that may be used in applying for an automobile insurance premium discount under subsection (1).

History: Add. 2006, Act 610, Imd. Eff. Jan. 3, 2007.

Compiler's note: Former MCL 500.2111a, which pertained to automobile insurance package policies within urban area territories, was repealed by Act 191 of 1991, Eff. Apr. 1, 1992.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2111b, 500.2111c Repealed. 1991, Act 191, Eff. Apr. 1, 1992.

Compiler's note: The repealed sections pertained to prohibited territorial base rate and reports.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2111d Home insurance; premium discount plan for senior citizens.

Sec. 2111d. Notwithstanding section 2111, an insurer may establish or maintain for home insurance a premium discount plan for senior citizens in this state who are at least 55 years of age or older, if the plan is uniformly applied by the insurer throughout this state.

History: Add. 1990, Act 131, Imd. Eff. June 26, 1990.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2111e Rates increase prohibited; applicability of section.

Sec. 2111e. Notwithstanding any other provision of this act, an automobile insurer shall not raise rates for automobile insurance before April 1, 1992. This section shall not apply to rate changes based upon assessments levied against insurers pursuant to section 3104 or 3330.

History: Add. 1991, Act 191, Eff. Jan. 1, 1992.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2111f Automobile insurance; premium rate reduction requirements for personal protection insurance coverage; approval by director; use of savings; applicability to certain increases; inclusion of catastrophic claims assessment; severability; definitions.

Sec. 2111f. (1) Before July 1, 2020, an insurer that offers automobile insurance in this state shall file premium rates for personal protection insurance coverage for automobile insurance policies effective after July 1, 2020.

(2) Subject to subsections (6) and (7), the premium rates filed as required by subsection (1), and any subsequent premium rates filed by the insurer for personal protection insurance coverage under automobile insurance policies effective before July 2, 2028, must result, as nearly as practicable, in an average reduction per vehicle from the premium rates for personal protection insurance coverage that were in effect for the insurer on May 1, 2019 as follows:

(a) For policies subject to the coverage limits under section 3107c(1)(a), an average 45% or greater reduction per vehicle.

(b) For policies subject to the coverage limits under section 3107c(1)(b), an average 35% or greater reduction per vehicle.

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(c) For policies subject to the coverage limits under section 3107c(1)(c), an average 20% or greater reduction per vehicle.

(d) For policies not subject to any coverage limit under section 3107c(1)(d), an average 10% or greater reduction per vehicle.

(3) For a policy under which an election under section 3107d has been made to not maintain coverage for personal protection insurance benefits payable under section 3107(1)(a), or for a policy to which an exclusion under section 3109a(2) applies, the premium rates filed under subsection (1), and any subsequent premium rates filed by the insurer for personal protection insurance coverage, must result in no premium charge for coverage for personal protection insurance benefits payable under section 3107(1)(a).

(4) The director shall review a filing submitted by an insurer under subsections (1) to (3) for compliance with this section. Subject to subsection (7), the director shall disapprove a filing if after review the director determines that the filing does not result in the premium reductions required by subsections (2) and (3).

(5) If the director disapproves a premium rate filing under subsection (4), the insurer shall submit a revised premium rate filing to the director within 15 days after the disapproval. The premium rate filing is subject to review in the same manner as an original premium rate filing under subsection (4).

(6) For policies issued or renewed in the year beginning July 1, 2024 and in the year beginning July 1, 2026, an automobile insurer that offers automobile insurance in this state shall make filings demonstrating its compliance with this section.

(7) At any time, an insurer may apply to the director for approval to file rates that result in a lower premium reduction level or an exemption from the requirements of subsection (2) and the director shall approve the application if the rates otherwise comply with this act and compliance with the premium reductions required by subsection (2) will result in any of the following:

(a) The insurer reaching the company action level risk-based capital.

(b) A violation of the Fourteenth Amendment of the United States Constitution as to the insurer. This subdivision does not apply after July 1, 2023.

(c) A violation of section 17 of article I of the state constitution of 1963, as to deprivation of property without due process. This subdivision does not apply after July 1, 2023.

(8) An insurer shall pass on, in filings to which this section applies, savings realized from the application of section 3157(2) to (12) to treatment, products, services, accommodations, or training rendered to individuals who suffered accidental bodily injury from motor vehicle accidents that occurred before July 2, 2021. An insurer shall provide the director with all documents and information requested by the director that the director determines are necessary to allow the director to evaluate the insurer's compliance with this subsection. After July 1, 2022, the director shall review all rate filings to which this section applies for compliance with this subsection.

(9) This section does not prohibit an increase for any individual insurance policy premium if the increase results from applying rating factors as approved under this chapter, including the requirements of this section.

(10) After July 1, 2020 and before July 2, 2028, an insurer shall not issue or renew an automobile insurance policy in this state unless the premium rates filed by the insurer for personal protection insurance coverage are approved under this section.

(11) For purposes of calculating a personal protection insurance premium or premium rate under this section, the premium must include the catastrophic claims assessment imposed under section 3104.

(12) If subsection (2) or the application of subsection (2) to any insurer is found to be invalid by a court, the remaining portions of the amendatory act that added this section are not severable and shall be deemed invalid and inoperable.

(13) As used in this section:

(a) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC report, including risk-based capital instructions adopted by the National Association of Insurance Commissioners and the director.

(b) "Company action level risk-based capital" means 2 times the insurer's authorized control level RBC.

(c) "RBC report" means the report of the insurer's RBC levels as required by the annual statement instructions.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019;—Add. 2019, Act 22, Imd. Eff. June 11, 2019.

Compiler's note: MCL 500.2111f was added by 2019 PA 21 and 2019 PA 22. 2019 PA 22, being substantively the same as 2019 PA 21 and enacted after 2019 PA 21, becomes the only version on its effective date.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

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500.2112 Written notice to policyholder; information available upon request; contact information; manner of providing; trade secret.

Sec. 2112. (1) Subject to subsection (3), at least annually, in conjunction with a renewal notice, a bill, or other notice of payment due issued to a policyholder in conjunction with an automobile or home insurance contract, an insurer shall send to the policyholder a written notice that all of the following information is available and will be provided to the policyholder on request:

(a) A description of the specific rating classifications by which the rates and premiums for the policy have been determined. The notice must be of sufficient detail and clarity so that the policyholder can reasonably verify the applicability and accuracy of the rating classifications.

(b) A general explanation of the extent to which rates or premiums vary among policyholders on the basis of the rating classifications used by the insurer.

(c) Sources and reasonable procedures by which the policyholder can obtain from the insurer additional information sufficient for the policyholder to calculate and confirm the accuracy of his or her specific premium.

(d) Relevant information regarding the rights of the policyholder, under sections 2113 and 2114, to appeal the application of the insurer's rating plan in determining his or her premium, to obtain documentation from the insurer regarding the determination of the rate, to appeal the application of the insurer's underwriting rules to the policyholder, to request an informal conference with the insurer, and to file with the director a complaint as an aggrieved person.

(e) A description of all of the insurer's underwriting rules based on insurance eligibility points and a description of all of the underwriting rules of the insurer's affiliates based on insurance eligibility points.

(f) A suggestion that the policyholder contact his or her agent to determine if he or she is eligible for insurance from an affiliate of the insurer or under a different rating plan of the insurer that would provide to the policyholder insurance at a more favorable premium.

(2) In a written notice provided under subsection (1), the insurer shall provide the policyholder with a telephone number and an Internet address, by either of which the policyholder may contact the insurer to request the information listed in subsection (1). On request of the policyholder, the insurer shall provide the policyholder with the requested information in either a written or electronic format, as requested by the policyholder.

(3) An insurer is not required to provide information to an insured under this section that is a trade secret as determined by the director under section 2108(5) or 2406(6).

History: Add. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 2012, Act 454, Imd. Eff. Dec. 27, 2012;—Am. 2015, Act 141, Eff. Jan. 11, 2016.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2113 Private informal managerial-level conference with insurer; internal procedures; review and determination by commissioner; procedure for determination; hearing matter as contested case.

Sec. 2113. (1) A person who has reason to believe that an insurer has improperly denied him or her automobile insurance or home insurance or has charged an incorrect premium for that insurance shall be entitled to a private informal managerial-level conference with the insurer and to a review before the commissioner, if the conference fails to resolve the dispute.

(2) An insurer shall establish reasonable internal procedures to provide a person with a private informal managerial-level conference regarding the matters described in subsection (1). These procedures shall include all of the following:

(a) A method of providing the person, upon request and payment of a reasonable copying charge, with information pertinent to the denial of insurance or to the premium charged.

(b) A method for resolving the dispute promptly and informally, while protecting the interests of both the person and the insurer.

(3) If the insurer fails to provide a conference and proposed resolution within 30 days after a request by a person, or if the person disagrees with the proposed resolution of the insurer after completion of the conference, the person shall be entitled to a determination of the matter by the commissioner.

(4) The commissioner shall by rule establish a procedure for determination under this section, which shall be reasonably calculated to resolve these matters informally and as rapidly as possible, while protecting the interests of both the person and the insurer.

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(5) If either the insurer or the person disagrees with a determination of the commissioner under this section, the commissioner, if requested to do so by either party, shall proceed to hear the matter as a contested case under Act No. 306 of the Public Acts of 1969, as amended.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2114 Person or organization aggrieved by filing; application for hearing; specification of grounds; notice of hearing; order of commissioner.

Sec. 2114. (1) A person or organization aggrieved with respect to any filing which is in effect and which affects the person or organization may make written application to the commissioner for a hearing on the filing. However, the insurer or rating organization which made the filing shall not be authorized to proceed under this subsection. The application shall specify the grounds to be relied upon by the applicant. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if the grounds specified are established, or that the grounds specified otherwise justify holding a hearing, the commissioner, not more than 30 days after receipt of the application, shall hold a hearing in accordance with Act No. 306 of the Public Acts of 1969, as amended, upon not less than 10 days' written notice to the applicant, the insurer, and the rating organization which made the filing.

(2) If after hearing initiated under subsection (1) or upon the commissioner's own motion pursuant to Act No. 306 of the Public Acts of 1969, as amended, the commissioner finds that a filing does not meet the requirements of sections 2109 and 2111, the commissioner shall issue an order stating the specific reasons for that finding. The order shall state when, within a reasonable time after issuance of the order, the filing shall be considered no longer effective. A copy of the order shall be sent to the applicant, if any, and to each insurer and rating organization subject to the order. The order shall not affect a contract or policy made or issued before the date the filing becomes ineffective, as indicated in the commissioner's order.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2115 Finding by commissioner that reasonable degree of competition does not exist on statewide basis; order requiring compliance with chapter 24 or 26; hearing; notice; new order.

Sec. 2115. (1) If as part of a decision in a proceeding under section 2114, or in a separate proceeding on the commissioner's own motion, held pursuant to Act No. 306 of the Public Acts of 1969, as amended, the commissioner finds that a reasonable degree of competition does not exist on a statewide basis with respect to automobile insurance or home insurance, the commissioner shall by order require each insurer which transacts that type of insurance in this state to comply with the provisions of chapter 24 or 26, as the case may be, with respect to that insurance which was the subject of the commissioner's finding. The order shall take effect not less than 90 nor more than 150 days after the order is issued. On or after the effective date of an order issued under this subsection, none of the provisions of this chapter shall be applicable to the insurance which was the subject of the order.

(2) After an order issued pursuant to subsection (1) has been in effect for 1 year, if the commissioner has reason to believe that there would be a reasonable degree of price competition for the type of insurance affected by the order, or if, upon the petition of an insurer or a resident of this state, there is a showing that there is reason to believe that there would be a reasonable degree of price competition for that type of insurance, the commissioner shall hold a hearing pursuant to Act No. 306 of the Public Acts of 1969, as amended, to determine if a reasonable degree of price competition would exist if the order were no longer in effect. The hearing shall be held upon not less than 20 days' written notice to each insurer subject to the order and upon not less than 20 days' notice in not less than 3 newspapers of general circulation within this state.

(3) If the commissioner finds after the hearing that a reasonable degree of price competition would exist, the commissioner shall by order state when, not less than 90 nor more than 150 days after issuance of a new order, the preceding order will no longer be effective. On and after the effective date of an order issued under this subsection, the provisions of this chapter shall be applicable to the type of insurance which was the subject of the order.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981.

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Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2116 Condition of licensure as insurance agent; penalizing insurance agent.

Sec. 2116. (1) A duly licensed insurance agent licensed to represent 1 or more insurers shall, as a condition of licensure, do all of the following:

(a) Provide each eligible person seeking automobile insurance or home insurance a premium quotation for the forms or types of insurance coverages that are offered by the insurers represented by the agent and that are sought by the eligible person.

(b) Inform the eligible person of the number of insurers that he or she represents. If the agent represents additional insurers from which the eligible person may obtain insurance, the agent may provide additional premium quotations as requested by the eligible person.

(c) Not attempt to channel an eligible person away from an insurer or insurance coverage with the purpose or effect of avoiding an agent's obligation to submit an application or an insurer's obligation to accept an eligible person.

(d) On request, submit an application of the eligible person for automobile insurance or home insurance to the insurer selected by the eligible person.

(e) For automobile insurance only, at least annually, supply, with the renewal of a policy, to each insured, unless the information is available from the insurer, all of the following:

(*i*) An explanation of the insurance eligibility point system.

(*ii*) A statement that if the insured is an eligible person he or she may qualify for insurance from more than 1 insurer, and possibly at a lower rate.

(*iii*) A statement that the agent will, on request, furnish to the insured a set of quotations from insurers represented by the agent from whom the insured may obtain insurance, as required in this subsection.

(2) With respect to automobile insurance or home insurance, an insurer shall not penalize an individual agent by paying less than normal commissions or normal compensation or salary because of the expected or actual experience produced by the agent's business or because of the geographic location of business written by the agent.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 2012, Act 454, Imd. Eff. Dec. 27, 2012.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

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500.2116a Automobile insurance; person on active duty in United States armed forces; lapse in coverage; prohibited conduct by insurer; conditions.

Sec. 2116a. An automobile insurer shall not refuse to insure, refuse to continue to insure, limit coverage available to, charge a reinstatement fee for, or increase the premiums for automobile insurance solely because a person failed to maintain insurance required by section 3101 for a vehicle owned by the person during the 6-month period immediately preceding application if the person certifies on a form provided by the insurer that the lapse in coverage was because the person was on active duty in the armed forces of the United States for at least 30 consecutive days and that the vehicle was not driven or moved during the 6-month period immediately preceding application or during the period of time the insurance was not maintained, whichever period is shorter. This section applies only to an eligible person.

History: Add. 2007, Act 35, Imd. Eff. July 11, 2007.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2116b Automobile insurance; lapse in coverage; prohibited conduct by insurer; applicability.

Sec. 2116b. (1) Subject to subsection (2), an automobile insurer shall not refuse to insure, refuse to continue to insure, limit coverage available to, charge a reinstatement fee for, or increase the premiums for automobile insurance for an eligible person solely because the person previously failed to maintain insurance required by section 3101 for a vehicle owned by the person.

(2) This section only applies to an eligible person that applies for automobile insurance before January 1, 2022.

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History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2117 Home insurance; condition of maintaining insurer's certificate of authority; basis of underwriting rules; provisions applicable to repair cost policy; rates; aggregation of claims; adjustment of minimum dollar amounts.

Sec. 2117. (1) As a condition of maintaining its certificate of authority, an insurer shall not refuse to insure, refuse to continue to insure, or limit the coverage available to an eligible person for home insurance, except in accordance with underwriting rules established under this section and section 2119.

(2) The underwriting rules that an insurer may establish for home insurance shall be based only on the following:

(a) Criteria identical to the standards set forth in section 2103(2).

(b) The physical condition of the property insured or to be insured, if the underwriting rules are objective, are directly related to the perils insured against, and, without regard to the age of the structure, are based on the specific provisions of a national, state, or local housing and safety code, a manufacturer's specification, or standards of similar specificity. If an applicant or insured obtains a certificate of compliance or habitation issued by an appropriate governmental unit or agency, certifying that a building is in substantial compliance with local housing and safety codes, the certificate creates a rebuttable presumption that the dwelling meets the insurer's underwriting rules relating to physical condition.

(c) For the renewal of a home insurance policy, the claim history of the person insured or to be insured during the 3-year period immediately preceding renewal of the policy, if that history is based on 1 or both of the following:

(*i*) Claim experience arising out of the insured's negligence.

(*ii*) Failure by the insured, after written notice from the insurer, to correct a physical condition that is directly related to a paid claim or that presents a clear risk of a significant loss under the property or liability portions of a homeowners policy.

(d) The relationship between market value and replacement cost of a dwelling insured or to be insured for a replacement cost policy, if a repair cost policy is offered by the insurer under subsection (3).

(e) For nonrenewal of a home insurance policy, the claim history under the policy, excluding liability claims, as follows:

(*i*) If there has been 1 or more of the following:

(A) Three paid claims within the immediately preceding 3-year period totaling $3,000.00 or more, exclusive of weather-related claims.

(B) Three paid claims within the immediately preceding 3-year period totaling $4,000.00 or more, including weather-related claims.

(*ii*) A history of 3 or more paid claims within an immediately preceding 3-year period if the insurer meets all of the following:

(A) Has an underwriting rule under subparagraph (*i*) in effect.

(B) The underwriting rule under this subparagraph is for a paid claim history that totals not less than the amount in subparagraph (*i*)(A) exclusive of weather-related claims and totals not less than the amount in subparagraph (*i*)(B) including weather-related claims.

(C) The underwriting rule under this subparagraph applies to an insured who has had a home insurance policy with the insurer for a continuous minimum period of time as determined by the insurer that may be any period of time between 5 and 10 years.

(f) Whether the number of residences within the dwelling are inconsistent with the policy forms approved by the commissioner for the insurer.

(g) Whether a dwelling has been unoccupied for more than 60 days, if there is evidence of an intent to vacate or keep the premises vacant or unoccupied, as to the applicant or insured.

(h) The existence of an adjacent physical hazard, if the hazard presents a significant risk of loss directly related to the perils insured or to be insured against for which a rate surcharge is not applicable. For purposes of this subdivision only, residential property or traffic patterns shall not be considered to cause a significant risk of loss. Nonrenewals based upon an adjacent physical hazard shall be due to a change in the hazard from that which existed at the original date of issuance of the policy.

(i) The failure of the insured or applicant to purchase an amount of insurance in excess of 80% of the replacement cost of the property to be insured under a replacement cost policy, if both of the following conditions are met:

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(*i*) The purchase of an amount of insurance in excess of 80% of the replacement cost is a condition for sale of the policy.

(*ii*) The insurer offers in this state at least 1 form of a replacement cost policy for which the insurer requires only a minimum amount of insurance equal to 80% of the replacement cost of the dwelling as a condition of purchase.

(j) One or more incidents involving a threat, harassment, or physical assault by the insured or applicant for insurance on an insurer employee, agent, or agent employee while acting within the scope of his or her employment, if a report of the incident was filed with an appropriate law enforcement agency.

(3) If an insurer establishes an underwriting rule based on the relationship between the market value and replacement cost under subsection (2)(d), both of the following apply to the repair cost policy:

(a) The insurer shall offer the repair cost policy with deductibles, terms and conditions, perils insured against, and types and amounts of coverage, which are substantially equivalent to the deductibles, terms and conditions, perils insured against, and types and amounts of coverage provided by the replacement cost policy of the insurer, at least equivalent to the HO-2 form replacement cost policy filed and in effect in this state for the principal rating organization as of October 1, 1979.

(b) The insurer shall not use an underwriting rule based on the relationship between the market value and replacement cost for the repair cost policy.

(4) The rates of an insurer for a repair cost policy shall be established so that the premium for a repair cost policy shall not exceed 105% of the premium for an amount of insurance equal to 80% of the replacement cost of the dwelling under the equivalent replacement cost policy described in subsection (3)(a). Premiums for dwellings with identical replacement costs shall vary on a schedule determined by the insurer in accordance with the market value of the dwellings.

(5) Off-premises claims may be aggregated for the purposes of subsection (2)(e), irrespective of the location of the insured dwelling. All claims other than off-premises losses used in a determination for purposes of subsection (2)(e) shall be aggregated only as to an insured dwelling. The minimum dollar amounts prescribed in subsection (2)(e)(*i*) shall be adjusted on January 1, 2006, and on January 1 of every sixth year thereafter to reflect the aggregate annual average percentage change in the consumer price index since the previous adjustment, rounded to the nearest hundred dollars. As used in this subsection, "consumer price index" means the consumer price index for all urban consumers in the U.S. city average, as most recently reported by the United States department of labor, bureau of labor statistics, and after certification by the commissioner in an administrative bulletin.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 2001, Act 25, Eff. Jan. 1, 2002;—Am. 2002, Act 492, Eff. Mar. 31, 2003;—Am. 2012, Act 441, Imd. Eff. Dec. 27, 2012.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

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500.2118 Automobile insurance; condition of maintaining insurer's certificate of authority; basis of underwriting rules.

Sec. 2118. (1) As a condition of maintaining its certificate of authority, an insurer shall not refuse to insure, refuse to continue to insure, or limit coverage available to an eligible person for automobile insurance, except in accordance with underwriting rules established as provided in this section and sections 2119 and 2120.

(2) The underwriting rules that an insurer may establish for automobile insurance must be based only on the following:

(a) Criteria identical to the standards set forth in section 2103(1).

(b) The insurance eligibility point accumulation in excess of the amounts established by section 2103(1) of a member of the household of the eligible person insured or to be insured, if the member of the household usually accounts for 10% or more of the use of a vehicle insured or to be insured. For purposes of this subdivision, a person who is the principal driver for 1 automobile insurance policy is rebuttably presumed not to usually account for more than 10% of the use of other vehicles of the household not insured under the policy of that person.

(c) With respect to a vehicle insured or to be insured, substantial modifications from the vehicle's original manufactured state for purposes of increasing the speed or acceleration capabilities of the vehicle.

(d) Except as otherwise provided in section 2116a or 2116b, failure by the person to provide proof that insurance required by section 3101 was maintained in force with respect to any vehicle that was both owned by the person and driven or moved by the person or by a member of the household of the person during the 6-month period immediately preceding application. The proof must take the form of a certification by the

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person on a form provided by the insurer that the vehicle was not driven or moved without maintaining the insurance required by section 3101 during the 6-month period immediately preceding application.

(e) Type of vehicle insured or to be insured, based on 1 of the following, without regard to the age of the vehicle:

(*i*) The vehicle is of limited production or of custom manufacture.

(*ii*) The insurer does not have a rate lawfully in effect for the type of vehicle.

(*iii*) The vehicle represents exposure to extraordinary expense for repair or replacement under comprehensive or collision coverage.

(f) Use of a vehicle insured or to be insured for transportation of passengers for hire, for rental purposes, or for commercial purposes. Rules under this subdivision must not be based on the use of a vehicle for volunteer or charitable purposes or for which reimbursement for normal operating expenses is received.

(g) Payment of a minimum deposit at the time of application or renewal, not to exceed the smallest deposit required under an extended payment or premium finance plan customarily used by the insurer.

(h) For purposes of requiring comprehensive deductibles of not more than $150.00, or of refusing to insure if the person refuses to accept a required deductible, the claim experience of the person with respect to comprehensive coverage.

(i) Total abstinence from the consumption of alcoholic beverages except if such beverages are consumed as part of a religious ceremony. However, an insurer shall not use an underwriting rule based on this subdivision unless the insurer was authorized to transact automobile insurance in this state before January 1, 1981, and has consistently used such an underwriting rule as part of the insurer's automobile insurance underwriting since being authorized to transact automobile insurance in this state.

(j) One or more incidents involving a threat, harassment, or physical assault by the insured or applicant for insurance on an insurer employee, agent, or agent employee while acting within the scope of his or her employment, if a report of the incident was filed with an appropriate law enforcement agency.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 1984, Act 7, Imd. Eff. Feb. 1, 1984;—Am. 1984, Act 350, Eff. Mar. 29, 1985;—Am. 1988, Act 43, Eff. Mar. 30, 1989;—Am. 2002, Act 492, Eff. Mar. 31, 2003;—Am. 2007, Act 35, Imd. Eff. July 11, 2007;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994 general election.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

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500.2119 Underwriting rules to be in writing; inconsistent transactions prohibited; uniform application of underwriting rules required; adoption of underwriting rules by insurer with more than 1 rating plan; underwriting rules for new applicants and for renewals; filing and public inspection of underwriting rules; order prohibiting use of inconsistent underwriting rule.

Sec. 2119. (1) Each insurer subject to this chapter shall put in writing all underwriting rules used by the insurer. An insurer shall not transact automobile or home insurance inconsistently with its underwriting rules.

(2) An insurer shall apply its underwriting rules uniformly and without exception throughout this state, so that every applicant or insured conforming with the underwriting rules will be insured or renewed, and so that every applicant or insured not conforming with the underwriting rules will be refused insurance or nonrenewed, when the information becomes available to the insurer.

(3) An insurer with more than 1 rating plan for automobile insurance contracts providing identical coverages shall not adopt underwriting rules that would permit a person to be insured, for automobile insurance, under more than 1 of the rating plans.

(4) An insurer may establish underwriting rules for new applicants that are different than rules for renewals of existing insureds only if the applicants or existing insureds are not eligible persons. Underwriting rules pertaining to renewals of existing insureds who are not eligible persons may be based on a contractual obligation of the insurer not to cancel or nonrenew.

(5) For informational purposes, an insurer shall file with the commissioner its underwriting rules before their use in this state. All filed underwriting rules shall be available for public inspection. If the commissioner finds that an underwriting rule is inconsistent with this chapter, the commissioner, after a hearing held under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, shall by order prohibit further use of the underwriting rule.

(6) This section does not prohibit an insurer from insuring persons who are not eligible persons under

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underwriting rules established under this section and sections 2117, 2118, and 2120.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 2012, Act 441, Imd. Eff. Dec. 27, 2012.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2119a Automobile insurance; calculating insurance eligibility points.

Sec. 2119a. In calculating insurance eligibility points for purposes of determining eligibility for automobile insurance and for purposes of applying underwriting rules, only the highest applicable insurance eligibility point value shall be accumulated for any single occurrence involving more than 1 violation, or for any single occurrence involving 1 or more violations together with 1 substantially at-fault accident determination.

History: Add. 1980, Act 461, Imd. Eff. Jan. 15, 1981.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2120 Automobile insurance; establishment of underwriting rules by affiliated insurers; applicability of subsection (1); compliance; separate rating plans; applicability of subsection (2); underwriting rules defining applicable rating plan; basis of underwriting rules.

Sec. 2120. (1) Affiliated insurers may establish underwriting rules so that each affiliate will provide automobile insurance only to certain eligible persons. This subsection applies only if an eligible person can obtain automobile insurance from 1 of the affiliates. The underwriting rules must be in compliance with this section and sections 2118 and 2119.

(2) An insurer may establish separate rating plans so that certain eligible persons are provided automobile insurance under 1 rating plan and other eligible persons are provided automobile insurance under another rating plan. This subsection applies only if all eligible persons can obtain automobile insurance under a rating plan of the insurer. Underwriting rules consistent with this section and sections 2118 and 2119 must be established to define the rating plan applicable to each eligible person.

(3) Underwriting rules under this section must be based only on the following:

(a) With respect to a vehicle insured or to be insured, substantial modifications from the vehicle's original manufactured state for purposes of increasing the speed or acceleration capabilities of the vehicle.

(b) Except as otherwise provided in section 2116a or 2116b, failure of the person to provide proof that insurance required by section 3101 was maintained in force with respect to any vehicle owned and operated by the person or by a member of the household of the person during the 6-month period immediately preceding application or renewal of the policy. The proof must take the form of a certification by the person that the required insurance was maintained in force for the 6-month period with respect to the vehicle.

(c) For purposes of insuring persons who have refused a deductible lawfully required under section 2118(2)(h), the claim experience of the person with respect to comprehensive coverage.

(d) Refusal of the person to pay a minimum deposit required under section 2118(2)(g).

(e) A person's insurance eligibility point accumulation under section 2103(1)(h), or the total insurance eligibility point accumulation of all persons who account for 10% or more of the use of 1 or more vehicles insured or to be insured under the policy.

(f) The type of vehicle insured or to be insured as provided in section 2118(2)(e).

History: Add. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 1984, Act 350, Eff. Mar. 29, 1985;—Am. 2007, Act 35, Imd. Eff. July 11, 2007;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994 general election.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2121 Home insurance; criteria for selecting dwellings for inspection; inspection program; filing inspection criteria; disapproval of inspection criteria; liability.

Sec. 2121. (1) If an insurer uses an inspection of a dwelling to determine whether the insured or applicant is an eligible person for home insurance, criteria for selecting dwellings for inspection shall not be based on

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race, color, creed, marital status, sex, national origin, residence, age, disability, or lawful occupation.

(2) If an insurer establishes an inspection program that provides for inspection of a portion of its existing business on a periodic basis, the inspection program shall not be based on any of the criteria in subsection (1).

(3) Criteria for selecting dwellings for inspection shall be filed with the commissioner for informational purposes only. The commissioner, after a hearing held pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, shall disapprove the further use of inspection criteria if the commissioner finds that the criteria are inconsistent with this chapter.

(4) There is no civil liability, other than contractual liability, if applicable, on the part of, and a cause of action of any nature does not arise against, the commissioner, an insurer, an inspection bureau, an authorized representative, agent, employee, or affiliate of the commissioner, an insurer, or an inspection bureau, or any licensed insurance agent for acts or omissions related solely to the physical condition of the property in an inspection conducted for insurance purposes under this chapter.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 1998, Act 26, Imd. Eff. Mar. 12, 1998;—Am. 2002, Act 492, Eff. Mar. 31, 2003;—Am. 2012, Act 441, Imd. Eff. Dec. 27, 2012.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2122 Declination of insurance; explanation of reasons; refusal of application form as declination.

Sec. 2122. (1) An insurer or agent, upon making a declination of insurance, shall inform the applicant of each specific reason for the declination. If the application or request for coverage was made in writing, the insurer or agent shall provide the explanation of reasons in writing. If the application or request for coverage was made orally, the insurer or agent may provide the applicant with an oral explanation instead of a written explanation, and shall offer to provide a written explanation if the applicant requests a written explanation within 90 days.

(2) A refusal, by an insurer or agent, to provide upon request an application form or other means of making an application or request for coverage shall be considered a declination subject to this section.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2123 Termination of insurance; delivery or mailing of notice; contents of notice; effective date of termination; conformity with underwriting rules; violation of chapter 32 not authorized.

Sec. 2123. (1) Except as provided in subsection (2) or (3), a termination of insurance shall not be effective unless the insurer, at least 30 days prior to the date of termination, delivers or mails to the named insured at the person's last known address a written notice of the termination. The notice shall state the effective date of termination and each specific reason for the termination.

(2) A notice of termination mailed or delivered within the first 55 days after the initial issuance of a policy may be made effective not less than 20 days after the date of mailing or delivery of the notice.

(3) A notice of termination for nonpayment of premium shall be effective as provided in the policy.

(4) A termination of insurance shall not be effective unless the termination is due to reasons which conform to the underwriting rules of the insurer for that insurance.

(5) This section shall not authorize an insurer to terminate an automobile insurance policy in violation of chapter 32.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2124 Liability for information or statement.

Sec. 2124. (1) There shall be no civil liability on the part of, and a cause of action of any nature shall not arise against, the commissioner, an insurer, an employee of an insurer, an authorized representative, agent, or employee of the commissioner, or any licensed insurance agent furnishing to an insurer information required pursuant to sections 2122 and 2123 relating to reasons for cancellation, nonrenewal, or declination, for any

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statement made by them concerning an insured or applicant for insurance.

(2) Subsection (1) shall not apply if a statement made is shown to have been made with gross negligence or in bad faith with malice in fact, and if the statement was made under any of the following circumstances:

(a) In a written notice of cancellation, nonrenewal, or declination, or in any other written or oral communication specifying the reason or reasons for cancellation, nonrenewal, or declination.

(b) In a communication providing information pertaining to a cancellation, nonrenewal, or declination.

(c) As a part of statements made or evidence submitted in a court or administrative proceeding, hearing, or informal inquiry in which the cancellation, nonrenewal, or declination to which the statement relates is an issue.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2125 Suspension of insurer's obligation under MCL 500.2117 or 500.2118; hearing; duration of suspension.

Sec. 2125. (1) After providing an opportunity for a hearing under Act No. 306 of the Public Acts of 1969, as amended, the commissioner shall suspend an insurer's obligations under section 2117, 2118, or both, if any of the following occurs:

(a) A condition exists for which the commissioner may suspend, revoke, or limit the authority of the insurer pursuant to section 436, and the commissioner determines that suspension of all or a part of the insurer's obligations would be in the best interests of the public, the insurer, and the policyholders of the insurer.

(b) The insurer requests suspension and the commissioner finds that requiring the insurer to comply with section 2117, 2118, or both would cause the insurer undue financial or administrative hardship.

(2) If an insurer requests suspension and avers that there is an immediate need to cease its compliance with section 2117, 2118, or both, because of undue financial or administrative hardship under subsection (1)(b), the insurer's obligation to comply with section 2117, 2118, or both shall be suspended 10 business days after the insurer has filed the request and supporting documentation with the commissioner, unless within that time, the commissioner holds a hearing and finds that undue hardship under subsection (1)(b) will not be caused by continued compliance.

(3) The suspension provided in subsection (1) shall continue until the commissioner, upon the commissioner's own motion or upon request, after providing opportunity for a hearing under Act No. 306 of the Public Acts of 1969, as amended, orders its revocation.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2126 Suspension of acceptance of applications; filing and contents of notice; disapproval.

Sec. 2126. An insurer may at any time suspend its acceptance of all applications from new automobile or home insurance risks by filing a notice with the commissioner. The notice shall specify the period of the suspension and the method by which the insurer proposes to effect the suspension. A suspension is subject to the disapproval of the commissioner if, after a hearing held pursuant to Act No. 306 of the Public Acts of 1969, as amended, the commissioner finds that the suspension does not have a legitimate business purpose which is consistent with the purposes of this chapter or that the suspension would adversely affect the maintenance of a competitive market.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2127 Collecting and reporting data; rule; use of sampling techniques.

Sec. 2127. The commissioner may by rule prospectively require insurers, rating organizations, and advisory organizations to collect and report data only to the extent necessary to monitor and evaluate the automobile and home insurance markets in this state. The commissioner shall authorize the use of sampling

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techniques in each instance where sampling is practicable and consistent with the purposes for which the data are to be collected and reported.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2128 Repealed. 1986, Act 10, Imd. Eff. Feb. 28, 1986.

Compiler's note: The repealed section pertained to development of sales offices to assure access to competitive insurance markets.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2129 Exemption from chapter; request; form; continuation of exemption; filing annual reporting form; order discontinuing exemption; requalification for exemption prohibited; ineligible insurers.

Sec. 2129. (1) Each insurer whose surplus as concerns policyholders as of December 31, 1979 as shown on the annual financial statement filed with the commissioner was $4,000,000.00 or less shall be exempt from the provisions of this chapter, if the insurer files with the commissioner a written request for such an exemption on or before January 1, 1981 on a form provided by the commissioner.

(2) The exemption granted under this section shall continue indefinitely with respect to an insurer initially qualifying, so long as that insurer experiences no disproportionate growth in premium volume in automobile insurance or home insurance, or changes in the insurer's pattern, location, or contours of that insurance business which indicate that the insurer is utilizing its exemption to take unfair competitive advantage of competing insurers who do not enjoy the benefits of the exemption.

(3) The commissioner shall provide each insurer with a reporting form which shall be filed annually with the commissioner by which the commissioner can monitor each insurer's continued compliance with the standards of business conduct required for the continuation of the exemption.

(4) If the commissioner finds after a hearing held pursuant to Act No. 306 of the Public Acts of 1969, as amended, that an insurer no longer qualifies for the exemption granted under this section, the commissioner shall issue an order to that effect. Beginning 6 months after the date of an order issued under this subsection, the insurer shall be fully subject to all the provisions of this chapter and shall not be permitted to requalify for an exemption under this section.

(5) An exemption under this section shall not be granted to any insurer that directly, or indirectly through 1 or more intermediaries, controls, or is controlled by, or is under common control with the insurer specified whose surplus as concerns policyholders is in excess of the amount stated in subsection (1).

(6) An insurer admitted to do business in this state after January 1, 1981 shall not be eligible to qualify for the exemption granted under this section.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2130 Rules requiring exchange of insurance claim information; liability.

Sec. 2130. (1) The commissioner shall promulgate rules requiring insurers to exchange automobile and home insurance claim information necessary to effectuate compliance with this chapter.

(2) There shall be no civil liability on the part of, and a cause of action of any nature shall not arise against, the commissioner, an insurer, or an authorized representative, agent, employee, or affiliate of the commissioner or an insurer, for acts or omissions, other than acts made with gross negligence or in bad faith with malice in fact, related to the exchange of claim information.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2131 Effective date of MCL 500.2101 to 500.2105, 500.2107, and 500.2131; effective date of chapter generally.

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Sec. 2131. Sections 2101 to 2105, 2107, and this section shall take effect January 1, 1980. The balance of this chapter shall take effect January 1, 1981.

History: Add. 1979, Act 145, Eff. Jan. 1, 1980.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.2134-500.2138 Repealed. 1991, Act 191, Eff. Apr. 1, 1992.

Compiler's note: The repealed sections pertained to requirements for an insurer transacting automobile insurance in state, verification of existence of automobile, and filing report of theft as condition to claim payment.

Popular name: Act 218

CHAPTER 21a
CREDIT INFORMATION AND CREDIT SCORES

500.2151 Definitions.

Sec. 2151. As used in this chapter:

(a) "Adverse action" means an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any personal insurance, existing or applied for.

(b) "Consumer reporting agency" means any person that, for monetary fees or dues or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

(c) "Credit information" means any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. Information that is not credit-related must not be considered credit information, regardless of whether it is contained in a credit report or in an application, or is used to calculate an insurance score.

(d) "Credit report" means any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, or credit capacity that is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in the rating of personal insurance.

(e) "Credit score" means the numerical score ranging from 300 to 850 assigned by a consumer reporting agency to measure credit risk and includes FICO credit score.

(f) "Insurance score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured.

(g) "Personal insurance" means property/casualty insurance written for personal, family, or household use, including automobile, home, motorcycle, mobile home, noncommercial dwelling fire, boat, personal watercraft, snowmobile, and recreational vehicle, whether written on an individual, group, franchise, blanket policy, or similar basis.

History: Add. 2012, Act 165, Eff. Mar. 28, 2013;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.2153 Credit information or insurance score; use.

Sec. 2153. An insurer shall not use credit information or an insurance score as any part of a decision to deny, cancel, or nonrenew a personal insurance policy under chapters 21, 24, and 26. However, credit information and an insurance score may be used to determine premium installment payment options and availability. An insurer shall not apply credit information or a credit-based insurance score that is otherwise permitted under this act unless all of the following are met:

(a) The insurer or its producer discloses, either on the insurance application or at the time the application is taken, that it may obtain credit information in connection with the application. This disclosure shall be either written or provided to an applicant in the same medium as the application for insurance. An insurer may use the following disclosure statement:

"In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score.".

(b) The insurer or a third party on behalf of the insurer does not use income, gender, address, zip code, ethnic group, religion, marital status, or nationality of the insured or insurance applicant in calculating an

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insurance score.

(c) The insurer does not take an adverse action against a consumer because he or she does not have a credit card account. However, an insurer may take an adverse action against that insured if it is based on any other applicable factor that is independent of the fact that the consumer does not have a credit card account.

(d) The insurer or a third party on behalf of the insurer does not consider an absence of credit information or an inability to calculate an insurance score in the rating of personal insurance unless any resulting rate differential is filed with and not disapproved by the office of financial and insurance regulation. The office of financial and insurance regulation shall not disapprove a filing under this subdivision if it meets 1 of the following:

(*i*) Is reasonably justified by differences in losses, expenses, or both.

(*ii*) Provides the insured or insurance applicant with a discount that is not less, on average, than the average credit based discount received by the insurer's insureds in this state.

(e) The insurer or a third party on the insurer's behalf uses a credit report issued within 90 days before the date an insurance score based on that credit report is first applied to the insured.

(f) Upon the insured's request or with the insured's permission the insured's producer's request at annual renewal, or upon the insured's request during the course of the policy, an insurer or a third party on the insurer's behalf shall obtain a new credit report or insurance score and rerate the insured. An insurer or a third party on the insurer's behalf is not required to obtain a new credit report or recalculate the insurance score more frequently than once in a 12-month period. An insurer or a third party on the insurer's behalf may order a credit report upon any renewal if the insurer does so using a consistent methodology with all its insureds.

(g) For insurance scores calculated or recalculated on or after the effective date of the amendatory act that added this section, the insurer or a third party on the insurer's behalf does not use the following as a negative factor in any insurance score or in reviewing credit information:

(*i*) Credit inquiries not initiated by the consumer or requested by the consumer for his or her own credit information.

(*ii*) Credit inquiries relating to insurance coverage, if so identified on an insured's or insurance applicant's credit report.

(*iii*) Multiple lender inquiries, if coded by the consumer reporting agency on the credit report as being from the home mortgage industry and made within 30 days of one another, unless only 1 inquiry is considered.

(*iv*) Multiple lender inquiries, if coded by the consumer reporting agency on the credit report as being from the automobile lending industry and made within 30 days of one another, unless only 1 inquiry is considered.

(*v*) Collection accounts with a medical industry code, if so identified on the consumer's credit report.

History: Add. 2012, Act 206, Eff. Mar. 28, 2013.

Popular name: Act 218

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500.2154 Reasonable exceptions.

Sec. 2154. (1) Notwithstanding any other law, rule, or regulation, an insurer that uses credit information shall, on written request from an insured or insurance applicant, provide reasonable exceptions to the application of that credit information on the insurer's rates, rating classifications, or company or tier placement for an insured or insurance applicant who has experienced and whose credit information has been directly influenced by any of the following events:

(a) Catastrophic event, as declared by the federal or state government.

(b) Serious illness or injury, or serious illness or injury to an immediate family member.

(c) Death of a spouse, child, or parent.

(d) Divorce or involuntary interruption of legally owed alimony or support payments.

(e) Identity theft.

(f) Temporary loss of employment for a period of 3 months or more, if it results from involuntary termination.

(g) Military deployment overseas.

(h) Predatory lending resulting in the foreclosure of, or commencement of proceedings or an action to foreclose, a mortgage of real property owned by the insured or insurance applicant.

(i) Other events, as determined by the insurer.

(2) If an insured or insurance applicant submits a request for an exception under subsection (1), an insurer may, but is not required to do, any of the following:

(a) Require a reasonable written and independently verifiable documentation of the event.

(b) Require the insured or insurance applicant to demonstrate that the event had direct and meaningful impact on the insured's or insurance applicant's credit information.

(c) Require a request to be made no more than 60 days from the date of the application for insurance or the

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policy renewal.

(d) Grant an exception even if the insured or insurance applicant did not provide an initial request for an exception in writing.

(e) Grant an exception where the insured or insurance applicant asks for consideration of repeated events or the insurer has considered this event previously.

(3) A law, rule, or regulation relating to underwriting, rating, or rate filing is not violated by any insurer as a result of granting an exception under this section.

(4) The insurer shall provide notice to insureds and insurance applicants that reasonable exceptions are available and information about how to inquire further.

(5) Within 30 days of the insurer's receipt of sufficient documentation of an event described in subsection (1), the insurer shall inform the insured or insurance applicant of the outcome of his or her request for a reasonable exception. This communication shall be in writing or provided in the same medium as the request for a reasonable exception.

History: Add. 2012, Act 207, Eff. Mar. 28, 2013.

Popular name: Act 218

500.2156 Notice of adverse action.

Sec. 2156. If an insurer takes an adverse action based upon credit information, the insurer shall notify the insured or applicant for insurance in accordance with 15 USC 1681m(a), that an adverse action has been taken. The insurer shall provide notice in clear and specific language of the reasons for the adverse action, including a description of all factors that were the primary or most significant influences for the adverse action and the insured's or the applicant's insurance score if not otherwise provided. However, not more than 4 factors for the adverse action need to be given. The use of generalized terms such as "poor credit history", "poor credit rating", or "poor insurance score" does not meet the description requirements of this section. Standardized credit explanations provided by consumer reporting agencies or other third party vendors meet the description requirements of this section.

History: Add. 2012, Act 206, Eff. Mar. 28, 2013.

Popular name: Act 218

500.2157 Incorrect or incomplete credit information; adjustments.

Sec. 2157. If it is determined through the dispute resolution process set forth in 15 USC 1681i(a) that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of this determination from either the consumer reporting agency or from the insured, the insurer shall reevaluate the insured within 30 days of receiving the notice. After reevaluating the insured, the insurer shall make any adjustments necessary, consistent with this act and the insurer's underwriting, rating guidelines, and premium discount plan. If an insurer determines that the insured has overpaid premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last 12 months of coverage or the actual policy period.

History: Add. 2012, Act 208, Eff. Mar. 28, 2013.

Popular name: Act 218

500.2159 Cause of action; construction of chapter.

Sec. 2159. Nothing in this chapter shall be construed to provide an insured or applicant for insurance with a cause of action that does not exist in the absence of this chapter.

History: Add. 2012, Act 205, Eff. Mar. 28, 2013.

Popular name: Act 218

500.2161 Use of credit information or insurance scores; liability, fees, and costs arising out of actions, errors, or omissions.

Sec. 2161. An insurer shall indemnify, defend, and hold harmless producers from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of a producer resulting from the use of credit information or insurance scores for the insurer, provided that the producer follows the procedures and instructions established by the insurer and complies with all applicable laws and regulations.

History: Add. 2012, Act 205, Eff. Mar. 28, 2013.

Popular name: Act 218

500.2162 Use of credit score to establish rates or rating classification for automobile insurance; prohibition.

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Sec. 2162. An insurer shall not use an individual's credit score to establish or maintain rates or rating classifications for automobile insurance.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

CHAPTER 22
THE INSURANCE CONTRACT

500.2204 Settlement of action brought by third party against person insured under commercial liability insurance policy; notice to insured required.

Sec. 2204. Prior to a trial, an insurer shall not settle an action brought by a third party against a person insured under a commercial liability insurance policy issued by the insurer, unless the insurer gives the insured notice of the settlement at least 10 days prior to the settlement. As used in this section, "commercial liability insurance" means insurance which provides indemnification for commercial, industrial, professional, or business liabilities.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

500.2205 Minor's contracts for insurance.

Sec. 2205. A contract for life or disability insurance made by a person between the ages of 16 and 18 years for his benefit, or for the benefit of his father, mother, husband, wife, child, brother or sister, or for the surrender of the insurance, or for the discharge of money payable or benefit accruing thereunder, shall be good and of the same force and effect as though the minor had attained his majority at the time of making the contract. This section shall not have the effect of making a promissory note or other evidence of indebtedness given by a minor in payment of premium or premiums on contracts for insurance valid, either in the hands of the original owner or a subsequent purchaser thereof.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1972, Act 47, Imd. Eff. Feb. 19, 1972.

Popular name: Act 218

500.2206 Repealed. 2014, Act 140, Eff. Mar. 31, 2015.

Compiler's note: The repealed section pertained to minor's capacity to receive insurance benefits.

500.2207 Insurable interest; personal insurance; rights of beneficiaries, creditors.

Sec. 2207. (1) It shall be lawful for any husband to insure his life for the benefit of his wife, and for any father to insure his life for the benefit of his children, or of any one or more of them; and in case that any money shall become payable under the insurance, the same shall be payable to the person or persons for whose benefit the insurance was procured, his, her or their representatives or assigns, for his, her or their own use and benefit, free from all claims of the representatives of such husband or father, or of any of his creditors; and any married woman, either in her own name or in the name of any third person as her trustee, may cause to be insured the life of her husband, or of any other person, for any definite period, or for the term of life, and the moneys that may become payable on the contract of insurance, shall be payable to her, her representatives or assigns, free from the claims of the representatives of the husband, or of such other person insured, or of any of his creditors; and in any contract of insurance, it shall be lawful to provide that on the decease of the person or persons for whose benefit it is obtained, before the sum insured shall become payable, the benefit thereof shall accrue to any other person or persons designated; and such other person or persons shall, on the happening of such contingency, succeed to all the rights and benefits of the deceased beneficiary or beneficiaries of the policy of insurance, notwithstanding he, she or they may not at the time have any such insurable interest as would have enabled him, her or them to obtain a new insurance; and the proceeds of any policy of life or endowment insurance, which is payable to the wife, husband or children of the insured or to a trustee for the benefit of the wife, husband or children of the insured, including the cash value thereof, shall be exempt from execution or liability to any creditor of the insured; and said exemption shall apply to insurance heretofore or hereafter issued; and shall apply to insurance payable to the above enumerated persons or classes of persons, whether they shall have become entitled thereto as originally designated beneficiaries, by beneficiary designation subsequent to the issuance of the policy, or by assignment (except in case of transfer with intent to defraud creditors).

(2) If a policy of insurance, or contract of annuity (whether heretofore or hereafter issued) is effected by any person on his own life or on another life in favor of a person other than himself, or (except in cases of transfer with intent to defraud creditors) if a policy of life insurance is assigned or in any way made payable

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to any such person, the lawful beneficiary or assignee thereof (other than the insured or the person so effecting such insurance, or his executors or administrators) shall be entitled to the proceeds and avails (including the cash value thereof) against the creditors and representatives of the insured and of the person effecting the same, (whether or not the right to change the beneficiary is reserved or permitted and whether or not the policy is made payable in the event that the beneficiary or assignee shall predecease such person, to the person whose life is insured or the person effecting the insurance): Provided, That, subject to the statute of limitations, the amount of any premiums for said insurance paid with intent to defraud creditors, with interest thereon, shall inure to their benefit from the proceeds of the policy: Provided further, That proof that such transfer was made and a particular debt or claim existed at the time of such transfer shall be prima facie evidence of intent to defraud said creditor as to said debt or claim; but the company issuing the policy shall be discharged of all liability thereon by payment of its proceeds in accordance with its terms, unless before such payment the company shall have written notice at its home office, by or in behalf of a creditor of a claim to recover for transfer made or premiums paid with intent to defraud creditors, with specification of the amount claimed.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2209 Insurable interest; married woman; right to proceeds, devise.

Sec. 2209. (1) It shall be lawful for any married woman, by herself, and in her name or in the name of any third person, with his assent, as her trustee, to cause to be insured for her sole use, the life of her husband or the life of any other person, in any life insurance company of any nature whatever, located in either of the states of the United States of America or in Great Britain, for any definite period, or for the term of his natural life; and in case of her surviving her husband, or such other person insured in her behalf, the sum or net amount of the policy of insurance due and payable by the terms of the insurance, shall be payable to her, to and for her own use, free from the claims of the representatives of her husband, or of such other person insured, or of any of his creditors, but such exemption shall not apply where the amount of premium annually paid shall exceed the sum of $300.00.

(2) In case of the death of the wife before the decease of her husband, or of such other person insured, the amount of the insurance may be made payable after her death to her children, for their use, and to their guardian, if under age, or the amount of the policy may be disposed of by such married woman by a last will and testament.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2210 Definitions; insurable interest; employer; trust; exemption from claims.

Sec. 2210. (1) As used in this section:

(a) "Employee benefit plan" means that term as defined by the employee retirement income security act of 1974, Public Law 93-406, 88 Stat. 829.

(b) "Employer" means an individual, sole proprietorship, partnership, firm, corporation, association, or any other legal entity, which has 1 or more employees and is legally doing business in this state.

(c) "Trust" means a trust established by an employer.

(2) Notwithstanding any other section of this act, an employer or a trust has an insurable interest in, and may, with the written consent of the insured, insure on an individual or group basis for its benefit the lives of the employer's directors, officers, managers, nonmanagement employees, and retired employees. An employer or a trust may insure the lives of the employer's nonmanagement employees and its retired employees only if those persons give written consent to be insured and the coverage is limited to an amount reasonably commensurate with the employer's projected unfunded liabilities to nonmanagement and retired employees for employee benefit plans, calculated according to accepted actuarial principles. An employer shall not retaliate in any manner against an employee or a retired employee for refusing consent to be insured.

(3) Notwithstanding any other section of this act, a trust maintained for the purpose of providing for the cost of benefits under an employee benefit plan maintained for employees or retired employees has an insurable interest in, and may, with the acquiescence of the insured, insure on an individual or group basis for its benefit the lives of the employer's directors, officers, managers, nonmanagement employees, and retired employees. A trust may insure the life of a nonmanagement employee and a retired employee only if that person is given written notice of the coverage, he or she has not notified either the employer or the trust in writing that he or she does not want to be insured for the coverage, and the coverage is limited to an amount reasonably commensurate with the employer's projected unfunded liabilities to nonmanagement and retired employees for employee benefit plans, calculated according to accepted actuarial principles. An employer or a

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trust shall not retaliate in any manner against an employee or a retired employee for providing the written notice that he or she does not want to be insured for the coverage.

(4) The proceeds of any policy or certificate issued pursuant to subsection (2) or (3) are exempt from the claims of any creditor or dependent of the insured.

History: Add. 1990, Act 349, Eff. Mar. 28, 1991;—Am. 1994, Act 227, Imd. Eff. June 27, 1994;—Am. 1998, Act 222, Imd. Eff. July 1, 1998.

Popular name: Act 218

500.2210a Trustee having insurable interest under MCL 700.7114.

Sec. 2210a. A trustee of a trust has an insurable interest in the life of an individual as provided in section 7114 of the estates and protected individuals code, 1998 PA 386, MCL 700.7114.

History: Add. 2014, Act 7, Imd. Eff. Feb. 11, 2014.

Popular name: Act 218

500.2211 Consent of insured.

Sec. 2211. (1) Any individual who has an insurable interest in the life of another human being shall not insure that other human being's life for the individual's benefit unless the human being whose life is to be insured consents to be insured in writing. That person's signature on the application for insurance constitutes consent.

(2) This section applies to life insurance policies and certificates of $10,000.00 or more delivered or issued for delivery in this state on and after 30 days after the effective date of this section. This section does not apply if the human being whose life is to be insured is less than 18 years of age.

History: Add. 1998, Act 91, Imd. Eff. May 14, 1998.

Popular name: Act 218

500.2212 Insurable interest in life of individual.

Sec. 2212. Notwithstanding any other section of this act, an organization described in and qualified under section 501(c)(3) of the internal revenue code of 1986, 26 U.S.C. 501, has an insurable interest in the life of an individual who gives written consent to the ownership or purchase of a policy on his or her life.

History: Add. 1996, Act 572, Imd. Eff. Jan. 16, 1997.

Popular name: Act 218

500.2212a Health insurance policy; written summary requirements; style, arrangement and appearance of policy; electronic copy permissible; "board certified" defined.

Sec. 2212a. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall provide a written summary of the health insurance policy in plain English to insureds. The written summary must provide a clear, complete, and accurate description of all of the following, as applicable:

(a) Uniform definitions of standard insurance terms and medical terms so that a consumer may compare health coverage and understand the terms of, or exceptions to, the consumer's coverage, in accordance with the most recent guidance issued by the United States Department of Health and Human Services.

(b) A description of the coverage, including cost sharing, for each category of benefits in the most recent guidance issued by the United States Department of Health and Human Services.

(c) The exceptions, reductions, and limitations of the health insurance policy.

(d) The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations.

(e) The renewability and continuation of coverage provisions.

(f) Coverage examples.

(g) A statement about whether the health insurance policy provides minimum essential coverage as defined under section 5000A(f) of the internal revenue code of 1986, 26 USC 5000A, and whether the health insurance policy's share of the total allowed costs of benefits provided under the health insurance policy meets applicable requirements.

(h) A statement that the summary is only a summary and that the health insurance policy should be consulted to determine the governing contractual provisions of the coverage.

(i) Contact information for questions.

(j) An internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

(k) For insurers that maintain 1 or more networks of providers, instructions for obtaining a list of network providers.

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(*l*) For insurers that use a formulary in providing prescription drug coverage, instructions for obtaining information on prescription drug coverage.

(m) Instructions for obtaining the uniform glossary, as described in subdivision (c), and a contact telephone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

(2) An insurer, or a group health plan to the extent the group health plan has contractually agreed to distribute the written summary under subsection (1), shall provide the written summary under subsection (1) as follows:

(a) To the applicant not later than 7 business days after the date of the receipt of the application.

(b) By the first date of coverage if the information provided at the time of application has changed.

(c) To the insured not later than 30 days after the effective date of a renewal of the policy.

(d) On request of the insured, not later than 7 days after the request.

(3) An insurer shall provide on request to insureds covered under a policy issued under section 3405 a clear, complete, and accurate description of any of the following information that has been requested:

(a) The current provider network in the service area, including names and locations of affiliated or participating providers by specialty or type of practice, a statement of limitations of accessibility and referrals to specialists, and a disclosure of which providers will not accept new subscribers.

(b) The professional credentials of affiliated or participating providers, including, but not limited to, affiliated or participating providers who are board certified in the specialty of pain medicine and the evaluation and treatment of pain and have reported that certification to the insurer, including all of the following:

(*i*) Relevant professional degrees.

(*ii*) Date of certification by the applicable nationally recognized boards and other professional bodies.

(*iii*) The names of licensed facilities on the provider panel where the provider currently has privileges for the treatment, illness, or procedure that is the subject of the request.

(c) The licensing verification telephone number for the department of licensing and regulatory affairs that can be accessed for information as to whether any disciplinary actions or open formal complaints have been taken or filed against a health care provider in the preceding 3 years.

(d) Any prior authorization requirements and any limitations, restrictions, or exclusions, including, but not limited to, drug formulary limitations and restrictions by category of service, benefit, and provider, and, if applicable, by specific service, benefit, or type of drug.

(e) The financial relationships between the insurer and any closed provider panel, including all of the following as applicable:

(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.

(*ii*) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.

(*iii*) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

(f) A telephone number and address to obtain from the insurer additional information concerning the items described in subdivisions (a) to (e).

(4) On request, any of the information provided under subsection (3) must be provided in writing. An insurer may require that a request under subsection (2) be submitted in writing.

(5) A health insurer shall not deliver or issue for delivery a policy of insurance to any person in this state unless all of the following requirements are met:

(a) The style, arrangement, and overall appearance of the policy do not give undue prominence to any portion of the text. Every printed portion of the text of the policy and of any endorsements or attached papers must be plainly printed in light-faced type of a style in general use, the size of which must be uniform and not less than 10-point with a lowercase unspaced alphabet length, not less than 120-point in length of line. As used in this subdivision, "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions.

(b) Except as otherwise provided in this subdivision or except as provided in sections 3406 to 3452, exceptions and reductions of indemnity are set forth in the policy and are printed, at the insurer's option, with the benefit provision to which they apply or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS". If an exception or reduction of indemnity specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

(c) Each form, including riders and endorsements, is identified by a form number in the lower left-hand corner of the first page of the form.

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(d) The policy contains no provision that purports to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy. This subdivision does not apply to the incorporation of or reference to a statement of rates, classification of risks, or short-rate table filed with the director.

(6) Subject to section 2266, the information required under this section may be provided electronically.

(7) As used in this section, "board certified" means certified to practice in a particular medical or other health professional specialty by the American Board of Medical Specialties, the American Osteopathic Association Bureau of Osteopathic Specialists, or another appropriate national health professional organization.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997;—Am. 1998, Act 424, Eff. Apr. 1, 1999;—Am. 2001, Act 235, Imd. Eff. Jan. 3, 2002;—Am. 2016, Act 276, Imd. Eff. July 1, 2016;—Am. 2023, Act 161, Eff. Feb. 13, 2024.

Compiler's note: Enacting section 1 of Act 235 of 2001 provides:

"Enacting section 1. The 2001 amendatory act that added section 2212a(4) to the insurance code of 1956, 1956 PA 218, MCL 500.2212a, shall not be construed as creating a new mandated benefit for any coverages issued under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302."

Popular name: Act 218

500.2212b Policy issued under MCL 550.3405 and to health maintenance organization contract; applicability; termination of affiliation or participation between primary care physician and insurer; notice to insured; effect of termination; definitions.

Sec. 2212b. (1) This section applies to a policy issued under section 3405 and to a health maintenance organization contract.

(2) If affiliation or participation between a primary care physician and an insurer terminates, the physician may provide written notice of this termination within 15 days after the physician becomes aware of the termination to each insured who has chosen the physician as his or her primary care physician. If an insured is in an ongoing course of treatment with any other physician that is affiliated or participating with the insurer and the affiliation or participation between the physician and the insurer terminates, the physician may provide written notice of this termination to the insured within 15 days after the physician becomes aware of the termination. The notices under this subsection may also describe the procedure for continuing care under subsections (3) and (4).

(3) If affiliation or participation between an insured's current physician and an insurer terminates, the insurer shall permit the insured to continue an ongoing course of treatment with that physician as follows:

(a) For 90 days after the date of notice to the insured by the physician of the physician's termination with the insurer.

(b) If the insured is in her second or third trimester of pregnancy at the time of the physician's termination, through postpartum care directly related to the pregnancy.

(c) If the insured is determined to have an advanced illness before a physician's termination or knowledge of the termination and the physician was treating the advanced illness before the date of termination or knowledge of the termination, for the remainder of the insured's life for care directly related to the treatment of the advanced illness.

(4) Subsection (3) applies only if the physician agrees to all of the following:

(a) To continue to accept as payment in full reimbursement from the insurer at the rates applicable before the termination.

(b) To adhere to the insurer's standards for maintaining quality health care and to provide to the insurer necessary medical information related to the care.

(c) To otherwise adhere to the insurer's policies and procedures, including, but not limited to, those concerning utilization review, referrals, preauthorizations, and treatment plans.

(5) An insurer shall provide written notice to each affiliated or participating physician that if affiliation or participation between the physician and the insurer terminates, the physician may do both of the following:

(a) Notify the insurer's insureds under the care of the physician of the termination if the physician does so within 15 days after the physician becomes aware of the termination.

(b) Include in the notice under subdivision (a) a description of the procedures for continuing care under subsections (3) and (4).

(6) This section does not create an obligation for an insurer to provide to an insured coverage beyond the maximum coverage limits permitted by the insurer's policy or certificate with the insured. This section does not create an obligation for an insurer to expand who may be a primary care physician under a policy or certificate.

(7) As used in this section:

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(a) "Advanced illness" means that term as defined in section 5653 of the public health code, 1978 PA 368, MCL 333.5653.

(b) "Physician" means an allopathic physician, osteopathic physician, or podiatric physician.

(c) "Terminates" or "termination" includes the nonrenewal, expiration, or ending for any reason of a participation agreement or affiliated provider contract between a physician and an insurer, but does not include a termination by the insurer for failure to meet applicable quality standards or for fraud.

History: Add. 1999, Act 230, Eff. July 1, 2000;—Am. 2000, Act 486, Imd. Eff. Jan. 11, 2001;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.2212c Prescription drug prior authorization workgroup; creation; development of methodology; prior authorization request; definitions.

Sec. 2212c. (1) By January 1, 2015, the workgroup shall develop a standard prior authorization methodology for use by prescribers to request and receive prior authorization from an insurer if a health benefit plan requires prior authorization for prescription drug benefits. The workgroup shall include in the standard prior authorization methodology the ability for the prescriber to designate the prior authorization request for expedited review. In order to designate a prior authorization request for expedited review, the prescriber shall certify that applying the review period under section 2212e(10) may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

(2) A prescription drug prior authorization workgroup is created. The department of health and human services and the department shall work together and appoint members to the workgroup. The workgroup must consist of a member who represents the department of health and human services, a member who represents the department, and members who represent insurers, prescribers, pharmacists, hospitals, and other stakeholders as determined necessary by the department of health and human services and the department. The workgroup shall appoint a chairperson from among its members. The chairperson of the workgroup shall schedule workgroup meetings. The department of health and human services and the department shall organize the initial meeting of the workgroup and shall provide administrative support for the workgroup.

(3) In developing the standard prior authorization methodology under subsection (1), the workgroup shall consider all of the following:

(a) Existing and potential technologies that could be used to transmit a standard prior authorization request.

(b) The national standards pertaining to electronic prior authorization developed by the National Council for Prescription Drug Programs.

(c) Any prior authorization forms and methodologies used in pilot programs in this state.

(d) Any prior authorization forms and methodologies developed by the Centers for Medicare and Medicaid Services.

(4) Beginning March 14, 2014, an insurer may specify in writing the materials and information necessary to constitute a properly completed standard prior authorization request if a health benefit plan requires prior authorization for prescription drug benefits.

(5) If the workgroup develops a paper form as the standard prior authorization methodology under subsection (1), the paper form must meet all of the following requirements:

(a) Consist of not more than 2 pages. However, an insurer may request and require additional information beyond the 2-page limitation of this subdivision, if that information is specified in writing by the insurer under subsection (4). As used in this subdivision, "additional information" includes, but is not limited to, any of the following:

(*i*) Patient clinical information including, but not limited to, diagnosis, chart notes, lab information, and genetic tests.

(*ii*) Information necessary for approval of the prior authorization request under plan criteria.

(*iii*) Drug specific information including, but not limited to, medication history, duration of therapy, and treatment use.

(b) Be electronically available.

(c) Be electronically transmissible, including, but not limited to, transmission by facsimile or similar device.

(6) Beginning July 1, 2016, if an insurer uses a prior authorization methodology that utilizes an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system, the prior authorization methodology described in subsection (5) does not apply. Subsection (4) and section 2212e apply to a prior authorization methodology that utilizes an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system.

(7) Beginning July 1, 2016, except as otherwise provided in subsection (6), an insurer shall use the

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standard prior authorization methodology developed under subsection (1) if a health benefit plan requires prior authorization for prescription drug benefits.

(8) As used in this section:

(a) "Health benefit plan" means that term as defined in section 2212e.

(b) "Insurer" means any of the following:

(*i*) An insurer that delivers, issues for delivery, renews, or administers a health benefit plan.

(*ii*) A health maintenance organization.

(*iii*) A health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

(*iv*) For purposes of this section and section 2212e only, a third party administrator of prescription drug benefits. As used in this subparagraph, "third party administrator" means that term as defined in section 2 of the third party administrator act, 1984 PA 218, MCL 550.902.

(c) "Prescriber" means that term as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708.

(d) "Prescription drug" means that term as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708.

(e) "Prescription drug benefit" means the right to have a payment made by an insurer for a prescription drug listed on the applicable formulary in accordance with coverage contained within a health benefit plan delivered, issued for delivery, or renewed in this state.

(f) "Workgroup" means the prescription drug prior authorization workgroup created under subsection (2).

History: Add. 2013, Act 30, Eff. Mar. 14, 2014;—Am. 2022, Act 60, Imd. Eff. Apr. 7, 2022.

Popular name: Act 218

500.2212d National or regional certification of physician; condition of payment or reimbursement by insurer or health maintenance organization; prohibited.

Sec. 2212d. An insurer that delivers, issues for delivery, or renews in this state a health insurance policy issued under chapter 34 or a health maintenance organization that issues a health maintenance contract under chapter 35 shall not require as the sole condition precedent to the payment or reimbursement of a claim under the policy or contract that an allopathic or osteopathic physician in the medical specialties of family practice, internal medicine, or pediatrics maintain a national or regional certification not otherwise specifically required for licensure under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

History: Add. 2018, Act 487, Imd. Eff. Dec. 27, 2018.

Popular name: Act 218

500.2212e Standard electronic prior authorization transaction process; requirements; adverse determination process; denial and appeals; standard report; modification program; definitions.

Sec. 2212e. (1) For an insurer that delivers, issues for delivery, renews, or administers a health benefit plan in this state, if the health benefit plan requires a prior authorization with respect to any benefit, the insurer or its designee utilization review organization shall, by June 1, 2023, make available a standardized electronic prior authorization request transaction process utilizing an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system. Beginning June 1, 2023, an insurer described in this subsection or its designee utilization review organization and the health professional shall perform a prior authorization utilizing only a standard electronic prior authorization transaction process, which allows the transmission of clinical information, unless the health professional is not able to use the standard electronic prior authorization transaction process because of a temporary technological or electrical failure. The current prior authorization requirements must be described in detail and written in easily understandable language. An insurer described in this subsection or its designee utilization review organization shall make any current prior authorization requirements and restrictions, including the written clinical review criteria, readily accessible and conspicuously posted on its website to insureds, enrollees, health professionals, and health care providers. Content published by a third party and licensed for use by an insurer described in this subsection or its designee utilization review organization may be made available through the insurer or its designee utilization review organization's secure, password-protected website if the access requirements of the website do not unreasonably restrict access to the content. The prior authorization requirements must be based on peer-reviewed clinical review criteria. All of the following apply to clinical review criteria under this subsection:

(a) Unless the criteria are developed as described in subdivision (g), the clinical review criteria must be

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criteria developed by either of the following:

(*i*) An entity to which both of the following apply:

(A) The entity works directly with clinicians, either within the organization or outside the organization, to develop the clinical review criteria.

(B) The entity does not receive direct payments based on the outcome of the clinical care decision.

(*ii*) A professional medical specialty society.

(b) The clinical review criteria must take into account the needs of atypical patient populations and diagnoses.

(c) The clinical review criteria must ensure quality of care and access to needed health care services.

(d) The clinical review criteria must be evidence-based criteria.

(e) The clinical review criteria must be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis.

(f) The clinical review criteria must be evaluated and updated, if necessary, at least annually.

(g) For coverage other than prescription drug benefit coverage, before establishing, or substantially or materially altering, its own written clinical review criteria, an insurer or its designee utilization review organization must obtain input from actively practicing licensed physicians representing major areas of the specialty. For coverage of a prescription drug benefit, before establishing, or substantially or materially altering, its own clinical review criteria, an insurer or its designee utilization review organization must obtain input from actively practicing licensed pharmacists or actively practicing licensed physicians. If criteria are developed for a health care service provided by a health professional not licensed to engage in the practice of medicine under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556, an insurer or designee utilization review organization must also seek input from a health professional in the same profession as the health professional providing the health care service.

(2) An insurer described in subsection (1) shall make available on the insurer's public website in a readily accessible format a list of all benefits that are subject to a prior authorization under the health benefit plan.

(3) If an insurer described in subsection (1) implements a new prior authorization requirement or restriction, or amends an existing requirement or restriction, with respect to any benefit under a health benefit plan, the insurer shall ensure that the new or amended requirement or restriction is posted on the insurer's public website before its implementation. For a benefit that does not involve coverage of a prescription drug, an insurer shall notify contracted health care providers via the insurer's provider portal of the new or amended requirement or restriction not less than 60 days before the requirement or restriction is implemented. For coverage of a prescription drug, an insurer shall make available on the insurer's public website or notify contracted health care providers via the insurer's provider portal of the new or amended requirement or restriction not less than 45 days before the requirement or restriction is implemented unless any of the following apply:

(a) The United States Food and Drug Administration has done any of the following:

(*i*) Issued a statement that calls into question the clinical safety of the drug.

(*ii*) Required the manufacturers to conduct postmarket safety studies and clinical trials after the approval of the drug.

(*iii*) Issued any drug safety-related labeling changes.

(*iv*) Required the manufacturers to implement special risk management programs.

(b) The drug receives a new United States Food and Drug Administration approval and has become available.

(c) The United States Food and Drug Administration has approved expanded use of the drug.

(4) The initial review of information submitted in support of a request for prior authorization may be conducted and approved by a health professional.

(5) For an adverse determination regarding a request for prior authorization for a benefit other than a prescription drug, the adverse determination must be made by a licensed physician. For an adverse determination of a health care service provided by a health professional that is not a licensed physician, a licensed physician may consider input from a health professional who is in the same profession as the health professional providing the health care service. The licensed physician shall make the adverse determination under this subsection under the general direction of the insurer's medical director who oversees the utilization management program. Medical directors under this subsection must be licensed to engage in the practice of medicine under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or the practice of osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556.

(6) For an adverse determination regarding a request for prior authorization for a prescription drug, the

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adverse determination must be made by a licensed pharmacist or licensed physician. The licensed pharmacist or licensed physician shall make the adverse determination under this subsection under the general direction of the insurer's medical director who oversees the utilization management program. Medical directors under this subsection must be licensed to engage in the practice of medicine under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or the practice of osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556.

(7) If an insurer described in subsection (1) denies a prior authorization, the insurer or its designee utilization review organization shall, on issuing a benefit denial, notify the health professional and insured or enrollee of all of the following:

(a) The reasons for the denial and related evidence-based criteria.

(b) The right to appeal the adverse determination.

(c) Instructions on how to file the appeal.

(d) Additional documentation necessary to support the appeal.

(8) Subject to subsection (9) an appeal of the denial under subsection (7) must be reviewed by a health professional to which all of the following apply:

(a) The health professional does not have a direct financial stake in the outcome of the appeal.

(b) The health professional has not been involved in making the adverse determination.

(c) The health professional considers all known clinical aspects of the health care services under review, including, but not limited to, a review of all pertinent medical records provided to the insurer or designee utilization review organization by the insured or enrollee's health care provider and any relevant records provided to the insurer or designee utilization review organization by a health care facility.

(d) The health professional may consider input from a health professional who is licensed in the same profession as the health professional providing the health care service or a licensed pharmacist if the adverse decision is regarding a prescription drug.

(9) An insurer or its designee utilization review organization shall not affirm the denial of an appeal under subsection (8) unless the appeal is reviewed by a licensed physician who is board certified or eligible in the same specialty as a health care provider who typically manages the medical condition or disease or provides the health care service. However, if an insurer or its designee utilization review organization cannot identify a licensed physician who meets the requirements described in this subsection without exceeding the applicable time limits imposed under subsection (10), the insurer or its designee utilization review organization may utilize a licensed physician in a similar specialty as considered appropriate, as determined by the insurer or its designee utilization review organization.

(10) Beginning June 1, 2023 through May 31, 2024, a prior authorization request under this section that has not been certified as urgent by the health care provider is considered granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails to grant the request, deny the request, or require additional information of the health care provider within 9 calendar days after the date and time of submission of the prior authorization. After May 31, 2024, a prior authorization request under this section that has not been certified as urgent by the health care provider is considered granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails to grant the request, deny the request, or require additional information of the health care provider within 7 calendar days after the date and time of submission of the prior authorization. Beginning June 1, 2023 through May 31, 2024, if additional information is requested by an insurer or its designee utilization review organization, the prior authorization request is considered to have been granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails to grant the request, deny the request, or otherwise respond to the request of the health care provider within 9 calendar days after the date and time of the submission of additional information. After May 31, 2024, if additional information is requested by an insurer or its designee utilization review organization, the prior authorization request is considered to have been granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails to grant the request, deny the request, or otherwise respond to the request of the health care provider within 7 calendar days after the date and time of the submission of additional information.

(11) Beginning June 1, 2023, a prior authorization request under this section that has been certified as urgent by the health care provider is considered granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails to grant the request, deny the request, or require additional information of the health care provider within 72 hours after the date and time of submission of the prior authorization request. If additional information is requested by an insurer or its designee utilization review organization, the prior authorization request is considered to have been granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review

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organization fails to grant the request, deny the request, or otherwise respond to the request of the health care provider within 72 hours after the date and time of the submission of additional information.

(12) A prior authorization request granted under this section is valid for not less than 60 calendar days or for a duration that is clinically appropriate, whichever is later.

(13) By June 1, 2023, and each June 1 after that date, an insurer shall report to the department, on a form issued by the department, the following aggregated trend data related to the insurer's prior authorization practices and experience for the prior plan year:

(a) The number of prior authorization requests.

(b) The number of prior authorization requests denied.

(c) The number of appeals received.

(d) The number of adverse determinations reversed on appeal.

(e) Of the total number of prior authorization requests, the number of prior authorization requests that were not submitted electronically.

(f) The top 10 services that were denied.

(g) The top 10 reasons prior authorization requests were denied.

(14) By October 1, 2023, and each October 1 after that date, the department shall aggregate and deidentify the data collected under subsection (13) into a standard report and shall not identify the name of the insurer that submitted the data. The report must be written in easily understandable language and posted on the department's public internet website.

(15) All of the following apply to any data, documents, materials, or other information described in subsection (13) that has not been aggregated, deidentified, and otherwise compiled into the standard report described in subsection (14):

(a) The data, documents, materials, or other information is considered proprietary and to contain trade secrets.

(b) The data, documents, materials, or other information is confidential and privileged and is not subject to disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(16) An insurer described in subsection (1) shall adopt a program, developed in consultation with health care providers participating with the insurer, that promotes the modification of prior authorization requirements of certain prescription drugs, medical care, or related benefits, based on any of the following:

(a) The performance of health care providers with respect to adherence to nationally recognized evidence-based medical guidelines, appropriateness, efficiency, and other quality criteria.

(b) Involvement of contracted health care providers with an insurer described in subsection (1) to participate in a financial risk-sharing payment plan, that includes downside risk.

(c) Health provider specialty, experience, or other factors.

(17) As used in this section:

(a) "Adverse determination" means that term as defined in section 2213.

(b) "Evidence-based criteria" means criteria developed using evidence-based standards.

(c) "Evidence-based standard" means that term as defined in section 3 of the patient's right to independent review act, 2000 PA 251, MCL 550.1903.

(d) "Health benefit plan" means an individual or group health insurance policy, an individual or group health maintenance organization contract, or a self-funded plan established or maintained by this state or a local unit of government for its employees. Health benefit plan includes prescription drug benefits. Health benefit plan does not include the Medicaid program. As used in this subdivision, "Medicaid program" means the program for medical assistance established under title XIX of the social security act, 42 USC 1396 to 1396w-6.

(e) "Health care provider" means any of the following:

(*i*) A health facility as that term is defined in section 2006.

(*ii*) A health professional.

(f) "Health professional" means an individual licensed, registered, or otherwise authorized to engage in a health profession under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, or under the laws of another state to engage in a health profession.

(g) "Insurer" means that term as defined in section 2212c.

(h) "Licensed pharmacist" means either of the following:

(*i*) A pharmacist licensed to engage in the practice of pharmacy under part 177 of the public health code, 1978 PA 368, MCL 333.17701 to 333.17780.

(*ii*) A pharmacist licensed in another state.

(i) "Licensed physician" means any of the following:

(*i*) A physician licensed to engage in the practice of medicine under part 170 of the public health code,

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1978 PA 368, MCL 333.17001 to 333.17097.

(*ii*) A physician licensed to engage in the practice of osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556.

(*iii*) A physician licensed in another state.

(j) "Peer-reviewed" means the clinical review criteria that is approved by a committee comprised of clinicians, including licensed physicians or licensed pharmacists, or both, that meets at regularly-scheduled intervals and evaluates, among other things, pharmaceutical literature or medical literature, or both, and scientific evidence to develop criteria that promotes appropriate, safe, and cost-effective drug utilization.

(k) "Prescription drug" means that term as defined in section 2212c.

(*l*) "Prescription drug benefit" means that term as defined in section 2212c.

(m) "Prior authorization" means a determination by an insurer or utilization review organization that a requested health care benefit has been reviewed and, based on the information provided, satisfies the insurer or utilization review organization requirements for medical necessity and appropriateness.

(n) "Standardized electronic prior authorization transaction process" means a standardized transmission process, identified by the director and aligned with standards that are nationally accepted, to enable prior authorization requests to be accessible, submitted by health care providers, and accepted by insurers or their designee utilization review organizations electronically through secure electronic transmissions with the goal of maximizing administrative simplification, efficiency, and timeliness. The process must allow health care providers to supply clinical information under the standardized electronic prior authorization process. Standard electronic prior authorization transaction process does not include a facsimile.

(o) "Urgent" means an insured or enrollee is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function or could subject the insured or enrollee to severe adverse health consequences that cannot be adequately managed without the care or treatment that is the subject of the prior authorization.

(p) "Utilization review organization" means that term as defined in section 3 of the patient's right to independent review act, 2000 PA 251, MCL 550.1903.

History: Add. 2022, Act 60, Imd. Eff. Apr. 7, 2022.

Popular name: Act 218

500.2213 Internal formal grievance procedure; approval by director; provisions; person authorized to act on behalf of insured or enrollee; section inapplicable to provider complaint and insurance listed in right to independent review act; written notice to be culturally and linguistically appropriate; definitions.

Sec. 2213. (1) Except as otherwise provided in subsection (4), an insurer that delivers, issues for delivery, or renews in this state a policy of health insurance shall establish an internal formal grievance procedure for approval by the director for persons covered under the policy that provides for all of the following:

(a) A designated person responsible for administering the grievance system.

(b) A designated person or telephone number for receiving grievances.

(c) A method that ensures full investigation of a grievance.

(d) Timely notification to the insured or enrollee as to the progress of an investigation of a grievance.

(e) The right of an insured or enrollee to appear before a designated person or committee to present a grievance.

(f) Notification to the insured or enrollee of the results of the insurer's investigation of a grievance and of the right to have the grievance reviewed by the director or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(g) A method for providing summary data on the number and types of grievances filed under this section. The insurer or health maintenance organization shall annually file the summary data for the prior calendar year with the director on forms provided by the director.

(h) Periodic management and governing body review of the data to ensure that appropriate actions have been taken.

(i) That copies of all grievances and responses are available at the principal office of the insurer for inspection by the director for 2 years following the year the grievance was filed.

(j) That when an adverse determination is made, a written statement containing the reasons for the adverse determination is provided to the insured or enrollee along with written notifications as required under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(k) That a final determination will be made in writing by the insurer not later than 30 calendar days after a formal preservice grievance is submitted or 60 calendar days after a formal postservice grievance is submitted

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in writing by the insured or enrollee. The 30-calendar-day period or 60-calendar-day period, as applicable, may be tolled, however, for any period of time the insured or enrollee is permitted to take under the grievance procedure and for a period of time that must not exceed 10 business days if the insurer has not received requested information from a health care facility or health professional. If the insurer's procedure for insureds or enrollees covered under a group policy or plan includes 2 steps to resolve the grievance, the time for the first step must be no longer than 15 calendar days for a preservice grievance or 30 calendar days for a postservice grievance.

(*l*) That a determination will be made by the insurer not later than 72 hours after receipt of an expedited grievance. Within 10 days after receipt of a determination, the insured or enrollee may request a determination of the matter by the director or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929. If the determination by the insurer is made orally, the insurer shall provide a written confirmation of the determination to the insured or enrollee not later than 2 business days after the oral determination. An expedited grievance under this subdivision applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subdivision (k) would seriously jeopardize the life or health of the insured or enrollee or would jeopardize the insured's or enrollee's ability to regain maximum function.

(m) That the insured or enrollee has the right to a determination of the matter by the director or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(2) An insured or enrollee may authorize in writing any person, including, but not limited to, a physician, to act on his or her behalf at any stage in a grievance proceeding under this section.

(3) This section does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services.

(4) This section does not apply to a policy, certificate, care, coverage, or insurance listed in section 5(2) of the patient's right to independent review act, 2000 PA 251, MCL 550.1905, as not being subject to the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(5) A written notice required to be given under this section must be provided in a culturally and linguistically appropriate manner, as required under 45 CFR 147.136(b)(2)(ii)(e).

(6) As used in this section:

(a) "Adverse determination" means any of the following:

(*i*) A determination by an insurer or its designee utilization review organization that a request for a benefit, on application of any utilization review technique, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.

(*ii*) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by an insurer or its designee utilization review organization of a covered person's eligibility for coverage from the insurer.

(*iii*) A prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit.

(*iv*) A rescission of coverage determination.

(*v*) Failure to respond in a timely manner to a request for a determination.

(b) "Grievance" means a formal complaint on behalf of an insured or enrollee submitted by an insured or enrollee concerning any of the following:

(*i*) The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.

(*ii*) Benefits or claims payment, handling, or reimbursement for health care services.

(*iii*) Matters pertaining to the contractual relationship between an insured or enrollee and the insurer.

(c) "Insurer" includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

(d) "Postservice grievance" means a grievance relating to services that have already been received by the insured or enrollee.

(e) "Preservice grievance" means a grievance relating to services for which the insurer conditions receipt of the services, in whole or in part, on approval of the services in advance of receiving the service.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997;—Am. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 707, Imd. Eff. Dec. 30, 2002;—Am. 2012, Act 445, Imd. Eff. Dec. 27, 2012;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

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Popular name: Act 218

500.2213a Expenses incurred by director; calculation; assessment; "insurer" defined.

Sec. 2213a. (1) The director shall calculate actual and necessary expenses incurred by the director under section 2213 by June 30 of each year for the immediately preceding fiscal year. Except as otherwise provided in subsection (2), the director shall divide these expenses among all insurers that issue a policy or certificate under chapter 34 or 35 in this state on a pro rata basis according to the direct written premiums of each insurer as reported in the insurer's annual statement for the immediately preceding calendar year. An insurer shall pay the assessment within 30 days after receipt of the assessment. The assessment is in addition to the regulatory fee provided for in section 224.

(2) This section does not apply to a policy, certificate, care, coverage, or insurance listed in section 5(2) of the patient's right to independent review act, 2000 PA 251, MCL 550.1905, as not being subject to the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(3) As used in this section, "insurer" includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997;—Am. 2002, Act 707, Imd. Eff. Dec. 30, 2002;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.2213b Renewal or continuation of policy; modification; guaranteed renewal; discontinuing plan or product in nongroup or group market; short-term or 1-time limited duration policy or certificate; reports.

Sec. 2213b. (1) Except as otherwise provided in this section and section 2213e, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall renew the policy or continue the policy in force at the option of the individual or, for a group plan, at the option of the plan sponsor.

(2) At the time of renewal of an individual health insurance policy, the insurer may modify the policy if the modification is consistent with state and federal law and is effective on a uniform basis among all individuals with coverage under the policy.

(3) At the time of renewal of a group health insurance policy issued under chapter 34, the insurer may modify the policy.

(4) Guaranteed renewal of a health insurance policy is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, noncompliance with minimum contribution requirements, or noncompliance with minimum participation requirements, if the insurer no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

(5) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not discontinue offering a particular plan or product in the nongroup or group market unless the insurer does all of the following:

(a) Provides notice to the director and to each covered individual or group, as applicable, provided coverage under the plan or product of the discontinuation at least 90 days before the date of the discontinuation.

(b) Offers to each covered individual or group, as applicable, provided coverage under the plan or product the option to purchase any other plan or product currently being offered in the nongroup market or group market, as applicable, by that insurer without excluding or limiting coverage for a preexisting condition or providing a waiting period.

(c) Acts uniformly without regard to any health status factor of enrolled individuals or individuals who may become eligible for coverage in making the determination to discontinue coverage and in offering other plans or products.

(6) An insurer shall not discontinue offering all coverage in the nongroup or group market unless the insurer does all of the following:

(a) Provides notice to the director and to each covered individual or group, as applicable, of the discontinuation at least 180 days before the date of the expiration of coverage.

(b) Discontinues all health benefit plans issued in the nongroup or group market from which the insurer withdrew and does not renew coverage under those plans.

(7) If an insurer discontinues coverage under subsection (6), the insurer shall not provide for the issuance of any health benefit plans in the nongroup or group market from which the insurer withdrew during the 5-year period beginning on the date of the discontinuation of the last plan not renewed under that subsection.

(8) Subsections (1) to (7) do not apply to a short-term or 1-time limited duration policy or certificate of not longer than 6 months.

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(9) For the purposes of this section, a short-term or 1-time limited duration policy or certificate of not longer than 6 months is an individual health policy that meets all of the following:

(a) Is issued to provide coverage for a period of 185 days or less, except that the health policy may permit a limited extension of benefits after the date the policy ended solely for expenses attributable to a condition for which a covered person incurred expenses during the term of the policy.

(b) Is nonrenewable, provided that the health insurer may provide coverage for 1 or more subsequent periods that satisfy subdivision (a), if the total of the periods of coverage do not exceed a total of 185 days out of any 365-day period, plus any additional days permitted by the policy for a condition for which a covered person incurred expenses during the term of the policy.

(c) Does not cover any preexisting conditions.

(d) Is available with an immediate effective date, without underwriting, upon receipt by the insurer of a completed application indicating eligibility under the insurer's eligibility requirements, except that coverage that includes optional benefits may be offered on a basis that does not meet this requirement.

(10) By March 31 each year, an insurer that delivers, issues for delivery, or renews in this state a short-term or 1-time limited duration policy or certificate of not longer than 6 months shall provide to the director a written annual report that discloses both of the following:

(a) The gross written premium for short-term or 1-time limited duration policies or certificates issued in this state during the preceding calendar year.

(b) The gross written premium for all individual health insurance policies issued or delivered in this state during the preceding calendar year other than policies or certificates described in subdivision (a).

(11) The director shall maintain copies of reports prepared under subsection (10) on file with the annual statement of each reporting insurer.

(12) In each calendar year, an insurer shall not continue to issue short-term or 1-time limited duration policies or certificates if to do so the collective gross written premiums on those policies or certificates would total more than 10% of the collective gross written premiums for all individual health insurance policies issued or delivered in this state either directly by the insurer or through a person that owns or is owned by the insurer.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997;—Am. 1998, Act 457, Imd. Eff. Jan. 4, 1999;—Am. 2013, Act 5, Imd. Eff. Mar. 18, 2013;—Am. 2016, Act 100, Eff. Aug. 1, 2016;—Am. 2016, Act 276, Imd. Eff. July 1, 2016;—Am. 2023, Act 162, Eff. Feb. 13, 2024.

Popular name: Act 218

500.2213c Disability income insurer; internal grievance procedure; establishment; contents; "grievance" defined.

Sec. 2213c. (1) Each disability income insurer shall establish an internal grievance procedure for persons covered under a disability income policy, certificate, or contract.

(2) An internal grievance procedure under subsection (1) shall include all of the following:

(a) Provide for a designated person responsible for administering the grievance procedure.

(b) Provide for a designated person or telephone number for receiving grievances.

(c) Ensure full investigation of a grievance.

(d) Provide for timely notification to the insured as to the progress of an investigation.

(e) Provide for the insured to have the right to have the grievance reviewed by a managerial-level person or group.

(f) Provide for notification to the insured of the results of the insurer's investigation and, if the insurer upholds its prior determination on the grievance, for advising the insured of his or her right to present the grievance to the commissioner for review.

(g) Provide that a final determination will be made in writing by the insurer not later than 45 calendar days after a grievance is submitted in writing by the insured unless the insurer requires an extension of time to obtain additional information to make a determination with respect to the subject of the grievance. The extension may not exceed 45 days from the end of the initial period unless the initial period is extended due to the insured's failure to submit information necessary to decide the claim on appeal. If the extension is due to an insured's failure to submit information, the period for making the determination shall be tolled until the date the insured responds to the request for additional information.

(h) Provide for copies of all grievances and responses to be available at the principal office of the insurer for inspection by the commissioner for 2 years following the year the grievance was filed.

(3) As used in this section, "grievance" means a written complaint by an insured concerning the payment of benefits under a disability income insurance policy.

History: Add. 2002, Act 707, Imd. Eff. Dec. 30, 2002.

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Popular name: Act 218

500.2213d Uniform prescription drug information card or other technology.

Sec. 2213d. (1) A health benefit plan that provides coverage or administers a plan that provides coverage for prescription drugs or devices and that issues, uses, or requires a card or other technology for prescription claims submission and adjudication shall issue for the plan's insureds, enrollees, members, or participants a uniform prescription drug information card or other technology as provided for in this section.

(2) By July 1, 2003, the commissioner shall develop a uniform prescription drug information card and uniform prescription drug information technology based on the standards and format approved by the national council for prescription drug programs pharmacy ID card implementation guide. The card and technology shall include all of the national council for prescription drug programs standard information required by the health plan for submission and adjudication of claims for prescription drug or device benefits, or at a minimum contain all of the following labeled information:

(a) The card issuer name or logo on the front of the card.

(b) The cardholder's name and identification number, which shall be displayed on the front of the card.

(c) Complete information for electronic transaction claims routing including all of the following:

(*i*) The international identification number labeled as RxBIN.

(*ii*) The processor control number labeled as RxPCN, if required for proper routing of electronic claim transactions for prescription benefits.

(*iii*) The group number labeled as RxGrp, if required for proper routing of electronic claim transactions for prescription benefits.

(d) The name and address of the benefits administrator or other entity responsible for prescription claims submission, adjudication, or pharmacy provider correspondence for prescription benefits claims.

(e) A help desk telephone number that pharmacy providers may call for pharmacy benefit claims assistance.

(3) All information required by subsection (2) that is necessary for submission and adjudication of claims for prescription drug or device benefits, exclusive of information that can be derived from the prescription, shall be included in a clear, readable, and understandable manner on the uniform prescription drug information card or other technology issued by the health plan. The content and format of all information required by subsection (2) shall be in the current content and format required by the health plan for electronic claims routing, submission, and adjudication.

(4) The uniform prescription drug information card or uniform prescription drug information technology developed under this section shall be issued by a health plan upon enrollment and reissued upon any change in coverage that impacts data contained on the card or technology. However, a health plan is not required to issue a new uniform prescription drug information card or other technology more often than once in a calendar year and if a health plan issues stickers or another similar mechanism to the insureds, enrollees, members, or participants to update the cards, then the health plan is not required to issue new uniform prescription drug information cards or other technology more often than once in 3 years from the issuance of the first stickers or other similar mechanisms. This subsection does not prevent a health plan from reissuing updated new uniform prescription drug information cards or other technology on a more frequent basis.

(5) The uniform prescription drug information card or other technology may be used for any and all health insurance coverage. Nothing in this section requires any person issuing, using, or requiring the uniform prescription drug information card or other technology to issue, use, or require a separate card for prescription coverage, provided that the card or other technology can accommodate the information necessary to process the claim as required by subsection (2).

(6) As used in this section, "health plan" means all of the following but does not include a department of community health pharmacy program:

(a) An insurer providing benefits under an expense-incurred hospital, medical, or surgical policy or certificate, but does not include any of the following:

(*i*) Any policy or certificate that provides coverage only for any of the following:

(A) Vision.

(B) Dental.

(C) Specific diseases.

(D) Accidents.

(E) Credit.

(*ii*) Hospital indemnity policy or certificate.

(*iii*) Disability income policy or certificate.

(*iv*) Coverage issued as a supplement to liability insurance.

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(*v*) Medical payments under automobile, homeowners, or worker's compensation insurance.

(b) A MEWA regulated under chapter 70 that provides hospital, medical, or surgical benefits.

(c) A health maintenance organization licensed or issued a certificate of authority in this state.

(d) A third party administrator licensed under the third party administrator act, 1984 PA 218, MCL 550.901 to 550.962.

History: Add. 2002, Act 708, Eff. Jan. 1, 2003.

Compiler's note: Enacting section 1 of Act 708 of 2002 provides:

"Enacting section 1. (1) This amendatory act takes effect January 1, 2003.

(2) This amendatory act applies to all health plan coverages issued or renewed on or after July 1, 2005."

Enacting section 2 of Act 708 of 2002 provides:

"Enacting section 2. It is the intent of the legislature that pharmacists, by July 1, 2008, be able to obtain information on and submit claims for prescription drug or device benefits by electronic means, including, but not limited to, the internet."

Popular name: Act 218

500.2213e Rescission of health insurance policy; conditions; "rescind coverage" defined; application.

Sec. 2213e. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, shall not rescind coverage under the policy unless both of the following apply:

(a) Either of the following applies:

(*i*) The individual or a person seeking coverage on behalf of the individual performs an act, practice, or omission that constitutes fraud. For purposes of this subparagraph, a person seeking coverage on behalf of an individual does not include an employee or authorized representative of the insurer or a producer.

(*ii*) The individual makes an intentional misrepresentation of material fact.

(b) The insurer provides written notice to the individual at least 30 days before the recission.

(2) As used in this section, "rescind coverage" means a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if any of the following apply:

(*i*) The cancellation or discontinuance of coverage has only a prospective effect.

(*ii*) The cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay required premiums or contributions, including COBRA premiums, toward the cost of coverage. As used in this subparagraph, "COBRA" means the consolidated omnibus budget reconciliation act of 1985, Public Law 99-272.

(*iii*) The cancellation or discontinuance of coverage is initiated by the individual or by the individual's authorized representative and the sponsor, employer, plan, or issuer does not, directly or indirectly, take action to influence the individual's decision to cancel or discontinue coverage retroactively or otherwise take any adverse action or retaliate against, interfere with, coerce, intimidate, or threaten the individual.

(*iv*) The cancellation or discontinuance of coverage is initiated by an exchange established under the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152, and any regulations promulgated under those acts.

(3) This section applies to a health insurance policy delivered, issued for delivery, or renewed in this state before, on, or after the date of the effective date of the amendatory act that added this section.

History: Add. 2023, Act 162, Eff. Feb. 13, 2024.

Popular name: Act 218

500.2214 Disability insurance; application, use as evidence.

Sec. 2214. (1) An insured is not bound by a statement made in an application for a disability insurance policy unless the application is included in the policy when the policy is issued. For purposes of this subsection, an application is not included in a policy unless the policy specifically states that it includes the application.

(2) If a policy described in subsection (1) that was delivered or issued for delivery to a person in this state is reinstated or renewed and the insured or a beneficiary or assignee of the policy makes a written request to the insurer for a copy of any application for reinstatement or renewal, the insurer shall, within 15 days after receiving the request at the home office or a branch office of the insurer, deliver or mail to the person making the request a copy of the application. If the copy is not delivered or mailed as required by this subsection, the insurer is precluded from introducing the application as evidence in an action or proceeding based on or involving the policy or the reinstatement or renewal.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

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Popular name: Act 218

500.2216 Life or disability insurance; alteration of application.

Sec. 2216. No alteration of any written application for any life or disability insurance policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957.

Popular name: Act 218

500.2218 Disability insurance; false statement in application; effect.

Sec. 2218. The falsity of any statement in the application for any disability insurance policy covered by chapter 34 of this code may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

(1) No misrepresentation shall avoid any contract of insurance or defeat recovery thereunder unless the misrepresentation was material. No misrepresentation shall be deemed material unless knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to make the contract.

(2) A representation is a statement as to past or present fact, made to the insurer by or by the authority of the applicant for insurance or the prospective insured, at or before the making of the insurance contract as an inducement to the making thereof. A misrepresentation is a false representation, and the facts misrepresented are those facts which make the representation false.

(3) In determining the question of materiality, evidence of the practice of the insurer which made the contract with respect to the acceptance or rejection of similar risks shall be admissible.

(4) A misrepresentation that an applicant for life, accident or health insurance has not had previous medical treatment, consultation or observation, or has not had previous treatment or care in a hospital or other like institution, shall be deemed, for the purpose of determining its materiality, a misrepresentation that the applicant has not had the disease, ailment or other medical impairment for which such treatment or care was given or which was discovered by any licensed medical practitioner as a result of such consultation or observation. If in any action to rescind any contract or to recover thereon, any misrepresentation is proved by the insurer, and the insured or any other person having or claiming a right under the contract, shall prevent full disclosure and proof of the nature of the medical impairment, the misrepresentation shall be presumed to have been material.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957.

Popular name: Act 218

500.2220 Life insurance; solicitor as agent of insurer.

Sec. 2220. Any person who shall solicit an application for insurance upon the life of another shall, in any controversy between the insured or his beneficiary and the insurer issuing any policy upon such application, be regarded as the agent of the insurer and not the agent of the insured.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2226 Life insurance; benefits, manner of payment, period, and premiums to be contained in policy.

Sec. 2226. (1) A life insurer shall not make with or issue to any citizen or resident of this state any contract of life insurance that does not distinctly state the amount of the life benefits, the manner of payment, the period of the continuance, and the amount of the annual, semi-annual, or quarterly premium, or by which the payment of the life benefit assured shall be contingent upon the payment of assessments made upon surviving members and shall be made in accordance with the statutes now or hereafter regulating the business of life insurance. For a universal or variable life insurance contract, the insurer shall clearly and specifically state the amount of benefits or manner in which the benefits are calculated.

(2) Every policy of life insurance hereafter issued or delivered within this state by any life insurer doing business within this state shall contain the entire contract between the parties and nothing shall be incorporated therein by reference to any constitution, bylaws, rules, application, or other writing unless the same are endorsed upon or attached to the policy when issued.

(3) For standard provisions required in life insurance contracts see chapters 40, 42, and 44.

History: 1956, Act 218, Eff. Jan. 1, 1955;—Am. 1993, Act 349, Eff. Oct. 1, 1994.

Popular name: Act 218

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500.2227 Withholding final settlement amount; notice; escrow procedure to be followed by city, village, or township; disposition of money by local treasurer; commingling funds prohibited; retention of interest to defray expenses; forwarding policy proceeds; proof; effect of failure to provide reasonable proof; demolition of property; civil action for return of policy proceeds; liability; applicability of section; list of cities, villages, and townships; exception to withholding requirements; definitions.

Sec. 2227. (1) If a claim is filed for a loss to insured real property due to fire, explosion, vandalism, malicious mischief, wind, hail, riot, or civil commotion and a final settlement is reached on the loss to the insured real property, an insurer shall withhold from payment 25% of the actual cash value of the insured real property at the time of the loss or 25% of the final settlement, whichever is less. Until December 31, 2014, for residential property, the 25% settlement or judgment withheld must not exceed $6,000.00 adjusted annually beginning June 1, 1999 in accordance with the Consumer Price Index. Beginning January 1, 2015 and before July 1, 2024, for residential property, the 25% settlement or judgment withheld must not exceed $12,000.00 adjusted January 1 of each year in accordance with the Consumer Price Index. Beginning July 1, 2024, for residential property, the 25% settlement or judgment withheld must not exceed $24,000.00 adjusted July 1 of each year in accordance with the Consumer Price Index. The director shall notify annually all insurance companies transacting property insurance in this state as to the new adjusted amount. At the time that 25% of the settlement or judgment is withheld, the insurer shall give notice of the withholding to the treasurer of the city, village, or township in which the insured real property is located, to the insured, and to any mortgagee having an existing lien or liens against the insured real property, if the mortgagee is named on the policy. For a judgment, the insurer shall also provide notice to the court in which judgment was entered. The notice must include all of the following:

(a) The identity and address of the insurer.

(b) The name and address or forwarding address of each policyholder, including any mortgagee.

(c) The location of the insured real property.

(d) The date of loss, policy number, and claim number.

(e) The amount of money withheld.

(f) A statement that the city, village, or township may have the withheld amount paid into a trust or escrow account established for the purposes of this section if within 15 days after the mailing of the notice the city, village, or township states that the money should be withheld to protect the public health and safety; otherwise, the withheld amount must be paid to the insured 15 days after the mailing of the notice.

(g) An explanation of the provisions of this section.

(2) For a city, village, or township to escrow the amount withheld by the insurer, and to retain that amount, the following procedure must be used:

(a) An authorized representative of the city, village, or township shall request the insurer to pay the withheld amount into an escrow account maintained by the treasurer of the city, village, or township. A final settlement that exceeds 49% of the insurance on the insured real property is prima facie evidence that the damaged insured structure violates existing health and safety standards of the city, village, or township and constitutes cause for the escrowing of the withheld amount as surety for the repair, replacement, or removal of the damaged structure.

(b) For a settlement, the request under subdivision (a) must be sent to the insurer with a copy to the insured and any mortgagees. The copy to the insured must contain the notice required under subdivision (d). On receipt of the request, the insurer shall forward the withheld amount to the treasurer of the city, village, or township, and shall provide notice of the forwarding to the insured and any mortgagees.

(c) For a judgment, the request under subdivision (a) must be sent to the insurer with a copy to the insured, any mortgagees, and the court in which judgment was entered. The copy to the insured must contain the notice required under subdivision (d). On motion of the city, village, or township, the court shall order the withheld amount transmitted to the treasurer of the city, village, or township.

(d) The city, village, or township shall notify the insured that the insured has 10 days from the date of the mailing of the notice to object to the city's, village's, or township's retention of the withheld amount. The notice must identify the authorized representative of the city, village, or township to whom the insured should address his or her objections and must state that the insured may do either of the following:

(*i*) Seek resolution with the representative of the city, village, or township designated to receive and resolve objections under this section. The city, village, or township shall make a final determination and shall notify the insured of that determination not later than 30 days after receipt of notice that the insured wishes to seek resolution under this subparagraph. This final determination must include notice to the insured that if the insured is still dissatisfied with the city's, village's, or township's determination, the insured may seek relief in

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circuit court.

(*ii*) Seek relief in the circuit court.

(3) On receipt of money and information from an insurer as prescribed in subsections (1) and (2), the local treasurer shall record the information and the date of receipt of the money and shall immediately deposit the money in a trust or escrow account established for the purposes of this section. The account may be interest-bearing. If a mortgage on the insured property is in default, the treasurer of the city, village, or township, on written request from the first mortgagee of the property, shall release to the mortgagee all or any part of the policy proceeds received by the city, village, or township not later than 10 days after receipt of the written request by the mortgagee, to the extent necessary to satisfy any outstanding lien of the mortgagee.

(4) Except as provided in subsection (7), money deposited in an account under subsection (3) must not be commingled with city, village, or township funds. Any interest earned on money placed in a trust or escrow account may be retained by the city, village, or township to defray administrative costs incurred under this section.

(5) Except as provided in subdivision (c), the policy proceeds deposited under subsection (3) must immediately be forwarded to the insured when the authorized representative of the city, village, or township designated by the governing body of the city, village, or township receives or is shown reasonable proof of any of the following:

(a) That the damaged or destroyed portions of the insured structure have been repaired or replaced, except to the extent that the amount withheld under this section is needed to complete repair or replacement.

(b) That the damaged or destroyed structure and all remnants of the structure have been removed from the land on which the structure or the remnants of the structure were situated, in compliance with the local code requirements of the city, village, or township in which the structure was located.

(c) That the insured has entered into a contract to perform repair, replacement, or removal services for the insured real property and that the insured consents to payment of money directly to the licensed contractor performing the services on completion. Money released under this subdivision may be forwarded only to a licensed contractor performing services on the insured property.

(6) Reasonable proof required under subsection (5) includes any of the following:

(a) Originals or copies of pertinent verifiable contracts, invoices, receipts, and other similar papers evidencing both the work performed or to be performed and the materials used or to be used by all contractors performing repair, replacement, or removal services for the insured real property, other than a licensed contractor subject to subdivision (b).

(b) An affidavit executed by the licensed contractor that has performed the greatest amount of repair or replacement work on the structure, or that has done most of the clearing and removal work if structure repair or replacement is not to be performed. The licensed contractor shall attach to the affidavit all pertinent contracts, invoices, and receipts and shall swear that these attached papers correctly indicate the nature and extent of the work performed to date by the licensed contractor and the materials used.

(c) An inspection of the insured real property to verify that repair, replacement, or clearing has been completed in accordance with subsection (5).

(7) Except as otherwise provided in this subsection, if, with respect to a loss, reasonable proof is not received by or shown to an authorized representative of the city, village, or township designated by the governing body of the city, village, or township within 120 days after the policy proceeds portion was received by the treasurer, the city, village, or township shall use the retained proceeds to secure, repair, or demolish the damaged or destroyed structure and clear the insured property so that the structure and property comply with local code requirements and applicable ordinances of the city, village, or township. The city, village, or township shall return to the insured any unused portion of the retained proceeds. The city, village, or township may extend the 120-day time period under this subsection. A city, village, or township may retain and use policy proceeds for repairing or demolishing any property if on or before the effective date of the amendatory act that added subsection (16)(g) the authorized representative had not received or been shown reasonable proof within 1 year after the insurer provided notice to the insured under subsection (1). The insured may file a civil action against the city, village, or township for the return of the policy proceeds. An action filed under this subsection must be filed within 3 years after the insurer provided notice to the insured under subsection (1) or 1 year after the effective date of the amendatory act that added subsection (16)(g), whichever is later.

(8) There is no liability on the part of, and a cause of action does not arise against, an insurer or an agent or employee of an insurer for withholding or transferring money in the course of complying or attempting to comply with this section. If there is a dispute with a lienholder concerning the distribution of an amount withheld from payment under this section, the insurer may file an action in circuit court to identify all parties that may have a financial interest in the withheld amount and to determine how the withheld amount should

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be distributed.

(9) This section applies only to property located in a city, village, or township described in subsection (12) if the city, village, or township under a resolution by its governing body notifies the director in writing that the city, village, or township has established a trust or escrow account to be used as prescribed in this section and intends to uniformly apply this section with respect to all property located within the city, village, or township following written notification to the director. The director shall prepare and distribute a list of all cities, villages, and townships that have elected to apply this section to all insurance companies transacting property insurance in this state.

(10) A city, village, or township may apply to be added to the list prepared under subsection (9) by making a written request for addition to the director. When a written request for addition from a city, village, or township has been received by the director, an amended list must be prepared and distributed indicating the addition. The addition is effective on the date specified by the director in the amendment. The director shall notify the city, village, or township, and the insurance companies, of the effective date of the addition that must be effective not less than 30 days after receipt of notice by the insurance company. A city, village, or township shall not apply this section to any loss that occurred before the effective date of the addition.

(11) A city, village, or township may request to be deleted from the list prepared under subsection (9) or may cease to apply this section for a period of not less than 6 months on not less than 30 days' written notice to the director. After receipt of a request to be deleted from the list, the director shall prepare and distribute an amendment to the list indicating the deletion. The deletion is effective on the date specified by the director in the amendment. The director shall notify the city, village, or township, and the insurance companies, of the effective date of the deletion that must be effective not less than 30 days after receipt of the notice by the insurance company. A city, village, or township shall continue to apply this section to any loss that occurred before the effective date of the deletion, notwithstanding the deletion.

(12) This section applies only to insured real property located in cities, villages, and townships that are located in counties with a population of 425,000 or more and to insured real property located in cities, villages, and townships that are located in counties with a population of less than 425,000 if the city, village, or township has a population of 50,000 or more. This section applies to insured real property located in a city, village, or township that has elected to apply this section as provided in subsection (9) or (10) or that has been included in this section as provided in subsection (13).

(13) Cities, villages, and townships located in counties with a population of 425,000 or more and cities, villages, and townships that are located in counties with a population of less than 425,000 if the city, village, or township has a population of 50,000 or more and that are on the list prepared by the director under section 2845(9) or (10) on October 1, 1998 are automatically included as participants in the procedure established in this section unless the city, village, or township makes a written request to be deleted under subsection (11).

(14) The director shall prepare and distribute to all insurance companies transacting property insurance in this state by November 1, 1998 new lists indicating which cities, villages, and townships are subject to this section and which cities, villages, and townships are subject to section 2845.

(15) The withholding requirements of this section do not apply if all of the following occur:

(a) Within 15 days after agreement on a final settlement between the insured and the insurer, the insured has filed with the insurer evidence of a contract to repair as described in subsection (6).

(b) The insured consents to the payment of money directly to the licensed contractor performing the repair services. Money released under this subdivision may be forwarded only to a licensed contractor performing the repair services on the insured property.

(c) On receipt of the contract to repair, the insurer gives notice to the city, village, or township in which the property is located that there will not be a withholding under this section because of the repair contract.

(16) If the insured and the insurer have agreed on the demolition costs or the debris removal costs as part of the final settlement of the real property insured claim, the insurer shall withhold 1 of the following amounts, whichever is the largest, and shall pay that amount in accordance with this section:

(a) The agreed cost of demolition or debris removal.

(b) Until December 31, 2014, 25% of the actual cash value of the insured real property at the time of loss if this amount for residential property does not exceed $6,000.00 adjusted annually beginning June 1, 1999 in accordance with the Consumer Price Index.

(c) Beginning January 1, 2015 and before July 1, 2024, 25% of the actual cash value of the insured real property at the time of the loss if this amount for residential property does not exceed $12,000.00 adjusted January 1 of each year in accordance with the Consumer Price Index.

(d) Beginning July 1, 2024, 25% of the actual cash value of the insured real property at the time of the loss if this amount for residential property does not exceed $24,000.00 adjusted July 1 of each year in accordance with the Consumer Price Index.

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(e) Until December 31, 2014, 25% of the final settlement of the insured real property claim if this amount for residential property does not exceed $6,000.00 adjusted annually beginning June 1, 1999 in accordance with the Consumer Price Index.

(f) Beginning January 1, 2015 and before January 1, 2024, 25% of the final settlement of the insured real property claim if this amount for residential property does not exceed $12,000.00 adjusted January 1 of each year in accordance with the Consumer Price Index.

(g) Beginning July 1, 2024, 25% of the final settlement of the insured real property claim if this amount for residential property does not exceed $24,000.00 adjusted July 1 of each year in accordance with the Consumer Price Index.

(17) This section applies only to final settlements that exceed 49% of the insurance on the insured real property.

(18) If an insurer withholds payment under a policy in good faith because of suspected arson, fraud, or other question concerning coverage, this section does not apply until the issue or question is resolved and final settlement is made.

(19) As used in this section:

(a) "Consumer Price Index" means that term as defined in section 2080.

(b) "Final settlement" means a determination of the amount due and owing to the insured for a loss to insured real property, but does not include contents damage, losses to personal property, or additional coverage not contained in the building coverage portion of the fire insurance policy, which determination is made by any of the following means:

(*i*) Acceptance of a proof of loss by the insurer.

(*ii*) Execution of a release by the insured.

(*iii*) Acceptance of an arbitration award by both the insured and the insurer.

(*iv*) Judgment of a court of competent jurisdiction.

(c) "Home insurance" means that term as defined in section 2103.

(d) "Residential property" means property on which home insurance can be issued.

History: Add. 1998, Act 217, Eff. (see compiler's note);—Am. 2014, Act 509, Imd. Eff. Jan. 14, 2015;—Am. 2024, Act 82, Imd. Eff. July 23, 2024.

Compiler's note: Enacting section 1 of Act 217 of 1998 provides:

"Enacting section 1. (1) Section 2227(1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), (13), (15), (16), (17), (18), and (19) of the insurance code of 1956, 1956 PA 218, MCL 500.2227, as added by this amendatory act, take effect on January 1, 1999 and apply to any loss that occurs on and after January 1, 1999.

"(2) Section 2227(14) of the insurance code of 1956, 1956 PA 218, MCL 500.2227, as added by this amendatory act, takes effect October 1, 1998."

Popular name: Act 218

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500.2228 Automobile insurance; contents of policy.

Sec. 2228. (1) No policy of insurance against fire, theft, property damage, collision, and/or liability in connection with automobile coverage shall be issued, unless the premium and amount of coverage is stated in the policy.

(2) For other provisions required in such policies, see chapter 30 of this code (casualty insurance contracts).

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2230 Mutual insurers other than life; contents of policy.

Sec. 2230. Mutual insurers, other than life insurers, may insert in any form of policy prescribed by the law of this state any provisions or conditions required by its plan of insurance, which are not inconsistent or in conflict with any law of this state. Such policy, in lieu of conforming to the language and form prescribed by such law, may conform thereto in substance, if such policy includes a provision or endorsement reciting that the policy shall be construed as if in the language and form prescribed by such law, and a copy of such policy and endorsement, if any, shall have been first filed with and shall not have been disapproved by the commissioner.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2232 Reciprocal insurers; contents of policy.

Sec. 2232. A reciprocal insurer may insert in any form of policy prescribed by the law of this state any provisions or conditions required by its plan of insurance which are not inconsistent or in conflict with the law

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of this state. Such policy, in lieu of conforming to the language and form prescribed by such law, shall be held to conform thereto in substance if such policy includes a provision or endorsement reciting that the policy shall be construed as if in the language and form prescribed by such law.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2235 Written notice to insured under worker's compensation insurance policy.

Sec. 2235. At least annually, in conjunction with a renewal notice, a bill, or other notice of payment due issued in connection with a policy of worker's compensation insurance, an insurer shall send to each insured a written notice containing all of the following statements:

(a) A description of the insured's right to all pertinent rating information within a reasonable time after making a written request and paying reasonable charges.

(b) A description of the procedures whereby an insured or an insured's representatives may request a review of the way in which the insured's rates and premiums have been determined, including a statement of the insured's right to appeal the result of the review to the commissioner.

(c) Relevant information regarding the right of an insured to obtain a payroll audit under section 2008.

(d) Relevant information regarding the right of an insured to request a conference with a management representative to review reserve or redemption decisions by the insurer under section 2419.

History: Add. 1982, Act 7, Eff. Jan. 1, 1983.

Popular name: Act 218

500.2236 Forms generally; filing; approval; type size; membership in or subscription to rating organization; substitute form; readability score and other requirements; approval of changes or additions; notice of disapproval or withdrawal of approval; prohibition; hearing; separate violation; penalty; applicability of filing requirements; satisfaction of requirement for delivery of form or notice; "exempt commercial policyholder" and "insurer" defined; court review of order.

Sec. 2236. (1) Except as otherwise provided in this section, an insurer shall not deliver or issue for delivery in this state a basic insurance policy form or annuity contract form; a printed rider or indorsement form or form of renewal certificate; or a group certificate in connection with the policy or contract unless a copy of the form is filed with the department and approved by the director as conforming with the requirements of this act and not inconsistent with the law. A form is considered approved if the director fails to act within 30 days after its submittal under this section. Except for disability insurance as described in section 3400, an insurer shall plainly print the form with a type size of not less than 8-point unless the director determines that portions of the form that are printed with type less than 8-point are not deceptive or misleading.

(2) An insurer may satisfy its obligations to make form filings by becoming a member of, or a subscriber to, a rating organization licensed under section 2436 or 2630 that makes the filings that are required under this section. An insurer described in this subsection shall file with the director a copy of its authorization of the rating organization to make the filings on its behalf. Except as otherwise provided in this subsection, an insurer that is a member of or subscriber to a rating organization shall adhere to the form filings made on its behalf by the organization. An insurer may file with the director a substitute form and if a subsequent form filing by the rating organization after the filling of a substitute form affects the use of the substitute form, the insurer shall review its use and notify the director whether to withdraw its substitute form.

(3) The director shall not approve a form filed under this section that provides for or relates to an insurance policy or an annuity contract for personal, family, or household purposes if the form fails to obtain the following readability score or meet the other requirements of this subsection, as applicable:

(a) The readability score must not be less than 45, as determined by the method provided in subdivisions (b) and (c).

(b) The readability score is determined as follows:

(*i*) For a form containing not more than 10,000 words, the entire form must be analyzed. For a form containing more than 10,000 words, not fewer than two 200-word samples per page must be analyzed instead of the entire form. The samples must be separated by at least 20 printed lines.

(*ii*) Count the number of words and sentences in the form or samples and divide the total number of words by the total number of sentences. Multiply this quotient by a factor of 1.015.

(*iii*) Count the total number of syllables in the form or samples and divide the total number of syllables by the total number of words. Multiply this quotient by a factor of 84.6. As used in this subparagraph, "syllable" means a unit of spoken language consisting of 1 or more letters of a word as indicated by an accepted

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dictionary. If the dictionary shows 2 or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(*iv*) Add the figures obtained in subparagraphs (*ii*) and (*iii*) and subtract this sum from 206.835. The figure obtained equals the readability score for the form.

(c) For the purposes of subdivision (b)(*ii*) and (*iii*), the following procedures must be used:

(*i*) A contraction, hyphenated word, or numbers and letters when separated by spaces are counted as 1 word.

(*ii*) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, is counted as 1 sentence.

(d) In determining the readability score, all of the following apply to the method provided in subdivisions (b) and (c):

(*i*) It must be applied to an insurance policy form or an annuity contract together with a rider or indorsement form usually associated with the insurance policy form or annuity contract. It may be applied to a group of policy, contract, rider, or indorsement forms that have substantially the same language resulting in a single readability score for those forms.

(*ii*) It must not be applied to a word or phrase that is defined in an insurance policy form or an annuity contract or a rider, indorsement, or group certificate associated with the insurance policy form or annuity contract.

(*iii*) It must not be applied to language specifically agreed upon through collective bargaining or required by a collective bargaining agreement.

(*iv*) It must not be applied to language that is prescribed by or based on state or federal statute or any related rules, regulations, or orders.

(*v*) It must not be applied to medical terms that are included in the form for coverage purposes.

(e) The form must contain both of the following:

(*i*) Topical captions.

(*ii*) An identification of exclusions.

(f) Except as otherwise provided in this subdivision, an insurance policy or annuity contract that has more than 3,000 words printed on not more than 3 pages of text or that has more than 3 pages of text regardless of the number of words must contain a table of contents. This subdivision does not apply to riders or indorsements.

(g) Each rider or indorsement form that changes coverage must do all of the following:

(*i*) Contain a properly descriptive title.

(*ii*) Reproduce either the entire paragraph or the provision as changed.

(*iii*) At the time of filing, be accompanied by an explanation of the change.

(h) If a computer system approved by the director calculates the readability score of a form as being in compliance with this subsection, the form is considered in compliance with the readability score requirements of this subsection.

(i) A variable life product or variable annuity product approved by the United States Securities and Exchange Commission for sale in this state is considered in compliance with this section.

(4) An insurer shall submit for approval under subsection (3) a change or addition to a policy or annuity contract form for personal, family, or household purposes, whether by indorsement, rider, or otherwise, or a change or addition to a rider or indorsement form associated with the policy form or annuity contract form, if the form has not been previously approved under subsection (3).

(5) Upon written notice to the insurer, the director may, on a case-by-case review, disapprove, withdraw approval, or prohibit the issuance, advertising, or delivery of a form to any person in this state if the form violates this act, contains inconsistent, ambiguous, or misleading clauses, or contains exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy. The director shall specify in the notice the objectionable provisions or conditions and state the reasons for the decision. If the form is legally in use by the insurer in this state, the director shall give the effective date of the disapproval in the notice, which must not be less than 30 days after the mailing or delivery of the notice to the insurer. If the form is not legally in use, the disapproval is effective immediately.

(6) If a form is disapproved or approval is withdrawn under this act, the insurer is entitled on demand to a hearing before the director or a deputy director within 30 days after the notice of disapproval or of withdrawal of approval. After the hearing, the director shall make findings of fact and law and affirm, modify, or withdraw his or her original order or decision. An insurer shall not issue the form after a final determination of disapproval or withdrawal of approval.

(7) Any issuance, use, or delivery by an insurer of a form without the prior approval of the director as required under subsection (1) or after withdrawal of approval under subsection (5) is a separate violation for

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which the director may order the imposition of a civil penalty of $25.00 for each offense, not to exceed a maximum penalty of $500.00 for any 1 series of offenses relating to any 1 basic policy form. The attorney general may act to recover the penalty under this subsection as provided in section 230.

(8) The filing requirements of this section do not apply to any of the following:

(a) Insurance against loss of or damage to any of the following:

(*i*) Imports, exports, or domestic shipments.

(*ii*) Bridges, tunnels, or other instrumentalities of transportation and communication.

(*iii*) Aircraft and attached equipment.

(*iv*) Vessels and watercraft that are under construction, are owned by or used in a business, or have a straight-line hull length of more than 24 feet.

(b) Insurance against loss resulting from liability, other than worker's disability compensation or employers' liability arising out of the ownership, maintenance, or use of any of the following:

(*i*) Imports, exports, or domestic shipments.

(*ii*) Aircraft and attached equipment.

(*iii*) Vessels and watercraft that are under construction, are owned by or used in a business, or have a straight-line hull length of more than 24 feet.

(c) Surety bonds other than fidelity bonds.

(d) Policies, riders, indorsements, or forms of unique character designed for and used with relation to insurance on a particular subject, or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. By order, the director may exempt from the filing requirements of this section and sections 3401a and 4430 for as long as he or she considers proper any insurance document or form, except that portion of the document or form that establishes a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles under section 3109a, as specified in the order to which this section is not practicably applied, or the filing and approval of which are considered unnecessary for the protection of the public. Insurance documents or forms providing medical payments or income replacement benefits, except that portion of the document or form that establishes a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles under section 3109a, exempt by order of the director from the filing requirements of this section and section 3401a are considered approved by the director for purposes of section 3430.

(e) An insurance policy to which both of the following apply:

(*i*) The insurance is sold to an exempt commercial policyholder.

(*ii*) The insurance policy contains a prominent disclaimer that states "This policy is exempt from the filing requirements of section 2236 of the insurance code of 1956, 1956 PA 218, MCL 500.2236." or words that are substantially similar.

(9) Notwithstanding any provision of this act to the contrary, a health insurer may satisfy a requirement for the delivery of an insurance form or notice required by this act to a subscriber, insured, enrollee, or contract holder by doing all of the following:

(a) Taking appropriate and necessary measures reasonably calculated to ensure that the system for furnishing a form or notice meets all of the following requirements:

(*i*) It results in the actual receipt of a delivered form or notice.

(*ii*) It protects the confidentiality of a subscriber's, insured's, enrollee's, or contract holder's personal information.

(b) Ensuring that an electronically delivered form or notice is prepared and furnished in a manner consistent with the style, format, and content requirements applicable to the particular form or notice.

(c) On request, delivering to the subscriber, insured, enrollee, or contract holder a paper version of an electronically delivered form or notice.

(10) Subject to the requirements of this section, an insurer may file health insurance policies, certificates, and riders quarterly. This subsection does not limit or restrict an insurer's ability to file large group health insurance policies, certificates, or riders at any time during the year.

(11) As used in this section and sections 2401 and 2601, "exempt commercial policyholder" means an insured that purchases the insurance for other than personal, family, or household purposes.

(12) As used in this section, "insurer" includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

(13) An order made by the director under this section is subject to court review as provided in section 244.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1963, Act 53, Eff. Sept. 6, 1963;—Am. 1970, Act 180, Imd. Eff. Aug. 3, 1970;—

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Am. 1987, Act 52, Imd. Eff. June 22, 1987;—Am. 1990, Act 137, Eff. June 29, 1990;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990;—Am. 1993, Act 200, Eff. Dec. 28, 1994;—Am. 2002, Act 664, Eff. Mar. 31, 2003;—Am. 2014, Act 140, Eff. Mar. 31, 2015;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Section 2 of Act 52 of 1987 provides:

"The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act apply to all insurance policies issued on or after January 1, 1957 that were either approved by the commissioner on or after January 1, 1957 or subject to an order of the commissioner exempting policies from filing on or after September 1, 1968. The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act are intended to codify and approve long-standing administrative and commercial practice taken and approved by the commissioner pursuant to his or her legal authority. This amendatory act shall serve to cure and clarify any misinterpretation of the operation of such sections since the effective date of their original enactment. It is the intent of this amendatory act to rectify the misconstruction of the insurance code of 1956 by the court of appeals in Bill v Northwestern National Life Insurance Company, 143 Mich App 766, with respect to the power of the insurance commissioner to exempt certain insurance documents from filing requirements and the offsetting of social security benefits against disability income insurance benefits. This amendatory act does not affect the relationship between disability insurance benefits and personal protection insurance benefits as provided in Federal Kemper v Health Insurance Administration Inc., 424 Mich 537."

Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Enacting section 3 of Act 276 of 2016 provides:

"Enacting section 3. On the effective date of this amendatory act, an insurer may submit to the director of the department of insurance and financial services for approval any modification to policies and certificates that were approved before or on the effective date of this amendatory act, to conform with amendments made to the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, by this amendatory act. This enacting section does not apply to rates and rating methodologies."

Popular name: Act 218

500.2236a Interest indexed universal life insurance; information to be maintained on file.

Sec. 2236a. All of the following information shall be maintained on file by the insurer for all interest indexed universal life insurance policies:

(a) A description of how the interest credits are determined, including all of the following:

(*i*) A description of the index.

(*ii*) The relationship between the value of the index and the actual interest rate to be credited.

(*iii*) The frequency and timing that determines the interest rate.

(*iv*) If more than 1 rate of interest applies to different portions of the policy value, the allocation of interest credits.

(b) The insurer's investment policy, which shall include a description of all of the following:

(*i*) How the insurer addresses the reinvestment risks.

(*ii*) How the insurer plans to address the risk of capital loss on cash outflows.

(*iii*) How the insurer plans to address the risk that appropriate investments may not be available or not available in sufficient quantities.

(*iv*) How the insurer plans to address the risk that the indexed interest rate may fall below the minimum contractual interest rate guaranteed in the policy.

(*v*) The amount and type of assets currently held for interest indexed policies.

(*vi*) The amount and type of assets expected to be acquired in the future.

(c) If a policy is linked to an index for a specified period less than the maturity date of the policy, a description of the method to be used to determine interest credits upon the expiration of the period.

(d) A description of any interest guarantee in addition to or in lieu of the index.

(e) A description of any maximum premium limitations and the conditions under which they apply.

History: Add. 1993, Act 349, Eff. Oct. 1, 1994.

Popular name: Act 218

500.2237 Policy issued under chapter 34; prohibited restriction of liability.

Sec. 2237. An insurer shall not deliver in this state an insurance policy issued under chapter 34, or issue the policy for delivery in this state, if the policy contains a provision that restricts the liability of the insurer to pay expenses because the expenses are incurred while the insured is in a hospital, institution, or other facility operated by this state or a political subdivision of this state if the insured would be legally required to pay the expenses in the absence of insurance.

History: Add. 1961, Act 133, Eff. Sept. 8, 1961;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

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500.2238 Repealed. 1970, Act 180, Imd. Eff. Aug. 3, 1970.

Compiler's note: The repealed section pertained to basic form of policy of insurance of personal property.

Popular name: Act 218

500.2239 Health care service rendered by dentist; benefits or reimbursement; "dentist" defined; policies to which section applicable.

Sec. 2239. (1) If a group or individual hospital, medical, or expense incurred policy delivered, issued for delivery, or renewed in this state provides for benefits for a health care service, those benefits or reimbursement for the provision of the service shall not be denied because the service was rendered by a dentist, provided the service was legally performed.

(2) As used in this section, "dentist" means an individual licensed under part 166 of Act No. 368 of the Public Acts of 1978, being sections 333.16601 to 333.16647 of the Michigan Compiled Laws.

(3) This section shall apply only with respect to policies issued or renewed on or after the effective date of this section, and shall apply notwithstanding any policy provision to the contrary.

History: Add. 1982, Act 291, Imd. Eff. Oct. 7, 1982.

Popular name: Act 218

500.2242 Group disability policy; filing and approval of form; grounds for disapproval; notice, hearing, and appeal requirements; withdrawal of approval; quarterly filing; applicability of section to forms filed by nonprofit dental corporation.

Sec. 2242. (1) Except as otherwise provided in section 2236(8)(d), a group disability policy must not be issued or delivered in this state unless a copy of the form has been filed with the director and approved by him or her.

(2) The director may within 60 days after the filing of a disability insurance policy form applicable to individual or family expense coverage, disapprove the form for any of the following, subject to the requirements as to notice, hearing, and appeal set forth in sections 244 and 2236:

(a) The benefits provided under the policy are unreasonable in relation to the premium charged.

(b) The policy contains a provision that is unjust, unfair, inequitable, misleading, or deceptive or that encourages misrepresentation of the policy.

(c) The policy does not comply with other provisions of law.

(3) The director may at any time withdraw his or her approval of an individual or family expense policy form on any of the grounds stated in subsection (2), subject to the requirements as to notice, hearing, and appeal set forth in sections 244 and 2236. An insurer shall not issue the form after the effective date of the withdrawal of approval.

(4) Subject to the requirements of this section, an insurer may file health insurance policies, certificates, riders, and rates quarterly. This subsection does not limit or restrict an insurer's ability to file large group health insurance policies, certificates, or riders at any time during the year.

(5) After December 31, 2016, this section applies to forms filed by a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1987, Act 52, Imd. Eff. June 22, 1987;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990;—Am. 2013, Act 5, Imd. Eff. Mar. 18, 2013;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Section 2 of Act 52 of 1987 provides:

"The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act apply to all insurance policies issued on or after January 1, 1957 that were either approved by the commissioner on or after January 1, 1957 or subject to an order of the commissioner exempting policies from filing on or after September 1, 1968. The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act are intended to codify and approve long-standing administrative and commercial practice taken and approved by the commissioner pursuant to his or her legal authority. This amendatory act shall serve to cure and clarify any misinterpretation of the operation of such sections since the effective date of their original enactment. It is the intent of this amendatory act to rectify the misconstruction of the insurance code of 1956 by the court of appeals in Bill v Northwestern National Life Insurance Company, 143 Mich App 766, with respect to the power of the insurance commissioner to exempt certain insurance documents from filing requirements and the offsetting of social security benefits against disability income insurance benefits. This amendatory act does not affect the relationship between disability insurance benefits and personal protection insurance benefits as provided in Federal Kemper v Health Insurance Administration Inc., 424 Mich 537."

Enacting section 3 of Act 276 of 2016 provides:

"Enacting section 3. On the effective date of this amendatory act, an insurer may submit to the director of the department of insurance and financial services for approval any modification to policies and certificates that were approved before or on the effective date of this amendatory act, to conform with amendments made to the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, by this amendatory act. This enacting section does not apply to rates and rating methodologies."

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Popular name: Act 218

500.2243 Group policies; optometric service; coverage.

Sec. 2243. (1) Notwithstanding any provision of a policy or contract of group accident, group health, or group accident and health insurance, executed after July 23, 1965, if the policy or contract provides for reimbursement for any optometric service that is within the lawful scope of practice of a duly licensed optometrist, a subscriber to such group accident, group health, or group accident and group health insurance policy or contract shall be entitled to reimbursement for such service, whether the service is performed by a physician or a duly licensed optometrist. Unless the policy or contract of group accident, group health, or group accident and health insurance otherwise provides, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses, or appurtenances.

(2) If a subscriber contract provides for and offers optometric services, the subscriber shall have freedom of choice to select either a physician or an optometrist to render the services. Unless the subscriber contract otherwise provides, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses, or appurtenances.

(3) This section does not require coverage or reimbursement for a practice of optometric service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.17401 of the Michigan Compiled Laws, as of May 20, 1992.

History: Add. 1965, Act 349, Imd. Eff. July 23, 1965;—Am. 1994, Act 438, Eff. Mar. 30, 1995.

Popular name: Act 218

500.2246 Insured or applicant for life insurance policy as victim of domestic violence; refusal to provide coverage prohibited; exceptions; liability; applicability to policies on or after June 1, 1998; "domestic violence" defined.

Sec. 2246. (1) A life insurer that delivers, issues for delivery, or renews in this state a life insurance policy shall not rate, cancel coverage on, refuse to provide coverage for, or refuse to issue or renew a policy solely because an insured or applicant for insurance is or has been a victim of domestic violence.

(2) This section does not prevent any of the following:

(a) An insurer from refusing to issue a life insurance policy insuring an individual who has been the victim of domestic violence if the individual who commits the domestic violence is the applicant for, prospective owner of, or beneficiary under the policy and 1 or more of the following apply:

(*i*) The applicant, prospective owner, or beneficiary under the policy is known on the basis of police or court records to have committed domestic violence.

(*ii*) The insurer knows of an arrest or conviction for a domestic violence related offense by the applicant for, prospective owner of, or beneficiary under the policy.

(*iii*) The insurer has reasonable grounds to believe that the applicant for, prospective owner of, or beneficiary under the policy is committing domestic violence.

(b) An insurer from inquiring about, underwriting, or charging a different premium on the basis of the individual's physical or mental condition, regardless of the cause of the condition.

(c) An insurer from refusing to issue a life insurance policy if the applicant for, prospective owner of, or beneficiary under the policy does not have an insurable interest in the life of the prospective insured individual.

(3) An insurer shall not be held civilly liable for any cause of action that may result from compliance with this section.

(4) This section applies to all life insurance policies issued or renewed on or after June 1, 1998.

(5) As used in this section, "domestic violence" means inflicting bodily injury, causing serious emotional injury or psychological trauma, or placing in fear of imminent physical harm by threat or force a person who is a spouse or former spouse of, has or has had a dating relationship with, resides or has resided with, or has a child in common with the person committing the violence.

History: Add. 1998, Act 130, Imd. Eff. June 24, 1998.

Popular name: Act 218

500.2248 Automobile insurance; delivery of policy to insured.

Sec. 2248. (1) A policy of insurance against fire, theft, property damage, collision, or liability in connection with automobile coverage shall not be issued unless the policy, or an exact copy of the policy, is delivered to the insured.

(2) For purposes of this section, a personal automobile insurance policy and endorsements that do not

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contain personally identifiable information may be delivered by mailing, delivery, or posting on the insurer's internet website. If the insurer elects to post an insurance policy and endorsements on its internet website in lieu of mailing or delivering them to the named insured, the insurer shall comply with all of the following conditions:

(a) The policy and endorsements are easily accessible and remain easily accessible for as long as the policy is in force.

(b) After the expiration of the policy, the insurer archives the policy and endorsements and makes them available on request at no charge or for a reasonable charge.

(c) The policy and endorsements are posted in a manner that enables the insured to print and save the policy and endorsements using programs or applications that are widely available on the internet and free to use.

(d) The insurer provides notice to the named insured with each declarations page of a method by which an insured may obtain, on request and without charge, a paper or electronic copy of the policy or endorsements.

(e) On each declarations page issued to an insured, the insurer clearly identifies the exact policy and endorsement forms purchased by the insured.

(f) The insurer provides notice, in the manner by which it customarily communicates with a named insured, of any of the changes to the forms or endorsements and the insured's right to obtain, on request and without charge, a paper copy of the forms or endorsements.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2012, Act 454, Imd. Eff. Dec. 27, 2012.

Popular name: Act 218

500.2250 Binders or other contracts for temporary insurance; applicability.

Sec. 2250. Binders or other contracts for temporary insurance shall be considered to include all of the terms and conditions of the policy for which application is made. This section does not apply to a life insurance policy.

History: Add. 1990, Act 305, Imd. Eff. Dec. 14, 1990;—Am. 1991, Act 106, Imd. Eff. Oct. 3, 1991.

Popular name: Act 218

500.2254 Action against domestic insurer by member or beneficiary; conditions.

Sec. 2254. Suits at law may be prosecuted and maintained by any member against a domestic insurance corporation for claims which may have accrued if payments are withheld more than 60 days after such claims shall have become due. No article, bylaw, resolution or policy provision adopted by any life, disability, surety, or casualty insurance company doing business in this state prohibiting a member or beneficiary from commencing and maintaining suits at law or in equity against such company shall be valid and no such article, bylaw, provision or resolution shall hereafter be a bar to any suit in any court in this state: Provided, however, That any reasonable remedy for adjudicating claims established by such company or companies shall first be exhausted by the claimant before commencing suit: Provided further, however, That the company shall finally pass upon any claim submitted to it within a period of 6 months from and after final proofs of loss or death shall have been furnished any such company by the claimant.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2260 Life or disability insurance; acts not constituting waiver of defenses.

Sec. 2260. The acknowledgement by any insurer of the receipt of notice given under any life or disability insurance policy or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2264 Termination of dependent coverage at specified age; exception.

Sec. 2264. Any contract or insurance policy delivered on or after July 12, 1966 in this state providing for hospital care or reimbursement for the care of the policyholders and dependents that provides for termination of dependent coverage at a specified age does not apply to an unmarried child of the policyholder who is incapable of self-support due to developmental disability or physical disability, and who is dependent upon the policyholder for support and maintenance, if the policyholder submits satisfactory proof of the dependent's incapacity to the insurance carrier not later than 31 days after the attainment of the age limit by the dependent child.

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History: Add. 1966, Act 274, Imd. Eff. July 12, 1966;—Am. 1998, Act 26, Imd. Eff. Mar. 12, 1998;—Am. 2014, Act 67, Imd. Eff. Mar. 28, 2014.

Popular name: Act 218

500.2264a Hospital or medical care coverage or reimbursement for children who are full-time or part-time students and take leave of absence.

Sec. 2264a. (1) Any policy or certificate delivered, issued for delivery, or renewed in this state that provides for hospital or medical care coverage or reimbursement for hospital or medical care for dependent children who are full-time or part-time students shall continue coverage for that dependent student if the dependent student is covered under that policy or certificate and takes a leave of absence from school due to illness or injury. Coverage under this section shall continue for 12 months from the last day of attendance in school or until the dependent reaches the age at which coverage would otherwise terminate, whichever period is shorter.

(2) To qualify for coverage under this section, the dependent student's attending physician shall certify in writing to the dependent's insurer or health maintenance organization that it is medically necessary for the dependent student to take a leave of absence from school.

(3) Coverage under this section shall be provided at the same rate as that charged for dependent student status.

(4) A dependent child must continue to meet all other eligibility requirements for dependent coverage in the policy or certificate if the dependent child takes a leave of absence from school due to illness or injury.

History: Add. 2006, Act 537, Eff. Jan. 1, 2007.

Compiler's note: Former MCL 500.2265a, which pertained to medicare supplemental policies, was repealed by Act 84 of 1992, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.2265-500.2290 Repealed. 1992, Act 84, Imd. Eff. June 2, 1992.

Compiler's note: The repealed sections pertained to medicare supplemental policies and long-term care coverage.

Popular name: Act 218

500.2266 Electronic delivery of insurance documents; requirements; withdrawal of consent; civil liability; applicability to health insurer or health maintenance organization; definitions.

Sec. 2266. (1) Subject to the requirements of this section, a notice to a party or any other document that is required in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored, and presented by electronic means if it meets the requirements of the uniform electronic transactions act, 2000 PA 305, MCL 450.831 to 450.849.

(2) Electronic delivery of a notice or document as provided in this section is equivalent to any delivery method otherwise required by law, including delivery by first-class mail, first-class mail postage prepaid, certified mail, or certificate of mailing.

(3) If an insurer has reason to believe that a party is not receiving notices or documents that the insurer attempts to deliver by electronic means, including if the insurer attempts delivery by electronic means and receives a notice that the delivery by electronic means has failed, the insurer shall deliver the notices or documents by first-class mail or by any other delivery method required for the notices or documents.

(4) An insurer may use electronic delivery of a notice or a document to a party under this section if the insurer meets the requirements of subsection (5) and if all of the following requirements are met:

(a) The party has affirmatively consented to the electronic delivery method and has not withdrawn consent.

(b) Before obtaining consent, the insurer provides the party with a clear and conspicuous statement informing the party of all of the following:

(*i*) The right of the party at any time to have the notice or the document provided or made available in paper form or by another nonelectronic form.

(*ii*) The right of the party at any time to withdraw consent to have a notice or document delivered by electronic means and any conditions or consequences imposed if consent is withdrawn.

(*iii*) The specific notice or document or categories of notices or documents that may be delivered by electronic means during the course of the relationship between the insurer and the party.

(*iv*) The means, after consent is given, by which the party may obtain a paper copy of a notice or document delivered by electronic means.

(*v*) The procedures for the party to follow to update information needed to contact the party electronically and to withdraw consent to have a notice or a document delivered by electronic means.

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(c) Before obtaining consent, the insurer provides the party with a statement of the hardware and software requirements for access to and retention of a notice or document delivered by electronic means. The party shall provide electronic consent to the hardware and software requirements or confirm consent electronically in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means.

(5) After the party consents as provided in subsection (4), if a change occurs in hardware or software needed to access or retain a notice or document delivered by electronic means that creates a material risk that the party will not be able to access or retain a notice or document to which consent applies, the insurer shall provide the party with a statement that includes all of the following:

(a) Information regarding the revised hardware or software requirements for access to and retention of a notice or document delivered by electronic means.

(b) A description of the right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed under subsection (4)(b)(*ii*).

(6) Withdrawal of consent to electronic delivery does not affect the legal effectiveness, validity, or enforceability of a notice or a document that is delivered by electronic means to a party before the withdrawal of consent is effective.

(7) Except as otherwise provided in this subsection, withdrawal of consent by a party becomes effective 30 days after the insurer receives notice of the withdrawal. Consent is automatically withdrawn if the insurer learns that the electronic delivery method currently used is no longer an effective delivery mechanism.

(8) Failure by an insurer to comply with subsection (5) may be treated, at the election of the party, as a withdrawal of consent.

(9) This section must not be construed to modify, limit, or supersede the federal electronic signatures in global national commerce act, 15 USC 7001 to 7031.

(10) An insurance producer is not subject to civil liability for any harm or injury to a party that occurs as a result of either of the following:

(a) The party's consent under subsection (4) to receive a notice or a document delivered by electronic means under this section.

(b) An insurer's failure to deliver a notice or document by electronic means unless the insurance producer causes the harm or injury.

(11) This section does not apply to a health insurer or health maintenance organization.

(12) As used in this section:

(a) "Delivered by electronic means", "delivery by electronic means", or "electronic delivery" mean delivery by either of the following methods:

(*i*) Delivery to an electronic mail address at which a party has consented to receive notices or documents.

(*ii*) Both of the following:

(A) Posting on an electronic network or site accessible by the internet through use of a mobile application, computer, mobile device, tablet, or any other electronic device.

(B) Sending separate notice of the posting described in sub-subparagraph (A) to the electronic mail address at which the party consented to receive notice of the posting or using any other delivery method to which the party has consented.

(b) "Party" means a recipient of a notice or document required as part of an insurance transaction and includes an applicant, insured, policy holder, or annuity contract holder.

History: Add. 2018, Act 205, Imd. Eff. June 20, 2018;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

CHAPTER 22A

500.2270 Definitions.

Sec. 2270. As used in this chapter:

(a) "Certificate of insurance" means a document, regardless of how titled or described, that is prepared by an insurer or insurance producer that is a statement or summary of an insured's property or casualty insurance coverage. Certificate of insurance does not include a policy of insurance, insurance binder, or policy endorsement.

(b) "Director" means the director of the department of insurance and financial services.

(c) "Insurance" means any of the lines of authority in chapter 6.

(d) "Insurance producer" means that term as defined in section 1201.

History: Add. 2014, Act 271, Imd. Eff. July 2, 2014.

Popular name: Act 218

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500.2271 Certificate of insurance; prohibitions.

Sec. 2271. A person shall not do any of the following:

(a) Issue or deliver a certificate of insurance that purports to affirmatively or negatively alter, amend, or extend the coverage provided by an insurance policy referenced in the certificate of insurance.

(b) Prepare or issue a certificate of insurance that contains any false or misleading information concerning an insurance policy referenced in the certificate of insurance.

(c) Demand or require the issuance of a certificate of insurance from an insurer, insurance producer, or policyholder that contains any false or misleading information concerning an insurance policy referenced in the certificate of insurance.

History: Add. 2014, Act 271, Imd. Eff. July 2, 2014.

Popular name: Act 218

500.2273 Certificate of insurance; representation.

Sec. 2273. Except as otherwise provided in an insurance policy, a certificate of insurance does not represent an insurer's obligation to give notice of cancellation or nonrenewal to a person.

History: Add. 2014, Act 271, Imd. Eff. July 2, 2014.

Popular name: Act 218

500.2275 Notice of cancellation, nonrenewal, and similar notice; limitation.

Sec. 2275. A person is entitled to notice of cancellation, nonrenewal, and any similar notice concerning a policy of insurance only if the person has notice rights under the terms of a policy of insurance or an endorsement to a policy of insurance. The terms and conditions of a notice described in this section are governed by the policy of insurance or endorsement. A certificate of insurance does not alter the terms and conditions of the notice.

History: Add. 2014, Act 271, Imd. Eff. July 2, 2014.

Popular name: Act 218

500.2277 Violation; findings and decision of director; order.

Sec. 2277. If the director finds that a person has violated this chapter, after an opportunity for a hearing under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director shall reduce the findings and decision to writing and shall issue and cause to be served upon the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from the violation. In addition, the director may order any of the following:

(a) Payment of a civil fine of not more than $500.00 for each violation. However, if the person knew or reasonably should have known that he or she was in violation of this chapter, the director may order the payment of a civil fine of not more than $2,500.00 for each violation. An order of the director under this section shall not require the payment of civil fines exceeding $25,000.00. A fine collected under this subdivision shall be turned over to the state treasurer and credited to the general fund of this state.

(b) The director may apply to the circuit court of Ingham county for an order of the court enjoining a violation of this chapter.

History: Add. 2014, Act 271, Imd. Eff. July 2, 2014.

Popular name: Act 218

CHAPTER 23

WORKER'S COMPENSATION INSURANCE RATES

500.2301 Participation in facility by insurers required; purposes.

Sec. 2301. Each insurer authorized to write worker's compensation insurance in this state shall participate in the Michigan worker's compensation placement facility for the purpose of doing all of the following:

(a) Providing worker's compensation insurance to any person who is unable to procure the insurance through ordinary methods.

(b) Preserving to the public the benefits of price competition by encouraging maximum use of the normal private insurance system.

History: Add. 1982, Act 8, Eff. Jan. 1, 1983;—Am. 1993, Act 200, Eff. Dec. 28, 1994.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section

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701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.2303 Definitions.

Sec. 2303. As used in this chapter:

(a) "Facility" means the Michigan worker's compensation placement facility created under this chapter.

(b) "Participating member" means an insurer who is a member of the facility and who in any given calendar year has a participation ratio greater than zero in the facility for that year.

(c) "Participation ratio" means the ratio of the participating member's voluntary Michigan worker's compensation premiums to the comparable statewide totals of all participating members.

(d) "Worker's compensation insurance" means insurance which provides any of the following:

(*i*) Security required pursuant to the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, as amended, being sections 418.101 to 418.941 of the Michigan Compiled Laws.

(*ii*) Security required pursuant to the United States longshoreman's and harbor worker's compensation act.

(*iii*) Coverage customarily known as employer's liability insurance, when contained in or endorsed to a policy providing the security in subparagraph (*i*) or (*ii*).

History: Add. 1982, Act 8, Eff. Jan. 1, 1983;—Am. 1993, Act 200, Eff. Dec. 28, 1994.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.2310 Facility; operation; board of governors; appointment, terms, and qualifications of members.

Sec. 2310. The facility shall operate subject to the supervision of a board of governors appointed by the commissioner. The members of the board of governors shall serve for terms of 2 years. The board shall consist of 5 participating members, 2 worker's compensation insurance policyholders, 1 licensed agent, and 1 member representing the general public.

History: Add. 1982, Act 8, Eff. Jan. 1, 1983.

Popular name: Act 218

500.2312 Facility; plan of operation; preparation, approval, review, and revision; required provisions; application of plans to insureds; retrospective evaluation of premiums and loss and expense experience.

Sec. 2312. (1) A plan of operation of the facility shall be prepared by the board of governors and shall be subject to the approval of the commissioner. The commissioner shall review the plan of operation on an ongoing basis, and the plan shall be subject to revision at the request of the commissioner at any time.

(2) The plan of operation shall provide for all of the following:

(a) Appointment by the board of governors of 1 or more servicing carriers, subject to the approval of the commissioner. Appointments may be rescinded for cause by either the board subject to the approval of the commissioner, or by the commissioner.

(b) Creation of servicing carrier performance standards including all of the following:

(*i*) Sufficient personnel to provide support for safety management services offered by the plan.

(*ii*) Providing for sufficient personnel for claims adjustment.

(c) Agreements among all insurers authorized to write worker's compensation insurance in this state with respect to the equitable apportionment among them of worker's compensation insurance which may be afforded applicants who are in good faith entitled to, but who are unable to procure such insurance through ordinary methods.

(d) Payment of commissions to producing agents not to exceed 5% of a total premium.

(e) Creation of 3 rating plans as follows:

(*i*) Rating plan "A" which shall provide coverage for insureds who have a demonstrated accident frequency problem, who have a measurably adverse loss ratio over a period of years, or who have demonstrated an attitude of noncompliance with safety requirements. The commissioner shall approve rates for rating plan A which shall be adequate to cover losses and which shall not be excessive, inadequate, or unfairly discriminatory. This plan shall contain a system of surcharges established by the board of governors and

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approved by the commissioner.

(*ii*) Rating plan "B" which shall provide coverage to those employers who apply for worker's compensation insurance in the facility and are either self-insured or a member of a self-insurance group. This plan shall be established by the board of governors of the facility and approved by the commissioner. The commissioner shall convene and consult with an advisory organization including representatives of self-insureds and group self-insureds prior to approving rating plan "B". The recommendations of the advisory organization shall be given reasonable consideration by the commissioner. The commissioner shall approve rates for rating plan B which shall be adequate to cover losses and which shall not be excessive, inadequate, or unfairly discriminatory.

(*iii*) Rating plan "C" which shall provide coverage to all other insureds of the facility. Rating plan "C" shall not contain any surcharge system. The commissioner shall approve rates for rating plan C that are set through the lower of either of the following methods:

(A) By using 20% of the loss experience of insurers from employers while participants in rating plan C and 80% of the statewide loss experience of all insurers writing worker's compensation insurance in this state.

(B) Through the use of rates adequate to cover losses and which shall not be excessive, inadequate, or unfairly discriminatory.

(f) Prompt and fair hearings for purposes of section 2350.

(3) The application of the plans created under subsection (2)(e) to insureds shall be as determined by the commissioner. The plans shall be applied to insureds regardless of the number of employees or amount of payroll of the insured.

(4) Retrospective evaluation of premiums and loss and expense experience of insureds within each rating plan under subsection (2)(e) shall be performed by the board of governors, in a manner approved by the commissioner. If this evaluation indicates that a return of a portion of premiums is in order, then such a return shall be accomplished, subject to the approval of the commissioner.

History: Add. 1982, Act 8, Eff. Jan. 1, 1983;—Am. 1990, Act 137, Eff. June 29, 1990;—Am. 1993, Act 200, Eff. Dec. 28, 1994.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.2318 Facility; classification and rating systems; determination and use.

Sec. 2318. (1) The classification and rating systems of the facility shall be determined by the designated advisory organization, subject to the requirements of this chapter and the approval of the commissioner.

(2) Every participating member designated to act on behalf of the facility shall be authorized to use the classification and rating systems of the facility on business placed through the facility and shall not use other rates for worker's compensation insurance placed through the facility.

History: Add. 1982, Act 8, Eff. Jan. 1, 1983.

Popular name: Act 218

500.2320 Facility; deferred premium payment plans.

Sec. 2320. The facility shall provide for deferred premium payment plans which shall include sufficient advance payments at least equal to the pro rata earned premium at all times.

History: Add. 1982, Act 8, Eff. Jan. 1, 1983.

Popular name: Act 218

500.2322 Agent authorized to solicit, negotiate, or effect worker's compensation insurance on behalf of facility or participating member; rights and duties.

Sec. 2322. Every agent who is authorized to solicit, negotiate, or effect worker's compensation insurance on behalf of the facility or on behalf of any participating member shall:

(a) Offer to place worker's compensation insurance through the facility for any applicant requesting the agent to do so.

(b) Be entitled to receive, and any participating member be entitled to pay, a commission for placing insurance through the facility at the uniform rates of commission as provided in the plan of operation.

History: Add. 1982, Act 8, Eff. Jan. 1, 1983.

Popular name: Act 218

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500.2350 Formal hearing and ruling by facility board of governors; request; appeal; commissioner's order.

Sec. 2350. (1) Any participating member, applicant, person, or business insured under a policy placed through the facility may request a formal hearing and ruling by the board of governors of the facility on any of the following:

(a) An alleged violation of the plan of operation.

(b) Any alleged improper act or ruling of the facility affecting an assessment, premium, or coverage furnished.

(2) Any formal ruling of the board of governors of the facility may be appealed to the commissioner by filing notice of appeal with the facility and the commissioner within 30 days after receipt of the written ruling.

(3) The commissioner shall issue an order either upholding the board of governors' ruling or reversing its ruling.

History: Add. 1982, Act 8, Eff. Jan. 1, 1983.

Popular name: Act 218

500.2352 Determinations made by commissioner.

Sec. 2352. Determinations made by the commissioner pursuant to this chapter shall be made independent of the credits provided to insurers pursuant to the former single business tax act, 1975 PA 288, or the Michigan business tax act, 2007 PA 36, MCL 208.1101 to 208.1601.

History: Add. 1987, Act 261, Imd. Eff. Dec. 28, 1987;—Am. 2007, Act 187, Imd. Eff. Dec. 21, 2007.

Compiler's note: The reference to "1975 PA 288" evidently should read "1975 PA 228".

Popular name: Act 218

CHAPTER 24
CASUALTY INSURANCE RATES

500.2400 Purposes and interpretation of chapter.

Sec. 2400. (1) Except with respect to worker's compensation insurance, the purpose of this chapter is to promote the public welfare by regulating insurance rates to the end that they shall not be excessive, inadequate, or unfairly discriminatory, and to authorize and regulate cooperative action among insurers in rate-making and in other matters within the scope of the insurance code. Nothing in this chapter is intended (1) to prohibit or discourage reasonable competition, or (2) to prohibit, or encourage except to the extent necessary to accomplish the aforementioned purpose, uniformity in insurance rates, rating systems, rating plans, or practices.

(2) With respect to worker's compensation insurance, the purposes of this chapter are:

(a) To protect policyholders and the public against the adverse effects of excessive, inadequate, or unfairly discriminatory rates.

(b) To promote price competition among insurers writing worker's compensation insurance so as to encourage rates which will result in the lowest possible rates consistent with the benefits established in the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, as amended, being sections 418.101 to 418.941 of the Michigan Compiled Laws, and with maintaining the solvency of insurers.

(c) To provide regulatory controls and other activity in the absence of competition.

(d) To improve the availability, fairness, and reliability of worker's compensation insurance.

(3) This chapter shall be liberally interpreted to carry into effect the provisions of this section.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1982, Act 8, Eff. Jan. 1, 1983.

Popular name: Act 218

500.2400a Repealed. 1993, Act 200, Eff. Dec. 28, 1994.

Compiler's note: The repealed section pertained to applicability of act to state accident fund.

Popular name: Act 218

500.2401 Applicability of chapter; insurance or coverage subject to regulation by another rate regulatory chapter; filing designation with commissioner; order for prior approval; absence of reasonable degree of competition.

Sec. 2401. (1) Except as provided in subsection (2), this chapter applies to the following kinds of insurance or coverages on risks or operations in this state:

(a) Casualty insurance, as defined in section 624, except as to livestock insurance.

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(b) Surety and fidelity.
(c) Automobile insurance, as defined or included under the following sections:
(*i*) 624 (general definition of casualty insurance).
(*ii*) 7202 (insuring powers of reciprocal insurers).
(*iii*) 620 (automobile insurance (limited) defined).
(*iv*) 614 (marine insurance defined).
(d) Worker's compensation insurance, as defined or included under the following sections:
(*i*) 624 (general definition of casualty insurance).
(*ii*) 7202 (insuring powers of reciprocal insurers).
(e) To all insurance transacted by a reciprocal insurer pursuant to section 7202 (insuring powers of reciprocal insurers).
(f) Personal property floaters.
(g) Title insurance.
(2) This chapter does not apply to any of the following:
(a) Reinsurance, other than joint reinsurance to the extent stated in section 2464.
(b) Disability insurance.
(c) Insurance against loss of or damage to aircraft or against liability, other than worker's compensation and employers' liability, arising out of the ownership, maintenance, or use of aircraft.
(d) Insurance that meets both of the following and is not worker's compensation insurance:
(*i*) Is sold to an exempt commercial policyholder.
(*ii*) Contains a prominent disclaimer that states "This policy is exempt from the filing requirements of section 2236 of the insurance code of 1956, 1956 PA 218, MCL 500.2236." or words that are substantially similar.
(3) This chapter applies to all classes of insurers admitted to do business in this state, including stock, mutual, reciprocal, and interinsurers authorized to write any of the kinds of insurance to which this chapter applies under this act.
(4) If any kind of insurance, subdivision, or combination thereof, or type of coverage, subject to this chapter, is also subject to regulation by another rate regulatory chapter of this act, an insurer to which both chapter 24 and chapter 26 are otherwise applicable shall file with the commissioner, a designation as to which rate regulatory chapter shall be applicable to the insurer with respect to such kind of insurance, subdivision, or combination thereof, or type of coverage.
(5) If, pursuant to subsection (6), the commissioner certifies the absence of a reasonable degree of competition for a specified classification, type, or kind of insurance, the commissioner may order that each insurer file for prior approval, subject to the provisions of this chapter, any changes to its manuals of classification, manuals of rules and rates, and rating plans the insurer proposes to use for that specified classification, type, or kind of insurance. The order shall state, in writing, the reasons for the commissioner's decision to order the filing. An order issued under this subsection expires 2 years after the date of issuance. If such an order is in effect, rates to which the order applies shall be filed at least 30 days before their proposed effective date. Failure of the commissioner to act within 30 days after submittal constitutes approval.
(6) A determination concerning the absence of a reasonable degree of competition shall take into account a reasonable spectrum of relevant economic tests, including the number of insurers actively engaged in writing the insurance in question, the present availability of that insurance compared to the availability in comparable past periods, the underwriting return of that insurance over a reasonable period of time sufficient to assure reliability in relation to the risk associated with that insurance, and the difficulty encountered by new insurers entering the market in order to compete for the writing of that insurance.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1966, Act 221, Imd. Eff. July 11, 1966;—Am. 1982, Act 8, Eff. Jan. 1, 1983;—Am. 2002, Act 664, Eff. Mar. 31, 2003.

Popular name: Act 218

500.2402 Definitions; data collection agency; creation; purpose; governing board; appointment, terms, and qualifications of members; conduct of business at public meeting.

Sec. 2402. (1) As used in this act with respect to worker's compensation insurance:
(a) "Data collection agency" means an agency established for the purpose of effectuating the worker's compensation data requirements of this chapter.
(b) "Designated advisory organization" means the advisory organization designated by the data collection agency pursuant to section 2407(2).
(c) "Rate" means the cost of insurance per payroll before adjustment for an individual insured's size,

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exposure, or loss experience.

(d) "Rating system" means every classification, rating plan, merit rating plan, rating values, and manual, containing the rules used by an insurer in the determination of premiums.

(2) There is created a data collection agency for the purpose of effectuating the worker's compensation data requirements of this chapter. The governing board of the data collection agency shall include all of the following:

(a) Three persons who represent private insurers in this state.

(b) One person who represents the general public.

(c) One person who represents employers in this state.

(d) One person who represents the executive branch of state government.

(e) One person who is an insurance agent.

(f) The commissioner of insurance.

(3) A member of the governing board of the data collection agency shall serve for a term of 1 year.

(4) The members specified in subsection (2)(b), (c), and (e) shall be appointed by the commissioner. The member specified in subsection (2)(d) shall be appointed by the governor with the advice and consent of the senate. The members specified in subsection (2)(a) shall be appointed by the commissioner from recommendations made by the insurance industry in this state and shall be generally representative of small, medium, and large insurers.

(5) Business of the governing board of the data collection agency shall be conducted at a public meeting pursuant to the open meetings act, Act No. 267 of the Public Acts of 1976, as amended, being sections 15.261 to 15.275 of the Michigan Compiled Laws. Notice of the date, time, and place of a public meeting of the governing body shall be as prescribed in Act No. 267 of the Public Acts of 1976, as amended.

History: Add. 1982, Act 7, Eff. Jan. 1, 1983;—Am. 1993, Act 200, Eff. Dec. 28, 1994.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

For transfer of position of commissioner of office of financial and insurance regulation as member or chairperson of board or commission to director of department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

Popular name: Act 218

500.2403 Rate-making provisions; uniformity among insurers.

Sec. 2403. (1) All rates shall be made in accordance with this section and all of the following:

(a) Due consideration shall be given to past and prospective loss experience within and outside this state; to catastrophe hazards; to a reasonable margin for underwriting profit and contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; to past and prospective expenses, both countrywide and those specially applicable to this state; to underwriting practice, judgment, and to all other relevant factors within and outside this state. For worker's compensation insurance, in determining the reasonableness of the margin for underwriting profit and contingencies, consideration shall be given to all after-tax investment profit or loss from unearned premium and loss reserves attributable to worker's compensation insurance, as well as the factors used to determine the amount of reserves. For all other kinds of insurance to which this chapter applies, all factors to which due consideration is given under this subdivision shall be treated in a manner consistent with the laws of this state that existed on December 28, 1981.

(b) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

(c) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans that measure variations in hazards, expense provisions, or both. The rating plans may measure any differences among risks that may have a probable effect upon losses or expenses as provided for in subdivision (a).

(d) Rates shall not be excessive, inadequate, or unfairly discriminatory. A rate shall not be held to be excessive unless the rate is unreasonably high for the insurance coverage provided and a reasonable degree of competition does not exist with respect to the classification, kind, or type of risks to which the rate is applicable. Except as otherwise provided in this subdivision, a rate shall not be held to be inadequate unless the rate is unreasonably low for the insurance coverage provided and the continued use of the rate endangers

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the solvency of the insurer; or unless the rate is unreasonably low for the insurance coverage provided and the use of the rate has or will have the effect of destroying competition among insurers, creating a monopoly, or causing a kind of insurance to be unavailable to a significant number of applicants who are in good faith entitled to procure the insurance through ordinary methods. For commercial liability insurance a rate shall not be held to be inadequate unless the rate, after consideration of investment income and marketing programs and underwriting programs, is unreasonably low for the insurance coverage provided and is insufficient to sustain projected losses and expenses; or unless the rate is unreasonably low for the insurance coverage provided and the use of the rate has or will have the effect of destroying competition among insurers, creating a monopoly, or causing a kind of insurance to be unavailable to a significant number of applicants who are in good faith entitled to procure the insurance through ordinary methods. As used in this subdivision, "commercial liability insurance" means insurance that provides indemnification for commercial, industrial, professional, or business liabilities. For worker's compensation insurance provided by an insurer that is controlled by a nonprofit health care corporation formed pursuant to the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws, a rate shall not be held to be inadequate unless the rate is unreasonably low for the insurance coverage provided. A rate for a coverage is unfairly discriminatory in relation to another rate for the same coverage, if the differential between the rates is not reasonably justified by differences in losses, expenses, or both, or by differences in the uncertainty of loss for the individuals or risks to which the rates apply. A reasonable justification shall be supported by a reasonable classification system; by sound actuarial principles when applicable; and by actual and credible loss and expense statistics or, in the case of new coverages and classifications, by reasonably anticipated loss and expense experience. A rate is not unfairly discriminatory because the rate reflects differences in expenses for individuals or risks with similar anticipated losses, or because the rate reflects differences in losses for individuals or risks with similar expenses. Rates are not unfairly discriminatory if they are averaged broadly among persons insured on a group, franchise, blanket policy, or similar basis.

(2) Except to the extent necessary to meet the provisions of subsection (1)(d), uniformity among insurers in any matters within the scope of this section is neither required nor prohibited.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1969, Act 346, Eff. Apr. 1, 1970;—Am. 1979, Act 145, Imd. Eff. Nov. 13, 1979;—Am. 1981, Act 204, Imd. Eff. Dec. 30, 1981;—Am. 1982, Act 7, Eff. Jan. 1, 1983;—Am. 1986, Act 173, Imd. Eff. July 7, 1986;—Am. 1993, Act 200, Eff. Dec. 28, 1994.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.2404 Secondary or merit rating plan for commercial liability insurance rates; rating plan for medical malpractice insurance; limitations; "commercial liability insurance" defined.

Sec. 2404. (1) Each authorized insurer which delivers or issues for delivery commercial liability insurance policies in this state shall develop and establish a secondary or merit rating plan for commercial liability insurance rates. A merit rating plan required under this section shall adjust rates for commercial liability insurance policies on the basis of risk management technique implemented by the insured.

(2) An insurer's rating plan for medical malpractice insurance may provide for a premium surcharge based upon the filing of an action against the insured, subject to all of the following limitations:

(a) The surcharge plan shall be filed with the commissioner.

(b) A surcharge shall not be based on an action that was filed more than 3 years immediately preceding the issuance or renewal of the policy.

(c) A surcharge shall not be based on an action for which the insured has been adjudged not liable or which has been dismissed or settled without indemnity being paid on behalf of the insured.

(d) A surcharge shall not be based on an action for which the insurer pays, on behalf of the insured, indemnity and loss adjustment expenses with respect to such action in an amount that is less than 51% of the annual premium paid by the insured for the policy period covering such action.

(3) As used in this section, "commercial liability insurance" means insurance which provides indemnification for commercial, industrial, professional, or business liabilities.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

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500.2405 Liquor liability insurance policies; server training discount plan; certified server training course.

Sec. 2405. Each insurer which delivers or issues for delivery liquor liability insurance policies in this state shall develop and maintain a server training discount plan pursuant to this section. A server training discount plan required under this section shall provide for a premium discount for liquor liability insurance policies based upon the completion of a certified server training course in compliance with the provisions of the Michigan liquor control act, Act No. 8 of the Public Acts of the Extra Session of 1933, being sections 436.1 to 436.58 of the Michigan Compiled Laws.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

500.2406 Required filings by insurers; insufficient information; supporting information; notice; public inspection; becoming member of or subscriber to licensed rating organization; rates and rating systems regarding worker's compensation insurance; filings; certification; trade secret.

Sec. 2406. (1) Except for worker's compensation insurance, an insurer shall file with the director a manual of classification, manual of rules and rates, rating plan, or modification of a manual of classification, manual of rules and rates, or rating plan that the insurer proposes to use. Each filing under this subsection must state the proposed effective date of the filing and must indicate the character and extent of the coverage contemplated. If a filing is not accompanied by the information on which the insurer supports the filing, and the director does not have sufficient information to determine if the filing meets the requirements of this chapter, the director shall within 10 days of the filing give written notice to the insurer to furnish the information that supports the filing. The information furnished in support of a filing may include the experience or judgment of the insurer or rating organization making the filing, its interpretation of any statistical data it relies on, the experience of other insurers or rating organizations, or any other relevant factors. Except as otherwise provided in subsection (6), the department shall make a filing under this subsection and any supporting information open to public inspection after the filing becomes effective.

(2) Except for worker's compensation insurance, an insurer may satisfy its obligation to make filings by becoming a member of, or a subscriber to, a licensed rating organization that makes filings, and by filing with the director a copy of its authorization of the rating organization to make filings on its behalf. This chapter does not require an insurer to become a member of or a subscriber to a rating organization.

(3) For worker's compensation insurance in this state, the insurer shall file with the director all rates and rating systems.

(4) The rates and rating systems for worker's compensation insurance must be filed not later than the date the rates and rating systems are to be effective. A filing under this subsection meets the requirements of this chapter unless and until the director disapproves a filing under section 2418 or 2420.

(5) A filing under subsections (3) and (4) must be accompanied by a certification by the insurer that, to the best of the insurer's information and belief, the filing conforms to the requirements of this chapter.

(6) An insurer or a rating organization filing on the insurer's behalf may designate information included in the filing or any accompanying information as a trade secret. The insurer or the rating organization filing on behalf of the insurer shall demonstrate to the director that the designated information is a trade secret. If the director determines that the information is a trade secret, the information is not subject to public inspection and is exempt from the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246. As used in this subsection, "trade secret" means that term as defined in section 2 of the uniform trade secrets act, 1998 PA 448, MCL 445.1902. However, trade secret does not include filings and information accompanying filings under this section that were subject to public inspection before the effective date of the amendatory act that added this subsection.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1970, Act 180, Imd. Eff. Aug. 3, 1970;—Am. 1982, Act 7, Eff. Jan. 1, 1983;—Am. 1993, Act 200, Eff. Dec. 28, 1994;—Am. 2015, Act 141, Eff. Jan. 11, 2016.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.2407 "Pure premium data" defined; worker's compensation insurance; collecting,

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compiling, or making available to insurers certain information; filing rating system incompatible with approved statistical plans; proposed plan for reporting data; hearing; sharing information in establishing rates prohibited; exception; cost of operating data collection agency; rules; applicability of section.

Sec. 2407. (1) As used in this section, "pure premium data" means all historical data, including actual historical loss data by classification per payroll, except data prohibited by subsection (4). Pursuant to this section, insurers shall supply information regarding pure premium data to the designated advisory organization.

(2) With respect to worker's compensation insurance:

(a) The data collection agency shall designate 1 advisory organization for the purpose of collecting historical data from all insurers and compiling pure premium data pursuant to the statistical plans of the designated advisory organization approved by the commissioner. All insurers shall make reports which conform to the data reporting requirements of the approved statistical plans of the designated advisory organization.

(b) The designated advisory organization shall make and file rates, rating systems and policy forms for the residual market in accordance with chapter 23.

(c) The data collection agency shall establish a plan providing for the collection of data, in addition to pure premium data, by the designated advisory organization to the extent necessary to establish proper residual market rates. The plan established pursuant to this subdivision shall be submitted to the commissioner for approval or amendment.

(d) The data collection agency shall authorize the designated advisory organization to compute how pure premium data which has been previously collected would have been affected by any significant change in a law resulting from a subsequent statute or subsequent court decision, if the change in the law were in effect before the pure premium data had been collected. The designated advisory organization shall determine the effect such a law change would have had in a manner which reasonably reflects the law change. The determination shall be disseminated only after approval or amendment by the commissioner. The commissioner shall approve, reject, or amend the determination to reasonably reflect the effects of the law change within 30 days after the determination is submitted to the commissioner. If the commissioner fails to approve, reject, or amend the determination with the 30 days, the determination shall be deemed approved.

(e) The designated advisory organization shall distribute to the data collection agency pure premium data for dissemination to all insurers.

(f) The designated advisory organization shall not:

(*i*) Collect any information other than historical data, except data collected pursuant to subdivisions (c) and (d).

(*ii*) Disseminate any data except as provided in this subsection.

(3) The data collection agency shall make available to insurers the information reported under subsection (2), except information necessary to operate the residual market.

(4) Neither the designated advisory organization nor the data collection agency shall collect, compile, or make available to insurers any information regarding the following except as provided in subsection (2)(b) to (d):

(a) Actuarial projections or trending factors.

(b) Profits.

(c) Expenses, except loss adjustment expenses.

(5) An insurer filing a rating system incompatible with the approved statistical plans shall file with the commissioner the proposed plan for reporting data which will conform with the data reporting requirements of the statistical plans approved by the commissioner and simultaneously furnish a copy of the filing with the data collection agency and the designated advisory organization. The data collection agency may request a hearing on any proposed plan for reporting data to determine if the plan will be compatible with the approved statistical plans. A request for a hearing under this subsection shall be made by first class mail, return receipt requested. The commissioner shall hold a hearing pursuant to Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.315 of the Michigan Compiled Laws, on a proposed plan not later than 30 days after receipt of the request for a hearing. At the hearing, consideration shall be given to the compatibility of the proposed plan with the data reporting requirements of the approved statistical plans of the data collection agency and the filer's practical capability of complying with those requirements. The commissioner shall issue a final order as to the compatibility of the proposed rating system and the capability of the filer within 30 days of the hearing. Unless the commissioner finds that the proposed system is compatible and the filer has the capability, the filer shall not use the proposed system but shall, at its option,

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use its prior rating system or file a new rating system.

(6) Except as provided in this section, insurers shall not share information in establishing rates or rating systems. A person, insurer, or organization that violates this subsection is subject to the penalties provided in section 2478. This subsection shall not prohibit an insurer from obtaining or utilizing information which is a matter of public record.

(7) The reasonable cost of the operation of the data collection agency shall be borne by the designated advisory organization.

(8) The commissioner shall promulgate rules pursuant to Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.315 of the Michigan Compiled Laws, for the purpose of establishing reporting periods and the method of reporting the information and data provided for under this section.

(9) This section only applies to and for the purposes of worker's compensation insurance.

History: Add. 1982, Act 7, Eff. Jan. 1, 1983.

Popular name: Act 218

Administrative rules: R 500.1351 et seq. of the Michigan Administrative Code.

500.2408 Review of filings by commissioner; purpose; waiting period; extension; effective date of filing; special filing; section inapplicable to worker's compensation insurance.

Sec. 2408. (1) The commissioner shall review filings as soon as reasonably possible after they have been made in order to determine whether the filings meet the requirements of this chapter.

(2) Subject to the exception specified in subsection (3), each filing whether or not accompanied by supporting information shall be on file for a waiting period of 15 days before it becomes effective, which period may be extended by the commissioner for 1 additional period not to exceed 15 days if the commissioner gives written notice within the waiting period to the insurer or rating organization which made the filing that he or she needs additional time for the consideration of the filing. Upon written application by the insurer or rating organization, the commissioner may authorize a filing which he or she has reviewed to become effective before expiration of the waiting period or any extension thereof. A filing whether or not accompanied by supporting information shall be considered to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or extension thereof. Except, if a filing is not accompanied by supporting information and the information is required by the commissioner under section 2406(1), the filing shall be considered to meet the requirements of this chapter unless disapproved by the commissioner within 15 days after the information is furnished.

(3) Any special filing with respect to a surety or guaranty bond required by law, or by court or executive order, or by order, rule, or regulation of a public body, not covered by a previous filing, shall become effective when filed and shall be considered to meet the requirements of this chapter until such time as the commissioner reviews the filing and so long thereafter as the filing remains in effect.

(4) This section shall not apply to worker's compensation insurance filings made pursuant to section 2406(3), (4), and (5).

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1982, Act 8, Eff. Jan. 1, 1983.

Popular name: Act 218

500.2409 Repealed. 2016, Act 101, Eff. Aug. 1, 2016.

Compiler's note: The repealed section pertained to report delineating classifications and kinds or types of insurance where competition does not exist.

500.2409a Repealed. 2016, Act 101, Eff. Aug. 1, 2016.

Compiler's note: The repealed section pertained to certification by commissioner and resolution by legislature that reasonable degree of competition does not exist with respect to worker compensation insurance market and inclusion of plan in report under MCL 500.2409.

500.2409b Repealed. 2016, Act 104, Eff. Aug. 1, 2016.

Compiler's note: The repealed section pertained to report detailing state of availability in liquor liability insurance market.

500.2409c Repealed. 2016, Act 99, Eff. Aug. 1, 2016.

Compiler's note: The repealed section pertained to public hearing to determine whether reasonable degree of competition in commercial liability insurance market exists.

500.2410 Filing requirements; modification or suspension by insurance commissioner.

Sec. 2410. Under such rules and regulations as he shall adopt the commissioner may, by written order, suspend or modify the requirement of filing as to any kind of insurance, subdivision or combination thereof,

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or as to classes of risks, the rates for 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 such examination as he may deem advisable to ascertain whether any rates affected by such order meet the standards set forth in section 2403 (1) (d) (rate standards).

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2411 Rates and rating systems; classifications; merit rating plan; use of single enterprise rule or similar rule prohibited.

Sec. 2411. (1) Rates and rating systems used by any insurer with regard to worker's compensation insurance within this state shall conform to the applicable requirements of this section.

(2) Classifications used by an insurer shall be based upon 1 or more of the following:

(a) The industry group to which an employer belongs.

(b) Similarity of expected losses as reflected by similarities in pure premium and similarities in operations of employers insured.

(c) Similarity of risk of compensable injury as reflected by the type of work performed by employees.

(d) Other factors that would encourage innovation and would encourage insurers to minimize the risk of loss from hazards insured against and would be consistent with both the statistical plan approved by the commissioner and the purposes of this chapter.

(3) Each insurer shall establish a merit rating plan for worker's compensation insurance whereby an insured's premium is modified either prospectively or retrospectively. The plans required under this subsection shall provide for premium surcharges or credits based upon loss experience within a specified period or other factors which are reasonably related to risk of loss. The plan shall provide for sufficient premium differentials so as to encourage safety and adequately reward employers without a claim during the merit rating period. The sensitivity of a rating system may vary by size of the risk involved.

(4) The single enterprise rule or similar rule requiring a worker's compensation insured to be classified according to the entire business in which the insured is engaged shall not be used. Upon request of an insured, an insurer shall classify employees in separate operations of a business in different classifications consistent with the insurers' rate system filing if payroll information is supplied to the insurer for each operation requested to be in a separate classification.

History: Add. 1982, Act 8, Eff. Jan. 1, 1983.

Popular name: Act 218

500.2412 Filing requirements; adherence by insurer.

Sec. 2412. No insurer shall make or issue a contract or policy except in accordance with filings which are in effect for said insurer as provided in this chapter or in accordance with sections 2410 or 2414.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2414 Filing requirements; excess rates on specific risks.

Sec. 2414. Upon the written application of the insured, stating his reasons therefor, filed with and approved by the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1970, Act 180, Imd. Eff. Aug. 3, 1970.

Popular name: Act 218

500.2416 Disapproval of filing; notice; waiting period.

Sec. 2416. (1) If within the waiting period or any extension thereof as provided in subsection (2) of section 2408, the commissioner finds that a filing does not meet the requirements of this chapter, he shall send to the insurer or rating organization which made such filing written notice of disapproval of such filing specifying therein what respects he finds such filing fails to meet the requirements of this chapter and stating that such filing shall not become effective.

(2) If within 30 days after a special surety or guaranty filing subject to subsection (3) of section 2408 has become effective, the commissioner finds that such filing does not meet the requirements of this chapter, he shall send to the insurer or rating organization which made such filing written notice of disapproval of such filing specifying therein in what respects he finds that such filing fails to meet the requirements of this chapter and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. Said disapproval shall not affect any contract made or issued prior to the expiration of the period set forth in said

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notice.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2418 Disapproval of filing after approval; hearing; notice; procedure.

Sec. 2418. If at any time after approval of any filing either by act or order of the commissioner or by operation of law, or before approval of a filing made by a worker's compensation insurer controlled by a nonprofit health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704, the commissioner finds that a filing does not meet the requirements of this chapter, the commissioner shall, after a hearing held upon not less than 10 days' written notice, specifying the matters to be considered at the hearing, to every insurer and rating organization that made the filing, issue an order specifying in what respects the commissioner finds that the filing fails to meet the requirements of this chapter, and stating for a filing that has gone into effect when, within a reasonable period thereafter, that filing shall be considered no longer effective. A copy of the order shall be sent to every insurer and rating organization subject to the order. The order shall not affect any contract or policy made or issued before the date the filing becomes ineffective as indicated in the commissioner's order.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1993, Act 200, Eff. Dec. 28, 1994;—Am. 2008, Act 241, Imd. Eff. July 17, 2008.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.2419 Excessive premium charges for worker's compensation insurance; personal meeting with management representative; providing reserve and redemption information to insured upon request; determination of dispute by commissioner; rules; redemption of worker's compensation claim; notice.

Sec. 2419. (1) An insured who has reason to believe that the insured's premium charges for worker's compensation insurance are excessive as a result of unreasonable reserves or the unreasonable redemption of a claim shall be entitled to a personal meeting with a management representative of the insurer.

(2) Upon receipt of a written request by the insured, the insurer shall provide within 30 days of the receipt of the request reserve and redemption information with regard to worker's compensation insurance which is pertinent to the premiums charged for that insurance.

(3) If a meeting between the insured and the management representative of the insurer under subsection (1) fails to resolve the dispute, the insured shall be entitled to a determination of the dispute by the commissioner. The commissioner shall promulgate rules pursuant to Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.315 of the Michigan Compiled Laws, establishing procedures for a determination under this subsection. The procedures shall provide for determinations to be made on a timely and informal basis.

(4) Upon written request of an insured, an insurer shall not redeem a worker's compensation claim without giving 10 business days' prior notice to the insured by first class mail, return receipt requested.

History: Add. 1982, Act 7, Eff. Jan. 1, 1983.

Popular name: Act 218

Administrative rules: R 500.1351 et seq. of the Michigan Administrative Code.

500.2420 Complaint of aggrieved person or organization; application for hearing; notice; order rendering filing ineffective; filing by insurer providing worker's compensation insurance controlled by nonprofit health care corporation; prohibited use of section.

Sec. 2420. (1) Any person or organization aggrieved with respect to any filing that is in effect may apply in writing to the commissioner for a hearing on the filing. The application shall specify the grounds to be relied upon by the applicant. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if his or her grounds are established, and that the grounds otherwise justify holding a hearing, the commissioner shall, within 30 days after receipt of the application, hold a hearing upon not less than 10 days' written notice to the applicant and to every insurer and rating organization that made the filing.

(2) If, after a hearing under subsection (1), the commissioner finds that the filing does not meet the requirements of this chapter, the commissioner shall issue an order specifying in what respects he or she finds

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that the filing fails to meet the requirements of this chapter, and stating when, within a reasonable period thereafter, the filing shall be considered no longer effective. Copies of the order shall be sent to the applicant and to every insurer and 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.

(3) Upon receipt of a rate or rating system filing by an insurer providing worker's compensation insurance that is controlled by a nonprofit health care corporation formed pursuant to the nonprofit health care corporation act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws, the commissioner shall immediately notify each person of the filing who has requested in writing notice of the filing within the 2 years immediately preceding the filing. Notice to the person shall identify the location, time, and place where a copy of the filing will be open to public inspection and copying. The filing shall become effective on the filing's proposed effective date unless stayed or disapproved by the commissioner. An aggrieved person, which shall include any insurer transacting worker's compensation insurance in this state and any person acting on behalf of 1 or more such insurers, who claims a rate in the filing is inadequate is entitled to a contested case hearing pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws. The request for this hearing shall be filed with the commissioner within 30 days of the date of the filing alleged to contain inadequate rates and shall state the grounds upon which a rate contained in the filing is alleged to be inadequate. The notice of hearing shall be served upon the insurer and shall state the time and place of the hearing and the grounds upon which the rate is alleged to be inadequate. Unless mutually agreed upon by the commissioner, the insurer, and the aggrieved person, the hearing shall occur not less than 15 days or more than 30 days after notice is served. Within 10 days of receipt of the request for hearing, the commissioner shall issue an order staying the use of any rate alleged to be inadequate and with respect to which, on the basis of affidavits and pleadings submitted by the aggrieved person and the insurer, it appears likely that the aggrieved person will prevail in the hearing. The nonprevailing party shall have the right to an interlocutory appeal to circuit court of the commissioner's decision granting or denying the stay, and the court shall review de novo the commissioner's decision.

(4) An insurer or rating organization shall not use this section to obtain a hearing with the commissioner on the insurer's or rating organization's own filing.

History: 1956, Act 218, Eff. Jan. 1, 1955;—Am. 1993, Act 200, Eff. Dec. 28, 1994.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.2421 Insurer authorized to write worker's compensation insurance; prohibited acts.

Sec. 2421. As a condition of maintaining its certificate of authority, an insurer authorized to write worker's compensation insurance shall not do any of the following:

(a) Be a member of a rating organization in this state for worker's compensation insurance or have any rates, rules, or forms filed on its behalf with regard to worker's compensation insurance in this state by a rating organization.

(b) Except as necessary to operate the residual market under chapter 23, agree with any other insurer or with an advisory organization to adhere to or use any rate, rating plan, rating schedule, rating rule, or underwriting rule with regard to worker's compensation insurance in this state.

(c) Make any agreement with any other insurer, advisory organization, or any other person which has the purpose or effect of restraining trade or of substantially lessening competition with regard to worker's compensation insurance in this state.

History: Add. 1982, Act 7, Eff. Jan. 1, 1983.

Popular name: Act 218

500.2426 Manual of classifications, rules and rating plans; rates meeting standards.

Sec. 2426. No manual of classifications, rule, rating plan, or any modification of any of the foregoing which measures variations in hazards or expense provisions, or both, and which has been filed pursuant to the requirements of this chapter shall be disapproved if the rates thereby produced meet the requirements of section 2403 (1) (d) (rate standards).

History: 1956, Act 218, Eff. Jan. 1, 1957.

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Popular name: Act 218

500.2430 Manual of classifications; rules and rating plans; alternative filing; effective date; hearing; order of disapproval; adjustment of premium; review of filing.

Sec. 2430. (1) In lieu of the filing requirements of this chapter and as an alternative method of filing, any insurer or rating organization may file with the commissioner any manual of classification, rules or rates, any rating plan and every modification of any of the foregoing which it proposes to use, the filing to indicate the character and extent of the coverage contemplated. Every such filing under this section shall state the effective date thereof, shall take effect on said date, shall not be subject to any waiting period requirements, and shall be deemed to meet the requirements of section 2403 (1) (d) (rate standards). A filing and any supporting information shall be open to public inspection, if the filing is not disapproved.

(2) At any time within 15 days from and after the date of any such filing, the commissioner may give written notice to the insurer or rating organization making such filing, specifying in what respect and to what extent he contends such filing fails to comply with the requirements of section 2403 (1) (d) and fixing a date for hearing not less than 10 days from the date of mailing of such notice. At such hearing the factors specified in section 2406 (1) shall be considered. If the commissioner after hearing finds that the filing does not comply with the provisions of this chapter, he may issue his order determining wherein and to what extent such filing is deemed to be improper and fixing a date thereafter, within a reasonable time, after which such filing shall no longer be effective. Any order of disapproval under this section must be entered within 30 days of the date of the filing affected.

(3) In the event that no notice of hearing shall be issued within 15 days from the date of any such filing, the filing shall be deemed to be approved. If such filing shall be disapproved, the insuring provisions of any contract or policy issued prior to the time the order becomes effective shall not be affected. But if the commissioner disapproves such filing as not being in compliance with section 2403 (1) (d) (rate standards), he may order an adjustment of the premium to be made with the policyholder either by refund or collection of additional premium, if the amount is substantial and equals or exceeds the cost of making the adjustment. The commissioner may thereafter review any such filing in the manner provided in sections 2418 and 2420, but if so reviewed, no adjustment of premium may be ordered. Sections 2406 (2) (filing may be made by rating organization), 2408 (1) (commissioner shall review filing as soon as reasonably possible), and 2412 (insurer must adhere to filing) shall be applicable to filings made under this section.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2431 Group rated automobile insurance; MCL 500.2430 inapplicable.

Sec. 2431. Section 2430 does not apply to group rated automobile insurance.

History: Add. 1969, Act 346, Eff. Apr. 1, 1970;—Am. 1982, Act 7, Eff. Jan. 1, 1983.

Popular name: Act 218

500.2434 Malpractice insurance for physicians; rating classifications; furnishing classifications to legislature and governor.

Sec. 2434. (1) The commissioner, after consultation with associations representative of physician interests and with authorized insurers writing malpractice insurance for physicians in this state shall prescribe the rating classifications for use by insurers in writing malpractice insurance for physicians.

(2) Before 1 year after the effective date of chapter 49 and before implementing the rating classifications prescribed pursuant to subsection (1), the commissioner shall furnish to the legislature and the governor the rating classifications which he or she intends to prescribe pursuant to this section.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

500.2436 Application for license as rating organization; issuance of license by commissioner; fee; duration; notification of changes.

Sec. 2436. (1) A corporation, an association, a partnership, or an individual, whether located within or outside this state, may make application to the commissioner for a license as a rating organization to make rates and insurance contract forms for the kinds of insurance or subdivisions thereof, except for worker's compensation insurance, as are specified in its application and shall file with the application all of the following:

(a) A copy of its constitution, its articles of agreement or association, or its certificate of incorporation, and of its bylaws and rules governing the conduct of its business.

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(b) A list of its members and subscribers.

(c) The name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting the rating organization may be served.

(d) A statement of its qualifications as a rating organization.

(2) If the commissioner finds that the applicant is competent, trustworthy, and otherwise qualified to act as a rating organization and that its constitution, articles of agreement or association, or certificate of incorporation, and its bylaws and rules governing the conduct of its business conform to the requirements of law, he or she shall issue a license specifying the kinds of insurance or subdivisions thereof for which the applicant is authorized to act as a rating organization. Every application shall be granted or denied in whole or in part by the commissioner within 60 days of the date of its filing with the commissioner.

(3) The fee for the license shall be $25.00 which shall be in lieu of all other fees, licenses, or taxes imposed by the state or any political subdivision of the state.

(4) Licenses issued pursuant to this section shall remain in force for 3 years from date of issuance unless suspended or revoked by the commissioner, after hearing upon notice, pursuant to section 2478, in the event the rating organization ceases to meet the requirements of this section.

(5) Every rating organization shall notify the commissioner promptly of every change in any of the following:

(a) Its constitution, its articles of agreement or association, or its certificate of incorporation, and its bylaws and rules governing the conduct of its business.

(b) Its list of members and subscribers.

(c) The name and address of the resident of this state designated by it upon whom notices or orders of the commissioner or process affecting the rating organization may be served.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1970, Act 180, Imd. Eff. Aug. 3, 1970;—Am. 1982, Act 7, Eff. Jan. 1, 1983.

Popular name: Act 218

500.2438 Rating organizations; subscribers; notice of changes in rules; furnishing of service without discrimination; review; order.

Sec. 2438. (1) Subject to rules and regulations which have been approved by the commissioner as reasonable, each rating organization shall permit any insurer, not a member, to be a subscriber to its rating services for any kind of insurance or subdivision thereof for which it is authorized to act as a rating organization. Notice of proposed changes in such rules and regulations shall be given to subscribers. Each rating organization shall furnish its rating services without discrimination to its members and subscribers.

(2) The reasonableness of any rule or regulation in its application to subscribers, or the refusal of any rating organization to admit an insurer as a subscriber, shall, at the request of any subscriber or any such insurer, be reviewed by the commissioner at a hearing held upon at least 10 days' written notice to such rating organization and to such subscriber or insurer. If the commissioner finds that such rule or regulation is unreasonable in its application to subscribers, he shall order that such rule or regulation shall not be applicable to subscribers.

(3) If the rating organization fails to grant or reject an insurer's application for subscribership within 30 days after it was made, the insurer may request a review by the commissioner as if the application had been rejected. If the commissioner finds that the insurer has been refused admittance to the rating organization as a subscriber without justification, he shall order the rating organization to admit the insurer as a subscriber. If he finds that the action of the rating organization was justified, he shall make an order affirming its action.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2440 Rating organizations; rules affecting payment of dividends, savings or unabsorbed premium.

Sec. 2440. No rating organization shall adopt any rule the effect of which would be to prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2446 Rating organizations; cooperation with other rating organizations and insurers, discontinuance.

Sec. 2446. Cooperation among rating organizations or among rating organizations and insurers in rate making or in other matters within the scope of this chapter is hereby authorized, provided the filings resulting

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from such cooperation are subject to all the provisions of this chapter which are applicable to filings generally. The commissioner may review such cooperative activities and practices and if, after a hearing, he finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, he may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, and requiring the discontinuance of such activity or practice.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2450 Rating organizations; deviation from filings, procedure, termination of deviation.

Sec. 2450. (1) Every member of or subscriber to a rating organization shall adhere to the filings made on its behalf by such organization except that any such insurer may make written application to the commissioner to file a deviation from the class rates, schedules, rating plans or rules respecting any kind of insurance, or class of risk within a kind of insurance, or combination thereof. Such application shall specify the basis for the modification and a copy shall also be sent simultaneously to such rating organization. In considering the application to file such deviation the commissioner shall give consideration to the available statistics and the principles for rate making provided in section 2403. The commissioner shall issue an order permitting the deviation for such insurer to be filed if he finds it to be justified and it shall thereupon become effective. He shall issue an order denying such application if he finds that the deviation applied for does not meet the requirements of this chapter.

(2) Each deviation permitted to be filed shall remain in effect for a period of not less than 1 year from the effective date unless sooner withdrawn by the insurer with the approval of the commissioner or until terminated in accordance with the provisions of sections 2418 or 2420.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1964, Act 146, Eff. Aug. 28, 1964.

Popular name: Act 218

500.2452 Rating organizations; alternative deviation, without waiting period, procedure, termination of deviation.

Sec. 2452. (1) In lieu of the requirements of section 2450 for deviation and as an alternative method for deviation every member of or subscriber to a rating organization shall adhere to the filings made on its behalf by such organization except that any such insurer may make application to the commissioner to file a deviation from the class rates, schedules, rating plans or rules respecting any kind of insurance, or class of risk within a kind of insurance, or combination thereof. Such application shall specify the basis for the modification and a copy shall also be sent simultaneously to such rating organization. Every such application shall become effective immediately as of the date filed with the commissioner. In considering the application to file such deviation the commissioner shall give consideration to the available statistics and the principles for rate making provided in section 2403. The commissioner shall issue an order approving of the deviation as filed if he finds it meets the requirements of section 2403. If the commissioner finds that the deviation does not comply with the requirements of this chapter, he may issue an order determining wherein and to what extent such proposal is deemed to be improper and fixing a date thereafter, within a reasonable time, after which such deviation shall no longer be effective. Any order of disapproval under this section must be entered within 30 days of the date the application for the deviation affected is filed with the commissioner. If such deviation shall be disapproved, the insuring provisions of any contract or policy issued prior to the time the order becomes effective shall not be affected. But if the commissioner disapproves such deviation as not being in compliance with section 2403, he may order an adjustment of the premium to be made with the policyholder either by refund or collection of additional premium, if the amount is substantial and equals or exceeds the cost of making the adjustment.

(2) Each deviation filed and so approved shall remain in effect for a period of not less than 1 year from the effective date unless sooner withdrawn by the insurer with the approval of the commissioner or until terminated in accordance with the provisions of sections 2418 or 2420.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1964, Act 146, Eff. Aug. 28, 1964.

Popular name: Act 218

500.2456 Rating organizations; subscriber appeal to insurance commissioner from action by organization.

Sec. 2456. (1) Any member of or subscriber to a rating organization may appeal to the commissioner from the action or decision of such rating organization in approving or rejecting any proposed change in or addition to the filings of such rating organization and the commissioner shall, after a hearing held upon not less than

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10 days' written notice to the appellant and to such rating organization, issue an order approving the action or decision of such rating organization or directing it to give further consideration to such proposal, or, if such appeal is from the action or decision of the rating organization in rejecting a proposed addition to its filings, he may, in the event he finds that such action or decision was unreasonable, issue an order directing the rating organization to make an addition to its filing, on behalf of its members and subscribers, in a manner consistent with his findings, within a reasonable time after the issuance of such order.

(2) If such appeal is based upon the failure of the rating organization to make a filing on behalf of such member or subscriber which is based on a system of expense provisions which differs, in accordance with the right granted in section 2403 (1) (b) from the system of expense provisions included in a filing made by the rating organization, the commissioner shall, if he grants the appeal, order the rating organization to make the requested filing for use by the appellant. In deciding such appeal the commissioner shall apply the standards set forth in section 2403.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2458 Furnishing information as to rates; hearings for persons aggrieved by rating system; appeal; representation.

Sec. 2458. Each rating organization and insurer that makes its own rates, within a reasonable time after receiving written request for the information and on payment of a reasonable charge, shall furnish to an insured affected by a rate made by the rating organization or insurer, or to the insured's authorized representative, all pertinent information as to the rate. Pertinent information under this section does not include information that is a trade secret as determined by the director under section 2108(5) or 2406(6). Each rating organization and insurer that makes its own rates shall provide within this state reasonable means for a person aggrieved by the application of its rating system to be heard, in person or by his or her authorized representative, on his or her written request to review the manner in which the rating system has been applied in connection with the insurance afforded to him or her. If the rating organization or insurer fails to grant or reject the request within 30 days after it is made, the applicant may proceed in the same manner as if his or her application had been rejected. A party affected by the action of the rating organization or insurer on the request may appeal, within 30 days after written notice of the action, to the director, who, after a hearing held on not less than 10 days' written notice to the appellant and to the rating organization or insurer, may affirm or reverse the action. A person who requests a hearing before the director under this section may be represented at the hearing by an attorney. A person, other than an individual, that requests a hearing before the director under this section may also be represented by an officer or employee of that person. An individual who requests a hearing before the director under this section may also be represented by a relative of the individual.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1988, Act 262, Imd. Eff. July 15, 1988;—Am. 2015, Act 141, Eff. Jan. 11, 2016.

Popular name: Act 218

500.2462 Advisory organizations; definition; filing; discontinuance of unfair or unreasonable practices; rate filings; violation.

Sec. 2462. (1) Every group, association or other organization of insurers, whether located within or outside this state, which assists insurers which make their own filings or rating organizations in rate making, by the collection and furnishing of loss or expense statistics, or by the submission of recommendations, but which does not make filings under this chapter, shall be known as an advisory organization.

(2) Every advisory organization shall file with the commissioner:

(a) A copy of its constitution, its articles of agreement or association or its certificate of incorporation and of its bylaws, rules and regulations governing its activities,

(b) A list of its members,

(c) The name and address of a resident of this state upon whom notices or orders of the commissioner or process issued at his direction may be served, and

(d) An agreement that the commissioner may examine such advisory organization in accordance with the provisions of section 2468.

(3) If, after a hearing, the commissioner finds that the furnishing of such information or assistance involves any act or practice which is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, he may issue a written order specifying in what respects such act or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, and requiring the discontinuance of such act or practice.

(4) No insurer which makes its own filings nor any rating organization shall support its filings by statistics

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or adopt rate making recommendations, furnished to it by an advisory organization which has not complied with this section or with an order of the commissioner involving such statistics or recommendations issued under subsection (3) of this section. If the commissioner finds such insurer or rating organization to be in violation of this subsection he may issue an order requiring the discontinuance of such violation.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2464 Joint underwriting or reinsurance; unfair activities.

Sec. 2464. (1) Every group, association or other organization of insurers which engages in joint underwriting or joint reinsurance, shall be subject to regulation with respect thereto as herein provided, subject, however, with respect to joint underwriting, to all other provisions of this chapter and, with respect to joint reinsurance, to sections 2468 (examination), 2478 (penalties), and 2482 (appeals).

(2) If, after a hearing, the commissioner finds that any activity or practice of any such group, association or other organization is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, he may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, and requiring the discontinuance of such activity or practice.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2468 Examination of rating organizations; report.

Sec. 2468. (1) The commissioner may make or cause to be made an examination of each rating organization licensed in this state under section 2436, each advisory organization referred to in section 2462, and of each group, association, or other organization referred to in section 2464. The reasonable costs of the examination shall be paid by the rating organization, advisory organization, or group, association, or other organization examined upon presentation to it of a detailed account of those costs. The officer, manager, agents, and employees of the rating organization, advisory organization, or group, association, or other organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation. The examination is subject to the procedure provided for in section 222 relating to examinations of insurance companies.

(2) Instead of an examination under subsection (1), the commissioner may accept the report of an examination made by the insurance supervisory official of another state, pursuant to the laws of that state.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2002, Act 37, Imd. Eff. Mar. 7, 2002.

Popular name: Act 218

500.2472 Statistical plans; exchange of data, consultation.

Sec. 2472. (1) The commissioner shall promulgate reasonable rules and statistical plans, reasonably adapted to each of the rating systems on file with him, which may be modified from time to time and which shall be used thereafter to the extent applicable to its particular rating system or systems, by each insurer in the recording and reporting of its loss and countrywide expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid him in determining whether rating systems comply with the standards set forth in section 2403. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible of determination by a prorating of countrywide expense experience. In promulgating such rules and plans, the commissioner shall give due consideration to the rating systems on file with him and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it and no insurer shall be required to record or report its loss or expense experience on any basis or statistical plan that differs from that which is regularly employed and maintained in the usual course of such insurer's business, or to any rating organization or agency of which it is not a member or subscriber. The commissioner may designate 1 or more rating organizations or other agencies to assist him in gathering such experience and making compilations thereof, and such compilations shall be made available, subject to reasonable rules promulgated by the commissioner, to insurers and rating organizations.

(2) Reasonable rules and plans may be promulgated by the commissioner for the interchange of data necessary for the application of rating plans.

(3) In order to further uniform administration of rate regulatory laws, the commissioner and every insurer and rating organization may exchange information and experience data with insurance supervisory officials,

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insurers and rating organizations in other states and may consult with them with respect to rate making and the application of rating systems.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2474 Prohibited acts; violation; penalties.

Sec. 2474. A person or organization shall not wilfully withhold information from, or knowingly give false or misleading information to, the commissioner, any statistical agency designated by the commissioner, any rating organization, any data collection agency, or any insurer, which will affect the rates or premiums chargeable under this chapter. A violation of this section shall subject the person or organization guilty of the violation to the penalties provided in section 2478.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1982, Act 8, Eff. Jan. 1, 1983.

Popular name: Act 218

500.2475 Policy forms and statistical plans for worker's compensation insurance; continuation.

Sec. 2475. The policy forms and statistical plans for worker's compensation insurance in effect on January 1, 1983 may continue to be used until changed pursuant to the requirements of this act.

History: Add. 1982, Act 7, Eff. Jan. 1, 1983.

Popular name: Act 218

500.2476 Assigned risks; rate modifications.

Sec. 2476. Agreements may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements and rate modifications to be subject to the approval of the commissioner.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2477 Repealed. 2016, Act 102, Eff. Aug. 1, 2016.

Compiler's note: The repealed section pertained to submission of data and information by insurer providing professional liability insurance.

500.2477a Repealed. 2016, Act 102, Eff. Aug. 1, 2016.

Compiler's note: The repealed section pertained to submission of data by insurer providing municipal liability insurance.

500.2477b Repealed. 2016, Act 102, Eff. Aug. 1, 2016.

Compiler's note: The repealed section pertained to submission of data by person paying or assuming liability to pay municipality liability or professional liability claim against health care provider.

500.2477c Repealed. 2016, Act 102, Eff. Aug. 1, 2016.

Compiler's note: The repealed section pertained to submission of data by attorney representing plaintiff or defendant in regard to municipal liability or professional liability claim against health care provider.

500.2477d Repealed. 2016, Act 98, Eff. Aug. 1, 2016.

Compiler's note: The repealed section pertained to publication of report by commissioner.

500.2478 Violation of chapter; imposition and disposition of civil fine; suspension or revocation of license.

Sec. 2478. (1) Subject to subsection (3), the commissioner may, if he or she finds that any person or organization has violated a provision of this chapter, previous to the date of his or her finding, impose a civil fine of not more than $300.00 for each violation, and if the violation is wilful, the commissioner may impose a civil fine of not more than $1,500.00 for each violation. A civil fine shall not be imposed for an offense that was committed more than 12 months prior to the date of the commissioner's findings. A fine collected under this subsection shall be turned over to the state treasurer and credited to the general fund of the state.

(2) The commissioner may suspend the license of any rating organization or insurer which fails to comply with an order of the commissioner within the time specified by the order, or any extension of the order which the commissioner may grant, but the suspension shall not affect the validity or continued effectiveness of rates

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previously filed and effective. The commissioner shall not suspend the license of any rating organization or insurer for failure to comply with an order until the time prescribed for an appeal from the order has expired, or, if an appeal has been taken, until the order has been affirmed. The commissioner may determine when a suspension of license shall become effective, and the suspension shall remain in effect for the period fixed by him or her, unless he or she modifies or rescinds the suspension, or until the order upon which the suspension is based is modified, rescinded, or reversed.

(3) A civil fine shall not be imposed and a license shall not be suspended or revoked except upon a written order of the commissioner, specifying the alleged violation and stating his or her findings, made after a hearing held upon not less than 10 days' written notice to the person or organization. An order issued by the commissioner pursuant to this section shall not require the payment of civil fines exceeding $10,000.00.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1984, Act 7, Imd. Eff. Feb. 1, 1984.

Popular name: Act 218

500.2482 Insurer or rating organization aggrieved by order without hearing; hearing, court review.

Sec. 2482. (1) Any insurer or rating organization aggrieved by any order or decision of the commissioner made without a hearing, may within 30 days after notice of the order to the insurer or organization, make written request to the commissioner for a hearing thereon. The commissioner shall hear such party or parties within 20 days after receipt of such request and shall give not less than 10 days' written notice of the time and place of the hearing. Within 15 days after such hearing the commissioner shall affirm, reverse or modify his previous action, specifying his reasons therefor. Pending such hearing and decision thereon the commissioner may suspend or postpone the effective date of his previous action.

(2) Any order or decision of the commissioner shall be subject to review in accordance with the provisions of section 244, but no order or decision appealed from as herein provided shall become effective or be enforced pending final disposition of such appeal.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2484 Insurance commissioner; regulatory powers.

Sec. 2484. The commissioner may make reasonable rules and regulations necessary to effect the purposes of this chapter.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

Administrative rules: R 500.901 et seq. and R 500.1201 et seq. of the Michigan Administrative Code.

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CHAPTER 25
BROWN-McNEELY INSURANCE FUND

500.2500-500.2517 Repealed. 1977, Act 42, Imd. Eff. June 28, 1977;—1996, Act 548, Imd. Eff. Jan. 15, 1997.

Popular name: Act 218

CHAPTER 26
FIRE AND INLAND MARINE RATES

500.2600 Purpose of chapter; construction.

Sec. 2600. The purpose of this chapter is to promote the public welfare by regulating insurance rates to the end that they shall not be excessive, inadequate or unfairly discriminatory, and to authorize and regulate cooperative action among insurers in rate making and in other matters within the scope of the insurance code. Nothing in this chapter is intended (1) to prohibit or discourage reasonable competition, or (2) to prohibit, or encourage except to the extent necessary to accomplish the aforementioned purpose, uniformity in insurance rates, rating systems, rating plans or practices. Conformity with this chapter shall not be deemed to be a violation of section 2075 (compacts to restrain competition prohibited). This chapter shall be liberally interpreted to carry into effect the provisions of this section.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

Administrative rules: R 501.251 et seq. of the Michigan Administrative Code.

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500.2601 Scope of chapter.

Sec. 2601. (1) This chapter applies to the following kinds of insurance as written on risks located in this state by and companies, associations, or other carriers, including reciprocals:

(a) Property insurance, as defined in section 610.

(b) Marine insurance, as defined in section 614.

(c) Inland navigation and transportation insurance, as defined in section 616.

(d) Automobile insurance (limited), as defined in section 620.

(2) "Inland marine insurance" shall be considered to include:

(a) Insurance against loss of or damage to domestic shipments, bridges, tunnels, and other inland instrumentalities of transportation or communication, excluding buildings, their furniture and furnishings, fixed contents, and supplies held in storage.

(b) Insurance defined by ruling of the commissioner as inland marine insurance.

(3) This chapter does not apply to any of the following:

(a) Reinsurance, other than joint reinsurance to the extent stated in section 2658.

(b) Insurance against loss of or damage to:

(*i*) Imports, exports, or domestic shipments.

(*ii*) Bridges, tunnels, or other instrumentalities of transportation and communication.

(*iii*) Aircraft and attached equipment.

(*iv*) Vessels and watercraft under construction or owned by or used in a business or having a straight-line hull length of more than 24 feet.

(c) Insurance against loss resulting from liability arising out of the ownership, maintenance, or use of:

(*i*) Imports, exports, or domestic shipments.

(*ii*) Aircraft and attached equipment.

(*iii*) Vessels and watercraft that are under construction or owned by or used in a business or having a straight-line hull length of more than 24 feet.

(d) Motor vehicle insurance, nor to insurance against liability arising out of the ownership, maintenance, or use of motor vehicles.

(e) Companies organized and doing business under chapter 68.

(f) Insurance that meets both of the following:

(*i*) Is sold to an exempt commercial policyholder.

(*ii*) Contains a prominent disclaimer that states "This policy is exempt from the filing requirements of section 2236 of the insurance code of 1956, 1956 PA 218, MCL 500.2236." or words that are substantially similar.

(4) If any kind of insurance, subdivision, or combination thereof, or type of coverage, subject to this chapter, is also subject to regulation by another rate regulatory chapter of this act, an insurer to which both chapters are otherwise applicable shall file with the commissioner a designation as to which rate regulatory chapter shall be applicable to it with respect to such kind of insurance, subdivision, or combination thereof, or type of coverage.

(5) If, pursuant to subsection (6), the commissioner certifies the absence of a reasonable degree of competition for a specified classification, type, or kind of insurance, the commissioner may order that each insurer file for prior approval, subject to the provisions of this chapter, any changes to its manuals of classification, manuals of rules and rates, and rating plans the insurer proposes to use for that specified classification, type, or kind of insurance. The order shall state, in writing, the reasons for the commissioner's decision to order the filing. An order issued under this subsection expires 2 years after the date of issuance. If such an order is in effect, rates to which the order applies shall be filed at least 30 days before their proposed effective date. Failure of the commissioner to act within 30 days after submittal constitutes approval.

(6) A determination concerning the existence of a reasonable degree of competition shall take into account a reasonable spectrum of relevant economic tests, including the number of insurers actively engaged in writing the insurance in question, the present availability of that insurance compared to the availability in comparable past periods, the underwriting return of that insurance over a reasonable period of time sufficient to assure reliability in relation to the risk associated with that insurance, and the difficulty encountered by new insurers entering the market in order to compete for the writing of that insurance.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1970, Act 180, Imd. Eff. Aug. 3, 1970;—Am. 2002, Act 664, Eff. Mar. 31, 2003.

Compiler's note: In subsection (1), the phrase “as written on risks located in this state by and companies” evidently should read “as written on risks located in this state by any companies”.

Popular name: Act 218

500.2603 Rate-making provisions; uniformity.

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Sec. 2603. (1) All rates shall be made in accordance with the following provisions:

(a) Due consideration shall be given to past and prospective loss experience within and outside this state; to catastrophe hazards; to a reasonable margin for underwriting profit and contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; to past and prospective expenses, both countrywide and those specially applicable to this state; and to all other relevant factors within and outside this state. In the case of fire insurance rates, consideration also shall be given to the experience of the fire insurance business during a period of not less than the most recent 5-year period for which that experience is available.

(b) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group with respect to any kind of insurance or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

(c) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which measure variations in hazards, expense provisions, or both. The rating plans may measure any differences among risks that may have a probable effect upon losses or expenses as provided for in subdivision (a).

(d) Rates shall not be excessive, inadequate, or unfairly discriminatory. A rate shall not be held to be excessive unless the rate is unreasonably high for the insurance coverage provided and a reasonable degree of competition does not exist with respect to the classification, kind, or type of risks to which the rate is applicable. A rate shall not be held to be inadequate unless the rate is unreasonably low for the insurance coverage provided and the continued use of the rate endangers the solvency of the insurer; or unless the rate is unreasonably low for the insurance provided and the use of the rate has or will have the effect of destroying competition among insurers, creating a monopoly, or causing a kind of insurance to be unavailable to a significant number of applicants who are in good faith entitled to procure the insurance through ordinary methods. A rate for a coverage is unfairly discriminatory in relation to another rate for the same coverage, if the differential between the rates is not reasonably justified by differences in losses, expenses, or both, or by differences in the uncertainty of loss for the individuals or risks to which the rates apply. A reasonable justification shall be supported by a reasonable classification system; by sound actuarial principles when applicable; and by actual and credible loss and expense statistics or, in the case of new coverages and classifications, by reasonably anticipated loss and expense experience. A rate is not unfairly discriminatory because the rate reflects differences in expenses for individuals or risks with similar anticipated losses, or because the rate reflects differences in losses for individuals or risks with similar expenses. Rates are not unfairly discriminatory if they are averaged broadly among persons insured on a group, franchise, blanket policy, or similar basis.

(2) Except to the extent necessary to meet the provisions of subsection (1)(d), uniformity among insurers in any matters within the scope of this section is neither required nor prohibited.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1969, Act 346, Eff. Apr. 1, 1970;—Am. 1979, Act 145, Imd. Eff. Nov. 13, 1979.

Popular name: Act 218

500.2604 Expired. 1980, Act 461, Eff. Dec. 31, 1980.

Compiler's note: The expired section pertained to underwriting.
Subsequent to its expiration, this section was amended by Act 461 of 1980.

Popular name: Act 218

500.2606 Rate filings; proposed effective date; character and extent of coverage; insufficient information; public inspection; trade secret; inland marine rates; insurer as member of or subscriber to rating organization.

Sec. 2606. (1) Each insurer shall file with the director, except as to inland marine risks that by general custom of the business are not written according to manual rates or rating plans, every manual, minimum, class rate, rating schedule or rating plan and every other rating rule, and every modification of any of the foregoing that it proposes to use. In its filing, each insurer shall state the proposed effective date of the filing and shall indicate the character and extent of the coverage contemplated.

(2) If a filing is not accompanied by the information on which the insurer supports the filing, and the director does not have sufficient information to determine whether the filing meets the requirements of this chapter, the director shall require the insurer to furnish the information that supports the filing and the waiting period commences on the date the information is furnished. The information furnished in support of a filing may include the experience or judgment of the insurer or rating organization making the filing, its

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interpretation of any statistical data it relies on, the experience of other insurers or rating organizations, or any other relevant factors.

(3) Except as otherwise provided in this subsection, the department shall make a filing under this section and any supporting information open to public inspection after the filing becomes effective. An insurer or a rating organization filing on the insurer's behalf may designate information included in the filing or any accompanying information as a trade secret. The insurer or the rating organization filing on behalf of the insurer shall demonstrate to the director that the designated information is a trade secret. If the director determines that the information is a trade secret, the information is not subject to public inspection and is exempt from the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246. As used in this subsection, "trade secret" means that term as defined in section 2 of the uniform trade secrets act, 1998 PA 448, MCL 445.1902. However, trade secret does not include filings and information accompanying filings under this section that were subject to public inspection before the effective date of the amendatory act that added this sentence.

(4) Specific inland marine rates on risks specially rated, made by a rating organization, must be filed with the director.

(5) An insurer may satisfy its obligation to make filings under this section by becoming a member of, or a subscriber to, a licensed rating organization that makes filings, and by filing with the director a copy of its authorization of the rating organization to make the filings on its behalf. This chapter does not require an insurer to become a member of or a subscriber to a rating organization.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1970, Act 180, Imd. Eff. Aug. 3, 1970;—Am. 2015, Act 141, Eff. Jan. 11, 2016.

Popular name: Act 218

500.2608 Rate filings; review by insurance commissioner; waiting period; specific inland marine rates on risks.

Sec. 2608. (1) The commissioner shall review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this chapter.

(2) Subject to the exception specified in subsection (3) of this section, each filing shall be on file for a waiting period of 15 days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed 15 days if he gives written notice within such waiting period to the insurer or rating organization which made the filing that he needs such additional time for the consideration of such filing. Upon written application by such insurer or rating organization, the commissioner may authorize a filing which he has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or any extension thereof.

(3) Specific inland marine rates on risks specially rated by a rating organization shall become effective when filed and shall be deemed to meet the requirements of this chapter until such time as the commissioner reviews the filing and so long thereafter as the filing remains in effect.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2610 Filing requirements; modification or suspension by insurance commissioner.

Sec. 2610. Under such rules and regulations as he shall adopt the commissioner may, by written order, suspend or modify the requirement of filing 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. Such orders, rules and regulations shall be made known to insurers and rating organizations affected thereby. The commissioner may make such examination as he may deem advisable to ascertain whether any rates affected by such order meet the standards set forth in subdivision (b) of subsection (1) of section 2603 (rate standards).

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2612 Rate filings; adherence by insurer.

Sec. 2612. No insurer shall make or issue a contract except in accordance with the filings which are in effect for said insurer as provided in this chapter or in accordance with sections 2610 or 2614. This section shall not apply to contracts or policies for inland marine risks as to which filings are not required.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2614 Rate organization; excess rates on specific risks.

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Sec. 2614. Upon the written application of the insured, stating his reasons therefor, filed with and approved by the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2616 Disapproval of filing by insurance commissioner; notice; waiting period; specific inland marine rate.

Sec. 2616. (1) If within the waiting period or any extension thereof as provided in section 2608 (2), the commissioner finds that a filing does not meet the requirements of this chapter, he shall send to the insurer or rating organization which made such filing, written notice of disapproval of such filing specifying therein in what respects he finds such filing fails to meet the requirements of this chapter and stating that such filing shall not become effective.

(2) If within 30 days after a specific inland marine rate on a risk specially rated by a rating organization, subject to section 2608 (3) has become effective, the commissioner finds that such filing does not meet the requirements of this chapter, he shall send to the rating organization which made such filing written notice of disapproval of such filing specifying therein in what respects he finds that such filing fails to meet the requirements of this chapter and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. Said disapproval shall not affect any contract made or issued prior to the expiration of the period set forth in said notice.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2618 Failure of filing to meet requirements; procedure.

Sec. 2618. If at any time after the applicable review period provided for in section 2616, the commissioner finds that a filing does not meet the requirements of this chapter, the commissioner shall, after a hearing held upon not less than 10 days' written notice, specifying the matters to be considered at the hearing, to every insurer and rating organization that made the filing, issue an order specifying in what respects the commissioner finds that the filing fails to meet the requirements of this chapter, and stating when, within a reasonable period thereafter, that filing shall be considered no longer effective. A copy of the order shall be sent to every insurer and rating organization subject to the order. The order shall not affect any contract or policy made or issued before the date the filing becomes ineffective as indicated in the commissioner's order.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2008, Act 241, Imd. Eff. July 17, 2008.

Popular name: Act 218

500.2620 Disapproval of filing; complaint of aggrieved person or organization; hearing; notice; order rendering filing ineffective.

Sec. 2620. (1) Any person or organization aggrieved with respect to any filing which is in effect may make written application to the commissioner for a hearing thereon: Provided, however, That the insurer or rating organization that made the filing shall not be authorized to proceed under this section. Such application shall specify the grounds to be relied upon by the applicant.

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

(3) If, after such hearing, the commissioner finds that the filing does not meet the requirements of this chapter, he shall issue an order specifying in what respects he finds that such filing fails to meet the requirements of this chapter, and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. Copies of said order shall be sent to the applicant and to every such insurer and rating organization. Said order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in said order.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2626 Manual, minimum, class rate, rating schedule, rating plan or rule; rates meeting standards.

Sec. 2626. No manual, minimum, class rate, rating schedule, rating plan, rating rule, or any modification of any of the foregoing which has been filed pursuant to the requirements of sections 2606 through 2614 shall be

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disapproved if the rates thereby produced meet the requirements of this chapter.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2628 Rates; alternative method of filing; disapproval; hearing; order; approval; adjustment of premium; review.

Sec. 2628. (1) In lieu of the filing requirements of this chapter and as an alternative method of filing, any insurer or rating organization may file with the commissioner any manual of classification, rules or rates, any rating plan and every modification of any of the foregoing which it proposes to use, the filing to indicate the character and extent of the coverage contemplated. Every such filing under this section shall state the effective date thereof, shall take effect on said date, shall not be subject to any waiting period requirements, and shall be deemed to meet the requirements of subdivision (d) of subsection (1) of section 2603 (rate standards). A filing and any supporting information shall be open to public inspection, if the filing is not disapproved.

(2) At any time within 15 days from and after the date of any such filing, the commissioner may give written notice to the insurer or rating organization making such filing specifying in what respect and to what extent he contends such filing fails to comply with the requirements of subdivision (d) of subsection (1) of section 2603 and fixing a date for hearing not less than 10 days from the date of mailing of such notice. At such hearing the factors specified in subsection (2) of section 2606 shall be considered. If the commissioner after hearing finds that the filing does not comply with the provisions of this chapter, he may issue his order determining wherein and to what extent such filing is deemed to be improper and fixing a date thereafter, within a reasonable time, after which such filing shall no longer be effective. Any order of disapproval under this section must be entered within 30 days of the date of the filing affected.

(3) In the event that no notice of hearing shall be issued within 15 days from the date of any such filing, the filing shall be deemed to be approved. If such filing shall be disapproved, the insuring provisions of any contract or policy issued prior to the time the order becomes effective shall not be affected. But if the commissioner disapproves such filing as not being in compliance with subdivision (d) of subsection (1) of section 2603 (rate standards), he may order an adjustment of the premium to be made with the policyholder either by refund or collection of additional premium, if the amount is substantial and equals or exceeds the cost of making the adjustment. The commissioner may thereafter review any such filing in the manner provided in sections 2618 and 2620, but if so reviewed, no adjustment of premium may be ordered. Subsection (5) of section 2606 (filing may be made by rating organization), subsection (1) of section 2608 (commissioner shall review filing as soon as reasonably possible), and 2612 (insurer must adhere to filing) shall be applicable to filings made under this section.

History: Add. 1969, Act 346, Eff. Apr. 1, 1970.

Popular name: Act 218

500.2630 Rating organization; license application, contents.

Sec. 2630. (1) A corporation, an unincorporated association, a partnership or an individual, whether located within or outside this state, may make application to the commissioner for license as a rating organization to make rates and insurance contract forms for such kinds of insurance, or subdivision or class of risk or a part or combination thereof as are specified in its application and shall file therewith:

(a) A copy of its constitution, its articles of agreement or association or its certificate of incorporation, and of its bylaws and rules governing the conduct of its business.

(b) A list of its members and subscribers.

(c) The name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting such rating organization may be served.

(d) A statement of its qualifications as a rating organization.

(2) If the commissioner finds that the applicant is competent, trustworthy and otherwise qualified to act as a rating organization and that its constitution, articles of agreement or association or certificate of incorporation, and its bylaws and rules governing the conduct of its business conform to the requirements of law, he shall issue a license specifying the kinds of insurance, or subdivision or class of risk or part or combination thereof for which the applicant is authorized to act as a rating organization. Every such application shall be granted or denied in whole or in part by the commissioner within 60 days of the date of its filing with him.

(3) Licenses issued pursuant to this section shall remain in effect for 3 years unless sooner suspended or revoked by the commissioner.

(4) The fee for the license shall be $25.00.

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(5) Licenses issued pursuant to this section may be suspended or revoked by the commissioner, after hearing upon notice, in the event the rating organization ceases to meet the requirements of this section.

(6) Every rating organization shall notify the commissioner promptly of every change in (a) its constitution, its articles of agreement or association, or its certificate of incorporation, and its bylaws and rules governing the conduct of its business, (b) its list of members and subscribers and (c) the name and address of the resident of this state designated by it upon whom notices or orders of the commissioner or process affecting such rating organization may be served.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1970, Act 180, Imd. Eff. Aug. 3, 1970.

Popular name: Act 218

500.2636 Rating organizations; subscribers; notice of changes in rules and regulations; review; order.

Sec. 2636. (1) Subject to rules and regulations which have been approved by the commissioner as reasonable, each rating organization shall permit any insurer, not a member, to be a subscriber to its rating services for any kind of insurance, subdivision, or class of risk or a part or combination thereof for which it is authorized to act as a rating organization. Notice of proposed changes in such rules and regulations shall be given to subscribers. Each rating organization shall furnish its rating services without discrimination to its members and subscribers.

(2) The reasonableness of any rule or regulation in its application to subscribers, or the refusal of any rating organization to admit an insurer as a subscriber, shall, at the request of any subscriber or any such insurer, be reviewed by the commissioner at a hearing held upon at least 10 days' written notice to such rating organization and to such subscriber or insurer. If the commissioner finds that such rule or regulation is unreasonable in its application to subscribers, he shall order that such rule or regulation shall not be applicable to subscribers.

(3) If the rating organization fails to grant or reject an insurer's application for subscribership within 30 days after it was made, the insurer may request a review by the commissioner as if the application had been rejected. If the commissioner finds that the insurer has been refused admittance to the rating organization as a subscriber without justification, he shall order the rating organization to admit the insurer as a subscriber. If he finds that the action of the rating organization was justified, he shall make an order affirming its action.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2638 Rating organizations; rules affecting payment of dividends, savings or unabsorbed premiums.

Sec. 2638. No rating organization shall adopt any rule the effect of which would be to prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2640 Rating organizations; cooperation with other rating organizations and insurers, discontinuance.

Sec. 2640. Cooperation among rating organizations or among rating organizations and insurers in rate making or in other matters within the scope of this chapter is hereby authorized, provided the filings resulting from such cooperation are subject to all the provisions of this chapter which are applicable to filings generally. The commissioner may review such cooperative activities and practices and if, after a hearing, he finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, he may issue a written order specifying in what respect such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, and requiring the discontinuance of such activity or practice.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2642 Rating organizations; submission of policies for examination; actuarial, technical, or other services.

Sec. 2642. (1) Any rating organization may provide for the examination of policies, daily reports, binders, renewal certificates, endorsements or other evidences of insurance, or the cancellation thereof, and may make reasonable rules governing their submission. Such rules shall contain a provision for the notification of the

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insurer and the agent involved of any error or omission in the matters examined, and shall also contain a provision that in the event any insurer does not within 60 days furnish satisfactory evidence to the rating organization of the correction of any error or omission previously called to its attention by the rating organization, it shall be the duty of the rating organization to notify the commissioner thereof. All information so submitted for examination shall be confidential.

(2) Any rating organization may subscribe for or purchase actuarial, technical or other services, and such services shall be available to all members and subscribers without discrimination.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2646 Rating organizations; deviation, procedure, termination of deviation.

Sec. 2646. (1) Every member of or subscriber to a rating organization shall adhere to the filings made on its behalf by such organization except that any such insurer may make written application to the commissioner to file a deviation from the class rates, schedules, rating plans or rules respecting any kind of insurance, or class of risk within a kind of insurance, or combination thereof. Such application shall specify the basis for the modification and a copy shall also be sent simultaneously to such rating organization. In considering the application to file such deviation the commissioner shall give consideration to the available statistics and the principles for rate making provided in section 2603. The commissioner shall issue an order permitting the deviation for such insurer to be filed if he finds it to be justified and it shall thereupon become effective. He shall issue an order denying such application if he finds that the deviation applied for does not meet the requirements of this chapter.

(2) Each deviation permitted to be filed shall remain in effect for a period of not less than 1 year from the effective date unless sooner withdrawn by the insurer with the approval of the commissioner or until terminated in accordance with the provisions of sections 2618 or 2620.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1964, Act 146, Eff. Aug. 28, 1964.

Popular name: Act 218

500.2648 Rating organizations; alternative methods for deviation.

Sec. 2648. (1) In lieu of the requirements of section 2646 for deviation and as an alternative method for deviation every member of or subscriber to a rating organization shall adhere to the filings made on its behalf by such organization except that any such insurer may make application to the commissioner to file a deviation from the class rates, schedules, rating plans or rules respecting any kind of insurance, or class of risk within a kind of insurance, or combination thereof. Such application shall specify the basis for the modification and a copy shall also be sent simultaneously to such rating organization. Every such application shall become effective immediately as of the date filed with the commissioner. In considering the application to file such deviation the commissioner shall give consideration to the available statistics and the principles for rate making provided in section 2603. The commissioner shall issue an order approving of the deviation as filed if he finds it meets the requirements of section 2603. If the commissioner finds that the deviation does not comply with the requirements of this chapter, he may issue an order determining wherein and to what extent such proposal is deemed to be improper and fixing a date thereafter, within a reasonable time, after which such deviation shall no longer be effective. Any order of disapproval under this section must be entered within 30 days of the date the application for the deviation affected is filed with the commissioner. If such deviation shall be disapproved, the insuring provisions of any contract or policy issued prior to the time the order becomes effective shall not be affected. But if the commissioner disapproves such deviation as not being in compliance with section 2603, he may order an adjustment of the premium to be made with the policyholder either by refund or collection of additional premium, if the amount is substantial and equals or exceeds the cost of making the adjustment.

(2) Each deviation filed and so approved shall remain in effect for a period of not less than 1 year from the effective date unless sooner withdrawn by the insurer with the approval of the commissioner or until terminated in accordance with the provisions of sections 2618 or 2620.

History: Add. 1969, Act 346, Eff. Apr. 1, 1970.

Popular name: Act 218

500.2650 Rating organizations; member or subscriber, appeal to insurance commissioner.

Sec. 2650. Any member of or subscriber to a rating organization may appeal to the commissioner from the action or decision of such rating organization in approving or rejecting any proposed change in or addition to the filings of such rating organization. The commissioner shall, after a hearing held upon not less than 10 days' written notice to the appellant and to such rating organization, issue an order approving the action or

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decision of such rating organization or directing it to give further consideration to such proposal, or, if such appeal is from the action or decision of the rating organization in rejecting a proposed addition to its filings, he may, in the event he finds that such action or decision was unreasonable, issue an order directing the rating organization to make an addition to its filings, on behalf of its members and subscribers, in a manner consistent with his findings, within a reasonable time after the issuance of such order.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2652 Rating organization and insurer; rating information to insured, hearing; appeal.

Sec. 2652. Each rating organization and insurer that makes its own rates, within a reasonable time after receiving written request for the information and on payment of a reasonable charge, shall furnish to an insured affected by a rate made by it, or to the insured's authorized representative, all pertinent information as to the rate. Pertinent information under this section does not include information that is a trade secret as determined by the director under section 2108(5) or 2406(6). Each rating organization and insurer that makes its own rates shall provide within this state reasonable means for a person aggrieved by the application of its rating system to be heard, in person or by his or her authorized representative, on his or her written request to review the manner in which the rating system has been applied in connection with the insurance afforded him or her. If the rating organization or insurer fails to grant or reject the request within 30 days after it is made, the applicant may proceed in the same manner as if the applicant's application had been rejected. A party affected by the action of the rating organization or the insurer on the request may appeal, within 30 days after written notice of the action, to the director, who, after a hearing held on not less than 10 days' written notice to the appellant and to the rating organization or insurer, may affirm or reverse the action.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2015, Act 141, Eff. Jan. 11, 2016.

Popular name: Act 218

500.2654 Advisory organizations; definition; filing; discontinuance of unfair or unreasonable practices; rate filings; violation.

Sec. 2654. (1) Every group, association or other organization of insurers, whether located within or outside this state, which assists insurers which make their own filings or rating organizations in rate making, by the collection and furnishing of loss or expense statistics, or by the submission of recommendations, but which does not make filings under this chapter, shall be known as an advisory organization.

(2) Every advisory organization shall file with the commissioner:

(a) A copy of its constitution, its articles of agreement or association or its certificate of incorporation and of its bylaws, rules and regulations governing its activities,

(b) A list of its members,

(c) The name and address of a resident of this state upon whom notices or orders of the commissioner or process issued at his direction may be served, and

(d) An agreement that the commissioner may examine such advisory organization in accordance with the provisions of section 2662.

(3) If, after a hearing, the commissioner finds that the furnishing of such information or assistance involves any act or practice which is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, he may issue a written order specifying in what respects such act or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, and requiring the discontinuance of such act or practice.

(4) No insurer which makes its own filings nor any rating organization shall support its filings by statistics or adopt rate making recommendations, furnished to it by an advisory organization which has not complied with this section or with an order of the commissioner involving such statistics or recommendations issued under subsection (3) of this section. If the commissioner finds such insurer or rating organization to be in violation of this subsection he may issue an order requiring the discontinuance of such violation.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2658 Joint underwriting or reinsurance; unfair activities.

Sec. 2658. (1) Every group, association or other organization of insurers which engages in joint underwriting or joint reinsurance, shall be subject to regulation with respect thereto as herein provided, subject, however, with respect to joint underwriting, to all other provisions of this chapter and, with respect to joint reinsurance, to sections 2662 (examination), 2670 (penalties), and 2672 (appeals).

(2) If, after a hearing, the commissioner finds that any activity or practice of any such group, association or

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other organization is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, he may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, and requiring the discontinuance of such activity or practice.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2662 Examination of rating advisory organizations; report.

Sec. 2662. (1) The commissioner may make or cause to be made an examination of each rating organization licensed in this state under section 2630, each advisory organization referred to in section 2654, and of each group, association, or other organization referred to in section 2658. The reasonable costs of the examination shall be paid by the rating organization, advisory organization, or group, association, or other organization examined upon presentation to it of a detailed account of those costs. The officers, managers, agents, and employees of the rating organization, advisory organization, or group, association, or other organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation. The examination is subject to the procedure provided for in section 222 relating to examinations of insurance companies.

(2) Instead of an examination under subsection (1), the commissioner may accept the report of an examination made by the insurance supervisory official of another state, pursuant to the laws of that state.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2002, Act 37, Imd. Eff. Mar. 7, 2002.

Popular name: Act 218

500.2664 Statistical plans; exchange of data, consultation.

Sec. 2664. (1) The commissioner shall promulgate reasonable rules and statistical plans, reasonably adapted to each of the rating systems on file with him, which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss and countrywide expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid him in determining whether rating systems comply with the standards set forth in section 2603. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible of determination by a prorating of countrywide expense experience. In promulgating such rules and plans, the commissioner shall give due consideration to the rating systems on file with him and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it. The commissioner may designate 1 or more rating organizations or other agencies to assist him in gathering such experience and making compilations thereof, and such compilations shall be made available, subject to reasonable rules promulgated by the commissioner, to insurers and rating organizations.

(2) Reasonable rules and plans may be promulgated by the commissioner for the interchange of data necessary for the application of rating plans.

(3) In order to further uniform administration of rate regulatory laws, the commissioner and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult with them with respect to rate making and the application of rating systems.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2666 Withholding information, false or misleading information; penalties.

Sec. 2666. No person or organization shall wilfully withhold information from, or knowingly give false or misleading information to, the commissioner, any statistical agency designated by the commissioner, any rating organization, or any insurer, which will affect the rates or premiums chargeable under this chapter. A violation of this section shall subject the one guilty of such violation to the penalties provided in section 2670.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2670 Violation of chapter; imposition and disposition of civil fines; suspension or revocation of license.

Sec. 2670. (1) Subject to subsection (3), the commissioner may, if he or she finds that any person or

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organization has violated any provision of this chapter, impose a civil fine of not more than $300.00 for each violation, but if the commissioner finds the violation to be wilful, the commissioner may impose a civil fine of not more than $1,500.00 for each violation. Civil fines imposed under this subsection may be in addition to any other penalty provided by law. A fine collected under this subsection shall be turned over to the state treasurer and credited to the general fund of the state.

(2) The commissioner may suspend the license of any rating organization or insurer which fails to comply with an order of the commissioner within the time specified by the order, or any extension of the order which the commissioner may grant. The commissioner shall not suspend the license of any rating organization or insurer for failure to comply with an order until the time prescribed for an appeal from the order has expired or if an appeal has been taken, until the order has been affirmed. The commissioner may determine when a suspension of license shall become effective, and the suspension shall remain in effect for the period fixed by the commissioner, unless he or she modifies or rescinds the suspension, or until the order upon which the suspension is based is modified, rescinded, or reversed.

(3) A civil fine shall not be imposed and a license shall not be suspended or revoked except upon a written order of the commissioner, specifying the alleged violation and stating his or her findings, made after a hearing held upon not less than 10 days' written notice to the person or organization. An order issued by the commissioner pursuant to this section shall not require the payment of civil fines exceeding $10,000.00.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1984, Act 7, Imd. Eff. Feb. 1, 1984.

Popular name: Act 218

500.2672 Insurer or rating organization aggrieved by order without hearing; hearing, court review.

Sec. 2672. (1) Any insurer or rating organization aggrieved by any order or decision of the commissioner made without a hearing, may, within 30 days after notice of the order to the insurer or organization, make written request to the commissioner for a hearing thereon. The commissioner shall hear such party or parties within 20 days after receipt of such request and shall give not less than 10 days' written notice of the time and place of the hearing. Within 15 days after such hearing the commissioner shall affirm, reverse or modify his previous action, specifying his reasons therefor. Pending such hearing and decision thereon the commissioner may suspend or postpone the effective date of his previous action.

(2) Any order or decision of the commissioner shall be subject to review in accordance with the provisions of section 244.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2674 Insurance commissioner; regulatory powers.

Sec. 2674. The commissioner may make reasonable rules and regulations necessary to effect the purposes of this chapter.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

Administrative rules: R 500.1301 et seq. and R 501.251 et seq. of the Michigan Administrative Code.

CHAPTER 27
LEGAL EXPENSE INSURANCE

500.2700 Applicability of chapter.

Sec. 2700. This chapter shall apply to legal expense insurance policies.

History: Add. 1982, Act 501, Imd. Eff. Dec. 31, 1982.

Popular name: Act 218

500.2702 Meaning of group legal expense insurance.

Sec. 2702. Group legal expense insurance is that form of voluntary legal expense insurance covering not less than 5 employees or members, with or without their eligible dependents, written under a master policy issued to any governmental corporation, unit, agency, or department thereof, or to any corporation, partnership, individual employer, or any association, upon application of any executive officer or trustee of such association having a constitution or bylaws, and formed in good faith for purposes other than that of obtaining insurance where officers, members, employees, or classes or departments thereof may be insured for their individual benefit.

History: Add. 1982, Act 501, Imd. Eff. Dec. 31, 1982.

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Popular name: Act 218

500.2704 Rate-making procedure; uniformity among insurers; excessive rates.

Sec. 2704. (1) All rates shall be made in accordance with this section and all of the following:

(a) Due consideration shall be given to past and prospective loss experience within and outside this state; to catastrophe hazards; to a reasonable margin for underwriting profit and contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; to past and prospective expenses, both countrywide and those specially applicable to this state; to underwriting practice, judgment, and to all other relevant factors within and outside this state. Experience rating is permitted for groups.

(b) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

(c) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which measure variations in hazards, expense provisions, or both. The rating plans may measure any differences among risks that may have a probable effect upon losses or expenses as provided for in subdivision (a).

(d) Rates shall not be excessive, inadequate, or unfairly discriminatory. A rate shall not be held to be excessive unless the rate is unreasonably high for the insurance coverage provided and a reasonable degree of competition does not exist with respect to the classification, kind, or type of risks to which the rate is applicable. A rate shall not be held to be inadequate unless the rate is unreasonably low for the insurance coverage provided and the continued use of the rate endangers the solvency of the insurer; or unless the rate is unreasonably low for the insurance provided and the use of the rate has or will have the effect of destroying competition among insurers, creating a monopoly, or causing a kind of insurance to be unavailable to a significant number of applicants who are in good faith entitled to procure the insurance through ordinary methods. A rate for a coverage is unfairly discriminatory in relation to another rate for the same coverage, if the differential between the rates is not reasonably justified by differences in losses, expenses, or both, or by differences in the uncertainty of loss for the individuals or risks to which the rates apply. A reasonable justification shall be supported by a reasonable classification system; by sound actuarial principles when applicable; and by actual and credible loss and expense statistics or, in the case of new coverages and classifications, by reasonably anticipated loss and expense experience. A rate is not unfairly discriminatory because the rate reflects differences in expenses for individuals or risks with similar anticipated losses, or because the rate reflects differences in losses for individuals or risks with similar expenses. Rates are not unfairly discriminatory if they are averaged broadly among persons insured on a group, franchise, blanket policy, or similar basis.

(2) Except to the extent necessary to meet the provisions of subsection (1)(d), uniformity among insurers in any matters within the scope of this section is neither required nor prohibited.

(3) Rates shall be considered excessive if the insurer fails to annually file an actuarial certification that the legal expense policies are expected to return to policyholders in the form of aggregate benefits under the policy, as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for that period, and in accordance with accepted actuarial principles and practices, the following:

(a) In the case of group policies other than group employee benefit policies, at least 75% of the aggregate amount of premiums collected.

(b) In the case of individual policies, at least 65% of the aggregate amount of premiums collected.

History: Add. 1982, Act 501, Imd. Eff. Dec. 31, 1982.

Popular name: Act 218

500.2706 Procedures and standards for approval of casualty rates and forms to apply to legal expense insurance.

Sec. 2706. (1) Except as provided in subsection (2), the procedures and standards contained in chapter 22, sections 2406 to 2430, section 2478, and chapter 30 for the approval of casualty rates and forms shall apply to legal expense insurance.

(2) Employee group policies shall be exempt from the rate filing requirements provided in subsection (1). An insurer which does not file rates for employee group policies shall retain such rates on file for a period of 5 years.

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History: Add. 1982, Act 501, Imd. Eff. Dec. 31, 1982.

Popular name: Act 218

CHAPTER 28
FIRE INSURANCE CONTRACTS

500.2804 Fire insurance contracts on property herein deemed made in Michigan.

Sec. 2804. All contracts of fire insurance upon property real or personal located in this state shall be held and deemed to be made and consummated within this state.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2806 Policy or contract of fire insurance; requirements.

Sec. 2806. A policy or contract of fire insurance shall not be made, issued, or delivered by an insurer or by an agent or representative of an insurer, on any property in this state, unless it conforms to the provisions of this chapter.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

Popular name: Act 218

500.2807, 500.2808 Repealed. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

Compiler's note: The repealed sections pertained to exemptions for and format for standard fire policy.

Popular name: Act 218

500.2810 Printing regulations on fire policy.

Sec. 2810. If a fire policy is issued by a mutual, cooperative, or reciprocal insurer having special regulations with respect to the payment by the policyholder of assessments, the regulations shall be printed upon the policy, and the insurer may print upon the policy regulations as may be required by its home state or appropriate to its form of organization.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

Popular name: Act 218

500.2812 Combination fire policy; mandatory provisions.

Sec. 2812. Two or more insurers authorized to transact fire insurance in this state may, with the approval of the commissioner, issue a combination fire policy which shall contain the following provisions:

(a) A provision substantially to the effect that the insurers executing the policy shall be severally liable for the full amount of any loss or damage, according to the terms of the policy, or for specified percentages or amounts thereof, aggregating the full amount of the insurance under the policy.

(b) A provision substantially to the effect that service of process, or of any notice or proof of loss required by the policy, upon any of the insurers executing the policy, shall be considered service upon all the insurers.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

Popular name: Act 218

500.2816-500.2824 Repealed. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

Compiler's note: The repealed sections pertained to binders or other contracts for temporary insurance and to riders and indorsements.

Popular name: Act 218

500.2826 Liability for difference between actual value of property and amount expended to repair, rebuild, or replace.

Sec. 2826. An insurer may issue a fire insurance policy, insuring property, by which the insurer agrees to reimburse and indemnify the insured for the difference between the actual value of the insured property at the time any loss or damages occurs, and the amount actually expended to repair, rebuild, or replace with new materials of like size, kind, and quality, but not to exceed the amount of liability covered by the fire policy. A fire policy issued pursuant to this section may provide that there shall be no liability by the insurer to pay the amount specified in the policy unless the property damaged is actually repaired, rebuilt, or replaced at the same or another site.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

Popular name: Act 218

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500.2827 Fire policy providing reimbursement for lost or damaged property; maximum liability; cash settlement; payment of amount in excess of actual cash value of lost or damaged property.

Sec. 2827. (1) An insurer may issue a fire policy, insuring property, by which the insurer agrees to reimburse and indemnify the insured for the difference between the actual cash value of the lost or damaged insured property at the time of the loss or damage, and the amount actually necessary to repair, rebuild, or replace the lost or damaged insured property to a condition and appearance similar to that which existed at the time of the loss or damage based on the use of conventional materials and construction methods which are currently available without extraordinary expense. The insurer's liability shall not exceed the amount of liability covered by the contract of insurance.

(2) The contract of insurance established pursuant to subsection (1) shall not preclude an insured from selecting a cash settlement based on the actual cash value of the lost or damaged insured property at the time of the loss or damage, but not to exceed the amount of liability covered by the contract.

(3) The contract of insurance established pursuant to subsection (1) may provide that there shall be no liability on the part of the insurer to pay an amount in excess of the actual cash value of the lost or damaged insured property at the time of the loss or damage, unless the lost or damaged property is actually repaired, rebuilt, or replaced at the same or another contiguous site. However, this subsection shall not apply if the amount of loss or damage to the insured property under the standards of subsection (1) exceeds the amount of liability covered by the contracts.

History: Add. 1979, Act 145, Imd. Eff. Nov. 13, 1979;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

Popular name: Act 218

500.2828 Repealed. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

Compiler's note: The repealed section pertained to coverage for loss or damage caused by nuclear reaction, nuclear radiation, or radioactive contamination.

Popular name: Act 218

500.2832 Repealed. 1990, Act 305, Eff. Jan. 1, 1992.

Compiler's note: The repealed section pertained to form of standard policy.

Popular name: Act 218

500.2833 Fire insurance policy; mandatory provisions; coverage.

Sec. 2833. (1) Each fire insurance policy issued or delivered in this state shall contain the following provisions:

(a) That the policy shall provide, at a minimum, coverage for the actual cash value of the property at the time of the loss, subject to all other provisions contained herein.

(b) That the policy shall provide, at a minimum, coverage for direct loss by fire and lightning and pro rata coverage for 5 days for insured property removed to another location if it is moved to preserve it from damage by a covered peril.

(c) That the policy may be void on the basis of misrepresentation, fraud, or concealment.

(d) That property which is not covered under the policy.

(e) Those perils that are not covered under the policy.

(f) Those conditions which result in the suspension or restriction of insurance.

(g) A provision for waiving or changing a provision under the policy.

(h) That the policy may be canceled at any time at the request of the insured. The minimum earned premium shall not be less than the pro rata premium for the expired time or $25.00, whichever is greater.

(i) That the policy may be canceled at any time by the insurer by mailing to each insured named in the policy at the insured's address last known to the insurer or an authorized agent of the insurer, not less than 10 days before the cancellation, with postage fully prepaid, a written notice of cancellation with or without tender of the excess minimum earned premium. The minimum earned premium shall not be less than the pro rata premium for the expired time or $25.00, whichever is greater. The excess, if not tendered, shall be refunded on demand and the notice of cancellation shall state that the excess premium, if not tendered, will be refunded on demand.

(j) That if a loss is payable under the policy, in whole or in part, to a designated mortgagee not named in the policy as the insured, the interest in the policy may be canceled by the insurer by giving to the mortgagee not less than 10 days' written notice of cancellation. If the insured fails to render proof of loss, the mortgagee, upon notice, shall render proof of loss within 60 days after the notice. If the insurer claims that no liability

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existed as to the mortgagor or owner, it shall, to the extent of payment of loss to the mortgagee, be subrogated to all the mortgagee's rights of recovery, but without impairing the mortgagee's right to sue; or the insurer may pay off the mortgage debt and require an assignment of the debt and of the mortgage. Subrogation pursuant to this subdivision shall include contractual as well as tort rights of action, but only to the extent of the loss. An action may be maintained by either the insured or insurer or by both of them jointly, to recover their respective portions of the loss.

(k) That the insurer's liability shall not be greater than the pro rata share with other insurance for the peril involved.

(*l*) The notification requirements when a loss occurs.

(m) That if the insured and insurer fail to agree on the actual cash value or amount of the loss, either party may make a written demand that the amount of the loss or the actual cash value be set by appraisal. If either makes a written demand for appraisal, each party shall select a competent, independent appraiser and notify the other of the appraiser's identity within 20 days after receipt of the written demand. The 2 appraisers shall then select a competent, impartial umpire. If the 2 appraisers are unable to agree upon an umpire within 15 days, the insured or insurer may ask a judge of the circuit court for the county in which the loss occurred or in which the property is located to select an umpire. The appraisers shall then set the amount of the loss and actual cash value as to each item. If the appraisers submit a written report of an agreement to the insurer, the amount agreed upon shall be the amount of the loss. If the appraisers fail to agree within a reasonable time, they shall submit their differences to the umpire. Written agreement signed by any 2 of these 3 shall set the amount of the loss. Each appraiser shall be paid by the party selecting that appraiser. Other expenses of the appraisal and the compensation of the umpire shall be paid equally by the insured and the insurer.

(n) That the insurer may repair, replace, rebuild, or take the property.

(o) That there can be no abandonment to the insurer of any property.

(p) Except as otherwise provided in section 2845, that the loss is payable within 30 days after receipt of proof of amount of loss.

(q) That an action under the policy may be commenced only after compliance with the policy requirements. An action must be commenced within 1 year after the loss or within the time period specified in the policy, whichever is longer. The time for commencing an action is tolled from the time the insured notifies the insurer of the loss until the insurer formally denies liability.

(r) That the insurer is subrogated to the insured's right of recovery from other parties.

(s) That each fire insurance policy subject to this section shall be effective at 12:01 a.m., standard time, at the location of the property involved.

(2) Except as otherwise provided in this act, each fire insurance policy issued or delivered in this state pursuant to subsection (1) shall contain, at a minimum, the coverage provided in the standard fire policy under former section 2832.

History: Add. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

Popular name: Act 218

500.2834 Fire insurance policy; exclusion related to terrorism; definition.

Sec. 2834. (1) Notwithstanding section 2833, a commercial fire insurance policy issued or delivered in this state may exclude coverage for loss by fire or other perils insured against if the fire or perils were caused directly or indirectly by terrorism.

(2) As used in this section, "terrorism" means any of the following:

(a) A certified act of terrorism as defined in the terrorism risk insurance act of 2002, Public Law 107-297, 116 Stat. 2322.

(b) A violent act or an act that is dangerous to human life, property, or infrastructure that is committed by an individual or individuals and that appears to be part of an effort to coerce a civilian population or to influence the policy or affect the conduct of any government by coercion.

(c) Terrorism as defined in a form that is voluntarily filed under and subject to section 2236 and is properly in use.

History: Add. 2003, Act 11, Imd. Eff. May 29, 2003.

Popular name: Act 218

500.2836 Breach of warranty or condition as defense; payment of losses.

Sec. 2836. (1) An insurer shall not base a defense under the terms of a fire insurance policy permitted to be used in this state, upon a breach of warranty or condition occurring before loss, unless the breach exists at the time of the loss or contributes to the loss or to the amount of the loss.

(2) Except as otherwise provided in section 2845, losses under any fire insurance policy shall be paid

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within 30 days after receipt of proof of the amount of the loss, notwithstanding the provisions of any contract or statute to the contrary.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1980, Act 495, Eff. Mar. 31, 1981;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

Popular name: Act 218

500.2840 Repealed. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

Compiler's note: The repealed section pertained to coinsurance clauses.

Popular name: Act 218

500.2842 Average or pro rata clause; form; filing and approval.

Sec. 2842. (1) An insurer authorized to do business within this state may attach to an existing policy or to one to be issued by the insurer an average or pro rata clause.

(2) The average or pro rata clause shall be made substantially in the following form:

"It is hereby agreed, in case of loss, this policy shall attach in or on each building, division, or location in such proportion as the values in or on the buildings, division, or location bear to the aggregate value of the property insured."

(3) It shall not be necessary for all average or pro rata rider clauses to be in the exact language used in subsection (2), but such clause shall not be attached to a policy unless the form of the clause was filed with and received the approval of the commissioner.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1962, Act 71, Eff. Mar. 28, 1963;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

Popular name: Act 218

500.2845 Withholding 25% of actual cash value or final settlement where loss to insured real property due to fire or explosion; notice to city, village, or township treasurer, insured, and mortgagee; escrowing and retaining withheld amount; procedure; recording information and depositing money in trust or escrow account; releasing policy proceeds to mortgagee; commingling funds prohibited; retaining earned interest; forwarding money to insured; reasonable proof; using retained proceeds to secure, repair, or demolish damaged or destroyed structure and clear property; returning unused portion of retained proceeds; demolition of property; civil action for return of policy proceeds; liability of insurer; applicability of section; list of cities, villages, and townships; exception to withholding requirements; definitions.

Sec. 2845. (1) If a claim is filed for a loss to insured real property due to fire or explosion and a final settlement is reached on the loss to the insured real property, an insurer shall withhold from payment 25% of the actual cash value of the insured real property at the time of the loss or 25% of the final settlement, whichever is less. Until December 31, 2014, for residential property, the 25% settlement or judgment withheld shall not exceed $6,000.00 adjusted annually beginning June 1, 1999 in accordance with the consumer price index. Beginning January 1, 2015, for residential property, the 25% settlement or judgment withheld shall not exceed $12,000.00 adjusted January 1 of each year in accordance with the consumer price index. The director shall notify annually all insurance companies transacting property insurance in this state as to the new adjusted amount. At the time that 25% of the settlement or judgment is withheld, the insurer shall give notice of the withholding to the treasurer of the city, village, or township in which the insured real property is located, to the insured, and to any mortgagee having an existing lien or liens against the insured real property, if the mortgagee is named on the policy. For a judgment, notice shall also be provided to the court in which judgment was entered. The notice must include all of the following:

(a) The identity and address of the insurer.

(b) The name and address or forwarding address of each policyholder, including any mortgagee.

(c) The location of the insured real property.

(d) The date of loss, policy number, and claim number.

(e) The amount of money withheld.

(f) A statement that the city, village, or township may have the withheld amount paid into a trust or escrow account established for the purposes of this section if within 15 days after the mailing of the notice the city, village, or township states that the money should be withheld to protect the public health and safety; otherwise, the withheld amount shall be paid to the insured 15 days after the mailing of the notice.

(g) An explanation of the provisions of this section.

(2) For a city, village, or township to escrow the amount withheld by the insurer, and to retain that amount, the following procedure shall be used:

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(a) An authorized representative of the city, village, or township shall request the insurer to pay the withheld amount into an escrow account maintained by the treasurer of the city, village, or township. A final settlement that exceeds 49% of the insurance on the insured real property is prima facie evidence that the damaged insured structure violates existing health and safety standards of the city, village, or township and constitutes cause for the escrowing of the withheld amount as surety for the repair, replacement, or removal of the damaged structure.

(b) For a settlement, the request under subdivision (a) shall be sent to the insurer with a copy to the insured and any mortgagees. The copy to the insured must contain the notice required under subdivision (d). On receipt of the request, the insurer shall forward the withheld amount to the treasurer of the city, village, or township, and shall provide notice of the forwarding to the insured and any mortgagees.

(c) For a judgment, the request under subdivision (a) shall be sent to the insurer with a copy to the insured, any mortgagees, and the court in which judgment was entered. The copy to the insured must contain the notice required under subdivision (d). On motion of the city, village, or township, the court shall order the withheld amount transmitted to the treasurer of the city, village, or township.

(d) The city, village, or township shall notify the insured that the insured has 10 days from the date of the mailing of the notice to object to the city's, village's, or township's retention of the withheld amount. The notice must identify the authorized representative of the city, village, or township to whom the insured should address his or her objections and must state that the insured may do either of the following:

(*i*) Seek resolution with the representative of the city, village, or township designated to receive and resolve objections under this section. The city, village, or township shall make a final determination and shall notify the insured of that determination not later than 30 days after receipt of notice that the insured wishes to seek resolution under this subparagraph. This final determination shall include notice to the insured that if the insured is still dissatisfied with the city's, village's, or township's determination, the insured may seek relief in circuit court.

(*ii*) Seek relief in the circuit court.

(3) Upon receipt of money and information from an insurer as prescribed in subsections (1) and (2), the local treasurer shall record the information and the date of receipt of the money and shall immediately deposit the money in a trust or escrow account established for the purposes of this section. The account may be interest-bearing. If a mortgage on the insured property is in default, the treasurer of the city, village, or township, on written request from the first mortgagee of the property, shall release to the mortgagee all or any part of the policy proceeds received by the city, village, or township not later than 10 days after receipt of the written request by the mortgagee, to the extent necessary to satisfy any outstanding lien of the mortgagee.

(4) Except as provided in subsection (7), money deposited in an account under subsection (3) shall not be commingled with city, village, or township funds. Any interest earned on money placed in a trust or escrow account may be retained by the city, village, or township to defray administrative costs incurred under this section.

(5) Except as provided in subdivision (c), the money deposited under subsection (3) shall immediately be forwarded to the insured when the authorized representative of the city, village, or township designated by the governing body of the city, village, or township receives or is shown reasonable proof of any of the following:

(a) That the damaged or destroyed portions of the insured structure have been repaired or replaced, except to the extent that the amount withheld under this section is needed to complete repair or replacement.

(b) That the damaged or destroyed structure and all remnants of the structure have been removed from the land on which the structure or the remnants of the structure were situated, in compliance with the local code requirements of the city, village, or township in which the structure was located.

(c) That the insured has entered into a contract to perform repair, replacement, or removal services for the insured real property and that the insured consents to payment of money directly to the contractor performing the services upon completion. Money released under this subdivision may be forwarded only to a contractor performing services on the insured property.

(6) Reasonable proof required under subsection (5) includes any of the following:

(a) Originals or copies of pertinent verifiable contracts, invoices, receipts, and other similar papers evidencing both the work performed or to be performed and the materials used or to be used by all contractors performing repair, replacement, or removal services for the insured real property, other than a contractor subject to subdivision (b).

(b) An affidavit executed by the contractor that has performed the greatest amount of repair or replacement work on the structure, or that has done most of the clearing and removal work if structure repair or replacement is not to be performed. The contractor shall attach to the affidavit all pertinent contracts, invoices, and receipts and shall swear that these attached papers correctly indicate the nature and extent of the work performed to date by the contractor and the materials used.

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(c) An inspection of the insured real property to verify that repair, replacement, or clearing has been completed in accordance with subsection (5).

(7) Except as otherwise provided in this subsection, if with respect to a loss, reasonable proof is not received by or shown to an authorized representative of the city, village, or township designated by the governing body of the city, village, or township within 120 days after the policy proceeds portion was received by the treasurer, the city, village, or township shall use the retained proceeds to secure, repair, or demolish the damaged or destroyed structure and clear the insured property so that the structure and property comply with local code requirements and applicable ordinances of the city, village, or township. The city, village, or township shall return to the insured any unused portion of the retained proceeds. The city, village, or township may extend the 120-day time period under this subsection. A city, village, or township may retain and use policy proceeds for demolishing any property if on or before the effective date of the amendatory act that added this sentence the authorized representative had not received or been shown reasonable proof within 1 year after the insurer provided notice to the insured under subsection (1) and the insured property has been demolished. The insured may file a civil action against the city, village, or township for the return of the policy proceeds. An action filed under this subsection must be filed within 3 years after the insurer provided notice to the insured under subsection (1) or 1 year after the effective date of the amendatory act that added this sentence, whichever is later.

(8) There is no liability on the part of, and a cause of action shall not arise against, an insurer or an agent or employee of an insurer for withholding or transferring money in the course of complying or attempting to comply with this section. If there is a dispute with a lienholder concerning the distribution of an amount withheld from payment under this section, the insurer may file an action in circuit court to identify all parties that may have a financial interest in the withheld amount and to determine how the withheld amount should be distributed.

(9) This section applies only to property located in a city, village, or township described in subsection (12) if the city, village, or township pursuant to a resolution by its governing body notifies the director in writing that the city, village, or township has established a trust or escrow account to be used as prescribed in this section and intends to uniformly apply this section with respect to all property located within the city, village, or township following written notification to the director. The director shall prepare and distribute a list of all cities, villages, and townships that have elected to apply this section to all insurance companies transacting property insurance in this state.

(10) A city, village, or township may apply to be added to the list prepared under subsection (9) by making a written request for addition to the director. When a written request for addition from a city, village, or township has been received by the director, an amended list shall be prepared and distributed indicating the addition. The addition is effective on the date specified by the director in the amendment. The director shall notify the city, village, township, and insurance companies of the effective date of the addition which shall be effective not less than 30 days after receipt of notice by the insurance company. A city, village, or township shall not apply this section to any loss that occurred before the effective date of the addition.

(11) A city, village, or township may request to be deleted from the list prepared under subsection (9) or may cease to apply this section for a period of not less than 6 months upon not less than 30 days' written notice to the director. After receipt of a request to be deleted from the list, the director shall prepare and distribute an amendment to the list indicating the deletion. The deletion is effective on the date specified by the director in the amendment. The director shall notify the city, village, township, and insurance companies of the effective date of the deletion which shall be effective not less than 30 days after receipt of the notice by the insurance company. A city, village, or township shall continue to apply this section to any loss that occurred before the effective date of the deletion, notwithstanding the deletion.

(12) This section applies only to insured real property located in cities, villages, and townships that are located in counties with a population of less than 425,000 except that this section does not apply to insured real property located in cities, villages, and townships that are located in counties with a population of less than 425,000 if the city, village, or township has a population of 50,000 or more. This section applies to insured real property located in a city, village, or township that has elected to apply this section as provided in subsection (9) or (10).

(13) The withholding requirements of this section do not apply if all of the following occur:

(a) Within 15 days after agreement on a final settlement between the insured and the insurer, the insured has filed with the insurer evidence of a contract to repair as described in subsection (6).

(b) The insured consents to the payment of money directly to the contractor performing the repair services. Money released under this subdivision may be forwarded only to a contractor performing the repair services on the insured property.

(c) On receipt of the contract to repair, the insurer gives notice to the city, village, or township in which the

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property is located that there will not be a withholding under this section because of the repair contract.

(14) If the insured and the insurer have agreed on the demolition costs or the debris removal costs as part of the final settlement of the real property insured claim, the insurer shall withhold 1 of the following amounts, whichever is the largest, and shall pay that amount in accordance with this section:

(a) The agreed cost of demolition or debris removal.

(b) Until December 31, 2014, 25% of the actual cash value of the insured real property at the time of loss if this amount for residential property does not exceed $6,000.00 adjusted annually beginning June 1, 1999 in accordance with the consumer price index.

(c) Beginning January 1, 2015, 25% of the actual cash value of the insured real property at the time of the loss if this amount for residential property does not exceed $12,000.00 adjusted January 1 of each year in accordance with the consumer price index.

(d) Until December 31, 2014, 25% of the final settlement of the insured real property claim if this amount for residential property does not exceed $6,000.00 adjusted annually beginning June 1, 1999 in accordance with the consumer price index.

(e) Beginning January 1, 2015, 25% of the final settlement of the insured real property claim if this amount for residential property does not exceed $12,000.00 adjusted January 1 of each year in accordance with the consumer price index.

(15) This section applies only to final settlements that exceed 49% of the insurance on the insured real property.

(16) If an insurer withholds payment under a policy in good faith because of suspected arson, fraud, or other question concerning coverage, this section does not apply until the issue or question is resolved and final settlement is made.

(17) As used in this section:

(a) "Consumer price index" means that term as defined in section 2080.

(b) "Final settlement" means a determination of the amount due and owing to the insured for a loss to insured real property, but does not include contents damage, losses to personal property, or additional coverage not contained in the building coverage portion of the fire insurance policy, which determination is made by any of the following means:

(*i*) Acceptance of a proof of loss by the insurer.

(*ii*) Execution of a release by the insured.

(*iii*) Acceptance of an arbitration award by both the insured and the insurer.

(*iv*) Judgment of a court of competent jurisdiction.

(c) "Home insurance" means that term as defined in section 2103.

(d) "Residential property" means property on which home insurance can be issued.

History: Add. 1980, Act 495, Eff. Apr. 1, 1982;—Am. 1984, Act 386, Eff. Mar. 29, 1985;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990;—Am. 1998, Act 216, Eff. Jan. 1, 1999;—Am. 2014, Act 509, Imd. Eff. Jan. 14, 2015.

Compiler's note: Enacting section 1 of Act 216 of 1998 provides:

"Enacting section 1. This amendatory act takes effect January 1, 1999 and applies to any loss that occurs on and after January 1, 1999. Losses that occur before January 1, 1999 are governed by section 2845 of the insurance code of 1956, 1956 PA 218, MCL 500.2845, as in effect before the amendments to that section were made by this amendatory act."

Popular name: Act 218

Administrative rules: R 500.1261 et seq. of the Michigan Administrative Code.

500.2850 Repealed. 1962, Act 71, Eff. Mar. 28, 1963.

Compiler's note: The repealed section prohibited limitation of liability for failure to insure property for certain amount.

Popular name: Act 218

500.2860 Contrary provision void.

Sec. 2860. Any provision of a fire insurance policy, which is contrary to the provisions of this chapter, shall be absolutely void, and an insurer issuing a fire insurance policy containing any such provision shall be liable to the insured under the policy in the same manner and to the same extent as if the provision were not contained in the policy.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1962, Act 71, Eff. Mar. 28, 1963;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

Popular name: Act 218

500.2862 Repealed. 1978, Act 219, Eff. Dec. 5, 1978.

Compiler's note: The repealed section pertained to termination of homeowner's policy.

Popular name: Act 218

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500.2866 Violation of chapter; forfeiture and disposition of fine; revocation of authority to transact business; reinstatement.

Sec. 2866. (1) Any person that, either as principal or agent, wilfully issues or causes to be issued, any policy or contract of fire insurance on property situated within this state, contrary to the provisions of this chapter, shall forfeit the sum of $1,500.00 for each policy or contract so issued. However, the maximum fine forfeited by a person under this subsection shall not exceed $10,000.00 in a 2-year period. A fine collected under this subsection shall be turned over to the state treasurer and credited to the general fund of the state.

(2) Any person violating the provisions of this chapter, upon notice and satisfactory proof of the violation being made to the commissioner, may have its authority to transact business in this state revoked for a period of not less than 90 days; and any person whose license to do business in this state is so revoked by the commissioner, shall not again be permitted to do business in this state until all penalties due under this chapter are paid, together with any expenses that may be due under the provisions of this chapter, to the commissioner.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1984, Act 7, Imd. Eff. Feb. 1, 1984.

Popular name: Act 218

CHAPTER 29
BASIC PROPERTY INSURANCE

500.2901 Definitions.

Sec. 2901. As used in this chapter:

(a) "Basic property insurance" means:

(*i*) Insurance against direct loss to any property caused by perils as defined and limited in a fire policy as provided in chapter 28 and an extended coverage indorsement and a vandalism and malicious mischief indorsement or combination thereof as approved by the commissioner.

(*ii*) The following insurance coverages in the amounts and subject to the deductibles and policy provisions approved by the commissioner:

(A) Residence burglary and robbery.

(B) Mercantile robbery.

(C) Office burglary and robbery.

(D) Storekeeper's burglary and robbery.

(E) Mercantile safe burglary.

(F) Mercantile open stock burglary.

(b) "Inspection bureau" means an organization designated by the commissioner to act as the inspection bureau.

(c) "Qualified property", for basic property insurance, means all real and tangible personal property at fixed locations whether or not subject to exposure from an external hazard located on property not owned or controlled by the prospective insured, and whether or not subject to exposure from riot hazard, which meets all of the following requirements:

(*i*) Is not used for farm purposes.

(*ii*) Complies with applicable state and local building codes and ordinances to the extent conditions on the property reasonably related to the perils insured against cannot be the subject of, or provide the basis for, a corrective administrative or judicial order, a criminal prosecution, or a civil fine or penalty. For purposes of this chapter, the housing law of Michigan, Act No. 167 of the Public Acts of 1917, as amended, being sections 125.401 to 125.543 of the Michigan Compiled Laws, shall be considered to constitute, without regard to the population limitations set forth in that act, the basic minimum applicable standard for qualified property, and may be applied for purposes of determining conformity with this section as if it were enforceable against all property in the state.

(*iii*) Is not commonly owned or controlled, or combinable for rating purposes, with property insured for similar coverages elsewhere.

(*iv*) Is not owned or controlled by any person or group of persons, except a city, county, township, village, school district, college, university, other political subdivision of this state, or an agency of a political subdivision of this state, who owns or controls property within this state with an aggregate insurable value in excess of 5% of the aggregate assessable premiums for all participating members for the most recent available calendar year.

(*v*) Is not used or occupied for an illegal purpose.

(*vi*) Is protected, where coverage included in subdivision (a)(*ii*) is applied for, by all appropriate protective

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devices, services, and procedures required pursuant to section 2924.

(d) "Assessable premiums", for basic property insurance, means gross direct premiums less all premiums and dividends returned to policyholders on policies written in this state for the following kinds of insurance: fire, extended coverage and allied lines, burglary and theft, inland marine, the components comparable to the foregoing in commercial multiple peril, and any other kind of insurance included in the definition of basic property insurance in subdivision (a). Aggregate premiums shall exclude premiums attributable to operation of the pool, premiums on farm property, and premiums on policies covering solely aircraft, watercraft, and motor vehicles.

(e) "Home insurance" means a homeowners multiple peril insurance policy for qualified property containing all of the following, but does not include insurance intended to insure commercial, industrial, professional, or business property, obligations, or liabilities:

(*i*) Fire insurance for an insured's dwelling of a type described in section 2103(2).

(*ii*) If contained in or endorsed to a fire insurance policy providing insurance for the insured's residence, other insurance intended primarily to insure nonbusiness property, obligations, or liabilities.

(*iii*) Other insurance coverages for an insured's residence as prescribed by rule promulgated by the commissioner pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.328 of the Michigan Compiled Laws. A rule proposed for promulgation pursuant to this section shall be transmitted in advance to each member of the standing committee in the house and the senate which has jurisdiction over insurance.

(f) "Qualified property", for home insurance, means an owner-occupied or tenant-occupied dwelling of the following types: a house, a condominium unit, a cooperative unit, a room, an apartment, or an owner-occupied multiple unit dwelling of not more than 4 residential units that:

(*i*) Meets all the requirements set forth in subdivision (c).

(*ii*) Is not being used for a demonstrably hazardous purpose.

(*iii*) Meets the minimum standards of insurability as established by rule promulgated by the commissioner pursuant to Act No. 306 of the Public Acts of 1969, as amended.

(*iv*) Is not intended for commercial, industrial, professional, or business purposes, obligations, or liabilities.

(g) "Qualified applicant", for home insurance, means a person who is an owner-occupant or a tenant-occupant of a qualified property for home insurance, but does not include a person who, in the immediately preceding 5 years, was either of the following:

(*i*) Convicted of 1 or more of the following:

(A) Arson, or conspiracy to commit arson.

(B) A crime under sections 72 to 77, 112, 211a, 377a, 377b, or 380 of the Michigan penal code, Act No. 328 of the Public Acts of 1931, as amended, being sections 750.72 to 750.77, 750.112, 750.211a, 750.377a, 750.377b, and 750.380 of the Michigan Compiled Laws.

(C) A crime under section 92, 151, 157b, or 218 of Act No. 328 of the Public Acts of 1931, as amended, being sections 750.92, 750.151, 750.157b, and 750.218 of the Michigan Compiled Laws, based upon a crime listed in subparagraph (B) committed by or on behalf of the individual.

(*ii*) Successfully denied payments by the pool, based on fraud or conspiracy to commit fraud by or on behalf of the applicant, of a claim in excess of $2,000.00 under a home insurance policy, and if the amount of the denied claim was greater than either of the following:

(A) For a claim under a repair cost policy, 15% of the amount of insurance in force.

(B) For a claim under a replacement cost policy, 10% of the amount of insurance in force.

(h) "Assessable premiums", for home insurance, means gross direct premiums less all premiums and dividends returned to policyholders on policies written in this state as homeowners multiple peril insurance.

(i) "Aggregate assessable premiums" means the assessable premiums for basic property insurance plus the assessable premiums for home insurance.

(j) "Participating member" means any member of the pool which in any pertinent calendar period has aggregate assessable premiums greater than zero.

History: Add. 1968, Act 262, Eff. Aug. 1, 1968;—Am. 1971, Act 74, Eff. Aug. 1, 1971;—Am. 1979, Act 145, Eff. Mar. 1, 1980;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 1982, Act 428, Eff. Mar. 30, 1983;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

Popular name: Act 218

Popular name: Essential Insurance

500.2910 Inspection of property; requests; operation of inspection bureau.

Sec. 2910. (1) Any person having an insurable interest in real and tangible personal property at fixed locations shall be entitled upon request to an inspection of the property by representatives of the inspection bureau. Such request shall be upon forms approved by the commissioner.

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(2) The plan of operation of the inspection bureau, the manner and scope of the inspection and the form of the inspection report shall be prescribed by the inspection bureau in written report subject to approval by the commissioner.

(3) A copy of the inspection report shall be made available to the applicant or his agent or the insurer upon request.

History: Add. 1968, Act 262, Eff. Aug. 1, 1968.

Popular name: Act 218

Popular name: Essential Insurance

500.2912 Issuing insurance at rate requiring consent under MCL 500.2414 or 500.2614; inspection; sworn statements; false affidavits; employing services of surplus lines agent; forms of sworn statements; descriptions of rights.

Sec. 2912. (1) A person shall not be issued a policy of home insurance at a rate requiring consent under section 2414 or 2614. A person shall not be issued basic property insurance coverage at a rate requiring consent under section 2414 or 2614 until an inspection has been made by the inspection bureau and the person has filed with the inspection bureau a sworn statement acknowledging his or her rights under this chapter and waiving those rights. The person's agent shall make a sworn statement that the person has been fully advised of his or her rights under this chapter and has been furnished a written description of those rights.

(2) A false affidavit by an agent is grounds for refusal, suspension, or revocation of license pursuant to section 1242.

(3) A person shall not employ the services of a surplus lines agent in obtaining basic property or home insurance until the person has filed with the commissioner a sworn statement acknowledging and waiving his or her rights under this chapter. The person's surplus lines agent shall make a sworn statement that the person has been fully advised of his or her rights under this chapter and has been furnished a written description of those rights.

(4) A false affidavit by a surplus lines agent constitutes grounds for refusal, suspension, or revocation of license pursuant to section 1242.

(5) The commissioner shall prescribe the forms of sworn statements and written descriptions of rights used in connection with this section.

History: Add. 1968, Act 262, Eff. Aug. 1, 1968;—Am. 1971, Act 74, Eff. Aug. 1, 1971;—Am. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 1979, Act 145, Eff. Mar. 1, 1980.

Popular name: Act 218

Popular name: Essential Insurance

500.2920 Michigan basic property insurance association or “pool”; membership; plan of operation and amendments to plan; approval; compliance; designation of members as servicing facilities; reimbursement and authority of facility; rules; rights and liabilities of pool.

Sec. 2920. (1) To implement the provisions of this chapter, there shall be maintained within this state, by all insurers authorized to transact in this state any of the kinds of insurance included in the definition of assessable premiums for basic property insurance and included in the definition of assessable premiums for home insurance, as those definitions are set forth in section 2901, other than insurers transacting insurance exclusively under chapter 68, an association of insurers to be known as the "Michigan basic property insurance association", hereafter referred to as the "pool". Every insurer described in this subsection shall be a member of the pool, as a condition of its authority to continue to transact insurance in this state.

(2) The pool shall adopt a plan of operation and any amendments to the plan, not inconsistent with this chapter, necessary to assure the fair, reasonable, equitable, and nondiscriminatory manner of administering the pool, including compliance with chapter 21, and to provide for any other matters as are necessary or advisable to implement this chapter. The plan of operation and any amendments to the plan shall be subject to prior written approval by the commissioner. All members of the pool shall comply with the plan of operation.

(3) In accordance with its plan of operation the pool may designate 1 or more of its members as servicing facilities. Each facility shall be reimbursed for its expenses and shall have the authority to issue policies and to perform any functions of the pool that the governors lawfully may delegate to it. The designation of facilities shall be subject to the approval of the commissioner. This section does not authorize an insurer to transact insurance which it is not otherwise authorized by law to transact.

(4) If for any reason the pool fails to adopt suitable needed amendments to the plan, the commissioner shall adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this

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chapter, which rules shall continue in force until modified by the commissioner or superseded by a plan of operation adopted by the pool and approved by the commissioner.

(5) The pool, either in its own name or through servicing facilities, may be sued and may use the courts to assert or defend any rights it may have under any policy of insurance or reinsurance issued in its name or by virtue of this chapter as reasonably necessary fully to effectuate the provisions of this chapter. A judgment against the pool shall not create any liabilities in the individual members of the pool except those provided in this chapter.

History: Add. 1968, Act 262, Eff. Aug. 1, 1968;—Am. 1971, Act 74, Eff. Aug. 1, 1971;—Am. 1979, Act 145, Eff. Mar. 1, 1980.

Popular name: Act 218

Popular name: Essential Insurance

500.2921 Board of governors as manager of pool; appointment, election, qualifications, and term of members; time of election; allotment of votes; increasing number of governors; vacancy.

Sec. 2921. (1) The pool shall be managed by a board, composed of 13 governors, each of whom shall serve for a term of 1 year. Four governors shall be appointed by the commissioner, 2 of whom shall be representative of insurance agents and 2 of whom shall be representative of the general public. Nine governors shall be elected by the participating members of the pool. The election shall be held within 60 days after the annual determination of aggregate assessable premiums for members of the pool. Each participating member shall be allotted votes equal to the number of whole dollars of aggregate assessable premiums written by the member during the preceding calendar year. Each participating member may divide its allotted votes among not more than 3 candidates' seats on the board. At least 4 members of the board of governors shall be from participating domestic members and shall be representative of all classifications of insurers to the degree possible. The number of governors may be increased by amendment of the plan of operation to a maximum of 21 governors. Two additional representatives of the general public shall be appointed by the commissioner, if the number of governors is increased. Other additional governors shall be elected by the participating members. At no time, however, shall representatives of the general public comprise more than 1/3 of the total membership of the board.

(2) Any vacancy on the board for a governor representing participating members shall be filled by a vote of the remaining governors representing those members.

(3) If at any time the participating members fail to elect the required number of governors within the time prescribed or a vacancy remains unfilled for more than 15 days, the commissioner may appoint the governors necessary to constitute a full board.

History: Add. 1968, Act 262, Eff. Aug. 1, 1968;—Am. 1971, Act 74, Eff. Aug. 1, 1971;—Am. 1979, Act 145, Eff. Mar. 1, 1980;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981.

Popular name: Act 218

Popular name: Essential Insurance

500.2923 Agents writing insurance on behalf of pool; commissions; losses.

Sec. 2923. (1) The pool, by its plan of operation, may provide that any agent licensed to write a kind of insurance included in the definition of basic property insurance or home insurance set forth in section 2901 on behalf of any participating member, may write that kind of insurance on behalf of the pool without obtaining an additional license to represent the pool.

(2) The pool, as part of its plan of operation, shall adopt reasonable and adequate commissions to be paid to agents who write and service policies on behalf of the pool.

(3) Losses incurred by an agent relative to policies written under the provisions of this chapter shall not be used by an insurer in determining the loss ratio of its agents.

History: Add. 1971, Act 74, Eff. Aug. 1, 1971;—Am. 1979, Act 145, Eff. Mar. 1, 1980.

Popular name: Act 218

Popular name: Essential Insurance

500.2924 Underwriting standards employed in determining acceptable risk for basic property insurance; basis of underwriting program for home insurance.

Sec. 2924. (1) The pool shall adopt, as part of its plan of operation, reasonable underwriting standards to be employed by it in determining whether or not a risk is acceptable for basic property insurance by the pool. The standards may include, but need not be limited to, protective devices, deductibles, coinsurance provisions, appropriate record keeping and limitations, not inconsistent with this chapter, on the amount of

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insurance that may be provided with respect to any 1 risk. The standards shall be relevant to the perils insured against and shall be consistent with the definition of qualified property, for basic property insurance, contained in section 2901.

(2) The pool shall adopt, as part of its plan of operation, a reasonable underwriting program for home insurance under which all qualified applicants may obtain home insurance for qualified property for home insurance in a convenient manner. The underwriting program shall be based only upon the following:

(a) The insured value under a replacement cost policy must be equal to at least 80% of the replacement cost of the property to be insured, as determined by inspection.

(b) The minimum insured value requirement for a repair cost policy shall be equal to at least 100% of the market value of the property to be insured. Policies may be issued in amounts up to 120% of the market value of the property to be insured.

History: Add. 1968, Act 262, Eff. Aug. 1, 1968;—Am. 1971, Act 74, Eff. Aug. 1, 1971;—Am. 1979, Act 145, Eff. Mar. 1, 1980.

Popular name: Act 218

Popular name: Essential Insurance

500.2925 Application to pool for basic property insurance; form; findings; issuance of policy; reinsuring policies; statement required if risk found not acceptable; term of policy; renewal of policy; waiver of inspection; issuance and term of binders.

Sec. 2925. (1) Any person who has an insurable interest in real or tangible personal property at fixed locations may apply to the pool for basic property insurance. The form of the application shall be prescribed by the commissioner.

(2) If the pool finds that: (a) the property has been inspected by the inspection bureau within the preceding 6 months; (b) the applicant made a good faith, diligent effort to obtain the same type of insurance through established channels in the insurance market provided by authorized insurers in this state appropriate to the nature, character, and value of the property; (c) there is no unpaid premium with respect to prior insurance on the property; and (d) the property constitutes qualified property and is an acceptable risk under the standards of the pool, then the pool in its own name, or a servicing facility in its own name, upon receipt of the premium, shall issue a policy for the applied for insurance. Policies issued in the name of a servicing facility may be reinsured by the pool.

(3) If the pool finds that the property is not an acceptable risk, the applicant shall be entitled to a written statement setting forth the features of the property or conditions which prevent it from constituting an acceptable risk and the measures which must be taken in order to make the property an acceptable risk.

(4) Policies issued by the pool or a servicing facility shall have a term of 1 year.

(5) Policies issued by the pool or a servicing facility may be renewed upon property otherwise meeting the conditions of this chapter for 2 consecutive successive terms without additional inspection, if the pool waives the inspection.

(6) The pool, upon receipt of an appropriate premium, may cause the issuance of binders for the applied for insurance for a period not exceeding 60 days upon property which at the time of issuance of the binders has not complied with all the applicable conditions of this chapter.

History: Add. 1968, Act 262, Eff. Aug. 1, 1968;—Am. 1971, Act 74, Eff. Aug. 1, 1971;—Am. 1979, Act 145, Eff. Mar. 1, 1980.

Popular name: Act 218

Popular name: Essential Insurance

500.2925a Application to pool for home insurance; form; findings; issuance of policy; reinsuring policies; statement required if property or applicant not qualified; term of policy; renewal of policy; selection of dwellings for inspection; issuance and term of binders.

Sec. 2925a. (1) Any qualified applicant for home insurance may apply to the pool for home insurance. The form of the application shall be prescribed by the commissioner.

(2) If the pool finds upon inspection that the property is qualified property for home insurance and that the person is a qualified applicant for home insurance, then the pool in its own name or in the name of a servicing facility, upon receipt of the premium, shall issue a policy of home insurance under the pool's underwriting program. Policies issued in the name of a servicing facility may be reinsured by the pool.

(3) If the pool finds that the property is not qualified property for home insurance or that the applicant is not a qualified applicant for home insurance, the applicant shall be entitled to a written statement setting forth the features of the property or conditions which prevent it from constituting qualified property or the applicant from being a qualified applicant and the measures which must be taken in order to make the property

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qualified property for home insurance or to make the applicant a qualified applicant for home insurance.

(4) Policies issued by the pool or a servicing facility shall have a term of 1 year.

(5) Policies issued by the pool or a servicing facility may be renewed upon property otherwise meeting the conditions of this chapter for 2 consecutive successive terms without additional inspection, if the pool waives the inspection. However, the selection of dwellings for inspection upon renewal of policies shall not be based upon any of the following:

(a) Location, whether by political subdivision, census tract, zip code, neighborhood, or area which may be described as a block, set of blocks, or by street coordinates.

(b) The age of the dwelling or the age of its plumbing, heating, electrical, or structural components, or of any other components which form a part of the dwelling.

(c) The market value of a dwelling, unless the value is used as a minimum value above which all dwellings will be inspected.

(d) The amount of insurance, unless the amount is used as a minimum above which all dwellings will be inspected.

(e) Race, color, creed, marital status, sex, national origin, residence, age, disability, or lawful occupation.

(6) The pool, upon receipt of an appropriate premium, may cause the issuance of binders for the applied for insurance for a period not exceeding 60 days upon property which at the time of issuance of the binders has not complied with all the applicable conditions of this chapter.

History: Add. 1979, Act 145, Eff. Mar. 1, 1980;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 1998, Act 26, Imd. Eff. Mar. 12, 1998.

Popular name: Act 218

Popular name: Essential Insurance

500.2925b Liability; inspection; enforcement by commissioner.

Sec. 2925b. (1) There shall be no civil liability, other than contractual liability where applicable, on the part of, and a cause of action of any nature shall not arise against, the commissioner, an insurer, the pool or any of its facilities, an inspection bureau, or an authorized representative, agent, employee, affiliate of the commissioner, an insurer, the pool or any of its facilities, or an inspection bureau or any licensed insurance agent for any of the following:

(a) Acts or omissions related solely to the physical condition of the property in an inspection conducted for insurance purposes pursuant to this chapter.

(b) Failure to conduct an inspection for insurance purposes pursuant to this chapter.

(2) Subsection (1) shall not prohibit the commissioner from enforcing any provisions of this chapter relating to inspections.

History: Add. 1979, Act 145, Eff. Mar. 1, 1980;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981.

Popular name: Act 218

Popular name: Essential Insurance

500.2925c Notice of rights to obtain home insurance.

Sec. 2925c. On and after January 1, 1981, prior to the renewal of each residential policy issued under this chapter, the pool on a notice form prescribed by the commissioner shall notify each insured of his or her rights to obtain home insurance under chapter 21 and of his or her rights to obtain home insurance under this chapter.

History: Add. 1979, Act 145, Imd. Eff. Nov. 13, 1979.

Popular name: Act 218

Popular name: Essential Insurance

500.2926-500.2929 Repealed. 1971, Act 74, Eff. Aug. 1, 1971.

Compiler's note: The repealed sections pertained to liabilities, contributions, and insolvency of pool members.

Popular name: Act 218

Popular name: Essential Insurance

500.2930 Basic property insurance; amount of premium; surcharge; establishment of rates; filing rates and policy forms.

Sec. 2930. (1) The premium for basic property insurance of any risk by the pool shall be equal to the rate for identical insurance established by a licensed rating organization for identical insurance within this state plus a uniform surcharge approved by the commissioner.

(2) The pool shall establish rates for any basic property insurance that is without rates established by a

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licensed rating organization or that the pool, with the approval of the commissioner, determines should be otherwise rated in order to better effectuate the purposes of this chapter. The pool shall file with the commissioner for his or her approval each rate and each policy form to be issued by it. The pool, acting as agent for participating members, shall file policy forms for basic property insurance to be issued by participating members under the provisions of this chapter. Rates and policy forms shall be filed in accordance with this chapter as the commissioner designates.

History: Add. 1968, Act 262, Eff. Aug. 1, 1968;—Am. 1971, Act 74, Eff. Aug. 1, 1971;—Am. 1979, Act 145, Eff. Mar. 1, 1980;—Am. 2002, Act 492, Eff. Mar. 31, 2003.

Popular name: Act 218

Popular name: Essential Insurance

500.2930a Rates charged in territory for home insurance; conditions; limitation on premium for repair cost policy; development of plans, rules, classifications, territories, and calculation steps; policy forms; filing; definitions.

Sec. 2930a. (1) Except as otherwise provided in subsection (5)(c), rates charged in each territory by the pool for home insurance shall be actuarially determined and calculated to generate a total premium sufficient to cover the expected losses and expenses that the pool will likely incur during the projected period for which the rates will be effective, subject to the following:

(a) If the pool's actuarially indicated overall rate change is greater than 5% but less than or equal to 20%, the pool shall take 1/2 of the actuarially indicated rate change amount.

(b) If the pool's actuarially indicated overall rate change is greater than 20%, the pool shall take the full amount that exceeds 20%, plus 10%.

(c) If the pool's actuarially indicated overall rate change is less than 5%, the pool shall take the entire indicated rate change amount.

(2) Rates developed under this section are subject to the following:

(a) The rates shall not be revised more than annually.

(b) The rates shall be filed with the commissioner for prior approval. A filing is considered to be approved unless it is disapproved by the commissioner within 30 days after it is received.

(c) If the commissioner disapproves a filing within 30 days after it is received, he or she shall send written notice of disapproval to the pool specifying in what respects the filing fails to meet the requirements of this act and stating that the filing shall not become effective.

(d) If at any time after the 30-day period specified in subdivision (b) the commissioner finds that a filing does not meet the requirements of this act, the commissioner shall, after a hearing held on not less than 10 days' written notice specifying the matters to be considered at the hearing, issue an order specifying in what respects the commissioner finds that the filing fails to meet the requirements of this act and stating when, within a reasonable period after the date of the order, the filing shall be considered no longer effective.

(3) In addition to the requirements of subsections (1) and (2), the premium established for the repair cost policy offered by the pool shall not exceed the premium for an amount of insurance equal to 80% of the replacement cost of the property under the replacement cost policy of the pool equivalent to the HO-2 form replacement cost policy filed and in effect in this state for a licensed rating organization. Premiums for dwellings with identical replacement costs shall vary on a schedule determined by the pool in accordance with the insured value of the dwelling.

(4) The pool or any other association or organization designated by the pool shall develop its own actuarially justified statistical plans, rating rules, classifications, territories, and rating calculation steps for home insurance issued on behalf of the pool consistent with this section.

(5) The pool shall offer at least the following home insurance policy forms:

(a) An HO-2 form replacement cost policy equivalent to the HO-2 form replacement cost policy filed and in effect in this state for a licensed rating organization.

(b) A repair cost policy providing the deductibles, terms and conditions, perils insured against, and types and amounts of coverage equivalent to those provided by the HO-2 replacement cost policy filed and in effect for a licensed rating organization.

(c) An HO-3 form replacement cost policy equivalent to the HO-3 form replacement cost policy filed and in effect in this state for a licensed rating organization. The rates established by the pool for the HO-3 form replacement cost policy offered pursuant to this subdivision shall be actuarially determined and calculated to generate a total premium sufficient to cover the expected losses and expenses of the pool related to the HO-3 replacement cost policy that the pool will likely incur during the projected period for which the rates will be effective. The premium shall be adjusted fully in a single period or over several periods in a manner provided for in the plan of operation for any excess or deficient premiums from previous periods. Rates established by

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the pool under this subdivision shall not be based upon the methodology provided for in subsection (1).

(6) Policy forms shall be filed with the commissioner for prior approval.

(7) As used in this section:

(a) "Actuarially indicated overall rate change" means rate change calculated within the framework and principles of the casualty actuarial society that uses a permissible combined ratio of 100%.

(b) "Combined ratio" means the sum of the loss ratio and the expense ratio where the loss ratio is the ratio of incurred loss and loss adjustment expenses to earned premium and the expense ratio is the ratio of underwriting expenses to earned premium.

History: Add. 1979, Act 145, Eff. Mar. 1, 1980;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 2002, Act 492, Eff. Mar. 31, 2003;—Am. 2012, Act 39, Imd. Eff. Mar. 6, 2012.

Popular name: Act 218

Popular name: Essential Insurance

500.2931 Limitation on annual premiums written by or on behalf of pool; premium ratios.

Sec. 2931. (1) At no time shall the annual premiums directly written by the pool or on its behalf by servicing facilities exceed 10% of the aggregate assessable premiums for the previous calendar year.

(2) In order to assure that property in areas of the state receives an equitable opportunity to utilize the pool up to its premium capacity, it shall be the operating principle of the pool to maintain a ratio of the total premiums written by or on behalf of the pool in any 1 county in the state in any 1 calendar year to the total authorized premiums for the pool in that same year to the same ratio that the aggregate assessed valuation of all taxable nonfarm property situated in such county, assessed at state equalized value, bears to the aggregate assessed valuation of all taxable nonfarm property in the state, assessed at state equalized value, according to the most recent available official assessed valuation figure. Pool premium writings in 1 or more counties may exceed the ratios for such counties, if it is determined by the commissioner that there is and will be authorized premium capacity in the pool which will not be required or utilized to meet basic property insurance needs in other counties in the state during the calendar year.

History: Add. 1968, Act 262, Eff. Aug. 1, 1968;—Am. 1971, Act 74, Eff. Aug. 1, 1971.

Popular name: Act 218

Popular name: Essential Insurance

500.2932 Annual rate of assessment; establishment; purpose; basis; notice; payment of assessments; estimating assessable premiums; adjustment of premium rates; annual statement; assessments as income; deficit or surplus; advance assessments; exempting or deferring assessment; duration of certain rate adjustments; certain deficits carried forward; sharing assets, liabilities, income, and disbursements.

Sec. 2932. (1) At least once each calendar year, before October 1 for the succeeding calendar year, or at such other times as may be requested by the board of governors and approved by the commissioner, the board shall establish the annual rate of assessment needed to cover any anticipated deficit from the operation of the pool. There shall be separate assessments for anticipated deficits with respect to basic property insurance and with respect to home insurance. The rate of assessment established by the board shall be based upon a reasonable estimate of the deficit which will probably occur, taking into consideration the probable amount of premiums which will be written by the pool for basic property insurance and for home insurance during the year, the past experience of the pool, the premium rates to be used by the pool, and other relevant information. Upon determination of the rate of assessment by the board of governors, the board shall notify each participating member of its assessment before October 1 of each calendar year, and shall file the notice with the commissioner.

(2) Participating members shall pay assessments to the pool after the end of each calendar quarter at the rate established upon the assessable premiums for basic property insurance and for home insurance written by participating members during the most recently completed calendar quarter. Assessable premiums written during the first 3 calendar quarters of each year may be estimated, with a reasonable degree of accuracy, subject to adjustment at the end of the calendar year.

(3) Each participating member may adjust its premium rates, in accordance with appropriate provisions of this chapter relating to rates for all insurance included in the corresponding definitions of assessable premiums in section 2901, to provide for the amount of the assessment established by the board.

(4) At the end of each calendar year the pool shall prepare an annual statement on forms prescribed by the commissioner. The assessments paid to the pool on assessable premiums written during a calendar year shall be included as income in the annual statement of the pool for that calendar year. If the pool has a deficit or

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surplus at the end of the calendar year, the deficit or surplus shall be carried forward to the next year and shall be considered in determining the rate of assessment established for the next year.

(5) For purposes of paying claims and expenses at any time, the board may levy appropriate advance assessments on all participating members, which shall be credited against assessments payable subsequently.

(6) The board may exempt or defer, in whole or in part, the assessment of a participating member if the assessment would cause the participating member's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the participating member is authorized to transact insurance.

(7) Rate adjustments which have been approved prior to August 1, 1971 shall continue in effect until the end of the period for which they were approved. A deficit existing on August 1, 1971 shall be carried forward and assessed under the provisions of this section.

(8) Upon dissolution, the participating members of the pool shall share in the assets, liabilities, income, and disbursements of the pool, as shown in the most recent annual statement of the pool, in proportion to their assessable premiums for basic property insurance and for home insurance, respectively, for the same calendar year.

History: Add. 1971, Act 74, Eff. Aug. 1, 1971;—Am. 1979, Act 145, Eff. Mar. 1, 1980;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981.

Popular name: Act 218

Popular name: Essential Insurance

500.2933 Pool exempted from fees and taxes; exception.

Sec. 2933. The pool is exempt from all license fees, income, franchise, premium and privilege taxes levied or assessed by this state or any political subdivision of this state, except taxes upon the real or personal property of the pool, which is to be assessed and taxed in the same manner as the real and personal property of nonexempt persons.

History: Add. 1971, Act 74, Eff. Aug. 1, 1971.

Popular name: Act 218

Popular name: Essential Insurance

500.2939 Reinsurance permitted.

Sec. 2939. Nothing in this chapter shall preclude the pool from acting as a reinsuring facility or from seeking reinsurance of all or a part of its risks with any reinsurer approved by the commissioner or with any agency of state or federal government having the power to issue such reinsurance.

History: Add. 1968, Act 262, Eff. Aug. 1, 1968.

Popular name: Act 218

Popular name: Essential Insurance

500.2940 Repealed. 2000, Act 486, Imd. Eff. Jan. 11, 2001.

Compiler's note: The repealed section pertained to promulgation of administrative rules.

Popular name: Act 218

Popular name: Essential Insurance

500.2941 Pool; supervision, regulation and examination.

Sec. 2941. The operation of the pool shall at all times be subject to the supervision and regulation of the commissioner. The commissioner, or any deputy or examiner, or any person whom he shall appoint, shall have the power of visitation and examination into the affairs of the pool and free access to all the books, papers and documents that relate to the business of the pool, may summon and qualify witnesses under oath, and may examine officers, agents or employees or any other person having knowledge of the affairs, transactions or conditions of the pool.

History: Add. 1968, Act 262, Eff. Aug. 1, 1968.

Popular name: Act 218

Popular name: Essential Insurance

500.2942 Liability for statements made in reports, at hearings, or in findings; reports of inspection bureau.

Sec. 2942. (1) There shall be no liability on the part of, and a cause of action of any nature shall not arise against, insurers, the inspection bureau, the pool or any of its facilities, governors, agents, or employees, or the commissioner or his or her authorized representatives, for any statements made by them in any reports

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concerning the property to be insured, or at the time of the hearings conducted in connection therewith, or in the findings required by the provisions of this chapter.

(2) The reports of the inspection bureau and the pool shall not be considered public documents.

History: Add. 1968, Act 262, Eff. Aug. 1, 1968;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981.

Popular name: Act 218

Popular name: Essential Insurance

500.2943 Appeal to insurance commissioner; hearing; order.

Sec. 2943. Any person aggrieved by any action or decision of the inspection bureau or the pool may appeal to the commissioner within 30 days from the action or decision. After a hearing held upon not less than 10 days' written notice to the aggrieved person and the inspection bureau or the pool, the commissioner shall issue an order approving the action or decision, disapproving the action or decision, or directing the inspection bureau or the pool to give further consideration to the matter.

Proceedings under this chapter are subject to Act No. 306 of the Public Acts of 1969, as amended.

History: Add. 1968, Act 262, Eff. Aug. 1, 1968;—Am. 1971, Act 74, Eff. Aug. 1, 1971.

Compiler's note: For provisions of Act 306 of 1969, referred to in this section, see MCL 24.201 et seq.

Popular name: Act 218

Popular name: Essential Insurance

500.2950 Repealed. 1971, Act 74, Eff. Aug. 1, 1971.

Compiler's note: The repealed section pertained to a voluntary plan of operation by authorized insurers.

Popular name: Act 218

Popular name: Essential Insurance

500.2952 Federal riot reinsurance reimbursement fund; contents, assessments, reimbursements, retroactive effect.

Sec. 2952. (1) There is created a fund to be known as the federal riot reinsurance reimbursement fund, hereinafter referred to as the fund, which shall be operated under the joint control of the state treasurer and the commissioner of insurance. The fund shall consist of all payments made to the fund by insurers in accordance with the provisions of this section. The state treasurer shall enforce the collection of the assessments provided hereunder as any other obligation due the state.

(2) The fund shall reimburse the secretary of the department of housing and urban development, hereinafter referred to as the secretary, in an amount up to 5% of the aggregate property insurance premiums earned in this state during the calendar year immediately preceding the calendar year, with respect to which the secretary paid losses on lines of insurance reinsured by him in this state during that year and for which he claims reimbursement from the fund in accordance with section 1223 of the housing and urban development act of 1968, Public Law 90-448, 90th congress, August 1, 1968, hereinafter referred to as the act.

(3) Whenever the secretary, in accordance with the act, shall present to the state a request for reimbursement under the act, the fund shall immediately assess all insurers which, during the calendar year with respect to which reimbursement is requested by the secretary, were reinsured under the act. The amount of each insurer's assessment shall be calculated by multiplying the amount of the reimbursement requested by the secretary by a fraction the numerator of which is the insurer's premiums actually reinsured in this state with the secretary in that calendar year and the denominator of which is the aggregate of such reinsured premiums for all insurers.

(4) The fund shall reimburse the secretary, up to amounts actually collected by it, upon drafts or vouchers duly authorized by the state treasurer with the approval of the commissioner of insurance.

(5) If any insurer fails, by reason of insolvency, to pay any assessment, the fund shall cause the reimbursement ratios, computed under subsection (3) to be immediately recalculated, excluding therefrom the insolvent insurer, so that, its assessment is in effect, assumed and redistributed among the remaining insurers.

(6) If the secretary determines that the provisions of this section are not sufficient to meet the requirements of section 1223 of the act, the fund shall assess, with respect to the calendar year in which the determination is made and for each calendar year thereafter, against each insurer, which during the applicable calendar year obtained reinsurance with the secretary on premiums earned in this state, an amount equal to the maximum for which the fund would be liable to the secretary for that calendar year multiplied by a fraction the numerator of which is the insurer's premiums actually reinsured in the state with the secretary during that calendar year and the denominator of which is the aggregate of such reinsured premiums for all insurers. As soon as practicable after the close of a calendar year, the fund, in accordance with the formula provided in

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subsection (3), shall calculate the actual liability of each insurer for reimbursement to the secretary for that calendar year. The difference between the actual liability so calculated and the amount previously assessed and paid with respect to that calendar year under this section shall be credited by the fund toward the assessment against each such insurer for the subsequent calendar year.

(7) In the event that the provisions of this section and the assessments made thereunder are no longer needed in order to effectuate the program for which they were intended, the amounts remaining in the fund shall be returned to the insurers in proportion to the amount which they paid.

(8) This section shall be retroactive to August 1, 1968.

History: Add. 1969, Act 135, Imd. Eff. July 31, 1969.

Popular name: Act 218

Popular name: Essential Insurance

500.2954 Determinations made by commissioner.

Sec. 2954. Determinations made by the commissioner pursuant to this chapter shall be made independent of the credits provided to insurers pursuant to the former single business tax act, 1975 PA 228, or the Michigan business tax act, 2007 PA 36, MCL 208.1101 to 208.1601.

History: Add. 1987, Act 261, Imd. Eff. Dec. 28, 1987;—Am. 2007, Act 187, Imd. Eff. Dec. 21, 2007.

Popular name: Act 218

Popular name: Essential Insurance

CHAPTER 30
CASUALTY INSURANCE CONTRACTS

500.3004 Liability insurance policies; contents required.

Sec. 3004. No policy of insurance against loss or damage resulting from accident to or injury suffered by an employee or other person and for which the person insured is liable, or against loss or damage to property caused by draft animals or by any vehicle drawn, propelled or operated by any motive power, and for which loss or damage the person insured is liable, shall be issued or delivered in this state by any insurer authorized to do business in this state, unless there shall be contained within such policy the provisions required under sections 3006 and 3008.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3006 Liability insurance policies; insolvency or bankruptcy of insured.

Sec. 3006. In such liability insurance policies there shall be a provision that the insolvency or bankruptcy of the person insured shall not release the insurer from the payment of damages for injury sustained or loss occasioned during the life of such policy, and stating that in case execution against the insured is returned unsatisfied in an action brought by the injured person, or his or her personal representative in case death results from the accident, because of such insolvency or bankruptcy, then an action in the nature of a writ of garnishment may be maintained by the injured person, or his or her personal representative, against such insurer under the terms of the policy for the amount of the judgment in the said action not exceeding the amount of the policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3008 Liability insurance policies; notice to insurer.

Sec. 3008. In such liability insurance policies there shall be a provision that notice given by or on behalf of the insured to any authorized agent of the insurer within this state, with particulars sufficient to identify the insured shall be deemed to be notice to the insurer; and also a provision that failure to give any notice required to be given by such policy within the time specified therein shall not invalidate any claim made by the insured if it shall be shown not to have been reasonably possible to give such notice within the prescribed time and that notice was given as soon as was reasonably possible.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3009 Automobile liability or motor vehicle liability policy; limits; exclusion of named person; notice; documentary evidence of deleted coverages.

Sec. 3009. (1) Subject to subsections (5) to (8), an automobile liability or motor vehicle liability policy that

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insures against loss resulting from liability imposed by law for property damage, bodily injury, or death suffered by any person arising out of the ownership, maintenance, or use of a motor vehicle must not be delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state unless the liability coverage is subject to all of the following limits:

(a) Before July 2, 2020, a limit, exclusive of interest and costs, of not less than $20,000.00 because of bodily injury to or death of 1 person in any 1 accident, and after July 1, 2020, a limit, exclusive of interest and costs, of not less than $250,000.00 because of bodily injury to or death of 1 person in any 1 accident.

(b) Before July 2, 2020 and subject to the limit for 1 person in subdivision (a), a limit of not less than $40,000.00 because of bodily injury to or death of 2 or more persons in any 1 accident, and after July 1, 2020, and subject to the limit for 1 person in subdivision (a), a limit of not less than $500,000.00 because of bodily injury to or death of 2 or more persons in any 1 accident.

(c) A limit of not less than $10,000.00 because of injury to or destruction of property of others in any accident.

(2) If authorized by the insured, automobile liability or motor vehicle liability coverage may be excluded when a vehicle is operated by a named person. An exclusion under this subsection is not valid unless the following notice is on the face of the policy or the declaration page or certificate of the policy and on the certificate of insurance:

Warning—when a named excluded person operates a vehicle all liability coverage is void—no one is insured. Owners of the vehicle and others legally responsible for the acts of the named excluded person remain fully personally liable.

(3) A liability policy described in subsection (1) may exclude coverage for liability as provided in section 3017.

(4) If an insurer deletes coverages from an automobile insurance policy under section 3101, the insurer shall send documentary evidence of the deletion to the insured.

(5) After July 1, 2020, an applicant for or named insured in the automobile liability or motor vehicle liability policy described in subsection (1) may choose to purchase lower limits than required under subsection (1)(a) and (b), but not lower than $50,000.00 under subsection (1)(a) and $100,000.00 under subsection (1)(b). To exercise an option under this subsection, the person shall complete a form issued by the director and provided as required by section 3107e, that meets the requirements of subsection (7).

(6) After July 1, 2020, on application for the issuance of a new policy or renewal of an existing policy, an insurer shall do all of the following:

(a) Provide the applicant or named insured the liability options available under this section.

(b) Provide the applicant or named insured a price for each option available under this section.

(c) Offer the applicant or named insured the option and form under this subsection.

(7) The form required under subsection (5) must do all of the following:

(a) State, in a conspicuous manner, the risks of choosing liability limits lower than those required by subsection (1)(a) and (b).

(b) Provide a way for the person to mark the form to acknowledge that he or she has received a list of the liability options available under this section and the price for each option.

(c) Provide a way for the person to mark the form to acknowledge that he or she has read the form and understands the risks of choosing the lower liability limits.

(d) Allow the person to sign the form.

(8) After July 1, 2020, if an insurance policy is issued or renewed as described in subsection (1) and the person named in the policy has not made an effective choice under subsection (5), the limits under subsection (1)(a) and (b) apply to the policy.

History: Add. 1971, Act 210, Imd. Eff. Dec. 29, 1971;—Am. 1988, Act 43, Eff. Mar. 30, 1989;—Am. 2016, Act 346, Eff. Mar. 21, 2017;—Am. 2019, Act 21, Imd. Eff. June 11, 2019;—Am. 2019, Act 22, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.3010 Loss or damage to insured vehicle caused by fire or explosion; payment of claim; report; applicability of section; local governments electing to apply section to all insurance companies; list; insurer withholding money while complying with section.

Sec. 3010. (1) Notwithstanding any other provision of this act, an automobile insurer shall not pay a claim of $2,000.00 or more for loss or damage caused by fire or explosion to an insured motor vehicle until a report under subsection (2) has been submitted and the insurer has received from the insured a copy of the report.

(2) If an insured motor vehicle suffers loss or damage caused by fire or explosion, the insured shall submit to the fire or law enforcement authority designated by the city, village, or township a report prescribed by the office of financial and insurance services in conjunction with the bureau of fire services created in section 1b

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of the fire prevention code, 1941 PA 207, MCL 29.1b, that requires information concerning the motor vehicle fire or explosion.

(3) This section does not apply to accidental fires or explosions as determined by the insurer or the fire or law enforcement authority designated by the city, village, or township. If the insurer or the fire or law enforcement authority designated by the city, village, or township determines that the fire or explosion may not be accidental, the insurer or the fire or law enforcement authority designated by the city, village, or township shall notify the insured of the requirement for a report under this section by not later than 30 days after the determination by the insurer or the fire or law enforcement authority designated by the city, village, or township.

(4) This section applies only if the fire or law enforcement authority responsible for investigating the fire or explosion is located in a city, village, or township described in subsection (8) and if the city, village, or township, pursuant to a resolution by its governing body, notifies the commissioner in writing of both of the following:

(a) That the city, village, or township has elected to receive the reports prepared under subsection (2).

(b) The name and address of the fire or law enforcement authority designated by the city, village, or township to receive reports prepared under subsection (2).

(5) The commissioner shall prepare and distribute a list of all cities, villages, and townships that have elected to apply this section to all insurance companies transacting automobile insurance in this state.

(6) A city, village, or township may be added to the list prepared under subsection (5) by submitting a written request containing the information required under subsection (4) to the commissioner. If a written request is received, the commissioner shall prepare and distribute an amended list indicating the addition. The addition shall be effective on the date specified by the commissioner in the amended list. The commissioner shall notify the city, village, township, and all insurers transacting automobile insurance in this state of the effective date of an addition, which shall be not less than 30 days after receipt of the notice by the insurance company. This section does not apply to any loss that occurred before the effective date of the addition.

(7) A city, village, or township may request to be deleted from the list or may cease to apply this section for a period of not less than 6 months upon not less than 30 days' written notice to the commissioner. After receipt of a request to be deleted from the list, the commissioner shall prepare and distribute an amendment to the list indicating the deletion. The deletion shall be effective on the date specified by the commissioner in the amendment. The commissioner shall notify the city, village, township, and all insurers transacting automobile insurance in this state of the effective date of a deletion which shall be effective not less than 30 days after receipt of the notice by the insurance company. A city, village, or township shall continue to apply this section to any loss that occurred before the effective date of the deletion, notwithstanding the deletion.

(8) A city, village, or township may elect to apply this section as provided in subsection (4) and as follows:

(a) If the city, village, or township is located in a county with a population of 425,000 or more.

(b) If the city, village, or township is located in a county with a population of less than 425,000 but the city, village, or township has a population of 50,000 or more.

(9) There is no liability on the part of, and a cause of action does not arise against, an insurer or an agent or employee of an insurer for withholding money in the course of complying with or attempting to comply with this section.

History: Add. 2000, Act 413, Imd. Eff. Jan. 8, 2001;—Am. 2006, Act 208, Imd. Eff. June 19, 2006.

Compiler's note: Former MCL 500.3010, which pertained to uninsured motorist coverage, was repealed by Act 345 of 1972, Eff. Oct. 1, 1973.

Popular name: Act 218

500.3011 Loss or damage caused by fire or explosion to insured building; failure or refusal to submit report to fire or law enforcement authority; withholding payments; list of cities, villages, and townships applying section to insurance companies; addition or deletion to list; liability.

Sec. 3011. (1) Notwithstanding any other provision of this act, an insurer of a building or other structure or of personal property located on real property shall not make any further payments to an insured on a claim of $2,000.00 or more for loss or damage caused by a fire or explosion to the insured building, other structure, or personal property if the insurer receives written notice from the fire or law enforcement authority that the insured failed or refused to submit the report described in subsection (2) within 21 days after the insured received a written demand to provide the report from the fire or law enforcement authority. Payments to an insured that have been withheld under this section may resume or commence if the insurer receives a copy of the requested report signed by the insured or receives notice that the requested signed report has been

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submitted to the fire or law enforcement authority.

(2) If an insured building or other structure suffers loss or damage caused by fire or explosion, the insured shall submit to the fire or law enforcement authority designated by the city, village, or township a report prescribed by the department in conjunction with the bureau of fire services created in section 1b of the fire prevention code, 1941 PA 207, MCL 29.1b, that requires information concerning the building or structure fire or explosion.

(3) This section applies only if the fire or law enforcement authority responsible for investigating the fire or explosion is located in a city, village, or township described in subsection (7) and if the city, village, or township, acting under a resolution by its governing body, notifies the director in writing of both of the following:

(a) That the city, village, or township has elected to receive the reports prepared under subsection (2).

(b) The name and address of the fire or law enforcement authority designated by the city, village, or township to receive reports prepared under subsection (2).

(4) The director shall prepare and distribute a list of all cities, villages, and townships that have elected to apply this section to all insurance companies transacting insurance that provides coverage for loss by fire to buildings or other structures in this state.

(5) A city, village, or township may be added to the list prepared under subsection (4) by submitting a written request containing the information required under subsection (3) to the director. If a written request is received, the director shall prepare and distribute an amended list indicating the addition. The addition is effective on the date specified by the director in the amended list. The director shall notify the city, village, township, and all insurers that issue policies in this state that provide coverage for loss by fire to buildings or other structures of the effective date of an addition, which must be not less than 30 days after receipt of the notice by the insurance company. This section does not apply to any loss that occurred before the effective date of the addition.

(6) A city, village, or township may request to be deleted from the list prepared under subsection (4) or may cease to apply this section for a period of not less than 6 months on not less than 30 days' written notice to the director. After receipt of a request to be deleted from the list, the director shall prepare and distribute an amendment to the list indicating the deletion. The deletion is effective on the date specified by the director in the amendment. The director shall notify the city, village, township, and all insurers that issue policies in this state that provide coverage for loss by fire to buildings or other structures of the effective date of a deletion, which must be effective not less than 30 days after receipt of the notice by the insurance company. A city, village, or township shall continue to apply this section to any loss that occurred before the effective date of the deletion, notwithstanding the deletion.

(7) A city, village, or township may elect to apply this section as provided in subsection (3) and as follows:

(a) If the city, village, or township is located in a county with a population of 425,000 or more.

(b) If the city, village, or township is located in a county with a population of less than 425,000 and the city, village, or township has a population of 50,000 or more.

(8) An insurer or an agent or employee of an insurer is not liable for damages for withholding money in compliance with this section.

History: Add. 2016, Act 511, Eff. Apr. 9, 2017.

500.3012 Liability insurance policy; noncomplying forms, defenses of insurer.

Sec. 3012. Such a liability insurance policy issued in violation of sections 3004 through 3012 shall, nevertheless, be held valid but be deemed to include the provisions required by such sections, and when any provision in such policy or rider is in conflict with the provisions required to be contained by such sections, the rights, duties and obligations of the insured, the policyholder and the injured person shall be governed by the provisions of such sections: Provided, however, That the insurer shall have all the defenses in any action brought under the provisions of such sections that it originally had against its insured under the terms of the policy providing the policy is not in conflict with the provisions of such sections.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3015 Repealed. 1991, Act 191, Eff. Apr. 1, 1992.

Compiler's note: The repealed section pertained to automobile theft coverage.

Popular name: Act 218

500.3017 Loss or injury while transportation network company driver is logged on to transportation network company digital network or transportation network company driver

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is providing prearranged ride; excluded coverage; examples; coverage not required; coverage for personal vehicle by contract or endorsement; defending or indemnifying claim; compliance with limousine, taxicab, and transportation network company act; exchange of information during investigation of coverage; definitions.

Sec. 3017. (1) An authorized insurer that issues an insurance policy insuring a personal vehicle may exclude all coverage afforded under the policy for any loss or injury that occurs while a transportation network company driver is logged on to a transportation network company digital network or while a transportation network company driver is providing a prearranged ride. By way of example and not as limitation, all of the following coverages may be excluded under this section:

(a) Residual liability insurance required under sections 3009 and 3101.

(b) Personal protection and property protection insurance required under section 3101.

(c) Uninsured and underinsured motorist coverage.

(d) Comprehensive coverage.

(e) Collision coverage, including coverage required to be offered under section 3037.

(2) This section does not require an automobile insurance policy to provide coverage under any of the following circumstances:

(a) While a transportation network company driver is logged on to a transportation network company digital network.

(b) While a transportation network company driver is engaged in providing a prearranged ride.

(c) While a transportation network company driver otherwise uses a vehicle to transport passengers for compensation.

(3) This section does not preclude an insurer from providing coverage for a transportation network company driver's personal vehicle by contract or endorsement.

(4) An insurer that excludes the coverage described in subsection (1) does not have a duty to defend or indemnify for any claim that is expressly excluded. This section does not invalidate or limit an exclusion contained in a policy, including a policy in use or approved for use in this state before the effective date of this section, that excludes coverage for vehicles that are used to carry individuals or property for a charge or that are available for hire by the public. An insurer that defends or indemnifies for a claim against a transportation network company driver who is excluded under the terms of the policy has a right of contribution against other insurers that provided automobile insurance to the transportation network company driver in satisfaction of the coverage requirements of section 23 of the limousine, taxicab, and transportation network company act at the time of the loss.

(5) An insurer that provides automobile insurance to a transportation network company shall comply with section 23(5), (6), and (9) of the limousine, taxicab, and transportation network company act.

(6) During an investigation of whether a claim is covered under an insurance policy, a transportation network company and any insurer that provides coverage under section 23 of the limousine, taxicab, and transportation network company act shall cooperate to facilitate the exchange of relevant information with persons who are directly involved and any insurer of the transportation network company driver. Relevant information required to be exchanged under this subsection includes, but is not limited to, all of the following:

(a) The times that the transportation network company driver logged on to and logged off of the transportation network company digital network during the 12 hours preceding the accident and the 12 hours following the accident.

(b) A clear description of the coverage, exclusions, and limits under any insurance policy maintained as required by section 23 of the limousine, taxicab, and transportation network company act.

(7) As used in this section, all of the following terms mean those terms as defined in section 2 of the limousine, taxicab, and transportation network company act:

(a) "Personal vehicle".

(b) "Prearranged ride".

(c) "Transportation network company".

(d) "Transportation network company digital network".

(e) "Transportation network company driver".

History: Add. 2016, Act 346, Eff. Mar. 21, 2017.

Popular name: Act 218

500.3020 Policy of casualty insurance; mandatory provisions; filing rule providing minimum retention of premium for automobile insurance; issuance of policy to meet MCL 257.227a; providing short rate premium for insurance on motorcycle, watercraft, off-road vehicle, or

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snowmobile; definitions; effect of cancellation on claim; mailing or delivery of notice; statement; rule establishing short rate premium.

Sec. 3020. (1) A policy of casualty insurance, except worker's compensation and mortgage guaranty insurance, including all classes of motor vehicle coverage, shall not be issued or delivered in this state by an insurer authorized to do business in this state for which a premium or advance assessment is charged, unless the policy contains the following provisions:

(a) That the policy may be canceled at any time at the request of the insured, in which case the insurer shall refund the excess of paid premium or assessment above the pro rata rates for the expired time, except as otherwise provided in subsections (2), (3), and (4).

(b) Except as otherwise provided in subdivision (d), that the policy may be canceled at any time by the insurer by mailing to the insured at the insured's address last known to the insurer or an authorized agent of the insurer, with postage fully prepaid, a not less than 10 days' written notice of cancellation with or without tender of the excess of paid premium or assessment above the pro rata premium for the expired time.

(c) That the minimum earned premium on any policy canceled pursuant to this subsection, other than automobile insurance as defined in section 2102(2)(a) and (b), shall not be less than the pro rata premium for the expired time or $25.00, whichever is greater.

(d) That an insurer may refuse to renew a malpractice insurance policy only by mailing to the insured at the insured's address last known to the insurer or an authorized agent of the insurer, with postage fully prepaid, a not less than 60 days' written notice of refusal to renew. As used in this subdivision, "malpractice insurance" means malpractice insurance as described in section 624(1)(h).

(2) An insurer may file a rule with the commissioner providing for a minimum retention of premium for automobile insurance as defined in section 2102(2)(a) and (b). The rule shall describe the circumstances under which the retention is applied and shall set forth the amount to be retained, which is subject to the approval of the commissioner. The rule shall include, but need not be limited to, the following provisions:

(a) That a minimum retention shall be applied only when the amount exceeds the amount that would have been retained had the policy been canceled on a pro rata basis.

(b) That a minimum retention does not apply to renewal policies.

(c) That a minimum retention does not apply when a policy is canceled for the following reasons:

(*i*) The insured is no longer required to maintain security pursuant to section 3101(1).

(*ii*) The insured has replaced the automobile insurance policy being canceled with an automobile insurance policy from another insurer and provides proof of the replacement coverage to the canceling insurer.

(3) Notwithstanding subsection (1), an insurer may issue a noncancelable, nonrefundable, 6-month prepaid automobile insurance policy in order for an insured to meet the registration requirements of section 227a of the Michigan vehicle code, 1949 PA 300, MCL 257.227a.

(4) An insurer may provide for a short rate premium for insurance on a motorcycle, watercraft, off-road vehicle, or snowmobile. As used in this subsection:

(a) "Motorcycle" means that term as defined in section 3101.

(b) "Off-road vehicle" means an ORV as defined in section 81101 of the natural resources and environmental protection act, 1994 PA 451, MCL 324.81101.

(c) "Snowmobile" means that term as defined in section 82101 of the natural resources and environmental protection act, 1994 PA 451, MCL 324.82101.

(d) "Watercraft" means that term as defined in section 80301 of the natural resources and environmental protection act, 1994 PA 451, MCL 324.80301.

(5) Cancellation as prescribed in this section is without prejudice to any claim originating before the cancellation. The mailing of notice is prima facie proof of notice. Delivery of written notice is equivalent to mailing.

(6) A notice of cancellation, including a cancellation notice under section 3224, shall be accompanied by a statement that the insured shall not operate or permit the operation of the vehicle to which notice of cancellation is applicable, or operate any other vehicle, unless the vehicle is insured as required by law.

(7) An insurer who wishes to provide for a short rate premium under subsection (4) shall file with the commissioner pursuant to chapter 24 or 26 a rule establishing a short rate premium. The rule shall describe the circumstances under which the short rate is applied and shall set forth the amount or percentage to be retained.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1967, Act 202, Eff. Aug. 1, 1967;—Am. 1971, Act 210, Imd. Eff. Dec. 29, 1971;—Am. 1978, Act 220, Imd. Eff. June 5, 1978;—Am. 1987, Act 168, Imd. Eff. Nov. 9, 1987;—Am. 1990, Act 170, Imd. Eff. July 2, 1990;—Am. 1995, Act 288, Imd. Eff. Jan. 9, 1996;—Am. 1996, Act 77, Imd. Eff. Feb. 26, 1996;—Am. 1998, Act 410, Imd. Eff. Dec. 21, 1998;—Am. 2006, Act 106, Imd. Eff. Apr. 7, 2006.

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Compiler's note: Act 202 of 1967 was presented to the governor on June 21, 1967, at 2:37 p.m., and, not having been returned by him to the house in which it originated, became law on July 5, 1967, at 2:37 p.m., the legislature having continued in session. (See 1967 House Journal, p. 3254).

Enacting section 1 of Act 106 of 2006 provides:

"Enacting section 1. This amendatory act applies to malpractice insurance policies in effect on, or issued on or after, the date this amendatory act is enacted."

Popular name: Act 218

500.3021 Liability insurance policy; prohibits age discrimination, conditions.

Sec. 3021. No policy including any class of motor vehicle coverage shall be cancelled by the insurer, nor shall the insurer refuse to issue a renewal policy, nor shall the premium for any such policy be increased solely because an insured has reached the age of 65 years, if the insured still has a valid Michigan motor vehicle operator's license.

History: Add. 1965, Act 231, Imd. Eff. July 19, 1965.

Popular name: Act 218

500.3030 Insurer not to be made or joined as party defendant; reference to insurer or insurance during trial.

Sec. 3030. In the original action brought by the injured person, or his or her personal representative in case death results from the accident, as mentioned in section 3006, the insurer shall not be made or joined as a party defendant, nor, except as otherwise provided by law, shall any reference whatever be made to such insurer or to the question of carrying of such insurance during the course of trial.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

500.3032 Court action; application of "Restatement of the Law, Liability Insurance" prohibited.

Sec. 3032. In an action brought in a court in this state, the court shall not apply a principle from the American Law Institute's "Restatement of the Law, Liability Insurance" in ruling on an issue in the case unless the principle is clearly expressed in a statute of this state, the common law, or case law precedent of this state.

History: Add. 2018, Act 520, Eff. Jan. 1, 2020.

Popular name: Act 218

500.3036 Liability policy in lieu of bond on appeal; recognizance for costs; deposit of policy or bond; admission of liability; agreement to pay judgment; judgment in excess of coverage; stay of execution upon filing bond for difference.

Sec. 3036. When an appeal is taken from a judgment in a case where it appears to the court that all or a part of the particular liability of the appellant is insured against by a surety company or insurance carrier authorized to do business in this state, and the court is satisfied of the coverage of the policy or suretyship, the court shall not require the appellant to provide an appeal bond or bond to stay execution pending an appeal up to the amount of the coverage of the policy or suretyship. The insurance carrier or surety company may be required by the court and is given authority to execute its written recognizance to the opposite party or parties for the payment of the taxable costs of the appeal. The surety company or insurance carrier shall deposit with the court a copy of the insurance policy or bond and shall admit its liability thereunder, and agree to pay a judgment against its insured, if any, as shall be affirmed by the appellate court, but not exceeding the amount of the liability under the policy or bond; and the court having jurisdiction thereof, on its own motion, may enter judgment against the surety company or carrier without further proceedings. If the amount of judgment exceeds the amount of coverage of the policy or suretyship, the court shall grant a stay of execution upon the filing of a bond by the appellant for the difference.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1975, Act 290, Imd. Eff. Dec. 10, 1975.

Popular name: Act 218

500.3037 Limited collision, broad form collision, and standard and limited collision coverages; deductibles; waiver of deductible; rejection of coverages; form; rejection statement; failure to sign or return written rejection statement; explanation of collision coverage options; providing policyholder with collision coverage information; "collision damage" and "substantially at fault" defined.

Sec. 3037. (1) At the time a new applicant for the insurance required by section 3101 for a private

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passenger nonfleet automobile makes an initial written application to the insurer, an insurer shall offer both of the following collision coverages to the applicant:

(a) Limited collision coverage, which must pay for collision damage to the insured vehicle without a deductible amount if the operator of the vehicle is not substantially at fault in the accident from which the damage arose.

(b) Broad form collision coverage, which must pay for collision damage to the insured vehicle regardless of fault, with deductibles in the amounts as approved by the director, which deductibles must be waived if the operator of the vehicle is not substantially at fault in the accident from which the damage arose.

(2) In addition to the coverages offered under subsection (1), standard and limited collision coverage may be offered with deductibles as approved by the director.

(3) An insurer may limit collision coverage offered under this section as provided in section 3017.

(4) If the applicant is required by the insurer to sign the written application form described in subsection (1), and if the applicant chooses to reject both of the collision coverages, or limited collision without a deductible, offered under subsection (1), the rejection must be made in writing, either on a separate form, as part of the application, or in some combination of these, as approved by the director. The rejection statement must inform the applicant of his or her rights if there is damage to the insured vehicle under the alternative coverage option selected.

(5) If a written application is made by mail, and if the applicant fails to sign or return a written rejection statement as required by subsection (4), the requirements of subsection (4) are considered to be satisfied with respect to the insurer if all of the following occur:

(a) The application provides the applicant with an opportunity to select the coverages required to be offered under subsection (1).

(b) The applicant is requested to sign the rejection statement, either as part of the application or as a separate form issued with the application, if the applicant fails to select either of the coverages specified in subsection (1).

(c) The applicant signed the application as otherwise required by the insurer.

(6) At the time of the initial written application described in subsection (1), an agent or insurer shall provide the applicant with a written explanation of collision coverage options in easily understandable language, if that information is not contained in the application form.

(7) At least annually in conjunction with the renewal of a private passenger nonfleet automobile insurance policy, or at the time of an addition, deletion, or substitution of a vehicle under an existing policy, other than a group policy, an insurer shall inform the policyholder, on a form approved by the director, of all of the following:

(a) The current status of collision coverage, if any, for the vehicle or vehicles affected by the renewal or change and the rights of the insured under the current coverage if the vehicle is damaged.

(b) The collision coverages available under the policy and the rights of the insured under each collision option if the vehicle is damaged.

(c) Procedures for the policyholder to follow if he or she wishes to change the current collision coverage.

(8) As used in this section:

(a) "Collision damage" does not include losses customarily insured under comprehensive coverages.

(b) "Substantially at fault" means a person's action or inaction was more than 50% of the cause of the accident.

History: Add. 1976, Act 303, Imd. Eff. Oct. 27, 1976;—Am. 1979, Act 145, Imd. Eff. Nov. 13, 1979;—Am. 1979, Act 147, Eff. Mar. 1, 1980;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 2016, Act 346, Eff. Mar. 21, 2017.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Popular name: Act 218

CHAPTER 30A

500.3051-500.3062 Repealed. 1993, Act 349, Imd. Eff. Jan. 10, 1994;—1993, Act 349, Eff. Oct. 1, 1995.

Compiler's note: The repealed sections pertained to the offering of professional liability insurance to health care providers or hospitals and arbitration procedures.

Popular name: Act 218

CHAPTER 31
MOTOR VEHICLE PERSONAL AND PROPERTY PROTECTION

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500.3101 Security for payment of benefits required; period security required to be in effect; definitions; policy of insurance or other method of providing security; filing proof of security; exclusion.

Sec. 3101. (1) Except as provided in sections 3107d and 3109a, the owner or registrant of a motor vehicle required to be registered in this state shall maintain security for payment of benefits under personal protection insurance and property protection insurance as required under this chapter, and residual liability insurance. Security is only required to be in effect during the period the motor vehicle is driven or moved on a highway.

(2) Except as provided in section 3107d, all automobile insurance policies offered in this state must include benefits under personal protection insurance, and property protection insurance as provided in this chapter, and residual liability insurance. Notwithstanding any other provision in this act, an insurer that has issued an automobile insurance policy may only delete portions of the coverages under the policy and maintain the comprehensive coverage portion on a motor vehicle that is not driven or moved on a highway in accordance with section 3009(4).

(3) As used in this chapter:

(a) "Automobile insurance" means that term as defined in section 2102.

(b) "Commercial quadricycle" means a vehicle to which all of the following apply:

(*i*) The vehicle has fully operative pedals for propulsion entirely by human power.

(*ii*) The vehicle has at least 4 wheels and is operated in a manner similar to a bicycle.

(*iii*) The vehicle has at least 6 seats for passengers.

(*iv*) The vehicle is designed to be occupied by a driver and powered either by passengers providing pedal power to the drive train of the vehicle or by a motor capable of propelling the vehicle in the absence of human power.

(*v*) The vehicle is used for commercial purposes.

(*vi*) The vehicle is operated by the owner of the vehicle or an employee of the owner of the vehicle.

(c) "Electric bicycle" means that term as defined in section 13e of the Michigan vehicle code, 1949 PA 300, MCL 257.13e.

(d) "Golf cart" means a vehicle designed for transportation while playing the game of golf.

(e) "Highway" means highway or street as that term is defined in section 20 of the Michigan vehicle code, 1949 PA 300, MCL 257.20.

(f) "Moped" means that term as defined in section 32b of the Michigan vehicle code, 1949 PA 300, MCL 257.32b.

(g) "Motorcycle" means a vehicle that has a saddle or seat for the use of the rider, is designed to travel on not more than 3 wheels in contact with the ground, and is equipped with a motor that exceeds 50 cubic centimeters piston displacement. For purposes of this subdivision, the wheels on any attachment to the vehicle are not considered as wheels in contact with the ground. Motorcycle does not include a moped or an ORV.

(h) "Motorcycle accident" means a loss that involves the ownership, operation, maintenance, or use of a motorcycle as a motorcycle, but does not involve the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle.

(i) "Motor vehicle" means a vehicle, including a trailer, that is operated or designed for operation on a public highway by power other than muscular power and has more than 2 wheels. Motor vehicle does not include any of the following:

(*i*) A motorcycle.

(*ii*) A moped.

(*iii*) A farm tractor or other implement of husbandry that is not subject to the registration requirements of the Michigan vehicle code under section 216 of the Michigan vehicle code, 1949 PA 300, MCL 257.216.

(*iv*) An ORV.

(*v*) A golf cart.

(*vi*) A power-driven mobility device.

(*vii*) A commercial quadricycle.

(*viii*) An electric bicycle.

(j) "Motor vehicle accident" means a loss that involves the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle regardless of whether the accident also involves the ownership, operation, maintenance, or use of a motorcycle as a motorcycle.

(k) "ORV" means a motor-driven recreation vehicle designed for off-road use and capable of cross-country travel without benefit of road or trail, on or immediately over land, snow, ice, marsh, swampland, or other natural terrain. ORV includes, but is not limited to, a multitrack or multiwheel drive vehicle, a motorcycle or related 2-wheel, 3-wheel, or 4-wheel vehicle, an amphibious machine, a ground effect air cushion vehicle, an

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ATV as defined in section 81101 of the natural resources and environmental protection act, 1994 PA 451, MCL 324.81101, or other means of transportation deriving motive power from a source other than muscle or wind. ORV does not include a vehicle described in this subdivision that is registered for use on a public highway and has the security required under subsection (1) or section 3103 in effect.

(*l*) "Owner" means any of the following:

(*i*) A person renting a motor vehicle or having the use of a motor vehicle, under a lease or otherwise, for a period that is greater than 30 days.

(*ii*) A person renting a motorcycle or having the use of a motorcycle under a lease for a period that is greater than 30 days, or otherwise for a period that is greater than 30 consecutive days. A person who borrows a motorcycle for a period that is less than 30 consecutive days with the consent of the owner is not an owner under this subparagraph.

(*iii*) A person that holds the legal title to a motor vehicle or motorcycle, other than a person engaged in the business of leasing motor vehicles or motorcycles that is the lessor of a motor vehicle or motorcycle under a lease that provides for the use of the motor vehicle or motorcycle by the lessee for a period that is greater than 30 days.

(*iv*) A person that has the immediate right of possession of a motor vehicle or motorcycle under an installment sale contract.

(m) "Power-driven mobility device" means a wheelchair or other mobility device powered by a battery, fuel, or other engine and designed to be used by an individual with a mobility disability for the purpose of locomotion.

(n) "Registrant" does not include a person engaged in the business of leasing motor vehicles or motorcycles that is the lessor of a motor vehicle or motorcycle under a lease that provides for the use of the motor vehicle or motorcycle by the lessee for a period that is longer than 30 days.

(4) Security required by subsection (1) may be provided under a policy issued by an authorized insurer that affords insurance for the payment of benefits described in subsection (1). A policy of insurance represented or sold as providing security is considered to provide insurance for the payment of the benefits.

(5) Security required by subsection (1) may be provided by any other method approved by the secretary of state as affording security equivalent to that afforded by a policy of insurance, if proof of the security is filed and continuously maintained with the secretary of state throughout the period the motor vehicle is driven or moved on a highway. The person filing the security has all the obligations and rights of an insurer under this chapter. When the context permits, "insurer" as used in this chapter, includes a person that files the security as provided in this section.

(6) An insurer that issues a policy that provides the security required under subsection (1) may exclude coverage under the policy as provided in section 3017.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1975, Act 329, Eff. Mar. 31, 1976;—Am. 1977, Act 54, Imd. Eff. July 6, 1977;—Am. 1980, Act 445, Imd. Eff. Jan. 15, 1981;—Am. 1984, Act 84, Imd. Eff. Apr. 19, 1984;—Am. 1987, Act 168, Imd. Eff. Nov. 9, 1987;—Am. 1988, Act 126, Imd. Eff. May 23, 1988;—Am. 2008, Act 241, Imd. Eff. July 17, 2008;—Am. 2014, Act 492, Imd. Eff. Jan. 13, 2015;—Am. 2016, Act 346, Eff. Mar. 21, 2017;—Am. 2017, Act 140, Imd. Eff. Oct. 30, 2017;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Constitutionality: Subsection (1) of this section is unconstitutional but subsection (2) does not violate the due process and equal protection clauses. Shavers v Attorney General, 402 Mich 554; 267 NW2d 72 (1978).

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Enacting section 1 of Act 492 of 2014 provides:

"Enacting section 1. Section 3101(2)(h)(vi) of the insurance code of 1956, 1956 PA 218, MCL 500.3101, as added by this amendatory act, shall be applied retroactively."

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3101a Providing certificate of insurance to secretary of state and policy information to the Michigan automobile insurance placement facility; vehicle identification number as proof of vehicle insurance; confidentiality of policy information; prohibited acts; misdemeanor; penalty; report; "automobile insurance" and "private passenger nonfleet automobile" defined.

Sec. 3101a. (1) An insurer, in conjunction with the issuance of an automobile insurance policy, shall provide to the insured 1 certificate of insurance for each insured vehicle and for private passenger nonfleet automobiles listed on the policy shall supply to the secretary of state the automobile insurer's name, the name

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of the named insured, the named insured's address, the vehicle identification number for each vehicle listed on the policy, and the policy number. The insurer shall transmit the information required under this subsection in a format as required by the secretary of state. The secretary of state shall not require the information to be transmitted more frequently than every 14 days.

(2) The secretary of state shall provide policy information received under subsection (1) to the Michigan automobile insurance placement facility as required for the Michigan automobile insurance placement facility to comply with this act. Information received by the Michigan automobile insurance placement facility under this subsection is confidential and is not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246. The Michigan automobile insurance placement facility shall only use the information for purposes of administering the assigned claims plan under this chapter and shall not disclose the information to any person unless it is for the purpose of administering the assigned claims plan or in compliance with an order by a court of competent jurisdiction in connection with a fraud investigation or prosecution.

(3) The secretary of state shall provide policy information received under subsection (1) to the department of health and human services as required for the department of health and human services to comply with 2006 PA 593, MCL 550.281 to 550.289.

(4) The secretary of state shall accept as proof of vehicle insurance a transmission of the insured vehicle's vehicle identification number. Policy information submitted by an insurer and received by the secretary of state under this section is confidential, is not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, and must not be disclosed to any person except the department of health and human services for purposes of 2006 PA 593, MCL 550.281 to 550.289, or pursuant to an order by a court of competent jurisdiction in connection with a claim or fraud investigation or prosecution. The transmission to the secretary of state of a vehicle identification number is proof of insurance to the secretary of state for motor vehicle registration purposes only and is not evidence that a policy of insurance actually exists between an insurer and an individual.

(5) A person who supplies false information to the secretary of state under this section or who issues or uses an altered, fraudulent, or counterfeit certificate of insurance is guilty of a misdemeanor punishable by imprisonment for not more than 1 year or a fine of not more than $1,000.00, or both.

(6) The department of health and human services shall report to the senate and house of representatives appropriations committees and standing committees concerning insurance issues on the number of claims and total dollar amount recovered from automobile insurers under 2006 PA 593, MCL 550.281 to 550.289. The reports required by this subsection must be given to the appropriations committees and standing committees concerning insurance issues by December 30 of each year and must cover the preceding 12-month period.

(7) As used in this section:

(a) "Automobile insurance" means that term as defined in section 3303.

(b) "Private passenger nonfleet automobile" means that term as defined in section 3303.

History: Add. 1980, Act 461, Eff. Apr. 1, 1981;—Am. 1995, Act 288, Imd. Eff. Jan. 9, 1996;—Am. 1996, Act 456, Imd. Eff. Dec. 23, 1996;—Am. 2011, Act 91, Imd. Eff. July 15, 2011;—Am. 2014, Act 419, Imd. Eff. Dec. 30, 2014;—Am. 2018, Act 510, Imd. Eff. Dec. 28, 2018;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3101b Repealed. 2011, Act 91, Imd. Eff. July 15, 2011.

Compiler's note: The repealed section pertained to providing proof of vehicle insurance through insurance verification board.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3101c Standard certified statement.

Sec. 3101c. The commissioner shall prescribe a standard certified statement that automobile insurers shall use to show pursuant to section 227a(1)(a) of the Michigan vehicle code, Act No. 300 of the Public Acts of 1949, being section 257.227a of the Michigan Compiled Laws, that a vehicle is insured under a 6-month prepaid, noncancelable policy.

History: Add. 1995, Act 288, Imd. Eff. Jan. 9, 1996.

Popular name: Act 218

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Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3101d Qualification as self-insurer; certificate; issuance; cancellation.

Sec. 3101d. (1) A person in whose name more than 25 motor vehicles are registered may qualify as a self-insurer by obtaining a certificate of self-insurance issued by the commissioner under subsection (2).

(2) The commissioner may, in his or her discretion, on the application of a person who wishes to qualify under subsection (1), issue a certificate of self-insurance to the person if the commissioner is satisfied that the person has and will continue to have the ability to pay judgments obtained against the person.

(3) On not less than 5 days' notice and a hearing in accordance with the notice, the commissioner may on reasonable grounds cancel a certificate of self-insurance issued under this section. Failure to pay a judgment within 30 days after the judgment becomes final is a reasonable ground for the cancellation of a certificate of self-insurance.

History: Add. 2012, Act 204, Eff. Jan. 1, 2013.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3102 Nonresident owner or registrant of motor vehicle or motorcycle to maintain security for payment of benefits; operation of motor vehicle or motorcycle by owner, registrant, or other person without security; penalty; failure to produce evidence of security; rebuttable presumption.

Sec. 3102. (1) A nonresident owner or registrant of a motor vehicle or motorcycle not registered in this state shall not operate or permit the motor vehicle or motorcycle to be operated in this state for an aggregate of more than 30 days in any calendar year unless he or she continuously maintains security for the payment of benefits pursuant to this chapter.

(2) An owner or registrant of a motor vehicle or motorcycle with respect to which security is required, who operates the motor vehicle or motorcycle or permits it to be operated upon a public highway in this state, without having in full force and effect security complying with this section or section 3101 or 3103 is guilty of a misdemeanor. A person who operates a motor vehicle or motorcycle upon a public highway in this state with the knowledge that the owner or registrant does not have security in full force and effect is guilty of a misdemeanor. A person convicted of a misdemeanor under this section shall be fined not less than $200.00 nor more than $500.00, imprisoned for not more than 1 year, or both.

(3) The failure of a person to produce evidence that a motor vehicle or motorcycle has in full force and effect security complying with this section or section 3101 or 3103 on the date of the issuance of the citation, creates a rebuttable presumption in a prosecution under subsection (2) that the motor vehicle or motorcycle did not have in full force and effect security complying with this section or section 3101 or 3103 on the date of the issuance of the citation.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1975, Act 329, Eff. Mar. 31, 1976;—Am. 1979, Act 145, Imd. Eff. Nov. 13, 1979;—Am. 1980, Act 446, Imd. Eff. Jan. 15, 1981;—Am. 1987, Act 187, Eff. Mar. 30, 1988;—Am. 1990, Act 79, Imd. Eff. May 24, 1990.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3103 Owner or registrant of motorcycle; security required; offering security for payment of first-party medical benefits; rates, deductibles, and provisions.

Sec. 3103. (1) An owner or registrant of a motorcycle shall provide security against loss resulting from liability imposed by law for property damage, bodily injury, or death suffered by a person arising out of the ownership, maintenance, or use of that motorcycle. The security shall conform with the requirements of section 3009(1).

(2) Each insurer transacting insurance in this state which affords coverage for a motorcycle as described in subsection (1) also shall offer, to an owner or registrant of a motorcycle, security for the payment of first-party medical benefits only, in increments of $5,000.00, payable in the event the owner or registrant is involved in a motorcycle accident. An insurer providing first-party medical benefits may offer, at appropriate premium rates, deductibles, provisions for the coordination of these benefits, and provisions for the subtraction of other benefits provided or required to be provided under the laws of any state or the federal government, subject to the prior approval of the commissioner. These deductibles and provisions shall apply

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only to benefits payable to the person named in the policy, the spouse of the insured, and any relative of either domiciled in the same household.

History: Add. 1975, Act 329, Eff. Mar. 31, 1976;—Am. 1977, Act 54, Imd. Eff. July 6, 1977;—Am. 1980, Act 445, Eff. Jan. 15, 1981;—Am. 1986, Act 173, Imd. Eff. July 7, 1986.

Constitutionality: The legislative scheme which allows motorcyclists to receive no-fault benefits for personal injuries without requiring them to maintain no-fault security does not deny automobile drivers equal protection or due process of law. Underhill v Safeco Insurance Company, 407 Mich 175; 284 NW2d 463 (1979).

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3104 Catastrophic claims association; board of directors; plan of operation; annual report; actuarial examination; refund; hearing; annual consumer statement; liability of association; definitions.

Sec. 3104. (1) The catastrophic claims association is created as an unincorporated, nonprofit association. Each insurer engaged in writing insurance coverages that provide the security required by section 3101(1) in this state, as a condition of its authority to transact insurance in this state, shall be a member of the association and is bound by the plan of operation of the association. An insurer engaged in writing insurance coverages that provide the security required by section 3103(1) in this state, as a condition of its authority to transact insurance in this state, is considered to be a member of the association, but only for purposes of premiums under subsection (7)(d). Except as expressly provided in this section, the association is not subject to any laws of this state with respect to insurers, but in all other respects the association is subject to the laws of this state to the extent that the association would be if it were an insurer organized and subsisting under chapter 50.

(2) For all motor vehicle accident policies issued or renewed before July 2, 2020 and for a motor vehicle accident policy issued or renewed after July 1, 2020 to which section 3107c(1)(d) applies, the association shall provide and each member shall accept indemnification for 100% of the amount of ultimate loss sustained under personal protection insurance coverages in excess of the following amounts in each loss occurrence:

(a) For a motor vehicle accident policy issued or renewed before July 1, 2002, $250,000.00.

(b) For a motor vehicle accident policy issued or renewed during the period July 1, 2002 to June 30, 2003, $300,000.00.

(c) For a motor vehicle accident policy issued or renewed during the period July 1, 2003 to June 30, 2004, $325,000.00.

(d) For a motor vehicle accident policy issued or renewed during the period July 1, 2004 to June 30, 2005, $350,000.00.

(e) For a motor vehicle accident policy issued or renewed during the period July 1, 2005 to June 30, 2006, $375,000.00.

(f) For a motor vehicle accident policy issued or renewed during the period July 1, 2006 to June 30, 2007, $400,000.00.

(g) For a motor vehicle accident policy issued or renewed during the period July 1, 2007 to June 30, 2008, $420,000.00.

(h) For a motor vehicle accident policy issued or renewed during the period July 1, 2008 to June 30, 2009, $440,000.00.

(i) For a motor vehicle accident policy issued or renewed during the period July 1, 2009 to June 30, 2010, $460,000.00.

(j) For a motor vehicle accident policy issued or renewed during the period July 1, 2010 to June 30, 2011, $480,000.00.

(k) For a motor vehicle accident policy issued or renewed during the period July 1, 2011 to June 30, 2013, $500,000.00.

(*l*) For a motor vehicle accident policy issued or renewed during the period July 1, 2013 to June 30, 2015, $530,000.00.

(m) For a motor vehicle accident policy issued or renewed during the period July 1, 2015 to June 30, 2017, $545,000.00.

(n) For a motor vehicle accident policy issued or renewed during the period July 1, 2017 to June 30, 2019, $555,000.00.

(o) For a motor vehicle accident policy issued or renewed during the period July 1, 2019 to June 30, 2021, $580,000.00. Beginning July 1, 2021, this $580,000.00 amount must be increased biennially on July 1 of each odd-numbered year, for policies issued or renewed before July 1 of the following odd-numbered year, by the

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lesser of 6% or the Consumer Price Index, and rounded to the nearest $5,000.00. The association shall calculate this biennial adjustment by January 1 of the year of its July 1 effective date.

(3) An insurer may withdraw from the association only on ceasing to write insurance that provides the security required by section 3101(1) in this state.

(4) An insurer whose membership in the association has been terminated by withdrawal continues to be bound by the plan of operation, and on withdrawal, all unpaid premiums that have been charged to the withdrawing member are payable as of the effective date of the withdrawal.

(5) An unsatisfied net liability to the association of an insolvent member must be assumed by and apportioned among the remaining members of the association as provided in the plan of operation. The association has all rights allowed by law on behalf of the remaining members against the estate or funds of the insolvent member for money due the association.

(6) If a member has been merged or consolidated into another insurer or another insurer has reinsured a member's entire business that provides the security required by section 3101(1) in this state, the member and successors in interest of the member remain liable for the member's obligations.

(7) The association shall do all of the following on behalf of the members of the association:

(a) Assume 100% of all liability as provided in subsection (2).

(b) Establish procedures by which members must promptly report to the association each claim that, on the basis of the injuries or damages sustained, may reasonably be anticipated to involve the association if the member is ultimately held legally liable for the injuries or damages. Solely for the purpose of reporting claims, the member shall in all instances consider itself legally liable for the injuries or damages. The member shall also advise the association of subsequent developments likely to materially affect the interest of the association in the claim.

(c) Maintain relevant loss and expense data relating to all liabilities of the association and require each member to furnish statistics, in connection with liabilities of the association, at the times and in the form and detail as required by the plan of operation.

(d) In a manner provided for in the plan of operation, calculate and charge to members of the association a total premium sufficient to cover the expected losses and expenses of the association that the association will likely incur during the period for which the premium is applicable. The total premium must include an amount to cover incurred but not reported losses for the period and must be adjusted for any excess or deficient premiums from previous periods. Excesses or deficiencies from previous periods must either be fully adjusted in a single period or be adjusted over several periods in a manner provided for in the plan of operation. Each member must be charged an amount equal to that member's total written car years of insurance providing the security required by section 3101(1) or 3103(1), or both, written in this state during the period to which the premium applies, with the total written car years of insurance multiplied by the applicable average premium per car. The average premium per car is the total premium, as adjusted for any excesses or deficiencies, divided by the total written car years of insurance providing the security required by section 3101(1) or 3103(1), or both, written in this state of all members during the period to which the premium applies, excluding cars insured under a policy with a coverage limit under section 3107c(1)(a), (b), or (c), cars as to which an election to not maintain personal protection insurance benefits has been made under section 3107d, or as to which an exclusion under section 3109a(2) applies, except for any portion of total premium that is an adjustment for a deficiency in a previous period. A member may not be charged a premium for a car insured under a policy with a coverage limit under section 3107c(1)(a), (b), or (c), as to which an election to not maintain personal protection insurance benefits has been made under section 3107d, or as to which an exclusion under section 3109a(2) applies, other than for the portion of the total premium attributable to an adjustment for a deficiency in a previous period. A member must be charged a premium for a historic vehicle that is insured with the member of 20% of the premium charged for a car insured with the member.

(e) Require and accept the payment of premiums from members of the association as provided for in the plan of operation. The association shall do either of the following:

(*i*) Require payment of the premium in full within 45 days after the premium charge.

(*ii*) Require payment of the premiums to be made periodically to cover the actual cash obligations of the association.

(f) Receive and distribute all money required by the operation of the association.

(g) Establish procedures for reviewing claims procedures and practices of members of the association. If the claims procedures or practices of a member are considered inadequate to properly service the liabilities of the association, the association may undertake or may contract with another person, including another member, to adjust or assist in the adjustment of claims for the member on claims that create a potential liability to the association and may charge the cost of the adjustment to the member.

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(h) Provide any records necessary or requested by the director for the actuarial examination under subsection (21).

(i) Subject to subsection (23), obey an order of the director for a refund under subsection (22).

(8) In addition to other powers granted to it by this section, the association may do all of the following:

(a) Sue and be sued in the name of the association. A judgment against the association does not create any direct liability against the individual members of the association. The association may provide for the indemnification of its members, members of the board of directors of the association, and officers, employees, and other persons lawfully acting on behalf of the association.

(b) Reinsure all or any portion of its potential liability with reinsurers licensed to transact insurance in this state or approved by the director.

(c) Provide for appropriate housing, equipment, and personnel as necessary to assure the efficient operation of the association.

(d) Pursuant to the plan of operation, adopt reasonable rules for the administration of the association, enforce those rules, and delegate authority, as the board considers necessary to assure the proper administration and operation of the association consistent with the plan of operation.

(e) Contract for goods and services, including independent claims management, actuarial, investment, and legal services, from others in or outside of this state to assure the efficient operation of the association.

(f) Hear and determine complaints of a company or other interested party concerning the operation of the association.

(g) Perform other acts not specifically enumerated in this section that are necessary or proper to accomplish the purposes of the association and that are not inconsistent with this section or the plan of operation.

(9) A board of directors is created and shall operate the association consistent with the plan of operation and this section.

(10) The plan of operation must provide for all of the following:

(a) The establishment of necessary facilities.

(b) The management and operation of the association.

(c) Procedures to be utilized in charging premiums, including adjustments from excess or deficient premiums from prior periods. The plan must require that any deficiency from a prior period be amortized over not fewer than 15 years.

(d) Procedures for a refund to members of the association, for distribution to insureds as provided in subsection (24), as ordered by the director under subsection (22). The procedures must provide for a distribution of a refund attributable to a historic vehicle equal to 20% of the refund for a car that is not a historic vehicle.

(e) Procedures governing the actual payment of premiums to the association.

(f) Reimbursement of each member of the board by the association for actual and necessary expenses incurred on association business.

(g) The investment policy of the association.

(h) Any other matters required by or necessary to effectively implement this section.

(11) The board must include members that would contribute a total of not less than 40% of the total premium calculated under subsection (7)(d). Each board member is entitled to 1 vote. The initial term of office of a board member is 2 years.

(12) As part of the plan of operation, the board shall adopt rules providing for the composition of the board and the terms of board members, consistent with the membership composition requirements in subsections (11) and (13). Terms of the board members must be staggered so that the terms of all the board members do not expire at the same time and so that a board member does not serve a term of more than 4 years.

(13) The board must consist of 5 board members and the director, who shall serve as an ex officio member of the board without vote.

(14) The director shall appoint the board members. A board member shall serve until his or her successor is selected and qualified. The board shall elect the chairperson of the board. The director shall fill any vacancy on the board as provided in the plan of operation.

(15) The board shall meet as often as the chairperson, the director, or the plan of operation requires, or at the request of any 3 board members. The chairperson may vote on all issues. Four board members constitute a quorum.

(16) The board shall furnish to each member of the association an annual report of the operations of the association in a form and detail as determined by the board.

(17) Any amendments to the plan of operation are subject to majority approval by the board, ratification by a majority of the membership of the association having a vote, with voting rights being apportioned according

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to the premiums charged in subsection (7)(d), and approval by the director.

(18) An insurer authorized to write insurance providing the security required by section 3101(1) in this state, as provided in this section, is bound by and shall formally subscribe to and participate in the plan of operation as a condition of maintaining its authority to transact insurance in this state.

(19) The association is subject to all the reporting, loss reserve, and investment requirements of the director to the same extent as is a member of the association.

(20) Premiums charged members by the association must be recognized in the rate-making procedures for insurance rates in the same manner that expenses and premium taxes are recognized. If a member of the association passes on any portion of the premium payable under this section to an insured, the amount passed on must equal the portion of the premium payable by the member under this section attributable to the car or historic vehicle insured, including any adjustments for excesses or deficiencies from a previous period.

(21) The director or an authorized representative of the director may visit the association at any time and examine any and all of the association's affairs. Beginning July 1, 2022, and every third year after 2022, the director shall engage 1 or more independent actuaries to examine the affairs and records of the association for the previous 3 years. The actuarial examination must be conducted using sound actuarial principles consistent with the applicable statements of principles and the code of professional conduct adopted by the Casualty Actuarial Society. By September 1, 2022 and by September 1 of every third year after 2022, the director shall provide a report to the legislature on the results of the audit conducted under this subsection.

(22) If the actuarial examination under subsection (21) shows that the assets of the association exceed 120% of its liabilities, including incurred but not reported liabilities, and if the refund will not threaten the association's ongoing ability to provide reimbursements for personal protection insurance benefits based on sound actuarial principles consistent with the applicable statements of principles and the code of professional conduct adopted by the Casualty Actuarial Society, the director shall order the association to refund an amount equal to the difference between the total excess and 120% of the liabilities of the association, including incurred but not reported liabilities, under subsection (10)(d) and order the members of the association to distribute the refunds under subsection (24).

(23) Within 30 days after receiving an order from the director under subsection (22), the association may request a hearing to review the order by filing a written request with the director. The department shall conduct the review as a contested case under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(24) A member of the association shall distribute any refund it receives under subsection (10)(d) to the persons that it insures under policies that provide the security required under section 3101(1) or 3103(1), or both, and that are subject to a premium under this section on a uniform basis per car and historic vehicle in a manner and on the date or dates provided by the director in accordance with an order issued by the director. A refund attributable to a historic vehicle must be equal to 20% of the refund for a car that is not a historic vehicle.

(25) By September 1 of each year, the association shall prepare, submit to the committees of the senate and house of representatives with jurisdiction over insurance matters, and post on the association website an annual consumer statement, written in a manner intended for the general public. The statement must include all of the following:

(a) The number of claims opened during the preceding 12 months, the amount expended on the claims, and the future anticipated costs of the claims.

(b) For each of the preceding 10 years, the total number of open claims, the amount expended on the claims, and the anticipated future costs of the claims.

(c) For each of the preceding 10 years, the total number of claims closed and the amount expended on the claims.

(d) For each of the preceding 10 years, the ratio of claims opened to claims closed.

(e) For each of the preceding 10 years, the average length of open claims.

(f) A statement of the current financial condition of the association and the reasons for any deficit or surplus in collected assessments compared to losses.

(g) A statement of the assumptions, methodology, and data used to make revenue projections. As used in this subdivision, "revenue" means return on investments.

(h) A statement of the assumptions, methodology, and data used to make cost projections.

(i) A list of the association's assets, sorted by category or type of asset, such as stocks, bonds, or mutual funds, and the expected return on each asset.

(j) The total amount of the association's discounted and undiscounted liabilities and a description and explanation of the liabilities, including an explanation of the association's definition of the terms discounted and undiscounted.

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(k) Measures taken by the association to contain costs.

(*l*) A statement explaining what portion of the assessment to insureds as recognized in rates under subsection (20) is attributable to claims occurring in the previous 12 months, administrative costs, and the amount, if any, to adjust for past deficits.

(m) A statement explaining any qualifications identified by the independent auditors in the most recent audit report prepared under subsection (21).

(n) A loss payment summary for each of the preceding years by category.

(o) For each of the preceding 10 years, an injury type summary, categorizing the injuries suffered by claimants the payment of whose claims are being reimbursed by the association, by brain injuries, injuries resulting in quadriplegia, injuries resulting in paraplegia, burn injuries, and other injuries.

(p) A summary of investment returns over the preceding 10 years showing the investment balance, the investment gain, and the percentage return on the investment balance.

(q) A summary of the mortality assumptions used in making cost projections.

(r) A summary of any financial practices that differ from those found in the National Association of Insurance Commissioners Accounting Practices and Procedures Manual.

(26) By September 1 of each year, the association shall prepare and provide to the committees of the senate and house of representatives with jurisdiction over insurance matters an annual report of the association. The report must contain all of the following:

(a) An executive summary.

(b) A discussion of the mortality assumptions used by the association in making cost projections.

(c) An evaluation of the accuracy of the association's actuarial assumptions over the preceding 5 years.

(d) The annual consumer statement prepared under subsection (25).

(e) Anything else the association determines is necessary to advise the legislature about the operations of the association.

(27) The association does not have liability for losses occurring before July 1, 1978. After July 1, 2020, the association does not have liability for an ultimate loss under personal protection insurance coverage for a motor vehicle accident policy to which a limit under section 3107c(1)(a), (b), or (c) is applicable.

(28) As used in this section:

(a) "Association" means the catastrophic claims association created in subsection (1).

(b) "Board" means the board of directors of the association created in subsection (9).

(c) "Car" includes a motorcycle but does not include a historic vehicle.

(d) "Consumer Price Index" means the percentage of change in the Consumer Price Index for all urban consumers in the United States city average for all items for the 24 months before October 1 of the year before the July 1 effective date of the biennial adjustment under subsection (2)(o) as reported by the United States Department of Labor, Bureau of Labor Statistics, and as certified by the director.

(e) "Historic vehicle" means a vehicle that is a registered historic vehicle under section 803a or 803p of the Michigan vehicle code, 1949 PA 300, MCL 257.803a and 257.803p.

(f) "Motor vehicle accident policy" means a policy providing the coverages required under section 3101(1).

(g) "Ultimate loss" means the actual loss amounts that a member is obligated to pay and that are paid or payable by the member, and do not include claim expenses. An ultimate loss is incurred by the association on the date that the loss occurs.

History: Add. 1978, Act 136, Eff. July 1, 1978;—Am. 1980, Act 445, Imd. Eff. Jan. 15, 1981;—Am. 2001, Act 3, Eff. July 1, 2002;—Am. 2002, Act 662, Eff. July 1, 2003;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

For transfer of position of commissioner of office of financial and insurance regulation as member or chairperson of board or commission to director of department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3105 Insurer liable for personal protection benefits without regard to fault; "bodily injury" and "accidental bodily injury" defined.

Sec. 3105. (1) Under personal protection insurance an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of this chapter.

(2) Personal protection insurance benefits are due under this chapter without regard to fault.

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(3) Bodily injury includes death resulting therefrom and damage to or loss of a person's prosthetic devices in connection with the injury.

(4) Bodily injury is accidental as to a person claiming personal protection insurance benefits unless suffered intentionally by the injured person or caused intentionally by the claimant. Even though a person knows that bodily injury is substantially certain to be caused by his act or omission, he does not cause or suffer injury intentionally if he acts or refrains from acting for the purpose of averting injury to property or to any person including himself.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3106 Accidental bodily injury arising out of ownership, operation, maintenance, or use of parked vehicle as motor vehicle; conditions.

Sec. 3106. (1) Accidental bodily injury does not arise out of the ownership, operation, maintenance, or use of a parked vehicle as a motor vehicle unless any of the following occur:

(a) The vehicle was parked in such a way as to cause unreasonable risk of the bodily injury which occurred.

(b) Except as provided in subsection (2), the injury was a direct result of physical contact with equipment permanently mounted on the vehicle, while the equipment was being operated or used, or property being lifted onto or lowered from the vehicle in the loading or unloading process.

(c) Except as provided in subsection (2), the injury was sustained by a person while occupying, entering into, or alighting from the vehicle.

(2) Accidental bodily injury does not arise out of the ownership, operation, maintenance, or use of a parked vehicle as a motor vehicle if benefits under the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, as amended, being sections 418.101 to 418.941 of the Michigan Compiled Laws, or under a similar law of another state or under a similar federal law, are available to an employee who sustains the injury in the course of his or her employment while doing either of the following:

(a) Loading, unloading, or doing mechanical work on a vehicle unless the injury arose from the use or operation of another vehicle. As used in this subdivision, "another vehicle" does not include a motor vehicle being loaded on, unloaded from, or secured to, as cargo or freight, a motor vehicle.

(b) Entering into or alighting from the vehicle unless the injury was sustained while entering into or alighting from the vehicle immediately after the vehicle became disabled. This subdivision shall not apply if the injury arose from the use or operation of another vehicle. As used in this subdivision, "another vehicle" does not include a motor vehicle being loaded on, unloaded from or secured to, as cargo or freight, a motor vehicle.

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History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1981, Act 209, Eff. Jan. 1, 1982;—Am. 1986, Act 318, Eff. June 1, 1987.

Compiler's note: Section 2 of Act 209 of 1981 provides: “This amendatory act shall take effect January 1, 1982 and shall be applicable to all causes of action which occur after the effective date of this amendatory act.”

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3107 Expenses and work loss for which personal protection insurance benefits payable.

Sec. 3107. (1) Subject to the exceptions and limitations in this chapter, and subject to chapter 31A, personal protection insurance benefits are payable for the following:

(a) Allowable expenses consisting of reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation. Allowable expenses do not include either of the following:

(*i*) Charges for a hospital room in excess of a reasonable and customary charge for semiprivate accommodations, unless the injured person requires special or intensive care.

(*ii*) Funeral and burial expenses in excess of the amount set forth in the policy, which must not be less than $1,750.00 or more than $5,000.00.

(b) Work loss consisting of loss of income from work an injured person would have performed during the first 3 years after the date of the accident if he or she had not been injured. Work loss does not include any loss after the date on which the injured person dies. Because the benefits received from personal protection insurance for loss of income are not taxable income, the benefits payable for the loss of income must be

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reduced 15% unless the claimant presents to the insurer in support of his or her claim reasonable proof of a lower value of the income tax advantage in his or her case, in which case the lower value must be applied. For the period beginning October 1, 2012 through September 30, 2013, the benefits payable for work loss sustained in a single 30-day period and the income earned by an injured person for work during the same period together must not exceed $5,189.00, which maximum must be applied pro rata to any lesser period of work loss. Beginning October 1, 2013, the maximum must be adjusted annually to reflect changes in the cost of living under rules prescribed by the director, but any change in the maximum must be applied only to benefits arising out of accidents occurring after the date of change in the maximum.

(c) Expenses not exceeding $20.00 per day, reasonably incurred in obtaining ordinary and necessary services in lieu of those that, if he or she had not been injured, an injured person would have performed during the first 3 years after the date of the accident, not for income but for the benefit of himself or herself or of his or her dependent.

(2) Both of the following apply to personal protection insurance benefits payable under subsection (1):

(a) A person who is 60 years of age or older and in the event of an accidental bodily injury would not be eligible to receive work loss benefits under subsection (1)(b) may waive coverage for work loss benefits by signing a waiver on a form provided by the insurer. An insurer shall offer a reduced premium rate to a person who waives coverage under this subdivision for work loss benefits. Waiver of coverage for work loss benefits applies only to work loss benefits payable to the person or persons who have signed the waiver form.

(b) An insurer is not required to provide coverage for the medical use of marihuana or for expenses related to the medical use of marihuana.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1988, Act 312, Eff. Mar. 30, 1989;—Am. 1991, Act 191, Eff. Jan. 1, 1992;—Am. 2012, Act 542, Imd. Eff. Jan. 2, 2013;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Constitutionality: The legislature did not violate constitutional due process or equal protection in providing for cost-of-living increases for no-fault insurance work loss benefits under subdivision (b) of this section, but not for no-fault insurance survivors' loss benefits under MCL 500.3108. Davey v Detroit Automobile Inter-Insurance Exchange, 414 Mich 1; 322 NW2d 541 (1982).

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

Administrative rules: R 500.811 of the Michigan Administrative Code.

500.3107a Basis of work loss for certain injured persons.

Sec. 3107a. Subject to the provisions of section 3107(1)(b), work loss for an injured person who is temporarily unemployed at the time of the accident or during the period of disability shall be based on earned income for the last month employed full time preceding the accident.

History: Add. 1975, Act 311, Imd. Eff. Dec. 22, 1975;—Am. 1991, Act 191, Eff. Jan. 1, 1992.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3107b Reimbursement or coverage for certain expenses not required.

Sec. 3107b. Reimbursement or coverage for expenses within personal protection insurance coverage under section 3107 is not required for any of the following:

(a) A practice of optometry service, unless that service was included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

(b) A practice of chiropractic service rendered before July 2, 2021, unless that service was included in the definition of practice of chiropractic under section 16401 of the public health code, 1978 PA 368, MCL 333.16401, as of January 1, 2009.

(c) A practice of physical therapy service or practice as a physical therapist assistant service, unless that service was provided by a licensed physical therapist or physical therapist assistant under the supervision of a licensed physical therapist under a prescription from a health care professional who holds a license issued under part 166, 170, 175, or 180 of the public health code, 1978 PA 368, MCL 333.16601 to 333.16659, 333.17001 to 333.17097, 333.17501 to 333.17556, and 333.18001 to 333.18058, or the equivalent license issued by another state.

History: Add. 1994, Act 438, Eff. Mar. 30, 1995;—Am. 2009, Act 222, Imd. Eff. Jan. 5, 2010;—Am. 2014, Act 263, Imd. Eff. July 1, 2014;—Am. 2020, Act 104, Imd. Eff. July 1, 2020.

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Compiler's note: Senate Bill No. 493 was not enacted into law by the 87th Legislature.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3107c Personal protection insurance benefits; coverage limits for allowable expenses; form; rebuttable presumption; application of coverage selection; stacking of insurance policies; applicability to transportation network company vehicle; rider for attendant care.

Sec. 3107c. (1) Except as provided in sections 3107d and 3109a, and subject to subsection (5), for an insurance policy that provides the security required under section 3101(1) and is issued or renewed after July 1, 2020, the applicant or named insured shall, in a way required under section 3107e and on a form approved by the director, select 1 of the following coverage levels for personal protection insurance benefits under section 3107(1)(a):

(a) A limit of $50,000.00 per individual per loss occurrence for any personal protection insurance benefits under section 3107(1)(a). The selection of a limit under this subdivision is only available to an applicant or named insured if both of the following apply:

(*i*) The applicant or named insured is enrolled in Medicaid, as that term is defined in section 3157.

(*ii*) The applicant's or named insured's spouse and any relative of either who resides in the same household has qualified health coverage, as that term is defined in section 3107d, is enrolled in Medicaid, or has coverage for the payment of benefits under section 3107(1)(a) from an insurer that provides the security required by section 3101(1).

(b) A limit of $250,000.00 per individual per loss occurrence for any personal protection insurance benefits under section 3107(1)(a).

(c) A limit of $500,000.00 per individual per loss occurrence for any personal protection insurance benefits under section 3107(1)(a).

(d) No limit for personal protection insurance benefits under section 3107(1)(a).

(2) The form required under subsection (1) must do all of the following:

(a) State, in a conspicuous manner, the benefits and risks associated with each coverage option.

(b) Provide a way for the applicant or named insured to mark the form to acknowledge that he or she has read the form and understands the options available.

(c) Allow the applicant or named insured to mark the form to make the selection of coverage level under subsection (1).

(d) Require the applicant or named insured to sign the form.

(3) If an insurance policy is issued or renewed as described in subsection (1) and the applicant or named insured has not made an effective selection under subsection (1) but a premium or premium installment has been paid, there is a rebuttable presumption that the amount of the premium or installment paid accurately reflects the level of coverage applicable to the policy under subsection (1).

(4) If an insurance policy is issued or renewed as described in subsection (1), the applicant or named insured has not made an effective selection under subsection (1), and a presumption under subsection (3) does not apply, subsection (1)(d) applies to the policy.

(5) The coverage level selected under subsection (1) applies to the named insured, the named insured's spouse, and a relative of either domiciled in the same household, and any other person with a right to claim personal protection insurance benefits under the policy.

(6) If benefits are payable under section 3107(1)(a) under 2 or more insurance policies, the benefits are only payable up to an aggregate coverage limit that equals the highest available coverage limit under any 1 of the policies.

(7) This section applies for a transportation network company vehicle, but an applicant or named insured that is a transportation network company shall only select limits under either subsection (1)(b), (c), or (d). As used in this subsection:

(a) "Transportation network company" means that term as defined in section 2 of the limousine, taxicab, and transportation network company act, 2016 PA 345, MCL 257.2102.

(b) "Transportation network company vehicle" means that term as defined in section 3114.

(8) An insurer shall offer, for a policy that provides the security required under section 3101(1) to which a limit under subsection (1)(a) to (c) applies, a rider that will provide coverage for attendant care in excess of the applicable limit.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019;—Add. 2019, Act 22, Imd. Eff. June 11, 2019.

Compiler's note: MCL 500.3107c was added by 2019 PA 21 and 2019 PA 22. 2019 PA 22, being substantively the same as 2019 PA 21 and enacted after 2019 PA 21, becomes the only version on its effective date.

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Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3107d Election to not maintain personal protection insurance benefit coverage; proof of qualified health coverage; form; failure to make election; termination of qualified health coverage; definitions.

Sec. 3107d. (1) For an insurance policy that provides the security required under section 3101(1) and is issued or renewed after July 1, 2020, the applicant or named insured may, in a way required under section 3107e and on a form approved by the director, elect to not maintain coverage for personal protection insurance benefits payable under section 3107(1)(a) if the applicant or named insured is a qualified person, and if the applicant's or named insured's spouse and any relative of either that resides in the same household have qualified health coverage or have coverage for benefits payable under section 3107(1)(a) from an insurer that provides the security required by section 3101(1).

(2) An applicant or named insured shall, when requesting issuance or renewal of a policy under subsection (1), provide to the insurer a document from the person that provides the qualified health coverage stating the names of all persons covered under the qualified health coverage.

(3) The form required under subsection (1) must do all of the following:

(a) Require the applicant or named insured to mark the form to certify whether all persons required to be qualified persons under subsection (1) are qualified persons.

(b) Disclose in a conspicuous manner that qualified persons are not obligated to but may purchase coverage for personal protection insurance coverage benefits payable under section 3107(1)(a).

(c) State, in a conspicuous manner, the coverage levels available under section 3107c.

(d) State, in a conspicuous manner, the benefits and risks associated with not maintaining the coverage.

(e) State, in a conspicuous manner, that if during the term of the policy the qualified health coverage ceases, the person has 30 days after the effective date of the termination of qualified health coverage to obtain insurance that provides coverage under section 3107(1)(a) or the person will be excluded from all personal protection insurance coverage benefits under section 3107(1)(a) during the period in which coverage under this section was not maintained.

(f) Provide a way for the applicant or named insured to mark the form to acknowledge that he or she has read the form and understands it and that he or she understands the options available to him or her.

(g) If all persons required to be qualified persons under subsection (1) are qualified persons, provide the person a way to mark the form to elect to not maintain the coverage.

(h) Require the applicant or named insured to sign the form.

(4) If an insurance policy is issued or renewed as described in subsection (1) and the applicant or named insured has not made an effective election under subsection (1), the policy is considered to provide personal protection benefits under section 3107c(1)(d).

(5) An election under this section applies to the applicant or named insured, the applicant or named insured's spouse, a relative of either domiciled in the same household, and any other person who would have had a right to claim personal protection insurance benefits under the policy but for the election.

(6) If, during the term of an insurance policy under which coverage for personal protection insurance benefits payable under section 3107(1)(a) are not maintained under this section, the persons required to have qualified health coverage under subsection (1) cease to have qualified health coverage, all of the following apply under this subsection:

(a) Within 30 days after the effective date of the termination of qualified health coverage, the named insured shall obtain insurance that includes coverage under section 3107(1)(a).

(b) An insurer that issues policies that provide the security required by section 3101(1) shall not refuse to prospectively insure, limit coverage available to, charge a reinstatement fee to, or increase the insurance premiums for a person who is an eligible person, as that term is defined in section 2103, solely because the person previously failed to obtain insurance that provides coverage for benefits under section 3107(1)(a) in the time required under subdivision (a).

(c) If the applicant or named insured does not obtain insurance as required under subdivision (a) and a person to whom the election under this section applies as described in subsection (5) suffers accidental bodily injury arising from a motor vehicle accident within the 30-day period, unless the injured person is entitled to coverage under some other policy, the injured person is not entitled to be paid personal protection insurance benefits under section 3107(1)(a) for the injury but is entitled to claim benefits under the assigned claims plan.

(7) As used in this section:

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(a) "Consumer Price Index" means the most comprehensive index of consumer prices available for this state from the United States Department of Labor, Bureau of Labor Statistics.

(b) "Qualified health coverage" means either of the following:

(*i*) Other health or accident coverage to which both of the following apply:

(A) The coverage does not exclude or limit coverage for injuries related to motor vehicle accidents.

(B) Any annual deductible for the coverage is $6,000.00 or less per individual. The director shall adjust the amount in this sub-subparagraph on July 1 of each year by the percentage change in the medical component of the Consumer Price Index for the preceding calendar year. However, the director shall not make the adjustment unless the adjustment, or the total of the adjustment and previous unadded adjustments, is $500.00 or more.

(*ii*) Coverage under parts A and B of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(c) "Qualified person" means a person who has qualified health coverage under subdivision (b)(*ii*).

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019;—Add. 2019, Act 22, Imd. Eff. June 11, 2019.

Compiler's note: MCL 500.3107d was added by 2019 PA 21 and 2019 PA 22. 2019 PA 22, being substantively the same as 2019 PA 21 and enacted after 2019 PA 21, becomes the only version on its effective date.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3107e Delivery of forms under MCL 500.3009, 500.3107c, 500.3107d; method of selection or election for forms.

Sec. 3107e. (1) A form under section 3009, 3107c, or 3107d must be delivered to the applicant or named insured using 1 of the following methods:

(a) Personal delivery.

(b) First-class mail, postage prepaid.

(c) Electronic means in accordance with section 2266.

(2) A person must make a selection under section 3009 or 3107c, or an election under section 3107d in 1 of the following ways:

(a) Marking and signing a paper form.

(b) Giving verbal instructions, in person or telephonically, that the form be marked and signed on behalf of the person. To be an effective selection or election, the verbal instructions must be recorded and the recording maintained by the person to whom the instructions were given. If there is a dispute over the effectiveness of a selection or election under this subdivision, there is a presumption that the selection or election was not effective and the insurer has the burden of rebutting the presumption with the recording.

(c) Electronically marking the form and providing an electronic signature as provided in the uniform electronic transactions act, 2000 PA 305, MCL 450.831 to 450.849.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3108 Survivor's loss; benefits.

Sec. 3108. (1) Except as provided in subsection (2), personal protection insurance benefits are payable for a survivor's loss which consists of a loss, after the date on which the deceased died, of contributions of tangible things of economic value, not including services, that dependents of the deceased at the time of the deceased's death would have received for support during their dependency from the deceased if the deceased had not suffered the accidental bodily injury causing death and expenses, not exceeding $20.00 per day, reasonably incurred by these dependents during their dependency and after the date on which the deceased died in obtaining ordinary and necessary services in lieu of those that the deceased would have performed for their benefit if the deceased had not suffered the injury causing death. Except as provided in section (2) the benefits payable for a survivors' loss in connection with the death of a person in a single 30-day period shall not exceed $1,000.00 for accidents occurring before October 1, 1978, and shall not exceed $1,475.00 for accidents occurring on or after October 1, 1978, and is not payable beyond the first three years after the date of the accident.

(2) The maximum payable shall be adjusted annually to reflect changes in the cost of living under rules prescribed by the commissioner. A change in the maximum shall apply only to benefits arising out of

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accidents occurring subsequent to the date of change in the maximum. The maximum shall apply to the aggregate benefits for all survivors payable under this section on account of the death of any one person.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1978, Act 459, Imd. Eff. Oct. 16, 1978.

Constitutionality: The legislature did not violate constitutional due process or equal protection in providing for cost-of-living increases for no-fault insurance work loss benefits under MCL 500.3107(b), but not for no-fault insurance survivors' loss benefits under this section. Davey v Detroit Automobile Inter-Insurance Exchange, 414 Mich 1; 322 NW2d 541 (1982).

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3109 Subtraction of other benefits from personal protection benefits; injured person defined; deductible provision.

Sec. 3109. (1) Benefits provided or required to be provided under the laws of any state or the federal government shall be subtracted from the personal protection insurance benefits otherwise payable for the injury under this chapter.

(2) An injured person is a natural person suffering accidental bodily injury.

(3) An insurer providing personal protection insurance benefits under this chapter may offer, at appropriately reduced premium rates, a deductible of a specified dollar amount. This deductible may be applicable to all or any specified types of personal protection insurance benefits, but shall apply only to benefits payable to the person named in the policy, his or her spouse, and any relative of either domiciled in the same household.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 2012, Act 454, Imd. Eff. Dec. 27, 2012.

Constitutionality: In O'Donnel v State Farm Mutual Automobile Insurance Company, 404 Mich 524; 273 NW2d 829 (1979), the Michigan supreme court held that MCL 500.3109(1) does not violate the due process clause or the equal protection clause of the state or federal constitutions.

In Underhill v Safeco Insurance Company, 407 Mich 175; 284 NW2d 463 (1979), the Michigan supreme court held that subsection (3) of this section authorizing the commissioner to approve deductibles was not an unconstitutional delegation of authority.

The Michigan supreme court in Mathis v Interstate Motor Freight System, 408 Mich 164; 289 NW2d 708 (1980), held that MCL 500.3109(1) as applied to workers' compensation benefits is sustainable under the equal protection clause of the Michigan constitution.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3109a Offering deductibles and exclusions reasonably related to other health and accident coverage; exclusion for qualified health coverage; reduced premium rates; applicability of exclusion; termination of qualified health coverage; refusal to insure for failure to obtain certain security prohibited; amount of premium reduction.

Sec. 3109a. (1) An insurer that provides personal protection insurance benefits under this chapter may offer deductibles and exclusions reasonably related to other health and accident coverage on the insured. Any deductibles and exclusions offered under this section must be offered at a reduced premium that reflects reasonably anticipated reductions in losses, expenses, or both, are subject to prior approval by the director, and must apply only to benefits payable to the person named in the policy, the spouse of the insured, and any relative of either domiciled in the same household.

(2) For an insurance policy issued or renewed after July 1, 2020, the insurer shall offer to an applicant or named insured that selects a personal protection benefit limit under section 3107c(1)(b) an exclusion related to qualified health coverage. All of the following apply to that exclusion:

(a) If the named insured has qualified health coverage as defined in section 3107d(7)(b)(*i*) that will cover injuries that occur as the result of a motor vehicle accident and if the named insured's spouse and any relatives of either the named insured or the spouse domiciled in the same household have qualified health coverage that will cover injuries that occur as the result of a motor vehicle accident, the premium for the personal protection insurance benefits payable under section 3107(1)(a) under the policy must be reduced by 100%.

(b) If a member, but not all members, of the household covered by the insurance policy has qualified health coverage that will cover injuries that occur as the result of a motor vehicle accident, the insurer shall offer a reduced premium that reflects reasonably anticipated reductions in losses, expenses, or both. The reduction must be in addition to the rate rollback required by section 2111f and the share of the premium reduction for the policy attributable to any person with qualified health coverage must be 100%.

(c) Subject to subdivision (d), a person subject to an exclusion under this subsection is not eligible for personal protection benefits under the insurance policy.

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(d) If a person subject to an exclusion under this subsection is no longer covered by the qualified health coverage, the named insured shall notify the insurer that the named insured or resident relative is no longer eligible for an exclusion. All of the following apply under this subdivision:

(*i*) The named insured shall, within 30 days after the effective date of the termination of the qualified health coverage, obtain insurance that provides the security required under section 3101(1) that includes coverage that was excluded under this subsection.

(*ii*) During the period described in subparagraph (*i*), if any person excluded suffers accidental bodily injury arising from a motor vehicle accident, the person is entitled to claim benefits under the assigned claims plan.

(e) If the named insured does not obtain insurance that provides the security required under section 3101(1) that includes the coverage excluded under this subsection during the period described in subdivision (d)(*i*) and the named insured or any person excluded under the policy suffers accidental bodily injury arising from a motor vehicle accident, unless the injured person is entitled to coverage under some other policy, the injured person is not entitled to be paid personal protection insurance benefits under section 3107(1)(a) for the injury that occurred during the period in which coverage under this section was excluded.

(3) An automobile insurer shall not refuse to prospectively insure, limit coverage available to, charge a reinstatement fee for, or increase the premiums for automobile insurance for an eligible person, as that term is defined in section 2103, solely because the person previously failed to obtain insurance that provides the security required under section 3101(1) in the time period provided under subsection (2)(d)(*i*).

(4) The amount of a premium reduction under subsection (1) must appear in a conspicuous manner in the declarations for the policy, and be expressed as a dollar amount or a percentage.

(5) As used in this section, "qualified health coverage" means that term as defined in section 3107d.

History: Add. 1974, Act 72, Eff. June 4, 1974;—Am. 2012, Act 454, Imd. Eff. Dec. 27, 2012;—Am. 2019, Act 21, Imd. Eff. June 11, 2019;—Am. 2019, Act 22, Imd. Eff. June 11, 2019.

Constitutionality: In O'Donnel v State Farm Mutual Automobile Insurance Company, 404 Mich 524; 273 NW2d 829 (1979), the Michigan supreme court declared this statute constitutional.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

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500.3110 Dependents of deceased person; termination of dependency; accrual of personal protection benefits.

Sec. 3110. (1) The following persons are conclusively presumed to be dependents of a deceased person:

(a) A wife is dependent on a husband with whom she lives at the time of his death.

(b) A husband is dependent on a wife with whom he lives at the time of her death.

(c) A child while under the age of 18 years, or over that age but physically or mentally incapacitated from earning, is dependent on the parent with whom he lives or from whom he receives support regularly at the time of the death of the parent.

(2) In all other cases, questions of dependency and the extent of dependency shall be determined in accordance with the facts as they exist at the time of death.

(3) The dependency of a surviving spouse terminates upon death or remarriage. The dependency of any other person terminates upon the death of the person and continues only so long as the person is under the age of 18 years, physically or mentally incapacitated from earning, or engaged full time in a formal program of academic or vocational education or training.

(4) Personal protection insurance benefits payable for accidental bodily injury accrue not when the injury occurs but as the allowable expense, work loss or survivors' loss is incurred.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3111 Payment of personal protection insurance benefits for accident occurring out of state.

Sec. 3111. Personal protection insurance benefits are payable for accidental bodily injury suffered in an accident occurring out of this state, if the accident occurs within the United States, its territories and possessions, or Canada, and the person whose injury is the basis of the claim was at the time of the accident a

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named insured under a personal protection insurance policy, the spouse of a named insured, a relative of either domiciled in the same household, or an occupant of a vehicle involved in the accident, if the occupant was a resident of this state or if the owner or registrant of the vehicle was insured under a personal protection insurance policy or provided security approved by the secretary of state under section 3101(5).

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 2019, Act 21, Imd. Eff. June 11, 2019;—Am. 2019, Act 22, Imd. Eff. June 11, 2019.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3112 Persons to whom personal protection insurance benefits payable; claim to recover overdue benefits; discharge of insurer's liability.

Sec. 3112. Personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his or her death, to or for the benefit of his or her dependents. A health care provider listed in section 3157 may make a claim and assert a direct cause of action against an insurer, or under the assigned claims plan under sections 3171 to 3175, to recover overdue benefits payable for charges for products, services, or accommodations provided to an injured person. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled to the benefits, the insurer, the claimant, or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:

(a) To the dependents of the injured person, the personal protection insurance benefits accrued before his or her death without appointment of an administrator or executor.

(b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: Enacting section 1 of Act 21 of 2019 provides:

"Enacting section 1. Section 3112 of the insurance code of 1956, 1956 PA 218, MCL 500.3112, as amended by this amendatory act, applies to products, services, or accommodations provided after the effective date of this amendatory act."

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3113 Person not entitled to personal protection insurance benefits.

Sec. 3113. A person is not entitled to be paid personal protection insurance benefits for accidental bodily injury if at the time of the accident any of the following circumstances existed:

(a) The person was willingly operating or willingly using a motor vehicle or motorcycle that was taken unlawfully, and the person knew or should have known that the motor vehicle or motorcycle was taken unlawfully.

(b) The person was the owner or registrant of a motor vehicle or motorcycle involved in the accident with respect to which the security required by section 3101 or 3103 was not in effect.

(c) The person was not a resident of this state, unless the person owned a motor vehicle that was registered and insured in this state.

(d) The person was operating a motor vehicle or motorcycle as to which he or she was named as an excluded operator as allowed under section 3009(2).

(e) The person was the owner or operator of a motor vehicle for which coverage was excluded under a policy exclusion authorized under section 3017.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1986, Act 93, Eff. July 8, 1986;—Am. 2014, Act 489, Imd. Eff. Jan. 13, 2015;—Am. 2016, Act 346, Eff. Mar. 21, 2017;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: Section 2 of Act 93 of 1986 provides: “This amendatory act shall not apply to causes of action arising before the effective date of this amendatory act.”

Popular name: Act 218

Popular name: Essential Insurance

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500.3114 Persons entitled to personal protection insurance benefits or personal injury benefits; order of priority for claim of motor vehicle occupant or motorcycle operator or passenger; assigned claims plan; 2 or more insurers in same order of priority; partial recoupment; definitions.

Sec. 3114. (1) Except as provided in subsections (2), (3), and (5), a personal protection insurance policy described in section 3101(1) applies to accidental bodily injury to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household, if the injury arises from a motor vehicle accident. A personal injury insurance policy described in section 3103(2) applies to accidental bodily injury to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household, if the injury arises from a motorcycle accident. If personal protection insurance benefits or personal injury benefits described in section 3103(2) are payable to or for the benefit of an injured person under his or her own policy and would also be payable under the policy of his or her spouse, relative, or relative's spouse, the injured person's insurer shall pay all of the benefits up to the coverage level applicable under section 3107c to the injured person's policy, and is not entitled to recoupment from the other insurer.

(2) A person who suffers accidental bodily injury while an operator or a passenger of a motor vehicle operated in the business of transporting passengers shall receive the personal protection insurance benefits to which the person is entitled from the insurer of the motor vehicle. This subsection does not apply to a passenger in any of the following, unless the passenger is not entitled to personal protection insurance benefits under any other policy:

(a) A school bus, as defined by the department of education, providing transportation not prohibited by law.

(b) A bus operated by a common carrier of passengers certified by the department of transportation.

(c) A bus operating under a government sponsored transportation program.

(d) A bus operated by or providing service to a nonprofit organization.

(e) A taxicab insured as prescribed in section 3101 or 3102.

(f) A bus operated by a canoe or other watercraft, bicycle, or horse livery used only to transport passengers to or from a destination point.

(g) A transportation network company vehicle.

(h) A motor vehicle insured under a policy for which the person named in the policy has elected to not maintain coverage for personal protection insurance benefits under section 3107d or as to which an exclusion under section 3109a(2) applies.

(3) An employee, his or her spouse, or a relative of either domiciled in the same household, who suffers accidental bodily injury while an occupant of a motor vehicle owned or registered by the employer, shall receive personal protection insurance benefits to which the employee is entitled from the insurer of the furnished vehicle.

(4) Except as provided in subsections (2) and (3), a person who suffers accidental bodily injury arising from a motor vehicle accident while an occupant of a motor vehicle who is not covered under a personal protection insurance policy as provided in subsection (1) shall claim personal protection insurance benefits under the assigned claims plan under sections 3171 to 3175. This subsection does not apply to a person insured under a policy for which the person named in the policy has elected to not maintain coverage for personal protection insurance benefits under section 3107d or as to which an exclusion under section 3109(2) applies, or who is not entitled to be paid personal protection benefits under section 3107d(6)(c) or 3109a(2)(d)(*ii*).

(5) Subject to subsections (6) and (7), a person who suffers accidental bodily injury arising from a motor vehicle accident that shows evidence of the involvement of a motor vehicle while an operator or passenger of a motorcycle shall claim personal protection insurance benefits from insurers in the following order of priority:

(a) The insurer of the owner or registrant of the motor vehicle involved in the accident.

(b) The insurer of the operator of the motor vehicle involved in the accident.

(c) The motor vehicle insurer of the operator of the motorcycle involved in the accident.

(d) The motor vehicle insurer of the owner or registrant of the motorcycle involved in the accident.

(6) If an applicable insurance policy in an order of priority under subsection (5) is a policy for which the person named in the policy has elected to not maintain coverage for personal protection insurance benefits under section 3107d, or as to which an exclusion under section 3109(2) applies, the injured person shall claim benefits only under other policies, subject to subsection (7), in the same order of priority for which no such election has been made. If there are no other policies for which no such election has been made, the injured

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person shall claim benefits under the next order of priority or, if there is not a next order of priority, under the assigned claims plan under sections 3171 to 3175.

(7) If personal protection insurance benefits are payable under subsection (5) under 2 or more insurance policies in the same order of priority, the benefits are only payable up to an aggregate coverage limit that equals the highest available coverage limit under any 1 of the policies.

(8) Subject to subsections (6) and (7), if 2 or more insurers are in the same order of priority to provide personal protection insurance benefits under subsection (5), an insurer that pays benefits due is entitled to partial recoupment from the other insurers in the same order of priority, and a reasonable amount of partial recoupment of the expense of processing the claim, in order to accomplish equitable distribution of the loss among all of the insurers.

(9) As used in this section:

(a) "Personal vehicle", "transportation network company digital network", and "transportation network company prearranged ride" mean those terms as defined in section 2 of the limousine, taxicab, and transportation network company act, 2016 PA 345, MCL 257.2102.

(b) "Transportation network company vehicle" means a personal vehicle while the driver is logged on to the transportation network company digital network or while the driver is engaged in a transportation network company prearranged ride.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1975, Act 137, Imd. Eff. July 3, 1975;—Am. 1976, Act 356, Imd. Eff. Dec. 21, 1976;—Am. 1977, Act 53, Imd. Eff. July 5, 1977;—Am. 1980, Act 445, Imd. Eff. Jan. 15, 1981;—Am. 1984, Act 372, Imd. Eff. Dec. 27, 1984;—Am. 2002, Act 38, Imd. Eff. Mar. 7, 2002;—Am. 2016, Act 347, Eff. Mar. 21, 2017;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: In subsections (4) and (6), the reference to "section 3109(2)" evidently should read "section 3109a(2)."

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3115 Personal protection insurance benefits under the assigned claims plan for claims of persons not occupants of vehicle.

Sec. 3115. Except as provided in section 3114(1), a person who suffers accidental bodily injury while not an occupant of a motor vehicle shall claim personal protection insurance benefits under the assigned claims plan under sections 3171 to 3175.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Constitutionality: The legislative scheme which allows motorcyclists to receive no-fault benefits for personal injuries without requiring them to maintain no-fault security does not deny automobile drivers equal protection or due process of law. Underhill v Safeco Insurance Company, 407 Mich 175; 284 NW2d 463 (1979).

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3116 Value of claim in tort; subtraction from or reimbursement for benefits.

Sec. 3116. (1) A subtraction from personal protection insurance benefits must not be made because of the value of a claim in tort based on the same accidental bodily injury.

(2) A subtraction from or reimbursement for personal protection insurance benefits paid or payable under this chapter may be made only if recovery is realized on a tort claim arising from an accident that occurred outside this state, a tort claim brought in this state against the owner or operator of a motor vehicle with respect to which the security required by section 3101 was not in effect, or a tort claim brought in this state based on intentionally caused harm to persons or property, and may be made only to the extent that the recovery realized by the claimant is for damages for which the claimant has received or would otherwise be entitled to receive personal protection insurance benefits. A subtraction may be made only to the extent of the recovery, exclusive of reasonable attorney fees and other reasonable expenses incurred in effecting the recovery. If personal protection insurance benefits have already been received, the claimant shall repay to the insurers out of the recovery an amount equal to the benefits received, but not more than the recovery exclusive of reasonable attorney fees and other reasonable expenses incurred in effecting the recovery. The insurer has a lien on the recovery to this extent. A recovery by an injured person or his or her estate for loss suffered by the person may not be subtracted in calculating benefits due a dependent after the death and a recovery by a dependent for loss suffered by the dependent after the death may not be subtracted in

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calculating benefits due the injured person.

(3) A personal protection insurer with a right of reimbursement under subsection (1), if suffering loss from inability to collect reimbursement out of a payment received by a claimant on a tort claim, is entitled to indemnity from a person who, with notice of the insurer's interest, made the payment to the claimant without making the claimant and the insurer joint payees as their interests may appear or without obtaining the insurer's consent to a different method of payment.

(4) A subtraction or reimbursement is not due the claimant's insurer from that portion of any recovery to the extent that recovery is realized for noneconomic loss as provided in section 3135(1) and (2)(b) or for allowable expenses, work loss, and survivor's loss as defined in sections 3107 to 3110 in excess of the amount recovered by the claimant from his or her insurer.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1978, Act 461, Imd. Eff. Oct. 16, 1978;—Am. 2019, Act 22, Imd. Eff. June 11, 2019.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3121 Liability for accidental damage to tangible property.

Sec. 3121. (1) Under property protection insurance an insurer is liable to pay benefits for accidental damage to tangible property arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle subject to the provisions of this section and sections 3123, 3125, and 3127. However, accidental damage to tangible property does not include accidental damage to tangible property, other than the insured motor vehicle, that occurs within the course of a business of repairing, servicing, or otherwise maintaining motor vehicles.

(2) Property protection insurance benefits are due under the conditions stated in this chapter without regard to fault.

(3) Damage to tangible property consists of physical injury to or destruction of the property and loss of use of the property so injured or destroyed.

(4) Damage to tangible property is accidental, as to a person claiming property protection insurance benefits, unless it is suffered or caused intentionally by the claimant. Even though a person knows that damage to tangible property is substantially certain to be caused by his or her act or omission, he or she does not cause or suffer such damage intentionally if he or she acts or refrains from acting for the purpose of averting injury to any person, including himself or herself, or for the purpose of averting damage to tangible property.

(5) Property protection insurance benefits consist of the lesser of reasonable repair costs or replacement costs less depreciation and, if applicable, the value of loss of use. However, property protection insurance benefits paid under 1 policy for damage to all tangible property arising from 1 accident shall not exceed $1,000,000.00.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1993, Act 290, Imd. Eff. Dec. 28, 1993.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3123 Exclusions from property protection insurance benefits.

Sec. 3123. (1) Damage to the following kinds of property is excluded from property protection insurance benefits:

(a) Vehicles and their contents, including trailers, operated or designed for operation upon a public highway by power other than muscular power, unless the vehicle is parked in a manner as not to cause unreasonable risk of the damage which occurred.

(b) Property owned by a person named in a property protection insurance policy, the person's spouse or a relative of either domiciled in the same household, if the person named, the person's spouse, or the relative was the owner, registrant, or operator of a vehicle involved in the motor vehicle accident out of which the property damage arose.

(2) Property protection insurance benefits are not payable for property damage arising from motor vehicle accidents occurring outside the state.

(3) Property protection insurance benefits are not payable for property damage to utility transmission lines, wires, or cables arising from the failure of a municipality, utility company, or cable television company to

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comply with the requirements of section 16 of Act No. 368 of the Public Acts of 1925, being section 247.186 of the Michigan Compiled Laws.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1978, Act 65, Imd. Eff. Mar. 14, 1978.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3125 Priorities in claiming property protection benefits.

Sec. 3125. A person suffering accidental property damage shall claim property protection insurance benefits from insurers in the following order of priority: insurers of owners or registrants of vehicles involved in the accident; and insurers of operators of vehicles involved in the accident.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3127 Distribution of loss, reimbursement, and indemnification among property protection insurers.

Sec. 3127. The provisions for distribution of loss and for reimbursement and indemnification among personal protection insurers as set forth in subsection (2) of section 3115 and in section 3116 also applies to property protection insurers.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3131 Residual liability insurance; coverage.

Sec. 3131. (1) Residual liability insurance shall cover bodily injury and property damage which occurs within the United States, its territories and possessions, or in Canada. This insurance shall afford coverage equivalent to that required as evidence of automobile liability insurance under the financial responsibility laws of the place in which the injury or damage occurs. In this state this insurance shall afford coverage for automobile liability retained by section 3135.

(2) This section shall not require coverage in this state other than that required by section 3009(1). This section shall apply to all insurance contracts in force as of October 1, 1973, or entered into after that date.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1978, Act 460, Imd. Eff. Oct. 16, 1978.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3135 Tort liability for noneconomic loss; exceptions; cause of action for damages; "serious impairment of body function" defined.

Sec. 3135. (1) A person remains subject to tort liability for noneconomic loss caused by his or her ownership, maintenance, or use of a motor vehicle only if the injured person has suffered death, serious impairment of body function, or permanent serious disfigurement.

(2) For a cause of action for damages under subsection (1) or (3)(d), all of the following apply:

(a) The issues of whether the injured person has suffered serious impairment of body function or permanent serious disfigurement are questions of law for the court if the court finds either of the following:

(*i*) There is no factual dispute concerning the nature and extent of the person's injuries.

(*ii*) There is a factual dispute concerning the nature and extent of the person's injuries, but the dispute is not material to the determination whether the person has suffered a serious impairment of body function or permanent serious disfigurement. However, for a closed-head injury, a question of fact for the jury is created if a licensed allopathic or osteopathic physician who regularly diagnoses or treats closed-head injuries testifies under oath that there may be a serious neurological injury.

(b) Damages must be assessed on the basis of comparative fault, except that damages must not be assessed in favor of a party who is more than 50% at fault.

(c) Damages must not be assessed in favor of a party who was operating his or her own vehicle at the time the injury occurred and did not have in effect for that motor vehicle the security required by section 3101(1) at

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the time the injury occurred.

(3) Notwithstanding any other provision of law, tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by section 3101(1) was in effect is abolished except as to:

(a) Intentionally caused harm to persons or property. Even though a person knows that harm to persons or property is substantially certain to be caused by his or her act or omission, the person does not cause or suffer that harm intentionally if he or she acts or refrains from acting for the purpose of averting injury to any person, including himself or herself, or for the purpose of averting damage to tangible property.

(b) Damages for noneconomic loss as provided and limited in subsections (1) and (2).

(c) Damages for allowable expenses, work loss, and survivor's loss as defined in sections 3107 to 3110, including all future allowable expenses and work loss, in excess of any applicable limit under section 3107c or the daily, monthly, and 3-year limitations contained in those sections, or without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d or if an exclusion under section 3109a(2) applies. The party liable for damages is entitled to an exemption reducing his or her liability by the amount of taxes that would have been payable on account of income the injured person would have received if he or she had not been injured.

(d) Damages for economic loss by a nonresident. However, to recover under this subdivision, the nonresident must have suffered death, serious impairment of body function, or permanent serious disfigurement.

(e) Damages up to $1,000.00 to a motor vehicle or, for motor vehicle accidents that occur after July 1, 2020, up to $3,000.00 to a motor vehicle, to the extent that the damages are not covered by insurance. An action for damages under this subdivision must be conducted as provided in subsection (4).

(4) All of the following apply to an action for damages under subsection (3)(e):

(a) Damages must be assessed on the basis of comparative fault, except that damages must not be assessed in favor of a party who is more than 50% at fault.

(b) Liability is not a component of residual liability, as prescribed in section 3131, for which maintenance of security is required by this act.

(c) The action must be commenced, whenever legally possible, in the small claims division of the district court or the municipal court. If the defendant or plaintiff removes the action to a higher court and does not prevail, the judge may assess costs.

(d) A decision of the court is not res judicata in any proceeding to determine any other liability arising from the same circumstances that gave rise to the action.

(e) Damages must not be assessed if the damaged motor vehicle was being operated at the time of the damage without the security required by section 3101(1).

(5) As used in this section, "serious impairment of body function" means an impairment that satisfies all of the following requirements:

(a) It is objectively manifested, meaning it is observable or perceivable from actual symptoms or conditions by someone other than the injured person.

(b) It is an impairment of an important body function, which is a body function of great value, significance, or consequence to the injured person.

(c) It affects the injured person's general ability to lead his or her normal life, meaning it has had an influence on some of the person's capacity to live in his or her normal manner of living. Although temporal considerations may be relevant, there is no temporal requirement for how long an impairment must last. This examination is inherently fact and circumstance specific to each injured person, must be conducted on a case-by-case basis, and requires comparison of the injured person's life before and after the incident.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1979, Act 145, Imd. Eff. Nov. 13, 1979;—Am. 1979, Act 147, Imd. Eff. Nov. 13, 1979;—Am. 1995, Act 222, Eff. Mar. 28, 1996;—Am. 2002, Act 697, Eff. Mar. 31, 2003;—Am. 2012, Act 158, Eff. Oct. 1, 2012;—Am. 2019, Act 21, Imd. Eff. June 11, 2019;—Am. 2019, Act 22, Imd. Eff. June 11, 2019.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Enacting section 2 of Act 21 of 2019 provides:

"Enacting section 2. Section 3135 of the insurance code of 1956, 1956 PA 218, MCL 500.3135, as amended by this amendatory act, is intended to codify and give full effect to the opinion of the Michigan supreme court in *McCormick v Carrier*, 487 Mich 180 (2010)."

Enacting section 1 of Act 22 of 2019 provides:

"Enacting section 1. Section 3135 of the insurance code of 1956, 1956 PA 218, MCL 500.3135, as amended by this amendatory act, is intended to codify and give full effect to the opinion of the Michigan supreme court in *McCormick v Carrier*, 487 Mich 180 (2010)."

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

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500.3136 Tort liability for damage to tangible property from 1 accident in excess of limit under MCL 500.3121.

Sec. 3136. (1) In addition to the exceptions expressed in section 3135, the abolition of tort liability under that section does not apply to damage to tangible property arising from 1 accident in excess of the limit in section 3121 for which liability insurance required by federal statute or regulation is in effect.

(2) The exception provided by subsection (1) is limited to the amount of the applicable limit under the insurance policy in effect less the limit under section 3121 or $4,000,000.00 in excess of the limit under section 3121, whichever is less.

History: Add. 2018, Act 677, Eff. Mar. 29, 2019.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3141 Notice of accident.

Sec. 3141. An insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the policy affords the security required by this chapter.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3142 Personal protection insurance benefits payable as loss accrues; overdue benefits; interest.

Sec. 3142. (1) Personal protection insurance benefits are payable as loss accrues.

(2) Subject to subsection (3), personal protection insurance benefits are overdue if not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained. Subject to subsection (3), if reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. Subject to subsection (3), any part of the remainder of the claim that is later supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. For the purpose of calculating the extent to which benefits are overdue, payment must be treated as made on the date a draft or other valid instrument was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

(3) For personal protection insurance benefits under section 3107(1)(a), if a bill for the product, service, accommodations, or training is not provided to the insurer within 90 days after the product, service, accommodations, or training is provided, the insurer has 60 days in addition to 30 days provided under subsection (2) to pay before the benefits are overdue.

(4) An overdue payment bears simple interest at the rate of 12% per annum.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3143 Assignment of right to future benefits void.

Sec. 3143. An agreement for assignment of a right to benefits payable in the future is void.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3145 Limitation of actions for recovery of personal or property protection insurance benefits; period of limitations; tolling; notice of injury.

Sec. 3145. (1) An action for recovery of personal protection insurance benefits payable under this chapter for an accidental bodily injury may not be commenced later than 1 year after the date of the accident that caused the injury unless written notice of injury as provided in subsection (4) has been given to the insurer

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within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury.

(2) Subject to subsection (3), if the notice has been given or a payment has been made, the action may be commenced at any time within 1 year after the most recent allowable expense, work loss, or survivor's loss has been incurred. However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced.

(3) A period of limitations applicable under subsection (2) to the commencement of an action and the recovery of benefits is tolled from the date of a specific claim for payment of the benefits until the date the insurer formally denies the claim. This subsection does not apply if the person claiming the benefits fails to pursue the claim with reasonable diligence.

(4) The notice of injury required by subsection (1) may be given to the insurer or any of its authorized agents by a person claiming to be entitled to benefits for the injury, or by someone in the person's behalf. The notice must give the name and address of the claimant and indicate in ordinary language the name of the person injured and the time, place, and nature of the person's injury.

(5) An action for recovery of property protection insurance benefits may not be commenced later than 1 year after the accident.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3146 Limitation of action by insurer for recovery or indemnity.

Sec. 3146. An action by an insurer to enforce its rights of recovery or indemnity under section 3116 may not be commenced later than 1 year after payment has been received by a claimant upon a tort claim with respect to which the insurer has a right of reimbursement or recovery under section 3116.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3148 Attorney's fee; restrictions.

Sec. 3148. (1) Subject to subsections (4) and (5), an attorney is entitled to a reasonable fee for advising and representing a claimant in an action for personal or property protection insurance benefits that are overdue. The attorney's fee is a charge against the insurer in addition to the benefits recovered, if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed in making proper payment. An attorney advising or representing an injured person concerning a claim for payment of personal protection insurance benefits from an insurer shall not claim, file, or serve a lien for payment of a fee or fees until both of the following apply:

(a) A payment for the claim is authorized under this chapter.

(b) A payment for the claim is overdue under this chapter.

(2) A court may award an insurer a reasonable amount against a claimant as an attorney fee for the insurer's attorney in defending against a claim that was in some respect fraudulent or so excessive as to have no reasonable foundation. A court may award an insurer a reasonable amount against a claimant's attorney as an attorney fee for defending against a claim for which the client was solicited by the attorney in violation of the laws of this state or the Michigan rules of professional conduct.

(3) To the extent that personal or property protection insurance benefits are then due or thereafter come due to the claimant because of loss resulting from the injury on which the claim is based, an attorney fee awarded in favor of the insurer may be taken as an offset against the benefits. Judgment may also be entered against the claimant for any amount of an attorney fee awarded that is not offset against benefits or otherwise paid.

(4) For a dispute over payment for allowable expenses under section 3107(1)(a) for attendant care or nursing services, attorney fees must not be awarded in relation to future payments ordered more than 3 years after the trial court judgment or order is entered. If attendant care or nursing services are subsequently suspended or terminated, attorney fees on future payments may be again awarded for not more than 3 years after a new trial court judgment or order is entered.

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(5) A court shall not award a fee to an attorney for advising or representing an injured person in an action for personal or property protection insurance benefits for a treatment, product, service, rehabilitative occupational training, or accommodation provided to the injured person if the attorney or a related person of the attorney has, or had at the time the treatment, product, service, rehabilitative occupational training, or accommodation was provided, a direct or indirect financial interest in the person that provided the treatment, product, service, rehabilitative occupational training, or accommodation. For purposes of this subsection, circumstances in which an attorney has a direct or indirect financial interest include, but are not limited to, the person that provided the treatment, product, service, rehabilitative occupational training, or accommodation making a direct or indirect payment or granting a financial incentive to the attorney or a related person of the attorney relating to the treatment, product, service, rehabilitative occupational training, or accommodation within 24 months before or after the treatment, product, service, rehabilitative occupational training, or accommodation is provided.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3151 Submission to mental or physical examination; physician requirements.

Sec. 3151. (1) If the mental or physical condition of a person is material to a claim that has been or may be made for past or future personal protection insurance benefits, at the request of an insurer the person shall submit to mental or physical examination by physicians. A personal protection insurer may include reasonable provisions that are in accord with this section in a personal protection insurance policy for mental and physical examination of persons claiming personal protection insurance benefits.

(2) A physician who conducts a mental or physical examination under this section must be licensed as a physician in this state or another state and meet the following criteria, as applicable:

(a) If care is being provided to the person to be examined by a specialist, the examining physician must specialize in the same specialty as the physician providing the care, and if the physician providing the care is board certified in the specialty, the examining physician must be board certified in that specialty.

(b) During the year immediately preceding the examination, the examining physician must have devoted a majority of his or her professional time to either or both of the following:

(*i*) The active clinical practice of medicine and, if subdivision (a) applies, the active clinical practice relevant to the specialty.

(*ii*) The instruction of students in an accredited medical school or in an accredited residency or clinical research program for physicians and, if subdivision (a) applies, the instruction of students is in the specialty.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 2019, Act 21, Imd. Eff. June 11, 2019;—Am. 2019, Act 22, Imd. Eff. June 11, 2019.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3152 Report of mental or physical examination.

Sec. 3152. If requested by a person examined, a party causing an examination to be made shall deliver to him a copy of every written report concerning the examination rendered by an examining physician, at least 1 of which reports shall set out his findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled upon request to receive from the person examined every written report available to him or his representative concerning any examination relevant to the claim, previously or thereafter made, of the same mental or physical condition, and the names and addresses of physicians and medical care facilities rendering diagnoses or treatment in regard to the injury or to a relevant past injury, and shall authorize the insurer to inspect and copy records of physicians, hospitals, clinics or other medical facilities relevant to the claim. By requesting and obtaining a report of the examination so ordered or by taking the deposition of the examiner, the person examined waives any privilege he may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined or may thereafter examine him in respect of the same mental or physical condition.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

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500.3153 Court orders as to noncompliance with MCL 500.3151 and 500.3152.

Sec. 3153. A court may make such orders in regard to the refusal to comply with sections 3151 and 3152 as are just, except that an order shall not be entered directing the arrest of a person for disobeying an order to submit to a physical or mental examination. The orders that may be made in regard to such a refusal include, but are not limited to:

(a) An order that the mental or physical condition of the disobedient person shall be taken to be established for the purposes of the claim in accordance with the contention of the party obtaining the order.

(b) An order refusing to allow the disobedient person to support or oppose designated claims or defenses, or prohibiting him from introducing evidence of mental or physical condition.

(c) An order rendering judgment by default against the disobedient person as to his entire claim or a designated part of it.

(d) An order requiring the disobedient person to reimburse the insurer for reasonable attorneys' fees and expenses incurred in defense against the claim.

(e) An order requiring delivery of a report, in conformity with section 3152, on such terms as are just, and if a physician fails or refuses to make the report a court may exclude his testimony if offered at trial.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3157 Charges for treatment or training for injured persons; limitation on eligibility for payment or reimbursement; applicability; "freestanding rehabilitation facility" defined; qualification for payment requirements; attendant care; neurological rehabilitation clinic; applicability to ambulance operation; definitions.

Sec. 3157. (1) Subject to subsections (2) to (14), a physician, hospital, clinic, or other person that lawfully renders treatment to an injured person for an accidental bodily injury covered by personal protection insurance, or a person that provides rehabilitative occupational training following the injury, may charge a reasonable amount for the treatment or training. The charge must not exceed the amount the person customarily charges for like treatment or training in cases that do not involve insurance.

(2) Subject to subsections (3) to (14), a physician, hospital, clinic, or other person that renders treatment or rehabilitative occupational training to an injured person for an accidental bodily injury covered by personal protection insurance is not eligible for payment or reimbursement under this chapter for more than the following:

(a) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 200% of the amount payable to the person for the treatment or training under Medicare.

(b) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 195% of the amount payable to the person for the treatment or training under Medicare.

(c) For treatment or training rendered after July 1, 2023, 190% of the amount payable to the person for the treatment or training under Medicare.

(3) Subject to subsections (5) to (14), a physician, hospital, clinic, or other person identified in subsection (4) that renders treatment or rehabilitative occupational training to an injured person for an accidental bodily injury covered by personal protection insurance is eligible for payment or reimbursement under this chapter of not more than the following:

(a) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 230% of the amount payable to the person for the treatment or training under Medicare.

(b) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 225% of the amount payable to the person for the treatment or training under Medicare.

(c) For treatment or training rendered after July 1, 2023, 220% of the amount payable to the person for the treatment or training under Medicare.

(4) Subject to subsection (5), subsection (3) only applies to a physician, hospital, clinic, or other person if either of the following applies to the person rendering the treatment or training:

(a) On July 1 of the year in which the person renders the treatment or training, the person has 20% or more, but less than 30%, indigent volume determined pursuant to the methodology used by the department of health and human services in determining inpatient medical/surgical factors used in measuring eligibility for Medicaid disproportionate share payments.

(b) The person is a freestanding rehabilitation facility. Each year the director shall designate not more than 2 freestanding rehabilitation facilities to qualify for payments under subsection (3) for that year. As used in

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this subdivision, "freestanding rehabilitation facility" means an acute care hospital to which all of the following apply:

(*i*) The hospital has staff with specialized and demonstrated rehabilitation medicine expertise.

(*ii*) The hospital possesses sophisticated technology and specialized facilities.

(*iii*) The hospital participates in rehabilitation research and clinical education.

(*iv*) The hospital assists patients to achieve excellent rehabilitation outcomes.

(*v*) The hospital coordinates necessary post-discharge services.

(*vi*) The hospital is accredited by 1 or more third-party, independent organizations focused on quality.

(*vii*) The hospital serves the rehabilitation needs of catastrophically injured patients in this state.

(*viii*) The hospital was in existence on May 1, 2019.

(5) To qualify for a payment under subsection (4)(a), a physician, hospital, clinic, or other person shall provide the director with all documents and information requested by the director that the director determines are necessary to allow the director to determine whether the person qualifies. The director shall annually review documents and information provided under this subsection and, if the person qualifies under subsection (4)(a), shall certify the person as qualifying and provide a list of qualifying persons to insurers and other persons that provide the security required under section 3101(1). A physician, hospital, clinic, or other person that provides 30% or more of its total treatment or training as described under subsection (4)(a) is entitled to receive, instead of an applicable percentage under subsection (3), 250% of the amount payable to the person for the treatment or training under Medicare.

(6) Subject to subsections (7) to (14), a hospital that is a level I or level II trauma center that renders treatment to an injured person for an accidental bodily injury covered by personal protection insurance, if the treatment is for an emergency medical condition and rendered before the patient is stabilized and transferred, is not eligible for payment or reimbursement under this chapter of more than the following:

(a) For treatment rendered after July 1, 2021 and before July 2, 2022, 240% of the amount payable to the hospital for the treatment under Medicare.

(b) For treatment rendered after July 1, 2022 and before July 2, 2023, 235% of the amount payable to the hospital for the treatment under Medicare.

(c) For treatment rendered after July 1, 2023, 230% of the amount payable to the hospital for the treatment under Medicare.

(7) If Medicare does not provide an amount payable for a treatment or rehabilitative occupational training under subsection (2), (3), (5), or (6), the physician, hospital, clinic, or other person that renders the treatment or training is not eligible for payment or reimbursement under this chapter of more than the following, as applicable:

(a) For a person to which subsection (2) applies, the applicable following percentage of the amount payable for the treatment or training under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, the applicable following percentage of the average amount the person charged for the treatment on January 1, 2019:

(*i*) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 55%.

(*ii*) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 54%.

(*iii*) For treatment or training rendered after July 1, 2023, 52.5%.

(b) For a person to which subsection (3) applies, the applicable following percentage of the amount payable for the treatment or training under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, the applicable following percentage of the average amount the person charged for the treatment or training on January 1, 2019:

(*i*) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 70%.

(*ii*) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 68%.

(*iii*) For treatment or training rendered after July 1, 2023, 66.5%.

(c) For a person to which subsection (5) applies, 78% of the amount payable for the treatment or training under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, 78% of the average amount the person charged for the treatment on January 1, 2019.

(d) For a person to which subsection (6) applies, the applicable following percentage of the amount payable for the treatment under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, the applicable following percentage of the average amount the person charged for the treatment on January 1, 2019:

(*i*) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 75%.

(*ii*) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 73%.

(*iii*) For treatment or training rendered after July 1, 2023, 71%.

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(8) For any change to an amount payable under Medicare as provided in subsection (2), (3), (5), or (6) that occurs after the effective date of the amendatory act that added this subsection, the change must be applied to the amount allowed for payment or reimbursement under that subsection. However, an amount allowed for payment or reimbursement under subsection (2), (3), (5), or (6) must not exceed the average amount charged by the physician, hospital, clinic, or other person for the treatment or training on January 1, 2019.

(9) An amount that is to be applied under subsection (7) or (8), that was in effect on January 1, 2019, including any prior adjustments to the amount made under this subsection, must be adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment.

(10) For attendant care rendered in the injured person's home, an insurer is only required to pay benefits for attendant care up to the hourly limitation in section 315 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.315. This subsection only applies if the attendant care is provided directly, or indirectly through another person, by any of the following:

(a) An individual who is related to the injured person.

(b) An individual who is domiciled in the household of the injured person.

(c) An individual with whom the injured person had a business or social relationship before the injury.

(11) An insurer may contract to pay benefits for attendant care for more than the hourly limitation under subsection (10).

(12) A neurological rehabilitation clinic is not entitled to payment or reimbursement for a treatment, training, product, service, or accommodation unless the neurological rehabilitation clinic is accredited by the Commission on Accreditation of Rehabilitation Facilities or a similar organization recognized by the director for purposes of accreditation under this subsection. This subsection does not apply to a neurological rehabilitation clinic that is in the process of becoming accredited as required under this subsection on July 1, 2021, unless 3 years have passed since the beginning of that process and the neurological rehabilitation clinic is still not accredited.

(13) Subsections (2) to (12) do not apply to emergency medical services rendered by an ambulance operation. As used in this subsection:

(a) "Ambulance operation" means that term as defined in section 20902 of the public health code, 1978 PA 368, MCL 333.20902.

(b) "Emergency medical services" means that term as defined in section 20904 of the public health code, 1978 PA 368, MCL 333.20904.

(14) Subsections (2) to (13) apply to treatment or rehabilitative occupational training rendered after July 1, 2021.

(15) As used in this section:

(a) "Charge description master" means a uniform schedule of charges represented by the person as its gross billed charge for a given service or item, regardless of payer type.

(b) "Consumer Price Index" means the most comprehensive index of consumer prices available for this state from the United States Department of Labor, Bureau of Labor Statistics.

(c) "Emergency medical condition" means that term as defined in section 1395dd of the social security act, 42 USC 1395dd.

(d) "Level I or level II trauma center" means a hospital that is verified as a level I or level II trauma center by the American College of Surgeons Committee on Trauma.

(e) "Medicaid" means a program for medical assistance established under subchapter XIX of the social security act, 42 USC 1396 to 1396w-5.

(f) "Medicare" means fee for service payments under part A, B, or D of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395*lll*, without regard to the limitations unrelated to the rates in the fee schedule such as limitation or supplemental payments related to utilization, readmissions, recaptures, bad debt adjustments, or sequestration.

(g) "Neurological rehabilitation clinic" means a person that provides post-acute brain and spinal rehabilitation care.

(h) "Person", as provided in section 114, includes, but is not limited to, an institution.

(i) "Stabilized" means that term as defined in section 1395dd of the social security act, 42 USC 1395dd.

(j) "Transfer" means that term as defined in section 1395dd of the social security act, 42 USC 1395dd.

(k) "Treatment" includes, but is not limited to, products, services, and accommodations.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

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Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3157a Provision of treatment, products, services, or accommodations under personal protection insurance; submission of records for utilization review; false or misleading information is a fraudulent insurance act; rules; appeal of determination.

Sec. 3157a. (1) By rendering any treatment, products, services, or accommodations to 1 or more injured persons for an accidental bodily injury covered by personal protection insurance under this chapter after July 1, 2020, a physician, hospital, clinic, or other person is considered to have agreed to do both of the following:

(a) Submit necessary records and other information concerning treatment, products, services, or accommodations provided for utilization review under this section.

(b) Comply with any decision of the department under this section.

(2) A physician, hospital, clinic, or other person or institution that knowingly submits under this section false or misleading records or other information to an insurer, the association created under section 3104, or the department commits a fraudulent insurance act under section 4503.

(3) The department shall promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to do both of the following:

(a) Establish criteria or standards for utilization review that identify utilization of treatment, products, services, or accommodations under this chapter above the usual range of utilization for the treatment, products, services, or accommodations based on medically accepted standards.

(b) Provide procedures related to utilization review, including procedures for all of the following:

(*i*) Acquiring necessary records, medical bills, and other information concerning the treatment, products, services, or accommodations provided.

(*ii*) Allowing an insurer to request an explanation for and requiring a physician, hospital, clinic, or other person to explain the necessity or indication for treatment, products, services, or accommodations provided.

(*iii*) Appealing determinations.

(4) If a physician, hospital, clinic, or other person provides treatment, products, services, or accommodations under this chapter that are not usually associated with, are longer in duration than, are more frequent than, or extend over a greater number of days than the treatment, products, services, or accommodations usually require for the diagnosis or condition for which the patient is being treated, the insurer or the association created under section 3104 may require the physician, hospital, clinic, or other person to explain the necessity or indication for the treatment, products, services, or accommodations in writing under the procedures provided under subsection (3).

(5) If an insurer or the association created under section 3104 determines that a physician, hospital, clinic, or other person overutilized or otherwise rendered or ordered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under this chapter, the physician, hospital, clinic, or other person may appeal the determination to the department under the procedures provided under subsection (3).

(6) As used in this section, "utilization review" means the initial evaluation by an insurer or the association created under section 3104 of the appropriateness in terms of both the level and the quality of treatment, products, services, or accommodations provided under this chapter based on medically accepted standards.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3157b Proprietary information; exemption from disclosure under the freedom of information act.

Sec. 3157b. Any proprietary information or sensitive personally identifiable information regarding a patient that is submitted to the department under section 3157a is exempt from disclosure under section 13(d) of the freedom of information act, 1976 PA 442, MCL 15.243, and the department shall exempt any such information from disclosure under any other applicable exemptions under section 13 of the freedom of information act, 1976 PA 442, MCL 15.243.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

Popular name: Essential Insurance

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Popular name: No-Fault Insurance

500.3158 Statement of earnings; report and records from medical institution.

Sec. 3158. (1) An employer, when a request is made by a personal protection insurer against whom a claim has been made, shall furnish forthwith, in a form approved by the commissioner of insurance, a sworn statement of the earnings since the time of the accidental bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.

(2) A physician, hospital, clinic or other medical institution providing, before or after an accidental bodily injury upon which a claim for personal protection insurance benefits is based, any product, service or accommodation in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, if requested to do so by the insurer against whom the claim has been made, (a) shall furnish forthwith a written report of the history, condition, treatment and dates and costs of treatment of the injured person and (b) shall produce forthwith and permit inspection and copying of its records regarding the history, condition, treatment and dates and costs of treatment.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3159 Discovery.

Sec. 3159. In a dispute regarding an insurer's right to discovery of facts about an injured person's earnings or about his history, condition, treatment and dates and costs of treatment, a court may enter an order for the discovery. The order may be made only on motion for good cause shown and upon notice to all persons having an interest, and shall specify the time, place, manner, conditions and scope of the discovery. A court, in order to protect against annoyance, embarrassment or oppression, as justice requires, may enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3163 Automobile insurer; not required to provide personal and property protection insurance benefits to out-of-state residents; exception.

Sec. 3163. An insurer authorized to transact automobile liability insurance and personal and property protection insurance in this state is not required to provide personal protection insurance or property protection insurance benefits under this chapter for accidental bodily injury or property damage occurring in this state arising from the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle by an out-of-state resident who is insured under the insurer's automobile liability insurance policies, unless the out-of-state resident is the owner of a motor vehicle that is registered and insured in this state.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 2002, Act 697, Eff. Mar. 31, 2003;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3171 Assigned claims plan; organization and maintenance; participation; costs; rules; adoption and maintenance by Michigan automobile insurance placement facility; approval of plan; amendments; provisions; report; definitions.

Sec. 3171. (1) Until an assigned claims plan is approved under subsection (3), the secretary of state shall organize and maintain an assigned claims facility and plan. A self-insurer and insurer writing insurance as provided by this chapter in this state shall participate in the assigned claims plan. Costs incurred in the operation of the facility and the plan shall be allocated fairly among insurers and self-insurers. The secretary of state shall promulgate rules to implement the facility and plan in accordance with and subject to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. After an assigned claims plan is approved under subsection (3), the secretary of state shall continue to maintain the assigned claims facility and plan organized under this subsection as required by the plan approved under subsection (3).

(2) The Michigan automobile insurance placement facility shall adopt and maintain an assigned claims

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plan. A self-insurer or insurer writing insurance as provided by this chapter in this state shall participate in the assigned claims plan. Costs incurred in the administration of the assigned claims plan shall be allocated fairly among insurers and self-insurers. On approval under subsection (3), the Michigan automobile insurance placement facility shall implement the assigned claims plan.

(3) By August 1, 2012, the Michigan automobile insurance placement facility board of governors shall adopt an assigned claims plan by majority vote and shall submit it to the commissioner for his or her approval. The commissioner shall review the plan within 30 days and respond in writing as provided in this subsection. If the commissioner finds that the plan meets the requirements of this chapter, he or she shall approve it. If the commissioner finds that the plan fails to meet the requirements of this chapter, he or she shall state in what respects the plan is deficient and shall afford the Michigan automobile insurance placement facility board of governors 10 days within which to correct the deficiency. If the commissioner and the Michigan automobile insurance placement facility board of governors fail to agree that the plan submitted, with any corrections, meets the requirements of this chapter, either party to the controversy may submit the issue to the circuit court for Ingham county for a determination. If the commissioner fails to render a written decision on the assigned claims plan within 30 days after receipt of the plan, the plan shall be considered approved. The Michigan automobile insurance placement facility shall forward a plan approved under this subsection to the secretary of state. The plan takes effect on approval by the commissioner.

(4) Amendments to the assigned claims plan approved under subsection (3) shall be adopted by the board of governors and approved by the commissioner as provided in subsection (3). Until the date established in the plan under subsection (5)(c), the board of governors shall give the secretary of state advance notice of any proposed amendments to the plan.

(5) The plan adopted under subsection (3) shall include all of the following:

(a) The date on and after which all claims for benefits through the assigned claims plan under section 3172 shall be filed with the Michigan automobile insurance placement facility.

(b) The date by which existing claims that have been assigned under the plan maintained by the secretary of state under subsection (1) will be transferred to the Michigan automobile insurance placement facility to be included in and administered under the adopted plan.

(c) A date by which all functions of the assigned claims plan maintained by the secretary of state, with the exception of driver license and vehicle sanctions, will be transferred to the Michigan automobile insurance placement facility.

(d) Requirements for the transfer of records relating to assigned claims from the secretary of state to the Michigan automobile insurance placement facility and the disposition by the secretary of state of records relating to assigned claims.

(e) Reimbursement of the secretary of state by the Michigan automobile insurance placement facility for all of the following:

(*i*) Expenses of developing the plan under subsection (6).

(*ii*)Expenses of transferring operations from the assigned claims facility to the Michigan automobile insurance placement facility.

(*iii*) Expenses incurred by the secretary of state after the transfer of operations from the assigned claims facility to the Michigan automobile insurance placement facility for operations performed by the secretary of state on behalf of the Michigan automobile insurance placement facility.

(6) The secretary of state and the Michigan automobile insurance placement facility shall cooperate and mutually develop the aspects of the plan to be adopted under subsection (3) that are required under subsection (5).

(7) The secretary of state shall provide the Michigan automobile insurance placement facility with all information necessary for the operation of the assigned claims fund.

(8) One year after the date established under subsection (5)(c), the commissioner shall report in writing to the senate and house of representatives standing committees on insurance issues on the cost of the transfer of the assigned claims plan to the Michigan automobile insurance placement facility and the effectiveness of operations under the new plan.

(9) As used in this section:

(a) "Michigan automobile insurance placement facility" means the Michigan automobile insurance placement facility created under chapter 33.

(b) "Michigan automobile insurance placement facility board of governors" means the board of governors created under section 3310.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1972, Act 345, Imd. Eff. Jan. 9, 1973;—Am. 2012, Act 204, Imd. Eff. June 27, 2012.

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Popular name: Act 218

Popular name: Essential Insurance

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Administrative rules: R 11.101 et seq. of the Michigan Administrative Code.

500.3172 Conditions to obtaining personal protection insurance benefits through assigned claims plan; collection of unpaid benefits; application and reasonable proof of loss; payment of interest; reimbursement from defaulting insurers; reduction of benefits; definitions; effect of dispute between insurers; limitation on benefits.

Sec. 3172. (1) A person entitled to claim because of accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle in this state may claim personal protection insurance benefits through the assigned claims plan if any of the following apply:

(a) No personal protection insurance is applicable to the injury.

(b) No personal protection insurance applicable to the injury can be identified.

(c) No personal protection insurance applicable to the injury can be ascertained because of a dispute between 2 or more automobile insurers concerning their obligation to provide coverage or the equitable distribution of the loss.

(d) The only identifiable personal protection insurance applicable to the injury is, because of financial inability of 1 or more insurers to fulfill their obligations, inadequate to provide benefits up to the maximum prescribed.

(2) Unpaid benefits due or coming due as described in subsection (1) may be collected under the assigned claims plan, and the insurer to which the claim is assigned is entitled to reimbursement from the defaulting insurers to the extent of their financial responsibility.

(3) A person entitled to claim personal protection insurance benefits through the assigned claims plan under subsection (1) shall file a completed application on a claim form provided by the Michigan automobile insurance placement facility and provide reasonable proof of loss to the Michigan automobile insurance placement facility. The Michigan automobile insurance placement facility or an insurer assigned to administer a claim on behalf of the Michigan automobile insurance placement facility under the assigned claims plan shall specify in writing the materials that constitute a reasonable proof of loss within 60 days after receipt by the Michigan automobile insurance placement facility of an application that complies with this subsection.

(4) The Michigan automobile insurance placement facility or an insurer assigned to administer a claim on behalf of the Michigan automobile insurance placement facility under the assigned claims plan is not required to pay interest in connection with a claim for any period of time during which the claim is reasonably in dispute.

(5) Except as otherwise provided in this subsection, personal protection insurance benefits, including benefits arising from accidents occurring before March 29, 1985, payable through the assigned claims plan must be reduced to the extent that benefits covering the same loss are available from other sources, regardless of the nature or number of benefit sources available and regardless of the nature or form of the benefits, to a person claiming personal protection insurance benefits through the assigned claims plan. This subsection only applies if the personal protection insurance benefits are payable through the assigned claims plan under subsection (1)(a), (b), or (d). As used in this subsection, "sources" and "benefit sources" do not include the program for medical assistance for the medically indigent under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b, or health insurance for the aged and disabled under subchapter XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(6) If the obligation to provide personal protection insurance benefits cannot be ascertained because of a dispute between 2 or more automobile insurers concerning their obligation to provide coverage or the equitable distribution of the loss, and if a method of voluntary payment of benefits cannot be agreed upon among or between the disputing insurers, all of the following apply:

(a) The insurers who are parties to the dispute shall, or the claimant may, immediately notify the Michigan automobile insurance placement facility of their inability to determine their statutory obligations.

(b) The Michigan automobile insurance placement facility shall assign the claim to an insurer and the insurer shall immediately provide personal protection insurance benefits to the claimant or claimants entitled to benefits.

(c) The insurer assigned the claim by the Michigan automobile insurance placement facility shall immediately commence an action on behalf of the Michigan automobile insurance placement facility in circuit court to declare the rights and duties of any interested party.

(d) The insurer to whom the claim is assigned shall join as parties defendant to the action commenced under subdivision (c) each insurer disputing either the obligation to provide personal protection insurance

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benefits or the equitable distribution of the loss among the insurers.

(e) The circuit court shall declare the rights and duties of any interested party whether or not other relief is sought or could be granted.

(f) After hearing the action, the circuit court shall determine the insurer or insurers, if any, obligated to provide the applicable personal protection insurance benefits and the equitable distribution, if any, among the insurers obligated, and shall order reimbursement to the Michigan automobile insurance placement facility from the insurer or insurers to the extent of the responsibility as determined by the court. The reimbursement ordered under this subdivision must include all benefits and costs paid or incurred by the Michigan automobile insurance placement facility and all benefits and costs paid or incurred by insurers determined not to be obligated to provide applicable personal protection insurance benefits, including incurred attorney fees and interest at the rate prescribed in section 3175 applicable on December 31 of the year preceding the determination of the circuit court.

(7) The Michigan automobile insurance placement facility and the insurer to whom a claim is assigned by the Michigan automobile insurance placement facility are only required to provide personal protection insurance benefits under section 3107(1)(a) up to whichever of the following is applicable:

(a) Unless subdivision (b) applies, the limit provided in section 3107c(1)(b).

(b) If the person is entitled to claim benefits under the assigned claims plan under section 3107d(6)(c) or 3109a(2)(d)(*ii*), $2,000,000.00.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1972, Act 345, Imd. Eff. Jan. 9, 1973;—Am. 1984, Act 426, Eff. Mar. 29, 1985;—Am. 2012, Act 204, Eff. Sept. 1, 2012;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Enacting section 1 of Act 204 of 2012 provides:

"Enacting section 1. Sections 3172, 3173a, 3174, and 3175 of the insurance code of 1956, 1956 PA 218, MCL 500.3172, 500.3173a, 500.3174, and 500.3175, as amended by this amendatory act, take effect on the date the assigned claims plan is approved by the insurance commissioner under section 3171(3) of the insurance code of 1956, 1956 PA 218, MCL 500.3171."

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3173 Certain persons disqualified from receiving benefits under assigned claims plans.

Sec. 3173. A person who because of a limitation or exclusion in sections 3105 to 3116 is disqualified from receiving personal protection insurance benefits under a policy otherwise applying to his accidental bodily injury is also disqualified from receiving benefits under the assigned claims plan.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3173a Eligibility for benefits; initial determination; denial; notice; false statement.

Sec. 3173a. (1) The Michigan automobile insurance placement facility shall review a claim for personal protection insurance benefits under the assigned claims plan, shall make an initial determination of the eligibility for benefits under this chapter and the assigned claims plan, and shall deny a claim that the Michigan automobile insurance placement facility determines is ineligible under this chapter or the assigned claims plan. If a claimant or person making a claim through or on behalf of a claimant fails to cooperate with the Michigan automobile insurance placement facility as required by subsection (2), the Michigan automobile insurance placement facility shall suspend benefits to the claimant under the assigned claims plan. A suspension under this subsection is not an irrevocable denial of benefits, and must continue only until the Michigan automobile insurance placement facility determines that the claimant or person making a claim through or on behalf of a claimant cooperates or resumes cooperation with the Michigan automobile insurance placement facility. The Michigan automobile insurance placement facility shall promptly notify in writing the claimant and any person that submitted a claim through or on behalf of a claimant of a denial and the reasons for the denial.

(2) A claimant or a person making a claim through or on behalf of a claimant shall cooperate with the Michigan automobile insurance placement facility in its determination of eligibility and the settlement or defense of any claim or suit, including, but not limited to, submitting to an examination under oath and compliance with sections 3151 to 3153. There is a rebuttable presumption that a person has satisfied the duty to cooperate under this section if all of the following apply:

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(a) The person submitted a claim for personal protection insurance benefits under the assigned claims plan by submitting to the Michigan automobile insurance placement facility a complete application on a form provided by the Michigan automobile insurance placement facility in accordance with the assigned claims plan.

(b) The person provided reasonable proof of loss under the assigned claims plan as described in section 3172.

(c) If required under this subsection to submit to an examination under oath, the person submitted to the examination, subject to all of the following:

(*i*) The person was provided at least 21 days' notice of the examination.

(*ii*) The examination was conducted in a location reasonably convenient for the person.

(*iii*) Any reasonable request by the person to reschedule the date, time, or location of the examination was accommodated.

(3) The Michigan automobile insurance placement facility may perform its functions and responsibilities under this section and the assigned claims plan directly or through an insurer assigned by the Michigan automobile insurance placement facility to administer the claim on behalf of the Michigan automobile insurance placement facility. The assignment of a claim by the Michigan automobile insurance placement facility to an insurer is not a determination of eligibility under this chapter or the assigned claims plan, and a claim assigned to an insurer by the Michigan automobile insurance placement facility may later be denied if the claim is not eligible under this chapter or the assigned claims plan.

(4) A person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the Michigan automobile insurance placement facility, or to an insurer to which the claim is assigned under the assigned claims plan, for payment or another benefit knowing that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under section 4503 that is subject to the penalties imposed under section 4511. A claim that contains or is supported by a fraudulent insurance act as described in this subsection is ineligible for payment of personal protection insurance benefits under the assigned claims plan.

(5) The Michigan automobile insurance placement facility may contract with other persons for all or a portion of the goods and services necessary for operating and maintaining the assigned claims plan.

History: Add. 1984, Act 426, Eff. Mar. 29, 1985;—Am. 2012, Act 204, Eff. Sept. 1, 2012;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: Enacting section 1 of Act 204 of 2012 provides:

"Enacting section 1. Sections 3172, 3173a, 3174, and 3175 of the insurance code of 1956, 1956 PA 218, MCL 500.3172, 500.3173a, 500.3174, and 500.3175, as amended by this amendatory act, take effect on the date the assigned claims plan is approved by the insurance commissioner under section 3171(3) of the insurance code of 1956, 1956 PA 218, MCL 500.3171."

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3174 Notice of claim through assigned claims plan; assignment of claim; notice to claimant; commencement of action by claimant.

Sec. 3174. A person claiming through the assigned claims plan shall notify the Michigan automobile insurance placement facility of his or her claim within 1 year after the date of the accident. On an initial determination of a claimant's eligibility for benefits through the assigned claims plan, the Michigan automobile insurance placement facility shall promptly assign the claim in accordance with the plan and notify the claimant of the identity and address of the insurer to which the claim is assigned. An action by a claimant must be commenced as provided in section 3145.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1972, Act 345, Imd. Eff. Jan. 9, 1973;—Am. 2012, Act 204, Eff. Sept. 1, 2012;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: Enacting section 1 of Act 204 of 2012 provides:

"Enacting section 1. Sections 3172, 3173a, 3174, and 3175 of the insurance code of 1956, 1956 PA 218, MCL 500.3172, 500.3173a, 500.3174, and 500.3175, as amended by this amendatory act, take effect on the date the assigned claims plan is approved by the insurance commissioner under section 3171(3) of the insurance code of 1956, 1956 PA 218, MCL 500.3171."

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3175 Rules for assignment of claims; duties of insurer to whom claims assigned; compromises and settlements; procedures; limitation on action to enforce rights; interest

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on delinquent payments; installment payments; default.

Sec. 3175. (1) The assignment of claims under the assigned claims plan must be made according to procedures established in the assigned claims plan that assure fair allocation of the burden of assigned claims among insurers doing business in this state on a basis reasonably related to the volume of automobile liability and personal protection insurance they write on motor vehicles or the number of self-insured motor vehicles. An insurer to whom claims have been assigned shall make prompt payment of loss in accordance with this act. An insurer is entitled to reimbursement by the Michigan automobile insurance placement facility for the payments, the established loss adjustment cost, and an amount determined by use of the average annual 90-day United States treasury bill yield rate, as reported by the Council of Economic Advisers as of December 31 of the year for which reimbursement is sought, as follows:

(a) For the calendar year in which claims are paid by the insurer, the amount must be determined by applying the specified annual yield rate specified in this subsection to 1/2 of the total claims payments and loss adjustment costs.

(b) For the period from the end of the calendar year in which claims are paid by the insurer to the date payments for the operation of the assigned claims plan are due, the amount must be determined by applying the annual yield rate specified in this subsection to the total claims payments and loss adjustment costs multiplied by a fraction, the denominator of which is 365 and the numerator of which is equal to the number of days that have elapsed between the end of the calendar year and the date payments for the operation of the assigned claims plan are due.

(2) An insurer assigned a claim by the Michigan automobile insurance placement facility under the assigned claims plan or a person authorized to act on behalf of the plan may bring an action for reimbursement and indemnification of the claim on behalf of the Michigan automobile insurance placement facility. The insurer to which the claim has been assigned shall preserve and enforce rights to indemnity or reimbursement against third parties and account to the Michigan automobile insurance placement facility for the rights and shall assign the rights to the Michigan automobile insurance placement facility on reimbursement by the Michigan automobile insurance placement facility. This section does not preclude an insurer from entering into reasonable compromises and settlements with third parties against whom rights to indemnity or reimbursement exist. The insurer shall account to the Michigan automobile insurance placement facility for any compromises and settlements. The procedures established under the assigned claims plan of operation must establish reasonable standards for enforcing rights to indemnity or reimbursement against third parties, including a standard establishing an amount below which actions to preserve and enforce the rights need not be pursued.

(3) An action to enforce rights to indemnity or reimbursement against a third party must not be commenced after the later of the following:

(a) Two years after the assignment of the claim to the insurer.

(b) One year after the date of the last payment to the claimant.

(c) One year after the date the responsible third party is identified.

(4) Payments for the operation of the assigned claims plan not paid by the due date bear interest at the rate of 20% per annum.

(5) The Michigan automobile insurance placement facility may enter into a written agreement with the debtor permitting the payment of the judgment or acknowledgment of debt in installments payable to the Michigan automobile insurance placement facility. A default in payment of installments under a judgment as agreed subjects the debtor to suspension or revocation of his or her motor vehicle license or registration in the same manner as for the failure by an uninsured motorist to pay a judgment by installments under section 3177, including responsibility for expenses as provided in section 3177(4).

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1972, Act 345, Imd. Eff. Jan. 9, 1973;—Am. 1984, Act 426, Eff. Mar. 29, 1985;—Am. 2012, Act 204, Eff. Sept. 1, 2012;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: Enacting section 1 of Act 204 of 2012 provides:

"Enacting section 1. Sections 3172, 3173a, 3174, and 3175 of the insurance code of 1956, 1956 PA 218, MCL 500.3172, 500.3173a, 500.3174, and 500.3175, as amended by this amendatory act, take effect on the date the assigned claims plan is approved by the insurance commissioner under section 3171(3) of the insurance code of 1956, 1956 PA 218, MCL 500.3171."

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3176 Taking costs into account in making and regulating rates.

Sec. 3176. Reasonable costs incurred in the handling and disposition of assigned claims, including amounts paid pursuant to assessments under section 3171, shall be taken into account in making and

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regulating rates for automobile liability and personal protection insurance.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1972, Act 345, Imd. Eff. Jan. 9, 1973.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3177 Recovery by insurer of benefits and costs from owner or registrant of uninsured motor vehicle; written agreement to pay judgment in installments; notice.

Sec. 3177. (1) The insurer obligated to pay personal protection insurance benefits for accidental bodily injury to a person arising out of the ownership, maintenance, or use of an uninsured motor vehicle as a motor vehicle may recover all benefits paid, incurred loss adjustment costs and expenses, and incurred attorney fees from the owner or registrant of the uninsured motor vehicle or from his or her estate. Failure of the owner or registrant to make payment within 30 days after a judgment is entered in an action for recovery under this subsection is a ground for suspension or revocation of his or her motor vehicle registration and license as defined in section 25 of the Michigan vehicle code, 1949 PA 300, MCL 257.25. For purposes of this section, an uninsured motor vehicle is a motor vehicle with respect to which security as required by sections 3101(1) and 3102 is not in effect at the time of the accident.

(2) The Michigan automobile insurance placement facility may make a written agreement with the owner or registrant of an uninsured vehicle or his or her estate permitting the payment of a judgment described in subsection (1) in installments payable to the Michigan automobile insurance placement facility. The motor vehicle registration and license of an owner or registrant who makes a written agreement under this subsection must not be suspended or revoked and, if already suspended or revoked under subsection (1), must be restored if the payment of any installments is not in default.

(3) The secretary of state, on receipt of a certified abstract of court record of a judgment described in subsection (1) or notice from an insurer or the Michigan automobile insurance placement facility or its designee of an acknowledgment of a debt described in subsection (1), shall notify the owner or registrant of the provisions of subsection (1) at the owner or registrant's last address recorded with the secretary of state and inform the owner or registrant of the right to enter into a written agreement under this section with the Michigan automobile insurance placement facility or its designee for the payment of the judgment or debt in installments.

(4) Expenses for the suspension, revocation, or reinstatement of a motor vehicle registration or license under this section are the responsibility of the owner or registrant or of his or her estate. An owner or registrant whose registration or license is suspended under this section shall pay any reinstatement fee as required under section 320e of the Michigan vehicle code, 1949 PA 300, MCL 257.320e.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973;—Am. 1984, Act 426, Eff. Mar. 29, 1985;—Am. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

500.3178 Annual report.

Sec. 3178. After an assigned claims plan is approved under section 3171(3), the Michigan automobile insurance placement facility board of governors shall report annually to the commissioner and the commissioner shall report to the standing committees of the senate and house of representatives with primary jurisdiction over insurance matters on the effectiveness of the assigned claims plan, including detailed demographic information on the individuals who are submitting claims and whose claims are being assigned.

History: Add. 2012, Act 204, Imd. Eff. June 27, 2012.

Popular name: Act 218

500.3179 Act applicable October 1, 1973.

Sec. 3179. This act applies to motor vehicle accidents occurring on or after October 1, 1973.

History: Add. 1972, Act 294, Eff. Mar. 30, 1973.

Popular name: Act 218

Popular name: Essential Insurance

Popular name: No-Fault Insurance

CHAPTER 31A

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500.3181 "Managed care option" defined.

Sec. 3181. As used in this chapter, "managed care option" means an optional coverage selected by an insured at the time a policy is issued that includes, but is not limited to, the monitoring and adjudication of an injured person's care, the use of a preferred provider program or other network, or other similar option.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.3182 Applicability of chapter.

Sec. 3182. This chapter applies to all automobile insurance whether written on an individual or group basis.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.3183 Automobile insurer; offering of managed care option; requirements.

Sec. 3183. An automobile insurer may offer a managed care option that provides for allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation. This managed care option is subject to all of the following:

(a) It must be uniformly offered in all areas where the managed care option is available.

(b) It must provide a discount that reflects reasonably anticipated reductions in losses or expenses or both.

(c) It must not apply to emergency care. Emergency care includes, but is not limited to, all care necessary to the point where no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Compiler's note: Act 218

500.3184 Offer of personal protection insurance benefits required for certain managed care options.

Sec. 3184. An automobile insurer that offers a managed care option under this chapter shall also offer personal protection insurance benefits under section 3107(1)(a) that are not subject to the managed care option.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.3185 Application of managed care option.

Sec. 3185. The managed care option must apply to the insured who selects the managed care option and any person who resides in an area where the managed care option is available and who is claiming personal protection insurance benefits under the policy with the managed care option.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.3186 Managed care option; deductibles and co-pays.

Sec. 3186. A managed care option may provide for deductibles, co-pays, or both deductibles and co-pays.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.3187 Managed care option; requirements.

Sec. 3187. A managed care option must provide for all of the following:

(a) That personal protection insurance benefits are primary and will not be coordinated with other health and accident coverage on the individual claiming personal protection insurance benefits under the policy with the managed care option.

(b) That personal protection insurance benefits must be exhausted by the individual claiming those benefits under the policy with the managed care option before the individual may seek benefits from another health or accident coverage provider.

(c) That deductibles, co-pays, or other similar sanctions will not be assessed or collected from other health and accident coverage providers for the individual claiming personal protection insurance benefits under the

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policy with the managed care option.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.3188 Selection of managed care option; written disclosure statement; requirements.

Sec. 3188. At the time of the initial selection of the managed care option by the insured, an automobile insurer shall obtain a signed acknowledgment that the insured received a written disclosure statement approved by the director or a written disclosure statement that includes all of the following:

(a) A summary of the provisions of the managed care option.

(b) The estimated range of the percentage of the discount provided by the managed care option.

(c) A general description of the differences between a managed care option under this chapter and personal protection insurance benefits under section 3107(1)(a) that are not subject to the managed care option, including any procedural differences in seeking treatment and filing a claim.

(d) The consequences for violating any provisions of the managed care option, including the possibility of a claim denial, the payment of a deductible and the amount of that deductible, and any additional out-of-pocket expenses that may be incurred.

(e) An explanation of whether the insurer offers an opt-out provision that would enable the insured to change his or her policy from a managed care option to personal protection insurance benefits under section 3107(1)(a) that are not subject to the managed care option and any restrictions placed upon the insured in regard to opting out of the managed care option.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.3189 Managed care disclosure statement; additional requirements.

Sec. 3189. The disclosure statement under section 3188 must include a postal mailing address and either a toll-free telephone number or an internet website address that insureds or applicants for insurance may write, call, or otherwise access for information on the managed care option.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

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CHAPTER 32
CANCELLATION OF AUTOMOBILE LIABILITY POLICIES

500.3201 Repealed. 1978, Act 218, Eff. Dec. 5, 1978.

Compiler's note: The repealed section pertained to termination of automobile insurance policies.

Popular name: Act 218

500.3204 Refusal to renew policy as cancellation; requisites.

Sec. 3204. (1) No insurer shall cancel a policy of automobile liability insurance issued after November 1, 1966, in pursuance of their certificate of authority by the department unless the cancellation is effected pursuant to the applicable provisions of this chapter.

(2) Refusal to renew any policy of automobile liability insurance shall not constitute a cancellation unless the insurer fails to mail, 20 days prior to the termination date of the policy, by first class mail, a notice to the insured that the policy will not be renewed.

History: Add. 1966, Act 342, Eff. Nov. 1, 1966.

Popular name: Act 218

500.3206 Policy of automobile insurance; definition.

Sec. 3206. As used in this chapter, "policy of automobile insurance" means a policy insuring private passenger automobiles, including those used in a car pool, or that portion of a combination policy which insures private passenger automobiles.

History: Add. 1966, Act 342, Eff. Nov. 1, 1966.

Popular name: Act 218

500.3208 Inapplicability of chapter; termination of coverage at end of policy period.

Sec. 3208. This chapter shall not be applicable with respect to termination of coverage at the end of any policy period or at any annual anniversary date of any policy which specifies no term, nor shall it be applicable with respect to any cancellation for failure of the named insured to discharge when due any of his

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obligations in connection with the payment of premiums for the policy, or any installment thereof, whether payable directly to the insurer or his agent indirectly under any premium finance plan.

History: Add. 1966, Act 342, Eff. Nov. 1, 1966.

Popular name: Act 218

500.3212 Inapplicability of chapter; nonpayment of premiums.

Sec. 3212. The provisions of this chapter are not applicable to cancellations occasioned by nonpayment of premiums and no hearings on appeals or other statutory provisions within this chapter are to be binding on any policy of insurance coverage that lapses due to nonpayment of premium.

History: Add. 1966, Act 342, Eff. Nov. 1, 1966.

Popular name: Act 218

500.3220 Cancellation; reasons.

Sec. 3220. Subject to the following provisions no insurer licensed to write automobile liability coverage, after a policy has been in effect 55 days or if the policy is a renewal, effective immediately, shall cancel a policy of automobile liability insurance except for any 1 or more of the following reasons:

(a) That during the 55 days following the date of original issue thereof the risk is unacceptable to the insurer.

(b) That the named insured or any other operator, either resident of the same household or who customarily operates an automobile insured under the policy has had his operator's license suspended during the policy period and the revocation or suspension has become final.

History: Add. 1966, Act 342, Eff. Nov. 1, 1966;—Am. 1970, Act 161, Imd. Eff. Aug. 2, 1970.

Popular name: Act 218

500.3224 Denial of coverage; notice of cancellation.

Sec. 3224. (1) The cancellation of a policy of insurance within the 55-day period enumerated in subdivision (a) of section 3220 shall not be subject to appeal by the insured. Failure to disclose the cancellation by any insured upon any application for insurance shall not be grounds to deny coverage on the basis of fraud by an insurer who may have accepted the risk thereafter.

(2) For the provisions of this chapter only, no cancellation shall be effective unless a written notice of cancellation is mailed by certified mail, return receipt requested, to the insured at the last address known to the insurer either through its records, the personal records of the agent who wrote the policy, or as supplied by the insured.

(3) The notice shall be mailed at least 20 days prior to the effective date of cancellation. For the purpose of this chapter only, delivery of such written notice by the insurer shall be the equivalent of mailing. The notice shall contain the reasons for the cancellation and shall state in bold type that the insured has the statutory right within 7 days from the date of mailing to appeal to the department. The commissioner shall approve the form of the cancellation notice.

History: Add. 1966, Act 342, Eff. Nov. 1, 1966.

Popular name: Act 218

500.3230 Validity of cancellation; request for hearing.

Sec. 3230. Any insured who wishes to contest the grounds of cancellation, within 7 days after the date of postmark indicating mailing of the notice of cancellation, which date shall be impressed upon the notice, shall file a written request for hearing directed to the commissioner.

History: Add. 1966, Act 342, Eff. Nov. 1, 1966;—Am. 2001, Act 141, Imd. Eff. Oct. 26, 2001.

Popular name: Act 218

500.3234 Validity of cancellation; appeal, hearing by insurance commissioner, notice.

Sec. 3234. Within 10 days after receiving the notice of appeal from the insured, the commissioner or his officially appointed designees shall hold a hearing to determine the validity of the cancellation. The notice of the hearing shall be mailed to the insured and the insurer at least 4 days prior to the date of the hearing. Each insurer licensed to do business in this state shall file with the commissioner, immediately upon the effective date of this chapter, a statement containing the name and address of the person authorized to receive such notice on behalf of the insurer.

History: Add. 1966, Act 342, Eff. Nov. 1, 1966.

Popular name: Act 218

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500.3240 Validity of cancellation; conduct of hearing, determination.

Sec. 3240. At the hearing both parties shall have an opportunity to be heard and to be represented by counsel of their own choosing if they desire. The commissioner or his duly designated representative shall make his determination in writing stating his disposition of the matter.

History: Add. 1966, Act 342, Eff. Nov. 1, 1966.

Popular name: Act 218

500.3244 Validity of cancellation; order for reinstatement or upholding cancellation; stay of cancellation; appeal.

Sec. 3244. The commissioner or his designated representative shall either order the policy reinstated or he may uphold the cancellation. The commissioner may stay the cancellation of the policy pending his determination in writing stating his disposition of the matter. Any person who considers himself aggrieved by any final determination of the commissioner or his designated representative may appeal such decision to the circuit court under the terms and provisions of Act No. 197 of the Public Acts of 1952, as amended, being sections 24.101 to 24.110 of the Compiled Laws of 1948.

History: Add. 1966, Act 342, Eff. Nov. 1, 1966.

Popular name: Act 218

500.3250 Statements in cancellation notice; liability.

Sec. 3250. There shall be no liability on the part of, and no cause of action of any nature shall arise against, any insurer or authorized representative, or its agents or employees, or the commissioner or his authorized representative for any statements made by them in any written notice of cancellation or at the time of the hearings conducted in connection therewith or in the findings required by the provisions of this chapter.

History: Add. 1966, Act 342, Eff. Nov. 1, 1966.

Popular name: Act 218

500.3254 Filing fee; return to insured; disposition of funds.

Sec. 3254. If the insured prevails in his appeal, the filing fee paid by the insured shall be returned to him by the insurer. All moneys collected under the provisions of this act shall be deposited to the credit of the general fund of the state.

History: Add. 1966, Act 342, Eff. Nov. 1, 1966.

Popular name: Act 218

500.3260 Insurance commissioner; regulatory powers.

Sec. 3260. The commissioner may make rules and regulations necessary for administration of this chapter. The rules shall be promulgated in accordance with the provisions of Act No. 88 of the Public Acts of 1943, as amended, being sections 24.71 to 24.80 of the Compiled Laws of 1948, and subject to Act No. 197 of the Public Acts of 1952, as amended.

History: Add. 1966, Act 342, Eff. Nov. 1, 1966.

Popular name: Act 218

500.3262 Private automobiles of peace officers, fire fighters, or ambulance drivers; cancellation of insurance; “ambulance driver” defined.

Sec. 3262. An insurer shall not cancel or refuse to renew a policy of insurance of any peace officer, fire fighter, or ambulance driver on his or her private automobile due to accident rate statistics compiled by the peace officer, fire fighter, or ambulance driver while driving police vehicles, fire department vehicles, or ambulances in the pursuit of his or her duties as a peace officer, fire fighter, or ambulance driver. As used in this section "ambulance driver" means a person authorized to drive an ambulance pursuant to part 207 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.20701 to 333.20773 of the Michigan Compiled Laws.

History: Add. 1967, Act 202, Eff. Aug. 1, 1967;—Am. 1968, Act 95, Imd. Eff. June 4, 1968;—Am. 1986, Act 190, Eff. Aug. 1, 1986

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Popular name: Act 218

CHAPTER 33
AUTOMOBILE INSURANCE PLACEMENT FACILITY

500.3301 Michigan automobile insurance placement facility; purpose; participation.

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Sec. 3301. (1) Every insurer authorized to write automobile insurance in this state shall participate in an organization for the purpose of doing all of the following:

(a) Providing the guarantee that automobile insurance coverage will be available to any person who is unable to procure that insurance through ordinary methods.

(b) Preserving to the public the benefits of price competition by encouraging maximum use of the normal private insurance system.

(2) The organization created under this chapter shall be called the "Michigan automobile insurance placement facility".

History: Add. 1969, Act 346, Eff. Apr. 1, 1970;—Am. 1979, Act 145, Eff. Jan. 1, 1981.

Popular name: Act 218

Popular name: Essential Insurance

500.3303 Definitions.

Sec. 3303. As used in this chapter:

(a) "Automobile insurance" means insurance for automobiles which provides any of the following:

(*i*) Security required pursuant to section 3101.

(*ii*) Personal protection, property protection, and residual liability insurance for amounts in excess of the amounts required under chapter 31.

(*iii*) Insurance coverage customarily known as comprehensive and collision.

(*iv*) Other insurance coverages for a private passenger nonfleet automobile as prescribed by rule promulgated by the commissioner.

(b) "Qualified applicant", for automobile insurance, means a person who is an owner or registrant of an automobile registered or to be registered in this state or who holds a valid license to operate a motor vehicle, but does not include any of the following:

(*i*) A person who is not required to maintain security pursuant to section 3101, unless the person intends to reside in this state for 30 days or more and makes a written statement of that intention on a form approved by the commissioner.

(*ii*) A person whose license to operate a vehicle is under suspension or revocation, unless the suspension was made pursuant to section 310, 310b, 310d, 315, 321a, 324, 328, 512, 515, 625, 625b, 625f, 748, 801c, or 907 of Act No. 300 of the Public Acts of 1949, as amended, being sections 257.310, 257.310b, 257.310d, 257.315, 257.321a, 257.324, 257.328, 257.512, 257.515, 257.625, 257.625b, 257.625f, 257.748, 257.801c, and 257.907 of the Michigan Compiled Laws.

(*iii*) A person whose policy of automobile insurance has been cancelled because of nonpayment of premium or finance premium within the immediately preceding 2-year period, unless the applicant or insured pays in full a premium installment developed under section 3350(a) before issuance, continuation, or renewal of the policy.

(c) "Facility" means the automobile insurance placement facility created pursuant to this chapter.

(d) "Participating member" means an insurer who is required by this chapter to be a member of the facility and who in any given calendar year has a participation ratio greater than zero in the facility for that year.

(e) "Participation ratio" means the ratio of the participating member's Michigan premiums or exposure units to the comparable statewide totals for all participating members, as follows:

(*i*) For private passenger nonfleet automobile insurance, for distribution of risk or distribution of loss, the ratio shall be based on voluntary net direct automobile insurance car years written in this state for the calendar year ending December 31 of the second prior year as reported to the statistical agent of each participating member as private passenger nonfleet exposure.

(*ii*) For all other automobile insurance, including insurance for fleets, commercial vehicles, public vehicles, and garages, the ratio for distribution of risks or distribution of loss shall be based on the total Michigan automobile insurance gross direct premiums written, including policy and membership fees, less return premiums and premiums on policies not taken, without including reinsurance assumed and without deducting reinsurance ceded, reduced by the amount of premiums reported as private passenger nonfleet for the calendar year ending December 31 of the second prior year.

(*iii*) For expenses of operation of the facility and for voting rights, the ratio shall be based on the total Michigan automobile insurance gross direct premiums written, including policy and membership fees, less return premiums and premiums on policies not taken, without including reinsurance assumed and without deducting reinsurance ceded for the calendar year ending December 31 of the second prior year.

(f) "Private passenger nonfleet automobile" means a motorized vehicle designed for transporting passengers or goods, subject to specific contemporary definitions for insurance purposes as provided in the

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plan of operation.

History: Add. 1969, Act 346, Eff. Apr. 1, 1970;—Am. 1971, Act 210, Imd. Eff. Dec. 29, 1971;—Am. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981.

Popular name: Act 218

Popular name: Essential Insurance

500.3310 Board of governors of facility; election and appointment of governors; representation of insurance agents and general public; terms; vacancies; adoption of plan of operation by facility committee; approval of plan; amendments and adherence to plan.

Sec. 3310. (1) The board of governors of the facility shall consist of 11 governors. Seven of the governors shall be elected as provided in the plan of operation. Four governors shall be appointed by the commissioner, of which 2 shall represent insurance agents subject to section 1209(1) and 2 shall represent the general public. Each governor appointed by the commissioner pursuant to this subsection shall serve an annual term. The 7 elected members of the board of governors of the facility shall be elected to serve annual terms commencing within 45 days after the annual determination of participation ratios. Vacancies shall be filled as provided for in the plan of operation.

(2) The facility committee shall adopt a plan of operation by majority vote of the committee and shall submit it to the commissioner for his or her approval. If the commissioner finds that the plan meets the requirements of this chapter, he or she shall approve it. If the commissioner finds that the plan fails to meet the requirements of this chapter, he or she shall state in what respects the plan is deficient and shall afford the facility committee 10 days within which to correct the deficiency. If the commissioner and the facility committee fail to agree that the provisions of the plan so submitted meet the requirements of this chapter, either party to the controversy may submit the issue to the circuit court for Ingham county for a determination. If the commissioner fails to render a written decision on the plan of operation within 30 days after receipt of the plan, the plan shall be considered approved.

(3) Amendments to the plan of operation shall be subject to majority approval by the board of governors and ratified by majority of the membership vote. The membership vote shall be determined as defined in section 3303(e)(*iii*). Amendments to the plan of operation shall be subject to the approval of the commissioner, as provided in subsection (2).

(4) Every insurer authorized to write automobile insurance in this state shall adhere to the plan of operation.

History: Add. 1969, Act 346, Eff. Apr. 1, 1970;—Am. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 1984, Act 367, Imd. Eff. Dec. 27, 1984;—Am. 1986, Act 10, Imd. Eff. Feb. 28, 1986;—Am. 2001, Act 228, Eff. Mar. 1, 2002.

Popular name: Act 218

Popular name: Essential Insurance

500.3315 Repealed. 1991, Act 191, Eff. Apr. 1, 1992.

Compiler's note: The repealed section pertained to a program to reduce participation ratio, definition of urban area, and the effective repeal date.

Popular name: Act 218

Popular name: Essential Insurance

500.3320 Private passenger nonfleet automobiles; duties of facility; insurance requirements.

Sec. 3320. (1) The facility, with respect to private passenger nonfleet automobiles, shall provide for all of the following:

(a) The equitable distribution of applicants to designated participating members in accordance with the plan of operation.

(b) Issuance of policies of automobile insurance to qualified applicants as provided in the plan of operation.

(c) The appointment of a number of participating members appointed by the facility to act on behalf of the facility for the distribution of risks or for the servicing of insureds, as provided in the plan of operation and consistent with this section. The facility shall do all of the following:

(*i*) Appoint those members having the 5 highest participation ratios, as defined in section 3303(e)(*i*), to act on behalf of the facility.

(*ii*) Appoint other members to act on behalf of the facility who volunteer to so act and who meet reasonable servicing standards established in the plan of operation, up to a maximum of 5 in addition to those appointed pursuant to subparagraph (*i*).

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(*iii*) Appoint additional members to act on behalf of the facility as necessary to do all of the following:

(A) Assure convenient access to the facility for all citizens of this state.

(B) Assure a reasonable quality of service for persons insured through the facility.

(C) Assure a reasonable representation of the various insurance marketing systems.

(D) Assure reasonable claims handling.

(E) Assure a reasonable range of choice of insurers for persons insured through the facility.

(d) Standards and monitoring procedures to assure that participating members acting on behalf of the facility do all of the following:

(*i*) Provide service to persons insured through the facility equivalent to the service provided to persons insured by the insurer voluntarily.

(*ii*) Handle claims in an efficient and reasonable manner.

(*iii*) Provide internal review procedures for persons insured through the facility identical to those established pursuant to chapter 21 for persons insured voluntarily.

(e) The establishment of procedures and guidelines for the issuance of binders by agents upon receipt of the application for coverage.

(f) Issuance of policies of automobile insurance to qualified applicants whose licenses to operate a vehicle have been suspended under section 310, 310d, 315, 321a, 324, 328, 512, 515, 625, 625b, 625f, 748, 801c, or 907 of the Michigan vehicle code, 1949 PA 300, MCL 257.310, 257.310d, 257.315, 257.321a, 257.324, 257.328, 257.512, 257.515, 257.625, 257.625b, 257.625f, 257.748, 257.801c, and 257.907, as provided in the plan of operation. These policies may be canceled after a period of not less than 30 days if the insured fails to produce proof that the suspended license has been reinstated.

(g) Administration of the assigned claims plan as required under chapter 31.

(2) Automobile insurance made available under this section shall be equivalent to the automobile insurance normally available in the voluntary competitive market in forms as approved by the commissioner with any changes, additions, and amendments adopted by the board of governors and approved by the commissioner.

History: Add. 1969, Act 346, Eff. Apr. 1, 1970;—Am. 1971, Act 210, Imd. Eff. Dec. 29, 1971;—Am. 1976, Act 303, Imd. Eff. Oct. 27, 1976;—Am. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 2012, Act 204, Imd. Eff. June 27, 2012.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Popular name: Act 218

Popular name: Essential Insurance

500.3321 Automobiles not included in MCL 500.3320; insurance required; equitable distribution of applicants to participating members.

Sec. 3321. The facility shall provide, with respect to all automobiles not included in section 3320:

(a) Only the insurance required by law or required by the commissioner of insurance. The commissioner may only require insurance for which a rate has been filed by an insurance rating organization or insurer and which rate is in effect and which the commissioner finds, after a public hearing, to be reasonable, necessary, and in the public interest. The temporary provision of insurance may be required pending the public hearing if the commissioner determines it necessary to do so.

(b) The equitable distribution of applicants to participating members in accordance with the participation ratios defined in section 3303.

History: Add. 1969, Act 346, Eff. Apr. 1, 1970;—Am. 1977, Act 53, Imd. Eff. July 5, 1977.

Popular name: Act 218

Popular name: Essential Insurance

500.3330 Board of governors; powers generally; establishment of automatic data processing system.

Sec. 3330. (1) The board of governors has the power to direct the operation of the facility, including, at a minimum, the power to do all of the following:

(a) To sue and be sued in the name of the facility. A judgment against the facility shall not create any liabilities in the individual participating members of the facility.

(b) To delegate ministerial duties, to hire a manager, to hire legal counsel, and to contract for goods and services from others.

(c) To assess participating members on the basis of participation ratios pursuant to section 3303 to cover anticipated costs of operation and administration of the facility, to provide for equitable servicing fees, and to share losses, profits, and expenses pursuant to the plan of operation.

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(d) To impose limitations on cancellation or nonrenewal by participating members of facility-placed business, in addition to the limitations imposed by chapters 21 and 32.

(e) To provide for a limited number of participating members to receive equitable distribution of applicants; or to provide for a limited number of participating members to service applicants in a plan of sharing of losses in accordance with section 3320(1)(c) and the plan of operation.

(f) To provide for standards of performance of service for the participating members designated under subdivision (e).

(g) To adopt a plan of operation and any amendments to the plan, consistent with this chapter, necessary to assure the fair, reasonable, equitable, and nondiscriminatory manner of administering the facility, including compliance with chapter 21, and to provide for any other matters necessary or advisable to implement this chapter, including matters necessary to comply with the requirements of chapter 21.

(h) To assess self-insurers and insurers consistent with chapter 31 and the assigned claims plan approved under section 3171.

(2) The board of governors shall institute or cause to be instituted by the facility or on its behalf an automatic data processing system for recording and compiling data relative to individuals insured through the facility. An automatic data processing system established under this subsection shall, to the greatest extent possible, be made compatible with the automatic data processing system maintained by the secretary of state, to provide for the identification and review of individuals insured through the facility.

History: Add. 1969, Act 346, Eff. Apr. 1, 1970;—Am. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 2012, Act 204, Imd. Eff. June 27, 2012.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Popular name: Act 218

Popular name: Essential Insurance

500.3340 Filing of classifications, rules, rates, and amendments thereto; approval; use of rates and rules; certain laws inapplicable; requirements for private passenger nonfleet automobile rates.

Sec. 3340. (1) As agent for participating members, the facility shall file with the commissioner every manual of classification, every manual of rules and rates, every rating plan and every modification of a manual of classification, manual of rules and rates, or rating plan proposed for use for private passenger nonfleet automobile insurance placed through the facility. The facility may incorporate by reference in its filings other material on file with the commissioner. The classifications, rules and rates and any amendments thereof shall be subject to prior written approval by the commissioner. Except as provided in this chapter, rates filed by the facility for private passenger nonfleet automobile insurance shall be in accordance with chapter 21 and rates by the facility for all other automobile insurance shall be filed in accordance with chapter 24.

(2) Every participating member designated to act on behalf of the facility shall be authorized to use the rates and rules approved by the commissioner for use by the facility on business placed through the facility and shall not use other rates for automobile insurance placed through the facility.

(3) Laws relating to rating organizations or advisory organizations shall not apply to functions provided for under this section.

(4) Private passenger nonfleet automobile rates for the facility shall comply with the following requirements:

(a) The territories for the facility shall be defined as those of the principal rating organization for the voluntary market.

(b) The base rates for the facility shall be derived from the weighted average of the base rates currently charged in each facility territory by the 5 largest insurer groups, determined by voluntary net direct automobile insurance car years written in the state for the calendar year ending December 31 of the second prior year as reported to the statistical agent.

(c) The base rates as determined in subdivision (b) in each facility territory shall be modified as follows:

(*i*) One hundred percent of the weighted average in each territory in the highest rated territory or territories in the state within a single political subdivision.

(*ii*) From 105% to 125% of the weighted average for all other facility territories, with the highest rated such territories receiving the lowest surcharge and increasing to the highest surcharge in the lowest rated facility territories in 5 percentage point increments. In no event, however, shall any such rate exceed the rate established in subdivision (i).

(d) The facility shall adjust its rates at least once each year or whenever changes in private competitive

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insurance market rate levels would produce a change in excess of 5% in the facility rate for any facility territory. However, changes shall not be made more often than quarterly.

(e) In the event that underwriting losses and administrative expenses resulting from the operation of the facility at rates established pursuant to this subsection would exceed an amount equal to 5% of the net direct private passenger nonfleet automobile premiums for this state, the levels specified in subdivision (c)(i) and (ii) shall be proportionately increased in an amount to produce underwriting losses and administrative expenses that do not exceed 5%.

History: Add. 1969, Act 346, Eff. Apr. 1, 1970;—Am. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1986, Act 10, Imd. Eff. Feb. 28, 1986.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Popular name: Act 218

Popular name: Essential Insurance

500.3341 Coverage for certain convictions; premium surcharges.

Sec. 3341. As part of its secondary or merit rating plan, the facility shall provide for premium surcharges for any or all coverages, other than comprehensive coverage, for convictions for 1 or more of the following, when that information becomes available to the facility:

(a) A violation of section 904 of the Michigan vehicle code, 1949 PA 300, MCL 257.904.

(b) A violation of section 904a of the Michigan vehicle code, 1949 PA 300, MCL 257.904a.

(c) A violation of section 91 of the Michigan penal code, 1931 PA 328, MCL 750.91, resulting from or in connection with the operation of a motor vehicle.

(d) A violation of section 316 of the Michigan penal code, 1931 PA 328, MCL 750.316, resulting from or in connection with the operation of a motor vehicle.

(e) A violation of section 317 of the Michigan penal code, 1931 PA 328, MCL 750.317, resulting from or in connection with the operation of a motor vehicle.

(f) A violation of section 321 of the Michigan penal code, 1931 PA 328, MCL 750.321, resulting from or in connection with the operation of a motor vehicle.

(g) A violation of section 324 of the Michigan penal code, 1931 PA 328, MCL 750.324, or section 601d of the Michigan vehicle code, 1949 PA 300, MCL 257.601d.

(h) A violation of section 382 of the Michigan penal code, 1931 PA 328, MCL 750.382, resulting from or in connection with the operation of a motor vehicle.

(i) A violation of section 413 of the Michigan penal code, 1931 PA 328, MCL 750.413.

(j) A violation of section 626c of the Michigan vehicle code, 1949 PA 300, MCL 257.626c.

(k) A violation substantially similar to any of the violations listed in subdivisions (a) through (j) under the laws of another state or a local unit of government of this state or another state.

History: Add. 2002, Act 251, Imd. Eff. May 1, 2002;—Am. 2002, Act 656, Imd. Eff. Dec. 23, 2002;—Am. 2008, Act 468, Eff. Oct. 31, 2010.

Popular name: Act 218

Popular name: Essential Insurance

500.3350 Additional duties of facility.

Sec. 3350. The facility shall provide for all of the following:

(a) One or more optional deferred premium payment plans, which shall require an advance payment at least equal to 25% of the total premium or $100.00, whichever is greater.

(b) That policies issued on facility placed business may be indorsed to exclude coverage for any named person who is operating a motor vehicle after his or her driver's license has been refused, revoked, or suspended by governmental authority other than pursuant to section 310, 310b, 310d, 315, 321a, 324, 328, 512, 515, 625, 625b, 625f, 748, 801c, or 907 of Act No. 300 of the Public Acts of 1949, as amended.

(c) For publicizing and developing public understanding of the facility.

(d) For the rendering of an annual financial statement to all participating members and the commissioner.

(e) For the reinsurance of facility placed risks including, if desired, a pool for reinsuring automobile insurance coverages with limits in excess of those required by statute, or such other underwriting arrangements as may be necessary to enable participating members to offer said limits of liability insurance.

History: Add. 1969, Act 346, Eff. Apr. 1, 1970;—Am. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 1980, Act 461, Imd. Eff. Jan. 15, 1981;—Am. 1982, Act 502, Eff. Mar. 30, 1983.

Popular name: Act 218

Popular name: Essential Insurance

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500.3355 Agent; duties; disqualification by facility; notice; request for hearing; ruling by board of governors; appeal; prohibited conduct by disqualified agent; standards and procedures.

Sec. 3355. (1) Every agent who is authorized to solicit, negotiate, or effect automobile insurance on behalf of any participating member shall:

(a) Offer to place automobile insurance through the facility for any qualified applicant requesting the agent to do so.

(b) If the qualified applicant accepts the offer in subdivision (a), forward the application and any deposit premium required in accordance with the plan of operation, rules, and procedures of the facility.

(c) Be entitled to receive, and any participating member be entitled to pay, a commission for placing insurance through the facility at the uniform rates of commission as provided in the plan of operation.

(2) The facility may disqualify an agent from placing automobile insurance through the facility if the agent persistently violates the facility's rules contained in the facility's plan of operation. The facility shall notify the agent of his or her disqualification in the manner prescribed in the plan of operation. If an agent is disqualified under this section, the facility shall notify the commissioner of the disqualification.

(3) An agent may submit a written request for a hearing before the facility's board of governors or its designee not later than 10 business days after the notice of disqualification is issued. If a written request for a hearing is received, the agent's disqualification shall be suspended pending a ruling by the board of governors. The board of governors or its designee shall hold a hearing not later than 10 business days after receipt of the written request for a hearing. The board of governors or its designee shall issue a ruling not later than 5 business days after the hearing and shall notify the commissioner of the ruling. A ruling of disqualification by the board of governors or its designee shall take effect 5 calendar days after the date of the ruling.

(4) A ruling of disqualification by the facility's board of governors or its designee may be appealed to the commissioner by filing a written notice of appeal with the facility and the commissioner within 30 calendar days after the date of the ruling. A disqualification ruling shall remain effective during the appeal process to the commissioner. Upon receipt of an appeal, the commissioner or his or her designee shall provide a hearing under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, and shall approve, disapprove, or direct the board of governors or its designee to reconsider its ruling.

(5) On and after the effective date of a disqualification, the disqualified agent shall not do any of the following during the period of disqualification:

(a) Solicit, negotiate, or effect automobile insurance on behalf of any participating member through the facility.

(b) Submit new applications to the facility.

(c) Service any existing facility policies except as permitted by the facility's user manual under procedures for disqualified agents.

(d) Be entitled to compensation for either new business applications or renewals.

(e) Obtain any binders or other supplies from the facility. Existing binders or other supplies shall be surrendered to the facility upon request.

(6) A disqualification under this section does not affect the disqualified agent's authority to place automobile insurance through an authorized insurer in the voluntary market.

(7) The facility shall amend its plan of operation to establish standards and procedures for disqualifying an agent from placing automobile insurance through the facility. These standards and procedures shall contain at least all of the following:

(a) The actions or inactions that may lead to an agent's disqualification.

(b) Standards and procedures under which an agent may petition the facility for removal of the disqualification.

(c) That written notification must be sent to an agent that has been disqualified that includes at least all of the following:

(*i*) The reasons for the disqualification.

(*ii*) The procedure to be followed to appeal the disqualification to the board of governors or its designee.

(*iii*) The conditions and procedures under which the agent can petition the facility for the removal of the disqualification.

(d) A procedure under which the disqualified agent may appeal the disqualification to the facility's board of governors, or its designee, that protects the interests of both the agent and the facility. This procedure shall include the opportunity for the agent, upon request and payment of a reasonable copying charge, to receive any information pertinent to the disqualification.

(e) A notice to the disqualified agent after the board of governors' or designee's ruling as to how the agent

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may appeal that ruling to the commissioner or his or her designee if the agent disagrees with the ruling.

History: Add. 1969, Act 346, Eff. Apr. 1, 1970;—Am. 1979, Act 145, Eff. Jan. 1, 1981;—Am. 2001, Act 140, Imd. Eff. Oct. 26, 2001.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Popular name: Act 218

Popular name: Essential Insurance

500.3360 Participating member and agent; relationship.

Sec. 3360. A participating member may not include the premiums and losses incurred from risks insured through the facility in determining the loss ratio of any of its agents, or otherwise use the experience from such risks as cause for altering the relationship between the participating member and its agent.

History: Add. 1969, Act 346, Eff. Apr. 1, 1970.

Popular name: Act 218

Popular name: Essential Insurance

500.3365 Eligibility for automobile insurance; requesting assignment, rejecting assignment, or requesting reassignment; notice of statutory eligibility standards.

Sec. 3365. (1) Any qualified applicant shall be eligible for automobile insurance as provided by this chapter through the facility.

(2) Any qualified applicant shall have the right to request assignment, reject assignment, or request reassignment to any designated participating member in accordance with procedures established by the board of governors. The procedures may limit the assignments to conform to the contractual arrangement of the recipient of assignments or servicing carrier with the facility. The opportunity to request assignment and reject assignment shall be provided on the application. The opportunity to request reassignment shall be stated on the policy at the time of issuance and shall be offered in writing to the insured at the time of renewal.

(3) At least once each year, each designated participating member shall notify all persons insured through the member on behalf of the facility, in a form approved by the commissioner, of the statutory eligibility standards for obtaining automobile insurance from insurers in the voluntary market.

History: Add. 1969, Act 346, Eff. Apr. 1, 1970;—Am. 1979, Act 145, Eff. Jan. 1, 1981.

Popular name: Act 218

Popular name: Essential Insurance

500.3370 Assistance in applying to facility for placement.

Sec. 3370. If the commissioner finds, after a hearing, held pursuant to Act No. 306 of the Public Acts of 1969, as amended, or if the board of governors, upon its own motion, finds that a large number of persons are failing to gain the benefits of the facility, the facility shall provide service to assist the public in making application to the facility for placement.

History: Add. 1969, Act 346, Eff. Apr. 1, 1970;—Am. 1979, Act 145, Eff. Jan. 1, 1981.

Popular name: Act 218

Popular name: Essential Insurance

500.3380 Hearing and ruling by board of governors; grounds; applicability of right to hearing; filing request for hearing; hearing to be prompt and fair; appeal; order.

Sec. 3380. (1) Any participating member, applicant, or person insured under a policy placed through the facility may request a formal hearing and ruling by the board of governors of the facility on any of the following:

(a) An alleged violation of the plan of operation.

(b) Any alleged improper act or ruling of the facility directly affecting an assessment, premium, or coverage furnished.

(c) A participating member's application to be a recipient of distributed assignments or to service risks.

(2) A right to a hearing under subsection (1) shall not apply to any claim arising out of insurance provided by any designated participating member. A request for hearing must be filed within 30 days after the date of the alleged act or decision.

(3) The plan of operation shall provide for prompt and fair hearings.

(4) Any formal ruling by the board of governors may be appealed to the commissioner by filing notice of appeal with the facility and commissioner within 30 days after issuance of the ruling.

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(5) The commissioner shall issue an order approving the action or decision, disapproving the action or decision, or directing the board of governors to reconsider the ruling.

History: Add. 1969, Act 346, Eff. Apr. 1, 1970;—Am. 1979, Act 145, Eff. Jan. 1, 1981.

Popular name: Act 218

Popular name: Essential Insurance

500.3385 Recoupment of assessments; surcharge; rate including factor for recoupment.

Sec. 3385. Any assessments paid by participating members pursuant to section 3330(1)(c) may be recouped through a surcharge in the insurers rates for automobile insurance policies issued by the member, including policies issued on behalf of the facility. A rate shall not be considered excessive because the rate includes a factor for recoupment pursuant to this section.

History: Add. 1979, Act 145, Eff. Jan. 1, 1981.

Popular name: Act 218

Popular name: Essential Insurance

500.3390 Determinations made by commissioner.

Sec. 3390. Determinations made by the commissioner pursuant to this chapter shall be made independent of the credits provided to insurers pursuant to the former single business tax act, 1975 PA 228, or the Michigan business tax act, 2007 PA 36, MCL 208.1101 to 208.1601.

History: Add. 1987, Act 261, Imd. Eff. Dec. 28, 1987;—Am. 2007, Act 187, Imd. Eff. Dec. 21, 2007.

Popular name: Act 218

Popular name: Essential Insurance

CHAPTER 34
DISABILITY INSURANCE POLICIES

500.3400 Definitions; scope of chapter, exemptions, exceptions.

Sec. 3400. (1) As used in this chapter:

(a) "Affiliated provider" means a health professional, licensed hospital, licensed pharmacy, or other person that has entered into a participating provider contract, directly or indirectly, with a health maintenance organization to render 1 or more health services to an enrollee. Affiliated provider includes a person described in this subdivision that has entered into a written arrangement with another person, including, but not limited to, a physician hospital organization or physician organization, that contracts directly with a health maintenance organization.

(b) "Disability insurance policy" includes an insurance policy or insurance contract that insures against loss resulting from sickness or from bodily injury or death by accident, or both, including also the granting of specific hospital benefits and medical, surgical, and sick-care benefits to an individual, family, or group, subject to the exclusions provided in this section.

(2) This chapter does not apply to or affect any of the following:

(a) A liability or worker's disability compensation insurance policy, regardless of whether supplementary expense coverage is included.

(b) A reinsurance policy or contract.

(c) Life insurance, endowment, or annuity contracts, or contracts supplemental to life insurance, endowment, or annuity contracts, that only contain provisions relating to disability insurance that do any of the following:

(*i*) Provide additional benefits in case of death or dismemberment or loss of sight by accident.

(*ii*) Operate to safeguard the contracts against lapse or to give a special surrender value, special benefit, or annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract. A supplemental contract described in this subparagraph must be issued under the authority of section 602.

(3) An insurer may omit the provisions required under sections 3407, 3411, and 3420 from ticket policies sold only to passengers by common carriers.

(4) Section 3475 applies to group, blanket, or family expense disability insurance contracts and the remaining provisions of this chapter apply to group, blanket, or family expense disability insurance contracts only as provided in this chapter.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1963, Act 56, Eff. Sept. 6, 1963;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

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500.3401 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to purpose and short title of chapter.

Popular name: Act 218

500.3401a Group disability insurance; issuance; filing and approval of form.

Sec. 3401a. (1) An insurer authorized to write disability insurance in this state may issue group disability insurance policies.

(2) Except as otherwise provided in section 2236(8)(d), an insurer shall not deliver or issue for delivery in this state a group disability insurance policy unless a copy of the form has been filed with and approved by the director.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Enacting section 3 of Act 276 of 2016 provides:

"Enacting section 3. On the effective date of this amendatory act, an insurer may submit to the director of the department of insurance and financial services for approval any modification to policies and certificates that were approved before or on the effective date of this amendatory act, to conform with amendments made to the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, by this amendatory act. This enacting section does not apply to rates and rating methodologies."

Popular name: Act 218

500.3402 Disability insurance policy; provisions required.

Sec. 3402. An insurer shall not deliver or issue for delivery in this state a disability insurance policy for an individual or family unless all of the following requirements are met:

(a) The entire money and other considerations for the policy are expressed in the policy.

(b) The time at which the insurance takes effect and terminates is expressed in the policy.

(c) The policy purports to insure only 1 individual, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who is considered to be the policyholder, any 2 or more eligible members of that family, including husband, wife, dependent children, any children under a specified age, and any other individual dependent upon the policyholder, if coverage is made available to any dependent child at least until the child turns 26 years of age for a health insurance policy or 19 years of age for a policy of disability insurance, a policy providing pediatric dental benefits, or a policy providing pediatric vision benefits.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3402a Group disability insurance policy; provisions required.

Sec. 3402a. An insurer shall include all of the following provisions in a group disability insurance policy:

(a) That the policy, application of the employer or of an executive officer or trustee of an association, and the individual applications, if any, of the employees or members insured, constitute the entire contract between the parties. The insurer's identification of what constitutes the entire contract creates a rebuttable presumption that the identified items are the entire contract.

(b) That a statement made by the employer, the executive officer or trustee of an association, or an individual employee or member, in the absence of fraud, is a representation and not a warranty. An insurer shall not use a statement made by the employer, the executive officer or trustee of an association, or an individual employee or member as a defense to a claim under the policy, unless the statement is contained in a written application.

(c) That the insurer will issue to the employer or the executive officer or trustee of an association, for delivery to an employee or member who is insured under the policy, an individual certificate that states the insurance protection to which the employee or member is entitled and to whom benefits are payable.

(d) That new employees or members, as applicable, who are eligible and who apply will be added to the group or class originally insured.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3402b Group or nongroup disability insurance policy; coordination of benefits; provision; limitation; "other coverage" defined; payment by each insurer.

Sec. 3402b. (1) Subject to the coordination of benefits act, 1984 PA 64, MCL 550.251 to 550.255, an insurer may include in a group or nongroup disability insurance policy a provision for the coordination of benefits otherwise payable under the policy with benefits payable for the same loss under other group or nongroup disability insurance. An insurer that does not include in a group or nongroup disability insurance

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policy a provision for the coordination of benefits as described in this subsection shall coordinate benefits under the policy in the manner prescribed in the coordination of benefits act, 1984 PA 64, MCL 550.251 to 550.255.

(2) Subject to subsection (1), an insurer may include a provision in a group or nongroup disability insurance policy that benefits payable by the policy may be limited if there is other valid coverage with another insurer that provides benefits for the same loss on an expense-incurred basis. The insurer may provide that if it is not given written notice on the application for coverage that the other valid coverage exists, or if other coverage is acquired after the effective date of the coverage, the only liability under any expense-incurred coverage of the policy is the amount of the covered claim that exceeds the benefits payable by the other coverage. An insurer shall apply benefits paid or payable by the primary insurer to satisfy any deductibles, coinsurance, and copayments with the policy. An insurer shall not apply payments made by a primary insurer to reduce the policy maximum limits on the policy. As used in this subsection, "other coverage" includes a plan that provides coverage under a health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or other expense-incurred plan or program. Other coverage does not include Medicaid, hospital daily indemnity plans, specified disease only policies, or limited occurrence policies that provide only for intensive care or coronary care at a hospital, first aid outpatient medical expenses resulting from accidents, or specified accidents such as travel accidents.

(3) If there are more than 1 group or nongroup disability insurance policies that cover the same loss and contain a provision described in subsection (2), and the insurers each pay a share of the covered expenses for the claim, neither insurer is required to pay more than it would have paid had it been the primary insurer.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3402c Family expense insurance policy.

Sec. 3402c. (1) For purposes of this chapter, family expense insurance is accident and health insurance that is written under 1 policy issued to the head of a family who may be either spouse and that insures the head of the family and 1 or more dependents, including a nondependent spouse. Benefits under a family expense insurance policy, except as applied to the head of the family, do not include indemnification for loss of time from any cause.

(2) An insurer authorized to write accident and health insurance in this state may issue family expense insurance policies.

(3) An insurer shall not deliver or issue for delivery in this state a family expense insurance policy unless a copy of the form of the policy is filed with and approved by the director.

(4) An insurer shall include in a family expense insurance policy the applicable provisions of sections 3406 to 3466 and all of the following provisions:

(a) That the policy and the application signed by the individual acting as the head of the family for the purpose of family expense insurance constitute the entire contract between the parties. The insurer's identification of what constitutes the entire contract creates a rebuttable presumption that the identified items are the entire contract.

(b) That a statement made by the head of the family, in the absence of fraud, is a representation and not a warranty. An insurer shall not use a statement made by the head of the family as a defense to a claim under the policy, unless the statement is contained in a written application.

(c) That new members of the family who are eligible, on application of the head of the family, will be added to the family group originally insured.

(5) A family expense insurance policy is subject to sections 3474 and 3474a.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Enacting section 3 of Act 276 of 2016 provides:

"Enacting section 3. On the effective date of this amendatory act, an insurer may submit to the director of the department of insurance and financial services for approval any modification to policies and certificates that were approved before or on the effective date of this amendatory act, to conform with amendments made to the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, by this amendatory act. This enacting section does not apply to rates and rating methodologies."

Popular name: Act 218

500.3402d Blanket disability insurance; coverage.

Sec. 3402d. (1) For purposes of this chapter, blanket disability insurance is disability insurance that covers special groups of individuals, as follows:

(a) A policy issued to a common carrier as the policyholder and that covers a group defined as all individuals who are passengers of the common carrier.

(b) A policy issued to an employer as the policyholder and that covers all employees or any group of

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employees defined by reference to exceptional hazards incidental to the employment.

(c) A policy issued to a university, college, school, or other educational institution, or to the head or principal of the university, college, school, or institution as the policyholder, that covers students or teachers.

(d) A policy issued to a volunteer fire department, first aid group, or other volunteer group as the policyholder that covers all of the members of the department or group.

(e) A policy issued to a creditor as the policyholder that insures debtors of the creditor.

(f) A policy issued to a sports team or camp as the policyholder that covers members or campers.

(2) In the discretion of the director, blanket disability insurance may be issued to any other special group of individuals that is substantially similar to a group described in subsection (1).

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3402e Blanket disability insurance policies; issuance.

Sec. 3402e. (1) An insurer authorized to write disability insurance in this state may issue blanket disability insurance policies.

(2) An insurer shall not deliver or issue for delivery in this state a blanket disability insurance policy unless a copy of the form of the policy is filed with and approved by the director.

(3) A blanket disability insurance policy is subject to sections 3474 and 3474a.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Enacting section 3 of Act 276 of 2016 provides:

"Enacting section 3. On the effective date of this amendatory act, an insurer may submit to the director of the department of insurance and financial services for approval any modification to policies and certificates that were approved before or on the effective date of this amendatory act, to conform with amendments made to the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, by this amendatory act. This enacting section does not apply to rates and rating methodologies."

Popular name: Act 218

500.3402f Blanket disability insurance policy; provisions.

Sec. 3402f. An insurer shall include in a blanket disability insurance policy the applicable provisions of sections 3406 to 3466 and all of the following provisions:

(a) That the policy and the application signed by the policyholder constitute the entire contract between the parties. The insurer's identification of what constitutes the entire contract creates a rebuttable presumption that the identified items are the entire contract.

(b) That a statement made by the policyholder, in the absence of fraud, is a representation and not a warranty. An insurer shall not use a statement made by the policyholder as a defense to a claim under the policy, unless the statement is contained in a written application.

(c) That individuals who are eligible for coverage, on application of the policyholder, will be added to the group or class originally insured.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3402g Blanket disability insurance policy; certificate; payment of benefits.

Sec. 3402g. (1) An insurer shall not require an individual application from an individual covered under a blanket disability insurance policy. The director may require the insurer to furnish a certificate to each individual insured under a blanket disability policy.

(2) Except as otherwise provided in this subsection, an insurer shall pay benefits under a blanket disability insurance policy to the insured or to the insured's designated beneficiary or estate. If the insured is a minor or developmentally disabled, an insurer may pay benefits under a blanket disability insurance policy to the insured's parent, guardian, or other person to which the insured is a dependent. An insurer may provide in a blanket disability insurance policy that, with the consent of the insured, the benefits may be paid directly to a person that legally furnishes hospital, medical, surgical, or sick-care services to the insured, within the limits under the policy and without other preference as to creditors.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3402h Legal liability of policyholder.

Sec. 3402h. Sections 3402d to 3402g do not affect the legal liability of a policyholder for the death of or injury to an employee, member, or other individual insured under the blanket disability insurance policy.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

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500.3403 Health insurance policy offering dependent coverage; required provisions; denial prohibited; grounds.

Sec. 3403. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that makes dependent coverage available under the health insurance policy shall do all of the following:

(a) Make available dependent coverage, at the option of the policyholder, until the dependent has attained 26 years of age.

(b) Provide the same health insurance benefits to a dependent child that are available to any other covered dependent.

(c) Provide health insurance benefits to a dependent child at the same rate or premium applicable to any other covered dependent.

(d) Include both of the following provisions in the health insurance policy:

(*i*) That the health insurance benefits applicable for children are payable with respect to a newly born child of the insured from the moment of birth.

(*ii*) That the coverage for newly born children consists of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(2) A health insurance policy that offers dependent coverage shall not deny enrollment to an insured's child on any of the following grounds:

(a) The child was born out of wedlock.

(b) The child is not claimed as a dependent on the insured's federal income tax return.

(c) The child does not reside with the insured or in the insurer's service area.

(3) This section does not require an insurer or plan to make coverage available for a child of a child receiving dependent coverage.

History: Add. 1975, Act 20, Imd. Eff. Apr. 3, 1975;—Am. 2016, Act 276, Imd. Eff. July 1, 2016;—Am. 2023, Act 158, Eff. Feb. 13, 2024.

Compiler's note: Section 2 of Act 20 of 1975 provides: "The requirements of this act shall apply to all insurance policies delivered or issued for delivery in this state more than 120 days after the effective date of the act."

Popular name: Act 218

500.3404 Insurance policy issued for delivery to nonresident.

Sec. 3404. The director may require that a policy issued by an insurer domiciled in this state for delivery to a person residing in another state meet the standards prescribed in sections 2212a, 3402, and 3406 to 3466 if the official that is responsible for the administration of the insurance laws of the other state advises the director that the policy is not subject to approval or disapproval by the official.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3405 Prudent purchaser agreements with providers of hospital, nursing, medical, surgical, or sick-care services; rates; discrimination prohibited; optometry, chiropractic, and physical therapy service.

Sec. 3405. (1) For the purpose of doing business as an organization under the prudent purchaser act, 1984 PA 233, MCL 550.51 to 550.63, an insurer authorized in this state to write health insurance may enter into prudent purchaser agreements with providers of hospital, nursing, medical, surgical, or sick-care services pursuant to this section and the prudent purchaser act, 1984 PA 233, MCL 550.51 to 550.63.

(2) An insurer may offer health insurance policies under which the insured persons shall be required, as a condition of coverage, to obtain health care services exclusively from health care providers who have entered into prudent purchaser agreements.

(3) An insurer may offer health insurance policies under which insured persons who elect to obtain health care services from health care providers who have entered into prudent purchaser agreements realize a financial advantage or other advantage by selecting providers who have entered into prudent purchaser agreements. Policies offered under this subsection shall not, as a condition of coverage, require insured persons to obtain hospital, nursing, medical, surgical, or sick-care services exclusively from health care providers who have entered into prudent purchaser agreements.

(4) An insurer shall not charge rates for coverage under policies issued under this section that are unreasonably lower than what is necessary to meet the expenses of the insurer for providing the coverage or that have an anticompetitive effect or result in predatory pricing in relation to prudent purchaser agreement coverages offered by other organizations.

(5) An insurer shall not discriminate against a class of health care providers when entering into prudent

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purchaser agreements with health care providers for its provider panel. This subsection does not do any of the following:

(a) Prohibit the formation of a provider panel consisting of a single class of providers if a service provided for in the specifications of a purchaser may legally be provided only by a single class of providers.

(b) Prohibit the formation of a provider panel that conforms to the specifications of a purchaser of the coverage authorized by this section if the specifications do not exclude any class of health care providers who may legally perform the services included in the coverage.

(c) Require an organization that has uniformly applied the standards filed under section 3(3) of the prudent purchaser act, 1984 PA 233, MCL 550.53, to contract with any individual provider.

(6) Notwithstanding any provision of this act to the contrary, if coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of optometry, an insurer is not required to provide coverage or reimburse for a practice of optometry service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

(7) Notwithstanding any provision of this act to the contrary, if coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of chiropractic, an insurer is not required to provide coverage or reimburse for a practice of chiropractic service unless that service was included in the definition of practice of chiropractic under section 16401 of the public health code, 1978 PA 368, MCL 333.16401, as of January 1, 2009.

(8) Notwithstanding any provision of this act to the contrary, if coverage under a prudent purchaser agreement provides for benefits for services that are provided by a licensed physical therapist or physical therapist assistant under the supervision of a licensed physical therapist, an insurer is not required to provide coverage or reimburse for services provided by a physical therapist or a physical therapist assistant unless that service was provided by a licensed physical therapist or physical therapist assistant under the supervision of a licensed physical therapist pursuant to a prescription from a health care professional who holds a license issued under part 166, 170, 175, or 180 of the public health code, 1978 PA 368, MCL 333.16601 to 333.16648, 333.17001 to 333.17084, 333.17501 to 333.17556, and 333.18001 to 333.18058, or the equivalent license issued by another state.

History: Add. 1984, Act 280, Imd. Eff. Dec. 20, 1984;—Am. 1989, Act 137, Eff. Jan. 3, 1990;—Am. 1994, Act 438, Eff. Mar. 30, 1995;—Am. 2009, Act 227, Imd. Eff. Jan. 5, 2010;—Am. 2014, Act 263, Imd. Eff. July 1, 2014;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Senate Bill No. 493 was not enacted into law by the 87th Legislature.

Popular name: Act 218

500.3405a Use of most favored nation clause.

Sec. 3405a. (1) Notwithstanding any provision of this act to the contrary, this section applies to the use of a most favored nation clause in a provider contract on and after February 1, 2013.

(2) Subject to subsection (3), beginning February 1, 2013, an insurer or a health maintenance organization shall not use a most favored nation clause in any provider contract, including a provider contract in effect on February 1, 2013, unless the most favored nation clause has been filed with and approved by the director. Subject to subsection (3), beginning February 1, 2013, an insurer or a health maintenance organization shall not enforce a most favored nation clause in any provider contract without the prior approval of the director.

(3) Beginning January 1, 2014, an insurer or a health maintenance organization shall not use a most favored nation clause in any provider contract, including a provider contract in effect on January 1, 2014.

(4) As used in this section, "most favored nation clause" means a clause that does any of the following:

(a) Prohibits, or grants a contracting insurer or health maintenance organization an option to prohibit, a provider from contracting with another party to provide health care services at a lower rate than the payment or reimbursement rate specified in the contract with the insurer or health maintenance organization.

(b) Requires, or grants a contracting insurer or health maintenance organization an option to require, a provider to accept a lower payment or reimbursement rate if the provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the insurer or health maintenance organization.

(c) Requires, or grants a contracting insurer or health maintenance organization an option to require, termination or renegotiation of an existing provider contract if a provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the insurer or health maintenance organization.

(d) Requires a provider to disclose, to the insurer or health maintenance organization or the insurer's or health maintenance organization's designee, the provider's contractual payment or reimbursement rates with

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other parties.

(5) As used in this section, after December 31, 2016, "insurer" includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

History: Add. 2013, Act 5, Imd. Eff. Mar. 18, 2013;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406 Disability insurance policy; provisions required, captions, omissions, substitutions.

Sec. 3406. (1) Except as provided in subsection (2) of this section, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in sections 3407 through 3424 in the words in which the same appear in such sections: Provided, however, That the insurer may, at its option, substitute for 1 or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in the pertinent section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(2) If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3406a Reconstructive surgery following mastectomy; prosthetic device.

Sec. 3406a. An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall offer benefits for prosthetic devices to maintain or replace the body parts of an individual who has undergone a mastectomy. This coverage must provide that reasonable charges for medical care and attendance for an individual who receives reconstructive surgery following a mastectomy or who is fitted with a prosthetic device are covered benefits after the individual's attending physician has certified the medical necessity or desirability of a proposed course of rehabilitative treatment. The cost and fitting of a prosthetic device following a mastectomy is included within the type of coverage required under this section.

History: Add. 1982, Act 527, Eff. Mar. 30, 1983;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406b Coverage for mental health services by mental health care provider.

Sec. 3406b. A policy or certificate which provides coverage for mental health services shall provide coverage for mental health services provided to an individual by a mental health care provider operated by or under contract with the department of mental health or a county community mental health board in those instances when appropriate mental health services cannot be delivered otherwise, or if the provider of the mental health services is designated by an order of a court; provided that the mental health provider meets the standards set by the insurer for all other providers of the type.

History: Add. 1984, Act 280, Imd. Eff. Dec. 20, 1984.

Popular name: Act 218

500.3406c Hospice care; definition; description of coverage.

Sec. 3406c. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides coverage for inpatient hospital care shall offer to include coverage for hospice care. As used in this section, "hospice" means a health care program that provides a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.

(2) If hospice care coverage is provided, an insurer shall include a description of the hospice coverage in communications sent to the insured.

History: Add. 1984, Act 368, Eff. Jan. 1, 1986;—Am. 1994, Act 233, Imd. Eff. June. 30, 1994;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406d Coverage for breast cancer diagnostic services, breast cancer outpatient

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treatment services, and breast cancer rehabilitative services; coverage for breast cancer screening mammography; definitions.

Sec. 3406d. (1) Subject to dollar limits, deductibles, and coinsurance provisions that are not less favorable than those for physical illness generally, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall offer or include coverage for breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services.

(2) Subject to dollar limits, deductibles, and coinsurance provisions that are not less favorable than those for physical illness generally, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall offer or include the following coverage for breast cancer screening mammography:

(a) If performed on a woman 35 years of age or older and under 40 years of age, coverage for 1 screening mammography examination during that 5-year period.

(b) If performed on a woman 40 years of age or older, coverage for 1 screening mammography examination every calendar year.

(3) As used in this section:

(a) "Breast cancer diagnostic services" means a procedure intended to aid in the diagnosis of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to mammography, surgical breast biopsy, and pathologic examination and interpretation.

(b) "Breast cancer rehabilitative services" means a procedure intended to improve the result of, or ameliorate the debilitating consequences of, treatment of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to reconstructive plastic surgery, physical therapy, and psychological and social support services.

(c) "Breast cancer screening mammography" means a standard 2-view per breast, low-dose radiographic examination of the breasts, using equipment designed and dedicated specifically for mammography, in order to detect unsuspected breast cancer.

(d) "Breast cancer outpatient treatment services" means a procedure intended to treat cancer of the human breast, delivered on an outpatient basis, including but not limited to surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

History: Add. 1989, Act 59, Eff. Nov. 1, 1989;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406e Coverage for drug used in antineoplastic therapy and cost of its administration; conditions.

Sec. 3406e. An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall provide coverage in each policy for a drug used in antineoplastic therapy and the reasonable cost of its administration. Coverage must be provided for any United States Food and Drug Administration approved drug regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the United States Food and Drug Administration if all of the following conditions are met:

(a) The drug is ordered by a physician for the treatment of a specific type of neoplasm.

(b) The drug is approved by the United States Food and Drug Administration for use in antineoplastic therapy.

(c) The drug is used as part of an antineoplastic drug regimen.

(d) Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.

(e) The physician has obtained informed consent from the patient for the treatment regimen that includes United States Food and Drug Administration approved drugs for off-label indications.

History: Add. 1989, Act 59, Imd. Eff. June 16, 1989;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406f Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to excluded or limited coverage and examination of issue of crediting prior continuous health care coverage.

Popular name: Act 218

500.3406g Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to prohibition against denying coverage to dependent child under certain conditions.

Popular name: Act 218

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500.3406h Eligibility of parent for dependent coverage; health coverage of child through noncustodial parent; duties of insurer; court or administrative order and notice required.

Sec. 3406h. (1) If a parent is eligible for dependent coverage through an insurer, the insurer shall:

(a) Permit the parent to enroll, under the dependent coverage, a child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under dependent coverage upon application by the friend of the court or by the child's other parent through the friend of the court.

(c) Not eliminate the child's coverage unless premiums have not been paid as required by the policy or certificate or the insurer is provided with satisfactory written evidence of either of the following:

(*i*) The court or administrative order is no longer in effect.

(*ii*) The child is or will be enrolled in comparable health coverage through another insurer, health care corporation, health maintenance organization, or self-funded health coverage plan that will take effect not later than the effective date of the cancellation of the existing coverage.

(2) If a child has health coverage through an insurer of a noncustodial parent, that insurer shall do all of the following:

(a) Provide the custodial parent with information necessary for the child to obtain benefits through that coverage.

(b) Permit the custodial parent or, with the custodial parent's approval, the provider to submit a claim for covered services without the noncustodial parent's approval.

(c) Make payment on claims submitted under subdivision (b) directly to the custodial parent or medical provider.

(3) This section applies only if a parent is required by a court or administrative order to provide health coverage for a child and the insurer is notified of that court or administrative order.

History: Add. 1995, Act 237, Eff. Mar. 28, 1996.

Popular name: Act 218

500.3406i Individual eligible under title XIX of social security act; assignment of rights of insured to department of social services.

Sec. 3406i. (1) An insurer shall not consider whether an individual is eligible for or has available medical assistance under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396g and 1396i to 1396v, in this or another state when considering eligibility for coverage or making payments under its plan for eligible insureds.

(2) If an insurer has a legal liability to make payments, and payment for covered expenses for medical goods or services furnished to an individual has been made under the medical assistance program established under section 105 of the social welfare act, Act No. 280 of the Public Acts of 1939, being section 400.105 of the Michigan Compiled Laws, the department of social services has the rights of the individual to payment by the insurer to the extent payment was made by the department of social services's medical assistance program for those medical goods or services.

(3) If the department of social services has been assigned the rights of an insured who is eligible for medical assistance under section 105 of Act No. 280 of the Public Acts of 1939 and is covered by an insurer, the insurer shall not impose requirements on the department of social services that are different from requirements that apply to an agent or assignee of any other covered insured.

History: Add. 1995, Act 237, Eff. Mar. 28, 1996.

Popular name: Act 218

500.3406j Insured or applicant as victim of domestic violence; refusal to provide coverage prohibited; liability; "domestic violence" defined.

Sec. 3406j. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not rate, cancel coverage on, refuse to provide coverage for, or refuse to issue or renew a health insurance policy solely because an insured or applicant for insurance is or has been a victim of domestic violence.

(2) An insurer is not civilly liable for any cause of action that may result from compliance with this section.

(3) As used in this section, "domestic violence" means inflicting bodily injury on, causing serious emotional injury or psychological trauma to, or placing in fear of imminent physical harm by threat or force a person who is a spouse or former spouse of, has or has had a dating relationship with, resides or has resided

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with, or has a child in common with the person committing the violence.

History: Add. 1998, Act 136, Imd. Eff. June 24, 1998;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406k Emergency health services; medically necessary coverage; "stabilization" defined.

Sec. 3406k. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides coverage for emergency health services shall provide coverage for medically necessary services provided to an insured for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An insurer shall not require a physician to transfer a patient before the physician determines that the patient has reached the point of stabilization. An insurer shall not deny payment for emergency health services up to the point of stabilization provided to an insured under this subsection because of either of the following:

(a) The final diagnosis.

(b) Prior authorization not being given by the insurer before emergency health services were provided.

(2) As used in this section, "stabilization" means the point at which no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient.

History: Add. 1998, Act 125, Imd. Eff. June 10, 1998;—Am. 2004, Act 7, Imd. Eff. Feb. 20, 2004;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406*l* Medical transportation services; reimbursement; exception.

Sec. 3406*l*. (1) Except as otherwise provided in subsections (2) and (3), an insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides benefits for emergency services shall provide for direct reimbursement to any provider of covered medical transportation services or shall provide that payment be made jointly to the insured and the provider, if the provider has not received payment for those services from any other source.

(2) Subsection (1) does not apply to a transaction between an insurer and a medical transportation service provider if the parties have entered into a contract providing for direct payment.

(3) An insurer for a policy issued under section 3405 does not have to provide for direct reimbursement to any nonaffiliated or nonparticipating provider for medical transportation services that were not emergency health services as described in section 3406k.

(4) This section does not apply to a health maintenance organization contract.

History: Add. 2004, Act 171, Imd. Eff. June 24, 2004;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406m Access by insured to obstetrician-gynecologist.

Sec. 3406m. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that requires an insured to designate a participating primary care provider and provides for annual well-woman examinations and routine obstetrical and gynecologic services shall permit a female insured to access an obstetrician-gynecologist for annual well-woman examinations and routine obstetrical and gynecologic services.

(2) An insurer shall not require prior authorization or referral for access under subsection (1) to an obstetrician-gynecologist who is participating with the insurer. An insurer may require prior authorization or referral for access to a nonparticipating obstetrician-gynecologist.

(3) An insurer shall include a description of the coverage required under this section in a communication sent to the insured or group purchaser of coverage.

History: Add. 1998, Act 402, Eff. Mar. 23, 1999;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406n Access to pediatric care services.

Sec. 3406n. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that requires an insured to designate a participating primary care provider and provides for dependent care coverage shall permit a dependent minor insured to select and access a pediatrician for general pediatric care services.

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(2) An insurer shall not require prior authorization or referral for access under subsection (1) to a pediatrician who participates with the insurer. An insurer may require prior authorization or referral for access to a nonparticipating pediatrician.

History: Add. 1999, Act 179, Imd. Eff. Nov. 16, 1999;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406o Insurer providing prescription drug coverage; formulary restrictions; expedited review of coverage for nonformulary alternative; determination; subject to 500.3406w.

Sec. 3406o. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides coverage for prescription drugs and limits those benefits to drugs included in a formulary shall do all of the following:

(a) Provide for participation of participating physicians, dentists, and pharmacists in the development of the formulary.

(b) Disclose to health care providers and upon request to insureds the nature of the formulary restrictions.

(c) Provide for exceptions from the formulary limitation when a nonformulary alternative is a medically necessary and appropriate alternative. This subdivision does not prevent an insurer from establishing prior authorization requirements or another process for consideration of coverage or higher cost-sharing for nonformulary alternatives.

(2) On a request for an expedited review of coverage for a nonformulary alternative based on exigent circumstances, an insurer shall make a determination and notify the enrollee or the enrollee's designee and the prescribing physician, or other prescriber, as appropriate, of the determination within 24 hours after the insurer receives all information necessary to determine whether the exception should be granted. For purposes of this subsection, exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

(3) If subsection (2) does not apply, an insurer shall make a determination on coverage for a nonformulary alternative and notify the enrollee or the enrollee's designee and the prescribing physician, or other prescriber, as appropriate, of the determination within 72 hours after the insurer receives all information necessary to determine whether the exception should be granted.

(4) This section is subject to section 3406w.

History: Add. 1999, Act 177, Imd. Eff. Nov. 16, 1999;—Am. 2016, Act 276, Imd. Eff. July 1, 2016;—Am. 2020, Act 322, Imd. Eff. Dec. 29, 2020.

Popular name: Act 218

500.3406p Establishment of program to prevent onset of clinical diabetes required; survey; coverages; "diabetes" defined.

Sec. 3406p. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall establish and provide to insureds, enrollees, and affiliated providers a program to prevent the onset of clinical diabetes. This program for affiliated providers must emphasize best practice guidelines to prevent the onset of clinical diabetes and to treat diabetes, including, but not limited to, diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment.

(2) An insurer that provides a program under subsection (1) shall regularly measure the effectiveness of the program by regularly surveying individuals covered by the health insurance policy.

(3) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall include coverage for the following equipment, supplies, and educational training for the treatment of diabetes, if determined to be medically necessary and prescribed by an allopathic or osteopathic physician:

(a) Blood glucose monitors and blood glucose monitors for the legally blind.

(b) Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.

(c) Syringes.

(d) Insulin pumps and medical supplies required for the use of an insulin pump.

(e) Diabetes self-management training to ensure that persons with diabetes are trained as to the proper self-management and treatment of their diabetic condition.

(4) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides outpatient pharmaceutical coverage directly or by rider shall include the following coverage for the treatment of diabetes, if determined to be medically necessary:

(a) Insulin, if prescribed by an allopathic or osteopathic physician.

(b) Nonexperimental medication for controlling blood sugar, if prescribed by an allopathic or osteopathic

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physician.

(c) Medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with diabetes, if prescribed by an allopathic, osteopathic, or podiatric physician.

(5) Coverage under subsection (3) for diabetes self-management training is subject to all of the following:

(a) The training is limited to completion of a certified diabetes education program if either of the following applies:

(*i*) The training is considered medically necessary upon the diagnosis of diabetes by an allopathic or osteopathic physician who is managing the patient's diabetic condition and is needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge.

(*ii*) An allopathic or osteopathic physician has diagnosed a significant change with long-term implications in the patient's symptoms or conditions that necessitates changes in the patient's self-management or a significant change in medical protocol or treatment modalities.

(b) The training must be provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the department of community health. Training provided under this subdivision must be conducted in group settings whenever practicable.

(6) Coverage under this section is not subject to dollar limits, deductibles, or copayment provisions that are greater than those for physical illness generally.

(7) As used in this section, "diabetes" includes all of the following:

(a) Gestational diabetes.

(b) Insulin-dependent diabetes.

(c) Non-insulin-dependent diabetes.

History: Add. 2000, Act 425, Eff. Mar. 28, 2001;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406q Off-label use of approved drug; coverage; conditions; compliance; use of copayment, deductible, sanction, or utilization control; limitation; definitions.

Sec. 3406q. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides pharmaceutical coverage shall provide coverage for an off-label use of a United States Food and Drug Administration approved drug and the reasonable cost of supplies medically necessary to administer the drug.

(2) Coverage for a drug under subsection (1) applies if all of the following conditions are met:

(a) The drug is approved by the United States Food and Drug Administration.

(b) The drug is prescribed by an allopathic or osteopathic physician for the treatment of either of the following:

(*i*) A life-threatening condition if the drug is medically necessary to treat the condition and the drug is on the plan formulary or accessible through the insurer's formulary procedures.

(*ii*) A chronic and seriously debilitating condition if the drug is medically necessary to treat the condition and the drug is on the plan formulary or accessible through the insurer's formulary procedures.

(c) The drug has been recognized for treatment for the condition for which it is prescribed by 1 of the following:

(*i*) The American Medical Association drug evaluations.

(*ii*) The American Hospital Formulary Service drug information.

(*iii*) The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional".

(*iv*) Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

(3) Upon request, the prescribing allopathic or osteopathic physician shall supply to the insurer documentation supporting compliance with subsection (2).

(4) This section does not prohibit the use of a copayment, deductible, sanction, or mechanism for appropriately controlling the utilization of a drug that is prescribed for a use different from the use for which the drug has been approved by the United States Food and Drug Administration. This may include prior approval or a drug utilization review program. Any copayment, deductible, sanction, prior approval, drug utilization review program, or mechanism described in this subsection must not be more restrictive than for prescription coverage generally.

(5) As used in this section:

(a) "Chronic and seriously debilitating" means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration and that causes significant long-term morbidity.

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(b) "Life-threatening" means a disease or condition as to which the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome and as to which the end point of clinical intervention is survival.

(c) "Off-label" means the use of a drug for clinical indications other than those stated in the labeling approved by the United States Food and Drug Administration.

History: Add. 2002, Act 538, Eff. Jan. 22, 2003;—Am. 2003, Act 88, Eff. Jan. 23, 2004;—Am. 2016, Act 276, Imd. Eff. July 1, 2016
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Popular name: Act 218

500.3406r Coverage for obstetrical and gynecological services by physician or nurse midwife.

Sec. 3406r. (1) As used in this section, "nurse midwife" means an individual licensed as a registered professional nurse under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, who has been issued a specialty certification in the practice of nurse midwifery by the Michigan board of nursing under section 17210 of the public health code, 1978 PA 368, MCL 333.17210.

(2) An insurer that delivers, issues for delivery, or renews in this state a policy of health insurance that provides coverage for obstetrical and gynecological services shall include coverage for obstetrical and gynecological services whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification or shall do 1 or both of the following:

(a) Offer to provide coverage for obstetrical and gynecological services whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification.

(b) Offer to provide coverage for maternity services and gynecological services rendered during pre- and post-natal care whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification.

History: Add. 2004, Act 375, Imd. Eff. Oct. 11, 2004;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406s Diagnosis and treatment of autism spectrum disorders; coverage; prohibition; availability of other benefits; conditions; qualified health plan offered through American health benefit exchange pursuant to federal law; short-term or 1-time limited duration policy or certificate; prescription drug plan; coordinated benefits; definitions.

Sec. 3406s. (1) Except as otherwise provided in this section, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall provide coverage for the diagnosis of autism spectrum disorders and treatment of autism spectrum disorders. An insurer shall not do any of the following:

(a) Terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage solely because an individual is diagnosed with, or has received treatment for, an autism spectrum disorder.

(b) Limit the number of visits an insured or enrollee may use for treatment of autism spectrum disorders covered under this section.

(c) Deny or limit coverage under this section on the basis that treatment is educational or habilitative in nature.

(d) Except as otherwise provided in this subdivision, subject coverage under this section to dollar limits, copays, deductibles, or coinsurance provisions that do not apply to physical illness generally. An insurer may limit coverage under this section for treatment of autism spectrum disorders to an insured or enrollee through 18 years of age and may subject the coverage to a maximum annual benefit as follows:

(*i*) For a covered insured or enrollee through 6 years of age, $50,000.00.

(*ii*) For a covered insured or enrollee from 7 years of age through 12 years of age, $40,000.00.

(*iii*) For a covered insured or enrollee from 13 years of age through 18 years of age, $30,000.00.

(2) This section does not limit benefits that are otherwise available to an insured or enrollee under a policy, contract, or certificate. An insurer shall utilize evidence-based care and managed care cost-containment practices pursuant to the insurer's procedures if the care and practices are consistent with this section. An insurer may subject coverage under this section to other general exclusions and limitations of the policy, contract, or certificate, including, but not limited to, coordination of benefits, affiliated provider requirements, restrictions on services provided by family or household members, utilization review of health care services including review of medical necessity, case management, and other managed care provisions.

(3) If an insured or enrollee is receiving treatment for an autism spectrum disorder, an insurer may, as a condition to providing the coverage under this section, do all of the following:

(a) Require a review of the treatment consistent with current protocols and may require a treatment plan. If requested by the insurer, the cost of treatment review must be borne by the insurer.

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(b) Request the results of the autism diagnostic observation schedule that has been used in the diagnosis of an autism spectrum disorder for the insured or enrollee.

(c) Request that the autism diagnostic observation schedule be performed on the insured or enrollee not more frequently than once every 3 years.

(d) Request that an annual development evaluation be conducted and the results of the annual development evaluation be submitted to the insurer.

(4) A qualified health plan offered through an American health benefit exchange established in this state pursuant to the federal act is not required to provide coverage under this section to the extent that it exceeds coverage that is included in the essential health benefits as required pursuant to the federal act. As used in this subsection, "federal act" means the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152, and any regulations promulgated under those acts.

(5) This section does not apply to a short-term or 1-time limited duration policy or certificate of no longer than 6 months as described in section 2213b.

(6) This section does not require the coverage of prescription drugs and related services unless the insured or enrollee is covered by a prescription drug plan. This section does not require an insurer to provide coverage for autism spectrum disorders to an insured or enrollee under more than 1 of its health insurance policies. If an insured or enrollee has more than 1 health insurance policy that covers autism spectrum disorders, the benefits provided are subject to the limits of this section when coordinating benefits.

(7) As used in this section:

(a) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(b) "Autism diagnostic observation schedule" means the protocol available through Western Psychological Services for diagnosing and assessing autism spectrum disorders or any other standardized diagnostic measure for autism spectrum disorders that is approved by the director, if the director determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

(c) "Autism spectrum disorders" means any of the following pervasive developmental disorders as defined by the Diagnostic and Statistical Manual:

(*i*) Autistic disorder.

(*ii*) Asperger's disorder.

(*iii*) Pervasive developmental disorder not otherwise specified.

(d) "Behavioral health treatment" means evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:

(*i*) Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

(*ii*) Are provided or supervised by a board certified behavior analyst or a licensed psychologist if the services performed are commensurate with the psychologist's formal university training and supervised experience.

(e) "Diagnosis of autism spectrum disorders" means assessments, evaluations, or tests, including the autism diagnostic observation schedule, performed by a licensed physician or a licensed psychologist to diagnose whether an individual has 1 of the autism spectrum disorders.

(f) "Diagnostic and Statistical Manual" means the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or another manual that contains common language and standard criteria for the classification of mental disorders and that is approved by the director, if the director determines that the manual is recognized by the health care industry and the classification of mental disorders is at least as comprehensive as the manual published by the American Psychiatric Association on April 18, 2012.

(g) "Pharmacy care" means medications prescribed by a licensed physician and related services performed by a licensed pharmacist and any health-related services considered medically necessary to determine the need or effectiveness of the medications.

(h) "Psychiatric care" means evidence-based direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(i) "Psychological care" means evidence-based direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

(j) "Therapeutic care" means evidence-based services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or social worker.

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(k) "Treatment of autism spectrum disorders" means evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with 1 of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary:

(*i*) Behavioral health treatment.

(*ii*) Pharmacy care.

(*iii*) Psychiatric care.

(*iv*) Psychological care.

(*v*) Therapeutic care.

(*l*) "Treatment plan" means a written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an autism spectrum disorder is first prescribed or ordered by a licensed physician or licensed psychologist as described in subdivision (k).

History: Add. 2012, Act 100, Imd. Eff. Apr. 18, 2012;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Enacting section 1 of Act 100 of 2012 provides:

"Enacting section 1. This amendatory act applies to policies, certificates, and contracts delivered, executed, issued, amended, adjusted, or renewed in this state, or outside of this state if covering residents of this state, beginning 180 days after the date this amendatory act is enacted into law."

Popular name: Act 218

500.3406t Synchronizing insured's or enrollee's multiple maintenance prescription drugs.

Sec. 3406t. (1) An insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical group or individual policy or certificate that provides prescription drug coverage, or a health maintenance organization that offers a group or individual contract that provides prescription drug coverage, shall provide a program for synchronizing multiple maintenance prescription drugs for an insured or enrollee if both of the following are met:

(a) The insured or enrollee, the insured's or enrollee's physician, and a pharmacist agree that synchronizing the insured's or enrollee's multiple maintenance prescription drugs for the treatment of a chronic long-term care condition is in the best interests of the insured or enrollee for the management or treatment of a chronic long-term care condition.

(b) The insured's or enrollee's multiple maintenance prescription drugs meet all of the following requirements:

(*i*) Are covered by the policy, certificate, or contract described in this section.

(*ii*) Are used for the management and treatment of a chronic long-term care condition and have authorized refills that remain available to the insured or enrollee.

(*iii*) Except as otherwise provided in this subparagraph, are not controlled substances included in schedules 2 to 5 under sections 7214, 7216, 7218, and 7220 of the public health code, 1978 PA 368, MCL 333.7214, 333.7216, 333.7218, and 333.7220. This subparagraph does not apply to anti-epileptic prescription drugs.

(*iv*) Meet all prior authorization requirements specific to the maintenance prescription drugs at the time of the request to synchronize the insured's or enrollee's multiple maintenance prescription drugs.

(*v*) Are of a formulation that can be effectively split over required short fill periods to achieve synchronization.

(*vi*) Do not have quantity limits or dose optimization criteria or requirements that will be violated when synchronizing the insured's or enrollee's multiple maintenance prescription drugs.

(2) An insurer or health maintenance organization described in subsection (1) shall apply a prorated daily cost-sharing rate for maintenance prescription drugs that are dispensed by an in-network pharmacy for the purpose of synchronizing the insured's or enrollee's multiple maintenance prescription drugs.

(3) An insurer or health maintenance organization described in subsection (1) shall not reimburse or pay any dispensing fee that is prorated. The insurer or health maintenance organization shall only pay or reimburse a dispensing fee that is based on each maintenance prescription drug dispensed.

History: Add. 2016, Act 38, Imd. Eff. Mar. 15, 2016.

Compiler's note: Enacting section 1 of Act 38 of 2016 provides:

"Enacting section 1. This amendatory act applies to policies, certificates, and contracts delivered, executed, issued, amended, adjusted, or renewed in this state, or outside of this state if covering residents of this state, beginning 365 days after the date this amendatory act is enacted into law."

Popular name: Act 218

500.3406u Coverage for prescription eyedrops; requirements; "prescriber" defined.

Sec. 3406u. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance

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policy that provides coverage for prescription eyedrops shall not deny coverage for a refill of the prescription if all of the following apply:

(a) For a 30-day supply, the amount of time has passed within which the insured should have used 75% of the dosage units of the drug according to the prescriber's instructions, or 23 days have passed after either of the following:

(*i*) The original date the prescription was distributed to the insured.

(*ii*) The date the most recent refill was distributed to the insured.

(b) The prescriber indicates on the original prescription that additional quantities are needed.

(c) The prescription eye drops prescribed by the prescriber are covered under the health insurance policy.

(2) As used in this section, "prescriber" means that term as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708.

History: Add. 2019, Act 139, Imd. Eff. Dec. 5, 2019.

Compiler's note: Enacting section 1 of Act 139 of 2019 provides:

"Enacting section 1. This amendatory act applies to health insurance policies delivered, executed, issued, amended, adjusted, or renewed in this state, or outside of this state if covering residents of this state, beginning 90 days after the date this amendatory act is enacted into law."

Ninety days after the enactment date of Act 139 of 2019 is March 4, 2020.

Popular name: Act 218

500.3406v Coverage for emergency supply of insulin.

Sec. 3406v. Beginning on the effective date of the amendatory act that added this section, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides coverage for prescription drugs shall provide coverage for any emergency supply of insulin that is covered under an insured's health insurance policy and that is dispensed to the insured by a pharmacist as provided in section 17744f of the public health code, 1978 PA 368, MCL 333.17744f.

History: Add. 2021, Act 37, Imd. Eff. July 1, 2021.

Popular name: Act 218

500.3406w Temporary emergency and early refills for prescription drugs; inapplicable after March 31, 2021.

Sec. 3406w. (1) Beginning on the effective date of the amendatory act that added this section, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides coverage for prescription drugs shall do both of the following:

(a) Provide coverage for an emergency refill of up to a 60-day supply of any covered maintenance prescription drug.

(b) Provide coverage for an early refill of any 30-day or 60-day covered maintenance prescription drug to allow for up to a 90-day supply, without regard to whether the pharmacy is mail order or in person.

(2) This section does not apply after March 31, 2021.

(3) As used in this section:

(a) "Emergency refill" means a refill where, in the pharmacist's professional judgment, failure to refill the prescription may interrupt the patient's ongoing care and have a significant adverse effect on the patient's well-being as provided in section 17713 of the public health code, 1978 PA 368, MCL 333.17713.

(b) "Maintenance prescription drug" means a prescription drug that meets the requirements under section 3406t(1)(b)(*i*) to (*iii*).

History: Add. 2020, Act 322, Imd. Eff. Dec. 29, 2020.

Popular name: Act 218

500.3406x Nonopioid directive form; website.

Sec. 3406x. An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall make available to the insurer's insureds a nonopioid directive form on the insurer's internet website. As used in this section, "nonopioid directive form" means that term as defined in section 9145 of the public health code, 1978 PA 368, MCL 333.9145.

History: Add. 2022, Act 43, Imd. Eff. Mar. 23, 2022.

Compiler's note: Enacting section 1 of Act 43 of 2022 provides:

"Enacting section 1. This amendatory act applies to policies delivered, executed, issued, amended, adjusted, or renewed in this state, or outside of this state if covering residents of this state, after March 31, 2022."

Popular name: Act 218

500.3406y Nonopioid directive form; enrollment.

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Sec. 3406y. An insurer that delivers, issues for delivery, or renews in this state a policy of health insurance shall provide a nonopioid directive form to insureds upon enrollment. As used in this section, "nonopioid directive form" means that term as defined in section 9145 of the public health code, 1978 PA 368, MCL 333.9145.

History: Add. 2022, Act 42, Imd. Eff. Mar. 23, 2022.

Compiler's note: Enacting section 1 of Act 42 of 2022 provides:
"Enacting section 1. This amendatory act applies to policies delivered, executed, issued, amended, adjusted, or renewed in this state, or outside of this state if covering residents of this state, after June 30, 2022."

Popular name: Act 218

500.3406z Essential health benefit coverage; annual and lifetime dollar limits; prohibition; applicability to grandfathered health plan coverage.

Sec. 3406z. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not institute either of the following:

(a) Lifetime limits on the dollar value of essential health benefit coverage under section 3406bb(1).

(b) Annual limits on the dollar value of essential health benefit coverage under section 3406bb(1).

(2) This section does not prevent an insurer from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits to the extent that the limits are otherwise permitted under applicable federal or state law.

(3) This section does not apply to grandfathered health plan coverage, as that term is defined in 45 CFR 147.140, or to a short-term or 1-time limited duration policy or certificate of not longer than 6 months.

History: Add. 2023, Act 159, Eff. Feb. 13, 2024.

Popular name: Act 218

500.3406z[1] Disability insurance policies; discrimination against living donors; prohibition; definitions.

Sec. 3406z. (1) This section applies to disability insurance policies or certificates delivered or issued for delivery after December 31, 2023.

(2) Unless there is an additional actuarial risk, as determined in accordance with sound actuarial principles as well as the individual's actual and reasonably anticipated experience, an insurer shall not do any of the following with respect to a disability insurance policy or certificate based solely on the individual's status as a living donor:

(a) Deny coverage.

(b) Cancel coverage.

(c) Refuse to issue the policy or certificate.

(d) Determine the price or premium for the policy or certificate.

(e) Otherwise vary a term or condition of the policy or certificate.

(3) As used in this section:

(a) "Living donor" means an individual who is not deceased and has donated any of the following:

(*i*) All or part of an organ.

(*ii*) A tissue.

(b) "Organ" means a human kidney, liver, heart, lung, pancreas, esophagus, stomach, or small or large intestine, a portion of the human gastrointestinal tract, or another part of the human body designated by the department by rule.

(c) "Tissue" means a portion of the human body other than an organ, including, but not limited to, an eye, skin, bone, bone marrow, a heart valve, a spermatozoon, an ova, an artery, a vein, a tendon, a ligament, blood, blood derivatives, a pituitary gland, or fluid.

History: Add. 2023, Act 192, Imd. Eff. Nov. 7, 2023.

Compiler's note: Section 3406z, as added by Act 192 of 2023, was compiled as 500.3406z[1] to distinguish it from another section 3406z, deriving from Act 159 of 2023 and pertaining to a prohibition on lifetime and annual dollar limits.

Popular name: Act 218

500.3406aa Third party access; dental provider network; requirements; exceptions; definitions.

Sec. 3406aa. (1) A contracting entity may grant a third party access to a provider network contract, or a provider's dental services or contractual discounts provided under a provider network contract, if both of the following requirements are met:

(a) At the time the provider network contract is entered into or renewed, or when there are material

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modifications to a contract relevant to granting access to a provider network contract to a third party, the contracting entity allows a provider that is part of the carrier's provider network to choose to not participate in third-party access to the provider network contract or to enter into a contract directly with the health insurer that acquired the provider network. If a provider chooses not to participate in third-party access, the contracting entity must not cancel or otherwise end a contractual relationship with the provider. When initially contracting with a provider, a contracting entity must accept a qualified provider if a provider rejects participation in third-party access. This subdivision does not apply to a contracting entity that is not a health insurer or dental carrier. As used in this subdivision, "qualified provider" means a provider who meets the contracting entity's criteria to enter into the provider network.

(b) All of the following are met:

(*i*) The provider network contract specifically states that the contracting entity may enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity, and if the contracting entity is a dental carrier, the provider chose to participate in third-party access at the time the provider network contract was entered into or renewed. If the contracting entity is an insurer, the third-party access provision of a provider network contract must specifically state that the provider network contract grants third-party access to the provider network and, for provider network contracts with dental carriers, that the dentist has the right to choose not to participate in third-party access.

(*ii*) The third party accessing the contract agrees to comply with all of the provider network contract's terms.

(*iii*) The contracting entity identifies, in writing or in electronic form to the provider, all third parties that would have access to the dental services or contractual discounts of the provider network as of the date the contract is entered into or renewed.

(*iv*) The contracting entity identifies all third parties in existence in a list on its website that is updated at least once every 30 days and displays the date the list was last updated.

(*v*) The contracting entity requires a third party to identify the source of the discount on all remittance advices or explanations of payment under which a discount is taken. This subparagraph does not apply to electronic transactions mandated by the health insurance portability and accountability act of 1996, Public Law 104-191.

(*vi*) The contracting entity notifies the third party of the termination of a provider network contract not later than 30 days after the termination date with the contracting entity.

(*vii*) A third party's right to a provider's discounted rate ceases as of the termination date of the provider network contract.

(*viii*) The contracting entity makes available a copy of the provider network contract relied on in the adjudication of a claim to a participating provider within 30 days after a request from the provider.

(2) A provider is not bound by or required to perform dental treatment or services under a provider network contract that has been granted by a contracting entity to a third party if the contracting entity does not meet the requirements under subsection (1).

(3) This section does not apply if any of the following apply:

(a) Access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity. A list identifying each of the contracting entity's affiliates as affiliates must be made available to a provider on the contracting entity's website.

(b) Access to a provider network contract is granted by a dental carrier that retains the responsibility for administering the dental benefit plan in accordance with its applicable provider network contracts, including all fee schedules and processing policies.

(c) A provider network contract for dental services provided to beneficiaries under health care coverage that is established or maintained by a local, state, or federal government including any of the following:

(*i*) Medicaid established under title XIX of the social security act, 42 USC 1396 to 1396w-6.

(*ii*) The state children's health insurance program established under title XXI of the social security act, 42 USC 1397aa to 1397mm.

(*iii*) Medicare advantage as that term is defined in section 3801.

(4) As used in this section:

(a) "Contracting entity" means a person that enters into direct contracts with providers for the delivery of dental services in the ordinary course of business, including a third-party administrator and a dental carrier.

(b) "Dental benefit plan" means a benefits plan that pays or provides dental expense benefits for covered dental services and is delivered or issued for delivery by or through a dental carrier on a stand-alone basis.

(c) "Dental carrier" means a nonprofit dental care corporation or other entity authorized to provide dental

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benefits, or a health benefits plan that includes coverage for dental services.

(d) "Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease. Dental services does not include services delivered by a provider that are billed as medical expenses under a health benefits plan.

(e) "Dentist" means that term as defined in section 2701 of the public health code, 1978 PA 368, MCL 333.2701.

(f) "Provider" means a person that, acting within the scope of licensure or certification, provides dental services or supplies defined by the health benefits or dental benefit plan. Provider does not include a physician organization or physician hospital organization that leases or rents the physician organization's or physician hospital organization's network to a third party.

(g) "Provider network contract" means a contract between a contracting entity and a provider that specifies the rights and responsibilities of the contracting entity and provides for the delivery and payment of dental services to an enrollee.

(h) "Third party" means a person that enters into a contract with a contracting entity or with another third party to gain access to the dental services or contractual discounts of a provider network contract. Third party does not include an employer or other group for whom the dental carrier or contracting entity provides administrative services.

History: Add. 2023, Act 168, Imd. Eff. Oct. 19, 2023.

Popular name: Act 218

500.3406bb Health insurance policy; minimum required coverage; use of in-network and out-of-network providers; use of reasonable medical management techniques; applicability to short-term or 1-time limited duration policies; effective date.

Sec. 3406bb. (1) An insurer that delivers, issues for delivery, or renews in the individual or small group market in this state a health insurance policy shall provide coverage for all of the following:

(a) Ambulatory patient services.

(b) Emergency services.

(c) Hospitalization.

(d) Pregnancy, maternity, and newborn care.

(e) Mental health and substance use disorder services, including behavioral health treatment.

(f) Prescription drugs.

(g) Rehabilitative and habilitative services and devices.

(h) Laboratory services.

(i) Preventive and wellness services and chronic disease management identified by the director as meeting a requirement under this subdivision. Coverage for an item or service is not required under this subdivision unless the item or service is 1 or more of the following:

(*i*) Evidence-based items or services if the United States Preventive Services Task Force has rated the item or service as "A" or "B" for the purposes of its recommendations currently in effect with respect to the individual involved.

(*ii*) An immunization with routine use in children, adolescents, and adults if the Advisory Committee on Immunization Practices of the United States Centers for Disease Control and Prevention has included the immunization for the purposes of its recommendations with respect to the individual involved.

(*iii*) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings if the United States Health Resources and Services Administration has included the care or screening for the purposes of its guidelines.

(*iv*) With respect to women, preventive care and screenings not described in subparagraph (*i*) if the United States Health Resources and Services Administration has included the care or screening for the purposes of its guidelines.

(j) Pediatric services, including oral and vision care. Pediatric oral care, as required under this subdivision, is not required if an insured has dental insurance from another source and provides evidence of the coverage to the insurer.

(2) Except as otherwise allowed under 45 CFR 147.130 (a)(2)(*i*),(*ii*), and (*iii*), an insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not impose any cost-sharing requirements for benefits provided under subsection (1)(i).

(3) Benefits provided under subsection (1) are subject to all requirements applicable to those benefits under this chapter.

(4) This section does not limit the requirements to provide additional benefits under this chapter.

(5) This section does not require an insurer that has a network of providers to provide benefits for items or

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services described in subsection (1) that are delivered by an out-of-network provider or preclude an insurer that has a network of providers from imposing cost-sharing requirements for items or services described in subsection (1) that are delivered by an out-of-network provider. If an insurer does not have in its network a provider who can provide an item or service described in subsection (1), the insurer must cover the item or service when performed by an out-of-network provider, and may not impose cost sharing with respect to the item or service.

(6) This section does not prevent an insurer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in subsection (1) to the extent not specified in the relevant recommendation or guideline. To the extent not specified in a recommendation or guideline, an insurer may rely on the relevant clinical evidence base and established reasonable medical management techniques to determine the frequency, method, treatment, or setting for coverage of a recommended preventive health service.

(7) This section does not require an insurer to cover items of the United States Preventive Services Task Force that have been downgraded to a "D" rating, or any item or service during the plan year that is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service.

(8) This section does not apply to a short-term or 1-time limited duration policy or certificate of not more than 6 months as described in section 2213b, or to a grandfathered plan as that term is defined in 45 CFR 147.140.

(9) Any changes to the items and services required under subsection (1)(i) must take effect for the plan year that begins on or after the date that is 1 year after the date the recommendation or guideline is issued.

History: Add. 2023, Act 160, Eff. Feb. 13, 2024.

Popular name: Act 218

500.3406ee Health insurance policies; individual or small group markets; mandatory levels of coverage; actuarial value; compliance; applicability.

Sec. 3406ee. (1) An insurer that delivers, issues for delivery, or renews in this state in the individual or small group market a health insurance policy shall offer health insurance policies that provide at least 1 of the following levels of coverage:

(a) Coverage designed to provide benefits actuarially equivalent to 60% of the full actuarial value of the benefits provided under the policy.

(b) Coverage designed to provide benefits actuarially equivalent to 70% of the full actuarial value of the benefits provided under the policy.

(c) Coverage designed to provide benefits actuarially equivalent to 80% of the full actuarial value of the benefits provided under the policy.

(d) Coverage designed to provide benefits actuarially equivalent to 90% of the full actuarial value of the benefits provided under the policy.

(2) For plan years beginning after the effective date of the amendatory act that added this section, the allowable variation in the actuarial value of a health insurance policy that does not result in a material difference in the true dollar value of the health insurance policy is the de minimis variation as described in 45 CFR 156.140.

(3) For purposes of determining compliance with subsections (1) to (2), an insurer described in subsection (1) must use the actuarial calculator developed and made available by the federal department of health and human services for the applicable plan year. Subject to subsection (4), if the federal department of health and human services has not developed and made available the calculator, an insurer described in subsection (1) may use the most recently issued calculator. If a health insurance policy's design is not compatible with the calculator, the insurer must submit an actuarial certification from an actuary, who is a member of the American Academy of Actuaries, using 1 of the following methodologies:

(a) Calculate the health insurance policy's actuarial value by:

(*i*) Estimating a fit of its plan design into the parameters of the calculator.

(*ii*) Having the actuary certify that the plan design fits appropriately in accordance with generally accepted actuarial principles and methodologies.

(b) Use the calculator to determine the actuarial value for the health insurance policy provisions that fit within the calculator parameters and have the actuary calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the actuarial value identified by the calculator, for plan design features that deviate substantially from the parameters of the calculator.

(4) The calculation methods described in subsection (3) may include only in-network cost-sharing, including multitier networks.

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(5) This section does not apply to a short-term or 1-time limited duration policy or certificate of not longer than 6 months as described in section 2213b, a grandfathered plan as that term is defined in 45 CFR 147.140, or a catastrophic plan as described in 45 CFR 156.155.

History: Add. 2023, Act 163, Eff. Feb. 13, 2024.

Popular name: Act 218

500.3406ff Financial parity for orally administered, intravenously administered and injected antineoplastic (anticancer) medications.

Sec. 3406ff. (1) A health insurance policy delivered, issued for delivery, or renewed in this state that provides coverage for prescribed orally administered antineoplastic medications and intravenously administered or injected antineoplastic medications must ensure either of the following:

(a) That financial requirements applicable to prescribed orally administered antineoplastic medications are not more restrictive than the financial requirements that apply to intravenously administered or injected antineoplastic medications that are covered by the health insurance policy.

(b) That the co-pay or coinsurance for orally administered antineoplastic medication does not exceed $250.00 per 30-day supply. Beginning January 1, 2026, and each January 1 after that date, the department shall adjust the financial requirement described in this subdivision by an amount determined by the state treasurer that reflects the cumulative annual change in the prescription drug index of the medical care component of the United States Consumer Price Index.

(2) An insurer cannot achieve compliance with this section by increasing cost-sharing requirements, reclassifying benefits with respect to antineoplastic medications, or imposing more restrictive treatment limitations on prescribed orally administered antineoplastic medications or intravenously administered or injected antineoplastic medications covered under a health insurance policy described in subsection (1).

(3) This section does not prohibit an insurer from applying utilization management techniques, including prior authorization, step therapy, limits on quantity dispensed, and days' supply per fill for any administered antineoplastic medication.

(4) As used in this section:

(a) "Antineoplastic medication" means a medication used to kill, slow, or prevent the growth of cancerous cells.

(b) "Cost-sharing requirement" means deductibles, copayments, coinsurance, out-of-pocket expenses, aggregate lifetime limits, and annual limits.

(c) "Treatment limitation" means limits on the frequency of treatment, days of coverage, or other similar limits on the scope or duration of treatment. Treatment limitation does not include the application of utilization management techniques described in subsection (3).

History: Add. 2023, Act 170, Eff. Feb. 13, 2024.

Compiler's note: Enacting section 1 of Act 170 of 2023 provides:

"Enacting section 1. This amendatory act applies to health insurance policies delivered, issued for delivery, or renewed in this state after December 31, 2025."

Popular name: Act 218

***** *500.3406hh.added THIS ADDED SECTION IS EFFECTIVE 91 DAYS AFTER ADJOURNMENT OF THE 2024 REGULAR SESSION SINE DIE* *****

500.3406hh.added Coverage for mental health and substance use disorder services.

Sec. 3406hh. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall provide coverage for mental health and substance use disorder services. All of the following apply to the coverage required under this subsection:

(a) Any financial requirements or quantitative treatment limitations applicable to mental health and substance use disorder benefits in any classification must be no more restrictive than the predominant financial requirements or quantitative treatment limitations applied to substantially all benefits provided for medical/surgical benefits in the same classification and there must be no separate cumulative financial requirements that are applicable only with respect to mental health or substance use disorder benefits.

(b) Except as otherwise provided in subsections (3) and (4), nonquantitative treatment limitations may be imposed on mental health or substance use disorder benefits in any classification only if the processes, strategies, evidentiary standards, or other factors used in developing and applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the same classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in developing and applying the limitation with respect to medical/surgical benefits in the

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same classification.

(c) The insurer may divide its benefits furnished on an outpatient basis into the following subclassifications:

(*i*) Office visits, such as physician visits.

(*ii*) Any other outpatient benefit, such as outpatient surgery, facility charges for day treatment centers, laboratory charges, and other medical items.

(2) Benefits provided under subsection (1) must meet all applicable federal parity requirements, including, but not limited to, 42 USC 300gg-26 and the regulations promulgated under that section. An insurer that meets the federal parity requirements described in this subsection is considered to meet the requirements under subsection (1) if the federal parity requirements are not less stringent than the requirements under subsection (1).

(3) If a health insurance policy provides benefits through multiple tiers of in-network providers, including an in-network tier of preferred providers with more generous cost-sharing to participants than a separate in-network tier of participating providers, the health plan may divide its benefits provided on an in-network basis into subclassifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the requirements for nonquantitative treatment limits and without regard to whether a provider provides services with respect to medical and surgical benefits or mental health or substance use disorder benefits. After the subclassifications are established, the health insurance policy must not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any subclassification that is more restrictive than the predominant financial requirement or treatment limit that applies to substantially all medical and surgical benefits in the subclassification.

(4) If a health insurance policy applies different levels of financial requirements to different tiers of prescription drug benefits that are based on reasonable factors determined in accordance with the requirements for nonquantitative treatment limits and without regard to whether a drug is generally prescribed with respect to medical and surgical benefits or with respect to mental health or substance use disorder benefits, the health plan satisfies the parity requirements of this section with respect to prescription drug benefits. As used in this subsection, "reasonable factors" include cost, efficacy, generic versus brand name drugs, and mail order versus pharmacy pick-up.

(5) As used in this section:

(a) "Classification" means any 1 of the following:

(*i*) Inpatient in-network.

(*ii*) Inpatient out-of-network.

(*iii*) Outpatient in-network.

(*iv*) Outpatient out-of-network.

(*v*) Emergency services.

(*vi*) Prescription drugs.

(b) "Financial requirements" means deductibles, copayments, coinsurance, and out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

(c) "Nonquantitative treatment limitations" means those limitations that are not expressed numerically but otherwise limit the scope or duration of benefits for treatment under a health insurance policy or coverage and includes, but is not limited to, the limitations described under 45 CFR 146.136. Nonquantitative treatment limitations do not include a complete exclusion of all benefits for a certain condition or disorder.

(d) "Predominant" means that term as defined in 45 CFR 146.136.

(e) "Quantitative treatment limitations" includes limitations that are expressed numerically, such as limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment, and includes, but is not limited to, the limitations described under 45 CFR 146.136. Quantitative treatment limitations do not include a complete exclusion of all benefits for a certain condition or disorder.

(f) "Substantially all" means that term as defined in 45 CFR 146.136.

History: Add. 2024, Act 41, Eff. (sine die).

Popular name: Act 218

500.3406ii Prohibition on the limitation or exclusion of benefits based on preexisting condition; exceptions.

Sec. 3406ii. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not limit or exclude coverage for an individual by imposing a preexisting condition exclusion on the individual.

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

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(a) Grandfathered health plan coverage, as that term is defined in 45 CFR 147.140.
(b) Insurance coverage that provides benefits for any of the following:
(*i*) Hospital confinement indemnity.
(*ii*) Disability income.
(*iii*) Accident only.
(*iv*) Long-term care.
(*v*) Medicare supplemental.
(*vi*) Limited benefit health.
(*vii*) Specified disease indemnity.
(*viii*) Sickness or bodily injury, or death by accident, or both.
(*ix*) Retiree-only health insurance coverage.
(*x*) Stand-alone dental plans.
(*xi*) Stand-alone vision plans.
(*xii*) Other limited benefit policies.
(3) As used in this section, "preexisting condition exclusion" means a limitation or exclusion of benefits or a denial of coverage based on the fact that a physical or mental condition was present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care, or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

History: Add. 2023, Act 157, Eff. Feb. 13, 2024.

Popular name: Act 218

500.3407 Entire contract; changes.

Sec. 3407. Except as otherwise provided in this act, an insurer shall include the following provision in a disability insurance policy:

ENTIRE CONTRACT; CHANGES: This policy, including the applicable riders and endorsements; the application for coverage if specified by the insurer; the identification card if specified by the insurer; and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved by an executive officer of the insurer and unless the approval is endorsed on this policy or attached to this policy. An insurance producer does not have authority to change this policy or to waive any of its provisions.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3407a Conduct on behalf of or information provided to insured by health care provider; prohibition or discouragement by disability insurer.

Sec. 3407a. A disability insurer shall not prohibit or discourage a health care provider from advocating on behalf of an insured for appropriate medical treatment options pursuant to the grievance procedure in section 2213 or from discussing with an insured or provider any of the following:
(a) Health care treatments and services.
(b) Quality assurance plans required by law, if applicable.
(c) The financial relationships between the insurer and the health care provider including all of the following as applicable:
(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.
(*ii*) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.
(*iii*) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

History: Add. 1997, Act 66, Imd. Eff. July 15, 1997.

Popular name: Act 218

500.3407b Undergoing genetic testing as condition of issuing, renewing, or continuing policy; disclosure of genetic testing or genetic information; definitions.

Sec. 3407b. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not require an insured or his or her dependent or an asymptomatic applicant for insurance or his or her asymptomatic dependent to do either of the following:
(a) Undergo genetic testing before issuing, renewing, or continuing the policy in this state.
(b) Disclose whether genetic testing has been conducted or the results of genetic testing or genetic

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information.

(2) As used in this section:

(a) "Clinical purposes" includes all of the following:

(*i*) Predicting risk of diseases.

(*ii*) Identifying carriers for single-gene disorders.

(*iii*) Establishing prenatal and clinical diagnosis or prognosis.

(*iv*) Prenatal, newborn, and other carrier screening, as well as testing in high-risk families.

(*v*) Testing for metabolites if undertaken with high probability that an excess or deficiency of the metabolite indicates or suggests the presence of heritable mutations in single genes.

(*vi*) Other testing if the intended purpose is diagnosis of a presymptomatic genetic condition.

(b) "Genetic information" means information about a gene, gene product, or inherited characteristic derived from a genetic test.

(c) "Genetic test" means the analysis of human DNA, RNA, chromosomes, and those proteins and metabolites used to detect heritable or somatic disease-related genotypes or karyotypes for clinical purposes. A genetic test must be generally accepted in the scientific and medical communities as being specifically determinative for the presence, absence, or mutation of a gene or chromosome to qualify under this definition. Genetic test does not include a routine physical examination or a routine analysis, including, but not limited to, a chemical analysis, of body fluids, unless conducted specifically to determine the presence, absence, or mutation of a gene or chromosome.

(d) After December 31, 2017, "insurer" includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

History: Add. 2000, Act 27, Imd. Eff. Mar. 15, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016;—Am. 2017, Act 223, Imd. Eff. Dec. 20, 2017.

Popular name: Act 218

500.3408 Time limit on certain defenses; incontestable policy.

Sec. 3408. (1) An insurer shall include in a disability insurance policy, other than a health insurance policy, a provision that consists of both of the following:

(a) One of the following, as applicable:

(*i*) **TIME LIMIT ON CERTAIN DEFENSES:** After 3 years from the date of issue of this policy, the insurer will not use a misstatement, except a fraudulent misstatement, made by the applicant in the application for the policy to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, beginning after the expiration of the 3-year period. This policy provision does not affect a legal requirement for avoidance of a policy or denial of a claim during the initial 3-year period, and does not limit the application of sections 3432, 3434, 3436, 3438, and 3440 if a misstatement with respect to age or occupation or other insurance is made.

(*ii*) Instead of the provision required under subparagraph (*i*), for a policy that the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, for a policy issued after age 44, for at least 5 years after its date of issue, an insurer may include the following in the policy, under the caption **"INCONTESTABLE":**

After this policy has been in force for a period of 3 years during the lifetime of the insured (excluding any period during which the insured is disabled), it becomes incontestable as to the statements contained in the application.

(b) A claim for a loss incurred or disability, as defined in the policy, beginning after 3 years from the date of issue of this policy will not be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed before the effective date of coverage of this policy.

(2) For the purpose of permitting insurers to use a uniform policy in several states, the insurer may print in the policy form in the provisions required under subsection (1)(a) and (b) the term of "3 years". Notwithstanding any provision of the contract or law to the contrary, the time limits for the defenses described in this section and included in a disability insurance policy, not including a health insurance policy, that is delivered or issued for delivery in this state must not exceed 2 years.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3409 Disability insurance policy; mandatory notices as to cancellation and refund of premium.

Sec. 3409. (1) Except as otherwise provided in this section, an insurer that delivers, issues for delivery, or

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renews in this state a disability insurance policy, other than a policy that provides group or blanket insurance, shall include the following notice, in substance printed or stamped on the front page and made a permanent part of the policy:

Cancellation during first 10 days: During a period of 10 days after the date the policyholder receives this policy, the policyholder may cancel the policy and receive from the insurer a prompt refund of any premium paid for the policy, including a policy fee or other charge, by mailing or otherwise surrendering the policy to the insurer together with a written request for cancellation. If a policyholder or purchaser pursuant to this notice returns the policy or contract to the company or association at its home or branch office or to the agent through whom it was purchased, it is void from the beginning and the parties are in the same position as if no policy or contract had been issued.

Cancellation after 10 days: A policyholder may cancel this policy after the first 10 days after receipt of the policy by giving written notice to the insurer effective upon receipt or on a later date as may be specified in the notice. If this policy is canceled under this paragraph, the insurer will promptly refund to the policyholder the excess of paid premium above the pro rata premium for the expired time. Cancellation under this paragraph is without prejudice to any claim originating before the effective date of cancellation.

(2) An insurer that sells a disability insurance policy through solicitation to a person who is eligible for Medicare shall include the following notice, in substance printed or stamped on the front page and made a permanent part of the policy:

Cancellation during the first 30 days: During a period of 30 days after the date the policyholder receives this policy, the policyholder may cancel the policy and receive from the insurer a prompt refund of any premium paid for the policy, including a policy fee or other charge, by mailing or otherwise surrendering the policy to the insurer together with a written request for cancellation. If a policyholder or purchaser pursuant to this notice returns the policy or contract to the company or association at its home or branch office or to the agent through whom it was purchased, it is void from the beginning and the parties are in the same position as if no policy or contract had been issued.

Cancellation after 30 days: A policyholder may cancel this policy after the first 30 days after receipt of the policy by giving written notice to the insurer effective upon receipt or on a later date as may be specified in the notice. If this policy is canceled under this paragraph, the insurer will promptly refund to the policyholder the excess of paid premium above the pro rata premium for the expired time. Cancellation under this paragraph is without prejudice to any claim originating before the effective date of cancellation.

(3) If a policyholder cancels a disability insurance policy during the first 30 days after receipt of the policy, the policyholder is responsible for claims paid by the insurer that were incurred before the effective date of cancellation.

History: Add. 1978, Act 144, Eff. Aug. 10, 1978;—Am. 1980, Act 329, Imd. Eff. Dec. 19, 1980;—Am. 1990, Act 170, Imd. Eff. July 2, 1990;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

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500.3410 Grace period; provision required.

Sec. 3410. There shall be a provision as follows:

GRACE PERIOD: A grace period of ..... (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy which contains a cancellation provision may add, at the end of the above provision, "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof." A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision, "unless not less than 5 days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted,").

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3411 Reinstatement; provision required.

Sec. 3411. (1) Subject to subsection (2), an insurer shall include the following provision in a disability insurance policy other than a health insurance policy:

REINSTATEMENT: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by an agent duly authorized by the insurer to accept the premium, without requiring in connection with the acceptance of the premium an application for

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reinstatement, is a reinstatement of the policy. However, if the insurer or its agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy is reinstated upon approval of the application by the insurer or, if not approved by the insurer, on the forty-fifth day after the date of the conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application. Under the reinstated policy, the insurer will cover only loss resulting from accidental injury that is sustained after the date of reinstatement and loss due to sickness that begins more than 10 days after that date. In all other respects, the insured and insurer have the same rights under the policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on the policy or attached to the policy in connection with the reinstatement. The insurer will apply any premium accepted in connection with a reinstatement to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

(2) An insurer may omit the last sentence of the provision required under subsection (1) from a policy that the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, for a policy issued after age 44, for at least 5 years after its date of issue.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3412 Notice of claim; provision required.

Sec. 3412. (1) Except as otherwise provided in subsection (2), an insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of a loss covered by the policy, or as soon after the loss as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ..... (insert the location of the office the insurer designates for this purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, is considered notice to the insurer.

(2) For a policy that provides a loss-of-time benefit payable for at least 2 years, an insurer may at its option insert the following between the first and second sentences of the provision required under subsection (1):

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity is payable for at least 2 years, the insured will, at least once in every 6 months after having given notice of claim, give to the insurer notice of continuance of the disability, unless the insured is legally incapacitated. The period of 6 months following any filing of proof by the insured or any payment by the insurer on account of the claim or any denial of liability in whole or in part by the insurer is excluded in applying this provision. Delay in giving the notice required under this provision does not impair the insured's right to any indemnity that would otherwise have accrued during the 6 months preceding the date on which the notice is actually given.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3413 Claim forms; provision required.

Sec. 3413. An insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant the forms that are usually furnished for filing proofs of loss. If the forms are not furnished within 15 days after the giving of the notice, the claimant is considered to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3414 Proofs of loss; provision required.

Sec. 3414. An insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its designated office. Proof of loss for a claim for loss for which this policy provides any periodic payment that is contingent upon continuing loss must be furnished within 90 days after the termination of the period for which the insurer is liable. Proof of loss for a claim for any other loss must be furnished within 90 days after the date of the loss. Failure to furnish the proof within the time required under this provision does not invalidate or reduce the

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claim if it was not reasonably possible to give proof within the time required if the proof is furnished as soon as reasonably possible and, unless the claimant is legally incapacitated, not later than 1 year after the time proof is otherwise required.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3416 Time of payment of claims; provision required.

Sec. 3416. An insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for a loss other than loss for which this policy provides a periodic payment will be paid immediately upon receipt of due written proof of the loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment that must not be less frequently than monthly) and any balance remaining unpaid on the termination of liability will be paid immediately upon receipt of due written proof.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3418 Payment of claims; provision required.

Sec. 3418. (1) Except as otherwise provided in subsection (2), an insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting the payment, which may be prescribed in this policy, and effective at the time of payment. If a designation or provision is not in effect, the indemnity is payable to the estate of the insured. Other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to the beneficiary or to the estate. All other indemnities are payable to the insured.

(2) One or more of the following provisions may be included with the provision required under subsection (1) at the option of the insurer:

(a) If indemnity under this policy is payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay the indemnity, up to an amount that does not exceed $..... (insert an amount that does not exceed $1,000.00), to any relative by blood or connection by marriage of the insured or beneficiary who is determined by the insurer to be equitably entitled to the indemnity. Payment made by the insurer in good faith pursuant to this provision fully discharges the insurer to the extent of the payment.

(b) Subject to any written direction of the insured in the application or otherwise, all or a portion of any indemnities provided by this policy on account of health care services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of the loss, be paid directly to the hospital or person rendering the health care services.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1984, Act 280, Imd. Eff. Dec. 20, 1984;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3420 Physical examinations and autopsy; provision required.

Sec. 3420. An insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense has the right and must be given the opportunity to examine the insured at reasonable times and as frequently as reasonably required during the pendency of a claim under this policy and to make an autopsy in case of death if not forbidden by law.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3422 Legal actions; provision required.

Sec. 3422. An insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

LEGAL ACTIONS: An insured must not bring an action at law or in equity to recover on this policy before the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. An insured must not bring an action at law or in equity after the expiration of 3

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years after the time written proof of loss is required to be furnished.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3424 Change of beneficiary; provision required.

Sec. 3424. (1) Except as otherwise provided in subsection (2), an insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the insured has the right to change the beneficiary under this policy. Consent of a beneficiary is not required to surrender this policy, for the assignment of the policy, to change a beneficiary, or to make any other changes in the policy.

(2) The first clause of the provision required under subsection (1), relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3425 Health insurance policy; coverage for intermediate and outpatient care for substance use disorder required; charges, terms, and conditions; reduction of coverage; deductibles and copayment provisions; definitions.

Sec. 3425. (1) Except as otherwise provided in this subsection, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall provide coverage for intermediate and outpatient care for substance use disorder. This section does not apply to limited classification policies.

(2) Charges, terms, and conditions for the coverage required to be provided under subsection (1) must not be less favorable than the maximum prescribed for any other comparable service.

(3) The insurer shall not reduce the coverage required to be provided under subsection (1) by terms or conditions that apply to other items of coverage in a health insurance policy, group or individual. This subsection does not prohibit an insurer from providing in a health insurance policy deductibles and copayment provisions for coverage for intermediate and outpatient care for substance use disorder.

(4) As used in this section:

(a) "Intermediate care" means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent on or abusing alcohol or drugs:

(*i*) Chemotherapy.

(*ii*) Counseling.

(*iii*) Detoxification services.

(*iv*) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in the treatment plan.

(b) "Limited classification policy" means an accident only policy, a limited accident policy, a travel accident policy, or a specified disease policy.

(c) "Outpatient care" means the use, on both a scheduled and a nonscheduled basis, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent on or abusing alcohol or drugs:

(*i*) Chemotherapy.

(*ii*) Counseling.

(*iii*) Detoxification services.

(*iv*) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in the treatment plan.

(d) "Substance use disorder" means that term as defined in section 100d of the mental health code, 1974 PA 258, MCL 330.1100d.

History: Add. 1980, Act 429, Eff. Jan. 1, 1982;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3426 Offer of wellness coverage by insurer.

Sec. 3426. (1) An insurer that delivers, issues for delivery, or renews in this state a group health insurance policy may offer group wellness coverage. An insurer may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program offered by the employer.

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The employer shall provide evidence of demonstrative maintenance or improvement of the insureds' or enrollees' health behaviors as determined by assessments of agreed-upon health status indicators between the employer and the insurer. Any rebate of premium provided by the insurer is presumed to be appropriate unless credible data demonstrate otherwise, but must not exceed 50% of paid premiums for tobacco cessation programs or 30% of paid premiums for other wellness programs, unless otherwise approved by the director. An insurer shall make available to employers all wellness coverage plans that the insurer markets to employers in this state.

(2) An insurer that delivers, issues for delivery, or renews in this state an individual or family health insurance policy may offer individual and family wellness coverage. An insurer may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program approved by the insurer. The insured or enrollee shall provide evidence of demonstrative maintenance or improvement of the individual's or family's health behaviors as determined by assessments of agreed-upon health status indicators between the insured and the insurer. Any rebate of premium provided by the insurer is presumed to be appropriate unless credible data demonstrate otherwise, but must not exceed 50% of paid premiums, unless otherwise approved by the director. An insurer shall make available to individuals and families all wellness coverage plans that the insurer markets to individuals and families in this state.

(3) An insurer is not required to continue any health behavior wellness, maintenance, or improvement program or to continue any incentive associated with a health behavior wellness, maintenance, or improvement program.

(4) A health behavior wellness, maintenance, or improvement program under this section may include other requirements in addition to those that are specific to health behavior wellness, maintenance, or improvement, if the program, taken as a whole, meets the intent of this section.

History: Add. 2006, Act 412, Eff. Mar. 30, 2007;—Am. 2013, Act 5, Imd. Eff. Mar. 18, 2013;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Enacting section 2 of Act 412 of 2006 provides:

"Enacting section 2. It is only the intent of this amendatory act to promote the availability of health behavior wellness, maintenance, and improvement programs."

Popular name: Act 218

500.3428 Provider network.

Sec. 3428. An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall establish and maintain a provider network that, at a minimum, satisfies any network adequacy requirements imposed by the director under federal law.

History: Add. 2013, Act 5, Imd. Eff. Mar. 18, 2013;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3430 Optional policy provisions; insurance commissioner's approval.

Sec. 3430. Except as provided in subsection (2) of section 3406 (inapplicable or inconsistent provisions), no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth in sections 3432 through 3454 unless such provisions are in the words in which the same appear in such sections: Provided, however, That the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in the pertinent section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3432 Change of occupation; optional provision.

Sec. 3432. An insurer may include in a disability insurance policy, other than a health insurance policy, a provision as follows:

CHANGE OF OCCUPATION: If the insured is injured or contracts an illness after changing his or her occupation to 1 classified by the insurer as more hazardous than the occupation stated in this policy or while doing for compensation anything pertaining to an occupation classified as more hazardous, the insurer will pay only the portion of the indemnities provided in this policy that the premium paid would have purchased at the rates and within the limits fixed by the insurer for the more hazardous occupation. If the insured changes

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his or her occupation to 1 classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of the change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of the proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates must be those that were last filed by the insurer before the occurrence of the loss for which the insurer is liable or before the date of proof of change in the occupation with the state official that supervises insurance in the state where the insured resided at the time this policy was issued. However, if that filing was not required in that state, the classification of occupational risk and the premium rates must be those last made effective by the insurer in that state before the occurrence of the loss or before the date of proof of change in the occupation.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3434 Misstatement of age; optional provision.

Sec. 3434. There may be a provision as follows:

MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3436 Other insurance with same insurer; optional provision.

Sec. 3436. There may be a provision as follows:

OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ..... (insert type of coverage or coverages) in excess of $..... (insert maximum limit of indemnity or indemnities), the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

Or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3438 Insurance with other insurers; optional provision; expense incurred benefits.

Sec. 3438. (1) An insurer may include in an individual disability insurance policy a provision as follows:

INSURANCE WITH OTHER INSURERS: If this insurer has not been given written notice before the occurrence or commencement of loss that the insured under this policy has other valid coverage, not with this insurer, and that other valid coverage provides benefits for the same loss on a provision of service basis or on an expense incurred basis, the only liability under any expense incurred coverage of this policy is for the proportion of the loss as the amount that would otherwise have been payable under this policy plus the total of the like amounts under all other valid coverages for the loss of which this insurer had notice bears to the total like amounts under all valid coverages for the loss, and for the return of the portion of the premium paid that exceeds the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the term "like amount" means with respect to the other coverage the amount that the services rendered would have cost in the absence of the coverage.

(2) If the policy provision described in subsection (1) is included in an individual policy of disability insurance that also contains the policy provision described in section 3440, the insurer shall add to the caption of the policy provision the phrase **"—EXPENSE INCURRED BENEFITS"**. The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the director, which definition must be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, to coverage provided by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the director. In the absence of a definition, the term must not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations, by union welfare plans, or by employer or employee benefit organizations.

(3) For the purpose of applying the policy provision under this section to any insured, any amount of benefit provided for the insured under a compulsory benefit statute, including a worker's disability

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compensation or employer's liability statute, whether provided by a governmental agency or other entity, must in all cases be considered to be other valid coverage of which the insurer has had notice. In applying the policy provision under this section, an insurer shall not include third party liability coverage as other valid coverage.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3439 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to provisions concerning insurance with other insurers.

Popular name: Act 218

500.3440 Insurance with other insurers; other benefits.

Sec. 3440. (1) An insurer may include in an individual disability insurance policy a provision as follows:

INSURANCE WITH OTHER INSURERS: If this insurer has not been given written notice before the occurrence or commencement of loss that the insured under this policy has other valid coverage, not with this insurer, and that other valid coverage provides benefits for the same loss on other than an expense incurred basis, the only liability for the benefits under this policy is for the proportion of the indemnities otherwise provided under this policy for the loss as the like indemnities of which the insurer had notice, including the indemnities under this policy, bear to the total amount of all like indemnities for the loss, and for the return of the portion of the premium paid that exceeds the pro rata portion for the indemnities determined under this provision.

(2) If the policy provision described in subsection (1) is included in an individual policy of disability insurance that also contains the policy provision described in section 3438, the insurer shall add to the caption of the policy provision the phrase **"—OTHER BENEFITS"**. The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the director, which definition must be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which is approved by the director. In the absence of a definition, the term must not include group insurance or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the policy provision with respect to any insured, any amount of benefit provided for the insured under any compulsory benefit statute, including worker's disability compensation or employer's liability statute, whether provided by a governmental agency or other entity, must in all cases be considered to be "other valid coverage" of which the insurer has had notice, unless the policy contains provisions for the reduction of benefits otherwise payable under the policy by the amount of income from other sources that the insured or the insured's dependents are qualified to receive because of the insured's age or disability from worker's disability compensation or federal social security, if at the time the policy was issued, the premium had been appropriately reduced to reflect the anticipated reduction in benefits. In applying the policy provision, an insurer shall not include third party liability coverage as other valid coverage.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1987, Act 52, Imd. Eff. June 22, 1987;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Section 2 of Act 52 of 1987 provides:

"The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act apply to all insurance policies issued on or after January 1, 1957 that were either approved by the commissioner on or after January 1, 1957 or subject to an order of the commissioner exempting policies from filing on or after September 1, 1968. The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act are intended to codify and approve long-standing administrative and commercial practice taken and approved by the commissioner pursuant to his or her legal authority. This amendatory act shall serve to cure and clarify any misinterpretation of the operation of such sections since the effective date of their original enactment. It is the intent of this amendatory act to rectify the misconstruction of the insurance code of 1956 by the court of appeals in Bill v Northwestern National Life Insurance Company 143 Mich App 766 with respect to the power of the insurance commissioner to exempt certain insurance documents from filing requirements and the offsetting of social security benefits against disability income insurance benefits. This amendatory act does not affect the relationship between disability insurance benefits and personal protection insurance benefits as provided in Federal Kemper v Health Insurance Administration Inc. 424 Mich 537."

Popular name: Act 218

500.3444 Relation of earnings to insurance; optional provision.

Sec. 3444. There may be a provision as follows:

RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a

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weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of 2 years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such 2 years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200.00 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time. (The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50, or (2) in the case of a policy issued after age 44, for at least 5 years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.)

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3446 Unpaid premium; optional provision.

Sec. 3446. There may be a provision as follows:

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3448 Cancellation; optional provision.

Sec. 3448. There may be a provision as follows:

CANCELLATION: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to the insured, stating when, not less than 5 days thereafter, the cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on a later date as may be specified in the notice. In the event of cancellation, the insurer may retain the pro rata premium for the expired time or $25.00, whichever is greater. Cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1987, Act 168, Imd. Eff. Nov. 9, 1987;—Am. 1990, Act 170, Imd. Eff. July 2, 1990.

Popular name: Act 218

500.3450 Conformity with state statutes; optional provision.

Sec. 3450. There may be a provision as follows:

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3452 Illegal occupation or criminal activity; optional provision; definitions.

Sec. 3452. (1) An insurer may include in a disability insurance policy a provision as follows:

ILLEGAL OCCUPATION OR CRIMINAL ACTIVITY: The insurer is not liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation or other willful criminal activity.

(2) As used in this section:

(a) "Willful criminal activity" includes, but is not limited to, any of the following:

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(*i*) Operating a vehicle while intoxicated in violation of section 625 of the Michigan vehicle code, 1949 PA 300, MCL 257.625, or similar law in a jurisdiction outside of this state.

(*ii*) Operating a methamphetamine laboratory. As used in this subdivision, "methamphetamine laboratory" means that term as defined in section 1 of 2006 PA 255, MCL 333.26371.

(b) "Willful criminal activity" does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3454 Repealed. 1980, Act 429, Eff. Mar. 31, 1981.

Compiler's note: The repealed section pertained to intoxicants and narcotics.

Popular name: Act 218

500.3460 Order of certain policy provisions.

Sec. 3460. The provisions which are the subject of sections 3406 through 3454, or any corresponding provisions which are used in lieu thereof in accordance with such sections, shall be printed in the consecutive order of the provisions in such sections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3462 Third party ownership of policy.

Sec. 3462. The word "insured", as used in this chapter, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3464 Foreign or alien insurers; provision required by other state law; domestic insurers; provision required by other state or country.

Sec. 3464. (1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this chapter and which is prescribed or required by the law of the state under which the insurer is organized.

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3466 Filing procedure; insurance commissioner, regulatory powers.

Sec. 3466. The commissioner may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to this chapter as are necessary, proper or advisable to the administration of this chapter. This provision shall not abridge any other authority granted the commissioner by law.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3468 Provisions violating code; construction of noncomplying policies and provisions.

Sec. 3468. (1) No policy provision which is not subject to sections 3406 through 3454 shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this chapter.

(2) A policy delivered or issued for delivery to any person in this state in violation of this insurance code shall be held valid but shall be construed as provided in this code. When any provision in a policy subject to this chapter is in conflict with any provision of this chapter, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of this chapter.

History: 1956, Act 218, Eff. Jan. 1, 1957.

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Popular name: Act 218

500.3470 Age of insured; provision regulations.

Sec. 3470. If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3471 Provision and nondisclosure of large employer group claims utilization and cost information; civil liability immunity; definitions.

Sec. 3471. (1) On request of a large employer group, an insurer shall provide the large employer group with claims utilization and cost information as provided in subsection (3) on presentation of a signed nondisclosure agreement to the insurer. In signing the nondisclosure agreement described in this subsection, the large employer group shall agree to keep confidential all information received under this section other than the information required to be disclosed under subsection (6).

(2) A large employer group that is part of a combined large employer group must be provided with claims utilization and cost information as provided in subsection (3)(a) that is aggregated for all the employees enrolled in the combined large employer group, and the information must not be separated out for any of those employers included in the combined large employer group.

(3) An insurer in this state shall compile, and shall make available to a large employer group in an electronic, spreadsheet-compatible format, complete and accurate claims utilization and cost information for the medical benefit plan in the aggregate and for each large employer group entitled to that information under subsection (1) or (2) and each subgroup of employees of the large employer group if the subgroup has 100 or more employees covered by the medical benefit plan, as follows:

(a) Incurred and paid claims data for the employee group covered by the medical benefit plan, including at least all of the following:

(*i*) For a plan that provides medical benefits, information concerning hospital and medical claims under the plan, presented in a manner that clearly shows all of the following:

(A) Number and total expenditures for inpatient claims for each month.

(B) Number and total expenditures for outpatient claims for each month.

(C) Number and total expenditures for all other medical claims for equipment, devices, and services, including services rendered in the private office of a physician or other health professional, for each month.

(D) The tax identification number or national provider identifier of each provider rendering service or care.

(*ii*) For a plan that provides prescription drug benefits, information concerning prescription drug claims under the plan, presented in a manner that clearly shows all of the following:

(A) Amount paid for prescription drug claims for each month.

(B) Amount paid for brand prescription drug claims for each month.

(C) Amount paid for generic prescription drug claims for each month.

(D) Amount paid for specialty prescription drug claims for each month.

(E) The 50 prescription drugs for which claims were most frequently paid.

(F) The 50 prescription drugs for which expenditures were the largest.

(*iii*) For a plan that provides medical or prescription drug benefits, in addition to the information required under subparagraphs (*i*) and (*ii*), as applicable, information concerning covered individuals with total medical or prescription drug claims, or both, exceeding $25,000.00 for any 12-month period for which claims utilization and cost information are provided, presented in a manner that clearly shows all of the following separately for each covered individual:

(A) Total medical expenditures for the individual.

(B) Total prescription drug expenditures for the individual.

(C) Whether the covered individual is currently covered by the medical benefit plan.

(D) The covered individual's diagnoses.

(*iv*) Fees and administrative expenses for the most recent experience year, reported separately for medical and prescription drug plans, and presented in a manner that clearly shows at least all of the following:

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(A) The dollar amounts paid for specific and aggregate stop-loss insurance.

(B) The dollar amount of administrative expenses incurred or paid, reported separately for medical and pharmacy.

(C) The total dollar amount of retentions and other expenses.

(D) The dollar amount for all service fees paid.

(*v*) The dollar amount of any fees or commissions paid to agents, consultants, third party administrators, or brokers by the medical benefit plan or by any large employer group or carrier participating in or providing services to the medical benefit plan, reported separately for medical, prescription drug, and stop-loss.

(*vi*) For medical and prescription drug plans, a benefit summary for the current year's plan and, if benefits have changed during any of the 2 most recent 12-month periods for which claims utilization and cost information are provided, a brief benefit summary for each of those periods for which the benefits were different.

(b) A census of all covered employees, including all of the following:

(*i*) Year of birth of each employee.

(*ii*) Gender of each employee.

(*iii*) Zip code in which each employee resides.

(*iv*) The contract coverage type for each employee, such as single, 2-person, or family, and number of individuals covered by contract.

(*v*) For each month, the total number of covered employees and the number of covered employees in each contract coverage type.

(*vi*) For each month, the total number of covered individuals and the number of covered individuals in each contract coverage type.

(*vii*) For a plan that provides prescription drug benefits, information concerning enrollment and prescription drugs claims under the plan, presented in a manner that clearly shows all of the following:

(A) For each month, the total number of covered employees and the number of covered employees in each contract coverage type.

(B) For each month, the total number of covered individuals and the number of covered individuals in each contract coverage type.

(C) Other information as required by the director.

(4) Except as otherwise provided in subsection (3) and subject to subsection (5), claims utilization and cost information required to be compiled under this section must be compiled at the request of a large employer group. The large employer group may not request claims utilization and cost information more than once per calendar year. Claims utilization and cost information compiled on the request of a large employer group must be compiled within 30 days after the request.

(5) Claims utilization and cost information compiled under this section must cover a relevant period. For purposes of this subsection, "relevant period" means the 24-month period ending not more than 60 days before the compilation of the information for the medical benefit plan under consideration. However, if the medical benefit plan has been in effect for less than 24 months, the relevant period is that shorter period.

(6) A large employer group or combined large employer group shall disclose the claims utilization and cost information required to be provided under subsections (2) and (3) to any carrier or administrator it solicits to provide benefits or administrative services for its medical benefit plan. A large employer group or combined large employer group shall make the claims utilization and cost information required under this section available within 30 days after the request. In addition, a large employer group or combined large employer group may disclose the claims utilization and costs information required to be provided under subsections (2) and (3) to any carrier or administrator who requests the opportunity to submit a proposal to provide benefits or administrative services for the medical benefit plan during the request for bids or proposals.

(7) On request of a large employer group or combined large employer group, an insurer shall provide the tax identification number or national provider identifier of each provider rendering service or care on presentation of a signed nondisclosure agreement to the insurer.

(8) The claims utilization and cost information required to be produced under subsection (3) must include only health information as permitted under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164, and must not include any protected health information as defined in the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.

(9) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides information in response to a request from a large employer group under this section is immune from civil liability for complying with the request and for the acts or omissions of any person's subsequent use of the data or information.

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(10) As used in this section:

(a) "Carrier" means any of the following:

(*i*) An insurer that offers a medical benefit plan.

(*ii*) An employee welfare benefit plan as that term is defined in section 7001.

(*iii*) A person operating a system of health care delivery and financing under section 3573.

(*iv*) A voluntary employees' beneficiary association described in section 501(c)(9) of the internal revenue code of 1986, 26 USC 501.

(b) "Combined large employer group" means either of the following:

(*i*) Two or more employers that are in an arrangement and together have 100 or more employees in medical benefit plans or have a signed letter of intent to enter together 100 or more employees into medical benefit plans.

(*ii*) A medical benefit plan in which the employees of 2 or more employers are enrolled.

(c) "Covered individual" means an employee covered under a medical benefit plan.

(d) "Full-time employees" means the term as used in section 3701.

(e) "Large employer group" means an employer that is issued a policy by a carrier under this chapter with enrollment of 100 or more full-time employees.

(f) "Medical benefit plan" means a plan, established and maintained by a large employer group, that provides for the payment of medical benefits, including, but not limited to, hospital and physician services, prescription drugs, and related benefits, to its employees. Medical benefit plan does not include either of the following:

(*i*) A medical benefit plan as defined in section 3 of the public employees health benefit act, 2007 PA 106, MCL 124.73, that is required to compile and make available claims utilization and cost information under section 15 of the public employees health benefit act, 2007 PA 106, MCL 124.85.

(*ii*) A plan that covers only a specified accident, accident only, credit, dental, disability income, long-term care, or vision benefits.

(g) "National provider identifier" means that term as described in 45 CFR part 162.

(h) "Provider" means provider of services as that term is defined in 42 USC 1395x.

(i) "Specialty prescription drug" means a prescription drug used to treat a rare, complex, or chronic medical condition that meets any of the following requirements:

(*i*) Requires special administration including, but not limited to, inhalation or infusion.

(*ii*) Requires special delivery or special storage.

(*iii*) Requires special oversight, intensive monitoring, or care coordination with a person licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

History: Add. 2022, Act 119, Eff. Sept. 22, 2022.

Popular name: Act 218

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500.3472 Open enrollment period; prohibitions; establishment of reasonable periods for health insurance policies; minimum standards for frequency and duration of open enrollment periods; denial of coverage.

Sec. 3472. (1) During an applicable open enrollment period, an insurer that offers, delivers, issues for delivery, or renews in this state a health insurance policy shall not deny or condition the issuance or effectiveness of the policy and shall not discriminate in the pricing of the policy on the basis of health status, claims experience, receipt of health care, or medical condition.

(2) Subject to prior approval of the director, an insurer shall establish reasonable open enrollment periods for all health insurance policies offered, delivered, issued for delivery, or renewed in this state.

(3) The director shall establish minimum standards for the frequency and duration of open enrollment periods established under subsection (2). The director shall uniformly apply the minimum standards for the frequency and duration of open enrollment periods established under this subsection to all insurers.

(4) Subject to approval by the director, an insurer may deny health insurance coverage in the group or individual market if the insurer does not have the network capacity or financial reserves necessary to offer additional coverage. An insurer described in this subsection shall act uniformly with regard to all employers or individuals in the group or individual market. An insurer described in this subsection shall act without regard to the claims experience of an individual or employer and its employees and the employee's dependents and without regard to any health-status-related factor relating to the individual or employer and its employees and the employee's dependents.

(5) Subject to approval by the director, an insurer that denies health insurance coverage to an employer or individual under subsection (4) shall not offer coverage in the group or individual market, as applicable, before the later of the one hundred eighty-first day after the date the insurer denies the coverage or the date

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the insurer demonstrates to the director that the insurer has sufficient network capacity or financial reserves, as applicable, to underwrite additional coverage.

(6) Subject to approval by the director, subsection (4) does not limit the insurer's ability to renew coverage already in force or relieve the insurer of the responsibility to renew the coverage.

(7) The director may provide for the application of subsection (4) on a service-area-specific basis for health maintenance organizations.

History: Add. 2013, Act 5, Imd. Eff. Mar. 18, 2013;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3474 Risk classification; rates; filing requirements.

Sec. 3474. No policy of insurance against loss or expense from the sickness, or from the bodily injury or death from accident of the insured, nor any application, rider or endorsement to be used in connection therewith, shall be delivered or issued for delivery to any person in this state, until the classification of risks and any premium rates pertaining thereto have been filed with the department of insurance.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3474a Premium rate after January 1, 2014; basis; factors.

Sec. 3474a. The premium rate charged by an insurer, health maintenance organization, or nonprofit health care corporation for health insurance coverage offered through a policy or certificate delivered, issued for delivery, or renewed in this state on or after January 1, 2014 in the individual or small group market shall vary based on the following factors only:

(a) Whether the policy or certificate covers an individual or family.

(b) The rating area.

(c) Age, except that the premium rate shall not vary by more than 3 to 1 for adults for all plans other than child-only plans.

(d) Tobacco use, except that the premium rate shall not vary by more than 1.5 to 1.

History: Add. 2013, Act 5, Imd. Eff. Mar. 18, 2013.

Popular name: Act 218

500.3475 Reimbursement for services by licensed psychologist, podiatrist, or chiropractor; section inapplicable to policy involving prudent purchaser agreement.

Sec. 3475. (1) Notwithstanding any provision of a disability insurance policy, if the disability insurance policy provides for reimbursement for any service that is legally performed by a person fully licensed as a psychologist under part 182 of the public health code, 1978 PA 368, MCL 333.18201 to 333.18237; by a podiatrist licensed under part 180 of the public health code, 1978 PA 368, MCL 333.18001 to 333.18058; or by a chiropractor licensed under part 164 of the public health code, 1978 PA 368, MCL 333.16401 to 333.16431, the insurer shall not deny reimbursement under the insurance policy if the service is rendered by a person fully licensed as a psychologist under part 182 of the public health code, 1978 PA 368, MCL 333.18201 to 333.18237; by a podiatrist licensed under part 180 of the public health code, 1978 PA 368, MCL 333.18001 to 333.18058; or by a chiropractor licensed under part 164 of the public health code, 1978 PA 368, MCL 333.16401 to 333.16431, within the statutory provisions provided in his or her individual practice act.

(2) This section does not require coverage for a psychologist in an insurance policy. This section does not require coverage or reimbursement for any of the following:

(a) A practice of chiropractic service unless the service was included in the definition of practice of chiropractic under section 16401 of the public health code, 1978 PA 368, MCL 333.16401, as of January 1, 2009.

(b) A service provided by a physical therapist or physical therapist assistant unless the service was provided by a licensed physical therapist or physical therapist assistant under the supervision of a licensed physical therapist pursuant to a prescription from a health care professional who holds a license issued under part 166, 170, 175, or 180 of the public health code, 1978 PA 368, MCL 333.16601 to 333.16648, 333.17001 to 333.17084, 333.17501 to 333.17556, and 333.18001 to 333.18058, or the equivalent license issued by another state.

(3) This section does not apply to a policy written under section 3405 that involves a prudent purchaser agreement.

History: Add. 1963, Act 56, Eff. Sept. 6, 1963;—Am. 1966, Act 92, Imd. Eff. June 15, 1966;—Am. 1968, Act 182, Eff. Nov. 15, 1968;—Am. 1984, Act 280, Imd. Eff. Dec. 20, 1984;—Am. 2009, Act 227, Imd. Eff. Jan. 5, 2010;—Am. 2014, Act 263, Imd. Eff. July 1,

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2014;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

****** 500.3476 THIS SECTION IS AMENDED EFFECTIVE 91 DAYS AFTER ADJOURNMENT OF THE 2024 REGULAR SESSION SINE DIE: See 500.3476.amended ******

500.3476 Telemedicine services; provisions; definitions.

Sec. 3476. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the insurer. Telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located. Telemedicine services are subject to all terms and conditions of the health insurance policy agreed upon between the policy holder and the insurer, including, but not limited to, required copayments, coinsurances, deductibles, and approved amounts.

(2) As used in this section:

(a) After December 31, 2017, "insurer" includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

(b) "Telemedicine" means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine under this section, the health care professional must be able to examine the patient via a health insurance portability and accountability act of 1996, Public Law 104-191 compliant, secure interactive audio or video, or both, telecommunications system, or through the use of store and forward online messaging.

History: Add. 2012, Act 215, Imd. Eff. June 28, 2012;—Am. 2016, Act 276, Imd. Eff. July 1, 2016;—Am. 2017, Act 223, Imd. Eff. Dec. 20, 2017;—Am. 2020, Act 97, Imd. Eff. June 24, 2020.

Popular name: Act 218

****** 500.3476.amended THIS AMENDED SECTION IS EFFECTIVE 91 DAYS AFTER ADJOURNMENT OF THE 2024 REGULAR SESSION SINE DIE ******

500.3476.amended Telemedicine services; provisions; definitions.

Sec. 3476. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the insurer. An insurer described in this subsection shall not require a health care professional to provide services for a patient through telemedicine unless the services are contractually required per the terms of a contract between the insurer and an affiliated provider or a third-party vendor for telemedicine first or telemedicine-only products, and clinically appropriate as determined by the health care professional. Telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in the health care professional's health care profession in the state where the patient is located. Telemedicine services are subject to all terms and conditions of the health insurance policy agreed on between the policy holder and the insurer, including, but not limited to, required copayments, coinsurances, deductibles, and approved amounts. If a service is provided through telemedicine under this section, the insurer shall provide at least the same coverage for that service as if the service involved face-to-face contact between the health care professional and the patient.

(2) As used in this section:

(a) After December 31, 2017, "insurer" includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

(b) "Telemedicine" means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine under this section, the health care professional must be able to examine the patient via a health insurance portability and accountability act of 1996, Public Law 104-191, compliant, secure interactive audio or video, or both, telecommunications system, or through the use of store and forward online messaging.

History: Add. 2012, Act 215, Imd. Eff. June 28, 2012;—Am. 2016, Act 276, Imd. Eff. July 1, 2016;—Am. 2017, Act 223, Imd. Eff. Dec. 20, 2017;—Am. 2020, Act 97, Imd. Eff. June 24, 2020;—Am. 2024, Act 51, Eff. (sine die);—Am. 2024, Act 52, Eff. (sine die).

Compiler's note: Enacting section 1 of Act 52 of 2024 provides:

"Enacting section 1. Section 3476 of the insurance code of 1956, 1956 PA 218, MCL 500.3476, as amended by this amendatory act, applies to health insurance policies delivered, executed, issued, amended, adjusted, or renewed in this state, or outside of this state if covering residents of this state, beginning on the effective date of this amendatory act."

Popular name: Act 218

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500.3477 Use of financial incentive or payment to act as inducement to deny, reduce, limit, or delay services; prohibition; exception.

Sec. 3477. (1) An insurer shall not use any financial incentive or make any payment to a health professional that acts directly or indirectly as an inducement to deny, reduce, limit, or delay specific medically necessary and appropriate services.

(2) Subsection (1) does not prohibit payment arrangements that are not tied to specific medical decisions or prohibit the use of risk sharing as otherwise authorized in this chapter.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3480 Repealed. 1963, Act 127, Eff. Sept. 6, 1963.

Compiler's note: The section imposed penalties for violation of disability insurance provisions.

Popular name: Act 218

CHAPTER 35
HEALTH MAINTENANCE ORGANIZATIONS

500.3501 Definitions.

Sec. 3501. As used in this chapter:

(a) "Affiliated provider" means a health professional, licensed hospital, licensed pharmacy, or any other institution, organization, or person that has entered into a participating provider contract, directly or indirectly, with a health maintenance organization to render 1 or more health services to an enrollee. Affiliated provider includes a person described in this subdivision that has entered into a written arrangement with another person, including, but not limited to, a physician hospital organization or physician organization, that contracts directly with a health maintenance organization.

(b) "Basic health services" means medically necessary health services that health maintenance organizations must offer to large employers in at least 1 health maintenance contract. Basic health services include all of the following:

(*i*) Physician services including primary care and specialty care.

(*ii*) Ambulatory services.

(*iii*) Inpatient hospital services.

(*iv*) Emergency health services.

(*v*) Mental health and substance use disorder services.

(*vi*) Diagnostic laboratory and diagnostic and therapeutic radiological services.

(*vii*) Home health services.

(*viii*) Preventive health services.

(c) "Credentialing verification" means the process of obtaining and verifying information about a health professional and evaluating the health professional when the health professional applies to become a participating provider with a health maintenance organization.

(d) "Health maintenance contract" means a contract between a health maintenance organization and a subscriber or group of subscribers to provide or arrange for the provision of health services within the health maintenance organization's service area. Health maintenance contract includes a prudent purchaser agreement under section 3405.

(e) "Health maintenance organization" means a person that, among other things, does the following:

(*i*) Delivers health services that are medically necessary to enrollees under the terms of its health maintenance contract, directly or through contracts with affiliated providers, in exchange for a fixed prepaid sum or per capita prepayment, without regard to the frequency, extent, or kind of health services.

(*ii*) Is responsible for the availability, accessibility, and quality of the health services provided.

(f) "Health professional" means an individual licensed, certified, or authorized in accordance with state law to practice a health profession in his or her respective state.

(g) "Health services" means services provided to enrollees of a health maintenance organization under their health maintenance contract.

(h) "Service area" means a defined geographical area in which covered health services are generally available and readily accessible to enrollees and where health maintenance organizations may market their contracts.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

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500.3503 Applicability of provisions to health maintenance organization.

Sec. 3503. (1) Unless specifically excluded, or otherwise specifically provided for in this chapter, all of the provisions of this act that apply to a domestic insurer authorized to issue a health insurance policy apply to a health maintenance organization.

(2) Sections 408, 410, 411, and 901, and chapters 77 and 79 do not apply to a health maintenance organization.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2006, Act 366, Imd. Eff. Sept. 18, 2006;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3505 Health maintenance contract; use of descriptive words; restrictions.

Sec. 3505. (1) A health maintenance organization shall not issue a health maintenance contract before it receives a certificate of authority under this act.

(2) A person shall not use the term health maintenance organization to describe or refer to a person, and a person shall not use any other descriptive words that may mislead, deceive, or imply that it is a health maintenance organization, unless the person described or referred to has a certificate of authority as a health maintenance organization under this act.

(3) Except as otherwise provided in this subsection, a health maintenance organization shall not use in its name, contracts, or literature the words "insurance", "casualty", "surety", or "mutual" or any other words descriptive of an insurance, casualty, or surety business or deceptively similar to the name or description of an insurance or surety corporation doing business in this state. A health maintenance organization may use a name or description that is similar to its affiliate.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3507 Authorizing and regulating health maintenance organization; establishment of system by director.

Sec. 3507. The director shall establish a system of authorizing and regulating health maintenance organizations in this state to protect and promote the public health through the assurance that the organizations provide all of the following:

(a) An acceptable quality of health care by qualified personnel.

(b) Health care facilities, equipment, and personnel that may reasonably be required to economically provide health services.

(c) Operational arrangements that integrate the delivery of various services.

(d) Financially sound prepayment plans for meeting health care costs.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3508 Quality assessment program; quality improvement program.

Sec. 3508. (1) A health maintenance organization shall develop and maintain a quality assessment program that includes, at a minimum, systematic collection, analysis, and reporting of relevant data in accordance with statutory and regulatory requirements.

(2) A health maintenance organization shall establish and maintain a quality improvement program to design, measure, assess, and improve the processes and outcomes of health care as identified in the program. A health maintenance organization shall place the quality improvement program under the direction of its medical director and include all of the following in the program:

(a) A written statement of the program's objectives, lines of authority and accountability, evaluation tools, including data collection responsibilities, and performance improvement activities.

(b) An annual effectiveness review of the program.

(c) A written quality improvement plan that, at a minimum, describes how the health maintenance organization analyzes both the processes and outcomes of care, identifies the targeted diagnoses and treatments to be reviewed each year, uses a range of appropriate methods to analyze quality, compares program findings with past performance and internal goals and external standards, measures the performance

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of affiliated providers, and conducts peer review activities.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3509 Certificate of authority; application; form; limitation; change of service area.

Sec. 3509. (1) An application to the director for a certificate of authority must be on a form prescribed and provided by the director.

(2) A certificate of authority issued to a health maintenance organization under this act is limited to the service area described in the application on which the certificate of authority was issued. Approved parts of a health maintenance organization's service area are not required to be contiguous.

(3) A health maintenance organization seeking to change the approved service area shall submit an application to change service area to the director and shall not change the service area until approval is received. The director shall specify the information required to be in the application under this subsection.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3511 Governing body; election of enrollee board members; requirements; meetings.

Sec. 3511. (1) A health maintenance organization's governing body must include no less than 1 individual who represents the health maintenance organization's membership.

(2) A health maintenance organization that is under a contract with this state to provide medical services authorized under subchapter XIX or XXI of the social security act, 42 USC 1396 to 1396w-5 and 1397aa to 1397mm, shall comply with either of the following requirements:

(a) A minimum of 1/3 of its governing body must be representatives of its membership consisting of enrollees of the organization who are not compensated officers, employees, or other individuals responsible for the conduct of, or financially interested in, the organization's affairs.

(b) The health maintenance organization must establish a consumer advisory council that reports to the governing body. The consumer advisory council must include at least 1 enrollee, 1 family member or legal guardian of an enrollee, and 1 consumer advocate.

(3) A health maintenance organization's governing body shall meet at least quarterly unless specifically exempted from this requirement by the director.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3513 Health maintenance organization operations; regulation by director; incorporation as legal entity.

Sec. 3513. (1) The director shall regulate health delivery aspects of health maintenance organization operations to ensure that health maintenance organizations are capable of providing care and services promptly, appropriately, and in a manner that ensures continuity and acceptable quality of health care. The director shall encourage health maintenance organizations to use a wide variety of health-related disciplines and facilities and to develop services that contribute to the prevention of disease and disability and the restoration of health.

(2) The director shall ensure that health maintenance organizations operate in the interest of enrollees consistent with overall health care cost containment while delivering acceptable quality of care and services that are available and accessible to enrollees with appropriate administrative costs and health care provider incentives. A health maintenance organization shall do all of the following:

(a) Provide, as promptly as appropriate, health services in a manner that ensures continuity and imparts quality health care under conditions the director considers to be in the public interest.

(b) Provide health services within its service area that are available and accessible to enrollees 24 hours a day and 7 days a week for the treatment of emergency episodes of illness or injury.

(c) Provide that reasonable provisions exist for an enrollee to obtain emergency health services both within and outside of its service area.

(3) A health maintenance organization must be incorporated as a distinct legal entity under the business corporation act, 1972 PA 284, MCL 450.1101 to 450.2098, the nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192, or the Michigan limited liability company act, 1993 PA 23, MCL 450.4101 to

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450.5200.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3515 Additional health services; deductibles; copayments; "preventive health care services" defined; partial payment from government or private person.

Sec. 3515. (1) A health maintenance organization may provide additional health services or any other related health care service or treatment not required under this act.

(2) A health maintenance organization may have health maintenance contracts with deductibles. A health maintenance organization may have health maintenance contracts that include copayments, stated as dollar amounts for the cost of covered services, and coinsurance, stated as percentages for the cost of covered services. This subsection does not limit the director's authority to regulate and establish fair, sound, and reasonable copayment and coinsurance limits including out of pocket maximums.

(3) A health maintenance organization shall not require that contributions be made to a deductible for preventive health care services. As used in this subsection, "preventive health care services" means services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness, or disability.

(4) A health maintenance organization may accept from governmental agencies and from private persons payments covering any part of the cost of health maintenance contracts.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2002, Act 621, Imd. Eff. Dec. 23, 2002;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005;—Am. 2016, Act 97, Eff. Aug. 1, 2016;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3517 Healthy lifestyle programs; emergency or out-of-area service; payment of expenses or fees.

Sec. 3517. (1) A health maintenance contract shall not provide for payment of cash or other material benefit to an enrollee other than as permitted under the law of this state or as approved by the director under section 2236.

(2) Subsection (1) does not prohibit a health maintenance organization from promoting optimum health by offering to all currently enrolled subscribers or to all currently covered enrollees 1 or more healthy lifestyle programs. As used in this subsection, "healthy lifestyle program" means a program recognized by a health maintenance organization that enhances health, educates enrollees on health-related matters, or reduces risk of disease, including, but not limited to, promoting nutrition and physical exercise and compliance with disease management programs and preventive service guidelines that are supported by evidence-based medical practice. A healthy lifestyle program may include other requirements in addition to those that enhance health, educate enrollees on health-related matters, or reduce risk of disease if the healthy lifestyle program, taken as a whole, meets the intent of this subsection. Subsection (1) does not prohibit a health maintenance organization from offering a currently enrolled subscriber or currently covered enrollee goods, vouchers, or equipment that supports achieving optimal health goals. An offering of goods, vouchers, or equipment under this subsection is not a violation of subsection (1) and is not valuable consideration, a material benefit, a gift, a rebate, or an inducement under this act.

(3) For an emergency episode of illness or injury that requires immediate treatment before it can be secured through the health maintenance organization, or for an out-of-area service specifically authorized by the health maintenance organization, an enrollee may use a provider in or outside of this state not normally engaged by the health maintenance organization to render service to its enrollees. The health maintenance organization shall pay reasonable expenses or fees to the provider or enrollee as appropriate in an individual case. These transactions are not acts of insurance and, except as provided in this chapter and section 3406k, are not otherwise subject to this act.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3519 Contract and contract rates; fairness; rate differential; basic health services to large employers required.

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Sec. 3519. (1) A health maintenance organization contract and the contract's rates, including any deductibles, copayments, and coinsurances, between the organization and its subscribers must be fair, sound, and reasonable in relation to the services provided, and the procedures for offering and terminating contracts must not be unfairly discriminatory.

(2) A health maintenance organization contract and the contract's rates must not discriminate on the basis of race, color, creed, national origin, residence within the approved service area of the health maintenance organization, lawful occupation, sex, handicap, or marital status, except that marital status may be used to classify individuals or risks for the purpose of insuring family units. The director may approve a rate differential based on sex, age, residence, disability, marital status, or lawful occupation, if the differential is supported by sound actuarial principles, a reasonable classification system, and is related to the actual and credible loss statistics or reasonably anticipated experience for new coverages. A healthy lifestyle program as defined in section 3517(2) is not subject to the director's approval under this subsection and is not required to be supported by sound actuarial principles, a reasonable classification system, or be related to actual and credible loss statistics or reasonably anticipated experience for new coverages.

(3) A health maintenance organization contract shall offer basic health services to large employers in at least 1 health maintenance contract.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2002, Act 621, Imd. Eff. Dec. 23, 2002;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3521 Prepayment rates; filing and approval of methodology; schedule.

Sec. 3521. (1) The methodology used to determine prepayment rates by category rates charged by the health maintenance organization and any changes to either the methodology or the rates shall be filed with and approved by the commissioner before becoming effective.

(2) A health maintenance organization shall submit supporting data used in the development of a prepayment rate or rating methodology and all other data sufficient to establish the financial soundness of the prepayment plan or rating methodology.

(3) The commissioner may annually require a schedule of rates for all subscriber contracts and riders. All submissions shall note changes of rates previously filed or approved.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

500.3523 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to provisions included in health maintenance contract.

Popular name: Act 218

Popular name: HMO

500.3525 Proposal to revise contract or rate; approval of commissioner; approval with modifications; hearing; disposition; exception; notice.

Sec. 3525. (1) Except as otherwise provided in subsection (2), if a health maintenance organization desires to change a contract it offers to enrollees or desires to change a rate charged, a copy of the proposed revised contract or rate shall be filed with the commissioner and shall not take effect until 60 days after the filing, unless the commissioner approves the change in writing before the expiration of 60 days after the filing. If the commissioner considers that the proposed revised contract or rate is illegal or unreasonable in relation to the services provided, the commissioner, not more than 60 days after the proposed revised contract or rate is filed, shall notify the organization in writing, specifying the reasons for disapproval or for approval with modifications. For an approval with modifications, the notice shall specify what modifications in the filing are required for approval, the reasons for the modifications, and that the filing becomes effective after the modifications are made and approved by the commissioner. The commissioner shall schedule a hearing not more than 30 days after receipt of a written request from the health maintenance organization, and the revised contract or rate shall not take effect until approved by the commissioner after the hearing. Within 30 days after the hearing, the commissioner shall notify the organization in writing of the disposition of the proposed revised contract or rate, together with the commissioner's findings of fact and conclusions.

(2) If the revised contract or rate is the result of collective bargaining and affects only the members of the groups engaged in the collective bargaining, subsection (1) does not apply but the revised contract or rate shall be immediately filed with the commissioner.

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(3) Except as provided in this subsection with respect to health maintenance contracts issued in connection with state and federal health programs under section 3571, not less than 30 days before the effective date of a proposed change in a health maintenance contract or the rate charged, the health maintenance organization shall issue to each subscriber or group of subscribers who will be affected by the proposed change a clear written statement stating the extent and nature of the proposed change. With respect to health maintenance contracts issued in connection with state and federal health programs under section 3571, advance notice is not required if the change in a health maintenance contract or rate arises from a change in the law, a state or federal administrative order, or an executive order and the change does not provide for a reasonable period of time for a health maintenance organization to give the required notice. In that case, the health maintenance organization shall provide notice within 30 days after the effective date of the change. If the commissioner has approved a proposed change in a contract or rate in writing before the expiration of 60 days after the date of filing, the organization immediately shall notify each subscriber or group of subscribers who will be affected by the proposed change.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2010, Act 172, Imd. Eff. Sept. 30, 2010.

Popular name: Act 218

Popular name: HMO

500.3527 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to performance of obligations under health maintenance contract.

Popular name: Act 218

Popular name: HMO

500.3528 Health maintenance organization; credentialing verification; accreditation by nationally recognized accredited body.

Sec. 3528. (1) A health maintenance organization shall establish written policies and procedures for credentialing verification of all health professionals with whom the health maintenance organization contracts. A health maintenance organization shall apply these standards consistently. This act does not require a health maintenance organization to select a provider as an affiliated provider solely because the provider meets the health maintenance organization's credentialing verification standards. This act does not prevent a health maintenance organization from using separate or additional criteria in selecting the health professionals with whom it contracts.

(2) A health maintenance organization is considered to meet the requirements of this section if the health maintenance organization is accredited by a nationally recognized accredited body approved by the director. As used in this subsection, "nationally recognized accredited body" includes the National Committee for Quality Assurance.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 621, Imd. Eff. Dec. 23, 2002;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3529 Affiliated provider contracts; collection of payments from enrollees; contract provisions; waiver of requirement under subsection (2); contract format; evidence of sufficient number of providers.

Sec. 3529. (1) A health maintenance organization may contract with or employ health professionals on the basis of cost, quality, availability of services to the membership, conformity to the administrative procedures of the health maintenance organization, and other factors relevant to delivery of economical, quality care, but shall not discriminate solely on the basis of the class of health professionals to which the health professional belongs.

(2) A health maintenance organization shall enter into contracts with providers through which health care services are usually provided to enrollees under the health maintenance organization plan.

(3) An affiliated provider contract shall prohibit the provider from seeking payment from the enrollee for services provided pursuant to the provider contract, except that the contract may allow affiliated providers to collect copayments, coinsurances, and deductibles directly from enrollees.

(4) An affiliated provider contract shall contain provisions assuring all of the following:

(a) The provider meets applicable licensure or certification requirements.

(b) Appropriate access by the health maintenance organization to records or reports concerning services to its enrollees.

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(c) The provider cooperates with the health maintenance organization's quality assurance activities.

(5) The commissioner may waive the contract requirement under subsection (2) if a health maintenance organization has demonstrated that it is unable to obtain a contract and accessibility to patient care would not be compromised. When 10% or more of a health maintenance organization's elective inpatient admissions, or projected admissions for a new health maintenance organization, occur in hospitals with which the health maintenance organization does not have contracts or agreements that protect enrollees from liability for authorized admissions and services, the health maintenance organization may be required to maintain a hospital reserve fund equal to 3 months' projected claims from such hospitals.

(6) A health maintenance organization shall submit to the commissioner for approval standard contract formats proposed for use with its affiliated providers and any substantive changes to those contracts. The contract format or change is considered approved 30 days after filing unless approved or disapproved within the 30 days. As used in this subsection, "substantive changes to contract formats" means a change to a provider contract that alters the method of payment to a provider, alters the risk assumed by each party to the contract, or affects a provision required by law.

(7) A health maintenance organization or applicant shall provide evidence that it has employed, or has executed affiliation contracts with, a sufficient number of providers to enable it to deliver the health maintenance services it proposes to offer.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005.

Popular name: Act 218

Popular name: HMO

500.3530 Availability of covered services; assurance; establishment and maintenance of proximity.

Sec. 3530. (1) A health maintenance organization shall maintain contracts with those numbers and those types of affiliated providers that are sufficient to assure that covered services are available to its enrollees without unreasonable delay. The commissioner shall determine what is sufficient as provided in this section and as may be established by reference to reasonable criteria used by the health maintenance organization, including, but not limited to, provider-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

(2) If a health maintenance organization has an insufficient number or type of participating providers to provide a covered benefit, the health maintenance organization shall ensure that the enrollee obtains the covered benefit at no greater cost to the enrollee than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the commissioner.

(3) A health maintenance organization shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of enrollees. In determining whether a health maintenance organization has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers in the service area.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

500.3531 Contracts with health care providers to become affiliated providers; requirements; standards; filing; duplicative standards; notice procedures; provider application period; approval or rejection as affiliated provider; termination of contract; providing information to insurer.

Sec. 3531. (1) This section applies if a health maintenance organization contracts with health care providers to become affiliated providers or offers a prudent purchaser contract.

(2) A health maintenance organization may enter into a contract with 1 or more health care providers to control health care costs, assure appropriate utilization of health maintenance services, and maintain quality of health care. The health maintenance organization may limit the number of contracts entered into under this section if the number of contracts is sufficient to assure reasonable levels of access to health maintenance services for recipients of those services. The number of contracts authorized by this section that are necessary to assure reasonable levels of access to health maintenance services for recipients shall be determined by the health maintenance organization as approved by the commissioner under this chapter. However, the health

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maintenance organization shall offer a contract, comparable to those contracts entered into with other affiliated providers, to at least 1 health care provider that provides the applicable health maintenance services and is located within a reasonable distance from the recipients of those health maintenance services, if a health care provider that provides the applicable health maintenance services is located within that reasonable distance.

(3) A health maintenance organization shall give all health care providers that provide the applicable health maintenance services and are located in the geographic area served by the health maintenance organization an opportunity to apply to the health maintenance organization to become an affiliated provider.

(4) A contract shall be based upon the following written standards which shall be filed by the health maintenance organization with the commissioner on a form and in a manner that is uniformly developed and applied by the commissioner:

(a) Standards for maintaining quality health care.

(b) Standards for controlling health care costs.

(c) Standards for assuring appropriate utilization of health care services.

(d) Standards for assuring reasonable levels of access to health care services.

(e) Other standards considered appropriate by the health maintenance organization.

(5) If the commissioner determines that standards under subsection (4) are duplicative of standards already filed by the health maintenance organization, those duplicative standards need not be filed under subsection (4).

(6) A health maintenance organization shall develop and institute procedures that are designed to notify health care providers that provide the applicable health maintenance services and are located in the geographic area served by the organization of the acceptance of applications for a provider panel. The procedures shall include the giving of notice to those providers upon request and shall include publication in a newspaper with general circulation in the geographic area served by the organization at least 30 days before the initial provider application period.

(7) A health maintenance organization shall provide for an initial 60-day provider application period during which providers may apply to the health maintenance organization to become affiliated providers. A health maintenance organization that has entered into a contract with an affiliated provider shall provide, at least once every 4 years, for a 60-day provider application period during which a provider may apply to the organization to become an affiliated provider. Notice of this provider application period shall be given to providers upon request and shall be published in a newspaper with general circulation in the geographic area served by the organization at least 30 days before the commencement of the provider application period. Upon receipt of a request by a health care provider, the organization shall provide the written standards required under this chapter to the health care provider. Within 90 days after the close of a provider application period, or within 30 days following the completion of the applicable physician credentialing process, whichever is later, a health maintenance organization shall notify an applicant in writing as to whether the application to become an affiliated provider has been accepted or rejected. If an applicant has been rejected, the health maintenance organization shall state in writing the reasons for rejection, citing 1 or more of the standards.

(8) A health care provider whose contract as an affiliated provider is terminated shall be provided upon request with a written explanation by the organization of the reasons for the termination.

(9) A health maintenance organization that is providing prudent purchaser agreement services to an insurer shall provide the insurer on a timely basis with information requested by the insurer that the organization has and that the insurer needs to comply with section 2212.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

500.3533 Prudent purchaser contracts; reimbursement for unauthorized services or services by nonaffiliated providers.

Sec. 3533. Subject to section 3405, a health maintenance organization may offer prudent purchaser contracts to groups or individuals and in conjunction with those contracts a health maintenance organization may pay or may reimburse enrollees, or may contract with another person to pay or reimburse enrollees, for unauthorized services or for services by nonaffiliated providers in accordance with the terms of the contract and subject to copayments, coinsurances, deductibles, or other financial penalties designed to encourage enrollees to obtain services from affiliated providers.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

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Popular name: Act 218

Popular name: HMO

500.3535 Solicitation or advertising.

Sec. 3535. Solicitation of enrollees or advertising of the services, charges, or other nonprofessional aspects of the health maintenance organization's operation under this section is not in violation of laws relating to solicitation or advertising by health professionals. A health maintenance organization shall not, in its solicitation or advertising allowed under this section, include advertising that makes a qualitative judgment as to a health professional who provides services for the health maintenance organization. A health maintenance organization shall not, in its solicitation or advertising allowed under this section, offer a material benefit or other thing of value as an inducement to prospective subscribers other than the services of the health maintenance organization.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3537 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to open enrollment period for health maintenance organizations.

Popular name: Act 218

Popular name: HMO

500.3539 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to exclusions and limitations contained in nongroup contract and renewal requirements.

Popular name: Act 218

Popular name: HMO

500.3541 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to health professional advocating on behalf of enrollee.

Popular name: Act 218

Popular name: HMO

500.3542 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to prohibition against use of financial inducement or payment to health professional.

Popular name: Act 218

Popular name: HMO

500.3543 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to owning or investing in third party administrator.

Popular name: Act 218

Popular name: HMO

500.3544 Noninsured benefit plan; processing and payment of claims.

Sec. 3544. (1) A health maintenance organization may process and pay claims on behalf of a noninsured benefit plan only after the health maintenance organization has received adequate money from the noninsured benefit plan sponsor to fully cover the claim payments.

(2) As used in this section, "noninsured benefit plan" means that term as defined in section 5208.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3545 Acquisition of obligations from another managed care entity.

Sec. 3545. With the director's prior approval, a health maintenance organization may acquire obligations from another managed care entity. The director shall not grant prior approval unless the director determines that the transaction will not jeopardize the health maintenance organization's financial security.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

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500.3547 Health care service operations; visitation or examination by director; consultation with enrollees; authority; access to information relating to delivery of services; submission of information regarding proposed contract.

Sec. 3547. (1) The director at any time may visit or examine the health care service operations of a health maintenance organization and consult with enrollees to the extent necessary to carry out the intent of this act.

(2) The director has the authority granted under chapter 2 with regard to a health maintenance organization under this chapter.

(3) A health maintenance organization shall give the director access to all information of the health maintenance organization relating to the delivery of health services, including, but not limited to books, papers, computer databases, and documents, in a manner that preserves the confidentiality of the health records of individual enrollees.

(4) At the request of the director, a health maintenance organization shall submit information regarding a proposed contract between the health maintenance organization and an affiliated provider that the director considers necessary to ensure that the contract is in compliance with this act.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3548 Maintenance of books, records, files, and financial records; funds and assets.

Sec. 3548. (1) A health maintenance organization shall keep all of its books, records, and files at or under the control of its principal place of doing business in this state, and shall keep a record of all of its securities, notes, mortgages, or other evidences of indebtedness, representing investment of funds at its principal place of doing business in this state in the same manner as provided for in section 5256.

(2) A health maintenance organization shall maintain financial records for its health maintenance activities separate from the financial records of any other operation or activity.

(3) A health maintenance organization shall hold and maintain legal title to all assets, including cash and investments. A health maintenance organization shall not commingle funds or assets in pooling or cash management type arrangements with affiliates or other persons. A health maintenance organization shall hold all of its assets separate from all other activities of other members in a holding company system.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3549 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to notice to appropriate board by health maintenance organization as to disciplinary action.

Popular name: Act 218

Popular name: HMO

500.3551 Health maintenance organization; net worth.

Sec. 3551. (1) A health maintenance organization shall determine its minimum net worth using accounting procedures approved by the director. The accounting procedures must ensure that a health maintenance organization is financially and actuarially sound.

(2) To obtain or maintain a certificate of authority in this state, a health maintenance organization shall possess and maintain unimpaired net worth in an amount determined adequate by the director to continue to comply with section 403 but not in an amount less than the following, as applicable:

(a) For a health maintenance organization that contracts with or employs providers in numbers sufficient to provide 90% of the health maintenance organization's benefit payout, minimum net worth is the greatest of the following:

(*i*) $1,500,000.00.

(*ii*) Four percent of the health maintenance organization's subscription revenue.

(*iii*) Three months' uncovered expenditures.

(b) For a health maintenance organization that does not contract with or employ providers in numbers sufficient to provide 90% of the health maintenance organization's benefit payout, minimum net worth is the greatest of the following:

(*i*) $3,000,000.00.

(*ii*) Ten percent of the health maintenance organization's subscription revenue.

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(*iii*) Three months' uncovered expenditures.

(3) The director shall take into account the risk-based capital requirements as developed by the National Association of Insurance Commissioners in order to determine adequate compliance with section 403 under this section.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3553 Certificate of authority; deposit requirements.

Sec. 3553. (1) To obtain or maintain a certificate of authority in this state, a health maintenance organization shall possess and maintain a deposit in an amount determined adequate by the director to continue to comply with section 403 but not less than $100,000.00 plus 5% of annual subscription revenue up to a $1,000,000.00 maximum deposit.

(2) A health maintenance organization shall make the deposit required under subsection (1) with the state treasurer or with a federal or state chartered financial institution under a trust indenture acceptable to the director for the sole benefit of the subscribers and enrollees in case of insolvency.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3555 Financial plan.

Sec. 3555. A health maintenance organization shall maintain a financial plan evaluating, at a minimum, cash flow needs and adequacy of working capital. The plan under this subsection must do all of the following:

(a) Demonstrate compliance with all health maintenance organization financial requirements provided for in this act.

(b) Provide for adequate working capital, which must not be negative at any time. The director may establish a minimum working capital requirement for a health maintenance organization to ensure the prompt payment of liabilities.

(c) Identify the means of achieving and maintaining a positive cash flow, including provisions for retirement of existing or proposed indebtedness.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3557 Notice of changes in operations.

Sec. 3557. A health maintenance organization shall file notice with the director of any substantive changes in operations within 30 days after the substantive change in operations occurs. A substantive change in operations includes, but is not limited to, any of the following:

(a) A change in the health maintenance organization's officers or directors. In addition to the notification, the health maintenance organization shall file a disclosure statement on a form prescribed by the director for each newly appointed or elected officer or director.

(b) A change in the location of corporate offices.

(c) A change in the organization's articles of incorporation or bylaws. A health maintenance organization shall include a copy of the revised articles of incorporation or bylaws with the notice.

(d) A change in contractual arrangements under which the health maintenance organization is managed.

(e) Any other significant change in operations.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3559 Reinsurance contract or plan of self-insurance; purpose; filing; approval; coverage.

Sec. 3559. (1) Subject to subsection (2), a health maintenance organization shall obtain a reinsurance contract or establish a plan of self-insurance as necessary to ensure solvency or to protect subscribers in the event of insolvency. A reinsurance contract must be with an insurer that is authorized or eligible to transact insurance in this state.

(2) A health maintenance organization shall file a reinsurance contract or plan under subsection (1) for approval with the director within 30 days after the finalization of the contract or plan. A reinsurance contract

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or plan must clearly state all services to be received by the health maintenance organization. A reinsurance contract or plan is considered approved 30 days after it is filed with the director unless disapproved in writing by the director before the expiration of the 30 days.

(3) A health maintenance organization shall maintain insurance coverage to protect the health maintenance organization that includes, at a minimum, fire, theft, fidelity, general liability, errors and omissions, director's and officer's liability coverage, and malpractice insurance. A health maintenance organization shall obtain the director's prior approval before self-insuring for these coverages.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Enacting section 3 of Act 276 of 2016 provides:

"Enacting section 3. On the effective date of this amendatory act, an insurer may submit to the director of the department of insurance and financial services for approval any modification to policies and certificates that were approved before or on the effective date of this amendatory act, to conform with amendments made to the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, by this amendatory act. This enacting section does not apply to rates and rating methodologies."

Popular name: Act 218

Popular name: HMO

500.3561 Insolvency; continuation of benefits.

Sec. 3561. A health maintenance organization shall have a plan for handling insolvency that allows for continuation of benefits for the duration of the health maintenance contract period for which premiums have been paid and continuation of benefits to any enrollee who is confined on the date of insolvency in an inpatient facility until his or her discharge from the facility. Continuation of benefits in the event of insolvency is satisfied if the health maintenance organization has at least 1 of the following, as approved by the director:

(a) A financial guarantee contract insured by a surety bond issued by an independent insurer with a secure rating from a rating agency that meets the requirements of section 436a(1)(p).

(b) A reinsurance contract issued by an authorized or eligible insurer to cover the expenses to be paid for continued benefits after an insolvency.

(c) A contract between the health maintenance organization and its affiliated providers that provides for the continuation of provider services in the event of the health maintenance organization's insolvency. A health maintenance organization shall include in a contract under this subdivision a mechanism for appropriate sharing by the health maintenance organization of the continuation of provider services as approved by the director and shall not include a provision that continuation of provider services is solely the responsibility of the affiliated providers.

(d) An irrevocable letter of credit.

(e) An insolvency reserve account established with a federal or state chartered financial institution under a trust indenture acceptable to the director for the sole benefit of subscribers and enrollees, equal to 3 months' premium income.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3563 Insolvency; offer of enrollment by health insurers participating in enrollment process; allocation of group coverage to health maintenance organizations or insurers within service area; nongroup coverage; reassignment of enrollees of insolvent organization contracting with state funded health care program; substitute coverage under American health benefit exchange.

Sec. 3563. (1) If a health maintenance organization becomes insolvent, upon the director's order all other health insurers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer the insolvent health maintenance organization's group enrollees a 30-day enrollment period beginning on the date of the director's order. Each health insurer shall offer the insolvent health maintenance organization's enrollees the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(2) If no other health insurer was offered to some groups enrolled in an insolvent health maintenance organization, or if the director determines that the other health insurers lack sufficient health care delivery resources to ensure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, the director shall allocate equitably the insolvent health maintenance organization's group contracts for these groups among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into

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consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are allocated under this subsection shall offer the group or groups the health maintenance organization's existing coverage that is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

(3) The director shall allocate equitably the insolvent health maintenance organization's nongroup enrollees who are unable to obtain other coverage among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated under this subsection shall offer the nongroup enrollees coverage without a preexisting condition limitation for individual coverage as determined by the enrollee's type of coverage in the insolvent health maintenance organization at rates under the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into 1 group for rating and coverage purposes.

(4) If a health maintenance organization that contracts with a state funded health care program becomes insolvent, the director shall inform the state agency responsible for the program of the insolvency. Notwithstanding any other provision of this section to the contrary, enrollees of an insolvent health maintenance organization covered by a state funded health care program may be reassigned under state and federal statutes governing the program.

(5) Notwithstanding any provision of this section to the contrary, an enrollee of an insolvent health maintenance organization who is eligible to obtain coverage as either an individual or a member of a small group under an American health benefit exchange established or operating in this state pursuant to the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152, may obtain substitute coverage through the exchange.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3565 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to cancellation of contract with nongroup member enrollee by nongroup subscriber.

Popular name: Act 218

Popular name: HMO

500.3567 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to cancellation of contract with nongroup member enrollee by health maintenance organization.

Popular name: Act 218

Popular name: HMO

500.3569 Assumption of financial risk.

Sec. 3569. (1) Except as provided in section 3515(2), a health maintenance organization shall assume full financial risk on a prospective basis for the provision of health services under a health maintenance organization contract. A health maintenance organization may do any of the following:

(a) Require an affiliated provider to assume financial risk under the terms of its contract.

(b) Obtain insurance.

(c) Make other arrangements for the cost of providing to an enrollee health services the aggregate value of which is more than $5,000.00 in a year for that enrollee.

(2) If the health maintenance organization requires an affiliated provider to assume financial risk under the terms of its contract, the contract must require both of the following:

(a) The health maintenance organization to pay the affiliated provider, including a subcontracted provider, directly or through a licensed third party administrator for health services provided to its enrollees.

(b) The health maintenance organization to keep all pooled funds and withhold amounts and account for them on its financial books and records and reconcile them at year end pursuant to the contract.

(3) For purposes of this section, a health maintenance organization requires an affiliated provider to assume financial risk if it shares with the affiliated provider, in return for consideration, a portion of the chance of loss, including expenses incurred, related to the delivery of health services to enrollees. The type of transactions under which a health maintenance organization may require an affiliated provider to assume

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financial risk under this section include, but are not limited to, full or partial capitation agreements, withholds, risk corridors, and indemnity agreements.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3571 State or federal health programs.

Sec. 3571. A health maintenance organization that participates in a state or federal health program shall meet the solvency and financial requirements of this act, unless the health maintenance organization is in receivership or under supervision. Notwithstanding any provision of this act to the contrary, a health maintenance organization that participates in a state or federal health program is not required to offer benefits or services that exceed the requirements of the applicable program. This section does not apply to state employee or federal employee health programs.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3573 Operation of health care delivery system not meeting requirements of act; permitted conduct; limitations.

Sec. 3573. (1) A person that proposes to operate a system of health care delivery and financing to be offered to individuals, whether or not as members of groups, in exchange for a fixed payment and to be organized so that providers and the organization are in some part at risk for the cost of services in a manner similar to a health maintenance organization, but that fails to meet the requirements of this act for a health maintenance organization, may operate the system of health care delivery and financing if the director finds that the proposed operation will benefit persons who will be served by it. The director shall authorize and regulate the operation of the system in the same manner as a health maintenance organization under this act, including the filing of periodic reports, except to the extent that the director finds that the regulation is inappropriate to the system of health care delivery and financing.

(2) A person operating a system of health care delivery and financing under this section shall not advertise or solicit or in any way identify itself in a manner implying to the public that it is a health maintenance organization authorized under this act.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3580 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to consumer guide to health maintenance organization.

Popular name: Act 218

Popular name: HMO

CHAPTER 36
GROUP AND BLANKET DISABILITY INSURANCE

500.3600 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to scope of chapter.

Popular name: Act 218

500.3601 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to "group disability insurance" definition.

Popular name: Act 218

500.3601a Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to issuance of group disability policy to trust or trustees.

Popular name: Act 218

500.3602 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to exemption as to worker's compensation insurance.

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Popular name: Act 218

500.3606 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to power to issue group disability insurance and filing and approval of form.

Popular name: Act 218

500.3607 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to replacement group disability insurance policy or certificate with preexisting condition limitation.

Popular name: Act 218

500.3608 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to provisions required in group disability insurance policy.

Popular name: Act 218

500.3609 Repealed. 2016, Act 276, Imd. Eff. July 1 2016.

Compiler's note: Prior to the repeal of MCL 500.3609, this section had expired by its own terms. 1980, Act 429, Eff. Jan. 1, 1982. The expired section pertained to coverage for treatment of alcoholism and drug abuse.

Popular name: Act 218

500.3609a Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to substance abuse provisions contained in group disability insurance policy.

Popular name: Act 218

500.3610 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to mandatory provisions contained in group disability insurance policy.

Popular name: Act 218

500.3610a Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to coordination of benefits.

Popular name: Act 218

500.3611 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to coverage for newly born children.

Popular name: Act 218

500.3612 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to individual conversion policy.

Popular name: Act 218

500.3612a Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to premiums for individual conversion policy.

Popular name: Act 218

500.3613 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to group hospital, medical, or surgical expense incurred policy and mastectomy benefit coverage.

Popular name: Act 218

500.3614 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to coverage for mental health services.

Popular name: Act 218

500.3615 Repealed. 2016, Act 276, Imd Eff. July 1, 2016.

Compiler's note: The repealed section pertained to hospice care coverage.

Popular name: Act 218

500.3616 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to breast cancer coverage.

Popular name: Act 218

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500.3616a Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to coverage for drug used in antineoplastic therapy.

Popular name: Act 218

500.3620 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to family expense insurance.

Popular name: Act 218

500.3630 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to payment under hospital, medical, surgical, and sick-care benefits.

Popular name: Act 218

500.3631 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to prudent purchaser agreements and disability insurance or family expense insurance.

Popular name: Act 218

500.3636 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to blanket disability insurance.

Popular name: Act 218

500.3638 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to power of insurer to issue blanket disability insurance.

Popular name: Act 218

500.3640 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to provisions required in blanket disability insurance policy.

Popular name: Act 218

500.3650 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to application, certificate, and payments relating to blanket disability insurance policy.

Popular name: Act 218

CHAPTER 37
SMALL EMPLOYER GROUP HEALTH COVERAGE

500.3701 Definitions.

Sec. 3701. As used in this chapter:

(a) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or another individual acceptable to the director that a small employer carrier is in compliance with section 3705, based on the individual's examination, including a review of the appropriate records and the actuarial assumptions and methods used by the carrier in establishing premiums for applicable health benefit plans.

(b) "Affiliation period" means a period of time required by a small employer carrier that must expire before health coverage becomes effective.

(c) "Base premium" means the lowest premium charged for a rating period under a rating system by a small employer carrier to small employers for a health benefit plan in a geographic area.

(d) "Carrier" means a person that provides health benefits, coverage, or insurance in this state. For the purposes of this chapter, carrier includes a health insurance company authorized to do business in this state, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health benefits, coverage, or insurance subject to state insurance regulation.

(e) "COBRA" means the consolidated omnibus budget reconciliation act of 1985, Public Law 99-272.

(f) "Commercial carrier" means a small employer carrier other than a health maintenance organization.

(g) "Creditable coverage" means, with respect to an individual, health benefits, coverage, or insurance provided under any of the following:

(*i*) A group health plan.

(*ii*) A health benefit plan.

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(*iii*) Part A or part B of subchapter XVIII of the social security act, 42 USC 1395c to 1395w-6.

(*iv*) Subchapter XIX of the social security act, 42 USC 1396 to 1396w-5, other than coverage consisting solely of benefits under 42 USC 1396t.

(*v*) Chapter 55 of title 10 of the United States Code, 10 USC 1071 to 1110b. For purposes of coverage under chapter 55 of title 10 of the United States Code, 10 USC 1071 to 1110b, "uniformed services" means the armed forces and the commissioned corps of the National Oceanic and Atmospheric Administration and of the Public Health Service.

(*vi*) A medical care program of the Indian Health Service or of a tribal organization.

(*vii*) A state health benefits risk pool.

(*viii*) A health plan offered under chapter 89 of title 5 of the United States Code, 5 USC 8901 to 8914.

(*ix*) A public health plan.

(*x*) A health benefit plan under section 5(e) of title I of the peace corps act, 22 USC 2504.

(h) "Eligible employee" means an employee who works on a full-time basis with a normal workweek of 30 or more hours. Eligible employee includes an employee who works on a full-time basis with a normal workweek of 17.5 to 30 hours, if an employer so chooses and if this eligibility criterion is applied uniformly among all of the employer's employees and without regard to health status-related factors.

(i) "Full-time employees" means the term as calculated in 26 USC 4890h(c)(4), including application of the special rules for determining group size as defined in 26 USC 4980h(c)(2) and the specification that full-time equivalents are treated as full-time employees for purposes of determining group size, as described in 26 USC 4980h(c)(2)(e).

(j) "Geographic area" means an area in this state that includes not less than 1 entire county, is established by a carrier under section 3705, and is used for adjusting premiums for a health benefit plan subject to this chapter. In addition, if the geographic area includes 1 entire county and additional counties or portions of counties, the counties or portions of counties must be contiguous with at least 1 other county or portion of another county in that geographic area.

(k) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of subtitle A of title I of the employee retirement income security act of 1974, Public Law 93-406, 29 USC 1002, to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise. As used in this chapter, all of the following apply to the term group health plan:

(*i*) Any plan, fund, or program that would not be, but for 42 USC 300gg-21(d), an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund, or program, directly or through insurance, reimbursement or otherwise, is, subject to subparagraph (*ii*), an employee welfare benefit plan that is a group health plan.

(*ii*) The term "employer" also includes the partnership in relation to any partner.

(*iii*) The term "participant" also includes an individual who is, or may become, eligible to receive a benefit under the plan, or the individual's beneficiary who is, or may become, eligible to receive a benefit under the plan. For a group health plan maintained by a partnership, the individual is a partner in relation to the partnership and for a group health plan maintained by a self-employed individual, under which 1 or more employees are participants, the individual is the self-employed individual.

(*l*) "Health benefit plan" or "plan" means an expense-incurred hospital, medical, or surgical policy or certificate, or health maintenance organization contract. Health benefit plan does not include accident-only, credit, dental, or disability income insurance; long-term care insurance; coverage issued as a supplement to liability insurance; coverage only for a specified disease or illness; worker's compensation or similar insurance; or automobile medical-payment insurance.

(m) "Index rate" means the arithmetic average during a rating period of the base premium and the highest premium charged per employee for each health benefit plan offered by each small employer carrier to small employers and sole proprietors in a geographic area.

(n) "Premium" means all money paid by a small employer, eligible employees, or eligible persons as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(o) "Public health plan" means a plan established or maintained by a state, county, or other political subdivision of a state that provides health insurance coverage to individuals enrolled in the plan.

(p) "Rating period" means the calendar period for which premiums established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(q) "Small employer" means any person actively engaged in business that, on at least 50% of its working

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days during the preceding and current calendar years, employed not fewer than 2 and not more than 50 eligible employees. Beginning January 1, 2018, "small employer" means any person engaged in business that, during the preceding calendar year, employed an average of at least 1 but not more than 50 full-time employees and who employs at least 1 employee on the first day of the plan year. In determining the number of full-time equivalent employees, persons that are affiliated with each other or that are eligible to file a combined tax return for state taxation purposes are considered 1 employer.

(r) "Small employer carrier" means a carrier that offers health benefit plans covering the employees of a small employer.

(s) "Waiting period" means, with respect to a health benefit plan and an individual who is a potential enrollee in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage under this chapter, a waiting period is not considered as a gap in coverage.

History: Add. 2003, Act 88, Eff. Jan. 23, 2004;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Former Chapter 37 and its contents, MCL 500.3701-500.3728, were repealed by Act 271 of 2001, Imd. Eff. Jan. 11, 2002.

Former Chapter 37 was entitled "GROUP HEALTH INSURANCE FOR PERSONS 65 OR OLDER." Former MCL 500.3701 pertained to purpose of chapter.

Popular name: Act 218

500.3702 Repealed. 2001, Act 271, Imd. Eff. Jan. 11, 2002.

Compiler's note: The repealed section pertained to definitions.

Popular name: Act 218

500.3703 Scope of chapter.

Sec. 3703. (1) This chapter applies to any health benefit plan that provides coverage to 2 or more employees of a small employer.

(2) This chapter does not apply to individual health insurance policies that are subject to policy form and premium approval by the director.

History: Add. 2003, Act 88, Eff. Jan. 23, 2004;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3704 Repealed. 2001, Act 271, Imd. Eff. Jan. 11, 2002.

Compiler's note: The repealed section pertained to joinder of insurers.

Popular name: Act 218

500.3705 Geographic areas; adjustment and determination of premiums; conditions; additional premium; small employer; rating factors.

Sec. 3705. (1) For adjusting premiums for health benefit plans subject to this chapter, a carrier shall use the defined geographic areas established by the director and allowed under federal law.

(2) Premiums for a health benefit plan under this chapter are subject to the following:

(a) For a health maintenance organization, only industry, age, and group size may be used for determining the premiums within a geographic area for a small employer located in the geographic area. For a commercial carrier, only industry, age, group size, and health status may be used for determining the premiums within a geographic area for a small employer located in the geographic area.

(b) For a health benefit plan delivered, issued for delivery, or renewed in this state on or after January 1, 2014, the premiums charged during a rating period to small employers must be determined only by using the rating factors set forth in section 3474a.

(c) The premiums charged during a rating period by a health maintenance organization or commercial carrier for a health benefit plan in a geographic area to small employers located in the geographic area must not vary from the index rate for the health benefit plan by more than 45% of the index rate.

(d) Except as otherwise provided in this section, the percentage increase in the premiums charged to a small employer in a geographic area for a new rating period must not exceed the sum of the annual percentage adjustment in the geographic area's index rate for the health benefit plan and an adjustment under subdivision (a). The adjustment under subdivision (a) must not exceed 15% annually and must be adjusted pro rata for rating periods of less than 1 year. This subdivision does not prohibit an adjustment because of change in coverage.

(3) Beginning January 23, 2005, if a small employer was covered by a self-insured health benefit plan immediately preceding application for a health benefit plan subject to this chapter, a carrier may charge an

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additional premium of up to 33% above the premium in subsection (2)(b) for no more than 2 years.

(4) Health benefit plan options, number of family members covered, and Medicare eligibility may be used in establishing a small employer's premium.

(5) A small employer carrier shall apply all rating factors consistently with respect to all small employers in a geographic area. Except as otherwise provided in subsection (4), a small employer carrier shall bill a small employer group only with a composite rate and shall not bill so that 1 or more employees in a small employer group are charged a higher premium than another employee in the small employer group.

History: Add. 2003, Act 88, Eff. Jan. 23, 2004;—Am. 2013, Act 5, Imd. Eff. Mar. 18, 2013;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3706 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to open enrollment period for small proprietors.

Popular name: Act 218

500.3707 Health benefit plan; marketing; affiliation period.

Sec. 3707. (1) As a condition of transacting business in this state with small employers, every small employer carrier shall make available to small employers all health benefit plans it markets to small employers in this state. A small employer carrier shall be considered to be marketing a health benefit plan if it offers that plan to a small employer not currently receiving a health benefit plan from that small employer carrier. A small employer carrier shall issue any health benefit plan to any small employer that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter.

(2) Except as otherwise provided in this subsection, a small employer carrier shall not offer or sell to small employers a health benefit plan that contains a waiting period applicable to new enrollees or late enrollees. However, a small employer carrier may offer or sell to small employers other than sole proprietors a health benefit plan that provides for an affiliation period of time that must expire before coverage becomes effective for a new enrollee or a late enrollee if all of the following are met:

(a) The affiliation period is applied uniformly to all new and late enrollees and dependents of the new and late enrollees of the small employer and without regard to any health status-related factor.

(b) The affiliation period does not exceed 60 days for new enrollees and does not exceed 90 days for late enrollees.

(c) The small employer carrier does not charge any premiums for the enrollee during the affiliation period.

(d) The coverage issued is not effective for the enrollee during the affiliation period.

History: Add. 2003, Act 88, Eff. Jan. 23, 2004.

Popular name: Act 218

500.3708 Special enrollment period.

Sec. 3708. (1) A health benefit plan offered to a small employer by a small employer carrier shall provide for the acceptance of late enrollees subject to this chapter.

(2) A small employer carrier shall permit an employee or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of the small employer health benefit plan during a special enrollment period if all of the following apply:

(a) The employee or dependent was covered under a group health plan or had coverage under a health benefit plan at the time coverage was previously offered to the employee or dependent.

(b) The employee stated in writing at the time coverage was previously offered that coverage under a group health plan or other health benefit plan was the reason for declining enrollment, but only if the small employer or carrier, if applicable, required such a statement at the time coverage was previously offered and provided notice to the employee of the requirement and the consequences of the requirement at that time.

(c) The employee's or dependent's coverage described in subdivision (a) was either under a COBRA continuation provision and that coverage has been exhausted or was not under a COBRA continuation provision and that other coverage has been terminated as a result of loss of eligibility for coverage, including because of a legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions toward that other coverage have been terminated. In either case, under the terms of the health benefit plan, the employee must request enrollment not later than 30 days after the date of exhaustion of coverage or termination of coverage or employer contribution. If an employee requests enrollment pursuant to this subdivision, the enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

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(3) A small employer carrier that makes dependent coverage available under a health benefit plan shall provide for a dependent special enrollment period during which the person may be enrolled under the health benefit plan as a dependent of the individual or, if not otherwise enrolled, the individual may be enrolled under the health benefit plan. For a birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage. This subsection applies only if both of the following occur:

(a) The individual is a participant under the health benefit plan or has met any affiliation period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan, but for a failure to enroll during a previous enrollment period.

(b) The person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption.

(4) The dependent special enrollment period under subsection (3) for individuals shall be a period of not less than 30 days and begins on the later of the date dependent coverage is made available or the date of the marriage, birth, or adoption or placement for adoption. If an individual seeks to enroll a dependent during the first 30 days of the dependent special enrollment period under subsection (3), the coverage of the dependent shall be effective as follows:

(a) For marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received.

(b) For a dependent's birth, as of the date of birth.

(c) For a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

History: Add. 2003, Act 88, Eff. Jan. 23, 2004.

Compiler's note: Former MCL 500.3708, which pertained to insurance coverage offered to residents of state 65 years of age or over, was repealed by Act 271 of 2001, Imd. Eff. Jan. 11, 2002.

Popular name: Act 218

500.3709 Minimum participation rules.

Sec. 3709. (1) Except as provided in this section, requirements used by a small employer carrier in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the small employer carrier. If a small employer carrier waives a minimum participation rule for a small employer, the carrier cannot later enforce that minimum participation rule for that small employer.

(2) A small employer carrier may deny coverage to a small employer if the small employer fails to enroll enough of its employees to meet the minimum participation rules established by the carrier pursuant to sound underwriting requirements. A minimum participation rule may require a small employer to enroll a certain number or percentage of employees with the small employer carrier as a condition of coverage. A minimum participation rule is subject to the following:

(a) For a small employer of 10 or fewer eligible employees, may require enrollment of up to 100% of the small employer's employees seeking health care coverage through the small employer.

(b) For a small employer of 11 to 25 eligible employees, may require enrollment of up to 75% of the small employer's employees seeking health care coverage through the small employer.

(c) For a small employer of 26 to 50 eligible employees, may require enrollment of up to 50% of the small employer's employees seeking health care coverage through the small employer.

History: Add. 2003, Act 88, Eff. Jan. 23, 2004.

Compiler's note: Former MCL 500.3709, which pertained to prudent purchase agreements with providers of hospital and other medical related services, was repealed by Act 271 of 2001, Imd. Eff. Jan. 11, 2002.

Popular name: Act 218

500.3710 Repealed. 2001, Act 271, Imd. Eff. Jan. 11, 2002.

Compiler's note: The repealed section pertained to federal or state programs for hospital, surgical, or medical benefits.

Popular name: Act 218

500.3711 Small employer carrier; guaranteed renewal; exceptions; modification.

Sec. 3711. (1) Except as otherwise provided in this section, a small employer carrier that offers health coverage in the small employer group market in connection with a health benefit plan shall renew or continue in force the plan at the option of the small employer.

(2) Guaranteed renewal under subsection (1) is not required in any of the following circumstances:

(a) There is fraud or intentional misrepresentation by the small employer.

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(b) For coverage of an insured individual, there is fraud or misrepresentation by the insured individual or the individual's representative.

(c) Lack of payment.

(d) Noncompliance with minimum contribution requirements.

(e) Noncompliance with minimum participation requirements.

(f) The small employer carrier no longer offers that particular type of coverage in the market.

(g) The small employer moves outside the geographic area.

(3) A small employer carrier that offers health coverage in the small employer group market may modify a health benefit plan if the modification is consistent with state law and effective on a uniform basis among all small employers with coverage under the health benefit plan.

History: Add. 2003, Act 88, Eff. Jan. 23, 2004;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Former MCL 500.3711, which pertained to mental health services by mental health care provider, was repealed by Act 271 of 2001, Imd. Eff. Jan. 11, 2002.

Popular name: Act 218

500.3712 Decision to discontinue plan in geographic area.

Sec. 3712. (1) If a small employer carrier decides to discontinue offering all small employer health benefit plans in a geographic area, all of the following apply:

(a) The small employer carrier shall provide notice to the commissioner and to each small employer covered by the small employer carrier in the geographic area of the discontinuation at least 180 days prior to the date of the discontinuation of the coverage.

(b) All small employer health benefit plans issued or delivered for issuance in the geographic area are discontinued and all current health benefit plans in the geographic area are not renewed.

(c) The small employer carrier shall not issue or deliver for issuance any small employer health benefit plans in the geographic area for 5 years beginning on the date the last small employer health benefit plan in the geographic area is not renewed under subdivision (b).

(d) The small employer carrier shall not issue or deliver for issuance for 5 years any small employer health benefit plans in an area that was not a geographic area where the small employer carrier was issuing or delivering for issuance small employer health benefit plans on the date notice was given under subdivision (a). The 5-year period under this subdivision begins on the date notice was given under subdivision (a).

(2) A small employer carrier shall not discontinue offering a particular plan or product in the small employer group market unless the small employer carrier does all of the following:

(a) Provides notice to the commissioner and to each small employer provided coverage under the plan or product of the discontinuation at least 90 days before the date of the discontinuation.

(b) Offers to each small employer provided coverage under the plan or product the option to purchase any other plan or product currently being offered in the small employer group market by that small employer carrier without excluding or limiting coverage for a preexisting condition or providing a waiting period.

(c) Acts uniformly without regard to any health status factor of enrolled individuals or individuals who may become eligible for coverage in making the determination to discontinue coverage and in offering other plans or products.

History: Add. 2003, Act 88, Eff. Jan. 23, 2004;—Am. 2013, Act 5, Imd. Eff. Mar. 18, 2013.

Compiler's note: Former MCL 500.3712, which pertained to articles, policies, applications, and certificates on evidence of insurance coverage, was repealed by Act 271 of 2001, Imd. Eff. Jan. 11, 2002.

Popular name: Act 218

500.3713 Information offered upon request.

Sec. 3713. Each small employer carrier shall provide all of the following to a small employer upon request and upon entering into a contract with the small employer:

(a) The extent to which premiums for a specific small employer are established or adjusted due to any permitted characteristic and rating factors of the small employer's employees and the employees' dependents.

(b) The provisions concerning the carrier's right to change premiums, permitted characteristics, and any rating factors under this chapter that affect changes in premiums.

(c) The provisions relating to renewability of coverage.

History: Add. 2003, Act 88, Eff. Jan. 23, 2004.

Popular name: Act 218

500.3714 Repealed. 2001, Act 271, Imd. Eff. Jan. 11, 2002.

Compiler's note: The repealed section pertained to summary statement concerning health insurance written under authority of

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chapter.

Popular name: Act 218

500.3715 Information and documentation; retention at principal place of business.

Sec. 3715. (1) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(2) Each small employer carrier shall file each March 1 with the commissioner an actuarial certification, that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound. A copy of the actuarial certification shall be retained by the carrier at its principal place of business.

(3) A small employer carrier shall make the information and documentation described in subsection (1) available to the commissioner upon request.

(4) This section is in addition to, and not in substitution of, the applicable filing provisions in this act and in the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

History: Add. 2003, Act 88, Eff. Jan. 23, 2004.

Popular name: Act 218

500.3716 Archer medical savings account; exception.

Sec. 3716. This chapter does not apply to a health benefit plan sponsored by a small employer that is an Archer medical savings account that meets all requirements of section 220 of the internal revenue code of 1986.

History: Add. 2003, Act 88, Eff. Jan. 23, 2004.

Compiler's note: Former MCL 500.3716, which pertained to sale of health insurance by agent or solicitor without additional licensing and to commission or allowance, was repealed by Act 271 of 2001, Imd. Eff. Jan. 11, 2002.

Popular name: Act 218

500.3717 Suspension; exemption; conditions; exception.

Sec. 3717. (1) Upon a request for suspension by the small employer carrier and a finding by the commissioner after consulting with the attorney general that the suspension is reasonable in light of the financial condition of the carrier and that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance, the commissioner may suspend all or any part of section 3705 as to the premiums applicable to 1 or more small employers for 1 or more rating periods and may suspend section 3712(1)(c) or (d).

(2) A commercial carrier whose capital and surplus as concerns policyholders as of December 31, 2003 as shown on the annual financial statement filed with the commissioner is $18,000,000.00 or less may be exempt from this chapter, if the commercial carrier had policyholders residing in Michigan before June 1, 2003, the commercial carrier files with the commissioner a written request for an exemption, and the commissioner, after reviewing the commercial carrier's request and annual financial statement, determines an exemption is warranted.

(3) An exemption granted under subsection (2) is effective for 3 years, so long as the commercial carrier experiences no disproportionate growth in premium volume in business written, or changes in the commercial carrier's pattern, location, or contours of that insurance business that indicate that the commercial carrier is utilizing its exemption to take unfair competitive advantage of competing small employer carriers who do not qualify for the exemption. A commercial carrier that meets the requirements of subsections (2) to (5) may reapply every 3 years to the commissioner for a subsection (2) exemption. The commissioner shall continue an exemption granted under subsection (2) if the commissioner finds the commercial carrier meets the criteria in subsections (2) to (5) for the exemption.

(4) The commissioner shall not grant an exemption under subsection (2) to any carrier that directly, or indirectly through 1 or more intermediaries, controls, is controlled by, or is under common control with a carrier whose surplus as concerns policyholders is in excess of the amount stated in subsection (2).

(5) A carrier admitted to do business in this state after June 1, 2003 is not eligible for an exemption under subsection (2).

History: Add. 2003, Act 88, Eff. Jan. 23, 2004.

Popular name: Act 218

500.3718 Applicability of MCL 550.1619.

Sec. 3718. A nonprofit health care corporation is subject to section 619 of the nonprofit health care

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corporation reform act, 1980 PA 350, MCL 550.1619.

History: Add. 2003, Act 88, Eff. Jan. 23, 2004.

Compiler's note: Former MCL 500.3718, which pertained to association formed for purposes of chapter, was repealed by Act 271 of 2001, Imd. Eff. Jan. 11, 2002.

Popular name: Act 218

500.3720 Repealed. 2001, Act 271, Imd. Eff. Jan. 11, 2002.

Compiler's note: The repealed section pertained to mutual insurers.

Popular name: Act 218

500.3721 Repealed. 2018, Act 304, Eff. Sept. 27, 2018.

Compiler's note: The repealed section pertained to a reporting requirement about competition in small employer carrier health market.

Popular name: Act 218

500.3722 Repealed. 2001, Act 271, Imd. Eff. Jan. 11, 2002.

Compiler's note: The repealed section pertained to designation of resident agent for service of process.

Popular name: Act 218

500.3723 Applicability of chapter; date of health benefit plan.

Sec. 3723. This chapter applies to a health benefit plan for a small employer that is delivered, issued for delivery, renewed, or continued in this state after January 22, 2004. For purposes of this section, the date a health benefit plan is continued is the first rating period that begins after January 22, 2004.

History: Add. 2003, Act 88, Eff. Jan. 23, 2004;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3724 Repealed. 2001, Act 271, Imd. Eff. Jan. 11, 2002.

Compiler's note: The repealed section pertained to immunity from liability under other laws for action taken pursuant to chapter.

Popular name: Act 218

500.3726 Repealed. 2001, Act 271, Imd. Eff. Jan. 11, 2002.

Compiler's note: The repealed section pertained to premiums for policies issued pursuant to chapter and to tax exemption.

Popular name: Act 218

500.3728 Repealed. 2001, Act 271, Imd. Eff. Jan. 11, 2002.

Compiler's note: The repealed section pertained to action taken under chapter subject to review by insurance commissioner.

Popular name: Act 218

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CHAPTER 38
MEDICARE SUPPLEMENT POLICIES AND CERTIFICATES

500.3801 Chapter; definitions.

Sec. 3801. As used in this chapter:

(a) "Applicant" means:

(*i*) For an individual Medicare supplement policy, the person who seeks to contract for benefits.

(*ii*) For a group Medicare supplement policy or certificate, the proposed certificate holder.

(b) "Bankruptcy" means, with respect to a Medicare advantage organization that is not an insurer, that the organization has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in this state.

(c) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

(d) "Certificate form" means the form on which a certificate is delivered or issued for delivery by an insurer.

(e) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

(f) "Creditable coverage" means coverage of an individual provided under any of the following:

(*i*) A group health plan.

(*ii*) Health insurance coverage.

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(*iii*) Part A or part B of Medicare.

(*iv*) Medicaid other than coverage consisting solely of benefits under 42 USC 1396s.

(*v*) Chapter 55 of title 10 of the United States Code, 10 USC 1071 to 1110b.

(*vi*) A medical care program of the Indian Health Service or of a tribal organization.

(*vii*) A state health benefits risk pool.

(*viii*) A health plan offered under chapter 89 of title 5 of the United States Code, 5 USC 8901 to 8914.

(*ix*) A public health plan as defined in federal regulation.

(*x*) Health care under 22 USC 2504(e).

(g) "Direct response solicitation" means solicitation in which an insurer representative does not contact the applicant in person and explain the coverage available, such as, but not limited to, solicitation through direct mail or through advertisements in periodicals and other media.

(h) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in 29 USC 1002.

(i) "Insolvency" means, with respect to an insurer licensed to transact the business of insurance in this state, that the insurer has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.

(j) "Insurer" includes any person that delivers or issues for delivery in this state Medicare supplement policies.

(k) "Medicaid" means subchapter XIX of the social security act, 42 USC 1396 to 1396w-5.

(*l*) "Medicare" means subchapter XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(m) "Medicare advantage" means a plan of coverage for health benefits under Medicare part C as described in 42 USC 1395w-28, and includes any of the following:

(*i*) Coordinated care plans that provide health care services, including, but not limited to, health maintenance organization plans with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans.

(*ii*) Medical savings account plans coupled with a contribution into a Medicare advantage medical savings account.

(*iii*) Medicare advantage private fee-for-service plans.

(n) "Medicare supplement buyer's guide" means the document entitled, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare", developed by the National Association of Insurance Commissioners and the United States Department of Health and Human Services, or a substantially similar document as approved by the director.

(o) "Medicare supplement policy" means an individual or group policy or certificate that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare and Medicare select policies and certificates under section 3817. Medicare supplement policy does not include a policy, certificate, or contract of 1 or more employers or labor organizations, or of the trustees of a fund established by 1 or more employers or labor organizations, or both, for employees or former employees, or both, or for members or former members, or both, of the labor organizations. Medicare supplement policy does not include Medicare advantage plans established under Medicare part C, outpatient prescription drug plans established under Medicare part D, or any health care prepayment plan that provides benefits pursuant to an agreement under 42 USC 1395*l*(a)(1).

(p) "PACE" means a program of all-inclusive care for the elderly as described in the social security act.

(q) "Prestandardized Medicare supplement benefit plan", "prestandardized benefit plan", or "prestandardized plan" means a group or individual policy of Medicare supplement insurance issued before June 2, 1992.

(r) "1990 standardized Medicare supplement benefit plan", "1990 standardized benefit plan", or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after June 2, 1992 with an effective date for coverage before June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date that are not replaced by the issuer at the request of the insured.

(s) "2010 standardized Medicare supplement benefit plan", "2010 standardized benefit plan", or "2010 plan" means a group or individual policy of Medicare supplement insurance with an effective date for coverage on or after June 1, 2010.

(t) "Policy form" means the form on which the policy or certificate is delivered or issued for delivery by the insurer.

(u) "Secretary" means the secretary of the United States Department of Health and Human Services.

(v) "Social security act" means the social security act, 42 USC 301 to 1397mm.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2006, Act 462, Imd. Eff.

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Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3803 Applicability of chapter.

Sec. 3803. (1) Except as provided in subsections (2) and (3), this chapter applies to a Medicare supplement policy delivered, issued for delivery, or renewed in this state.

(2) Sections 3807, 3809, 3811, and 3819 apply to a Medicare supplement policy delivered or issued for delivery in this state on or after June 2, 1992 with an effective date for coverage before June 1, 2010.

(3) Sections 3807a, 3809a, 3811a, and 3819a apply to a Medicare supplement policy delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3804 Repealed. 2018, Act 429, Eff. Mar. 20, 2019.

Compiler's note: The repealed section pertained to the applicability of medicare supplement policies by a certain health care corporation.

Popular name: Act 218

500.3805 Medicare supplement policy; definitions.

Sec. 3805. As used in a medicare supplement policy:

(a) The definition of "accident", "accidental injury", or "accidental means" shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any worker's compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(b) The definition of "benefit period" or "medicare benefit period" shall not be defined in a more restrictive manner than as defined in medicare.

(c) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the joint commission on accreditation of hospitals, but not more restrictively than as defined in medicare.

(d) The definition of "medicare eligible expenses" shall mean health care expenses of the kinds covered by part A and part B of medicare, to the extent recognized as reasonable and medically necessary by medicare.

(e) "Nurses" may be defined so that the description of nurse is to a type of nurse, such as a registered professional nurse or a licensed practical nurse. If the words "nurse", "trained nurse", or "registered nurse" are used without specific instruction, then the use of those terms requires the insurer to recognize the services of any individual who qualifies under those terms in accordance with the public health code, 1978 PA 368, MCL 333.1101 to 333.25211.

(f) "Physician" shall not be defined more restrictively than as defined in medicare.

(g) "Sickness" shall not be defined more restrictively than to mean illness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided to the insured under any worker's compensation, occupational disease, employer's liability, or similar law.

(h) "Skilled nursing facility" shall not be defined more restrictively than as defined in medicare.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006.

Popular name: Act 218

500.3807 Basic core package of benefits; standards for plans K and L; applicability of section.

Sec. 3807. (1) Every insurer issuing a medicare supplement insurance policy in this state shall make available a medicare supplement insurance policy that includes a basic core package of benefits to each prospective insured. An insurer issuing a medicare supplement insurance policy in this state may make available to prospective insureds benefits pursuant to section 3809 that are in addition to, but not instead of, the basic core package. The basic core package of benefits shall include all of the following:

(a) Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period.

(b) Coverage of part A medicare eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used.

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(c) Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100% of the medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the insurer's payment as payment in full and may not bill the insured for any balance.

(d) Coverage under medicare parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations unless replaced in accordance with federal regulations.

(e) Coverage for the coinsurance amount, or the copayment amount paid for hospital outpatient department services under a prospective payment system, of medicare eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible.

(2) Standards for plans K and L are as follows:

(a) Standardized medicare supplement benefit plan K shall consist of the following:

(*i*) Coverage of 100% of the part A hospital coinsurance amount for each day used from the sixty-first day through the ninetieth day in any medicare benefit period.

(*ii*) Coverage of 100% of the part A hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the ninety-first day through the one hundred fiftieth day in any medicare benefit period.

(*iii*) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the insurer's payment as payment in full and may not bill the insured for any balance.

(*iv*) Medicare part A deductible: coverage for 50% of the medicare part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*v*) Skilled nursing facility care: coverage for 50% of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*vi*) Hospice care: coverage for 50% of cost sharing for all part A medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*vii*) Coverage for 50%, under medicare part A or B, of the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*viii*) Except for coverage provided in subparagraph (*ix*) below, coverage for 50% of the cost sharing otherwise applicable under medicare part B after the policyholder pays the part B deductible until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*ix*) Coverage of 100% of the cost sharing for medicare part B preventive services after the policyholder pays the part B deductible.

(*x*) Coverage of 100% of all cost sharing under medicare parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare parts A and B of $4,000.00 in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the United States department of health and human services.

(b) Standardized medicare supplement benefit plan L shall consist of the following:

(*i*) The benefits described in subdivision (a)(*i*), (*ii*), (*iii*), and (*ix*).

(*ii*) The benefit described in subdivision (a)(*iv*), (*v*), (*vi*), (*vii*), and (*viii*), but substituting 75% for 50%.

(*iii*) The benefit described in subdivision (a)(*x*), but substituting $2,000.00 for $4,000.00.

(3) This section applies to medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage prior to June 1, 2010.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3807a Medicare supplement policies or certificates with effective date for coverage on or after June 1, 2010; basic core package of benefits.

Sec. 3807a. (1) This section applies to all medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage on or after June 1, 2010. A policy or certificate shall not be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards. An issuer shall not offer any 1990 plan for sale on

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or after June 1, 2010. Benefit standards applicable to medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of section 3807.

(2) Every insurer issuing a medicare supplement insurance policy in this state shall make available a medicare supplement insurance policy that includes a basic core package of benefits to each prospective insured. An insurer issuing a medicare supplement insurance policy in this state may make available to prospective insureds benefits pursuant to section 3809a that are in addition to, but not instead of, the basic core package. The basic core package of benefits shall include all of the following:

(a) Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period.

(b) Coverage of part A medicare eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used.

(c) Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100% of the medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the insurer's payment as payment in full and may not bill the insured for any balance.

(d) Coverage under medicare parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations unless replaced in accordance with federal regulations.

(e) Coverage for the coinsurance amount, or the copayment amount paid for hospital outpatient department services under a prospective payment system, of medicare eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible.

(f) Coverage of cost sharing for all part A medicare eligible hospice care and respite care expenses.

History: Add. 2009, Act 220, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3808 Repealed. 2018, Act 429, Eff. Mar. 20, 2019.

Compiler's note: The repealed section pertained to medicare supplement insurance policies.

Popular name: Act 218

500.3809 Additional benefits; reimbursement for preventive screening tests and services; definitions; applicability of section.

Sec. 3809. (1) In addition to the basic core package of benefits required under section 3807, the following benefits may be included in a medicare supplement insurance policy and if included shall conform to section 3811(5)(b) to (j):

(a) Medicare part A deductible: coverage for all of the medicare part A inpatient hospital deductible amount per benefit period.

(b) Skilled nursing facility care: coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A.

(c) Medicare part B deductible: coverage for all of the medicare part B deductible amount per calendar year regardless of hospital confinement.

(d) Eighty percent of the medicare part B excess charges: coverage for 80% of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by medicare or state law, and the medicare-approved part B charge.

(e) One hundred percent of the medicare part B excess charges: coverage for all of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by medicare or state law, and the medicare-approved part B charge.

(f) Basic outpatient prescription drug benefit: coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $1,250.00 in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may be included for sale or issuance in a medicare supplement policy until January 1, 2006.

(g) Extended outpatient prescription drug benefit: coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $3,000.00 in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may be included for sale or issuance in a medicare supplement policy until January 1, 2006.

(h) Medically necessary emergency care in a foreign country: coverage to the extent not covered by medicare for 80% of the billed charges for medicare-eligible expenses for medically necessary emergency

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hospital, physician, and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250.00, and a lifetime maximum benefit of $50,000.00. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive medical care benefit: Coverage for the following preventive health services not covered by medicare:

(*i*) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (*ii*) and patient education to address preventive health care measures.

(*ii*) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

(j) At-home recovery benefit: coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery. At-home recovery services provided shall be primarily services that assist in activities of daily living. The insured's attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by medicare. Coverage is excluded for home care visits paid for by medicare or other government programs and care provided by family members, unpaid volunteers, or providers who are not care providers. Coverage is limited to:

(*i*) No more than the number of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of medicare approved home health care visits under a medicare approved home care plan of treatment.

(*ii*) The actual charges for each visit up to a maximum reimbursement of $40.00 per visit.

(*iii*) One thousand six hundred dollars per calendar year.

(*iv*) Seven visits in any 1 week.

(*v*) Care furnished on a visiting basis in the insured's home.

(*vi*) Services provided by a care provider as defined in this section.

(*vii*) At-home recovery visits while the insured is covered under the insurance policy and not otherwise excluded.

(*viii*) At-home recovery visits received during the period the insured is receiving medicare approved home care services or no more than 8 weeks after the service date of the last medicare approved home health care visit.

(k) New or innovative benefits: an insurer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

(2) Reimbursement for the preventive screening tests and services under subsection (1)(i)(*ii*) shall be for the actual charges up to 100% of the medicare-approved amount for each test or service, as if medicare were to cover the test or service as identified in the American medical association current procedural terminology codes, to a maximum of $120.00 annually under this benefit. This benefit shall not include payment for any procedure covered by medicare.

(3) As used in subsection (1)(j):

(a) "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(b) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(c) "Home" means any place used by the insured as a place of residence, provided that it qualifies as a residence for home health care services covered by medicare. A hospital or skilled nursing facility shall not be considered the insured's home.

(d) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is 1 visit.

(4) This section applies to medicare supplement policies or certificates delivered or issued for delivery on or after June 2, 1992 with an effective date for coverage prior to June 1, 2010.

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History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3809a Medicare supplement policies or certificates with effective date for coverage on or after June 1, 2010; additional benefits.

Sec. 3809a. (1) This section applies to all medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage on or after June 1, 2010.

(2) In addition to the basic core package of benefits required under section 3807a, the following benefits may be included in a medicare supplement insurance policy and if included shall conform to section 3811a(6)(b) to (j):

(a) Medicare part A deductible: coverage for 100% of the medicare part A inpatient hospital deductible amount per benefit period.

(b) Medicare part A deductible: coverage for 50% of the medicare part A inpatient hospital deductible amount per benefit period.

(c) Skilled nursing facility care: coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A.

(d) Medicare part B deductible: coverage for 100% of the medicare part B deductible amount per calendar year regardless of hospital confinement.

(e) One hundred percent of the medicare part B excess charges: coverage for all of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by medicare or state law, and the medicare-approved part B charge.

(f) Medically necessary emergency care in a foreign country: coverage to the extent not covered by medicare for 80% of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250.00, and a lifetime maximum benefit of $50,000.00. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

History: Add. 2009, Act 220, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3811 Basic core benefits; availability; sale of certain benefits prohibited; designations, structure, language, and format; other designations; requirements; applicability of section.

Sec. 3811. (1) An insurer shall make available to each prospective medicare supplement policyholder and certificate holder a policy form or certificate form containing only the basic core benefits as provided in section 3807.

(2) Groups, packages, or combinations of medicare supplement benefits other than those listed in this section shall not be offered for sale in this state except as may be permitted in section 3809(1)(k).

(3) Benefit plans shall contain the appropriate A through L designations, shall be uniform in structure, language, and format to the standard benefit plans in subsection (5), and shall conform to the definitions in this chapter. Each benefit shall be structured in accordance with sections 3807 and 3809 and list the benefits in the order shown in subsection (5). For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(4) In addition to the benefit plan designations A through L as provided under subsection (5), an insurer may use other designations to the extent permitted by law.

(5) A medicare supplement insurance benefit plan shall conform to 1 of the following:

(a) A standardized medicare supplement benefit plan A shall be limited to the basic core benefits common to all benefit plans as defined in section 3807.

(b) A standardized medicare supplement benefit plan B shall include only the following: the core benefits as defined in section 3807 and the medicare part A deductible as defined in section 3809(1)(a).

(c) A standardized medicare supplement benefit plan C shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (c), and (h).

(d) A standardized medicare supplement benefit plan D shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medically necessary

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emergency care in a foreign country, and the at-home recovery benefit as defined in section 3809(1)(a), (b), (h), and (j).

(e) A standardized medicare supplement benefit plan E shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in section 3809(1)(a), (b), (h), and (i).

(f) A standardized medicare supplement benefit plan F shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (c), (e), and (h). A standardized medicare supplement plan F high deductible shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan F deductible. The covered expenses include the core benefits as defined in section 3807, plus the medicare part A deductible, skilled nursing facility care, the medicare part B deductible, 100% of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (c), (e), and (h). The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan F deductible is $1,790.00 for calendar year 2006, and the secretary shall adjust it annually thereafter to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00.

(g) A standardized medicare supplement benefit plan G shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, 80% of the medicare part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in section 3809(1)(a), (b), (d), (h), and (j).

(h) A standardized medicare supplement benefit plan H shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (f), and (h). The outpatient drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

(i) A standardized medicare supplement benefit plan I shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, 100% of the medicare part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in section 3809(1)(a), (b), (e), (f), (h), and (j). The outpatient drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

(j) A standardized medicare supplement benefit plan J shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in section 3809(1)(a), (b), (c), (e), (g), (h), (i), and (j). A standardized medicare supplement benefit plan J high deductible plan shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan J deductible. The covered expenses include the core benefits as defined in section 3807, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in section 3809(1)(a), (b), (c), (e), (g), (h), (i), and (j). The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,790.00 for calendar year 2006, and the secretary shall adjust it annually thereafter to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00. The outpatient drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

(k) A standardized medicare supplement benefit plan K shall consist of only those benefits described in section 3807(2)(a).

(*l*) A standardized medicare supplement benefit plan L shall consist of only those benefits described in section 3807(2)(b).

(6) This section applies to medicare supplement policies or certificates delivered or issued for delivery on or after June 2, 1992 with an effective date for coverage prior to June 1, 2010.

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History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3811a Medicare supplement policies or certificates with effective date for coverage on or after June 1, 2010; basic core benefits; availability; sale of certain benefits prohibited; structure, language, designation, and format; other designations; requirements.

Sec. 3811a. (1) This section applies to all Medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage on or after June 1, 2010. A policy or certificate must not be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of section 3811.

(2) An insurer shall make available to each prospective Medicare supplement policyholder and certificate holder a policy form or certificate form containing only the basic core benefits as provided in section 3807a. If an insurer makes available any of the additional benefits described in section 3809a or offers standardized benefit plans K or L, the insurer shall make available to each prospective Medicare supplement policyholder and certificate holder a policy form or certificate form containing either standardized benefit plan C or standardized benefit plan F.

(3) Groups, packages, or combinations of Medicare supplement benefits other than those listed in this section must not be offered for sale in this state except as may be permitted in subsection (6)(k).

(4) Benefit plans must be uniform in structure, language, designation, and format to the standard benefit plans in subsection (6) and must conform to the definitions in this chapter. Each benefit must be structured in accordance with sections 3807a and 3809a and list the benefits in the order shown in subsection (6). As used in this section, "structure, language, designation, and format" means style, arrangement, and overall content of a benefit.

(5) In addition to the benefit plan designations as provided under subsection (6), an insurer may use other designations to the extent permitted by law.

(6) A Medicare supplement insurance benefit plan must conform to 1 of the following:

(a) A standardized Medicare supplement benefit plan A must be limited to the basic core benefits common to all benefit plans as required under section 3807a.

(b) A standardized Medicare supplement benefit plan B must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible as defined in section 3809a(2)(a).

(c) A standardized Medicare supplement benefit plan C must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, 100% of the Medicare part B deductible, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (d), and (f).

(d) A standardized Medicare supplement benefit plan D must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), and (f).

(e) A standardized Medicare supplement benefit plan F must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, 100% of the Medicare part B deductible, 100% of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (d), (e), and (f). A standardized Medicare supplement plan F high deductible must include only the following: 100% of covered expenses following the payment of the annual high-deductible plan F deductible. The covered expenses include the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, 100% of the Medicare part B deductible, 100% of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (d), (e), and (f). The annual high-deductible plan F deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan F policy, and must be in addition to any other specific benefit deductibles. The annual high-deductible plan F deductible is $1,500.00 for calendar year 1999, and the secretary shall adjust it annually thereafter to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00.

(f) A standardized Medicare supplement benefit plan G must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care,

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100% of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (e), and (f). Effective January 1, 2020, the standardized plan F high deductible benefit plan, redesignated in section 3811b(2)(d) as plan G high deductible, may be offered to an individual who was eligible for Medicare before January 1, 2020.

(g) Standardized Medicare supplement benefit plan K must consist of the following:

(*i*) Coverage of 100% of the part A hospital coinsurance amount for each day used from the sixty-first day through the ninetieth day in any Medicare benefit period.

(*ii*) Coverage of 100% of the part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first day through the one hundred fiftieth day in any Medicare benefit period.

(*iii*) On exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the insurer's payment as payment in full and may not bill the insured for any balance.

(*iv*) Medicare part A deductible: coverage for 50% of the Medicare part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*v*) Skilled nursing facility care: coverage for 50% of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare part A until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*vi*) Hospice care: coverage for 50% of cost sharing for all part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*vii*) Coverage for 50%, under Medicare part A or B, of the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*viii*) Except for coverage provided in subparagraph (*ix*), coverage for 50% of the cost sharing otherwise applicable under Medicare part B after the policyholder pays the part B deductible until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*ix*) Coverage of 100% of the cost sharing for Medicare part B preventive services after the policyholder pays the part B deductible.

(*x*) Coverage of 100% of all cost sharing under Medicare parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare parts A and B of $4,000.00 in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the United States Department of Health and Human Services.

(h) Standardized Medicare supplement benefit plan L must consist of the following:

(*i*) The benefits described in subdivision (g)(*i*), (*ii*), (*iii*), and (*ix*).

(*ii*) The benefits described in subdivision (g)(*iv*), (*v*), (*vi*), (*vii*), and (*viii*), but substituting 75% for 50%.

(*iii*) The benefit described in subdivision (g)(*x*), but substituting $2,000.00 for $4,000.00.

(i) A standardized Medicare supplement benefit plan M must include only the following: the core benefits as required under section 3807a and 50% of the Medicare part A deductible, skilled nursing care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(b), (c), and (f).

(j) A standardized Medicare supplement benefit plan N must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), and (f) with copayments in the following amounts:

(*i*) The lesser of $20.00 or the Medicare part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists.

(*ii*) The lesser of $50.00 or the Medicare part B coinsurance or copayment for each covered emergency room visit. The copayment must be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare part A expense.

(k) New or innovative benefits: an insurer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. The innovative benefit must not include an outpatient prescription drug benefit. New or innovative benefits must not be used to change or reduce benefits, including a change of any cost-sharing provision, in any

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standardized plan.

History: Add. 2009, Act 220, Imd. Eff. Jan. 5, 2010;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3811b Medicare supplement policies or certificates for newly eligible individuals after December 31, 2019; exceptions to standards and requirements.

Sec. 3811b. (1) This section applies to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare after December 31, 2019. A policy or certificate that provides coverage of the Medicare part B deductible must not be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare after December 31, 2019, unless it complies with the benefit standards provided in this section. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020 remain subject to the requirements of section 3811a.

(2) The standards and requirements of section 3811a apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare after December 31, 2019, with the following exceptions:

(a) Standardized Medicare supplement benefit plan C is redesignated as plan D and must provide the benefits contained in section 3811a(6)(c), but must not provide coverage for 100% or any portion of the Medicare part B deductible.

(b) Standardized Medicare supplement benefit plan F is redesignated as plan G and must provide the benefits contained in section 3811a(6)(e), as applicable, but must not provide coverage for 100% or any portion of the Medicare part B deductible.

(c) Standardized Medicare supplement benefit plans C, F, and F high deductible may not be offered to individuals newly eligible for Medicare after December 31, 2019.

(d) Standardized Medicare supplement benefit plan F high deductible is redesignated as plan G high deductible and must provide the benefits in section 3811a(6)(e), as applicable, but must not provide coverage for 100% or any portion of the Medicare part B deductible. The Medicare part B deductible paid by the beneficiary is considered an out-of-pocket expense in meeting the annual high deductible.

(e) The reference to plan C or plan F contained in section 3811a(2) is deemed a reference to plan D or plan G, respectively, for purposes of this section.

(3) This section only applies to individuals that are newly eligible for Medicare after December 31, 2019 because of either of the following:

(a) By reason of attaining age 65 after December 31, 2019.

(b) By reason of entitlement to benefits under Medicare part A under section 226(b) or 226a of the social security act, or who is deemed to be eligible for benefits under section 226a of the social security act after December 31, 2019.

(4) For purposes of section 3830(5) to (8), for an individual newly eligible for Medicare after December 31, 2019, any reference to Medicare supplement policy or certificate plans C, F, or F high deductible is deemed to be a reference to Medicare supplement policy or certificate plans D, G, or G high deductible, respectively, that meet the requirements of subsection (2).

(5) After December 31, 2019, the standardized benefit plans described in subsection (2)(d) may be offered to an individual who was eligible for Medicare before January 1, 2020, in addition to the standardized plans described in section 3811a(6).

History: Add. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3813 Disability coverage; medicare supplement buyer's guide; applicability of section.

Sec. 3813. An insurer that issues a policy that provides health insurance coverage to a person eligible for Medicare by reason of age shall provide the prospective policyholder with a Medicare supplement buyer's guide in written or electronic format, which must be furnished at the time of application, and the insurer shall obtain, in written or electronic format, acknowledgment of receipt of the buyer's guide. However, for direct response solicitation policies, the guide must be furnished with the policy in written or electronic format and the insurer need not obtain acknowledgment of receipt. This section does not apply to policies that provide accidental death benefits for travel or other accidents, or if the medical expense or indemnity payments are only incidental to the accidental death benefits for travel or other accidents.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

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500.3815 Outline of coverage; acknowledgment of receipt; compliance with notice requirements; substitute; language, written or electronic format, and required items.

Sec. 3815. (1) An insurer that offers a Medicare supplement policy shall provide to the applicant at the time of application an outline of coverage in written or electronic format and, except for direct response solicitation policies, shall obtain an acknowledgment of receipt of the outline of coverage from the applicant in written or electronic format. The outline of coverage provided to applicants under this section must consist of the following 4 parts:

(a) A cover page.

(b) Premium information.

(c) Disclosure pages.

(d) Charts displaying the features of each benefit plan offered by the insurer.

(2) Insurers shall comply with any notice requirements of the Medicare prescription drug, improvement, and modernization act of 2003, Public Law 108-173.

(3) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and must contain the following statement, in not less than 12-point type, immediately above the company name:

NOTICE: Read this outline of coverage carefully.
It is not identical to the outline of coverage
provided on application and the coverage
originally applied for has not been issued.

(4) An outline of coverage under subsection (1) must be in the language and in a written or electronic format prescribed in this section and in not less than 12-point type. The letter designation of the plan must be shown on the cover page and the plans offered by the insurer must be prominently identified. Premium information must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and method of payment mode must be stated for all plans that are offered to the applicant. All possible premiums for the applicant must be illustrated. The following items must be included in the outline of coverage in the order prescribed below and in substantially the following form, as approved by the director:

BENEFIT CHART OF MEDICARE SUPPLEMENT PLANS SOLD
ON OR AFTER JUNE 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale. (This sentence must not appear after June 1, 2011.)

BASIC BENEFITS:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
Blood: First three pints of blood each year.
Hospice: Part A coinsurance

A	B	C**	D	F|F* **	G/G*
Basic, including 100% Part B coin-surance	Basic, including 100% Part B coinsur-ance	Basic, including 100% Part B coinsur-ance	Basic, including 100% Part B coinsur-ance	Basic, including 100% Part B coinsur-ance	Basic, including 100% Part B coinsur-ance
		Skilled Nursing Facility Coinsur-ance	Skilled Nursing Facility Coinsur-ance	Skilled Nursing Facility Coinsur-ance	Skilled Nursing Facility Coinsur-ance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B		Part B	

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		Deductible		Deductible	
				Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $5,240; paid at 100% after limit reached	Out-of-pocket limit $2,620; paid at 100% after limit reached		

* Plans F and G also have options called high-deductible Plan F and high-deductible Plan G. These high-deductible plans pay the same benefits as Plan F or Plan G, as applicable, after one has paid a calendar year $2,240 deductible. Benefits from high-deductible Plan F or high-deductible Plan G will not begin until out-of-pocket expenses exceed $2,240. Out-of-pocket expenses for these deductibles are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

** Plan C, Plan F, and high-deductible Plan F are only available to individuals eligible for Medicare before January 1, 2020.

PREMIUM INFORMATION

We (insert insurer's name) can only raise your premium if we raise the premium for all policies like yours in this state. (If the premium is based on the increasing age of the insured, include information specifying when premiums will change).

DISCLOSURES

Use this outline to compare benefits and premiums among policies, certificates, and contracts.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates before June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. (This sentence must not appear after June 1, 2011.)

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to (insert insurer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

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POLICY REPLACEMENT

If you are replacing another health insurance policy, do not cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

[For agent issued policies]

Neither (insert insurer's name) nor its agents are connected with Medicare.

[For direct response issued policies]

(Insert insurer's name) is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan offered by the insurer a chart showing the services, Medicare payments, plan payments, and insured payments using the same language, in the same order, and using uniform layout and format as shown in the charts that follow. An insurer may use additional benefit plan designations on these charts under section 3809(1)(k). Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director. The insurer issuing the policy shall change the dollar amounts each year to reflect current figures. No more than 4 plans may be shown on 1 chart.] Charts for each plan are as follows:

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$0	$1,340 (Part A Deductible)
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-			

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approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	$0	Up to $167.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY			

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SERVICES— Tests for diagnostic services	100%	$0	$0
	PARTS A & B		
HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,340	$1,340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within			

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30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	$0	Up to $167.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY			

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SERVICES— Tests for diagnostic services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies —Durable medical equipment First $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $183 (Part B Deductible) $0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,340	$1,340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-			

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approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$183 (Part B Deductible)	$0

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Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $183 of Medicare Approved Amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used:			

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—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic			

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tests, durable medical equipment, First $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	$0 80% $0	$0 20% $0	$183 (Part B Deductible) $0 All Costs
BLOOD First 3 pints Next $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 $0 80%	All Costs $0 20%	$0 $183 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies —Durable medical equipment First $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $183 (Part B Deductible) $0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

PLAN F OR HIGH-DEDUCTIBLE PLAN F
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high-deductible plan pays the same benefits as plan F after you have paid a calendar year $2,240 deductible. Benefits from the high-deductible plan F will not begin until out-of-pocket expenses are $2,240.

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Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes Medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,240 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,240 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE	All but very limited	Medicare copayment/	$0

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	copayment/ coinsurance	coinsurance	
You must meet Medicare's requirements, including a doctor's certification of terminal illness	for outpatient drugs and inpatient respite care		

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high-deductible plan pays the same benefits as plan F after you have paid a calendar year $2,240 deductible. Benefits from the high-deductible plan F will not begin until out-of-pocket expenses are $2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes Medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,240 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,240 DEDUCTIBLE**, YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			

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Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $183 of Medicare Approved Amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G OR HIGH-DEDUCTIBLE PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** This high-deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,240 deductible. Benefits from the high-deductible Plan G will not begin until out-of-pocket expenses are $2,240. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,240 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,240 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after —While using 60			

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lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G OR HIGH-DEDUCTIBLE PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

** This high-deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,240 deductible. Benefits from the high-deductible Plan G will not begin until out-of-pocket expenses are $2,240.

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Out-of-pocket expenses for this deductible include expenses for the Medicare part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,240 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,240 DEDUCTIBLE**, YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $183 of Medicare Approved Amounts*	$0	$0	$163 (Unless Part B Deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	0%
BLOOD First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Unless Part B Deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE Medicare Approved Services —Medically necessary			

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skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $5,240 each calendar year. The amounts that count toward your annual limit are noted with diamonds[1] in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$670 (50% of Part A Deducti-ble)	$670 (50% of Part A Deductible) 1
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare	$0***

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—Beyond the Additional 365 days	$0	Eligible Expenses $0	All Costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $83.75 a day	Up to $83.75 a day 1
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50% 1
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsur-ance	50% of Medicare copayment/ coinsurance 1

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***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

****Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical			

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equipment, First $183 of Medicare Approved Amounts****	$0	$0	$183 (Part B Deductible) **** 1
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare ap- proved amounts	Remainder of Medi- care approved amounts	All costs above Medi- care approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% 1
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out- of-pocket limit of $5,240)*
BLOOD First 3 pints	$0	50%	50% 1
Next $183 of Medicare Approved Amounts****	$0	$0	$183 (Part B Deductible) **** 1
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% 1
CLINICAL LABORATORY SERVICES—Tests for diagnostic services	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $5,240 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $183 of Medicare Approved Amounts*****	$0	$0	$183 (Part B Deductible)1
Remainder of Medicare Approved Amounts	80%	10%	10% 1

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,620 each calendar year. The amounts that count toward your annual limit are noted with diamonds[1] in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare

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copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN L

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,005 (75% of Part A Deductible)	$335 (25% of Part A Deductible) 1
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $125.63 a day	Up to $41.88 a day 1
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25% 1
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's		75% of copayment/ coinsurance	25% of copayment/ coinsurance 1

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certification of terminal illness	All but very limited copay-ment/coinsur-ance for outpatient drugs and inpatient respite care		

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

****Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts****	$0	$0	$183 (Part B Deducti-ble)**** 1
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medi-care approved amounts	All costs above Medi-care approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% 1
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $2,620)*
BLOOD			
First 3 pints	$0	75%	25% 1
Next $183 of Medicare Approved Amounts****	$0	$0	$183 (Part B Deductible) 1
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% 1
CLINICAL LABORATORY			

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SERVICES—Tests for diagnostic services	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2,620 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $183 of Medicare Approved Amounts*****	$0	$0	$183 (Part B Deducti-ble) 1
Remainder of Medicare Approved Amounts	80%	15%	5% 1

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$670 (50% of Part A Deduc-tible)	$670 (50% of Part A Deduc-tible)
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including			

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having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deduc-tible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			

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First 3 pints	$0	All costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deduc-tible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—Tests for diagnostic services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $183 of Medicare Approved Amounts	$0	$0	$183 (Part B Deduc-tible)
Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL—Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A Deduc-tible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0

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91st day and after: —While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT			

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HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deduc-tible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deduc-tible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—Tests for diagnostic services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE Medicare Approved Services —Medically necessary			

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skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deduc-tible)
Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL—Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Compiler's note: In Plans K and L, a superscript numeral "1" has been substituted wherever a diamond symbol should occur.

Popular name: Act 218

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500.3817 Medicare select policies and certificates; definitions; requirements for issuance; plan of operation; filing, format, and contents; proposed changes; updated list of network providers; payment for covered services not available through network providers; disclosure; receipt of information; grievance procedure; report; availability of comparable or lesser benefits; continuation of coverage; requests for data by state or federal agencies.

Sec. 3817. (1) This section applies to medicare select policies and certificates.

(2) As used in this section:

(a) "Complaint" means any dissatisfaction expressed by an individual concerning a medicare select insurer or its network providers.

(b) "Grievance" means a dissatisfaction expressed in writing by an individual insured under a medicare select policy or certificate with the administration, claims practices, or provision of services concerning a medicare select insurer or its network providers.

(c) "Medicare select insurer" means an insurer offering, or seeking to offer, a medicare select policy or certificate.

(d) "Medicare select policy" or "medicare select certificate" means a medicare supplement policy or certificate that contains restricted network provisions.

(e) "Network provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the insurer to provide benefits under a medicare select policy or certificate.

(f) "Restricted network provision" means any provision that conditions the payment of benefits, in whole or in part, on the use of network providers.

(g) "Service area" means the geographic area approved by the commissioner within which an insurer is authorized to offer a medicare select policy or certificate.

(3) A policy or certificate shall not be advertised as a medicare select policy or certificate unless it meets

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the requirements of this section.

(4) The commissioner may authorize an insurer to offer a medicare select policy or certificate, pursuant to this section and section 1882 of part C of title XVIII of the social security act, 42 USC 1395ss, if the commissioner finds that the insurer has satisfied all necessary requirements.

(5) A medicare select insurer shall not issue a medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner.

(6) A medicare select insurer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(a) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, as follows:

(*i*) That services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(*ii*) That the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either to deliver adequately all services that are subject to a restricted network provision or to make appropriate referrals.

(*iii*) That there are written agreements with network providers describing specific responsibilities.

(*iv*) That emergency care is available 24 hours per day and 7 days per week.

(*v*) That in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a medicare select policy or certificate. This subparagraph does not apply to supplemental charges or coinsurance amounts as stated in the medicare select policy or certificate.

(b) A statement or map providing a clear description of the service area.

(c) A description of the grievance procedure to be used.

(d) A description of the quality assurance program, including all of the following:

(*i*) The formal organizational structure.

(*ii*) The written criteria for selection, retention, and removal of network providers.

(*iii*) The procedures for evaluating quality of care provided by network providers and the process to initiate corrective action if warranted.

(e) A list and description, by specialty, of the network providers.

(f) Copies of the written information proposed to be used by the insurer to comply with subsection (10).

(g) Any other information requested by the commissioner.

(7) A medicare select insurer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing any changes. An updated list of network providers shall be filed with the commissioner at least quarterly. Changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

(8) A medicare select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition and it is not reasonable to obtain such services through a network provider.

(9) A medicare select policy or certificate shall provide payment for full coverage under the policy or certificate for covered services that are not available through network providers.

(10) A medicare select insurer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the medicare select policy or certificate to each applicant. This disclosure shall include at least all of the following:

(a) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the medicare select policy or certificate with other medicare supplement policies or certificates offered by the insurer or offered by other insurers.

(b) A description, including address, phone number, and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

(c) A description of the restricted network provisions, including payments for coinsurance and deductibles if providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.

(d) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

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(e) A description of limitations on referrals to restricted network providers and to other providers.

(f) A description of the policyholder's rights to purchase any other medicare supplement policy or certificate otherwise offered by the insurer.

(g) A description of the medicare select insurer's quality assurance program and grievance procedure.

(11) Prior to the sale of a medicare select policy or certificate, a medicare select insurer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (10) and that the applicant understands the restrictions of the medicare select policy or certificate.

(12) A medicare select insurer shall have and use procedures for hearing complaints and resolving written grievances from subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures. The grievance procedure shall be described in the policy and certificate and in the outline of coverage. At the time the policy or certificate is issued, the insurer shall provide detailed information to the policyholder describing how a grievance may be registered with the insurer. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action. If a grievance is found to be valid, corrective action shall be taken promptly. All concerned parties shall be notified about the results of a grievance. The insurer shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of those grievances.

(13) At the time of initial purchase, a medicare select insurer shall make available to each applicant for a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate otherwise offered by the insurer.

(14) At the request of an individual insured under a medicare select policy or certificate, a medicare select insurer shall make available to the individual insured the opportunity to purchase a medicare supplement policy or certificate offered by the insurer that has comparable or lesser benefits and that does not contain a restricted network provision. The insurer shall make the policies or certificates available without requiring evidence of insurability after the medicare supplement policy or certificate has been in force for 6 months. For the purposes of this subsection, a medicare supplement policy or certificate shall be considered to have comparable or lesser benefits unless it contains 1 or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the medicare part A deductible, coverage for at-home recovery services, or coverage for part B excess charges.

(15) Medicare select policies and certificates shall provide for continuation of coverage if the secretary of health and human services determines that medicare select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the medicare select program to be reauthorized under law or its substantial amendment. Each medicare select insurer shall make available to each individual insured under a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate offered by the insurer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability. For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains 1 or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the medicare part A deductible, coverage for at-home recovery service, or coverage for part B excess charges.

(16) A medicare select insurer shall comply with reasonable requests for data made by state or federal agencies, including the United States department of health and human services, for the purposes of evaluating the medicare select program.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006.

Popular name: Act 218

500.3819 Minimum standards; suspension of benefits and premiums; notice; reinstitution; offer to exchange 1990 standardized plan to 2010 plan.

Sec. 3819. (1) An insurance policy shall not be titled, advertised, solicited, or issued for delivery in this state as a medicare supplement policy if the policy does not meet the minimum standards prescribed in this section. These minimum standards are in addition to all other requirements of this chapter.

(2) The following standards apply to medicare supplement policies:

(a) A medicare supplement policy shall not deny a claim for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not

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define a preexisting condition more restrictively than to mean a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(b) A medicare supplement policy shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(c) A medicare supplement policy shall provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(d) A medicare supplement policy shall be guaranteed renewable. Termination shall be for nonpayment of premium or material misrepresentation only.

(e) Termination of a medicare supplement policy shall not reduce or limit the payment of benefits for any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of medicare part D benefits will not be considered in determining a continuous loss.

(f) If a medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the medicare prescription drug, improvement, and modernization act of 2003, Public Law 108-173, the modified policy shall be considered to satisfy the guaranteed renewal of this subsection.

(g) A medicare supplement policy shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(3) A medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder or certificate holder for a period not to exceed 24 months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under medicaid, but only if the policyholder or certificate holder notifies the insurer of such assistance within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the insurer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of medicaid eligibility, subject to adjustment for paid claims. If a suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance under medicaid, the policy shall be automatically reinstituted effective as of the date of termination of the assistance if the policyholder or certificate holder provides notice of loss of medicaid medical assistance within 90 days after the date of the loss and pays the premium attributable to the period effective as of the date of termination of the assistance. Each medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of title II of the social security act, and is covered under a group health plan as defined in section 1862(b)(1)(A)(*v*) of the social security act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. All of the following apply to the reinstitution of a medicare supplement policy under this subsection:

(a) The reinstitution shall not provide for any waiting period with respect to treatment of preexisting conditions.

(b) Reinstituted coverage shall be substantially equivalent to coverage in effect before the date of the suspension. If the suspended medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for medicare part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of the suspension.

(c) Classification of premiums for reinstituted coverage shall be on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(4) If an insurer makes a written offer to the medicare supplement policyholders or certificate holders of 1 or more of its plans, to exchange during a specified period from his or her 1990 standardized plan to a 2010 standardized plan, the offer and subsequent exchange shall comply with the following requirements:

(a) An insurer need not provide justification to the commissioner if the insured replaces a 1990 standardized policy or certificate with an issue age rated 2010 standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an

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issue age rate schedule at that time of that offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the prefunding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner.

(b) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(c) An insurer may not apply new preexisting condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 standardized policy or certificate of the insured, but may apply preexisting condition limitations of no more than 6 months to any added benefits contained in the new 2010 standardized policy or certificate not contained in the exchanged policy.

(d) The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

(5) This section applies to medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage prior to June 1, 2010.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3819a Medicare supplement policies or certificates with effective date for coverage on or after June 1, 2010; minimum standards.

Sec. 3819a. (1) This section applies to all Medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage on or after June 1, 2010.

(2) An insurance policy must not be titled, advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if the policy does not meet the minimum standards prescribed in this section. These minimum standards are in addition to all other requirements of this chapter. An issuer shall not offer any 1990 plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of section 3819.

(3) The following standards apply to Medicare supplement policies:

(a) A Medicare supplement policy must not deny a claim for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate must not define a preexisting condition more restrictively than to mean a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(b) A Medicare supplement policy must not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(c) A Medicare supplement policy must provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(d) A Medicare supplement policy must be guaranteed renewable. Termination must be for nonpayment of premium or material misrepresentation only.

(e) Termination of a Medicare supplement policy must not reduce or limit the payment of benefits for any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated on the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare part D benefits will not be considered in determining a continuous loss.

(f) A Medicare supplement policy must not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(4) A Medicare supplement policy must provide that benefits and premiums under the policy will be suspended at the request of the policyholder or certificate holder for a period not to exceed 24 months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Medicaid, but only if the policyholder or certificate holder notifies the insurer of the assistance within 90 days after the date the individual becomes entitled to the assistance. On receipt of timely notice, the insurer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims. If a suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance under Medicaid, the policy must be automatically reinstituted effective as of the date of termination of the assistance if the policyholder or certificate holder provides notice of loss of Medicaid medical assistance within 90 days after the date of the

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loss and pays the premium attributable to the period effective as of the date of termination of the assistance. A Medicare supplement policy must provide that benefits and premiums under the policy will be suspended at the request of the policyholder if the policyholder is entitled to benefits under 42 USC 426(b), and is covered under a group health plan as defined in 42 USC 1395y(b)(1)(a)(*v*). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy must be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. All of the following apply to the reinstitution of a Medicare supplement policy under this subsection:

(a) The reinstitution must not provide for any waiting period with respect to treatment of preexisting conditions.

(b) Reinstituted coverage must be substantially equivalent to coverage in effect before the date of the suspension.

(c) Classification of premiums for reinstituted coverage must be on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

History: Add. 2009, Act 220, Imd. Eff. Jan. 5, 2010;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3821 Issuance of policy to person not enrolled in medicare parts A and B prohibited; refund; interest.

Sec. 3821. (1) An insurer shall not issue an individual medicare supplement policy to a person who has not applied for or enrolled in medicare, parts A and B. If it is later determined that a person has not applied for or enrolled in medicare, parts A and B, an insurer shall refund all premiums received from the person for a medicare supplement policy issued to the person plus interest less the amount of any benefits received by the person under the policy.

(2) Interest under subsection (1) shall be calculated at 6-month intervals from the date the first premium payment was received at a rate of interest equal to 1% plus the average interest rate paid at auctions of 5-year United States treasury notes during the 6 months immediately preceding July 1 and January 1, as certified by the state treasurer, and compounded annually.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3823 Covered benefits more restrictive than benefits under medicare and required under state law prohibited; benefits for outpatient prescription drugs.

Sec. 3823. (1) An insurance policy shall not be titled, advertised, solicited, or issued for delivery in this state as a medicare supplement policy unless the definitions and terms contained in the policy are such that covered benefits under the policy are not more restrictive than covered benefits under medicare and those required to be provided under state law.

(2) A medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in part D at the option of the policyholder.

(3) A medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(4) After December 31, 2005, a medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in medicare part D unless:

(a) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a part D plan.

(b) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of medicare part D enrollment, accounting for any claims paid, if applicable.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006.

Popular name: Act 218

500.3825 Preexisting diseases or conditions; waiver prohibited.

Sec. 3825. A medicare supplement policy shall not use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

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Popular name: Act 218

500.3827 Duplicate benefits prohibited; application; statements and questions whether another policy in force; list of policies sold to applicant; notice regarding replacement coverage.

Sec. 3827. (1) A Medicare supplement insurance policy or certificate must not be delivered or issued for delivery in this state if the policy or certificate provides benefits that duplicate benefits provided by Medicare.

(2) Application forms or a supplementary application or other form to be signed by the applicant and agent for Medicare supplement policies, which may be provided in written or electronic format, must include the following statements and questions designed to inform and elicit information as to whether, on the date of the application, the applicant has Medicare supplement, Medicare advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any health policy or certificate presently in force:

[STATEMENTS]

(1) You do not need more than 1 Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days after becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy, or, if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days after losing Medicaid eligibility. If the Medicare supplement provided coverage for outpatient prescription drugs and you enrolled in Medicare part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy, or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days after losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.

[QUESTIONS]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X"]

To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months?
Yes ____ No ____

(b) Did you enroll in Medicare part B in the last 6 months?
Yes ____ No ____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?
[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

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Yes _____ No _____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes _____ No _____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare part B premium?

Yes _____ No _____

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes _____ No _____

(c) Was this your first time in this type of Medicare plan?

Yes _____ No _____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes _____ No _____

(4) (a) Do you have another Medicare supplement policy in force?

Yes _____ No _____

(b) If so, with what company, and what plan do you have [optional for direct mailers]?

_____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes _____ No _____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes _____ No _____

(a) If so, with what company and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)

(3) An agent shall list on the application form for a Medicare supplement policy any other health insurance policies, certificates, or contracts he or she has sold to the applicant, including policies, certificates, or contracts sold that are still in force and policies, certificates, and contracts sold in the past 5 years that are no longer in force.

(4) For a direct response insurer, the insurer shall return a copy of the application or supplement form, signed by the applicant, and acknowledged by the insurer, to the applicant on delivery of the policy or certificate.

(5) On determining that a sale will involve replacement of Medicare supplement coverage, an insurer, other than a direct response insurer or its agent, shall furnish the applicant before issuance or delivery of the Medicare supplement policy the following notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, unless the coverage is sold without an agent, must be provided to the applicant and an additional signed copy must be retained by the insurer. A direct

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response insurer shall deliver to the applicant at the time of issuance of the policy or certificate the following notice, regarding replacement of Medicare supplement coverage. The notice regarding replacement of Medicare supplement coverage must be provided in substantially the following form and in not less than 12-point type:

"NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE
(INSURANCE COMPANY'S NAME AND ADDRESS)
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to drop or otherwise terminate existing Medicare supplement coverage or Medicare advantage plan and replace it with a policy or certificate to be issued by (company name) insurance company. Your new policy or certificate provides 30 days within which you may decide without cost whether you desire to keep the policy or certificate.

You should review this new coverage carefully comparing it with all disability and other health coverage you now have and terminate your present coverage only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

Statement to applicant by insurer, agent, or other representative:

(Use additional sheets as necessary.)

I have reviewed your current medical or health coverage. The replacement of coverage involved in this transaction does not duplicate your existing Medicare supplement, or, if applicable, Medicare advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare advantage plan, to the best of my knowledge. The replacement policy is being purchased for the following reasons (check 1):

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ My plan has outpatient prescription drug coverage and I am enrolling in part D

_____ Disenrollment from a Medicare advantage plan. Please explain reason for disenrollment. [Optional only for direct mailers.]

_____ Other. (Please specify)

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. This paragraph may be deleted by an insurer if the replacement does not involve application of a new pre-existing condition limitation.

2. Your insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy or certificate for similar benefits to the extent such time was spent or depleted under the original coverage. This paragraph may be deleted by an insurer if the replacement does not involve application of a new preexisting condition limitation.

3. If, after thinking about it carefully, you still wish to drop your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed, and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

4. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
Signature of Agent, Broker, or Other Representative
(* Signature not required for direct response sales.)

_____
Typed Name and Address of Agent or Broker

_____
(Date)

The above "Notice to Applicant" was delivered to me on:

_____
(Date)
_____

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(Applicant's Signature)

_____

(Applicant's Printed Name)

_____

(Applicant's Address)

(Policy, Certificate, or Contract Number being Replaced)"

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3829 Denying or conditioning issuance based on health status, claims experience, receipt of health care, or medical condition of applicant prohibited; condition; exclusion of benefits based on preexisting conditions; reduction; creditable coverage.

Sec. 3829. (1) An insurer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy available for sale in this state, or discriminate in the pricing of such a policy, because of the health status, claims experience, receipt of health care, or medical condition of an applicant if an application for the policy is submitted during the 6-month period beginning with the first month in which an individual who is 65 years of age or older enrolled for benefits under Medicare part B. Each Medicare supplement policy currently available from an insurer must be made available to all applicants who qualify under this section without regard to age.

(2) If an applicant qualifies under subsection (1), submits an application during the time period provided in subsection (1), and as of the date of application has had a continuous period of creditable coverage of not less than 6 months, the insurer shall not exclude benefits based on a preexisting condition. If the applicant qualifies under subsection (1), submits an application during the time period in subsection (1), and as of the date of application has had a continuous period of creditable coverage that is less than 6 months, the insurer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subsection.

(3) Except as provided in subsection (2) and section 3833, subsection (1) does not prevent the exclusion of benefits under a policy, during the first 6 months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the 6 months before the coverage became effective.

(4) As used in this section, "creditable coverage" does not include any of the following:

(a) One or more of the following:

(*i*) Coverage only for accident or disability income insurance, or any combination of accident or disability income insurance.

(*ii*) Coverage issued as a supplement to liability insurance.

(*iii*) Liability insurance, including general liability insurance and automobile liability insurance.

(*iv*) Workers' compensation or similar insurance.

(*v*) Automobile medical payment insurance.

(*vi*) Credit-only insurance.

(*vii*) Coverage for on-site medical clinics.

(*viii*) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) The following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(*i*) Limited scope dental or vision benefits.

(*ii*) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of long-term care, nursing home care, home health care, or community-based care.

(*iii*) Such other similar, limited benefits as are specified in federal regulations.

(c) The following benefits if offered as independent, noncoordinated benefits:

(*i*) Coverage only for a specified disease or illness.

(*ii*) Hospital indemnity or other fixed indemnity insurance.

(d) The following if it is offered as a separate policy, certificate, or contract of insurance:

(*i*) Medicare supplemental policy as defined in 42 USC 1395ss.

(*ii*) Coverage supplemental to the coverage provided under chapter 55 of title 10 of the United States Code, 10 USC 1071 to 1110b.

(*iii*) Similar supplemental coverage provided to coverage under a group health plan.

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History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3829a Medicare supplement policies or certificates delivered, issued for delivery, or renewed on or after May 21, 2009; genetic test; definitions.

Sec. 3829a. (1) This section applies to all medicare supplement policies or certificates delivered, issued for delivery, or renewed on or after May 21, 2009.

(2) An insurer of a medicare supplement policy or certificate shall not do either of the following:

(a) Deny or condition the issuance or effectiveness of the policy or certificate, including the imposition of any exclusion of benefits under the policy based on a preexisting condition, on the basis of the genetic information with respect to that individual.

(b) Discriminate in the pricing of the policy or certificate, including the adjustment of premium rates, of an individual on the basis of the genetic information with respect to that individual.

(3) Nothing in subsection (2) limits the ability of an insurer, to the extent otherwise permitted by law, from doing either of the following:

(a) Denying or conditioning the issuance or effectiveness of a policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant.

(b) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. However, the manifestation of a disease or disorder in 1 individual cannot be used as genetic information about other group members and to further increase the premium for the group.

(4) An insurer of a medicare supplement policy or certificate shall not request or require an individual or a family member of that individual to undergo a genetic test.

(5) Subsection (4) does not preclude an insurer of a medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment, as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the health insurance portability and accountability act of 1996, 42 USC 1320d to 1320d-8, and consistent with subsection (2).

(6) For purposes of carrying out subsection (5), an insurer of a medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(7) Notwithstanding subsection (4), an insurer of a medicare supplement policy may request, but not require, that an individual, or a family member of that individual, undergo a genetic test if each of the following conditions is met:

(a) The request is made pursuant to research that complies with 45 CFR part 46, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.

(b) The insurer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of that child, to whom the request is made, that compliance with the request is voluntary and that noncompliance will have no effect on enrollment status or premium or contribution amounts.

(c) Genetic information collected or acquired under this subsection shall not be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(d) The insurer notifies the commissioner in writing that the insurer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.

(e) The insurer complies with any other conditions as the commissioner may by regulation require for activities conducted under this subsection.

(8) An insurer of a medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

(9) An insurer of a medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to that individual's enrollment under the policy in connection with that enrollment.

(10) If an insurer of a medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, that request, requirement, or purchase is not a violation of subsection (9) if that request, requirement, or purchase does not violate subsection (8).

(11) As used in this section:

(a) "Family member" means, with respect to an individual, any other individual who is a first-degree,

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second-degree, third-degree, or fourth-degree relative of that individual.

(b) "Genetic information" means, with respect to any individual, information about that individual's genetic tests, the genetic tests of family members of that individual, and the manifestation of a disease or disorder in family members of that individual. Genetic information includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by that individual or any family member of that individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman includes genetic information of any fetus carried by that pregnant woman or, with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. Genetic information does not include information about the sex or age of any individual.

(c) "Genetic services" means a genetic test, genetic counseling, including obtaining, interpreting, or assessing genetic information, or genetic education.

(d) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. Genetic test does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(e) "Insurer of a medicare supplement policy or certificate" includes a third-party administrator or other person acting for or on behalf of that insurer.

(f) "Underwriting purposes" means all of the following:

(*i*) Rules for, or determination of, eligibility, including enrollment and continued eligibility, for benefits under the policy.

(*ii*) The computation of premium or contribution amounts under the policy.

(*iii*) The application of any preexisting condition exclusion under the policy.

(*iv*) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

History: Add. 2009, Act 219, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3830 Eligible person; requirements.

Sec. 3830. (1) An eligible person is an individual described in subsection (2) who applies to enroll under a medicare supplement policy during the period described in subsection (3), and who submits evidence of the date of termination or disenrollment or medicare part D enrollment with the application for a medicare supplement policy. For an eligible person, an insurer shall not deny or condition the issuance or effectiveness of a medicare supplement policy described in subsections (5), (6), and (7) that is offered and is available for issuance to new enrollees by the insurer, shall not discriminate in the pricing of the medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under the medicare supplement policy.

(2) An eligible person under this section is an individual that meets any of the following:

(a) Is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under medicare and the plan terminates or the plan ceases to provide all those supplemental health benefits to the individual.

(b) Is enrolled with a medicare advantage organization under a medicare advantage plan under part C of medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1894 of the social security act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a medicare advantage plan:

(*i*) The certification of the organization or plan has been terminated.

(*ii*) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(*iii*) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(b) of the social security act, where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards established under section 1856 of the social security act, or the plan is terminated for all individuals within a residence area.

(*iv*) The individual demonstrates, in accordance with guidelines established by the secretary, that the

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organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide covered care in accordance with applicable quality standards, or the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(*v*) The individual meets other exceptional conditions as the secretary may provide.

(c) Is enrolled with an eligible organization under a contract under section 1876 of the social security act, a similar organization operating under demonstration project authority, effective for periods before April 1, 1999, an organization under an agreement under section 1833(a)(1)(A) of the social security act, health care prepayment plan, or an organization under a medicare select policy, and the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subdivision (b).

(d) Is enrolled under a medicare supplement policy and the enrollment ceases because of any of the following:

(*i*) The insolvency of the insurer or bankruptcy of the noninsurer organization or of other involuntary termination of coverage or enrollment under the policy.

(*ii*) The insurer substantially violated a material provision of the policy.

(*iii*) The insurer, or an agent or other entity acting on the insurer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(e) Was enrolled under a medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any medicare advantage organization under a medicare advantage plan under part C of medicare, any eligible organization under a contract under section 1876 of the social security act, medicare cost, any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the social security act, or a medicare select policy; and the subsequent enrollment is terminated by the enrollee during any period within the first 12 months of the subsequent enrollment during which the enrollee is permitted to terminate the subsequent enrollment under section 1851(e) of the social security act.

(f) Upon first becoming eligible for benefits under part A of medicare at age 65, enrolls in a medicare advantage plan under part C of medicare, or with a PACE provider under section 1894 of the social security act, and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment.

(g) Enrolls in a medicare part D plan during the initial enrollment period and, at the time of enrollment in part D, was enrolled under a medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the medicare supplement policy and submits evidence of enrollment in medicare part D along with the application for a policy described in subsection (5).

(3) The guaranteed issue time periods under this section are as follows:

(a) For an individual described in subsection (2)(a), the guaranteed issue time period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if a notice is not received, notice that a claim has been denied because of a termination or cessation, or the date that the applicable coverage terminates or ceases, whichever occurs later, and ends 63 days after that date.

(b) For an individual described in subsection (2)(b), (c), (e), or (f) whose enrollment is terminated involuntarily, the guaranteed issue time period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(c) For an individual described in subsection (2)(d)(*i*), the guaranteed issue time period begins on the earlier of the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, or the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(d) For an individual described in subsection (2)(b), (d)(*ii*), (d)(*iii*), (e), or (f) who disenrolls voluntarily, the guaranteed issue time period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

(e) In the case of an individual described in subsection (2)(g), the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the social security act from the medicare supplement issuer during the 60-day period immediately preceding the initial part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under medicare part D.

(f) For an individual described in subsection (2) but not described in subdivisions (a) to (d), the guaranteed issue time period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(4) For an individual described in subsection (2)(e) whose enrollment with an organization or provider described in subsection (2)(e) is involuntarily terminated within the first 12 months of enrollment, and who,

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without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be considered an initial enrollment described in subsection (2)(e). For an individual described in subsection (2)(f) whose enrollment within a plan or in a program described in subsection (2)(f) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be considered an initial enrollment described in subsection (2)(f). For purposes of subsections (2)(e) and (f), an enrollment of an individual with an organization or provider described in subsection (2)(e), or with a plan or provider described in subsection (2)(f), shall not be considered to be an initial enrollment after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, or plan.

(5) Subject to this subsection, the medicare supplement policy to which an eligible person is entitled under subsection (2)(a), (b), (c), and (d) is a medicare supplement policy that has a benefit package classified as plan A, B, C, or F including F with a high deductible, K, or L offered by any insurer. After December 31, 2005, if the individual was most recently enrolled in a medicare supplement policy with an outpatient prescription drug benefit, a medicare supplement policy described in this subsection is:

(a) The policy available from the same insurer but modified to remove outpatient prescription drug coverage.

(b) At the election of the policyholder, an A, B, C, F, including F with a high deductible, K, or L policy that is offered by any insurer.

(6) The medicare supplement policy to which an eligible person is entitled under subsection (2)(e) is the same medicare supplement policy in which the individual was most recently previously enrolled, if available from the same insurer, or, if not so available, a policy described in subsection (5).

(7) The medicare supplement policy to which an eligible person is entitled under subsection (2)(f) shall include any medicare supplement policy offered by any insurer.

(8) Subsection (2)(g) is a medicare supplement policy that has a benefit package classified as plan A, B, C, F, including F with a high deductible, K, or L, and that is offered and is available for issuance to new enrollees by the same insurer that issued the individual's medicare supplement policy with outpatient prescription drug coverage.

History: Add. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006.

Popular name: Act 218

500.3830a Termination of contract or agreement; notice to individual.

Sec. 3830a. (1) At the time of an event described in section 3830(2) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the insurer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under section 3830 and of the obligations of insurers of medicare supplement policies under section 3830(1). The notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in section 3830(2) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under section 3830 and of the obligations of insurers of medicare supplement policies under section 3830(1). The notice shall be communicated within 10 working days of the insurer receiving notification of disenrollment.

History: Add. 2002, Act 304, Imd. Eff. May 10, 2002.

Popular name: Act 218

500.3831 Individual or group expense incurred hospital, medical, or surgical policies; right of continuation or conversion to medicare supplemental plan; request for coverage; exclusion from preexisting conditions; notice of availability of coverage; utilization of another insurer to write coverage.

Sec. 3831. (1) Each insurer offering group expense incurred hospital, medical, or surgical policies or certificates in this state shall make available without restriction, to any person who requests coverage from an insurer and has been insured with an insurer, if the person loses coverage under a group policy after becoming eligible for Medicare, a right of continuation or conversion to 1 of the following Medicare supplement plans that is guaranteed renewable or noncancellable:

(a) A policy form or certificate form that contains the basic core benefits as described in section 3807 or 3807a.

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(b) A policy form or certificate form that the insurer has chosen to offer that contains either standardized benefit plan C or standardized benefit plan F. For an individual newly eligible for Medicare after December 31, 2019, any reference to standardized benefit plan C or standardized benefit plan F is deemed a reference to Medicare supplement standardized benefit plan D or Medicare supplement standardized benefit plan G, respectively.

(2) A person who is hospitalized or has been informed by a physician that he or she will require hospitalization within 30 days after the time of application is not entitled to coverage under subsection (1) until the day following the date of discharge. However, if the hospitalized person was insured by the insurer immediately before losing coverage under a group policy after becoming eligible for Medicare, the person is eligible for immediate coverage from the previous insurer under subsection (1). A person is not entitled to a Medicare supplemental policy under subsection (1) unless the person presents satisfactory proof to the insurer that he or she was insured with an insurer subject to this section. A person who wishes coverage under subsection (1) must request coverage within 180 days after losing coverage under a group policy. A person 60 years of age or older who loses coverage under a group policy is entitled to coverage under a Medicare supplemental policy without restriction from the insurer providing the former group coverage, if he or she requests coverage within 90 days before or 90 days after the month he or she becomes eligible for Medicare.

(3) Except as provided in section 3833, a person not insured under a group hospital, medical, or surgical expense incurred policy as specified in subsection (1), after applying for coverage under a Medicare supplemental policy required to be offered under subsection (1), is entitled to coverage under a Medicare supplemental policy that may include a provision for exclusion from preexisting conditions for 6 months after the inception of coverage, consistent with the provisions of section 3819(2)(a) or 3819a(3)(a).

(4) Each group policyholder providing hospital, medical, or surgical expense incurred coverage in this state shall give to each certificate holder who is covered at the time he or she becomes eligible for Medicare, written notice of the availability of coverage under this section.

(5) Notwithstanding the requirements of this section, an insurer offering or renewing group expense incurred hospital, medical, or surgical policies or certificates after June 27, 2005 may comply with the requirement of providing Medicare supplemental coverage to eligible policyholders by utilizing another insurer to write this coverage if the insurer meets all of the following requirements:

(a) The insurer provides its policyholders the name of the insurer that will provide the Medicare supplemental coverage.

(b) The insurer gives its policyholders the telephone numbers at which the Medicare supplemental insurer can be reached.

(c) The insurer remains responsible for providing Medicare supplemental coverage to its policyholders if the other insurer no longer provides coverage and another insurer is not found to take its place.

(d) The insurer provides certification from an executive officer for the specific insurer or affiliate of the insurer wishing to utilize this option. This certification must identify the process provided in subdivisions (a) to (c) and must clearly state that the insurer understands that the director may void this arrangement if the affiliate fails to ensure that eligible policyholders are immediately offered Medicare supplemental policies.

(e) If the insurer is unable to meet the requirements of subdivisions (a) to (d), the insurer certifies to the director that it is in the process of discontinuing in this state its offering of individual or group expense incurred hospital, medical, or surgical policies or certificates.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3833 Replacement policy; waiver of certain time periods.

Sec. 3833. If a medicare supplement policy or certificate replaces another medicare supplement policy, certificate, or contract, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new medicare supplement policy for similar benefits to the extent such time was spent under the original coverage.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3835 Marketing procedures; determining appropriateness of recommended purchase or replacement; more than 1 policy prohibited; individual enrolled in medicare advantage; "notice to buyer" displayed.

Sec. 3835. (1) An insurer that markets Medicare supplement insurance coverage in this state directly or through its agents shall do all of the following:

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(a) Establish marketing procedures to ensure that any comparison of policies by its agents will be fair and accurate.

(b) Establish marketing procedures to ensure excessive insurance is not sold or issued.

(c) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant for Medicare supplement insurance already has health coverage.

(d) Establish auditable procedures for verifying compliance with this subsection.

(2) In recommending the purchase or replacement of any Medicare supplement coverage, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(3) Any sale of Medicare supplement coverage that will provide an individual with more than 1 Medicare supplement policy, certificate, or contract is prohibited.

(4) An insurer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare advantage unless the effective date of the coverage is after the termination date of the individual's Medicare advantage coverage.

(5) A medical supplement policy must display prominently by type, stamp, or other appropriate means, on the first page of the policy the following: "Notice to buyer: This policy may not cover all of your medical expenses.".

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3837 Repealed. 2002, Act 304, Imd. Eff. May 10, 2002.

Compiler's note: The repealed section pertained to report to commissioner.

Popular name: Act 218

500.3839 Renewal or continuation provision; effect of termination or replacement; elimination of outpatient prescription drug benefit.

Sec. 3839. (1) Each medicare supplement policy shall include a renewal or continuation provision. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the term of coverage for which the policy is issued and for which it may be renewed. The provision shall include any reservation by the insurer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) If a medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subsection (4), the issuer shall offer certificate holders an individual medicare supplement policy that at the option of the certificate holder provides for continuation of the benefits contained in the group policy or provides for such benefits as otherwise meet the requirements of section 3819 or 3819a.

(3) If an individual is a certificate holder in a group medicare supplement policy and the individual terminates membership in the group, the issuer shall offer the certificate holder the conversion opportunity described in subsection (2) or (4) or at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(4) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(5) If a medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the medicare prescription drug, improvement, and modernization act of 2003, Public Law 108-173, the modified policy shall be considered to satisfy the guaranteed renewal requirements of this section.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3841 Riders or endorsements; signed acceptance or agreement; additional premium; use of certain standards, terms, and words; filing of changes in medicare benefits; elimination of duplicate benefits; notice of modifications; notice requirements of medicare prescription drug, improvement, and modernization act of 2003.

Sec. 3841. (1) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured, exercises a specifically reserved right under a medicare supplement policy, or as required to reduce or eliminate benefits to avoid duplication of medicare benefits, all riders or endorsements added to a

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medicare supplement policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured. After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing and signed by the insured, unless the benefits are required minimum standards for medicare supplement policies or if the increase in benefits or coverage is required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charged shall be set forth in the policy.

(2) A medicare supplement policy shall not provide for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import.

(3) If a medicare supplement policy contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy and shall be labeled as "preexisting condition limitations".

(4) The term "medicare supplement", "medigap", "medicare wrap-around", or words of similar import shall not be used unless the policy is issued in compliance with this chapter.

(5) As soon as practicable but prior to the effective date of any changes in medicare benefits, every insurer offering medicare supplement insurance policies in this state shall file with the commissioner both of the following:

(a) Any appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies and any supporting documents necessary to justify the adjustment.

(b) Any appropriate riders, endorsements, or policy forms needed to accomplish the medicare supplement insurance modifications necessary to eliminate benefits under the policy or certificate that duplicate benefits provided by medicare. The riders, endorsements, and policy forms shall provide a clear description of the medicare supplement benefits provided by the policy.

(6) Upon satisfying the filing and approval requirements, an insurer providing medicare supplement policies delivered or issued for delivery in this state shall provide to each covered policyholder any rider, endorsement, or policy form necessary to eliminate benefits under the policy that duplicate benefits provided by medicare.

(7) As soon as practicable but no later than 30 days before the annual effective date of any medicare benefit changes, every insurer of medicare supplement policies delivered or issued for delivery in this state shall notify each covered policyholder or certificate holder of modifications made to its medicare supplement policies in a format acceptable to the commissioner. The notice shall be in outline form, contain clear and simple language, shall not contain or be accompanied by any solicitation, and shall include both of the following:

(a) A description of revisions to the medicare program and of each modification made to the coverage provided under the medicare supplement policy.

(b) Whether a premium adjustment is due to changes in medicare.

(8) Insurers shall comply with any notice requirements of the medicare prescription drug, improvement, and modernization act of 2003, Public Law 108-173.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006.

Popular name: Act 218

500.3843 Health insurance; notice; contents; applicability of subsection (1).

Sec. 3843. (1) A policy or certificate of health insurance issued for delivery in this state to persons eligible for Medicare by reason of age must notify insureds under the policy or certificate that the policy is not a Medicare supplement policy. The notice must either be printed or attached to the first page of the coverage outline delivered to insureds under the policy or certificate or, if a coverage outline is not delivered, to the first page of the policy or certificate delivered to insureds. The notice must be in not less than 12-point type, and must contain the following language:

"This (policy or certificate) is not a Medicare supplement (policy or certificate). It is not designed to fit with Medicare. It may not fit all of the gaps in Medicare and it may duplicate some Medicare benefits. If you are eligible for Medicare, review the Medicare supplement buyer's guide available from the company. If you decide to consider buying this policy or certificate, be sure you understand what it covers, what it does not cover, and whether it duplicates coverage you already have."

(2) Subsection (1) does not apply to any of the following:

(a) A Medicare supplement policy or certificate.

(b) A disability income policy or certificate.

(c) A single premium nonrenewable policy or certificate.

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History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3847 Advertising; filing copy with director.

Sec. 3847. An insurer that provides Medicare supplement insurance coverage in this state shall file with the director for review a copy of any written, radio, or television advertisement for Medicare supplement insurance intended for use in this state at least 30 days before the date the insurer desires to use the advertising. The filing must include a sample or photocopy of all applicable Medicare supplement policies and related forms and the approval status of the policies and forms.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3849 Filing and approval requirements; deletion of outpatient prescription drug benefits; issuance of policy; use and change in premium rates; additional forms; availability; conditions and effect of discontinuance; combining forms for purposes of refund or credit calculation; compliance with federal law; "type" defined.

Sec. 3849. (1) An insurer shall not deliver or issue for delivery a medicare supplement policy to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

(2) An insurer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the medicare prescription drug, improvement, and modernization act of 2003, Public Law 108-173, only with the commissioner in the state in which the policy or certificate was issued.

(3) An insurer shall not use or change premium rates for a medicare supplement policy unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

(4) Except as provided in subsection (5), an insurer shall not file for approval more than 1 form of a policy or certificate for each individual policy and group policy standard medicare supplement benefit plan.

(5) With the approval of the commissioner, an issuer may offer up to 4 additional policy forms or certificate forms of the same type for the same standard medicare supplement benefit plan, 1 for each of the following cases:

(a) The inclusion of new or innovative benefits.

(b) The addition of either direct response or agent marketing methods.

(c) The addition of either guaranteed issue or underwritten coverage.

(d) The offering of coverage to individuals eligible for medicare by reason of disability.

(6) Except as provided in subsection (7), an insurer shall continue to make available for purchase any medicare supplement policy form or certificate form issued after the effective date of this chapter that has been approved by the commissioner. A medicare supplement policy form or certificate form shall not be considered to be available for purchase unless the insurer has actively offered it for sale in the previous 12 months.

(7) An insurer may discontinue the availability of a medicare supplement policy form or certificate form if the insurer provides to the commissioner in writing its decision to discontinue at least 30 days prior to discontinuing the availability of the form of the medicare supplement policy. After receipt of the notice by the commissioner, the insurer shall no longer offer for sale the medicare supplement policy form or certificate form in this state.

(8) An insurer that discontinues the availability of a medicare supplement policy form or certificate form pursuant to subsection (7) shall not file for approval a new medicare supplement policy form or certificate form of the same type for the same standard medicare supplement benefit plan as the discontinued form for a period of 5 years after the insurer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(9) The sale or other transfer of medicare supplement business to another insurer shall be considered a discontinuance for the purposes of this section. In addition, a change in the rating structure or methodology shall be considered a discontinuance under this section unless the insurer complies with the following requirements:

(a) The insurer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing methodology and existing rates.

(b) The insurer does not subsequently put into effect a change of rates or rating factors that would cause

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the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

(10) The experience of all medicare supplement policy forms or certificate forms of the same type in a standard medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section 3853 except that forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(11) Each insurer that issues medicare supplement policies for delivery in this state shall comply with sections 1842 and 1882 of title XVIII of the social security act, 42 USC 1395u and 1395ss, and shall certify that compliance on the medicare supplement insurance experience reporting form.

(12) For the purposes of this section, "type" means an individual policy, a group policy, an individual medicare select policy, or a group medicare select policy.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006.

Popular name: Act 218

500.3851 Aggregate benefits; rates, rating schedules, and rate revisions.

Sec. 3851. (1) A medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, the following:

(a) For group policies at least 75% of the aggregate amount of premiums earned calculated on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed and in accordance with accepted actuarial principles and practices.

(b) For individual policies at least 65% of the aggregate amount of premium earned calculated on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed and in accordance with accepted actuarial principles and practices.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3852 Benchmark ratio.

Sec. 3852. An insurer shall file by May 31 of each year a reporting form for the calculation of benchmark ratio since inception in a format prescribed by the commissioner for each type in a standard medicare supplement benefit plan.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3853 Refund or credit calculation; form; interest; due date.

Sec. 3853. If on the basis of the experience as reported by an insurer under section 3852 the benchmark ratio since inception (ratio 1) exceeds the adjusted experienced ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis on a refund calculation form in a format prescribed by the commissioner for each type in a standard medicare supplement benefit plan. For purposes of the refund or credit calculation, only experience on policies issued within the reporting year shall be excluded. A refund or credit shall be made only where the benchmark loss ratio exceeds the adjusted experienced loss ratio and the amount to be refunded or credited exceeds the minimum level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but not less than the average rate of interest for 13-week treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3855 Annual filing of rates, rating schedule, and supporting documentation; premium adjustments; public hearing for rate increase; failure to make premium adjustments.

Sec. 3855. (1) Each insurer that issues medicare supplement policies for delivery in this state shall file

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annually with the commissioner, on a form and in the manner prescribed by the commissioner, its rates, rating schedule, and supporting documentation including all claims experience of the insurer for medicare supplement coverage. The filings and schedules shall demonstrate that the actual and expected losses in relation to premiums are in compliance with the applicable loss ratio standards of this state. The supporting documentation shall also be in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed excluding active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage under section 3851 shall be demonstrated for policies or certificates in force less than 3 years.

(2) An insurer shall make such premium adjustments as are necessary to produce an expected loss ratio under the medicare supplement policy as will conform with minimum loss ratio standards for medicare supplement policies and certificates and that are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the insurer for such medicare supplement insurance policies. A premium adjustment that would modify the loss ratio experience under the policy shall not be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(3) The commissioner may conduct a public hearing to gather information concerning a request by a medicare supplement insurer for an increase in a rate for a medicare supplement policy form or certificate form issued before or after the effective date of this chapter if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance shall be made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner considered appropriate by the commissioner.

(4) If a medicare supplement insurer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds, or premium credits considered necessary to achieve the loss ratio required by this section.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3857 Duties of insurer; certification of compliance with subsection (1)(a).

Sec. 3857. (1) An insurer shall do all of the following:

(a) Accept a notice from a medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and make a payment determination on the basis of the information contained in that notice.

(b) Notify the participating physician or supplier and the beneficiary of the payment determination.

(c) Pay the participating physician or supplier directly.

(d) Furnish, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a medicare carrier may be sent.

(e) Pay user fees for claim notices that are transmitted electronically or otherwise.

(f) Provide to the secretary of health and human services, at least annually, a central mailing address to which all claims may be sent by medicare carriers.

(2) Compliance with the requirements set forth in subsection (1)(a) shall be certified on the medicare supplement insurance experience reporting form.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3859 Prohibited conduct; violation as misdemeanor; penalty.

Sec. 3859. (1) A person shall not knowingly sell a health insurance policy or certificate to an individual entitled to benefits under part A or enrolled under part B of medicare with knowledge that the policy or certificate substantially duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of state or federal law other than medicare. A person who violates this subsection is guilty of a misdemeanor punishable by imprisonment for not more than 2 years, or a fine of not more than $10,000.00, or both. The court may order a person convicted under this subsection to pay restitution to individuals for expenses incurred as a result of violation of this subsection. For purposes of this subsection, benefits that are payable to or on behalf of an individual without regard to other health benefit coverage of the individual shall not be considered as duplicative. The selling of a group certificate or contract of the trustees of a fund established by 1 or more employers, labor organizations, or both, for employees, former employees, or both, or for members or former members, or both, of labor organizations, shall not be considered to be a violation of this subsection.

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(2) A person shall not falsely assume or pretend to be acting or misrepresent in any way that he or she is acting under the authority of or in association with medicare or any state or federal agency, for the purpose of selling or attempting to sell insurance or, in such a pretended character, demand or obtain money, paper, documents, or any thing of value. A person who violates this subsection is guilty of a misdemeanor punishable by imprisonment for not more than 2 years, or a fine of not more than $10,000.00, or both.

(3) A person shall not solicit, offer for sale, or deliver a medicare supplement policy in this state, unless the policy has been approved by the commissioner. A person who violates this subsection is guilty of a misdemeanor punishable by imprisonment for not more than 1 year, or a fine of not more than $5,000.00, or both.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3861 Probable cause of violation; notice of hearing; opportunity to confer and discuss; hearing; applicability of MCL 500.2038 to 500.2040; violation; penalty.

Sec. 3861. (1) If the commissioner has probable cause to believe that an insurer or agent has violated or is violating this chapter and that a hearing by the commissioner would be in the public interest, the commissioner shall give notice in writing to the person involved pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, setting forth the general nature of the complaint against him or her, and the proceedings contemplated. Before the issuance of a notice of hearing, the commissioner shall give the person an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or his or her representative, and the matter may be disposed of summarily upon agreement of the parties.

(2) The provisions of section 2030 shall apply with respect to a hearing held pursuant to subsection (1), except that the use of an independent hearing officer shall not be allowed.

(3) If, after opportunity for a hearing held pursuant to Act No. 306 of the Public Acts of 1969, the commissioner determines that the insurer or agent has violated this chapter, the provisions of sections 2038 to 2040 shall apply. Each medicare supplement policy issued or delivered in violation of any of the provisions contained in this chapter shall constitute a separate violation for purposes of assessing a civil fine.

(4) In addition to any other applicable penalties for violations of this act, the commissioner may require insurers violating this chapter to cease marketing any medicare supplement policy or certificate in this state that is related directly or indirectly to a violation or may require the insurer to take such actions as are necessary to comply with this chapter.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

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CHAPTER 39
LONG-TERM CARE INSURANCE

500.3901 Long-term care insurance; definitions.

Sec. 3901. As used in this chapter:

(a) "Acute condition" means that the individual is medically unstable, requiring frequent monitoring by medical professionals in order to maintain his or her health status.

(b) "Applicant" means:

(*i*) For an individual long-term care insurance policy, the person who seeks to contract for long-term care benefits.

(*ii*) For a group long-term care insurance certificate, the proposed certificate holder.

(c) "Group long-term care insurance" means a long-term care insurance certificate that is delivered or issued for delivery in this state and issued to any of the following:

(*i*) One or more employers or labor organizations, or to a trust or the trustees of a fund established by 1 or more employers or labor organizations for employees or former employees or members or former members of the labor organization.

(*ii*) A professional, trade, or occupational association for its members or former or retired members if the association is composed of individuals who were all actively engaged in the same profession, trade, or occupation and the association has been maintained in good faith for purposes other than obtaining insurance unless waived by the commissioner.

(*iii*) Subject to section 3903(2), an association or to a trust or to the trustees of a fund established, created, or maintained for the benefit of members of 1 or more associations.

(*iv*) A group other than that described in subparagraphs (*i*), (*ii*), or (*iii*) if the commissioner determines all

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of the following:

(A) The issuance of the group certificate is not contrary to the best interests of the public.

(B) The issuance of the group certificate would result in economies of acquisition or administration.

(C) The benefits are reasonable in relation to the premiums charged.

(d) "Guaranteed renewable" means the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and the insurer does not have a unilateral right to make any change in any provision of the policy or rider while the insurance is in force and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(e) "Home care services" means 1 or more of the following prescribed services or assessment team recommended services for the long-term care and treatment of an insured that are to be provided in a noninstitutional setting according to a written diagnosis and plan of care or individual assessment and plan of care:

(*i*) Nursing services under the direction of a registered nurse, including the service of a home health aide.

(*ii*) Physical therapy.

(*iii*) Speech therapy.

(*iv*) Respiratory therapy.

(*v*) Occupational therapy.

(*vi*) Nutritional services provided by a registered dietitian.

(*vii*) Personal care services, homemaker services, adult day care, and similar nonmedical services.

(*viii*) Medical social services.

(*ix*) Other similar medical services and health-related support services.

(f) "Home health or care agency" means a person certified by medicare whose business is to provide to individuals in their places of residence other than in a hospital, nursing home, or county medical care facility, 1 or more of the following services: nursing services, therapeutic services, social work services, homemaker services, home health aide services, or other related services.

(g) "Intermediate care facility" means a facility, or distinct part of a facility, certified by the department of community health to provide intermediate care, custodial care, or basic care that is less than skilled nursing care but more than room and board.

(h) "Long-term care insurance" means an individual or group insurance policy, certificate, or rider advertised, marketed, offered, or designed to provide coverage for at least 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for 1 or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, personal, or custodial care services provided in a setting, including an assisted living facility operating legally in this state, but not including an acute care unit of a hospital. Long-term care insurance includes individual or group annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. Long-term care insurance does not include a life insurance policy that accelerates the death benefit specifically for 1 or more of the qualifying events of terminal illness or medical conditions requiring extraordinary medical intervention or permanent institutional confinement and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Long-term care insurance does not include an insurance policy offered primarily to provide coverage for rehabilitative and convalescent care and is not offered, advertised, or marketed as a long-term care policy, or offered primarily to provide basic medicare supplemental coverage, hospital confinement indemnity coverage, basic hospital expense coverage, basic medical-surgical expense coverage, major medical expense coverage, disability income protection coverage, catastrophic coverage, comprehensive coverage, accident only coverage, specific disease or specified accident coverage, or limited benefit health coverage.

(i) "Medicare" means title XVIII of the social security act, 42 USC 1395 to 1395ggg.

(j) "Nonprofit health care corporation" means a nonprofit health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

(k) "Preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within the 6 months immediately before the effective date of coverage of an insured person.

(*l*) "Policy" means an insurance policy or certificate, rider, or endorsement delivered or issued for delivery in this state by an insurer or subsidiary of a nonprofit health care corporation.

(m) "Skilled nursing facility" means a facility, or a distinct part of a facility, certified by the department of community health to provide skilled nursing care.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 441, Imd. Eff. Oct. 19, 2006.

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Popular name: Act 218

500.3901a Long-term care insurance policies; discrimination against living donors; prohibition; definitions.

Sec. 3901a. (1) This section applies to all long-term care insurance policies or certificates delivered or issued for delivery after December 31, 2023.

(2) Unless there is an additional actuarial risk, as determined in accordance with sound actuarial principles as well as the individual's actual and reasonably anticipated experience, an insurer shall not do any of the following with respect to a long-term care insurance policy or certificate based solely on the individual's status as a living donor:

(a) Deny coverage.

(b) Cancel coverage.

(c) Refuse to issue the policy or certificate.

(d) Determine the price or premium for the policy or certificate.

(e) Otherwise vary a term or condition of the policy or certificate.

(3) As used in this section:

(a) "Living donor" means an individual who is not deceased and has donated any of the following:

(*i*) All or part of an organ.

(*ii*) A tissue.

(b) "Organ" means a human kidney, liver, heart, lung, pancreas, esophagus, stomach, or small or large intestine, a portion of the gastrointestinal tract, or another part of the human body designated by the department by rule.

(c) "Tissue" means a portion of the human body other than an organ, including, but not limited to, an eye, skin, bone, bone marrow, a heart valve, a spermatozoon, an ova, an artery, a vein, a tendon, a ligament, blood, blood derivatives, a pituitary gland, or fluid.

History: Add. 2023, Act 192, Imd. Eff. Nov. 7, 2023.

Popular name: Act 218

500.3902 Offer of long-term care coverage by subsidiary of health care corporation.

Sec. 3902. A nonprofit health care corporation shall only offer long-term care coverage through a subsidiary of the health care corporation and as provided in this chapter. If a health care corporation subsidiary offers long-term care coverage in this state, the sale of that coverage is not exempt from taxation by this state or any political subdivision of this state.

History: Add. 2006, Act 441, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3903 Group long-term care insurance; coverage offered to groups described in MCL 500.3901(c)(iv) and 500.3901(c)(iii).

Sec. 3903. (1) Group long-term care insurance coverage shall not be offered to a resident of this state under a group certificate issued in another state to a group described in section 3901(c)(*iv*), unless this state or another state which the commissioner determines has and enforces statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that those requirements have been met.

(2) Before advertising, marketing, or offering a group long-term care insurance certificate within this state to a group described in section 3901(c)(*iii*), the group or the insurer shall file evidence with the commissioner that the group meets all of the following requirements:

(a) Consists of at least 100 members.

(b) Has been in active existence for at least 1 year.

(c) Holds regular meetings at least annually.

(d) Except for credit unions, the group collects dues or solicits contributions from members.

(e) The members have voting privileges and representation on the governing board and committees.

(f) Has been organized and maintained in good faith for purposes other than obtaining insurance unless the commissioner waives this requirement.

(3) Thirty days after making the filing under this section, the group described in section 3901(c)(*iii*) shall be considered to satisfy subsection (2) organizational requirements, unless the commissioner makes a finding that the group does not satisfy those organizational requirements.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

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500.3905 Long-term care coverage; requirements; certain coverages requiring care recommendations.

Sec. 3905. (1) Long-term care coverage shall meet all of the following requirements:

(a) Shall include coverage for intermediate/basic care, which shall not be significantly less than the coverage provided for skilled nursing care.

(b) Shall not limit or exclude coverage by type of illness, type of provider, territorial limitations, treatment, medical condition, or accident other than a motor vehicle accident, except as follows:

(*i*) Preexisting conditions.

(*ii*) Mental or nervous disorders; however, this shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder and shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or related disorders.

(*iii*) Alcoholism or drug addiction.

(*iv*) Illness, treatment, or medical condition arising out of any of the following:

(A) War or act of war, whether declared or undeclared.

(B) Participation in a felony, riot, or insurrection.

(C) Service in the armed forces or units auxiliary to the armed forces.

(D) Suicide, whether or not the individual was sane or insane at the time of the suicide, attempted suicide, or intentionally self-inflicted injury.

(2) Long-term care coverage other than home care coverage may provide that before certain coverages in the policy take effect, care must first be recommended by a person or persons as provided in the policy and approved by the commissioner or prescribed by a licensed treating physician. Long-term care coverage for home care may provide that before coverage for home care in the policy takes effect, care must first be prescribed or recommended by a person or persons as provided in the policy and approved by the commissioner.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3906 Designation of person to receive notice of termination; reinstatement of coverage; effective date of section.

Sec. 3906. (1) An individual long-term care policy or certificate shall not be issued until the insurer has received from the applicant either a written designation of at least 1 person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant may designate at least 1 person who is to receive the notice of termination, in addition to the insured. A designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation shall provide space clearly designated for listing at least 1 person. The designation shall include each person's full name and home address. For an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least 1 person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer shall notify the insured of the right to change this written designation, no less often than once every 2 years.

(2) If the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, subsection (1) does not apply until 60 days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(3) An individual long-term care policy or certificate shall not lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated under subsection (1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States mail, postage prepaid, and notice shall not be given until 30 days after a premium is due and unpaid. Notice shall be considered given 5 days after the date of mailing.

(4) A long-term care insurance policy or certificate shall provide for reinstatement of coverage if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within 5 months after termination and shall allow for the collection of past due

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premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

(5) This section takes effect March 1, 2007 and applies to long-term care policies and certificates issued on or after March 1, 2007.

History: Add. 2006, Act 442, Eff. Mar. 1, 2007.

Popular name: Act 218

500.3907 Individual long-term care policy; guaranteed renewable provision; conversion; new limitation period; intermediate care facility or skilled nursing facility; home care services.

Sec. 3907. (1) Each individual long-term care policy shall contain a guaranteed renewable provision. An insurer shall not cancel or otherwise terminate a long-term care insurance policy on the grounds of the age or the deterioration of the mental or physical health of the insured.

(2) Each group long-term care certificate shall contain a conversion provision permitting an individual entitled to benefits under the group certificate to elect to convert from the group certificate to an individual long-term care policy with the option of receiving benefits substantially similar to the prior coverage. An individual shall be entitled to convert to the individual policy at all times except under the following circumstances:

(a) Termination of the individual's group coverage resulted from the individual's failure to make any required payment of premium when due.

(b) The terminating coverage is replaced by other group coverage effective on the day following the termination of the other group coverage.

(3) If existing coverage is converted to or replaced by a long-term care insurance policy with the same insurer, the long-term care insurance policy shall not contain a provision establishing a new limitation period except with respect to an increase in benefits voluntarily selected by the insured. The premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group certificate.

(4) A long-term care insurance policy that provides coverage for care in an intermediate care facility or a skilled nursing facility shall also provide coverage for home care services that is a dollar amount equivalent to at least 1/2 of 1 year's coverage available for nursing home benefits under the policy at the time covered home health services are being received.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3908 Long-term care partnership program policy; conversion or replacement.

Sec. 3908. (1) Subject to subsection (2), long-term care insurance that is delivered or issued for delivery in this state after December 31, 2007, and before long-term care partnership program policies are approved for sale in this state, may be converted to or replaced with a long-term care partnership program policy.

(2) Before converting the long-term care insurance to, or replacing the long-term care insurance with, a long-term care partnership program policy under this section, the insured and the insurer shall both agree to the conversion or the replacement.

(3) As used in this section, "long-term care partnership program policy" means that term as defined in section 3957.

History: Add. 2015, Act 198, Eff. Feb. 22, 2016.

Popular name: Act 218

500.3909 Option to purchase inflation protection; summary of coverage; applicability of section.

Sec. 3909. (1) An insurer shall not offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations that are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers shall offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than 1 of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5%.

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined.

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The amount of the additional benefit shall be not less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) If the policy is issued to a group, the required offer in subsection (1) shall be made to the group policyholder. However, if the policy is issued to a group defined in section 3901(c)(*iv*) other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

(3) Insurers shall include all of the following information in or with the summary of coverage:

(a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.

(b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

(4) This section does not apply to life insurance products that accelerate the death benefit to provide long-term care benefits.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3910 Option of purchasing policy or certificate including nonforfeiture benefits; offer.

Sec. 3910. (1) This section does not apply to life insurance policies or riders containing accelerated benefits for long-term care.

(2) Except as provided in subsection (3), a long-term care insurance policy shall not be delivered or issued for delivery in this state unless the policyholder or certificateholder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. An offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder or certificateholder. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. If the policyholder or certificateholder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

(3) When a group long-term care insurance policy is issued, the offer required in subsection (2) shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in section 3901(c)(*iv*), other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificateholder.

History: Add. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3910a Nonforfeiture benefits; coverage elements, eligibility, benefit triggers, and benefit length; contingent benefit; premium increase; notification; duties of insurer; limitation on maximum benefits; effective date of section; premiums subject to loss ratio requirements; conditions for offering nonforfeiture benefit.

Sec. 3910a. (1) This section does not apply to life insurance policies or riders containing accelerated benefits for long-term care.

(2) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefits described in subsection (8).

(3) If the offer required to be made under section 3910 is rejected, the insurer shall provide a contingent benefit upon lapse as described in this section for individual and group policies without nonforfeiture benefits issued on and after June 1, 2007.

(4) If a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(5) Except as otherwise required, policyholders shall be notified not less than 45 days before the due date of a premium increase and of the amount of the increase.

(6) The contingent benefit on lapse is triggered every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the

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insured's initial annual premium as follows based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased:

TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(7) On or before the effective date of a substantial premium increase as defined in subsection (6), the insurer shall do all of the following:

(a) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased.

(b) Offer to convert the coverage to a paid-up status with a shortened benefit period as provided in subsection (8). This option may be elected at any time during the 120-day period under subsection (6).

(c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period under subsection (6) is considered to be the election of the offer to convert under subdivision (b).

(8) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are as follows:

(a) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date that increases age at least 1% per year prior to age 50 and at least 3% per year beyond age 50.

(b) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits shall be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as provided in

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subdivision (c). As used in this subdivision, "same benefits" means amounts and frequency in effect at the time of lapse but not increased thereafter.

(c) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection (9).

(d) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first 3 years as well as thereafter. However, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of the end of the tenth year following the policy or certificate issue date or the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(e) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(9) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid-up status shall not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium paying status.

(10) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(11) This section is effective June 1, 2007 and shall apply as follows:

(a) Except as otherwise provided in subdivision (b), this section applies to any long-term care policy issued in this state on or after June 1, 2007.

(b) This section does not apply to certificates issued on or after June 1, 2007, under a group long-term care insurance policy as defined in section 3901(c)(*i*), which policy was in force at the time this section became effective.

(12) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse are subject to the loss ratio requirements of section 3926a treating the policy as a whole.

(13) To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (6), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(14) For qualified long-term care insurance contracts that are level premium contracts, an insurer shall offer a nonforfeiture benefit that meets all of the following:

(a) Is appropriately captioned.

(b) Provides a benefit available in the event of a default in the payment of any premiums and states that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form.

(c) Provides at least 1 of the following:

(*i*) Reduced paid-up insurance.

(*ii*) Extended term insurance.

(*iii*) Shortened benefit period.

(*iv*) Other offerings approved by the commissioner that are similar to subparagraphs (*i*) to (*iii*).

History: Add. 2006, Act 442, Eff. June 1, 2007.

Popular name: Act 218

***** *500.3910b SEE SUBSECTION (7) FOR APPLICABILITY* *****

500.3910b Reduction options; applicability of section to long-term care policies and certificates issued on or after June 1, 2007.

Sec. 3910b. (1) A long-term care insurance policy or certificate shall provide that a policyholder or certificateholder who wishes to reduce coverage and lower the policy or certificate premium may choose at least 1 of the following options:

(a) Reducing the lifetime maximum benefit.

(b) Reducing the daily, weekly, or monthly benefit amount.

(2) In addition to the reduction options listed in subsection (1), a long-term care insurer may offer additional reduction options that are consistent with the policy or certificate design or the insurer's

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administrative processes.

(3) A long-term care insurer shall include in the long-term care insurance policy or certificate a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

(4) The age to determine the premium for reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.

(5) A long-term care insurer may limit any reduction in coverage to plans available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

(6) If a long-term care insurance policy or certificate is about to lapse, the insurer shall provide written notice to the insured of the options in subsection (1) to lower the premium by reducing coverage and of the premiums applicable to the reduced coverage options. The insurer may include in the notice additional options to those required in subsection (1). The notice shall provide the insured at least 30 days in which to elect to reduce coverage, and the policy or certificate shall be reinstated without underwriting if the insured elects the reduced coverage.

(7) This section applies to long-term care policies and certificates issued on or after June 1, 2007.

History: Add. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3911 Preexisting condition; limitation period; definition.

Sec. 3911. (1) A preexisting condition limitation period in a long-term care insurance policy, other than a group long-term care certificate described in section 3901(c)(*i*), shall not exceed 1 of the following:

(a) Six months after the effective date of coverage.

(b) A period of time set by the commissioner if the commissioner has found that a longer limitation period than provided for in subdivision (a) is justified because the group is specially limited by age, group categories, or other specific policy provisions and that the longer limitation period will be in the best interest of the public.

(2) A long-term care insurance policy, other than a group long-term care certificate described in section 3901(c)(*i*) , shall not use a definition of preexisting condition that is more restrictive than the definition in section 3901.

(3) The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, underwrite in accordance with that insurer's established underwriting standards.

(4) Unless otherwise provided in the policy, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until after the limitation period. A long-term care insurance policy shall not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting conditions beyond the limitation period.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3913 Home health care benefits.

Sec. 3913. (1) A long-term care insurance policy shall not limit or exclude services for home health care benefits in any of the following ways:

(a) By requiring that the insured would need skilled care in a skilled nursing facility if home health care services were not provided.

(b) By requiring that the insured first or simultaneously receive nursing or therapeutic services in a home or community setting before home health care services are covered.

(c) By limiting eligible services to services provided by registered nurses or licensed practical nurses.

(d) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of his or her licensure or certification.

(e) By requiring that the insured have an acute condition before home health care services are covered.

(f) By limiting benefits to services provided by medicare-certified agencies or providers.

(2) Home health care coverage may be applied to the nonhome health care benefits provided in the policy when determining maximum coverage under the terms of the policy.

(3) A long-term care insurance policy that provides coverage for home care services or assisted living services shall define and provide a detailed explanation in plain English of what home care services or assisted living services are covered. A long-term care insurance policy that provides coverage for assisted living facility stays shall define in plain English what assisted living facilities are covered.

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History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2001, Act 4, Imd. Eff. Mar. 30, 2001.

Popular name: Act 218

500.3915 Certain conditions prohibited.

Sec. 3915. A long-term care insurance policy sold before, on, or after June 2, 1992 shall not condition benefits on any of the following:

(a) The prior institutionalization of the insured.

(b) Prior receipt of a higher level of institutional care.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3917 Replacement policy; waiver of time periods applicable to preexisting conditions and probationary periods.

Sec. 3917. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods for similar benefits in the new long-term care policy to the extent that similar exclusions have been satisfied under the original policy.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3919 Institutionalization; extension of benefits; limitations.

Sec. 3919. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care coverage was in force and continues without interruption after termination. An extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period and all other applicable provisions of the policy.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3921 Application; questions relating to health condition; delivery; record of policy rescissions; annual report to commissioner.

Sec. 3921. (1) All applications for long-term care insurance policies except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the applicant's health condition.

(2) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it shall also ask the applicant to list the medication that has been prescribed.

(3) If any medications listed in an application were known by the insurer or should have been known at the time of application to be directly related to a medical condition for which coverage would otherwise be denied, then the policy shall not be rescinded for that condition.

(4) Except for policies that are guaranteed issue, all of the following apply:

(a) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy:

"Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."

(b) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy at the time of delivery:

"Caution: The issuance of this long-term care insurance policy is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]"

(c) Prior to issuance of a long-term care policy to an applicant age 80 or older, the insurer shall obtain 1 of the following:

(*i*) A report of a physical examination.

(*ii*) An assessment of functional capacity.

(*iii*) An attending physician's statement.

(*iv*) Copies of medical records.

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(5) A copy of the completed application or enrollment form, whichever is applicable, shall be delivered to the insured no later than at the time of delivery of the policy unless it was retained by the applicant at the time of application.

(6) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy rescissions, both state and countrywide, except those the insured voluntarily effectuated, and shall annually furnish this information to the commissioner.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3923 Riders or endorsements; certain changes in benefits or premiums; definition, explanation, description, and labeling of certain terms.

Sec. 3923. (1) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to a long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured individual. After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing and signed by the insured, except if the increased benefits or coverage are required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, that premium charge shall be set forth in the policy, rider, or endorsement.

(2) A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import shall include a definition of the terms and an explanation of the terms in its accompanying summary of coverage.

(3) If a long-term care insurance policy contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy and shall be labeled as "preexisting condition limitations".

(4) A long-term care insurance policy containing any limitations or conditions for eligibility shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy and shall label the paragraph "limitations or conditions on eligibility for benefits".

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

***** *500.3925 SEE SUBSECTION (1) FOR APPLICABILITY* *****

500.3925 Applicability of section to long-term care policy or certificate issued on or after June 1, 2007; information to be provided on forms; acknowledgement of disclosure; notice of premium rate schedule increase; personal worksheet; availability of free and independent insurance purchasing and public benefits counseling.

Sec. 3925. (1) Except as provided in subsection (2), this section applies to any long-term care policy or certificate issued in this state on or after June 1, 2007.

(2) For a long-term care certificate issued on or after June 1, 2007 under a group long-term care insurance policy described in section 3901(c)(*i*), which policy was in force on June 1, 2007, this section applies on the policy anniversary date following June 1, 2007.

(3) Other than long-term care policies or certificates for which no applicable premium rate or rate schedule increases can be made, an insurer shall provide on forms approved by the commissioner all of the following information to the applicant at the time of application or enrollment or, if the method of application does not allow for delivery at that time, an insurer shall provide on forms approved by the commissioner all of the following information to the applicant no later than at the time of delivery of the policy or certificate:

(a) A statement that the policy may be subject to rate increases in the future.

(b) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision.

(c) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase.

(d) A general explanation for applying premium rate or rate schedule adjustments that shall include a description of when premium rate or rate schedule adjustments will be effective and the right to a revised premium rate or rate schedule if the premium rate or rate schedule is changed.

(e) Information concerning each premium rate increase on the policy or certificate or similar policies or

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certificates over the past 10 years for this state or any other state that, at a minimum, identifies all of the following:

(*i*) The policies or certificates for which premium rates have been increased.

(*ii*) The calendar years when the policy or certificate was available for purchase.

(*iii*) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics. An insurer may exclude from this disclosure premium rate increases that only apply to blocks of business acquired from another nonaffiliated insurer or the long-term care policies or certificates acquired from another nonaffiliated insurer when those increases occurred prior to the acquisition. If an acquiring insurer files for a rate increase on a long-term care policy or certificate acquired from a nonaffiliated insurer or a block of policies or certificates acquired from a nonaffiliated insurer before the later of June 1, 2007 or the end of a 24-month period following the acquisition of the block of policies or certificates, the acquiring insurer may exclude that rate increase from this disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase as provided in subparagraph (*i*). If the acquiring insurer files for a subsequent rate increase, even within the 24-month period, on the same policy or certificate acquired from a nonaffiliated insurer or block of policies or certificates acquired from a nonaffiliated insurer, the acquiring insurer shall make all disclosures required by this subdivision, including disclosure of the earlier rate increase.

(4) The insurer may, in a fair manner, provide explanatory information related to the rate increases in addition to that required under subsection (3).

(5) Except as otherwise provided in this subsection, an applicant shall sign an acknowledgment at the time of application that the insurer made the disclosure required under subsection (3). If due to the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign an acknowledgment that the insurer made the disclosure required under subsection (3) no later than at the time of delivery of the policy or certificate.

(6) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsection (3) when the rate increase is implemented.

(7) A long-term care insurer shall provide to an applicant a long-term care insurance personal worksheet approved by the commissioner that the applicant can use for help in determining whether long-term care insurance should be purchased.

(8) A long-term care insurer shall provide to an applicant who is 60 years of age or older or who is disabled a current brochure, or the web address where the brochure can be obtained and the telephone number for the agency that can provide the brochure, from the state's medicare medicaid assistance program that contains information on the availability of free and independent insurance purchasing and public benefits counseling.

History: Add. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

****** 500.3926 SEE SUBSECTION (1) FOR APPLICABILITY ******

500.3926 Applicability of section to long-term care policy or certificate issued on or after June 1, 2007; information to be provided to commissioner; premium rate schedule; statement; request by commissioner for actuarial demonstration; additional information.

Sec. 3926. (1) This section applies to any long-term care policy or certificate issued in this state on or after June 1, 2007.

(2) An insurer shall provide all of the following information to the commissioner 30 days prior to making a long-term care insurance policy or certificate available for sale:

(a) A copy of the disclosure documents required in section 3925.

(b) An actuarial certification consisting of at least all of the following:

(*i*) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the policy or certificate with no future premium increases anticipated.

(*ii*) A statement that the policy or certificate design and coverage provided have been reviewed and taken into consideration.

(*iii*) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration.

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(*iv*) A complete description of the basis for contract reserves that are anticipated to be held under the policy or certificate, with sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held, a statement that the assumptions used for reserves contain reasonable margins for adverse experience, a statement that the net valuation premium for renewal years does not increase except for attained-age rating where permitted, and a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under subsection (3) based on a standard age distribution.

(*v*) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policies or certificates also available from the insurer except for reasonable differences attributable to benefits or a comparison of the premium schedules for similar policies or certificates that are currently available from the insurer with an explanation of the differences.

(3) Prior to the expiration of the 30 days under subsection (2), the commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policies or certificates, adjusted for any premium or benefit differences, or relevant and credible data from other studies, or both. If the commissioner asks for this additional information, the 30-day time period under subsection (2) is tolled until the commissioner receives the requested information.

History: Add. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

***** *500.3926a SEE SUBSECTION (1) FOR APPLICABILITY* *****

500.3926a Applicability of section to long-term care policy or certificate issued on or after June 1, 2007; notice of pending premium rate schedule increase; requirements; review and approval by commissioner; eligibility for contingent benefit upon lapse; applicability of subsections to certain policies or certificates; exceptional increases; definitions.

Sec. 3926a. (1) Except as provided in subsection (2), this section applies to any long-term care policy or certificate issued in this state on or after June 1, 2007.

(2) For certificates issued on or after June 1, 2007 under a group long-term care insurance policy described in section 3901(c)(*i*), which policy was in force on June 1, 2007, this section applies on the policy anniversary date following June 1, 2007.

(3) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least 30 days prior to the notice to the policyholders. This notice to the commissioner shall include all of the following:

(a) Information required by section 3925.

(b) Certification by a qualified actuary that if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated and that the premium rate filing is in compliance with the provisions of this section.

(c) An actuarial memorandum justifying the rate schedule change request that includes all of the following:

(*i*) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other policies or certificates currently available for sale. Annual values for the 5 years preceding and the 3 years following the valuation date shall be provided separately. The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase. The projections shall demonstrate compliance with subsection (4). For exceptional increases, the projected experience shall be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase and if the commissioner determines that offsets may exist, the insurer shall use appropriate net projected experience.

(*ii*) If the rate increase will trigger contingent benefit upon lapse, disclosure of how reserves have been incorporated in this rate increase.

(*iii*) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the insurer have been relied on by the actuary.

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(*iv*) A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration.

(*v*) If it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates.

(d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner.

(e) Sufficient information for review and approval of the premium rate schedule increase by the commissioner.

(4) All premium rate schedule increases shall be determined in accordance with the following requirements:

(a) Exceptional increases shall provide that 70% of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits.

(b) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(*i*) The accumulated value of the initial earned premium times 58%.

(*ii*) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis.

(*iii*) The present value of future projected initial earned premiums times 58%.

(*iv*) Eighty-five percent of the present value of future projected premiums not in subparagraph (*iii*) on an earned basis.

(c) If a policy or certificate has both exceptional and other increases, the values in subdivision (b)(*ii*) and (*iv*) shall also include 70% for exceptional rate increase amounts.

(d) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in section 733(1). The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

(5) For each rate increase that is implemented, the insurer shall file for review and approval by the commissioner updated projections, as described in subsection (3)(c)(*i*), annually for the next 3 years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than 3 years if actual results are not consistent with projected values from prior projections. For group insurance certificates that meet the conditions in subsection (13), the projection required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(6) If any premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, lifetime projections, as described in subsection (3)(c)(*i*), shall be filed for review and approval by the commissioner every 5 years following the end of the required period in subsection (5). For group insurance certificates that meet the conditions in subsection (13), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(7) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (4), the commissioner may require the insurer to implement premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience adequately matches the projected experience, consideration should be given to subsection (3)(c)(*iii*), if applicable.

(8) If the majority of the policies or certificates to which an increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file both of the following with the commissioner:

(a) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy or certificate requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect.

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (4) had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in subsection (4)(b)(*i*) and (*iii*).

(9) The commissioner shall review, for all policies and certificates included in a filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated for any rate increase filing meeting the following criteria:

(a) The rate increase is not the first rate increase requested for the specific policy or certificate.

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(b) The rate increase is not an exceptional increase.

(c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(10) If significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with 1 or more reasonably comparable products being offered by the insurer or its affiliates. An offer under this subsection is subject to the commissioner's approval, shall be based on actuarially sound principles, but shall not be based on attained age, and shall provide that maximum benefits under any new policy or certificate accepted by an insured shall be reduced by comparable benefits already paid under the existing policy or certificate. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy or certificate. If a rate increase is requested on the policy or certificate, the rate increase shall be limited to the lesser of the maximum rate increase determined based on the combined experience and the maximum rate increase determined based only on the experience of the insureds originally issued the policy or certificate plus 10%.

(11) If the commissioner determines that an insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner, in addition to the provisions of subsections (9) and (10), may prohibit the insurer from either of the following:

(a) Filing and marketing comparable coverage for a period of up to 5 years.

(b) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(12) Subsections (1) to (11) do not apply to policies or certificates for which the long-term care benefits provided by the policy or certificate are incidental, if the policy or certificate complies with all of the following:

(a) For any plan that may have a cash value, the interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy or certificate.

(b) The portion of the policy or certificate that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in section 4060 or 4072.

(c) The policy or certificate meets sections 3928, 3933, 3951, and 3953.

(d) The portion of the policy or certificate that provides insurance benefits other than long-term care coverage meets, as applicable, the policy illustrations and disclosure requirements under section 4038.

(e) An actuarial memorandum is filed with the office of financial and insurance services that includes all of the following:

(*i*) A description of the basis on which the long-term care rates were determined.

(*ii*) A description of the basis for the reserves.

(*iii*) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance.

(*iv*) A description and a table of each actuarial assumption used. For expenses, an insurer shall include percent of premium dollars per policy or certificate and dollars per unit of benefits, if any.

(*v*) A description and a table of the anticipated policy or certificate reserves and additional reserves to be held in each future year for active lives.

(*vi*) The estimated average annual premium per policy or certificate and the average issue age.

(*vii*) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. For a group certificate, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs.

(*viii*) A description of the effect of the long-term care policy or certificate provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy or certificate, both for active lives and those in long-term care claim status.

(13) Subsections (7), (8), and (9) do not apply to a group insurance policy described in section 3901(c)(*i*) if the policy insures 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer or the policyholder, and not the certificate holders, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

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(14) Except as otherwise provided in this section, exceptional increases are subject to the same requirements as other premium rate schedule increases. The commissioner may request a review by an independent qualified actuary or a professional qualified actuarial body of the basis for a request that an increase be considered an exceptional increase. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

(15) As used in this section:

(a) "Exceptional increase" means only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this state or due to increased and unexpected utilization that affects the majority of insurers of similar products.

(b) "Incidental" means that the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy or certificate as measured on the date of issue.

(c) "Qualified actuary" means a member in good standing of the American academy of actuaries.

(d) "Similar policies" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy or certificate being considered. Certificates of groups described in section 3901(c)(*i*) are not considered similar to policies or certificates otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policies, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

History: Add. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3927 Reasonableness of benefits relative to premiums; expected loss ratio; evaluation of factors; applicability of section.

Sec. 3927. (1) Benefits under individual long-term care insurance policies shall be considered reasonable in relation to premiums provided the expected loss ratio is at least 60%, calculated in a manner that provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

(a) Statistical credibility of incurred claims experience and earned premiums.

(b) The period for which rates are computed to provide coverage.

(c) Experienced and projected trends.

(d) Concentration of experience within early policy duration.

(e) Expected claim fluctuation.

(f) Experience refunds, adjustments, or dividends.

(g) Renewability features.

(h) All appropriate expense factors.

(i) Interest.

(j) Experimental nature of the coverage.

(k) Policy reserves.

(*l*) Mix of business by risk classification.

(m) Product features such as long elimination periods, high deductibles, and high maximum limits.

(n) Premiums charged and losses incurred for other similar policies.

(2) This section does not apply to fixed indivisible premium life insurance policies that fund long-term care benefits entirely by accelerating the death benefit.

(3) This section applies to all long-term care insurance policies or certificates except those described in sections 3926(1) and 3926a(1) and (2).

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3928 Fixed indivisible premium life insurance policy funding long-term care benefits by accelerating death benefit; reasonableness of benefits relative to premiums; provisions.

Sec. 3928. A fixed indivisible premium life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums provided that the policy complies with all of the following provisions:

(a) Premiums required to be paid are fixed and guaranteed for the life of the policy.

(b) The guaranteed cash surrender value is stated in the policy.

(c) The death benefit and long-term care benefits are guaranteed for the life of the policy, and the policy

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contains the schedule of the guarantees.

(d) The risk charges for mortality and morbidity benefits and any other charges made internally to determine cash value accumulations, if any, are guaranteed not to exceed the maximum charges set forth in the policy.

(e) The interest credited internally to determine cash value accumulations, if any, are guaranteed not to be less than the minimum interest rate set forth in the policy.

(f) The benefits cannot be terminated by the insurer except for nonpayment of premium.

(g) The policy meets the nonforfeiture requirements of chapter 40.

(h) At the time of issue, the policy is accompanied by an illustration that clearly discloses the year-by-year progression of cash values and face amount.

(i) The policy provides that the policy owner is supplied annually with a report showing the current cash value, death benefit, and long-term care benefits, and shows the calculation of the change in the cash value from the previous report by the addition of interest and premium payments, if any, and the deduction of the risk charges and any other charges.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3929 Increasing premiums prohibited; conditions.

Sec. 3929. The premiums charged to an insured for long-term care insurance shall not increase due to either of the following:

(a) The increasing age of the insured at ages beyond 65.

(b) The duration the insured has been covered under the policy.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3930 Acceleration of benefits under group or individual life policies or riders; determination of policy reserves.

Sec. 3930. (1) If long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to those policies, policy reserves for the benefits must be determined in accordance with section 834(1)(g). Claim reserves must also be established if the policy or rider is in claim status.

(2) Reserves for policies and riders subject to subsection (1) must be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations may be used if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, the reserves for the long-term care benefit and the life insurance benefit must not be less than the reserves for the life insurance benefit assuming no long-term care benefit.

(3) In the development and calculation of reserves for policies and riders subject to subsection (1), due regard must be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations that have an impact on projected claim costs, including, but not limited to, all of the following:

(a) Definition of insured events.

(b) Covered long-term care facilities.

(c) Existence of home convalescence care coverage.

(d) Definition of facilities.

(e) Existence or absence of barriers to eligibility.

(f) Premium waiver provision.

(g) Renewability.

(h) Ability to raise premiums.

(i) Marketing method.

(j) Underwriting procedures.

(k) Claims adjustment procedures.

(*l*) Waiting period.

(m) Maximum benefit.

(n) Availability of eligible facilities.

(o) Margins in claim costs.

(p) Optional nature of benefit.

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(q) Delay in eligibility for benefit.

(r) Inflation protection provisions.

(s) Guaranteed insurability option.

(4) Any applicable valuation morbidity table must be certified as appropriate as a statutory valuation table by a member of the American academy of actuaries.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2014, Act 571, Eff. Mar. 31, 2015.

Popular name: Act 218

500.3931 Rules.

Sec. 3931. The commissioner may promulgate rules including the following:

(a) Rules establishing standards for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents if provided in the policy, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, definitions of terms, and for full and fair disclosure setting forth the manner, content, and required disclosures.

(b) Rules establishing loss ratio standards for long-term care insurance policies.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3933 Summary of coverage.

Sec. 3933. An insurer that offers long-term care insurance shall provide to a prospective applicant before application and upon request before renewal a summary of coverage and shall obtain an acknowledgment of receipt of the summary on the application form or renewal form by obtaining the applicant's signature. An insurer using direct sales response shall provide the summary of coverage to an applicant in conjunction with the initial application and upon request before renewal. The summary of coverage shall be a free-standing document, using no smaller than 10-point type, and shall not contain advertising material. The summary of coverage shall be in substantially the following form:

(COMPANY NAME)
(ADDRESS: CITY AND STATE)
(TELEPHONE)
LONG-TERM CARE POLICY SUMMARY OF COVERAGE

[Policy number or group master policy and certificate number] Caution: The issuance of this long-term care insurance policy is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [use 1 of the following:] an individual policy of insurance; a group certificate that was issued in the [indicate jurisdiction in which group certificate was issued].

2. Purpose of the summary of coverage. This summary of coverage provides a very brief description of the important features of the policy. You should compare this summary of coverage to summaries of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the policy contains governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you read your policy carefully.

3. The following are terms under which the policy may be returned and premium refunded:

(a) Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy.

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy. If the policy contains these provisions, include a description of them.]

4. This is not medicare supplemental coverage. If you are eligible for medicare, review the medicare supplemental buyer's guide available from the insurance company. [For agents] neither [insert company name] nor its agents represent medicare, the federal government, or any state government. [For direct response] [insert company name] is not representing medicare, the federal government, or any state government.

5. Long-term care coverage. Policies of this category are designed to provide coverage for 1 or more

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necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home. This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

6. Benefits provided by this policy are the following:

Category	Definition	Company Benefits
Skilled nursing care	Requires daily attendance, monitoring, evaluation and/or observation by licensed health personnel in a licensed skilled nursing care facility	$___ per day
Maximum days payable		___ days
Intermediate/basic/custodial nursing care	Is care that includes assistance in activities of daily living that can be provided by persons without medical skill in a licensed intermediate or skilled nursing care facility	$___ per day
Maximum days payable		___ days
Home health benefits:— Daily benefit—Maximum days payable—Restrictions	Will this policy cover home care and what are the restrictions?	___Yes ___No $___ per day ___ days
Prior hospitalization	Policies may not require that you be placed in a hospital for a certain number of days before you can receive coverage for nursing home care	
Day benefits begin	After you have entered the nursing home, when will the policy start to pay for coverage?	
Preexisting conditions waiting period	If you have been treated in the last 6 months for a condition, will this policy cover your treatment?	___Yes ___No
	Does this policy cover you only after a waiting period?	___Yes ___No
	How long is the waiting period?	___ days
Prior approval for coverage	Is prior approval needed before your policy will give you coverage?	___Yes ___No
Motor vehicle accidents	Will this policy provide coverage for long-term care needed as a result of a motor vehicle accident?	___Yes ___No
Evidence of insurability	Is a physical examination required?	___Yes ___No
	Do you have to answer a series of health questions?	___Yes ___No
Guaranteed renewal	As long as you pay your premiums on time, the company will continue to insure you.	
Waiver of premium	Are there circumstances under which you receive coverage, but do not have to pay the premium?	___Yes ___No

7. This policy may not cover all the expenses associated with your long-term care needs. [Provide a brief specific description of any policy provisions that limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits.]

8. Relationship of cost of care and benefits. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time.

(b) Any automatic benefit adjustment provisions.

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage.

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations.

(e) Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

9. Terms under which the policy may be continued in force or discontinued.

[(a) Describe the policy renewability provisions.

(b) For group coverage, specifically describe applicable continuation/conversion provisions.

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(c) Describe waiver of premium provisions or state that there are no such provisions.

(d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which the premium may change.]

10. Organic brain disorders and dementia, including Alzheimer's disease.

[State that the policy provides coverage for insureds who are clinically diagnosed as having dementia or related degenerative illnesses including Alzheimer's disease. Specifically describe each benefit screen or other policy provision that provides preconditions to the availability of policy benefits for such an insured including whether there is a screen for cognitive impairment.]

11. Premium.

[(a) State the total annual premium for the policy.

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium that corresponds to each benefit option.]

12. Additional features.

[(a) Indicate if medical underwriting is used.

(b) Describe other important features.]

I have read this summary and understand that this summary is for my own use and is mine to keep.

Prospective Applicant's Signature

Date

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3935 Statement relating to request for additional information.

Sec. 3935. An application for a long-term care policy shall contain the following statement printed, stamped, or as part of a sticker permanently affixed to the application in capital letters on the first page:

"For additional information about long-term care coverage write to the office of financial and insurance services, P.O. Box 30220, Lansing, MI 48909 or call the area agency on aging in your community.".

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3937 Shopper's guide; format; providing to applicants; exception.

Sec. 3937. (1) A long-term care insurance shopper's guide in the format developed by the national association of insurance commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy in the following manner:

(a) For agent solicitations, an agent shall deliver the shopper's guide prior to the presentation of an application or enrollment form.

(b) For direct response solicitations, the shopper's guide shall be presented in conjunction with any application or enrollment form.

(2) Life insurance policies or riders containing long-term care benefits are not required to furnish a shopper's guide pursuant to subsection (1), but shall furnish a summary of coverage as provided in section 3951.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3939 Application; questions relating to other policies in force or use as replacement; agent's list of other policies sold; notice to applicant and existing insurer; appropriateness of recommended purchase or replacement.

Sec. 3939. (1) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force:

(a) Do you have another long-term care insurance policy or certificate in force?

(b) Do you have other long-term care coverage through a health care corporation or a health maintenance organization?

(c) Did you have another long-term care insurance policy or certificate in force during the last 12 months?

(*i*) If so, with which company?

(*ii*) If that policy lapsed, when did it lapse?

(d) Are you covered by medicaid?

(e) Do you intend to replace any of your medical or health insurance coverage with this policy?

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(2) Unless the coverage is sold without an agent, a supplementary application or other form containing the questions in subsection (1) requiring the applicant's and agent's signatures may be used.

(3) With regard to a replacement policy issued to a group under section 3904(c)(*iv*), the questions in subsection (1) may be modified but only to the extent necessary to elicit information about health or long-term care insurance policies other than the group certificate being replaced and provided that the certificate holder has been notified of the replacement.

(4) Agents shall list any other health insurance policies they have sold to the applicant in the past 5 years and indicate whether or not they are still in force.

(5) Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

"Notice to applicant regarding replacement of individual accident and sickness or long-term care insurance

[Insurance company's name and address]

Save this notice! It may be important to you in the future. According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] insurance company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision. Statement to applicant by agent [broker or other representative]: (Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate cannot contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical

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information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature agent, broker, or other representative)

[Typed name and address of agent or broker]

The above "notice to applicant" was delivered to me on:

_____

(Date)

_____

(Applicant's signature)"

(6) Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

"Notice to applicant regarding replacement of accident and sickness or long-term care insurance

[Insurance company's name and address]

Save this notice! It may be important to you in the future. According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy issued by [company name] insurance company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate cannot contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim

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to be denied. Carefully check the application and write
to [company name and address] within 30 days if any
information is not correct and complete, or if any past
medical history has been left out of the application.

                                  _____________________________
                                  (Company name)"
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(7) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured, and policy number or address including zip code. The notice shall be made within 5 working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(8) In recommending the purchase or replacement of any long-term care insurance policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3941 Advertising; filing copy with commissioner.

Sec. 3941. Every insurer providing long-term care insurance coverage in this state shall file with the commissioner for review a copy of any written, radio, or television advertisement for long-term care insurance intended for use in this state at least 45 days before the date the insurer desires to use the advertising. The filing shall include a sample or photocopy of all applicable long-term care policies and related forms and the approval status of the policies and forms. In addition, all advertisements shall be retained by the insurer or other entity for at least 3 years from the date the advertisement was first used.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3941a Inapplicability of section to life insurance policies or riders containing accelerated benefits; development of suitability standards.

Sec. 3941a. (1) This section does not apply to life insurance policies or riders containing accelerated benefits for long-term care.

(2) Every insurer or other entity marketing long-term care insurance shall do all of the following:

(a) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant.

(b) Train its producers in the use of and require producers to use its suitability standards.

(c) Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

(d) To determine whether the applicant meets the developed suitability standards, the insurer shall make reasonable efforts to obtain all of the following information:

(*i*) The applicant's ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.

(*ii*) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs.

(*iii*) The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

(3) If the insurer determines that the applicant does not meet its suitability standards, or if the applicant has declined to provide the necessary information, the insurer may reject the application for long-term care insurance.

History: Add. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3942 Marketing; duties of insurer; use of "level premium" or "noncancelable" prohibited; exception.

Sec. 3942. (1) Every insurer marketing long-term care insurance coverage in this state, directly or through its producers, shall do all of the following:

(a) Establish marketing procedures to assure that any comparison of policies by its producers or other producers are fair and accurate.

(b) Establish marketing procedures to assure excessive insurance is not sold or issued.

(c) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of

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coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.".

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of such insurance.

(e) Establish auditable procedures for verifying compliance with this section.

(2) An insurer marketing long-term care insurance coverage in this state shall not use the term "level premium" or "noncancelable" unless the insurer does not have the right to change the premium for the product being marketed.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 442, Imd. Eff. Oct. 19, 2006.

Popular name: Act 218

500.3942a Reporting requirements; agent activities; preparation of report.

Sec. 3942a. (1) Every insurer marketing long-term care insurance in Michigan shall comply with all of the following reporting requirements for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance:

(a) Maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales and report annually by June 30 the top 10% of its agents that have the greatest percentages of lapses and replacements.

(b) Report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(c) Report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

(2) All reports prepared pursuant to subsection (1) shall be on a statewide basis.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3943 Right to return policy; notice; "direct response solicitation" defined.

Sec. 3943. (1) Except as otherwise provided in subsection (2), an applicant for long-term care insurance shall have the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination of the policy, the applicant is not satisfied for any reason and benefits have not been incurred under the policy. Long-term care insurance policies shall have a notice prominently printed on the first page of the policy and the summary of coverage stating in substance that the applicant has the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination of the policy, the applicant is not satisfied for any reason.

(2) A person insured under a long-term care insurance policy issued pursuant to a direct response solicitation shall have the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page of the policy and the summary of coverage stating in substance that the insured person shall have the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination, the insured person is not satisfied for any reason. As used in this section, "direct response solicitation" means solicitation in which a representative of the insurer does not contact the applicant in person and explain the coverage available, such as, but not limited to, solicitation through direct mail or through advertisements in periodicals and other media.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3945 Violation; penalty.

Sec. 3945. In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to 3 times the amount of any commissions paid for each policy involved in the violation or up to $10,000.00, whichever is greater.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

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500.3949 Life and long-term care benefits; marketing; compliance.

Sec. 3949. (1) An insurer that has both life and disability authority in this state may market policies containing both life benefits and long-term care benefits.

(2) Except as otherwise provided in this act, if life insurance products contain long-term care benefits, the life insurance benefits in those products shall comply with the requirements of chapters 40 and 44 and the long-term care benefits shall comply with this chapter.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3951 Policy summary; compliance with MCL 500.3933; additional provisions; monthly report.

Sec. 3951. (1) A policy summary shall be delivered for a life insurance policy or certificate that provides long-term care benefits. The summary shall comply with the requirements in section 3933. For direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request and shall make the delivery no later than at the time of policy delivery. In addition to the policy summary provisions in section 3933, the policy summary shall include all of the following:

(a) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits.

(b) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person.

(c) Any exclusions, reductions, and limitations on benefits of long-term care.

(d) If applicable to the policy type, the summary shall also include all of the following:

(*i*) A disclosure of the effects of exercising other rights under the policy.

(*ii*) A disclosure of guarantees related to long-term care costs of insurance charges.

(*iii*) Current and projected maximum lifetime benefits.

(2) If a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include all of the following:

(a) Any long-term care benefits paid out during the month.

(b) An explanation of any changes in the policy, for example, death benefits or cash values due to long-term care benefits being paid out.

(c) The amount of long-term care benefits existing or remaining.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3953 Disclosure statement.

Sec. 3953. A life insurance policy that provides an accelerated benefit for long-term care shall provide a disclosure statement at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted stating that receipt of accelerated benefits may be taxable and that assistance should be sought from a personal tax adviser. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3955 Compliance with chapter and applicable laws.

Sec. 3955. Each insurance policy that is advertised, marketed, or offered as long-term care insurance or nursing home insurance shall comply with this chapter and the other applicable provisions of this act.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

CHAPTER 39A
LONG-TERM CARE PARTNERSHIP PROGRAM INSURANCE

500.3957 Definitions.

Sec. 3957. As used in this chapter:

(a) "Applicant" means that term as defined in section 3901.

(b) "Long-term care partnership program policy" or "partnership policy" means a policy that meets all of

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the requirements for the long-term care partnership program under section 112c of the social welfare act, 1939 PA 280, MCL 400.112c, and all of the following requirements:

(*i*) The policy covers an insured who was a resident of this state when coverage first became effective under the policy.

(*ii*) The policy is either a qualified long-term care insurance contract as that term is defined in section 7702B(b) of the internal revenue code of 1986, 26 USC 7702B, that is issued no earlier than the effective date of the amendatory act that added this chapter or a policy that has been converted or replaced under section 3908.

(*iii*) The policy meets all of the applicable requirements of chapter 39.

(*iv*) The policy meets the requirements of the National Association of Insurance Commissioners' model act and model regulation listed in section 1917(b)(5)(A) of title XIX of the social security act, 42 USC 1396p, as required under section 1917(b)(1)(C)(iii)(III) of title XIX of the social security act, 42 USC 1396p.

(*v*) The policy provides the following inflation protection features:

(A) If the policy is sold to an individual who has not attained age 61 as of the date of purchase, the policy must provide compound annual inflation protection.

(B) If the policy is sold to an individual who has attained age 61 but has not attained age 76 as of the date of purchase, the policy must provide some level of inflation protection.

(C) If the policy is sold to an individual who has attained age 76 as of the date of purchase, the policy may provide some level of inflation protection.

(c) "Policy" means that term as defined in section 3901.

History: Add. 2015, Act 198, Eff. Feb. 22, 2016.

Popular name: Act 218

500.3959 Long-term care partnership program policy; applicability of chapter and applicable sections of chapter 39.

Sec. 3959. Pursuant to section 6021 of the deficit reduction act of 2005, Public Law 109-171, and section 112c of the social welfare act, 1939 PA 280, MCL 400.112c, this chapter applies to a long-term care partnership program policy. The applicable sections of chapter 39 also apply to a long-term care partnership program policy.

History: Add. 2015, Act 198, Eff. Feb. 22, 2016.

Popular name: Act 218

500.3961 Partnership policy; solicitation or sale; notice.

Sec. 3961. (1) If an insurer or its agent solicits or offers to sell a policy that is intended to qualify as a partnership policy, the insurer or its agent shall provide to a prospective applicant the notice described in section 112c of the social welfare act, 1939 PA 280, MCL 400.112c, or, if filed with and approved by the department, a notice similar to the notice described in section 112c of the social welfare act, 1939 PA 280, MCL 400.112c.

(2) An insurer or its agent shall provide the notice required under subsection (1) to a prospective applicant with the summary of coverage described in section 3933.

History: Add. 2015, Act 198, Eff. Feb. 22, 2016.

Popular name: Act 218

500.3963 Partnership policy; delivery or issuance for delivery; filing and approval required; submission of completed partnership certification form or similar form to department; "partnership certification form" defined.

Sec. 3963. (1) A partnership policy shall not be delivered or issued for delivery in this state unless the partnership policy is filed with the department and approved by the director under section 2236(1).

(2) A policy submitted to the department for approval as a partnership policy under subsection (1) must be submitted with a completed partnership certification form or a similar form. The completed partnership certification form or similar form also must be approved by the director of the department.

(3) As used in this section, "partnership certification form" means a form developed by the department in consultation with the state department of health and human services.

History: Add. 2015, Act 198, Eff. Feb. 22, 2016.

Popular name: Act 218

500.3965 Regular reports to be provided to department of health and human services.

Sec. 3965. An insurer that issues a partnership policy shall provide copies of the regular reports described

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in 45 CFR 144.200 to 144.214 to the state department of health and human services.

History: Add. 2015, Act 198, Eff. Feb. 22, 2016.

Popular name: Act 218

CHAPTER 40

LIFE INSURANCE POLICIES AND ANNUITY CONTRACT (OTHER THAN INDUSTRIAL OR GROUP)

500.4000 Scope of chapter.

Sec. 4000. (1) This chapter applies to life insurance policies, other than reinsurance, group life insurance, group annuities, and industrial life insurance. However, sections 4004 (policy must contain entire contract), 4040 (supplementary benefits), 4048 (provisions required by laws of other states, countries), 4052 (preliminary term insurance), 4054 (insurer may hold proceeds; exemption from creditors), 4060 (standard nonforfeiture law), 4062 (loan value; deferment), and 4064 (computation of loan indebtedness) apply to industrial life insurance policies.

(2) This chapter applies to annuity contracts only to the extent provided in sections 4070, 4072 and 4073.

(3) This chapter applies to life insurance contracts on a variable basis. However, the commissioner may by rule prescribe appropriate modifications to sections 4022, 4024, 4026, 4028, 4060, 4062, and 4064 applicable to life insurance contracts on a variable basis. The commissioner may by rule set reasonable standards for life insurance contracts on a variable basis which do all of the following:

(a) Require insurers to establish and file with the commissioner standards for marketing life insurance on a variable basis.

(b) Define terms to be used.

(c) Prescribe conditions under which life insurance on a variable basis may be issued, redeemed, or exchanged for a nonvariable contract.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1974, Act 225, Eff. Nov. 1, 1974;—Am. 1980, Act 58, Eff. Oct. 1, 1980.

Popular name: Act 218

Administrative rules: R 500.402 et seq. and R 500.841 et seq. of the Michigan Administrative Code.

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500.4001 Universal life insurance; definitions.

Sec. 4001. As used in this chapter, the following definitions apply only to universal life insurance:

(a) "Cash surrender value" means the net cash surrender value plus any amounts outstanding as policy loans.

(b) "Fixed premium universal life insurance policy" means a universal life insurance policy other than a flexible premium universal life insurance policy.

(c) "Flexible premium universal life insurance policy" means a universal life insurance policy that permits the policyowner to vary, independently of each other, the amount or timing of 1 or more premium payments or the amount of insurance.

(d) "Interest-indexed universal life insurance policy" means any universal life insurance policy where the interest credits are linked to an external referent.

(e) "Net cash surrender value" means the maximum amount payable to the policyowner upon surrender.

(f) "Policy value" means the amount to which separately identified interest credits and mortality, expense, or other charges are made under a universal life insurance policy.

(g) "Universal life insurance" means any individual or group life insurance policy under the policy provisions of which separately identified interest credits, other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts, and mortality and expense charges are made to the policy. A universal life insurance policy may provide for other credits and charges, such as charges for the cost of benefits provided by rider.

History: Add. 1993, Act 349, Eff. Oct. 1, 1994.

Popular name: Act 218

500.4002 Life insurance policies; discrimination against living donors; prohibition; definitions.

Sec. 4002. (1) This section applies to life insurance policies or certificates delivered or issued for delivery after December 31, 2023.

(2) Unless there is an additional actuarial risk, as determined in accordance with sound actuarial principles as well as the individual's actual and reasonably anticipated experience, an insurer shall not do any of the following with respect to a life insurance policy or certificate based solely on the individual's status as a living

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donor:

(a) Deny coverage.

(b) Cancel coverage.

(c) Refuse to issue the policy or certificate.

(d) Determine the price or premium for the policy or certificate.

(e) Otherwise vary a term or condition of the policy or certificate.

(3) As used in this section:

(a) "Living donor" means an individual who is not deceased and has donated any of the following:

(*i*) All or part of an organ.

(*ii*) A tissue.

(b) "Organ" means a human kidney, liver, heart, lung, pancreas, esophagus, stomach, or small or large intestine, a portion of the gastrointestinal tract, or another part of the human body designated by the department by rule.

(c) "Tissue" means a portion of the human body other than an organ, including, but not limited to, an eye, skin, bone, bone marrow, a heart valve, a spermatozoon, an ova, an artery, a vein, a tendon, a ligament, blood, blood derivatives, a pituitary gland, or fluid.

History: Add. 2023, Act 192, Imd. Eff. Nov. 7, 2023.

Popular name: Act 218

500.4004 Entire contract.

Sec. 4004. Every policy of life insurance hereafter issued or delivered within this state by any life insurer doing business within this state shall contain the entire contract between the parties. And nothing shall be incorporated therein by reference to any constitution, bylaws, rules, application or other writing unless the same are endorsed upon or attached to the policy when issued.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4008 Life insurance; provisions required; single premium policies.

Sec. 4008. (1) No policy of life insurance shall be issued in this state unless it contains the provisions set forth in sections 4010 through 4036.

(2) Any of such provisions or portion thereof relating to premiums not applicable to single premium policies, shall to that extent not be incorporated therein.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4010 Premiums; payment; provision required.

Sec. 4010. There shall be a provision that all premiums shall be payable in advance, either at the home office of the company or to an agent of the company, upon delivery of a receipt signed by 1 or more of the officers who shall be named in the policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4012 Life insurance policy; provision required.

Sec. 4012. Each life insurance policy shall contain the following provisions:

(a) A grace period of 1 month for the payment of every premium after the first year, which may be subject to an interest charge, during which month the insurance shall continue in force and which provision may contain a stipulation that if the insured dies during the month of the grace period, the overdue premium will be deducted in any settlement under the policy.

(b) That written notice shall be sent by the insurer to the policyowner's last known address at least 30 days prior to termination of coverage. This subdivision does not apply to an insurer that collects a majority of its annual premium in person.

History: 1956, Act 218, Eff. Jan. 1, 1955;—Am. 1993, Act 349, Eff. Oct. 1, 1994;—Am. 1994, Act 226, Eff. Oct. 1, 1994.

Popular name: Act 218

500.4014 Entire contract; incontestability; exceptions.

Sec. 4014. There shall be a provision that the policy, together with the application therefor, a copy of which application shall be endorsed upon or attached to the policy and made a part thereof, shall constitute the entire contract between the parties and shall be incontestable after it shall have been in force during the

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lifetime of the insured for 2 years from its date, except for non-payment of premiums and except for violations of the policy relating to naval and military services in time of war, and at the option of the company provisions relative to benefits in the event of total and permanent disability and provisions which grant additional insurance specifically against death by accident may also be excepted.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4015 Policy of life insurance; mandatory notice as to cancellation of policy and refund of premium.

Sec. 4015. A policy of life insurance, other than group insurance, shall not be delivered or issued for delivery in this state unless the policy contains on the front page a notice, in substance printed or stamped made as a permanent part of the policy, that during a period of not less than 10 days after the date the policyholder receives the policy, the policyholder may cancel the policy and receive from the insurer a prompt refund of any premium paid for the policy, including a policy fee or other charge, by mailing or otherwise surrendering the policy to the insurer together with a written request for cancellation. If a policyholder or purchaser pursuant to such notice, returns the policy or contract to the company or association at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy or contract had been issued.

History: Add. 1978, Act 144, Eff. Aug. 10, 1978.

Popular name: Act 218

500.4016 Statements considered representations; provision required; electronic application; endorsement.

Sec. 4016. (1) Each life insurance policy shall contain a provision that all statements made by the insured, shall, in the absence of fraud, be considered representations and not warranties. The statement shall not avoid the policy unless the statement is contained in a written application and a copy of the application must be endorsed upon or attached to the policy when issued.

(2) An application obtained through electronic means is an application under subsection (1). The information contained in that application must be endorsed upon or attached to the policy.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2014, Act 143, Eff. Mar. 31, 2015.

Popular name: Act 218

500.4018 Misstatement of age or sex; provisions required.

Sec. 4018. Each life insurance policy shall contain a provision that if there is a misstatement as to the age or sex of the insured in the policy, the amount payable or the death benefit under the policy shall be that which would be purchased by the most recent mortality charge or premium at the correct age or sex.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1993, Act 349, Eff. Oct. 1, 1994.

Popular name: Act 218

500.4020 Participation in surplus; provision required.

Sec. 4020. There shall be a provision that the policy shall participate in the surplus of the company, and that, beginning not later than the end of the fifth policy year, the company will determine and account for the portion of the divisible surplus accruing on the policy, and that the owner of the policy shall have the right to have the current dividend arising from such participation paid in cash, and that at periods of not more than 5 years such accounting and payment at the option of the policyholder shall be had. This provision shall not be required in non-participating policies.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4022 Policy loans generally.

Sec. 4022. There shall be a provision that after 3 full year premiums have been paid, the company at any time, while the policy is in force, shall advance, on proper assignment of the policy and on the sole security thereof, subject to the approval of the insurance commissioner as herein provided, at a rate of interest not exceeding the rate specified in section 4023, a sum equal to, or at the option of the owner of the policy, less than the amount required by section 4062 under the conditions specified thereby; and that the company will deduct from the loan value any indebtedness not already deducted in determining the loan value and any unpaid balance of the premium for the current policy year, and may collect interest in advance on the loan to the end of the current policy year. It shall be further stipulated in the policy that failure to pay any advance or

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to pay interest shall not void the policy unless the total indebtedness thereon to the company equals or exceeds the loan value at the time of the failure and until 1 month after notice is mailed by the company to the last known address of the insured and of the assignee if any. A condition other than as provided in this section shall not be exacted as a prerequisite to any advance. This provision shall not be required in term insurances. The interest limit provided for in section 4023 shall also apply to loans on annuity contracts.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1976, Act 405, Imd. Eff. Jan. 5, 1977;—Am. 1982, Act 427, Imd. Eff. Dec. 29, 1982.

Compiler's note: Section 2 of Act 405 of 1976 provides: "The amendments made by this act shall not impair the terms and conditions of any policy of life insurance in force before the effective date of this act."

Popular name: Act 218

500.4023 Policy loans; interest rates; notice; information; policy not to terminate as sole result of change in interest rate; applicability of section to insurance or annuity contract.

Sec. 4023. (1) As used in this section:

(a) "Policyholder" includes the owner of the policy or the person designated to pay premiums as shown on the records of the insurer.

(b) "Policy loan" includes any premium loan made under a policy to pay 1 or more premiums that were not paid to the insurer as the premiums became due.

(c) "Published monthly average" means the Moody's corporate bond yield average-monthly average corporates as published by Moody's investors service, inc., or in the event that the Moody's corporate bond yield average-monthly average corporates is no longer published, a substantially similar average as determined by the commissioner.

(2) Policies issued on or after the effective date of this section shall provide for policy loan interest rates by 1 of the following:

(a) A provision permitting a maximum interest rate of not more than 8% per annum.

(b) A provision permitting an adjustable maximum interest rate of not more than 18% per annum, which rate is established from time to time by the insurer as provided by this section.

(3) The rate of interest charged on a policy loan made under subsection (2)(b) shall not exceed the higher of the following:

(a) The published monthly average for the calendar month ending 2 months before the date on which the rate is determined.

(b) The rate used to compute the cash surrender values under the policy during the applicable period plus 1% per annum.

(4) If the maximum rate of interest is determined pursuant to subsection (2)(b), the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy. The maximum rate of interest for a policy loan made under subsection (2)(b) shall be determined at least once every 12 months, but not more than once every 3 months. With respect to a policy loan made under subsection (2)(b), at the intervals specified in the policy:

(a) The interest rate being charged may be increased when an increase as determined under subsection (2)(b) would increase the rate by 1/2% or more per annum.

(b) The interest rate being charged shall be reduced when a reduction as determined under subsection (2)(b) would decrease that rate by 1/2% or more per annum.

(5) Each insurer which makes a policy loan under subsection (2)(b) shall do all of the following:

(a) Notify the policyholder at the time the loan is made of the initial rate of interest on the loan.

(b) Not less than 30 days before making a change in the interest rate pursuant to subsection (4), notify the policyholder of the change.

(c) Furnish to the policyholder the information provided in subsections (2) and (4).

(6) A policy shall not terminate in a policy year as the sole result of change in the interest rate during that policy year, and the insurer shall maintain coverage during that policy year until the time at which the policy would otherwise have terminated if there had not been a change during that policy year.

(7) This section shall not apply to any insurance or annuity contract issued before the effective date of this section unless the policyholder agrees in writing to the applicability of this section. Prior to the receipt of any policyholder's written agreement as to the applicability of this section, each insurer shall furnish to the policyholder written notice identifying all the changes in terms and conditions of the policy including information in subsections (2), (3), and (4). This written notice shall identify the benefits which may insure to the policyholder as a result of the applicability of this section.

History: Add. 1982, Act 427, Imd. Eff. Dec. 29, 1982.

Popular name: Act 218

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500.4024 Nonforfeiture benefits; cash surrender values; provision required.

Sec. 4024. Each life insurance policy shall contain a provision for nonforfeiture benefits and cash surrender values in accordance with the requirements of section 4058, 4060, or 4061.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1993, Act 349, Eff. Oct. 1, 1994.

Popular name: Act 218

500.4026 Table of loan values and options; provision required.

Sec. 4026. Except for universal life insurance policies, each life insurance policy shall contain a table showing in figures the loan values and the options available under the policies each year upon default in premium payments during at least the first 20 years of the policy. Universal life insurance policies shall clearly describe and illustrate calculations used to determine loan values and the options available under the policies upon default in premium payments.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1993, Act 349, Eff. Oct. 1, 1994.

Popular name: Act 218

500.4028 Default in premium payments; reinstatement; provision required.

Sec. 4028. There shall be a provision that if, in event of default in premium payments, the value of the policy shall be applied to the purchase of other insurance, and if such insurance shall be in force and the original policy shall not have been surrendered to the company and canceled, the policy may be reinstated within 3 years from such default, upon evidence of insurability satisfactory to the company and payment of arrears of premiums with interest.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4030 Settlement of claim upon death of insured; provision required.

Sec. 4030. There shall be a provision that when a policy shall become a claim by the death of the insured, settlement shall be made upon receipt of due proof of death, or not later than 2 months after receipt of such proof.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4032 Table of installments; provision required.

Sec. 4032. There shall be a table showing the amounts of installments in which the policy may provide its proceeds may be payable.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4036 Title required.

Sec. 4036. There shall be a title on the face and on the back of the policy correctly describing the same.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4037 Universal life insurance policy; provisions required.

Sec. 4037. Each universal life insurance policy shall contain all of the following provisions:

(a) That the insurer will send to the policyholder without charge at least annually a report advising the policyholder as to the policy status. The end of the current report period shall be not more than 3 months prior to the date of the mailing of the report. The report shall include all of the following:

(*i*) The beginning and end of the current report period.

(*ii*) The policy value at the end of the previous report period and at the end of the current report period.

(*iii*) The total of all amounts, identifying each by type such as interest, mortality, expense, and riders, that have been credited or debited to the policy value during the current report period.

(*iv*) The current death benefit at the end of the current report period on each life covered by the policy.

(*v*) The net cash surrender value of the policy as of the end of the current report period.

(*vi*) The amount of outstanding loans, if any, as of the end of the current report period.

(*vii*) For fixed premium universal life insurance policies, if, assuming guaranteed interest, mortality, and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect.

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(*viii*) For flexible premium universal life insurance policies, if, assuming guaranteed interest, mortality, and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to this effect.

(b) An illustrative report that will be sent to the policyowner upon request. This report shall contain the same minimum requirements as those set forth in the universal life disclosure requirements in section 4038.

(c) Guarantees of minimum interest credits and maximum mortality and expense charges, all values and data shown in the policy are based on guarantees, figures based on nonguarantees are not included in the policy, minimum and maximum guarantees are in addition to any index guarantees, and if guaranteed credits or charges are also the current credits or charges, the amounts may be included in the policy if clearly labelled. The maturity date is not considered a guarantee for purposes of this section.

(d) At least a general description of the calculation of cash surrender values including all of the following information:

(*i*) The guaranteed maximum expense charges and loads.

(*ii*) Any limitation on the crediting of additional interest. Interest credits shall not remain conditional for a period longer than 12 months.

(*iii*) The guaranteed minimum rate or rates of interest.

(*iv*) The guaranteed maximum mortality charges.

(*v*) Any other guaranteed charges.

(*vi*) Any surrender or partial withdrawal charges.

(e) If the policyowner has the right to change the basic coverage, a statement of any limitation on the amount or timing of the change. If the policyowner has the right to increase the basic coverage, a statement as to whether a new period of contestability or suicide is applicable to the additional coverage.

(f) If a policy provides for a maturity date, end date, or similar date, then a statement, in close proximity to that date, that it is possible that coverage may not continue to the maturity date even if scheduled premiums are paid in a timely manner, if such is the case.

(g) That written notice shall be sent by the insurer to the policyowner's last known address at least 30 days prior to termination of coverage. A flexible premium universal life insurance policy shall provide for a grace period of at least 30 days after lapse with lapse occurring on that date on which the net cash surrender value first equals zero or as otherwise defined in the policy.

History: Add. 1993, Act 349, Eff. Oct. 1, 1994;—Am. 1994, Act 226, Eff. Oct. 1, 1994.

Popular name: Act 218

500.4038 "Policy cost factors" defined; initial disclosure; statement of policy information; delivery; extension of free-look period; furnishing statement at time of policy delivery.

Sec. 4038. (1) As used in this section, "policy cost factors" means those amounts that affect the price per thousand of life insurance coverage or other benefits. They include interest, mortality, expense charges, and fees, including any surrender or withdrawal charges, but not persistency assumptions.

(2) Unless a statement of policy information is provided pursuant to subsection (3), for initial disclosure in connection with any advertising, solicitation, or negotiation of a universal life insurance policy all of the following are required:

(a) Any statement of policy cost factors or benefits shall contain all of the following:

(*i*) The corresponding guaranteed policy cost factors or benefits, clearly identified.

(*ii*) A statement explaining the nonguaranteed nature of any current interest rates, charges, or other fees applied to the policy, including the insurer's rights to alter any of these factors.

(*iii*) Any limitation on the crediting of interest, including identification of those portions of the policy to which a specified interest rate shall be credited.

(b) Any illustration of the policy value shall be accompanied by the corresponding net cash surrender value.

(c) Any statement regarding the crediting of a specific current interest rate shall also contain the frequency and timing by which that rate is determined.

(d) If any statement refers to the policy being interest-indexed, the index shall be described. In addition, a description shall be given of the frequency and timing of determining the interest rate and of any adjustments made to the index in arriving at the interest rate credited under the policy.

(e) Any illustrated benefits based upon nonguaranteed interest, mortality, or expense factors shall be accompanied by a statement indicating that these benefits are not guaranteed.

(f) If the guaranteed cost factors or initial policy cost factor assumptions would result in policy values becoming exhausted before the policy's maturity date, that fact shall be disclosed, including notice that coverage will terminate under those circumstances.

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(3) At the time the agent takes an application for a policy, except as provided in subsection (4), the agent shall furnish to the applicant a statement of policy information for the applicant in a format approved by the commissioner. The illustration of policy premium, death benefit, and cash value shall be shown for an interest rate no higher than the current interest rate actually being paid on the policy illustrated or to be issued and for the interest rate guaranteed in the policy. Interest rates higher than these shall not be illustrated. The commissioner shall issue guidelines for the statement of policy information.

(4) If the policy information for the applicant is not furnished at the time of application, it shall be delivered within 15 working days after the application is taken, but at least 5 days before delivery of the policy.

(5) If the policy is delivered sooner than 5 days after the policy information for the applicant, the free-look period shall be extended to 15 days. If the statement of policy information for applicant is not delivered at the time of application, the disclosure shall be accompanied by a statement that it is delivered for the express purpose of allowing comparison with other policies.

(6) For direct response solicitation methods, the statement of policy information for the applicant in compliance with the guidelines may be furnished at the time of delivery of the policy, if the purchaser is given an unconditional refund provision of at least 10 days.

History: Add. 1993, Act 349, Eff. Oct. 1, 1994;—Am. 1998, Act 107, Imd. Eff. June 3, 1998.

Popular name: Act 218

500.4040 Safeguard against lapse; special surrender value; optional provisions; supplemental contract.

Sec. 4040. (1) Any life insurer may include in its policy a provision intended to safeguard such life insurance against lapse, or provisions that shall provide a special surrender value therefor in the event that the insured thereunder shall, by reason of accidental bodily injury or disease, be unable to continue the premium payments thereon.

(2) A life insurance policy may also contain, or provide through contracts supplemental thereto, such provisions relating to accident and sickness insurance as are authorized under section 602(2) (accidental death, dismemberment, or loss of sight; certain benefits in event of total and permanent disability). No such supplemental contract shall be issued or delivered to any person in this state unless and until a copy of the form thereof has been submitted to and approved by the commissioner, under such reasonable rules and regulations as he shall make concerning the provisions in such contracts and their submission to and approval by him.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4042 Liability limitation; aviation, military or naval service.

Sec. 4042. Nothing contained in this chapter shall be construed as prohibiting a life insurer from placing in its policies provisions limiting its liability with respect to:

(1) Death resulting from aviation other than as a fare-paying passenger on a regularly scheduled route between definitely established airports;

(2) Military or naval service;

Provided, That if the liability of the insurer is limited as herein provided, the liability shall in no event be fixed at an amount less than the reserve on the policy (including the reserve for any dividend additions thereto and excluding the reserve for any additional benefits in the event of death by accident or accidental means or for benefits in event of any type of disability), less any indebtedness on or secured by such policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4046 Provisions prohibited; forfeiture of policy for failure to repay loan; limitation of actions; predating policy; settlement at maturity for less than full value.

Sec. 4046. No policy of life insurance other than industrial life insurance shall be issued or delivered in this state if it contain any of the following provisions:

(1) A provision for the forfeiture of the policy for failure to repay any loan on the policy or to pay interest on such loan while the total indebtedness on the policy is less than the loan value thereof; or any provision for forfeiture for failure to repay any such loan or to pay interest thereon, unless such provision contains a stipulation that no such forfeiture shall occur until at least 1 month after notice shall have been mailed by the insurer to the last known address of the insured and of the assignee, if any; or a provision contemplating any proposed benefit not essentially a part of the insurance contract or any connection of the insured with the

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insurer other than that of policyholder;

(2) A provision limiting the time within which any action at law or in equity may be commenced to less than 6 years after the cause of action shall accrue;

(3) A provision by which the policy shall purport to be issued or to take effect as of a date more than 6 months before the application therefor was made, if thereby the premium on such policy or contract is reduced below the premium which would be payable thereon as determined by the nearest birthday of the insured at the time when such application was made. Nothing contained in this subdivision shall invalidate any contract made in violation of this subdivision. This subdivision shall not be construed to prohibit the exchange, alteration or conversion of policies of life insurance or annuity contracts as of the original date of such policies or contracts if the amount of insurance provided under the new policy does not exceed the amount of insurance under the original policy or the amount of insurance which the premium paid for the original policy or contract would have purchased if the new policy had been originally applied for, whichever is greater; nor to prohibit the exercise of any conversion privilege contained in any policy or contract;

(4) A provision for any mode of settlement at maturity of less value than the amount insured by the policy plus dividend additions, if any, less any indebtedness to the insurer on the policy and less any premium that may by the terms of the policy be deducted, payments to be made in accordance with the terms of the policy. This prohibition shall not apply to substandard policies.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4047 Profit sharing, charter or founders and coupon policies; definitions; prohibitions, violations.

Sec. 4047. (1) As used in this section, "profit sharing policy" means any life insurance policy which by its terms represents that the policyholder will receive preferential treatment in the distribution of earnings or surplus of the insurance company with special advantages not available to persons holding other types of policies.

(2) "Charter policy" or "founders policy" means any life insurance policy which by its terms expressly provides that the policyholder will receive some preferential or discriminatory advantage or benefit not available to persons who purchase insurance from the company at future dates or under other circumstances.

(3) "Coupon policy" means any life insurance policy which includes a series of coupons payable at a specified future date if the insured person is living.

(4) A "series of pure endowments" means any provision in a life insurance policy providing for a series of predetermined benefits maturing at specified dates if the insured is then living, any one of which series of benefits is less than the gross annual policy premium.

(5) No profit sharing, charter, founders or coupon policy or policy containing a series of pure endowments shall be issued or delivered in this state after the effective date of this section. Policies in force prior to the effective date shall not be affected.

(6) No sales material or oral presentations may be used if they represent a life insurance policy to be a profit sharing, charter, founders or coupon policy or a policy containing a series of pure endowments. Any violation hereof shall also constitute a violation of section 2064.

History: Add. 1969, Act 246, Eff. Jan. 1, 1971.

Popular name: Act 218

500.4048 Provisions required by laws of other states or counties.

Sec. 4048. The policies of a foreign or alien life insurer, may, if approved by the commissioner, contain any provision which the law of the state, territory, district or country under which the insurer is organized, prescribed shall be in such policies, when issued in this state, and the policies of a domestic life insurer, may when issued or delivered in any other state, territory, district or country, contain any provision required by the laws of the state, territory, district or country in which the same are issued, anything in this code to the contrary notwithstanding.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4052 Preliminary term insurance on old policies; reserve.

Sec. 4052. Policies may be issued in this state providing for not more than 1 year preliminary term insurance by the incorporation therein of a clause on the face of the policy distinctly specifying that the first year's insurance is term insurance. If the premium charged for term insurance under a limited payment life preliminary term policy providing for the payment of all premiums thereon in less than 20 years from the date

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of the policy, or under an endowment preliminary term policy, exceeds that charged for life insurance under 20 pay life preliminary term policies of the same insurer at the same age, the reserve thereon at the end of any year, including the first, shall not be less than the reserve on a 20 pay life preliminary term policy issued in the same year and at the same age, together with an amount which shall be equivalent to the accumulation of a net level premium sufficient to provide for a pure endowment at the end of the premium payment period equal to the difference between the value at the end of such period for such 20 pay life preliminary term policy and the full reserve at such time of such a limited payment life or endowment policy: Provided, That this section shall apply to all policies issued subsequent to January 1, 1930, and prior to the operative date of section 4060 (standard nonforfeiture law).

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4054 Proceeds of policy; exemption from creditors.

Sec. 4054. (1) Any authorized life insurer shall have power to hold the proceeds of any life or endowment insurance or annuity contract issued by it (a) upon such terms and restrictions as to revocation by the insured and control by beneficiaries; (b) with such exemptions from legal process and the claims of creditors of beneficiaries other than the insured; and (c) upon such other terms and conditions, irrespective of the time and manner of payment of said proceeds, as shall have been agreed to in writing by such insurer and the insured or beneficiary.

(2) Such insurer shall not be required to segregate funds so held but may hold them as a part of its general corporate assets.

(3) Any life or endowment insurance or annuity contract issued by a domestic, foreign or alien insurer may provide that the proceeds thereof or payments thereunder shall not be subject to the claims of creditors of any beneficiary other than the insured or any legal process against any beneficiary other than the insured; and if the said contract so provides, the benefits accruing thereunder to such beneficiary other than the insured shall not be transferable nor subject to commutation or encumbrance, or to process.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4058 Nonforfeiture benefits on old policies.

Sec. 4058. This section shall apply only to policies of life insurance other than industrial life insurance issued prior to the operative date of section 4060 (the standard nonforfeiture law).

The nonforfeiture benefit referred to in section 4024 shall be available to the owner of the policy in event of default in premium payments, after premiums shall have been paid for 3 years and shall be a stipulated form of insurance, the net value of which shall be at least equal to the reserve at the date of default on the policy and on any dividend additions thereto, specifying the mortality table and rate of interest adopted for computing such reserves, less a sum not more than 2 1/2% of the amount insured by the policy and of any existing dividend additions thereto, and less any existing indebtedness to the insurer on the policy. Such provision shall stipulate that the policy may be surrendered to the insurer at its home office within 1 month from date of default for a specified cash value at least equal to the sum which would otherwise be available for the purchase of insurance as aforesaid and may stipulate that the insurer may defer payment for not more than 6 months after the application therefor is made. This section shall not be applicable to term insurances of 20 years or less.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4060 Standard nonforfeiture law for life insurance.

Sec. 4060. (1) This section shall be known as the standard nonforfeiture law for life insurance and applies to life insurance contracts except as otherwise provided in section 4061 for universal life insurance contracts.

(2) Subject to subdivisions (g) and (h), for policies issued on and after the operative date of this section, as defined in subsection (10), a policy of life insurance, except as provided in subsection (9), may not be delivered or issued for delivery in this state unless it contains in substance all of the following provisions, or corresponding provisions that in the opinion of the director are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements specified in this subsection and are essentially in compliance with subsection (8):

(a) If there is a default in a premium payment, the company will grant, on proper request not later than 60 days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of that due date, of an amount as specified in this section. Instead of the stipulated paid-up

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nonforfeiture benefit, the company may substitute, on proper request not later than 60 days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit that provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

(b) On surrender of the policy within 60 days after the due date of a premium payment in default, after premiums have been paid for not less than 3 full years for ordinary insurance or 5 full years for industrial insurance, the company will pay, in place of any paid-up nonforfeiture benefit, a cash surrender value of an amount specified in this section.

(c) The specified paid-up nonforfeiture benefit will become effective as specified in the policy unless the person entitled to make the election elects another available option not later than 60 days after the due date of the premium in default.

(d) If the policy has become paid up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit that became effective on or after the third policy anniversary for ordinary insurance or the fifth policy anniversary for industrial insurance, the company will pay, upon surrender of the policy within 30 days after any policy anniversary, a cash surrender value of an amount specified in this section.

(e) For policies that cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or that provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy.

For all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first 20 policy years or during the term of the policy, whichever is shorter. The values and benefits must be calculated on the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy.

(f) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or under the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated in the policy, a statement that the method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to calculate the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which the values and benefits are consecutively shown in the policy.

(g) Subdivisions (a) to (f) or portions of those subdivisions not applicable by reason of the plan of insurance, to the extent inapplicable, may be omitted from the policy.

(h) The company shall reserve the right to defer the payment of any cash surrender value for a period of 6 months after demand for the payment with surrender of the policy.

(3) A cash surrender value available under a policy if there is a default in a premium payment due on any policy anniversary, whether or not required by subsection (2), must be an amount not less than the excess, if any, of the present value, on the anniversary, of the future guaranteed benefits that would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of the then present value of the adjusted premiums as defined in subsection (5), corresponding to premiums that would have fallen due on and after the anniversary, and the amount of any indebtedness to the company on the policy. However, for a policy issued on or after the operative date of paragraphs 9 to 18 of subsection (5) that provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value must be an amount not less than the sum of the cash surrender value for an otherwise similar policy issued at the same age without the rider or supplemental policy provision and the cash surrender value for a policy that provides only the benefits otherwise provided by the rider or supplemental policy provision.

For a family policy issued on or after the operative date of paragraphs 9 to 18 of subsection (5) that defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age 71, the cash surrender value must be an amount not less than the sum of the cash surrender value for an otherwise similar policy issued at the same age without the term insurance on the life of the spouse and the cash surrender value for a policy that provides only the benefits otherwise provided by the term insurance on the life of the spouse.

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A cash surrender value available within 30 days after a policy anniversary under a policy paid up by completion of all premium payments or a policy continued under a paid-up nonforfeiture benefit, whether or not required by subsection (2), must be an amount not less than the present value, on the anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the company on the policy.

(4) A paid-up nonforfeiture benefit available under a policy if there is a default in a premium payment due on a policy anniversary must be such that its present value as of the anniversary must at least equal the cash surrender value then provided for by the policy or, if the policy does not provide for a cash surrender value, that cash surrender value that would have been required by this section in the absence of the condition that premiums must have been paid for at least a specified period.

(5) Paragraphs 1 to 8 of this subsection do not apply to policies issued on or after the operative date of paragraphs 9 to 18 as defined in paragraph 18. Except as provided in paragraph 3 of this subsection, the adjusted premiums for a policy must be calculated on an annual basis and must be a uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, so that the present value, at the date of issue of the policy, of all the adjusted premiums equals the sum of (*i*) the then present value of the future guaranteed benefits provided for by the policy; (*ii*) 2% of the amount of insurance, if the insurance is uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy; (*iii*) 40% of the adjusted premium for the first policy year; (*iv*) 25% of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less. In applying the percentages specified in items (*iii*) and (*iv*) above, an adjusted premium must not be considered to exceed 4% of the amount of insurance or uniform amount equivalent to the amount of insurance. The date of issue of a policy for the purpose of this subsection is the date that the rated age of the insured is determined.

For a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount of the policy for the purpose of this subsection is considered to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy. However, for a policy providing a varying amount of insurance issued on the life of a child under age 10, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy before the attainment of age 10 were the amount provided by the policy at age 10.

The adjusted premiums for a policy providing term insurance benefits by rider or supplemental policy provision must be equal to (a) the adjusted premiums for an otherwise similar policy issued at the same age without the term insurance benefits, increased, during the period for which premiums for the term insurance benefits are payable, by (b) the adjusted premiums for that term insurance. Items (a) and (b) must be calculated separately and as specified in the first 2 paragraphs of this subsection. However, for the purposes of items (*ii*), (*iii*), and (*iv*) of the first paragraph of this subsection, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (b) must be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (a).

Except as otherwise provided in paragraph 5 of this subsection, for all policies of ordinary insurance, all adjusted premiums and present values referred to in this section must be calculated on the basis of the commissioners 1941 standard ordinary mortality table. For a category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than 3 years younger than the actual age of the insured. Except as otherwise provided in paragraph 7 of this subsection, the calculations for all policies of industrial insurance must be made on the basis of the 1941 standard industrial mortality table. All calculations must be made on the basis of the rate of interest, not exceeding 3-1/2% per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than 130% of the rates of mortality according to the applicable table. For insurance issued on a substandard basis, the calculation of adjusted premiums and present values may be based on another table of mortality as specified by the company and approved by the director.

For ordinary policies issued on or after the operative date of this paragraph, as defined in paragraph 6, all adjusted premiums and present values referred to in this section must be calculated on the basis of the commissioners 1958 standard ordinary mortality table and the rate of interest specified in the policy for

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calculating cash surrender values and paid-up nonforfeiture benefits. However, the rate of interest may not exceed 3-1/2% per annum, except that a rate of interest not exceeding 4% per annum may be used for policies issued on or after October 21, 1974, and before October 1, 1980, and a rate of interest not exceeding 5-1/2% per annum may be used for policies issued on or after October 1, 1980. For a category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than 6 years younger than the actual age of the insured. In calculating the present value of a paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners 1958 extended term insurance table. For insurance issued on a substandard basis, the calculation of adjusted premiums and present values may be based on another table of mortality as specified by the company and approved by the director.

After May 23, 1960, a company may file with the director a written notice of its election to invoke paragraph 5 after a specified date before January 1, 1966. After the filing of the notice, then on the specified date, that is the operative date for the company, paragraph 5 is operative with respect to the ordinary policies issued by the company and bearing a date of issue that is the same as or later than the specified date. If a company does not make an election, the operative date of paragraph 5 for the company is January 1, 1966.

For industrial policies issued on or after the operative date of this paragraph, as defined in paragraph 8, all adjusted premiums and present values referred to in this section must be calculated on the basis of the commissioners 1961 standard industrial mortality table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. However, the rate of interest may not exceed 3-1/2% per annum, except that a rate of interest not exceeding 4% per annum may be used for policies issued after October 20, 1974, and before October 1, 1980, and a rate of interest not exceeding 5-1/2% per annum may be used for policies issued after September 30, 1980. In calculating the present value of paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners 1961 industrial extended term insurance table. For insurance issued on a substandard basis, the calculation of adjusted premiums and present values may be based on another table of mortality as specified by the company and approved by the director.

After May 23, 1969, a company may file with the director a written notice of its election to invoke paragraph 7 after a specified date before January 1, 1968. After the filing of the notice, then on the specified date, which is the operative date for the company, paragraph 7 is operative with respect to the industrial policies issued by the company and that bear a date of issue the same as or later than the specified date. If a company does not make an election, the operative date of paragraph 7 for the company is January 1, 1968.

Paragraphs 9 to 18 apply to all policies issued on or after the operative date of those paragraphs as defined in paragraph 18. Except as provided in paragraph 15, the adjusted premiums for any policy must be calculated on an annual basis and must be a uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method that is used to calculate the cash surrender values and paid-up nonforfeiture benefits, so that the present value, at the date of issue of the policy, of all adjusted premiums is equal to the sum of (*i*) the then present value of the future guaranteed benefits provided for by the policy; (*ii*) 1% of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years; and (*iii*) 125% of the nonforfeiture net level premium as defined in this subsection. However, in applying the percentage specified in (*iii*), the nonforfeiture net level premium shall not be considered to exceed 4% of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years. The date of issue of a policy for the purpose of this subsection is the date on which the rated age of the insured is determined.

The nonforfeiture net level premium must be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of 1 per annum payable on the date of issue of the policy and on each anniversary of the policy on which a premium falls due.

For policies that cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or that provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values initially must be calculated on the assumption that future benefits and premiums will not change from those stipulated at the date of issue of the policy. At the time of a change in the benefits or premiums, the future adjusted premiums, nonforfeiture net level premiums, and present values must be recalculated on the assumption that future benefits and premiums will not change from those stipulated by the policy immediately after the change.

Except as otherwise provided in paragraph 15 of this subsection, the recalculated future adjusted premiums is a uniform percentage of the respective future premiums specified in the policy for each policy year,

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excluding amounts payable as extra premiums to cover impairments and special hazards and excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to calculate the cash surrender values and paid-up nonforfeiture benefits, so that the present value, at the time of change to the newly defined benefits or premiums, of all the future adjusted premiums is equal to the excess of the sum of the then present value of the then future guaranteed benefits provided for by the policy and the additional expense allowance, if any, over the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

The additional expense allowance, at the time of the change to the newly defined benefits or premiums, is the sum of 1% of the excess, if positive, of the average amount of insurance at the beginning of each of the first 10 policy years after the change over the average amount of insurance before the change at the beginning of each of the first 10 policy years after the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and 125% of the increase, if positive, in the nonforfeiture net level premium.

The recalculated nonforfeiture net level premium is equal to the result obtained by dividing (a) by (b) where (a) equals the sum of (*i*) the nonforfeiture net level premium applicable before the change times the present value of an annuity of 1 per annum payable on each anniversary of the policy on or after the date of the change on which a premium would have fallen due had the change not occurred; and (*ii*) the present value of the increase in future guaranteed benefits provided for by the policy, and (b) equals the present value of an annuity of 1 per annum payable on each anniversary of the policy on or after the date of change on which a premium falls due.

Notwithstanding any other provisions of this subsection to the contrary, for a policy issued on a substandard basis that provides reduced graded amounts of insurance so that, in each policy year, the policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis that provides higher uniform amounts of insurance, adjusted premiums and present values for the substandard policy may be calculated as if it were issued to provide the higher uniform amounts of insurance on the standard basis.

All adjusted premiums and present values referred to in this section for all policies of ordinary insurance must be calculated on the basis of the commissioners 1980 standard ordinary mortality table or, at the election of the company for any 1 or more specified plans of life insurance, the commissioners 1980 standard ordinary mortality table with 10-year select mortality factors. All adjusted premiums and present values referred to in this section for all policies of industrial insurance must be calculated on the basis of the commissioners 1961 standard industrial mortality table. All adjusted premiums and present values referred to in this section for all policies issued in a particular calendar year must be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subsection for policies issued in that calendar year. However:

(a) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year.

(b) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by subsection (2), must be calculated on the basis of the mortality table and rate of interest used in determining the amount of that paid-up nonforfeiture benefit and paid-up dividend additions, if any.

(c) A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit, including any paid-up additions, under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

(d) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners 1980 extended term insurance table for policies of ordinary insurance and not more than the commissioners 1961 industrial extended term insurance table for policies of industrial insurance.

(e) For insurance issued on a substandard basis, the calculation of adjusted premiums and present values may be based on appropriate modifications of the tables provided in subdivision (d).

(f) For a policy issued before the operative date of the valuation manual, any commissioners standard ordinary mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by a rule promulgated by the director for use in determining the minimum nonforfeiture standard or as provided under section 838 may be substituted for the commissioners 1980 standard ordinary mortality table with or without 10-year select mortality factors or for the commissioners 1980 extended term insurance table.

(g) For policies issued on or after the operative date of the valuation manual, the valuation manual must provide the commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the commissioners 1980 standard ordinary mortality table with or without

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10-year select mortality factors or for the commissioners 1980 extended term insurance table. If the director approves by regulation any commissioners standard ordinary mortality table adopted by the national association of insurance commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, the minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(h) For a policy issued before the operative date of the valuation manual, any commissioners standard industrial mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by a rule promulgated by the director for use in determining the minimum nonforfeiture standard may be substituted for the commissioners 1961 standard industrial mortality table or the commissioners 1961 industrial extended term insurance table.

(i) For policies issued on or after the operative date of the valuation manual, the valuation manual must provide the commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the commissioners 1961 standard industrial mortality table or the commissioners 1961 industrial extended term insurance table. If the director approves by regulation any commissioners standard industrial mortality table adopted by the national association of insurance commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, the minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual. The following applies to the nonforfeiture interest rate:

(*i*) Subject to this subparagraph, for a policy issued before the operative date of the valuation manual, the nonforfeiture interest rate per annum for a policy issued in a particular calendar year is equal to 125% of the calendar year statutory valuation interest rate for the policy as defined in the standard valuation law, rounded to the nearest 0.25%. The nonforfeiture interest rate under this subparagraph may not be less than 4%.

(*ii*) For policies issued on and after the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year is provided by the valuation manual.

Notwithstanding any other provision in this act to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form that involves only a change in the interest rate or mortality table used to compute nonforfeiture values may not require refiling of any other provisions of that policy form.

After July 10, 1982, a company may file with the director a written notice of its election to comply with paragraphs 9 to 18 of this subsection at a specified date before January 1, 1989, that is the operative date of those paragraphs for that company. If a company does not make an election, the operative date of paragraphs 9 to 18 of this subsection for the company is January 1, 1989.

(6) For a plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or for a plan of life insurance as to which the minimum values cannot be determined by the methods described in subsections (2) to (5), all of the following apply:

(a) The director must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by subsections (2) to (5).

(b) The director must be satisfied that the benefits and the pattern of premiums of that plan are not misleading to prospective policyholders or insureds.

(c) The cash surrender values and paid-up nonforfeiture benefits provided by the plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this section, as determined by rules promulgated by the director.

(7) A cash surrender value and paid-up nonforfeiture benefit, available under the policy if there is a default in a premium payment due at a time other than on the policy anniversary, must be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in subsections (3), (4), and (5) may be calculated on the assumption that a death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, must be not less than the amounts used to provide the additions. Notwithstanding subsection (3), additional benefits payable in any of the following ways, and premiums for all these additional benefits, must be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and the additional benefits are not required to be included in any paid-up nonforfeiture benefits:

(a) In the event of death or dismemberment by accident or accidental means.

(b) In the event of total and permanent disability.

(c) As reversionary annuity or deferred reversionary annuity benefits.

(d) As term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply.

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(e) As term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if the term insurance expires before the child's age is 26, is uniform in amount after the child's age is 1, and has not become paid-up by reason of the death of a parent of the child.

(f) As other policy benefits additional to life insurance and endowment benefits.

(8) This subsection applies to all policies issued after December 31, 1985. Any cash surrender value available under the policy if there is a default in a premium payment due on any policy anniversary must be in an amount that does not differ by more than 0.2% of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years from the sum of (a) the greater of zero and the basic cash value as specified in this subsection and (b) the present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

The basic cash value must be equal to the present value on the anniversary of the future guaranteed benefits that would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors, as defined in this subsection, corresponding to premiums that would have fallen due on and after the anniversary. However, the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage must be the same as are the effects specified in subsection (3) or (5), whichever is applicable, on the cash surrender values.

The nonforfeiture factor for each policy year must be an amount equal to a percentage of the adjusted premium for the policy year, as defined in paragraphs 1 to 4 of subsection (5) or paragraphs 9 to 18 of subsection (5), whichever is applicable. The nonforfeiture factor:

(a) Must be the same percentage for each policy year between the second policy anniversary and the later of the fifth policy anniversary and the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least 0.2% of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years.

(b) Must be such that no percentage after the later of the 2 policy anniversaries specified in subdivision (a) may apply to fewer than 5 consecutive policy years.

However, the basic cash value may not be less than the value that would be obtained if the adjusted premiums for the policy, as defined in paragraphs 1 to 4 or paragraphs 9 to 18 of subsection (5), whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

All adjusted premiums and present values referred to in this subsection must be calculated for a particular policy on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other subsections of this section. The cash surrender values referred to in this subsection must include any endowment benefits provided for by the policy.

Any cash surrender value available other than if there is a default in a premium payment due on a policy anniversary and the amount of any paid-up nonforfeiture benefit available under the policy if there is a default in a premium payment must be determined in manners consistent with the manners specified for determining the analogous minimum amounts in subsections (2), (3), (4), and (7) and paragraphs 9 to 18 of subsection (5). The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed in subsection (7) must conform with the principles of this subsection.

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

(a) Reinsurance.

(b) Group insurance.

(c) Pure endowment.

(d) Annuity or reversionary annuity contract.

(e) A term policy of uniform amount that does not provide guaranteed nonforfeiture or endowment benefits, or renewal of guaranteed nonforfeiture or endowment benefits, of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy.

(f) A term policy of decreasing amount that does not provide guaranteed nonforfeiture or endowment benefits and on which each adjusted premium, calculated as specified in subsection (5), is less than the adjusted premium calculated under subsection (5), on a term policy of uniform amount, or the renewal of a term policy that does not provide guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy.

(g) A policy that does not provide guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy

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year, calculated as specified in subsections (3) to (5), exceeds 2.5% of the amount of insurance at the beginning of the same policy year.

(h) A policy that is delivered outside this state through an agent or other representative of the company issuing the policy.

For purposes of determining the applicability of this section, the age at expiry for a joint term life insurance policy is the age at expiry of the oldest life.

(10) After July 30, 1943, a company may file with the director a written notice of its election to comply with this section after a specified date before January 1, 1948. After the filing of the notice, then on the specified date, that is the operative date for the company, this section is operative with respect to the policies thereafter issued by the company. If a company does not make an election, the operative date of this section for the company is January 1, 1948.

(11) As used in this section, "operative date of the valuation manual" means January 1 of the first calendar year that the valuation manual as that term is defined in section 836b is effective.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1960, Act 153, Imd. Eff. May 23, 1960;—Am. 1961, Act 226, Eff. Sept. 8, 1961;—Am. 1963, Act 110, Eff. Sept. 6, 1963;—Am. 1974, Act 302, Imd. Eff. Oct. 21, 1974;—Am. 1980, Act 58, Eff. Oct. 1, 1980;—Am. 1982, Act 222, Imd. Eff. July 10, 1982;—Am. 1993, Act 349, Eff. Oct. 1, 1994;—Am. 2004, Act 236, Imd. Eff. July 21, 2004;—Am. 2014, Act 571, Eff. Mar. 31, 2015.

Popular name: Act 218

500.4061 Flexible premium universal life insurance policies; provisions applicable to minimum cash surrender values; minimum paid-up nonforfeiture benefits.

Sec. 4061. (1) All of the following apply to the minimum cash surrender values for flexible premium universal life insurance policies:

(a) Minimum cash surrender values for flexible premium universal life insurance policies must be determined separately for the basic policy and any benefits and riders for which premiums are paid separately. For a basic policy and any benefits and riders for which premiums are not paid separately, all of the following requirements apply:

(*i*) All accumulations must be at the actual rate or rates of interest at which interest credits have been made unconditionally to the policy, or have been made conditionally, but for which the conditions have since been met. The minimum cash surrender value, before adjustment for indebtedness and dividend credits, available on a date as of which interest is credited to the policy must be equal to the accumulation to that date of the premiums paid minus the accumulations to that date of all of the following minus any unamortized unused initial and additional expense allowances:

(A) The benefits charges.

(B) The averaged administrative expense charges for the first policy year and any insurance-increase years.

(C) Actual administrative expense charges for other years.

(D) Initial and additional acquisition expense charges not exceeding the initial or additional expense allowances, respectively.

(E) Any service charges actually made.

(F) Any deductions made for partial withdrawals.

(*ii*) Interest on the premiums and on all charges referred to in subparagraph (*i*) (A) through (F) must be accumulated from and to such dates as are consistent with the manner in which interest is credited in determining the policy value.

(*iii*) Service charges must exclude charges for cash surrender or election of a paid-up nonforfeiture benefit and include charges permitted by the policy to be imposed as the result of a policyowner's request for a service by the insurer, such as the furnishing of future benefit illustrations or of special transactions.

(*iv*) Benefit charges must include the charges made for mortality and any charges made for riders or supplementary benefits for which premiums are not paid separately. If benefit charges are substantially level by duration and develop low or no cash values, the director may require higher cash values unless the insurer provides adequate justification that the cash values are appropriate in relation to the policy's other characteristics.

(*v*) If the amount of insurance is subsequently increased on request of the policyowner or by the terms of the policy, an additional expense allowance and an unused additional expense allowance must be determined on a basis consistent with this subsection and with section 4060(5) paragraph 13 using the face amount and the latest maturity date permitted at that time under the policy.

(*vi*) The unamortized unused initial expense allowance during the policy year beginning on the policy anniversary at age x+t, where "x" is the same issue age, must be the unused initial expense allowance multiplied by

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$$\frac{a_{x+t}}{a_x}$$

where ax+t and a x are present values of an annuity of 1 per year payable on policy anniversaries beginning at ages x+t and x, respectively, and continuing until the highest attained age at which a premium may be paid under the policy, both on the mortality and interest bases guaranteed in the policy. An unamortized unused additional expense allowance must be the unused additional expense allowance multiplied by a similar ratio of annuities, with a x replaced by an annuity beginning on the date as of which the additional expense allowance was determined.

(b) As used in this subsection:

(*i*) "Additional acquisition expense charges" means the excess of the expense charges, other than service charges, actually made in an insurance-increase year over the averaged administrative expense charges for that year.

(*ii*) "Administrative expense charges" means charges per premium payment, charges per dollar of premium paid, periodic charges per thousand dollars of insurance, periodic per policy charges, and any other charges permitted by the policy to be imposed without regard to the policyowner's request for services.

(*iii*) "Averaged administrative expense charges" means those charges that would have been imposed in a year if the charge rate or rates for each transaction or period within that year had been equal to the arithmetic average of the corresponding charge rates that the policy states will be imposed in policy years 2 through 20 in determining the policy value.

(*iv*) "Initial acquisition expense charges" means the excess of the expense charges, other than service charges, actually made in the first policy year over the averaged administrative expense charges for that year.

(*v*) "Initial expense allowance" means the allowance provided by items (*ii*), (*iii*), and (*iv*) of section 4060(5) paragraph 1 or by items (*ii*) and (*iii*) of section 4060(5) paragraph 9, as applicable, for a fixed premium, fixed benefit endowment policy with a face amount equal to the initial face amount of the flexible premium universal life insurance policy, with level premiums paid annually until the highest attained age at which a premium may be paid under the flexible premium universal life insurance policy, and maturing on the latest maturity date permitted under the policy, if any, otherwise at the highest age in the valuation mortality table.

(*vi*) "Insurance-increase year" means the year beginning on the date of increase in the amount of insurance by policyowner request or by the terms of the policy.

(*vii*) "Unused initial expense allowance" means the excess, if any, of the initial expense allowance over the initial acquisition expense charges.

(2) All of the following provisions apply to the minimum cash surrender values for fixed premium universal life insurance policies:

(a) The minimum cash surrender values must be determined separately for the basic policy and any benefits and riders for which premiums are paid separately. All of the following requirements apply to a basic policy and any benefits and riders for which premiums are not paid separately:

(*i*) The minimum cash surrender value before adjustment for indebtedness and dividend credits that is available on a date as of which interest is credited to the policy is equal to (A - B - C - D).

(*ii*) Future guaranteed benefits are determined by both of the following:

(A) Projecting the policy value, taking into account future premiums, if any, and using all guarantees of interest, mortality, expense deductions, and other guarantees, that depend upon the policy value, contained in the policy or declared by the insurer.

(B) Taking into account any benefits guaranteed in the policy or by declaration that do not depend on the policy value.

(*iii*) All present values must be determined using an interest rate or rates specified by section 4060 for policies issued in the same year and the mortality rates specified by section 4060 for policies issued in the same year or contained in any other table as approved by the director for this purpose.

(b) As used in this subsection:

(*i*) "A" means the present value of all future guaranteed benefits.

(*ii*) "B" means the present value of future adjusted premiums. The adjusted premiums are calculated as described in section 4060(5) paragraphs 1 to 6 and 9, as applicable. If section 4060(5) paragraph 9 is applicable, the nonforfeiture net level premium is equal to the quantity

$$\frac{PVFB}{a_x}.$$

(*iii*) "C" means the present value of any quantities analogous to the nonforfeiture net level premium that arise because of guarantees declared by the insurer after the issue date of the policy. Also, a x must be replaced by an annuity beginning on the date as of which the declaration became effective and payable until

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the end of the period covered by the declaration. The types of quantities included in "C" are increased current interest rate credits guaranteed for a future period, decreased current mortality rate charges guaranteed for a future period, or decreased current expense charges guaranteed for a future period.

(*iv*) "D" means the sum of any quantities analogous to "B" which arise because of structural changes in the policy.

(*v*) "PVFB" equals the present value of all benefits guaranteed at issue assuming future premiums are paid by the policyowner and all guarantees contained in the policy or declared by the insurer.

(*vi*) "Structural changes" means those changes that are separate from the automatic workings of the policy. Structural changes usually would be initiated by the policy owner and include changes in the guaranteed benefits, changes in latest maturity date, or changes in allowable premium payment period.

(*vii*) "ax" equals the present value of an annuity of 1 per year payable on policy anniversaries beginning at age x and continuing until the highest attained age at which a premium may be paid under the policy.

(3) All of the following apply to minimum paid-up nonforfeiture benefits:

(a) If a universal life insurance policy provides for the optional election of a paid-up nonforfeiture benefit, the present value of the paid-up nonforfeiture benefit must be at least equal to the cash surrender value provided for by the policy on the effective date of the election. The present value must be based on mortality and interest standards at least as favorable to the policyowner as 1 of the following:

(*i*) For a flexible premium universal life insurance policy, the mortality and interest bases guaranteed in the policy for determining the policy value.

(*ii*) For a fixed premium policy, the mortality and interest standards permitted for paid-up nonforfeiture benefits in section 4060.

(b) Instead of the paid-up nonforfeiture benefit, the insurer may substitute, on proper request not later than 60 days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit that provides a greater amount or longer period of death benefits, or, if applicable, a greater amount or earlier payment of endowment benefits.

(c) Any secondary guarantees should be taken into consideration when computing minimum paid-up nonforfeiture benefits.

(d) A charge may be made at the surrender of the policy if the result after the deduction of the charge is not less than the minimum cash surrender value required by this section.

(e) To preserve equity between policies on a premium paying basis and on a paid-up basis, present values must comply with subsection (1) for flexible premium universal life insurance policies and with subsection (2) for fixed premium universal life insurance policies.

History: Add. 1993, Act 349, Eff. Oct. 1, 1994;—Am. 2014, Act 571, Eff. Mar. 31, 2015.

Popular name: Act 218

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500.4062 Loan value; deferment.

Sec. 4062. (1) In the case of policies issued prior to the operative date of section 4060 (the standard nonforfeiture law), the loan value referred to in section 4022 shall be the reserve at the end of the current policy year on the policy and on any dividend additions thereto, specifying the mortality table and rate of interest adopted for computing such reserve less a sum not more than 2 1/2% of the amount insured by the policy and of any dividend additions thereto. Such policies may further provide that such loan may be deferred for not exceeding 6 months after the application therefor is made.

(2) In the case of policies issued on and after the operative date of section 4060 (the standard nonforfeiture law), the loan value referred to in section 4022 shall be the cash surrender value at the end of the current policy year as required by section 4060. The insurer shall reserve the right to defer such loan, except when made to pay premiums, for 6 months after application therefor is made.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4064 Loan indebtedness; right to compound interest.

Sec. 4064. In ascertaining the indebtedness due upon any loan upon any policy of insurance issued in this state, the interest, if not paid when due, shall be added to the principal of such loan, and shall bear interest at the rate specified in the note or loan agreement.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4070 Insurance and annuities on same life; automatic conversion of deferred annuity into paid-up annuity.

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Sec. 4070. (1) Contracts may be issued in this state providing for both insurance and annuities on the same life, and sections 4008 to 4036 (standard provisions), 4042 (limitation of liability), 4046 (prohibited provisions), 4204 to 4238, 4242, and 4244 shall apply only to that part of the contracts providing for insurance.

(2) Except a contract subject to section 4060 (standard nonforfeiture law for life insurance) or section 4072 (standard nonforfeiture law for individual deferred annuities), every contract prescribed in subsection (1) providing for a deferred annuity on the life of the insured only, or a deferred annuity issued on a single life, unless paid for by a single premium, shall provide that in the event of the nonpayment of a premium after 3 full years of premiums have been paid, the annuity shall automatically become converted into a paid-up annuity for the proportion of the original annuity as the number of completed years of premiums paid bears to the total number of premiums required under the contract.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1980, Act 58, Eff. Oct. 1, 1980.

Popular name: Act 218

500.4072 Standard nonforfeiture law for individual deferred annuities.

Sec. 4072. (1) This section shall be known as the standard nonforfeiture law for individual deferred annuities.

(2) This section does not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the internal revenue code of 1986, 26 USC 408, premium deposit fund, variable annuity, investment annuity, immediate annuity, a deferred annuity contract after annuity payments have commenced, or reversionary annuity, or to a contract delivered outside this state through an agent or other representative of the company issuing the contract.

(3) Except as provided in subsection (2), a contract of annuity must not be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions that in the director's opinion are at least as favorable to the contract holder, on cessation of payment of consideration under the contract:

(a) That on cessation of payment of consideration under a contract, or on the written request of the contract owner, the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of a value specified in subsections (8), (9), (10), (11), and (13).

(b) If a contract provides for a lump sum settlement at maturity, or at any other time, that on surrender of the contract at or before the commencement of any annuity payments, the company shall pay in place of any paid-up annuity benefit, a cash surrender benefit of an amount specified in subsections (8), (9), (11), and (13). The company may reserve the right to defer the payment of the cash surrender benefit for a period of 6 months after demand for the payment with surrender of the contract if the company makes a written request to the director showing the necessity and equitability to all policyholders of the deferral and the director gives written approval.

(c) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of the benefits.

(d) A statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by law of the state in which the contract is delivered, and an explanation of the manner in which the benefits are altered by the existence of additional amounts credited by the company to the contract, indebtedness to the company on the contract, or prior withdrawals from or partial surrenders of the contract.

(4) Notwithstanding the requirements of subsection (3), a deferred annuity contract may provide that if considerations have not been received under a contract for a period of 2 full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid before this period would be less than $20.00 monthly, the company may at its option terminate the contract by payment in cash of the then present value of that portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit. This payment relieves the company of further obligation under the contract.

(5) The minimum values as specified in subsections (8), (9), (10), (11), and (13) of any paid-up annuity, cash surrender, or death benefits available under an annuity contract must be based on the following:

(a) Until January 1, 2005 for contracts providing for flexible considerations, the minimum nonforfeiture amount at any time at or before the commencement of any annuity payments must be equal to an accumulation up to that time at a rate of interest of 1.5% per annum of percentages of the net considerations,

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as defined in subdivision (c), paid before that time, decreased by the sum of subparagraphs (*i*) and (*ii*), and increased by any existing additional amounts credited by the company to the contract:

(*i*) Prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of 1.5% per annum.

(*ii*) The amount of any indebtedness to the company on the contract, including interest due and accrued.

(b) The minimum nonforfeiture amount at any time at or before the commencement of any annuity payments must be equal to an accumulation up to that time at rates of interest as provided in subsection (6) of the net considerations, as defined in subdivision (c), paid before that time, decreased by the sum of subparagraphs (*i*) to (*iv*):

(*i*) Prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as provided in subsection (6).

(*ii*) An annual contract charge of $50.00, accumulated at rates of interest as provided in subsection (6).

(*iii*) Any premium tax paid by the company for the contract, accumulated at rates of interest as provided in subsection (6).

(*iv*) The amount of any indebtedness to the company on the contract, including interest due and accrued.

(c) The net consideration for a given contract year used to define the minimum nonforfeiture amount must be an amount equal to 87.5% of the gross considerations credited to the contract during that contract year.

(6) The interest rate used in determining minimum nonforfeiture amounts must be an annual rate of interest determined as the lesser of 3% per annum and the following, which must be specified in the contract if the interest rate will be reset:

(a) The 5-year constant maturity treasury rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest 1/20 of 1%, specified in the contract no longer than 15 months before the contract issue date or redetermination date under subdivision (d).

(b) Reduced by 125 basis points.

(c) If the resulting interest rate is not less than 0.15%.

(d) The interest rate must apply for an initial period and may be redetermined for additional periods. The redetermination date, basis, and period, if any, must be stated in the contract. As used in this subdivision, "basis" means the date or average over a specified period that produces the value of the 5-year constant maturity treasury rate to be used at each redetermination date.

(7) During the period or term that a contract provides substantive participation in an equity indexed benefit, the contract may provide for an increase in the reduction described in subsection (6)(b) of up to an additional 100 basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date after the issue date, of the additional reduction must not exceed the market value of the benefit. The director may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit and, if the demonstration is unacceptable, may disallow or limit the additional reduction. The director may adopt rules to implement this subsection and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the director determines adjustments are justified.

(8) Any paid-up annuity benefit available under a contract must be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. This present value must be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

(9) For contracts that provide cash surrender benefits, the cash surrender benefits available before maturity must not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit that would be provided under the contract at maturity arising from considerations paid before the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract. The present value must be calculated on the basis of an interest rate not more than 1% higher than the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. However, a cash surrender benefit must not be less than the minimum nonforfeiture amount at that time. The death benefit under contracts that provide cash surrender benefits must be at least equal to the cash surrender benefit. Until January 1, 2005, as used in this subsection, "maturity value" means an accumulation up to the maturity date at the rate of interest guaranteed in the contract for accumulating the net considerations to determine the maturity value, but not less than 1.5% per annum, of the percentages of the net considerations, as defined in subsection (5), paid before that time, decreased by the sum of prior withdrawals from or partial surrenders of the contract accumulated at the rate of interest guaranteed in the

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contract for accumulating net considerations to determine the maturity value but not less than 1.5% per annum and the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by excess interest previously credited by the company to the contract. As used in this subsection, the excess interest is the amount credited over and above the guaranteed interest.

(10) For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time before maturity must not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid before the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity. The present value must be calculated for the period before the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, and increased by any additional amounts credited by the company to the contract. For contracts that do not provide death benefits before the commencement of annuity payments, the present values must be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, the present value of a paid-up annuity benefit must not be less than the minimum nonforfeiture amount at that time.

(11) In determining the benefits calculated under subsections (9) and (10), for annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date is considered to be the latest date for which election shall be permitted by the contract, but must not be later than the anniversary of the contract next following the annuitant's seventieth birthday, or the tenth anniversary of the contract, whichever is later.

(12) A contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount before the commencement of annuity payments must include a statement in a prominent place in the contract that those benefits are not provided.

(13) Any paid-up annuity, cash surrender, or death benefits available at any time, other than on the contract anniversary under a contract with fixed scheduled considerations, must be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(14) For a contract that provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits must be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding subsections (8), (9), (10), (11), and (13), additional benefits payable for total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all additional benefits described in this subsection, must be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits that may be required by this section. The inclusion of the additional benefits is not required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits.

(15) Until January 1, 2005, an insurer may elect to proceed under subsection (5)(a) or (b). On and after January 1, 2005, an insurer shall proceed under subsection (5)(b).

History: Add. 1980, Act 58, Eff. Oct. 1, 1980;—Am. 1986, Act 11, Imd. Eff. Mar. 3, 1986;—Am. 1986, Act 318, Eff. June 1, 1987;—Am. 2002, Act 635, Imd. Eff. Dec. 23, 2002;—Am. 2003, Act 200, Imd. Eff. Nov. 14, 2003;—Am. 2022, Act 150, Eff. Mar. 29, 2023.

Popular name: Act 218

500.4073 Annuity policy or contract; notice of right to cancel and receive refund; effect of returning policy or contract; variable annuity contract; exceptions.

Sec. 4073. (1) Subject to subsection (2), an annuity contract shall not be delivered or issued for delivery in this state unless the contract contains on the front page a notice, in substance printed or stamped made as a permanent part of the policy, that during a period of not less than 10 days after the date the policyholder receives the policy, the policyholder may cancel the policy and receive from the insurer a prompt refund of any premium paid for the policy, including a policy fee or other charge, by mailing or otherwise surrendering the policy to the insurer together with a written request for cancellation. If a policyholder or purchaser pursuant to the notice, returns the policy or contract to the company or association at its home or branch office or to the agent through whom it was purchased, it is void from the beginning and the parties are in the same position as if no policy or contract had been issued.

(2) For a variable annuity contract, the refund under subsection (1) shall equal the sum of the following:

(a) The difference between the premiums paid, including any policy or contract fees or other charges, and

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the amounts allocated to any separate accounts under the policy or contract.

(b) The value of the amounts allocated to any separate accounts under the policy or contract on the date the returned policy is received by the insurer or its insurance producer.

(3) This section does not apply to policies or contracts issued to an employee in connection with the funding of a pension, annuity or profit-sharing plan, qualified or exempt under section 401, 403, 404, or 501 of the internal revenue code of 1986, 26 USC 401, 403, 404, and 501 if participation in the plan is a condition of employment.

History: Add. 1980, Act 58, Eff. Oct. 1, 1980;—Am. 2014, Act 143, Eff. Mar. 31, 2015.

Popular name: Act 218

CHAPTER 41
MODIFIED GUARANTEED ANNUITIES

500.4101 Definitions.

Sec. 4101. As used in this chapter:

(a) "Interest credits" means all interest that is credited to a deferred annuity contract.

(b) "Modified guaranteed annuity" means a deferred annuity contract, the underlying assets of which are held in a separate account, and the values of which are guaranteed if held for specified periods. It contains nonforfeiture values that are based upon a market-value adjustment formula if held for shorter periods. This formula may, or may not, reflect the value of assets held in the separate account. The assets underlying the contract shall be in a separate account during the period the contract holder can surrender the contract.

(c) "Separate account" means a separate account established pursuant to this chapter or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

History: Add. 1991, Act 85, Imd. Eff. July 18, 1991.

Popular name: Act 218

500.4103 Delivery or issuance by insurer of modified guaranteed annuity; conditions.

Sec. 4103. (1) An insurer shall not deliver or issue for delivery a modified guaranteed annuity within this state unless it is licensed or organized to do a life insurance or annuity business in this state, and the commissioner is satisfied that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. In making this determination, the commissioner shall consider among other things the insurer's history and financial condition, the character, responsibility, and fitness of the insurer's officers and directors, and the law and regulation under which the insurer is authorized in the state of domicile to issue such annuities.

(2) If the insurer is a subsidiary of an admitted life insurance company or affiliated with such insurer by common management or ownership, the commissioner may consider subsection (1) satisfied if either the subsidiary or affiliated insurer or the admitted life company satisfies subsection (1) and the insurer is licensed and has a satisfactory record of doing business in this state for a period of at least 3 years.

(3) Before an insurer delivers or issues for delivery a modified guaranteed annuity within this state, it shall submit to the commissioner the following:

(a) A general description of the kinds of modified guaranteed annuities it intends to issue.

(b) If requested by the commissioner, a copy of the statutes and regulations of its state of domicile under which it is authorized to issue modified guaranteed annuities.

(c) If requested by the commissioner, biographical data of the insurer's officers and directors.

History: Add. 1991, Act 85, Imd. Eff. July 18, 1991.

Popular name: Act 218

500.4105 Sales and advertising material; illustrations of benefits payable; prospectus.

Sec. 4105. (1) An insurer authorized to transact modified guaranteed annuity business in this state shall not use any sales material, advertising material, or descriptive literature or other materials of any kind in connection with its modified guaranteed annuity business in this state that is false, misleading, deceptive, or inaccurate.

(2) Illustrations of benefits payable under a modified guaranteed annuity shall not include projections of past investment experience into the future or attempted predictions of future investment experience. However, hypothetical assumed interest credits may be used to illustrate possible levels of benefits.

(3) Before an insurer delivers or issues for delivery a modified guaranteed annuity contract in this state, the commissioner may require the filing of a copy of any prospectus or other sales material to be used in connection with the marketing of the insurer's modified guaranteed annuity contract. The sales material shall

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clearly illustrate that there can be both upward and downward adjustments due to the application of the market-value adjustment formula in determining nonforfeiture benefits.

History: Add. 1991, Act 85, Imd. Eff. July 18, 1991.

Popular name: Act 218

500.4107 Separate account annual statement and other information to be submitted to commissioner.

Sec. 4107. An insurer authorized to transact modified guaranteed annuity business in this state shall submit to the commissioner both of the following:

(a) A separate account annual statement that includes the business of its modified guaranteed annuities.

(b) Such additional information concerning its modified guaranteed annuity operations or separate accounts as the commissioner considers necessary.

History: Add. 1991, Act 85, Imd. Eff. July 18, 1991.

Popular name: Act 218

500.4109 Disapproval by commissioner of filed material.

Sec. 4109. Material required to be filed with and approved by the commissioner is subject to disapproval if at any time it is found by the commissioner not to comply with this chapter.

History: Add. 1991, Act 85, Imd. Eff. July 18, 1991.

Popular name: Act 218

500.4111 Filing requirements.

Sec. 4111. The filing requirements applicable to modified guaranteed annuities are those filing requirements otherwise applicable under existing statutes and regulations of this state concerning individual and group life insurance and annuity contract form filings, to the extent appropriate, provided, however, filings shall include a demonstration in a form satisfactory to the commissioner that the nonforfeiture provisions of the contract comply with section 4115.

History: Add. 1991, Act 85, Imd. Eff. July 18, 1991.

Popular name: Act 218

500.4113 Modified guaranteed annuity contract; required provisions; market-value adjustment formula.

Sec. 4113. (1) A modified guaranteed annuity contract delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurer in determining the dollar amount of nonforfeiture benefits.

(2) A modified guaranteed annuity contract calling for the payment of periodic stipulated payments shall not be delivered or issued for delivery in this state unless it contains in substance all of the following provisions:

(a) A grace period of 30 days or of 1 month during which the contract shall remain in force and within which any payment due to the insurer other than the first may be made. The contract may include a statement of the basis for determining the date as of which any such payment received during the grace period shall be applied to produce the values under the contract.

(b) A provision that, at any time within 1 year from the date of default, the contract may be reinstated upon payment to the insurer of the overdue payments as required by contract, and of all indebtedness to the insurer on the contract, including interest. Reinstatement may not occur if the cash value has been paid. The contract may include a statement of the basis for determining the date as of which the amount to cover the overdue payments and indebtedness shall be applied to produce the values under the contract.

(c) A provision that, to the extent set out in the contract, the portion of the assets of any separate account that equal the reserves and other contract liabilities of the account shall not be chargeable with liabilities arising out of any other business of the insurer.

(3) The market-value adjustment formula, used in determining nonforfeiture benefits, shall be stated in the contract and shall be applicable for both upward and downward adjustments. When a contract is filed, it shall be accompanied by an actuarial statement indicating the basis for the market-value adjustment formula and that the formula provides reasonable equity to both the contract holder and the insurer.

History: Add. 1991, Act 85, Imd. Eff. July 18, 1991;—Am. 1993, Act 264, Imd. Eff. Dec. 21, 1993.

Popular name: Act 218

500.4115 Nonapplicability of section; required provisions; minimum values of paid-up

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annuity, cash surrender, or death benefits available under modified guaranteed annuity contract; nonforfeiture amounts; percentages of net considerations.

Sec. 4115. (1) This section does not apply to any of the following:

(a) Reinsurance.

(b) A group annuity contract purchased in connection with 1 or more retirement plans or plans of deferred compensation established or maintained by or for 1 or more employers, employee organizations, or any combination thereof, other than plans providing individual retirement accounts or individual retirement annuities under section 408 of the internal revenue code of 1986, 26 U.S.C. 408.

(c) Premium deposit fund.

(d) Investment annuity.

(e) Immediate annuity.

(f) Deferred annuity contract after annuity payments have commenced.

(g) Reversionary annuity.

(h) A contract that is to be delivered outside this state through an agent or other representative of the insurer issuing the contract.

(2) A modified guaranteed annuity contract shall not be delivered or issued for delivery in this state unless it contains in substance both of the following provisions:

(a) That upon cessation of payment of considerations under a contract, the insurer will grant a paid-up annuity benefit on a plan described in the contract that complies with subsection (5). The description shall include a statement of the mortality table, if any, and guaranteed or assumed interest rates used in calculating annuity payments.

(b) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the insurer will pay in lieu of any paid-up annuity benefit a cash surrender benefit as described in the contract that complies with subsection (6). The contract may provide that the insurer may defer payment of this cash surrender benefit for a period of 6 months after demand.

(3) The minimum values as specified in this section of any paid-up annuity, cash surrender, or death benefits available under a modified guaranteed annuity contract shall be based upon nonforfeiture amounts meeting the requirements of this subsection. Guaranteed interest credits in each year for any period of time for which interest credits are guaranteed shall be reasonably related to the average guaranteed interest credits over that period of time. The minimum nonforfeiture amount shall be the unadjusted minimum nonforfeiture amount adjusted by the market-value adjustment formula contained in the contract. The unadjusted minimum nonforfeiture amount on any date prior to the annuity commencement date shall be an amount equal to the percentages of net considerations as specified in subsection (4) increased by the interest credits allocated to the percentage of net considerations, which amount shall be reduced to reflect the effect of the following:

(a) Any partial withdrawals from or partial surrender of the contract.

(b) The amount of any indebtedness on the contract, including interest due and accrued.

(c) An annual contract charge not less than 0 and equal to the lesser of $30.00 and 2% of the end of year contract value, less the amount of any annual contract charge deducted from any gross considerations credited to the contract during the contract year. The $30.00 annual contract charge shall be adjusted as provided in subsection (4).

(d) A transaction charge of $10.00 for each transfer to another investment division within the same contract. The $10.00 transaction charge shall be adjusted as provided in subsection (4).

(4) The percentages of net considerations used to define the minimum nonforfeiture amount in subsection (3) shall meet the following requirements:

(a) For contracts providing for periodic considerations, the net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount not less than 0 and shall be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of $30.00 and less a collection charge of $1.25 per consideration credited to the contract during that contract year and less any charges for premium taxes. The percentages of net considerations shall be 65% for the first contract year and 87-1/2% for the second and later contract years. Notwithstanding the provisions of the preceding sentence, the percentage shall be 65% of the portion of the total net consideration for any renewal contract year that exceeds by not more than 2 times the sum of those portions of the net considerations in all prior contract years for which the percentage was 65%. The $30.00 annual contract charge and the $1.25 collection charge shall be adjusted pursuant to subdivision (c).

(b) For contracts providing for a single consideration, the net consideration used to define the minimum nonforfeiture amount shall be the gross consideration less a contract charge of $75.00 and less any charge for

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premium taxes. The percentage of the net consideration shall be 90%. The $75.00 contract charge shall be adjusted pursuant to subdivision (c).

(c) The contract and collection charges shall be multiplied by the ratio of the consumer price index for June of the calendar year preceding the date of filing, to the consumer price index for June 1979. As used in this subdivision, the consumer price index means such index for all urban consumers for all items as published by the United States department of labor and as certified by the commissioner.

(5) A paid-up annuity benefit available under a modified guaranteed annuity contract shall be such that its present value on the annuity commencement date is at least equal to the minimum nonforfeiture amount on that date. This present value shall be computed using the mortality table, if any, and the guaranteed or assumed interest rates used in calculating the annuity payments.

(6) For modified guaranteed annuity contracts that provide cash surrender benefits, the cash surrender benefit at any time prior to the annuity commencement date shall not be less than the minimum nonforfeiture amount next computed after the request for surrender is received by the insurer. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

(7) A modified guaranteed annuity contract that does not provide cash surrender benefits, or does not provide death benefits at least equal to the minimum nonforfeiture amount, prior to the annuity commencement date shall include a statement in a prominent place in the contract that such benefits are not provided.

(8) Notwithstanding the requirements of this section, a modified guaranteed annuity contract may provide that under either of the following situations the insurer, at its option, may cancel the annuity and pay the contract holder the larger of the unadjusted minimum nonforfeiture amount and the minimum nonforfeiture amount, and by such payment be released of any further obligation under the contract:

(a) If at the time the annuity becomes payable, the larger of the unadjusted minimum nonforfeiture amount and the minimum nonforfeiture amount is less than $2,000.00, or would provide an income the initial amount of which is less than $20.00 per month.

(b) If prior to the time the annuity becomes payable under a periodic payment contract no considerations have been received under the contract for a period of 2 full years and both the total considerations paid prior to such period, reduced to reflect any partial withdrawals from or partial surrenders of the contract, and the larger of the unadjusted minimum nonforfeiture amount and the minimum nonforfeiture amount is less than $2,000.00.

(9) For a modified guaranteed annuity contract that provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of subsection (2), additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits that may be required by this section. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits.

History: Add. 1991, Act 85, Imd. Eff. July 18, 1991.

Popular name: Act 218

500.4117 Application for modified guaranteed annuity.

Sec. 4117. The application for a modified guaranteed annuity shall prominently set forth immediately preceding the signature line language denoting that amounts payable under the contract are subject to a market-value adjustment prior to a date or dates specified in the contract.

History: Add. 1991, Act 85, Imd. Eff. July 18, 1991.

Popular name: Act 218

500.4119 Reserve liabilities.

Sec. 4119. Reserve liabilities for a modified guaranteed annuity shall be established in accordance with actuarial procedures that recognize that assets of the separate account are based on market values, the variable nature of benefits provided, and any mortality guarantees. At a minimum, the separate account liability shall equal the surrender value based upon the market-value adjustment formula contained in the contract. If that liability is greater than the asset's market value, a transfer of assets shall be made into the separate account so

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that the asset's market value at least equals that of the liabilities. Also, any additional reserve that is needed to cover future guaranteed benefits shall also be set up by the valuation actuary. The market-value adjustment formula, the interest guarantees, and the degree to which projected cash flow of assets and liabilities are matched shall also be considered. Each year, the valuation actuary shall provide an opinion on whether the assets in the separate account are adequate to provide all future benefits that are guaranteed.

History: Add. 1991, Act 85, Imd. Eff. July 18, 1991.

Popular name: Act 218

500.4121 Modified guaranteed annuity separate accounts.

Sec. 4121. The following requirements apply to the establishment and administration of modified guaranteed annuity separate accounts by a domestic insurer:

(a) An insurer issuing a modified guaranteed annuity shall establish 1 or more separate accounts pursuant to this chapter.

(b) The insurer shall maintain in each separate account assets with a market value or other value comporting to standards set out in this chapter, at least equal to the valuation reserves and other contract liabilities respecting the account.

(c) Investments of the separate account shall be valued at their market value on the date of valuation, or at amortized cost if it approximates market value, or pursuant to standards contained in this chapter.

(d) Unless otherwise approved by the commissioner, separate accounts relating to modified guaranteed annuities shall be subject to investment laws applicable to the insurer's general asset account.

History: Add. 1991, Act 85, Imd. Eff. July 18, 1991.

Popular name: Act 218

500.4123 Annual report.

Sec. 4123. An insurer shall annually provide their contract holders with a report showing both the account value and the cash surrender value. The report shall clearly indicate that the account value is prior to the application of any surrender charges or market-value adjustment formula and shall specify the surrender charge and market-value adjustment used to determine the cash surrender value.

History: Add. 1991, Act 85, Imd. Eff. July 18, 1991.

Popular name: Act 218

500.4125 Compliance with law or regulation in place of domicile of foreign insurer as compliance with this chapter.

Sec. 4125. If the law or regulation in the place of domicile of a foreign insurer provides a degree of protection to the policyholders and the public that is substantially similar to that provided by these regulations, the commissioner to the extent considered appropriate by him or her may consider compliance with that law or regulation as compliance with this chapter.

History: Add. 1991, Act 85, Imd. Eff. July 18, 1991.

Popular name: Act 218

500.4127 License to sell variable annuities required to sell modified guaranteed annuity contracts.

Sec. 4127. A person, corporation, partnership, or other legal entity shall not sell or offer for sale in this state any modified guaranteed annuity contract unless licensed to sell variable annuities under this act.

History: Add. 1991, Act 85, Imd. Eff. July 18, 1991.

Popular name: Act 218

CHAPTER 41A

ANNUITY RECOMMENDATION TO CONSUMERS

500.4151 Definitions.

Sec. 4151. As used in this chapter:

(a) "Annuity" means an annuity that is an insurance product under state law that is individually solicited, whether the product is classified as an individual or group annuity.

(b) "Cash compensation" means any discount, concession, fee, service fee, commission, sales charge, loan, override, or cash benefit received by a producer in connection with the recommendation or sale of an annuity from an insurer or intermediary, or directly from the consumer.

(c) "Consumer profile information" means information that is reasonably appropriate to determine whether

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a recommendation addresses the consumer's financial situation, insurance needs, and financial objectives, including, at a minimum, the following:

(*i*) Age.

(*ii*) Annual income.

(*iii*) Financial situation and needs, including debts and other obligations.

(*iv*) Financial experience.

(*v*) Insurance needs.

(*vi*) Financial objectives.

(*vii*) Intended use of the annuity.

(*viii*) Financial time horizon.

(*ix*) Existing assets or financial products, including investment, annuity, and insurance holdings.

(*x*) Liquidity needs.

(*xi*) Liquid net worth.

(*xii*) Risk tolerance, including, but not limited to, willingness to accept nonguaranteed elements in the annuity.

(*xiii*) Financial resources used to fund the annuity.

(*xiv*) Tax status.

(d) "Insurance producer" or "producer" means insurance producer as defined in section 1201 and includes a business entity described in section 1205(2) that is licensed as an insurance producer under this act. Insurance producer or producer includes an insurer if no producer is involved.

(e) "Intermediary" means an entity contracted directly with an insurer or with another entity contracted with an insurer to facilitate the sale of the insurer's annuities by producers.

(f) "Material conflict of interest" means a financial interest of the producer in the sale of an annuity that a reasonable person would expect to influence the impartiality of a recommendation. Material conflict of interest does not include cash compensation or noncash compensation.

(g) "Noncash compensation" means a form of compensation that is not cash compensation, including, but not limited to, health insurance, office rent, office support, and retirement benefits.

(h) "Nonguaranteed elements" means the premiums, credited interest rates, including any bonus, benefits, values, dividends, noninterest based credits, charges, or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

(i) "Recommendation" means advice provided by a producer to an individual consumer that was intended to result or does result in a purchase, exchange, or replacement of an annuity in accordance with that advice. Recommendation does not include general communication to the public, generalized customer services assistance or administrative support, general educational information and tools, prospectuses, or other product and sales material.

(j) "Replacement" or "replace" means a transaction in which a new annuity is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer whether or not a producer is involved, that by reason of the transaction, an existing annuity or other insurance policy has been or is to be any of the following:

(*i*) Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer, or otherwise terminated.

(*ii*) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values.

(*iii*) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid.

(*iv*) Reissued with any reduction in cash value.

(*v*) Used in a financed purchase.

History: Add. 2006, Act 399, Imd. Eff. Sept. 29, 2006;—Am. 2012, Act 544, Eff. June 1, 2013;—Am. 2020, Act 266, Eff. June 29, 2021.

500.4153 Scope of chapter.

Sec. 4153. (1) This chapter applies to any sale or recommendation of an annuity.

(2) Except as otherwise provided in this chapter, this chapter does not apply to any recommendation to purchase, exchange, or replace an annuity involving any of the following:

(a) Direct response solicitations if there is no recommendation based on information collected from the consumer.

(b) Contracts used to fund any of the following:

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(*i*) An employee pension or welfare benefit plan that is covered by the employee retirement income security act of 1974, Public Law 93-406.

(*ii*) A plan described by 26 USC 401(a), 26 USC 401(k), 26 USC 403(b), 26 USC 408(k), or 26 USC 408(p), if established or maintained by an employer.

(*iii*) A governmental or church plan defined in 26 USC 414, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under 26 USC 457.

(*iv*) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(*v*) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process.

(*vi*) Formal prepaid funeral contracts.

(3) This chapter does not require a producer to obtain any license other than a producer license with the appropriate line of authority to sell, solicit, or negotiate insurance in this state, including, but not limited to, any securities license, to fulfill the duties and obligations contained under this chapter if the producer does not give advice or provide services that are otherwise subject to securities laws or engage in any other activity requiring other professional licenses.

(4) This chapter does not create or imply a private cause of action for a violation of this chapter or subject a producer to civil liability under the standard of care outlined in section 4155 or under standards governing the conduct of a fiduciary or a fiduciary relationship.

History: Add. 2006, Act 399, Imd. Eff. Sept. 29, 2006;—Am. 2012, Act 544, Eff. June 1, 2013;—Am. 2020, Act 266, Eff. June 29, 2021.

500.4155 Purchase or exchange of annuity; recommendations; effort and obligation to act in best interest of consumer; reasonable basis; duties of producer; exceptions.

Sec. 4155. (1) A producer, when making a recommendation of an annuity, shall act in the best interest of the consumer under the circumstances known at the time the recommendation is made, without placing the producer's or the insurer's financial interest ahead of the consumer's interest. A producer is held to standards applicable to a producer with similar authority and licensure. A producer has acted in the best interest of the consumer if the producer has satisfied all of the following obligations regarding care, disclosure, conflict of interest, and documentation:

(a) Subject to subdivision (b), the producer, in making a recommendation, shall exercise reasonable diligence, care, and skill to do all of the following:

(*i*) Know the consumer's financial situation, insurance needs, and financial objectives.

(*ii*) Understand the available recommendation options after making a reasonable inquiry into options available to the producer.

(*iii*) Have a reasonable basis to believe the recommended option effectively addresses the consumer's financial situation, insurance needs, and financial objectives over the life of the product, as evaluated in light of the consumer profile information.

(*iv*) Communicate the basis or bases of the recommendation.

(b) All of the following apply to the obligation of exercising reasonable diligence, care, and skill under subdivision (a):

(*i*) To meet the obligations under subdivision (a), the producer must do all of the following:

(A) Make reasonable efforts to obtain consumer profile information from the consumer before the recommendation of an annuity. The consumer profile information, characteristics of the insurer, and product costs, rates, benefits, and features are those factors generally relevant in making a determination whether an annuity effectively addresses the consumer's financial situation, insurance needs, and financial objectives, but the level of importance of each factor under the care obligation of this subdivision may vary depending on the facts and circumstances of a particular case. However, each factor may not be considered in isolation.

(B) Consider the types of products the producer is authorized and licensed to recommend or sell that address the consumer's financial situation, insurance needs, and financial objectives. This sub-subparagraph does not require the producer to analyze or consider any products outside the authority and license of the producer or other possible alternative products or strategies available in the market at the time of the recommendation.

(C) Have a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, death or living benefit, or other insurance-related features.

(*ii*) The obligations under subdivision (a) apply to the particular annuity as a whole and the underlying subaccounts to which funds are allocated at the time of purchase or exchange of an annuity, and riders and similar product enhancements, if any.

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(*iii*) The obligations under subdivision (a) do not require the producer to recommend the annuity with the lowest 1-time or multiple occurrence compensation structure.

(*iv*) The obligations under subdivision (a) do not mean the producer has ongoing monitoring obligations under the care obligation under subdivision (a), although the obligation may be separately owed under the terms of a fiduciary, consulting, investment advising, or financial planning agreement between the consumer and the producer.

(c) For an exchange or replacement of an annuity, the producer shall consider the whole transaction, which includes taking into consideration all of the following:

(*i*) Whether the consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits, such as death, living, or other contractual benefits, or be subject to increased fees, investment advisory fees, or charges for riders and similar product enhancements.

(*ii*) Whether the replacing product would substantially benefit the consumer in comparison to the replaced product over the life of the product.

(*iii*) Whether the consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 60 months.

(d) Before the recommendation or sale of an annuity, the producer shall prominently disclose to the consumer on a form issued by the director all of the following information:

(*i*) A description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction.

(*ii*) An affirmative statement on whether the producer is licensed and authorized to sell all of the following products:

(A) Fixed annuities.

(B) Fixed indexed annuities.

(C) Variable annuities.

(D) Life insurance.

(E) Mutual funds.

(F) Stocks and bonds.

(G) Certificates of deposit.

(*iii*) An affirmative statement describing the insurers the producer is authorized, contracted or appointed, or otherwise able to sell insurance products for, using any of the following descriptions:

(A) One insurer.

(B) From 2 or more insurers.

(C) From 2 or more insurers although primarily contracted with 1 insurer.

(*iv*) A description of the sources and types of cash compensation and noncash compensation to be received by the producer, including whether the producer is to be compensated for the sale of a recommended annuity by commission as part of premium or other remuneration received from the insurer, intermediary, or other producer or by fee as a result of a contract for advice or consulting services.

(*v*) A notice of the consumer's right to request additional information regarding cash compensation described in subdivision (e).

(e) On request of the consumer or the consumer's designated representative, the producer shall disclose both of the following:

(*i*) A reasonable estimate of the amount of cash compensation to be received by the producer, which may be stated as a range of amounts or percentages.

(*ii*) Whether the cash compensation is a 1-time or multiple occurrence amount and, if a multiple occurrence amount, the frequency and amount of the occurrence, which may be stated as a range of amounts or percentages.

(f) Before or at the time of the recommendation or sale of an annuity, the producer must have a reasonable basis to believe the consumer has been informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders, or annuitizes the annuity, mortality and expense fees, investment advisory fees, any annual fees, potential charges for and features of riders or other options of the annuity, limitations on interest returns, potential changes in nonguaranteed elements of the annuity, insurance and investment components, and market risk.

(g) A producer shall identify and avoid or reasonably manage and disclose material conflicts of interest, including material conflicts of interest related to an ownership interest.

(h) A producer shall at the time of recommendation or sale do all of the following:

(*i*) Make a written record of any recommendation and the basis for the recommendation subject to this chapter.

(*ii*) Obtain a consumer signed statement on a form that documents both of the following:

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(A) The consumer's refusal to provide the consumer profile information, if any.

(B) The consumer's understanding of the ramifications of not providing his or her consumer profile information or providing insufficient consumer profile information.

(*iii*) Obtain a consumer signed statement on a form acknowledging the annuity transaction is not recommended if a consumer decides to enter into an annuity transaction that is not based on the producer's recommendation.

(2) The requirements under subsection (1) do not create a fiduciary obligation or relationship and create only a regulatory obligation as established under this chapter.

(3) Any requirement applicable to a producer under subsection (1) applies to each producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer. Activities such as providing or delivering marketing or educational materials, product wholesaling, or other back office product support, and general supervision of a producer do not, in and of themselves, constitute material control or influence.

(4) Except as provided under subsection (5), a producer does not have any obligation to a consumer under subsection (1) related to any annuity transaction if any of the following apply:

(a) A recommendation is not made.

(b) A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer.

(c) A consumer refuses to provide relevant consumer profile information and the annuity transaction is not recommended.

(d) A consumer decides to enter into an annuity transaction that is not based on a recommendation of the insurer or the insurance producer.

(5) An insurer's issuance of an annuity subject to subsection (4) must be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

(6) Except as permitted under subsections (4) and (5), an insurer shall not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity would effectively address the particular consumer's financial situation, insurance needs, and financial objectives based on the consumer's consumer profile information.

History: Add. 2006, Act 399, Imd. Eff. Sept. 29, 2006;—Am. 2012, Act 544, Eff. June 1, 2013;—Am. 2020, Act 266, Eff. June 29, 2021.

500.4157 Repealed. 2012, Act 544, Eff. June 1, 2013.

Compiler's note: The repealed section pertained to system to supervise recommendations of insurance providers.

500.4158 Insurer's supervision system.

Sec. 4158. (1) An insurer shall establish and maintain a supervision system that is reasonably designed to achieve the insurer's and its producers' compliance with this chapter, including, but not limited to, all of the following:

(a) Establish and maintain reasonable procedures to inform its producers of the requirements of this chapter and incorporate the requirements of this chapter into relevant producer training manuals.

(b) Establish and maintain standards for producer product training and maintain reasonable procedures to require its producers to comply with section 4160.

(c) Provide product-specific training and training materials that explain all material features of its annuity products to its producers.

(d) Establish and maintain procedures for review of each recommendation before issuance of an annuity that are designed to ensure there is a reasonable basis to determine that the recommended annuity would effectively address the particular consumer's financial situation, insurance needs, and financial objectives. Review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and may be accomplished electronically or through other means, including, but not limited to, physical review. An electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria.

(e) Establish and maintain reasonable procedures to detect recommendations that are not in compliance with section 4155. These may include, but are not limited to, confirmation of the consumer's profile information, systematic consumer surveys, producer and consumer interviews, confirmation letters, producer statements and attestations, and programs of internal monitoring. This subdivision does not prevent an insurer from complying with this subdivision by applying sampling procedures or by confirming the consumer profile information or other required information under this section after issuance or delivery of the annuity.

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(f) Establish and maintain reasonable procedures to assess, before or on issuance or delivery of an annuity, whether a producer has provided to the consumer the information required to be provided under section 4155.

(g) Establish and maintain reasonable procedures to identify and address suspicious consumer refusals to provide consumer profile information.

(h) Establish and maintain reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses, and noncash compensation that are based on the sales of specific annuities within a limited period of time. The requirements of this subdivision are not intended to prohibit the receipt of health insurance, office rent, office support, retirement benefits, or other employee benefits by employees if those benefits are not based on the volume of sales of a specific annuity within a limited period of time.

(i) Annually provide a written report to senior management, including to the senior manager responsible for audit functions, that details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

(2) This section does not restrict an insurer from contracting for performance of a function, including maintenance of procedures, required under subsection (1). An insurer shall take appropriate corrective action and may be subject to sanctions and penalties under this act regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with subsection (3).

(3) An insurer's supervision system under this section must include supervision of contractual performance. This includes, but is not limited to, the following:

(a) Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed.

(b) Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

(4) An insurer is not required to include either of the following in its system of supervision:

(a) A producer's recommendations to consumers of products other than the annuities offered by the insurer.

(b) Consideration of or comparison to options available to the producer or compensation relating to those options other than annuities or other products offered by the insurer.

History: Add. 2012, Act 544, Eff. June 1, 2013;—Am. 2020, Act 266, Eff. June 29, 2021.

500.4159 Dissuading consumer from certain acts prohibited.

Sec. 4159. A producer shall not dissuade, or attempt to dissuade, a consumer from any of the following:

(a) Truthfully responding to an insurer's request for confirmation of the consumer profile information.

(b) Filing a complaint.

(c) Cooperating with the investigation of a complaint.

History: Add. 2012, Act 544, Eff. June 1, 2013;—Am. 2020, Act 266, Eff. June 29, 2021.

500.4160 Sale of annuities; completion of annuity training course; requirements.

Sec. 4160. (1) A producer shall not solicit the sale of an annuity unless the producer has adequate knowledge of the product to recommend the annuity and the producer is in compliance with the insurer's standards for product training. A producer may rely on insurer-provided product-specific training standards and materials to comply with this subsection.

(2) A producer who engages in the sale of annuities shall complete a 1-time 4-credit training course approved by the director and provided by an insurance producer program of study registered under chapter 12. Insurance producers who hold a life insurance line of authority on June 1, 2013 and who desire to sell annuities shall complete the requirements of this subsection by December 1, 2013. Individuals who obtain a life insurance line of authority after May 31, 2013 shall not engage in the sale of annuities until the annuity training course required under this subsection has been completed.

(3) The minimum length of the training required under subsection (2) must be not less than 4 hours, as defined in section 1204c, and may be longer.

(4) The training required under subsection (2) must include information on all of the following:

(a) The types of annuities and various classifications of annuities.

(b) Identification of the parties to an annuity.

(c) How fixed, variable, and indexed annuity contract provisions affect consumers.

(d) The income taxation of qualified and nonqualified annuities.

(e) The primary uses of annuities.

(f) Appropriate standard of conduct, sales practices, and replacement and disclosure requirements.

(5) Registered insurance producer programs of study must cover all topics under subsection (4) and must

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not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the topics under subsection (4).

(6) A provider of an annuity training course intended to comply with this section shall register with the director as a continuing education provider in this state and comply with any requirements of the director applicable to insurance producer continuing education.

(7) A producer who has completed an annuity training course approved by the director before the effective date of the 2020 amendatory act that amended this section shall, within 6 months after the effective date of the 2020 amendatory act that amended this section, complete either of the following:

(a) A new 4-credit training course approved by the director after the effective date of the 2020 amendatory act that amended this section.

(b) An additional 1-time 1-credit training course approved by the director and provided by the department-approved education provider on appropriate sales practices, replacement, and disclosure requirements under this chapter.

(8) Annuity training courses may be conducted and completed by classroom or self–study methods in accordance with requirements of the director.

(9) Providers of annuity training shall comply with any reporting requirements imposed by the director and shall issue certificates of completion in accordance with any requirements of the director.

(10) The satisfaction of the training requirements of another state that the director determines to be substantially similar to this section satisfies the training requirements of this section.

(11) The satisfaction of the components of the training requirements of any course or courses with components substantially similar to this section satisfies the training requirements of this section.

(12) An insurer shall verify that an insurance producer has completed the annuity training course required under this section before allowing the producer to sell an annuity for that insurer. An insurer may satisfy its responsibility under this section by obtaining certificates of completion of the training course or obtaining reports provided by director-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with a registered insurance producer program of study.

History: Add. 2012, Act 544, Eff. June 1, 2013;—Am. 2020, Act 266, Eff. June 29, 2021.

500.4161 Copy of annuity policy.

Sec. 4161. For a consumer purchasing an individual annuity, the consumer shall be given a copy of the annuity policy within a reasonable time after the annuity is accepted and issued.

History: Add. 2012, Act 544, Eff. June 1, 2013.

500.4163 Records; maintenance, availability.

Sec. 4163. (1) An insurer and an insurance producer shall maintain or be able to make available to the commissioner records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions for 5 years after the insurance transaction is completed by the insurer. An insurer is permitted, but is not required, to maintain documentation on behalf of an insurance producer.

(2) Records required to be maintained by this chapter may be maintained in paper, photographic, microprocess, magnetic, mechanical, or electronic media or by any process that accurately reproduces the actual document.

History: Add. 2006, Act 399, Imd. Eff. Sept. 29, 2006.

500.4165 Applicability of subsections; definitions.

Sec. 4165. (1) Subject to subsection (2), a recommendation or sale made in compliance with comparable standards satisfies the requirements of this chapter. This subsection applies to a recommendation or sale of an annuity made by a financial professional in compliance with business rules, controls, and procedures that satisfy a comparable standard even if the standard would not otherwise apply to the product or recommendation at issue. However, this subsection does not limit the director's ability to investigate and enforce this chapter.

(2) Subsection (1) applies if the insurer does both of the following:

(a) Monitors the relevant conduct of the financial professional seeking to rely on subsection (1) or the entity responsible for supervising the financial professional, such as the financial professional's broker-dealer or an investment adviser registered under federal securities laws using information collected in the normal course of the insurer's business.

(b) Provides to the entity responsible for supervising the financial professional seeking to rely on

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subsection (1), such as the financial professional's broker-dealer or investment adviser registered under federal securities laws, information and reports that are reasonably appropriate to assist the entity to maintain its supervision system.

(3) Subsection (1) does not limit an insurer's obligation to comply with section 4155(6). However, an insurer may base its analysis on information received from either the financial professional or the entity supervising the financial professional.

(4) As used in this section:

(a) "Comparable standards" means all of the following, as applicable:

(*i*) With respect to broker-dealers and registered representatives of broker-dealers, applicable United States Securities and Exchange Commission and Financial Industry Regulatory Authority rules pertaining to best interest obligations and supervision of annuity recommendations and sales, including, but not limited to, Regulation Best Interest.

(*ii*) With respect to investment advisers registered under federal securities laws or investment adviser representatives, the fiduciary duties and all other requirements imposed on the investment advisers or investment adviser representatives by contract or under the Investment Advisers Act of 1940, including, but not limited to, the Form ADV.

(*iii*) With respect to plan fiduciaries or fiduciaries, the duties, obligations, prohibitions, and all other requirements attendant to such status under the employee retirement income security act of 1974, Public Law 93-406, or the internal revenue code of 1986, 26 USC 1 to 9834.

(b) "Financial professional" means a producer that is regulated and acting as any of the following:

(*i*) A broker-dealer registered under federal securities laws or a registered representative of a broker-dealer.

(*ii*) An investment adviser registered under federal securities laws or an investment adviser representative associated with the federal registered investment adviser.

(*iii*) A plan fiduciary under section 3(21) of the employee retirement income security act of 1974 or fiduciary under section 4975(e)(3) of the internal revenue code of 1986, 26 USC 4975.

History: Add. 2006, Act 399, Imd. Eff. Sept. 29, 2006;—Am. 2012, Act 544, Eff. June 1, 2013;—Am. 2020, Act 266, Eff. June 29, 2021.

500.4166 Compliance with chapter; violation orders.

Sec. 4166. (1) An insurer is responsible for compliance with this chapter. If a violation occurs, either because of the action or inaction of the insurer or its producer, the director may order any of the following:

(a) The insurer to take reasonably appropriate corrective action for any consumer harmed by a failure to comply with this chapter by the insurer, an entity contracted to perform the insurer's supervisory duties, or the producer.

(b) The producer to take reasonably appropriate corrective action for any consumer harmed by the producer's violation of this chapter.

(c) Appropriate sanctions.

(2) Any order under subsection (1) for a violation of this chapter may be reduced or eliminated by the director if corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice.

History: Add. 2020, Act 266, Eff. June 29, 2021.

CHAPTER 42
INDUSTRIAL LIFE INSURANCE

500.4200 Scope of chapter; other applicable provisions.

Sec. 4200. (1) This chapter shall apply only with respect to industrial life insurance policies.

(2) The following sections of chapter 40 (life insurance policies and annuity contracts) shall apply also to industrial life insurance policies: 4004 (policy must contain entire contract); 4040 (supplementary benefits); 4048 (provisions required by laws of other states, countries); 4052 (preliminary term insurance); 4054 (insurer may hold proceeds; exemption from creditors); 4060 (standard nonforfeiture law); 4062 (loan value; deferment); and 4064 (computation of loan indebtedness).

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4201 Industrial life insurance; definitions.

Sec. 4201. "Industrial life insurance," as used in this code, means that form of life insurance either (1) under which the premiums are payable weekly, or (2) under which the premiums are payable monthly or

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oftener, but less often than weekly, if the face amount of insurance provided in any such policy is $1,000.00 or less and if the words "industrial policy" are printed upon the policy as a part of the descriptive matter.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4204 Required policy provisions; exceptions.

Sec. 4204. (1) In the case of industrial policies issued on and after January 1, 1944, no policy of industrial life insurance shall be issued or delivered in this state, unless the same shall contain in substance the provisions set forth in sections 4206 through 4238.

(2) Any of such provisions or portions thereof not applicable to single premium or nonparticipating insurance policies shall to that extent not be incorporated therein.

(3) This section and the sections referred to in subsection (1), above, shall not apply to policies issued or granted pursuant to nonforfeiture provisions prescribed in section 4220.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4206 Grace period; provision required.

Sec. 4206. There shall be a provision that the insured is entitled to a grace period of 4 weeks within which the payment of any premium after the first may be made, except that where premiums are payable monthly the period of grace shall be 1 month; and that during the period of grace the policy shall continue in full force, but if during such grace period the policy becomes a claim, then any overdue and unpaid premiums may be deducted from any amount payable under the policy in settlement.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4208 Incontestability; provision required, exceptions.

Sec. 4208. There shall be a provision that the policy shall be incontestable after it has been in force during the lifetime of the insured for a period of 2 years from its date of issue, except for non-payment of premiums and except for violation of the conditions of the policy relating to military or naval service in time of war, and at the option of the insurer provisions relative to benefits in the event of total and permanent disability, and provisions which grant additional insurance specifically against death by accident may also be excepted.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4210 Policy constitutes entire contract; provision required.

Sec. 4210. There shall be a provision that the policy shall constitute the entire contract between the parties, or, if a copy of the application is endorsed upon and attached to the policy when issued, a provision that the policy and the application therefor shall constitute the entire contract between the parties, and in the latter case a provision that all statements made by the insured shall, in the absence of fraud, be deemed representations and not warranties.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4212 Misstatement of age; provision required.

Sec. 4212. There shall be a provision that if the age of the person insured has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4214 Participation in surplus; provision required.

Sec. 4214. There shall be a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4216 Conversion; weekly premium policies; provision required; monthly premium policies.

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Sec. 4216. (1) There shall be a provision in the case of weekly premium policies granting, upon proper written request and upon presentation of evidence of the insurability of the insured satisfactory to the company, the privilege of converting his weekly premium industrial insurance to any form of life insurance with less frequent premium payments regularly issued by the company, in accordance with terms and conditions agreed upon with the company. The privilege of making such conversion need be granted only if the company's weekly premium industrial policies on the life insured, in force as premium paying insurance and on which conversion is requested, grant benefits in event of death, exclusive of additional accidental death benefits and exclusive of any dividend additions, in an amount not less than the minimum amount of such insurance with less frequent premium payments issued by the company at the age of the insured on the plan of industrial or ordinary insurance desired.

(2) There shall be a provision, in the case of monthly premium industrial policies, granting, upon proper written request and upon presentation of evidence of the insurability of the insured satisfactory to the company, the privilege of converting his monthly premium industrial insurance to any form of ordinary life insurance regularly issued by the company, in accordance with terms and conditions agreed upon with the company. The privilege of making such conversions need be granted only if the company's monthly premium industrial policies on the life insured, in force as premium paying insurance and on which conversion is requested, grant benefits in event of death, exclusive of additional accidental death benefits and exclusive of any dividend additions, in an amount not less than the minimum amount of ordinary insurance issued by the company at the age of the insured on the plan of ordinary insurance desired.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4220 Nonforfeiture and cash surrender values.

Sec. 4220. (1) In the case of policies issued prior to the operative date of section 4060 (the standard nonforfeiture law), there shall be a provision which in event of default in premium payments, after premiums shall have been paid for 3 years, shall secure to the owner of the policy a stipulated form of insurance, the net value of which shall be at least equal to the reserve at the date of default on the policy and on any dividend additions thereto, specifying the mortality table and rate of interest adopted for computing such reserves less a sum of not more than 2 1/2% of the amount insured by the policy and of any existing dividend additions thereto, and less any existing indebtedness to the company on the policy. Such provision shall stipulate that the policy, after premiums shall have been paid for 5 years, may be surrendered to the company at its home office within 13 weeks, or 3 months, from date of default for a specified cash value at least equal to the sum which would otherwise be available for the purchase of insurance as aforesaid and may stipulate that the company may defer payment for not more than 6 months after application therefor is made. This provision shall not be required in term insurance of 20 years or less.

(2) In the case of policies issued on and after the operative date of section 4060 (the standard nonforfeiture law) there shall be a provision for such nonforfeiture and cash surrender values as are required for industrial insurance by said section 4060.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4222 Table of nonforfeiture benefits.

Sec. 4222. There shall be a table showing in figures the nonforfeiture benefits available under the policy every year upon default in payment of premiums during at least the first 20 years of the policy, and a provision that the company will furnish upon request an extension of such table beyond the year shown in the policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4224 Nonforfeiture benefit; automatic option; provision required.

Sec. 4224. There shall be a provision if more than 1 nonforfeiture benefit is provided, as to which of such benefits shall apply in the event 1 of the available benefits is not selected as required by the policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4228 Reinstatement; provision required.

Sec. 4228. There shall be a provision that the policy may be reinstated at any time within 2 years from date of the premium in default, unless the cash value has been paid or the period of extended term insurance

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expired, upon evidence of insurability satisfactory to the company and payment of arrears of premiums with interest at a rate not exceeding 6% per annum payable annually.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4230 Settlement of claim upon death of insured; provision required.

Sec. 4230. There shall be a provision that when a policy shall become a claim by the death of the insured, settlement shall be made upon receipt of due proof of death, or not later than 2 months after receipt of such proof.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4236 Title required.

Sec. 4236. There shall be a title on the face and on the back of the policy correctly describing the same.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4238 Beneficiary changes.

Sec. 4238. There shall be a space on the front or the back page of the policy for the name of the beneficiary designated by the insured with a reservation of the insured's right to designate or change the beneficiary after the issuance of the policy. The policy may also provide that no designation or change of beneficiary shall be binding on the insurer until endorsed on the policy by the insurer, and that the insurer may refuse to endorse the name of any proposed beneficiary who does not appear to the insurer to have an insurable interest in the life of the insured. Such policy may also contain a provision that if the beneficiary designated in the policy does not surrender the policy with due proof of death within the period stated in the policy, which shall not be less than 30 days after the death of the insured, or if the beneficiary is the estate of the insured, or is a minor, or dies before the insured, or is not legally competent to give a valid release, then the insurer may make any payment thereunder to the executor or administrator of the insured, or to any of the insured's relatives by blood or legal adoption or connections by marriage or to any person appearing to the insurer to be equitably entitled thereto by reason of having been named as beneficiary or by reason of having incurred expense for the maintenance, medical attention or burial of the insured.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4242 Limitation of liability; aviation, military or naval service.

Sec. 4242. Nothing contained in this chapter shall be construed as prohibiting a life insurance company from placing in its industrial life insurance policies provisions limiting its liability with respect to (1) death resulting from aviation other than as a fare-paying passenger on a regularly scheduled route between definitely established airports, (2) military or naval service: Provided, That if the liability of the company is limited as herein provided, the liability shall in no event be fixed at an amount less than the reserve on the policy (including the reserve for any dividend additions thereto and excluding the reserve for any additional benefits in the event of death by accident or accidental means or for benefits in the event of any type of disability), less any indebtedness on or secured by such policy.

Nothing contained herein shall apply to any provision in an industrial life insurance policy for additional benefits in the event of death by accident or accidental means.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4244 Industrial life insurance; provisions prohibited; right to declare policy void for disease or ailment; rejection; payment of proceeds to other than beneficiary; limitation; settlement at maturity for less than full value; accidental death.

Sec. 4244. (1) No policy of industrial life insurance issued on or after January 1, 1944, shall be issued or delivered in this state if it contains any of the following provisions:

(a) A provision giving the insurer the right to declare the policy void because the insured has had any disease or ailment, whether specified or not, or because the insured has received institutional, hospital, medical or surgical treatment or attention, except a provision which gives the insurer the right to declare the policy void if the insured has, within 2 years prior to the issuance of the policy, received institutional, hospital, medical or surgical treatment or attention and if the insured or the claimant under the policy fails to

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show that the condition occasioning such treatment or attention was not of a serious nature or was not material to the risk.

(b) A provision giving the insurer the right to declare the policy void because the insured had been rejected for insurance, unless such right be conditioned upon a showing by the insurer that knowledge of such rejection would have led to a refusal by the insurer to make such contract.

(c) A provision by which the company may pay the proceeds of the policy at the death of the insured to any person other than the named beneficiary, except in accordance with a standard provision as specified in section 4238.

(d) A provision limiting the time within which any action at law or in equity may be commenced to less than 6 years after the cause of action shall accrue.

(e) A provision for any mode of settlement at maturity of less value than the amount insured by the policy plus dividend additions, if any, less any indebtedness to the company on the policy and less any premium that may by the terms of the policy be deducted, payments to be made in accordance with the terms of the policy.

(2) Nothing contained herein shall apply to any provision in an industrial life insurance policy for additional benefits in the event of death by accident or accidental means.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

CHAPTER 44

GROUP LIFE INSURANCE

500.4400 Scope of chapter; compliance required.

Sec. 4400. (1) This chapter applies only with respect to group life insurance.

(2) Except as provided in this chapter it shall be unlawful to make a contract of life insurance covering a group in this state.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4404 Employee groups; required number of participants; premium payments; group life insurance as part of combined group life and disability insurance policy; "employees" defined.

Sec. 4404. (1) Group life insurance may be issued covering not less than 2 employees with or without medical examination, written under a policy issued to the employer or to the trustees of a fund established by the employer, the premium on which is to be paid by the employer, the employees, or by the employer and the employees jointly, and insuring only all of his or her employees, or all of any class or classes of employees determined by conditions pertaining to the employment, for amounts of insurance based upon some plan that will preclude individual selection, for the benefit of persons other than the employer. This section does not require an employee to purchase group life insurance. Group life insurance may be written as part of a combined group life and disability insurance policy.

(2) A policy issued under subsection (1) may define "employees" to include 1 or more of the following:

(a) The employees of 1 or more subsidiary corporations.

(b) The employees, individual proprietors, and partners of 1 or more affiliated corporations, proprietorships, or partnerships if the business of the employer and the affiliated corporations, proprietorships, or partnerships is under common control.

(c) The retired employees, former employees, and directors of a corporate employer.

(d) For a policy issued to insure the employees of a public body, elected or appointed officials.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 20, Imd. Eff. Apr. 19, 1957;—Am. 1995, Act 210, Imd. Eff. Nov. 29, 1995;—Am. 2006, Act 511, Imd. Eff. Dec. 29, 2006;—Am. 2014, Act 139, Eff. Mar. 31, 2015.

Popular name: Act 218

500.4405 Group life insurance policy; issuance to trust or trustees; requirements.

Sec. 4405. Notwithstanding section 4404, a group life insurance policy may be issued to a trust or trustees of a fund established by 2 or more employers to insure 1 or more employees of the employers.

History: Add. 1988, Act 312, Eff. Mar. 30, 1989.

Popular name: Act 218

500.4408 National guard groups; participation authorization.

Sec. 4408. Group life insurance may be issued covering the members of 1 or more companies, batteries,

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troops or other units of the national guard of any state, written under a policy issued to the commanding general of the national guard who shall be deemed to be the employer for the purposes of this chapter, the premium on which is to be paid by the members of such units for the benefit of persons other than the employer: Provided, however, That when the benefits of the policy are offered to all eligible members of a unit of the national guard, not less than 75% of the members of such a unit must be so insured.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4412 Labor union, teacher and postal clerk groups; participation authorization.

Sec. 4412. Group life insurance may be issued covering the members of any labor union, or state associations of teachers or postal clerks written under a policy issued to such union or association which shall be deemed to be the employer for the purposes of this chapter, the premium on which is to be paid by the union or association or by the union or association and its members jointly, and insuring only all of its members for amounts of insurance based upon some plan which will preclude individual selection, for the benefit of persons other than the union or association or its officials: Provided, however, That when the premium is to be paid by the union or association and its members jointly and the benefits are offered to all eligible members, not less than 75% of such members may be so insured: Provided further, That when members apply and pay for additional amounts of insurance, a smaller percentage of members may be insured for such additional amounts if they pass satisfactory medical examination.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4416 Group life insurance; groups of borrowers or purchasers.

Sec. 4416. Group life insurance may be issued covering only the lives of members of a group of persons who become borrowers from 1 financial institution, including subsidiary or affiliated companies, or who become purchasers of merchandise or other tangible property from 1 vendor under agreement to repay the sum borrowed or to pay the balance of the price of the merchandise or other tangible property purchased on the installment plan over a period of not more than 10 years, to the extent of their indebtedness to the financial institution or vendor. The policy may be issued on the application of, and made payable to, the financial institution or vendor or other creditor to whom the vendor may have transferred title to the indebtedness, as beneficiary, the premium on the policy to be payable either from funds of the financial institution, vendor or other creditor, or from charges collected from insured borrowers or purchasers, or both. If all or part of the premium is derived from the collection of an identifiable charge for the insurance from the insured borrowers or purchasers, the borrowers or purchasers shall have the option to reject the insurance. The total amount charged to the borrower for interest and for the insurance premium shall not exceed the maximum amount of interest which could be lawfully charged. The financial institution, including subsidiaries or affiliated companies, shall not act as agent for the group life insurance transaction. The provisions of section 4438 shall not apply to insurance described in this section. The borrower shall be given written notification of the application of the insurance when written. If a beneficiary receives money from a policy issued under this section, the person whose indebtedness is insured, or the estate of the deceased, shall be released from liability for the payment of the indebtedness to the amount paid to the beneficiary on the policy.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 78, Eff. Sept. 27, 1957;—Am. 1961, Act 226, Eff. Sept. 8, 1961;—Am. 1978, Act 169, Imd. Eff. May 27, 1978;—Am. 1988, Act 374, Imd. Eff. Dec. 21, 1988.

Popular name: Act 218

500.4418 Group life insurance; loans on dwellings or mobile homes; insurer providing monetary benefits to financial institutions; payment of dividends to financial institution.

Sec. 4418. (1) Group life insurance may be issued in connection with loans on dwellings or mobile homes when provided through a group if the lending or servicing financial institution directly or indirectly is the group policyholder. The insurance shall be only on a decreasing term basis and shall be limited in initial amount to the amount of the loan. Dividends payable under these group policies shall inure solely to the benefit of the party paying the premiums on the insurance and shall be proportionate to that portion of the premium paid by or on behalf of the certificate holder. Policies issued under this section shall contain a conversion privilege specifying that within 31 days after the repayment of the mortgage, the insured may convert the insurance then in force to a permanent form of life insurance. The available forms of converted insurance shall include whole life. The insurer may limit the converted policy to a minimum of $1,000.00 or to a maximum equal to 80% of the insurance then in force, or both. If the loan for which the insurance was issued is repaid, any prepaid premiums in excess of $5.00 shall be returned to the insured.

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(2) An insurer may provide for or pay to the lending or servicing financial institutions monetary or financial benefits as a result of insurance on the life of a borrower in connection with a loan on a dwelling or mobile home made or serviced by the financial institution. However, if the insurance authorized under this section is offered in connection with the origination of a loan, an insurer may provide for or pay to the lending or servicing financial institutions monetary or financial benefits as a result of that insurance only if the insurer has taken reasonable steps to ensure each of the following:

(a) The loan and insurance transactions are separated through a written disclosure given by the lending or servicing financial institution to the borrower, at the time it first initiates discussion of the insurance with the borrower, stating that insurance offered under this section need not be purchased as a condition of the loan.

(b) The written disclosure states that the borrower is not required to decide whether or not to apply for the insurance until after approval of the loan has been communicated to the borrower.

(c) The lending or servicing financial institution gives a written disclosure to the borrower that it or an affiliate has a financial interest in the insurance transaction by not later than the time the borrower is asked to decide whether or not to apply for the insurance coverage offered under this section.

(d) The loan and insurance transactions are completed through separate documents.

(3) This section does not supersede or modify section 1243(35).

(4) Dividends paid before, on, or after the effective date of this subsection to a financial institution or its affiliate on stock owned in a reinsurer that accepts cessions from an insurance company that provides group insurance of the types authorized by this section are lawful.

History: Add. 1968, Act 224, Eff. Jan. 1, 1969;—Am. 1973, Act 10, Imd. Eff. Apr. 12, 1973;—Am. 1982, Act 379, Eff. Mar. 30, 1983;—Am. 1996, Act 158, Imd. Eff. Apr. 3, 1996.

Popular name: Act 218

500.4419 Prepaid funeral contracts; group life insurance.

Sec. 4419. Group life insurance may be issued in connection with prepaid funeral contracts only if it meets all of the following:

(a) Is issued to an association covering the lives of its members or to a trustee of a group.

(b) Is issued as an associated life insurance policy or annuity contract under section 2080.

(c) Conforms with section 2080.

History: Add. 1998, Act 457, Imd. Eff. Jan. 4, 1999.

Popular name: Act 218

500.4420 Nonprofit incorporated industrial association groups; executives; participation; other associations, trusts, or trustees; criteria; conditions.

Sec. 4420. (1) Group life insurance may be issued covering the executives of employer members of any nonprofit incorporated industrial association, that is now and has been actively functioning as a nonprofit incorporated industrial association under its articles of incorporation for a period of not less than 10 years, written under a policy issued to the association that is the employer for the purposes of this chapter, or to the association and the executives of the employer members jointly, and insuring only all of the executives for amounts of insurance based upon a plan that will preclude individual selection, for the benefit of persons other than the association, and the premium on which shall be paid by the employer members or the employer members and the executives of the employer members jointly.

(2) In addition to a policy issued under subsection (1), group life insurance may be issued to an association, other than an association described under subsection (1), or to a trust or to the trustees of a fund established or maintained for the benefit of members of 1 or more associations. Group life insurance shall not be issued to an association under this subsection unless all of the following criteria are met:

(a) The association at the outset has not fewer than 100 members.

(b) The association has been organized and maintained for a purpose other than obtaining insurance.

(c) The association has been in active existence for not less than 2 years.

(d) The association's bylaws provide for all of the following:

(*i*) Association members shall meet not less frequently than annually.

(*ii*) Except for an association that is a credit union, the association shall collect dues and solicit contributions from its members.

(*iii*) The members shall have voting rights and representation on the governing board.

(3) A policy issued under subsection (2) is subject to all of the following:

(a) The policy may insure members of the association, employees of the association, or employees of members for the benefit of persons other than the employee's employer.

(b) The premium for the policy shall be paid from money contributed by 1 or more of the following:

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(*i*) The association.

(*ii*) Employer members.

(*iii*) Covered persons.

(c) Except as provided in subdivision (d), a policy on which no part of the premium shall come from money contributed by the covered persons specifically for their insurance must insure all eligible persons, except those eligible persons who reject coverage in writing.

(d) An insurer may exclude or limit coverage on an individual as to whom evidence of individual insurability is not satisfactory to the insurer.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2014, Act 139, Eff. Mar. 31, 2015.

Popular name: Act 218

500.4424 Group life insurance offered to groups other than described in MCL 500.4404 to 500.4420.

Sec. 4424. Group life insurance offered to a resident of this state under a group life insurance policy issued to a group other than a group described in sections 4404 to 4420 is subject to all of the following:

(a) A group life insurance policy shall not be issued in this state unless the director of the department of insurance and financial services finds all of the following:

(*i*) The issuance of the group policy is not contrary to the best interest of the public.

(*ii*) The issuance of the group policy would result in economies of acquisition and administration.

(*iii*) The benefits of the group policy are reasonable in relation to the premiums charged.

(b) The premium for the policy is paid from the policy holder's funds, the funds contributed by the covered persons, or both.

(c) An insurer may exclude or limit the coverage on an individual as to whom evidence of individual insurability is not satisfactory to the insurer.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 77, Eff. Sept. 27, 1957;—Am. 1968, Act 113, Imd. Eff. June 11, 1968;—Am. 1976, Act 351, Imd. Eff. Dec. 21, 1976;—Am. 1980, Act 263, Imd. Eff. Sept. 15, 1980;—Am. 1981, Act 1, Imd. Eff. Mar. 30, 1981;—Am. 1982, Act 27, Imd. Eff. Mar. 9, 1982;—Am. 1998, Act 457, Imd. Eff. Jan. 4, 1999;—Am. 2008, Act 497, Imd. Eff. Jan. 13, 2009;—Am. 2014, Act 139, Eff. Mar. 31, 2015.

Popular name: Act 218

Administrative rules: R 500.402 et seq. of the Michigan Administrative Code.

500.4426 Extension of coverage to eligible dependents; amounts; payment of premiums; definitions.

Sec. 4426. (1) Insurance under any group life insurance policy issued under sections 4400, 4404, 4408, 4412, 4420, and 4424 may be extended to insure the eligible dependents of each insured employee or member who so elects.

(2) The amounts of dependent insurance shall be in accordance with a plan that precludes individual selection.

(3) The premiums for the insurance on dependents may be paid by the employer or policyholder, or the employee or member, or the employer or policyholder and the employee or member, jointly.

(4) As used in this section:

(a) "Child" includes a biological, legally adopted, and step or foster child of an employee or member who is dependent on the employee or member.

(b) "Eligible dependent" includes the legal spouse and a child of an employee or member.

History: Add. 1972, Act 201, Imd. Eff. June 30, 1972;—Am. 2014, Act 139, Eff. Mar. 31, 2015.

Popular name: Act 218

500.4430 Group life insurance policy; filing and approval of form; certain provisions required.

Sec. 4430. (1) Except as otherwise provided in section 2236(8)(d), a policy of group life insurance shall not be issued or delivered in this state unless and until a copy of the form of the group life insurance has been filed with and approved by the commissioner.

(2) A policy of group life insurance shall not be issued or delivered unless it contains in substance the provisions of sections 4432 through 4442. A group universal life policy as defined in section 4001(g) shall not be issued or delivered unless it complies with the provisions of chapter 40.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1987, Act 52, Imd. Eff. June 22, 1987;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990;—Am. 1993, Act 349, Eff. Oct. 1, 1994.

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Compiler's note: Section 2 of Act 52 of 1987 provides:

"The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act apply to all insurance policies issued on or after January 1, 1957 that were either approved by the commissioner on or after January 1, 1957 or subject to an order of the commissioner exempting policies from filing on or after September 1, 1968. The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act are intended to codify and approve long-standing administrative and commercial practice taken and approved by the commissioner pursuant to his or her legal authority. This amendatory act shall serve to cure and clarify any misinterpretation of the operation of such sections since the effective date of their original enactment. It is the intent of this amendatory act to rectify the misconstruction of the insurance code of 1956 by the court of appeals in Bill v Northwestern National Life Insurance Company, 143 Mich App 766, with respect to the power of the insurance commissioner to exempt certain insurance documents from filing requirements and the offsetting of social security benefits against disability income insurance benefits. This amendatory act does not affect the relationship between disability insurance benefits and personal protection insurance benefits as provided in Federal Kemper v Health Insurance Administration Inc., 424 Mich 537."

Popular name: Act 218

500.4432 Group life insurance policy; incontestability.

Sec. 4432. There shall be a provision that the policy shall be incontestable after 2 years from its date of issue, except for non-payment of premiums and except for violation of the conditions of the policy relating to military or naval service in time of war.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4434 Entire contract; provision; application; representations.

Sec. 4434. Each group life insurance policy shall contain a provision that the policy and the applications of the employer and, if applicable, of the individual employees insured, are the entire contract between the parties, and that all statements made by the employer or by the individual employees shall, in the absence of fraud, be considered representations and not warranties. Any such statement shall not be used in defense to a claim under the policy, unless the statement is contained in a written application. For purposes of this section, an enrollment form is not an application described in this section.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2014, Act 139, Eff. Mar. 31, 2015.

Popular name: Act 218

500.4436 Misstatement of age; provision required.

Sec. 4436. There shall be a provision for the equitable adjustment of the premium or the amount of insurance payable in the event of a misstatement of the age of an employee.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4438 Individual certificate; notice of conversion rights.

Sec. 4438. (1) Each group life insurance policy shall contain a provision that the company will issue to the employer for delivery to the employee, whose life is insured under the policy, an individual certificate that contains all of the following:

(a) A description of the employee's insurance coverage and to whom the insurance is payable.

(b) A statement that if the employee is terminated from employment for any reason, the employee is entitled to have issued to the employee by the company, without further evidence of insurability, upon application made to the company within 31 days after the termination, and upon the payment of the premium applicable to the class of risk to which the employee belongs and to the form and amount of the policy at the employee's then attained age, a policy of life insurance in any 1 of the forms customarily issued by the company, except term insurance, in an amount equal to the amount of the employee's coverage under the group insurance policy at the time of the employee's termination of employment.

(2) An individual certificate under subsection (1) is notice to the employee of his or her conversion rights under a group policy. A separate notice at the time of the employee's termination is not required.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2014, Act 139, Eff. Mar. 31, 2015.

Popular name: Act 218

500.4439 Insurance under group policy; assignment of rights, effect.

Sec. 4439. A person whose life is insured under a group insurance policy may, subject and pursuant to the terms of the policy, or pursuant to an arrangement between the insured, the employer and the company, assign (other than to the employer) all or any part of his incidents of ownership, rights, title and interests, both present and future, under such policy including specifically, but not by way of limitation, the right to

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designate and redesignate a beneficiary or beneficiaries thereunder, the right to make any requisite contributions to maintain the insurance in force, and the right to have an individual policy issued to him in case of termination of employment. Such an assignment by the insured, made either before or after the effective date hereof, is valid for the purpose of vesting in the assignee, in accordance with any provisions included therein as to the time at which it is to be effective, all of such incidents of ownership, rights, title and interests so assigned, but without prejudice to the company on account of any payment it may make or individual policy it may issue prior to receipt of notice of the assignment. This section is not intended to alter the law of this state but is intended only to confirm in express statutory form the law as it exists presently.

History: Add. 1969, Act 330, Imd. Eff. Oct. 27, 1969;—Am. 1970, Act 158, Imd. Eff. Aug. 2, 1970.

Popular name: Act 218

500.4442 New employee; provision required.

Sec. 4442. Each group life insurance policy shall contain a provision that each new employee of an employer shall periodically be added to coverage if the new employee satisfies the conditions for coverage and is in the group or class of an employee originally insured.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2014, Act 139, Eff. Mar. 31, 2015.

Popular name: Act 218

500.4446 Policy issued in another state; determination by director.

Sec. 4446. A group policy offered by an insurer issued in another state shall not be issued in this state unless the director of the department of insurance and financial services determines that requirements substantially similar to section 4424(a) have been met.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2014, Act 139, Eff. Mar. 31, 2015.

Popular name: Act 218

500.4450 Employer deemed policyholder.

Sec. 4450. In every group life insurance policy issued in this state, the employer shall be deemed to be the policyholder for all purposes within the meaning of this chapter, and, if entitled to vote at meetings of the insurer, shall be entitled to 1 vote thereat.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.4454 Readjustment of premium rate; optional provisions.

Sec. 4454. Any group life insurance policy may provide for a readjustment of the rate based on experience at the end of the first year or any subsequent year of insurance, which readjustment may be made retroactive for such policy year only.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

CHAPTER 45
INSURANCE FRAUD

500.4501 Definitions.

Sec. 4501. As used in this chapter:

(a) "Authorized agency" means the department of state police; a city, village, or township police department; a county sheriff's department; a United States criminal investigative department or agency; the prosecuting authority of a city, village, township, county, or state or of the United States; the office of financial and insurance regulation; or the department of state.

(b) "Financial loss" includes, but is not limited to, loss of earnings, out-of-pocket and other expenses, repair and replacement costs, investigative costs, and claims payments.

(c) "Insurance policy" or "policy" means an insurance policy, benefit contract of a self-funded plan, health maintenance organization contract, nonprofit dental care corporation certificate, or health care corporation certificate.

(d) "Insurer" means a property-casualty insurer, life insurer, third party administrator, self-funded plan, health insurer, health maintenance organization, nonprofit dental care corporation, health care corporation, reinsurer, or any other entity regulated by the insurance laws of this state and providing any form of insurance.

(e) "Organization" means an organization or internal department of an insurer established to detect and

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prevent insurance fraud.

(f) "Person" includes an individual, insurer, company, association, organization, Lloyds, society, reciprocal or inter-insurance exchange, partnership, syndicate, business trust, corporation, and any other legal entity.

(g) "Practitioner" means a licensee of this state authorized to practice medicine and surgery, psychology, chiropractic, or law, any other licensee of the state, or an unlicensed health care provider whose services are compensated, directly or indirectly, by insurance proceeds, or a licensee similarly licensed in other states and nations, or the practitioner of any nonmedical treatment rendered in accordance with a recognized religious method of healing.

(h) "Runner", "capper", or "steerer" means a person who receives a pecuniary or other benefit from a practitioner, whether directly or indirectly, for procuring or attempting to procure a client, patient, or customer at the direction or request of, or in cooperation with, a practitioner whose intent is to obtain benefits under a contract of insurance or to assert a claim against an insured or an insurer for providing services to the client, patient, or customer. Runner, capper, or steerer does not include a practitioner who procures clients, patients, or customers through the use of public media.

(i) "Statement" includes, but is not limited to, any notice statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, claim form, diagnosis, prescription, hospital or doctor record, X-rays, test result, or other evidence of loss, injury, or expense.

History: Add. 1995, Act 276, Eff. Mar. 28, 1996;—Am. 2012, Act 39, Imd. Eff. Mar. 6, 2012.

Compiler's note: For references to office of financial and insurance regulation to be deemed as department of insurance and financial services, and abolishment of office of financial and insurance regulation, see E.R.O. No. 2013-1, compiled at MCL 550.991.

For references to commissioner of office of financial and insurance regulation to be deemed as references to director of department of insurance and financial services, and abolishment of office of commissioner of office of financial and insurance regulation, see E.R.O. No. 2013-1, compiled at MCL 550.991.

Popular name: Act 218

500.4503 Fraudulent insurance acts.

Sec. 4503. A fraudulent insurance act includes, but is not limited to, acts or omissions committed by any person who knowingly, and with an intent to injure, defraud, or deceive:

(a) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer or any agent of an insurer, or any agent of an insurer, reinsurer, or broker any oral or written statement knowing that the statement contains any false information concerning any fact material to an application for the issuance of an insurance policy.

(b) Prepares or assists, abets, solicits, or conspires with another to prepare or make an oral or written statement that is intended to be presented to or by any insurer in connection with, or in support of, any application for the issuance of an insurance policy, knowing that the statement contains any false information concerning any fact or thing material to the application.

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

(d) Assists, abets, solicits, or conspires with another to prepare or make any oral or written statement including computer-generated documents that is intended to be presented to or by any insurer in connection with, or in support of, any claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false information concerning any fact or thing material to the claim.

(e) Solicits or accepts new or renewal insurance risks by or for an insolvent insurer.

(f) Removes or attempts to remove the assets or records of assets, transactions, and affairs, or a material part of the assets or records, from the home office or other place of business of the insurer or from the place of safekeeping of the insurer, or who conceals or attempts to conceal the assets or record of assets, transactions, and affairs, or a material part of the assets or records, from the commissioner.

(g) Diverts, attempts to divert, or conspires to divert funds of an insurer or of other persons in connection with any of the following:

(*i*) The transaction of insurance or reinsurance.

(*ii*) The conduct of business activities by an insurer.

(*iii*) The formation, acquisition, or dissolution of an insurer.

(h) Employs, uses, or acts as a runner, capper, or steerer with the intent to falsely or fraudulently obtain benefits under a contract of insurance or to falsely or fraudulently assert a claim against an insured or an insurer for providing services to the client, patient, or customer.

(i) Knowingly and willfully assists, conspires with, or urges any person to fraudulently violate this act, or

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any person who due to that assistance, conspiracy, or urging knowingly and willfully benefits from the proceeds derived from the fraud.

History: Add. 1995, Act 276, Eff. Mar. 28, 1996;—Am. 2012, Act 39, Imd. Eff. Mar. 6, 2012.

Popular name: Act 218

500.4507 Release of information; purpose.

Sec. 4507. (1) Upon written request by an authorized agency to an insurer, the insurer or an agent authorized by the insurer to act on its behalf may release to the authorized agency, at the authorized agency's expense, any or all information that is considered important relating to any suspected insurance fraud. An authorized agency may release information on suspected insurance fraud to an insurer or an agent authorized by an insurer to act on its behalf upon a showing of good cause by the insurer or the insurer's authorized agent. This information may include, but is not limited to, the following:

(a) Insurance policy information relevant to an investigation, including any application for a policy.

(b) Policy premium payment records that are available.

(c) History of previous claims made by the insured.

(d) Information relating to the investigation of the suspected insurance fraud, including statements of any person, proofs of loss, and notice of loss.

(2) If an insurer knows or reasonably believes it knows the identity of a person who it has reason to believe committed a fraudulent insurance act or has knowledge of a suspected fraudulent insurance act that is reasonably believed not to have been reported to an authorized agency, then for the purpose of notification and investigation, the insurer or an agent authorized by an insurer to act on its behalf may notify an authorized agency of the knowledge or belief and provide any additional information in accordance with subsection (1).

(3) An insurer providing information to an authorized agency pursuant to subsection (2) has the right to request in writing information in the possession or control of the authorized agency relating to the same suspected fraudulent insurance act of which the insurer notifies the authorized agency under subsection (2). Upon a showing of good cause by the insurer, the authorized agency may provide the requested information at the insurer's expense within 30 days of the request.

(4) In addition to providing information to an insurer under subsection (3), the authorized agency provided with information pursuant to subsection (1) or (2) may release or provide the information to any other authorized agency.

(5) Nothing in this chapter impairs a person's right, as of the effective date of this chapter, to submit to the insurer or the insurer's representative a statement fully explaining the basis of the claim and to have that statement placed in the claim file.

(6) An authorized agency, insurer, or an agent authorized by an insurer to act on its behalf shall not request or release information under subsection (1) for any purpose other than for the investigation of suspected insurance fraud.

History: Add. 1995, Act 276, Eff. Mar. 28, 1996.

Popular name: Act 218

500.4509 Civil liability; immunity.

Sec. 4509. (1) A person acting without malice is not subject to liability for filing a report or requesting or furnishing orally or in writing other information concerning suspected or completed insurance fraud, if the reports or information are provided to or received from the insurance bureau, the national association of insurance commissioners, any federal, state, or governmental agency established to detect and prevent insurance fraud, as well as any other organization, and their agents, employees, or designees, unless that person knows that the report or other information contains false information pertaining to any material fact or thing.

(2) In a prosecution for perjury or insurance fraud, and in the absence of malice, an insurer, or any officer, employee, or agent of an insurer, or any private person who cooperates with, furnishes evidence, or provides or receives information regarding suspected insurance fraud to or from an authorized agency, the national association of insurance commissioners, or any organization, or who complies with an order issued by a court acting in response to a request by any of these entities to provide evidence or testimony, is not subject to civil liability with respect to any act concerning the suspected insurance fraud that the person testifies to or produces relevant matter, unless that person knows that the evidence, information, testimony, or other matter contains false information pertaining to any material fact or thing.

(3) In the absence of malice, an insurer, or any officer, employee, or agent of an insurer, or any person who cooperates with, furnishes evidence, or provides information regarding suspected insurance fraud to an authorized agency, the national association of insurance commissioners, or any organization, or who complies

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with an order issued by a court of competent jurisdiction acting in response to a request by any of these entities to furnish evidence or provide testimony, is not subject to civil liability for libel, slander, or any other tort, and a civil cause of action of any nature does not exist against the person, for filing a report, providing information, or otherwise cooperating with an investigation or examination of any of these entities, unless that person knows that the evidence, information, testimony, or matter contains false information pertaining to any material fact or thing.

(4) The authorized agency, the national association of insurance commissioners, or any organization, and any employee or agent of any of these entities, when acting without malice, is not subject to civil liability for libel, slander, or any other tort, and a civil cause of action of any nature does not exist against the person for official activities or duties of the entity because of the publication of any report or bulletin related to the entity's official activities or duties, unless the report or bulletin contains false information concerning any material fact or thing and the authorized agency, the national association of insurance commissioners, an organization, or an employee or agent of these entities knows that the information is false.

(5) This section does not abrogate or modify in any way common law or statutory privilege or immunity otherwise available to any person or entity.

History: Add. 1995, Act 276, Eff. Mar. 28, 1996.

Popular name: Act 218

500.4511 Violation as felony; penalty; notice to licensing authority.

Sec. 4511. (1) A person who commits a fraudulent insurance act under section 4503 is guilty of a felony punishable by imprisonment for not more than 4 years or a fine of not more than $50,000.00, or both, and shall be ordered to pay restitution as provided in section 1a of chapter IX of the code of criminal procedure, Act No. 175 of the Public Acts of 1927, being section 769.1a of the Michigan Compiled Laws, and in the crime victim's rights act, Act No. 87 of the Public Acts of 1985, being sections 780.751 to 780.834 of the Michigan Compiled Laws.

(2) A person who enters into an agreement or conspiracy to commit a fraudulent insurance act under section 4503 is guilty of a felony, punishable by imprisonment for not more than 10 years or by a fine of not more than $50,000.00, or both, and shall be ordered to pay restitution as provided in section 1a of chapter IX of the code of criminal procedure, Act No. 175 of the Public Acts of 1927, being section 769.1a of the Michigan Compiled Laws, and in the crime victim's rights act, Act No. 87 of the Public Acts of 1985, being sections 780.751 to 780.834 of the Michigan Compiled Laws.

(3) If the court finds a practitioner or insurer responsible for or guilty of a fraudulent insurance act under section 4503, the court shall notify the appropriate licensing authority in this state of the adjudication.

History: Add. 1995, Act 276, Eff. Mar. 28, 1996.

Popular name: Act 218

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CHAPTER 46
CAPTIVE INSURANCE COMPANIES

500.4601 Definitions.

Sec. 4601. As used in this chapter:

(a) "Affiliated company" means a company in the same corporate system as a parent, an industrial insured, or a member organization by virtue of common ownership, control, operation, or management.

(b) "Alien captive insurance company" means an insurer formed to write insurance business for its parents and affiliates and licensed pursuant to the laws of a country other than the United States or a state, district, commonwealth, territory, or possession of the United States.

(c) "Association" means a legal group of individuals, corporations, limited liability companies, partnerships, political subdivisions, or groups that has been in continuous existence for at least 1 year and the member organizations of which collectively, or that does itself, own, control, or hold, with power to vote, all of the outstanding voting securities of an association captive insurance company incorporated as a stock insurer or organized as a limited liability company; or has complete voting control over an association captive insurance company organized as a mutual insurer.

(d) "Association captive insurance company" means a company that insures risks of the member organizations of the association and their affiliated companies.

(e) "Branch business" means any insurance business transacted by a branch captive insurance company in this state.

(f) "Branch captive insurance company" means an alien captive insurance company authorized by the director to transact the business of insurance in this state through a business unit with a principal place of

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business in this state.

(g) "Branch operations" means any business operations of a branch captive insurance company in this state.

(h) "Captive insurance company" means a pure captive insurance company, association captive insurance company, sponsored captive insurance company, special purpose captive insurance company, or industrial insured captive insurance company authorized under this chapter. For purposes of this chapter, a branch captive insurance company must be a pure captive insurance company with respect to operations in this state, unless otherwise permitted by the director.

(i) "Control", including the terms "controlling", "controlled by", and "under common control with", means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of another person. A showing that control does not exist may rebut this presumption.

(j) "Controlled unaffiliated business" means a company to which all of the following apply:

(*i*) The company is not in the corporate system of a parent and affiliated companies.

(*ii*) The company has an existing contractual relationship with a parent or affiliated company.

(*iii*) The company has risks managed by a captive insurance company in accordance with this chapter.

(k) "Foreign captive insurer" means an insurer formed under the laws of the District of Columbia, or a state, commonwealth, territory, or possession of the United States other than this state.

(*l*) "GAAP" means generally accepted accounting principles.

(m) "Industrial insured" means an insured to which all of the following apply:

(*i*) The insured procures insurance by use of the services of a full-time employee acting as a risk manager or insurance manager or utilizing the services of a regularly and continuously qualified insurance consultant.

(*ii*) The insured's aggregate annual premiums for insurance on all risks total at least $25,000.00.

(*iii*) The insured has at least 25 full-time employees.

(n) "Industrial insured captive insurance company" means a company that insures risks of the industrial insureds that comprise the industrial insured group and their affiliated companies.

(o) "Industrial insured group" means a group that meets either of the following criteria:

(*i*) The group is a group of industrial insureds that collectively own, control, or hold, with power to vote, all of the outstanding voting securities of an industrial insured captive insurance company incorporated as a stock insurer or limited liability company or have complete voting control over an industrial insured captive insurance company incorporated as a mutual insurer.

(*ii*) The group is a group created under the liability risk retention act of 1986, 15 USC 3901 to 3906, and chapter 18, as a corporation or other limited liability association taxable as a stock insurance company or a mutual insurer under this chapter.

(p) "Irrevocable letter of credit" means a letter of credit that meets the description in section 1105(c).

(q) "Member organization" means an individual, corporation, limited liability company, partnership, or association that belongs to an association.

(r) "Office" means the department.

(s) "Organizational document" means the articles of incorporation, articles of organization, bylaws, operating agreement, or other foundational documents that create a legal entity or prescribe its existence.

(t) "Parent" means a corporation, limited liability company, partnership, or individual that directly or indirectly owns, controls, or holds with power to vote more than 50% of the outstanding voting interests of a company.

(u) "Participant" means an entity as described in section 4667, and any affiliates of the entity, that are insured by a sponsored captive insurance company, if the recovery of the participant is limited through a participant contract to the assets of a protected cell.

(v) "Participant contract" means a contract by which a sponsored captive insurance company insures the risks of a participant and limits the recovery of the participant to the assets of a protected cell.

(w) "Protected cell" means a segregated account established and maintained by a sponsored captive insurance company for 1 participant.

(x) "Pure captive insurance company" means a company that insures risks of its parent, affiliated companies, controlled unaffiliated businesses, or a combination of its parent, affiliated companies, and controlled unaffiliated businesses.

(y) "Qualified United States financial institution" means that term as defined in section 1101.

(z) "Safe, reliable, and entitled to public confidence" means that term as defined in section 116.

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(aa) "Special purpose captive insurance company" means a captive insurance company that is authorized under this chapter and chapter 47 that does not meet the definition of any other type of captive insurance company defined in this section.

(bb) "Sponsor" means an entity that meets the requirements of section 4665 and is approved by the director to provide all or part of the capital and retained earnings required by applicable law and to organize and operate a sponsored captive insurance company.

(cc) "Sponsored captive insurance company" means a captive insurance company in which the minimum capital and retained earnings required by applicable law is provided by 1 or more sponsors, that is authorized under this chapter, that insures the risks of separate participants through the participant contract, and that segregates each participant's liability through 1 or more protected cells.

(dd) "Surplus" means unassigned funds for an entity using statutory accounting principles, with capital and surplus including all capital stock, paid in capital and contributed surplus, and other surplus funds with corresponding items under GAAP consisting of retained earnings and accumulated other comprehensive income, with capital and retained earnings including all capital stock, additional paid in capital, and other equity funds.

(ee) "Treasury rates" means the United States treasury strips asked yield as published in the Wall Street Journal as of a balance sheet date.

(ff) "Voting security" includes any security convertible into or evidencing the right to acquire a voting security.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: For references to office of financial and insurance regulation to be deemed as department of insurance and financial services, and abolishment of office of financial and insurance regulation, see E.R.O. No. 2013-1, compiled at MCL 550.991.

For references to commissioner of office of financial and insurance regulation to be deemed as references to director of department of insurance and financial services, and abolishment of office of commissioner of office of financial and insurance regulation, see E.R.O. No. 2013-1, compiled at MCL 550.991.

Popular name: Act 218

500.4603 Limited certificate of authority; application; conditions; organizational documents; submission; contents; liability of director; submission of documents to attorney general for examination; duty of commissioner to require, consider, and review certain documents and factors; issuance of certificate; confidentiality; fee; foreign captive insurance company as captive insurance company.

Sec. 4603. (1) A captive insurance company, if permitted by its organizational documents, may apply to the commissioner for a limited certificate of authority to do any and all insurance authorized by this chapter except worker's compensation insurance, long-term care insurance, critical care insurance, personal automobile insurance, or homeowners insurance, or any component of these coverages. A captive insurance company is subject to all of the following:

(a) A pure captive insurance company shall not insure any risks other than those of its parent, affiliated companies, controlled unaffiliated business, or a combination of its parent, affiliated companies, and controlled unaffiliated business.

(b) An association captive insurance company shall not insure any risks other than those of the member organizations of its association and their affiliated companies.

(c) An industrial insured captive insurance company shall not insure any risks other than those of the industrial insureds that comprise the industrial insured group and their affiliated companies.

(d) In general, a special purpose captive insurance company shall only insure the risks of its parent. Notwithstanding any other provisions of this chapter, a special purpose captive insurance company may provide insurance or reinsurance, or both, for risks as approved by the commissioner.

(e) A captive insurance company shall not accept or cede reinsurance except as provided in section 4641.

(2) To conduct insurance business in this state, a captive insurance company shall do all of the following:

(a) Obtain from the commissioner a limited certificate of authority authorizing it to conduct insurance business in this state.

(b) Hold at least 1 board of directors meeting, or for a limited liability company, a meeting of the managing board, each year in this state.

(c) Maintain its principal place of business in this state, or for a branch captive insurance company, maintain the principal place of business for its branch operations in this state.

(d) File with the commissioner the name and address of a resident registered agent designated to accept service of process and to otherwise act on its behalf in this state. The designation shall remain in force as long as any liability remains within this state.

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(3) Before granting a limited certificate of authority, the commissioner shall require the applicant to submit organizational documents that contain the following:

(a) The names and places of residence of at least 3 incorporators or organizers of whom at least 2 are residents of this state.

(b) The location of the principal office in this state.

(c) The name by which the legal entity will be known.

(d) The purposes of the creation of the entity including a reference to this chapter.

(e) The manner in which the corporate powers are to be exercised.

(f) The number of directors or managers, as applicable.

(g) The number of directors or managers, as applicable, that constitute a quorum for the purposes of doing business which shall consist of no fewer than 1/3 of the directors or managers.

(h) The amount and value of capital stock, if any. Each share of authorized capital stock shall have a value of not less than $1.00.

(i) The term of existence of the entity.

(4) The organizational documents of a proposed captive insurance company may contain a provision providing that a director is not personally liable to the corporation or its shareholders or policyholders for monetary damages for a breach of the director's fiduciary duty. However, the provision does not eliminate or limit the liability of a director for any of the following:

(a) A breach of the director's duty of loyalty to the corporation or its shareholders or policyholders.

(b) Acts or omissions not in good faith or that involve intentional misconduct or knowing violation of law.

(c) A transaction from which the director derived an improper personal benefit.

(5) Before the organizational documents shall be effective for the purposes of this chapter, the organizational documents shall be submitted to the office of the attorney general for examination. If such documents are found to be in compliance with this chapter, the office of the attorney general shall so certify to the commissioner. Each applicant for a captive insurance company limited certificate of authority that submits its organizational documents to the office of the attorney general shall pay to the attorney general the examination fee provided in section 240(2).

(6) Prior to granting a limited certificate of authority to any applicant, the commissioner shall require, consider, and review all of the following:

(a) A statement acknowledging that all financial records of the captive insurance company, including records pertaining to protected cells, if applicable, shall be made available for inspection or examination by the commissioner.

(b) A plan of operation, including, if applicable, a business plan demonstrating how the applicant will account for the loss and expense experience of each protected cell at a level of detail found to be sufficient by the commissioner and how it will report the experience to the commissioner.

(c) Evidence of the source and form of the minimum capitalization to be contributed to the company.

(d) Evidence of the amount and liquidity of its assets relative to the risks to be assumed.

(e) Evidence of the character, reputation, financial standing, and purposes of the incorporators or organizers.

(f) Evidence of the character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors or managers.

(g) Biographical affidavits in the format prescribed by the commissioner for all officers and directors.

(h) Evidence of the adequacy of the loss prevention programs of its parent, member organization, or industrial insureds as applicable.

(i) For sponsored insurance companies, copies of all contracts or sample contracts with participants and evidence that expenses will be allocated to each protected cell in an equitable manner.

(j) For limited liability company applicants, a certificate of status demonstrating that the limited liability company has been formed pursuant to the Michigan limited liability company act, 1993 PA 23, MCL 450.4101 to 450.5200, and is in good standing.

(k) Such other factors or documentation considered relevant by the commissioner.

(7) The commissioner shall issue a limited certificate of authority to an applicant if, after reviewing the documents and information provided pursuant to this chapter, the commissioner finds that the documents and statements filed by the applicant comply with this chapter, the applicant meets the standards in this chapter and will promote the general good of the state, and all required fees have been paid. The limited certificate of authority shall authorize the applicant to do business in this state until March 1, at which time the commissioner may renew the limited certificate of authority.

(8) Information submitted pursuant to this section is confidential as provided in section 4609.

(9) An applicant shall pay to the office a nonrefundable $10,000.00 fee for processing its application for a

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limited certificate of authority. In addition, the commissioner may retain legal, financial, and examination services from outside the office to examine and investigate the application, the reasonable cost of which may be charged against the applicant, or the commissioner may use internal resources to examine and investigate the application for a $2,700.00 fee.

(10) Upon approval of the commissioner, a foreign captive insurance company may become a captive insurance company by complying with all of the requirements of law relative to the authorization of a captive insurance company of the same or equivalent type in this state. After this is accomplished, the foreign captive insurance company is entitled to a limited certificate of authority to transact business in this state and is subject to the authority and jurisdiction of this state. It is not necessary for a foreign captive insurance company redomesticating into this state to merge, consolidate, transfer assets, or otherwise engage in any other reorganization, other than as specified in this section.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4607 Adoption of name by captive insurance company.

Sec. 4607. A captive insurance company shall not adopt a name that is the same as, deceptively similar to, or likely to be confused with or mistaken for any other existing business name registered in this state.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4609 Confidentiality requirements.

Sec. 4609. (1) Information and testimony submitted or furnished to the office pursuant to this chapter, examination reports, preliminary examination reports or results, and the office's work papers, correspondence, memoranda, reports, records, and other written or oral information related to an examination report or an investigation shall be confidential, shall be withheld from public inspection, shall not be subject to subpoena, and shall not be divulged to any person, except as provided in this section or with the written consent of the company. If assurances are provided that the information will be kept confidential, the commissioner may disclose confidential work papers, correspondence, memoranda, reports, records, or other information as follows:

(a) To the governor or the attorney general.

(b) To any relevant regulatory agency, including regulatory agencies of other states or the federal government.

(c) In connection with an enforcement action brought pursuant to this or another applicable act.

(d) To law enforcement officials.

(e) To persons authorized by the Ingham county circuit court to receive the information.

(f) To persons entitled to receive such information in order to discharge duties specifically provided for in this act.

(2) The confidentiality requirements of subsection (1) do not apply in any proceeding or action brought against or by the captive insurer under this act or any other applicable act of this state, any other state, or the United States.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4611 Issuance of limited certificate of authority; possession and maintenance of unimpaired paid-in capital and retained earnings; form of minimum capitalization; incorporation as nonprofit; unencumbered equity; assets; evidence to be submitted to commissioner; additional capital; branch captive insurance company; security for payment of liabilities; trust fund; payment of dividends; limitation; distributions.

Sec. 4611. (1) The commissioner shall not issue a limited certificate of authority to a captive insurance company unless the company possesses and maintains unimpaired paid in capital and retained earnings as follows:

(a) For a pure captive insurance company, not less than $150,000.00.

(b) For an association captive insurance company incorporated as a stock insurer or organized as a limited liability company, not less than $400,000.00.

(c) For an association captive insurance company incorporated as a mutual insurer, not less than $750,000.00.

(d) For an industrial insured captive insurance company incorporated as a stock insurer or organized as a limited liability company, not less than $300,000.00.

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(e) For a sponsored captive insurance company, not less than $500,000.00. However, if the sponsored captive insurance company does not assume any risk, the risks insured by the protected cells are homogeneous, and there are no more than 10 cells, the commissioner may reduce this amount to an amount not less than $150,000.00.

(f) For a special purpose captive insurance company, an amount determined by the commissioner after giving due consideration to the company's business plan, feasibility study, and pro formas, including the nature of the risks to be insured.

(2) Except for a sponsored captive that does not assume any risk, a captive insurance company initially shall possess and after that maintain minimum capitalization as required by subsection (1). All of the minimum initial capitalization shall be in cash. All other funds of the captive insurer in excess of its minimum initial capitalization shall be in the forms as provided by this chapter.

(3) The commissioner shall not issue a limited certificate of authority to a captive insurance company incorporated as a nonprofit corporation unless the company possesses and maintains unencumbered equity as follows:

(a) For a pure captive insurance company, not less than $250,000.00.

(b) For a special purpose captive insurance company, an amount determined by the commissioner after giving due consideration to the company's business plan, feasibility study, and pro formas, including the nature of the risks to be insured.

(4) Net assets required by subsection (3) of a captive insurance company incorporated as a nonprofit corporation shall be in the form of cash, cash equivalent, or an irrevocable letter of credit.

(5) For the purposes of subsections (1) through (4), the commissioner may issue a limited certificate of authority expressly conditioned upon the captive insurance company providing to the commissioner satisfactory evidence of possession of the minimum required unimpaired paid in capital. Until this evidence is provided, the captive insurance company shall not issue any policy, assume any liability, or otherwise provide coverage. The commissioner may revoke the conditional limited certificate of authority without legal recourse by the company if satisfactory evidence of the required capital is not provided within a maximum period of time, not to exceed 1 year, to be established by the commissioner at the time the conditional limited certificate of authority is issued.

(6) The commissioner may prescribe additional capital based upon the type, volume, and nature of insurance business transacted. This additional capital shall be in the form of cash, cash equivalent, an irrevocable letter of credit, or securities invested as provided in section 4639.

(7) For a branch captive insurance company, as security for the payment of liabilities attributable to branch operations, the commissioner shall require that a trust fund, funded by an irrevocable letter of credit or other acceptable asset, be established and maintained in the United States for the benefit of United States policyholders and United States ceding insurers under insurance policies issued or reinsurance contracts issued or assumed, by the branch captive insurance company through its branch operations. The amount of the security shall be no less than the capital and retained earnings required by this chapter and the reserves on these insurance policies or reinsurance contracts, including reserves for losses, allocated loss adjustment expenses, incurred but not reported losses and unearned premiums with regard to business written through branch operations; however, the commissioner may permit a branch captive insurance company that is required to post security for loss reserves on branch business by its reinsurer to reduce the funds in the trust account required by this section by the same amount so long as the security remains posted with the reinsurer.

(8) A captive insurance company shall not pay a dividend out of, or other distribution with respect to, capital or retained earnings, in excess of the limitations set forth in section 1343, without the prior approval of the commissioner. Approval of an ongoing plan for the payment of dividends or other distributions shall be conditioned upon retention, at the time of each payment, of capital or retained earnings in excess of amounts specified by, or determined in accordance with formulas approved by, the commissioner. A captive insurance company incorporated as a nonprofit corporation shall not make any distributions without the prior approval of the commissioner.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4619 Pure captive insurance company or sponsored captive insurance company; association captive insurance company or industrial insured captive insurance company; incorporation as stock insurer or limited liability company; issuance of capital stock or membership interests; formation of captive insurance company as corporation or nonprofit corporation or as limited liability company; state residency; chapter as

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controlling provision of law.

Sec. 4619. (1) A pure captive insurance company or a sponsored captive insurance company may be any of the following:

(a) Incorporated as a stock insurer with its capital divided into shares and held by the stockholders.

(b) Incorporated as a public benefit, mutual benefit, or religious nonprofit corporation with members in accordance with the Michigan nonprofit corporation act of 1982, 1982 PA 162, MCL 450.2101 to 450.3192.

(c) Organized as a limited liability company with its capital divided into capital accounts and held by its members.

(2) An association captive insurance company or an industrial insured captive insurance company may be any of the following:

(a) Incorporated as a stock insurer with its capital divided into shares and held by the stockholders.

(b) Organized as a limited liability company with its capital divided into capital accounts and held by its members.

(c) Incorporated as a mutual insurer without capital stock, the governing body of which is elected by the member organizations of its association.

(3) The capital stock or membership interests of a captive insurance company incorporated as a stock insurer or limited liability company shall be issued at not less than par value.

(4) For a captive insurance company formed as a corporation or a nonprofit corporation, at least 1 of the members of the board of directors of a captive insurance company incorporated in this state shall be a resident of this state.

(5) For a captive insurance company formed as a limited liability company, at least 1 of the managers of the captive insurance company shall be a resident of this state.

(6) A captive insurance company formed as a limited liability company has the privileges and is subject to the provisions of the Michigan limited liability company act, 1993 PA 23, MCL 450.4101 to 450.5200, for limited liability companies, as well as the applicable provisions contained in this chapter. If a conflict occurs between a provision of the Michigan limited liability company act, 1993 PA 23, MCL 450.4101 to 450.5200, for limited liability companies, and a provision of this chapter, this chapter controls.

(7) All captive insurers formed as corporations under this chapter are considered bodies corporate and politic, in fact and in name, are subject to all of the provisions of law in relation to corporations as far as they are applicable, and have the corporate powers provided for in chapter 52.

(8) This act's provisions pertaining to mergers, consolidations, conversions, mutualizations, and redomestications apply in determining the procedures to be followed by a captive insurance company in carrying out any of the transactions described in those provisions.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4621 Reports and inquiries.

Sec. 4621. (1) A captive insurance company is not required to make an annual report except as provided in this chapter.

(2) Annually, not later than 60 days after the end of a captive insurance company's fiscal year, the captive insurance company shall submit to the director a report of its financial condition, verified by oath of 2 of its executive officers. A captive insurance company may report using generally accepted accounting principles or, with the approval of the director, international financial reporting standards or statutory accounting principles, with useful or necessary modifications or adaptations required or approved or accepted by the director for the type of insurance and kinds of insurers to be reported on, and as supplemented by additional information required by the director. The director may prescribe the form and manner in which captive insurance companies shall report. Information submitted under this section is confidential as provided in section 4609.

(3) The director may address inquiries to a captive insurer concerning the insurer's activities or conditions or any other matter connected with the insurer's transactions. An insurer addressed under this subsection shall reply in writing to each inquiry from the director within 30 days after receipt of the inquiry.

(4) The director may require interim reporting on any of the captive insurer's business, including any matter, condition, or requirement regulated by this chapter. The director shall prescribe the format and content of the interim report.

(5) A captive insurer that fails to file a report required by this section, or fails to reply within 30 days to an inquiry of the director, is subject to a civil penalty of not less than $1,000.00 or more than $5,000.00 per occurrence, and an additional $50.00 for every day that the captive insurer fails to file the report or reply to the inquiry. In addition, a captive insurer that fails to file a report, or fails to make a satisfactory reply to an

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inquiry of the director concerning the captive insurer's affairs, is subject to proceedings under section 4637.

(6) A pure captive insurance company may make written application for filing the annual report on a fiscal year end that is consistent with the parent company's fiscal year. The annual report must be on a form prescribed by the director.

(7) A branch captive insurance company shall file with the director 60 days after the fiscal year end a copy of all reports and statements required to be filed under the laws of the jurisdiction in which the alien captive insurance company is formed, verified by oath by 2 of its executive officers. If the director is satisfied that the annual report filed by the alien captive insurance company in its domiciliary jurisdiction provides adequate information concerning the financial condition of the alien captive insurance company, the director may waive the requirement for completion of the captive annual statement.

(8) A captive insurance company shall annually submit to the director the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the reserves are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The actuarial opinion required by this section must be submitted in a form prescribed by the director. For purposes of this section, "qualified actuary" means a member of either the American Academy of Actuaries or the Society of Actuaries who also meets any other criteria that the director may establish by rule, regulation, or order.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008;—Am. 2018, Act 397, Eff. Mar. 29, 2019.

Popular name: Act 218

500.4623 Sponsored captive insurance company; discount of reserves.

Sec. 4623. (1) A sponsored captive insurance company may discount its loss and loss adjustment expense reserves at the lesser of treasury rates or the captive insurance company's actual rate of return applied to the applicable payments projected through the use of the expected payment pattern associated with the reserves.

(2) The commissioner may disallow the discounting of reserves if a sponsored captive insurance company violates a provision of this act.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4625 Conflict between act and chapter; exemption; applicability of certain sections; expenses and charges of examination; annual renewal fee; other fees; employment of legal counsel; confidentiality.

Sec. 4625. (1) No provisions of this act, other than those specifically referenced in this chapter, apply to a captive insurance company, and those provisions apply only as modified by this chapter. If a conflict occurs between a provision of this act and a provision of this chapter, this chapter controls.

(2) The commissioner by rule, regulation, or order may exempt special purpose captive insurance companies, on a case-by-case basis, from provisions of this chapter that the commissioner determines to be inappropriate given the nature of the risks to be insured.

(3) Sections 210 to 222, 226 to 238, 244 to 251, and 2057 to 2062, and chapter 45 apply to captive insurance companies.

(4) The expenses and charges of a captive insurance company examination shall be paid to the state by the captive insurance company or companies examined, and the office shall issue warrants for the proper charges incurred in all examinations. The payments received by the state shall be deposited into the captive insurance regulatory and supervision fund.

(5) A captive insurance company shall pay an annual renewal fee by March 1 of each calendar year. The annual renewal fee shall be calculated based upon the annual volume of insurance or reinsurance premiums received by the captive insurance company as follows:

(a) For annual premiums less than $5,000,000.00, the renewal fee shall be $5,000.00.

(b) For annual premiums equal to or greater than $5,000,000.00, but less than $10,000,000.00, the renewal fee shall be $10,000.00.

(c) For annual premiums equal to or greater than $10,000,000.00, but less then $15,000,000.00, the renewal fee shall be $15,000.00.

(d) For annual premiums equal to or greater than $15,000,000.00, but less than $25,000,000.00, the renewal fee shall be $25,000.00.

(e) For annual premiums equal to or greater than $25,000,000.00, but less than $40,000,000.00, the renewal fee shall be $40,000.00.

(f) For annual premiums equal to or greater than $40,000,000.00, but less than $55,000,000.00, the renewal fee shall be $50,000.00.

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(g) For annual premiums equal to or greater than $55,000,000.00, but less than $75,000,000.00, the renewal fee shall be $75,000.00.

(h) For annual premiums equal to or greater than $75,000,000.00, the renewal fee shall be $100,000.00.

(6) The office may charge a $15.00 fee for any document requiring certification of authenticity or the signature of the commissioner. The payments received shall be deposited into the captive insurance regulatory and supervision fund.

(7) The office may charge a fee of $25.00 payable to the attorney general for the examination of any amendment to the organizational documents.

(8) Notwithstanding any other provision of law, the commissioner may employ legal counsel as he or she considers necessary to assist in his or her responsibilities under this chapter.

(9) The confidentiality provisions of this chapter do not extend to final examination reports produced by the commissioner in inspecting or examining a captive insurance company formed as a risk retention group under the liability risk retention act of 1986, 15 USC 3901 to 3906.

(10) Section 222 applies to all business written by a captive insurance company except that the examination for a branch captive insurance company shall be of branch business and branch operations only, as long as the branch captive insurance company provides annually to the commissioner, a certificate of compliance, or its equivalent, issued by or filed with the licensing authority of the jurisdiction in which the branch captive insurance company is formed and demonstrates to the commissioner's satisfaction that it is operating in sound financial condition in accordance with all applicable laws and regulations of that jurisdiction.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4637 Limited certificate of authority; suspension or revocation; findings; best interest of public and policyholders.

Sec. 4637. (1) The limited certificate of authority of a captive insurance company to conduct an insurance business in this state may be suspended or revoked by the commissioner for any of the following:

(a) Insolvency or impairment of capital or retained earnings.

(b) Failure to meet the requirements of section 4611.

(c) Refusal or failure to submit an annual report, as required by section 4621, or any other report or statement required by law or by order of the commissioner.

(d) Failure to comply with its own charter, bylaws, or other organizational document.

(e) Failure to submit to examination or any legal obligation relative to an examination, as required by section 4625.

(f) Refusal or failure to pay the cost of examination as required by section 4625.

(g) The company is no longer safe, reliable, or entitled to public confidence or is unsound, or is using financial methods and practices in the conduct of its business that render further transaction of insurance by the company in this state hazardous to policyholders, creditors, or the public.

(h) The certificate of authority or equivalent authorization of a branch captive insurance company has been suspended or revoked in the jurisdiction in which the company was formed.

(i) For a captive insurer formed as a limited liability company, the captive insurer is no longer in good standing under the Michigan limited liability company act, 1993 PA 23, MCL 450.4101 to 450.5200.

(j) The company has failed, after written request by the commissioner, to remove or discharge an officer or director whose record of business conduct does not satisfy the requirements of section 4603 or who has been convicted of any crime involving fraud, dishonesty, or like moral turpitude.

(k) The company has failed, within 30 days after notice of delinquency from the commissioner, to cure its failure to pay taxes, fees, assessments, or expenses required by this act.

(*l*) The captive insurance company has failed for an unreasonable period to pay any final judgment rendered against it in this state on any policy, bond, recognizance, or undertaking issued or guaranteed by it.

(m) Failure otherwise to comply with the laws of this state.

(2) If the commissioner finds, upon examination, hearing, or other evidence, that a captive insurance company has committed any of the acts specified in subsection (1), the commissioner may suspend or revoke the captive insurance company's limited certificate of authority if the commissioner considers it in the best interest of the public and the policyholders of the captive insurance company, notwithstanding any other provision of this act.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

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500.4639 Association captive insurance company and industrial insured captive insurance company; compliance with investment requirements; pure captive insurance company and special purpose captive insurance company not subject to restrictions on allowable investments; exception; loans; combining of assets for purposes of investment; sponsored captive insurance companies to be in compliance with chapter 9; waiver of investment requirements.

Sec. 4639. (1) An association captive insurance company and an industrial insured captive insurance company insuring the risks of an industrial insured group shall comply with the investment requirements contained in sections 910 to 947. Notwithstanding any other provision of this chapter or in chapter 9, the commissioner may approve the use of alternative reliable methods of valuation and rating.

(2) A pure captive insurance company and a special purpose captive insurance company are not subject to any restrictions on allowable investments contained in chapter 9 except that the commissioner may request a written investment plan and may prohibit or limit an investment that threatens the solvency or liquidity of the company.

(3) Only a pure captive insurance company may make loans to its parent company or affiliates and only upon the prior written approval of the commissioner evidenced by a note in a form approved by the commissioner. Loans of minimum capital and retained earnings required to be held by section 4611(1) are prohibited.

(4) Notwithstanding the provisions of sections 4663 and 4665, the assets of 2 or more protected cells may be combined for purposes of investment upon written agreement of the participants, and this combination shall not be construed as defeating the segregation of those assets for accounting or other purposes.

(5) Sponsored captive insurance companies shall comply with the investment requirements contained in chapter 9, as applicable; provided, however, that compliance with such investment requirements shall be waived for sponsored captive insurance companies to the extent that credit for reinsurance ceded to reinsurers is allowed pursuant to section 4641(2) or to the extent otherwise considered reasonable and appropriate by the commissioner. Sections 841 and 842 shall apply to sponsored captive insurance companies except to the extent it is inconsistent with approved accounting standards in use by the company. Notwithstanding any other provision of this act, the commissioner may approve the use of alternative reliable methods of valuation and rating.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

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500.4641 Reinsurance on risks ceded by other insurer.

Sec. 4641. (1) A captive insurance company may provide reinsurance, as authorized by this act and with the prior approval of the commissioner, on risks ceded by any other insurer.

(2) A captive insurance company may take credit for reserves on risks or portions of risks ceded to reinsurers complying with the provisions of sections 1103 and 1105. A captive insurer shall not take credit for reserves on risks or portions of risks ceded to a reinsurer if the reinsurer is not in compliance with sections 1103 and 1105.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4643 Rating organization; joining not required.

Sec. 4643. A captive insurance company shall not be required to join a rating organization.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4645 Plan, pool, association, or guaranty or insolvency fund; joining, contributing to, or receiving benefit from prohibited.

Sec. 4645. A captive insurance company shall not join or contribute financially to a plan, pool, association, or guaranty or insolvency fund in this state. A captive insurance company, its insured, its parent, or any affiliated company or any member organization of its association, shall not receive a benefit from a plan, pool, association, or guaranty or insolvency fund for claims arising out of the operations of the captive insurance company.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

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500.4651 Rules.

Sec. 4651. The commissioner may promulgate pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, rules, and may issue regulations and orders relating to captive insurance companies as are necessary to enable the commissioner to carry out the provisions of this chapter.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4655 Applicability of terms and conditions in chapter 81 pertaining to administrative supervision, conservation, rehabilitation, receivership, and liquidation of insurers; payment of expenses or claims from assets of protected cell or from capital and surplus of sponsored captive insurance company.

Sec. 4655. (1) Except as otherwise provided in this section, the terms and conditions under chapter 81 pertaining to administrative supervision, conservation, rehabilitation, receivership, and liquidation of insurers apply in full to captive insurers authorized under this chapter.

(2) For a sponsored captive insurance company, both of the following apply:

(a) The assets of the protected cell shall not be used to pay expenses or claims other than those attributable to the protected cell.

(b) The capital and surplus of the sponsored captive insurance company shall at all times be available to pay expenses of or claims against the sponsored captive insurance company and shall not be used to pay expenses or claims attributable to a protected cell.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4659 Exercise of control of risk management function by parent or affiliated company; standards.

Sec. 4659. The commissioner by rule, regulation, or order may establish standards to ensure that a parent or affiliated company is able to exercise control of the risk management function of any controlled unaffiliated business to be insured by the pure captive insurance company. Until such time as the standards are established, the commissioner may by temporary order grant authority to a pure captive insurance company to insure risks.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4663 Sponsored captive insurance company; formation; establishment and maintenance of protected cell to insure risks; conditions.

Sec. 4663. (1) One or more sponsors may form a sponsored captive insurance company under this chapter.

(2) A sponsored captive insurance company authorized under this chapter may establish and maintain 1 or more protected cells to insure risks of 1 or more participants, subject to all of the following:

(a) The shareholders of a sponsored captive insurance company shall be limited to its participants and sponsors, provided that a sponsored captive insurance company may issue nonvoting securities to other persons on terms approved by the commissioner.

(b) Each protected cell shall be accounted for separately on the books and records of the sponsored captive insurance company to reflect the financial condition and results of operations of the protected cell, net income or loss, dividends or other distributions to participants, and other factors may be provided in the participant contract or required by the commissioner.

(c) The assets of a protected cell shall not be chargeable with liabilities arising out of any other insurance business the sponsored captive insurance company may conduct.

(d) No sale, exchange, or other transfer of assets shall be made by the sponsored captive insurance company between or among any of its protected cells without the consent of the protected cells.

(e) No sale, exchange, or other transfer of assets shall be made from a protected cell to a sponsor or participant unless the captive insurer has notified the commissioner in writing at least 30 days, or a shorter period as the commissioner allows, prior to such transaction and the commissioner has not disapproved the transaction during that period.

(f) No dividend or distribution shall be made from a protected cell to a sponsor or participant without the commissioner's approval and in no event shall the approval be given if the dividend or distribution would result in insolvency or impairment with respect to a protected cell.

(g) A sponsored captive insurance company shall file annually with the commissioner financial reports the

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commissioner requires, which shall include, but are not limited to, accounting statements detailing the financial experience of each protected cell.

(h) A sponsored captive insurance company shall notify the commissioner in writing within 10 business days of a protected cell that is insolvent or otherwise unable to meet its claim or expense obligations.

(i) No participant contract shall take effect without the commissioner's prior written approval, and the addition of each new protected cell and withdrawal of any participant of any existing protected cell requires the commissioner's prior written approval.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4665 Sponsor of sponsored captive insurance company; authorized insurer; risk retention group as sponsor or participant prohibited; business written by sponsored captive insurance company with respect to protected cell; requirements.

Sec. 4665. A sponsor of a sponsored captive insurance company shall be an insurer authorized pursuant to the laws of a state or the District of Columbia, an insurance holding company that controls an insurer authorized pursuant to the laws of a state or the District of Columbia and subject to registration pursuant to the insurance holding company system laws of the state of domicile of the insurer, a reinsurer authorized or approved pursuant to the laws of a state or the District of Columbia, or a captive insurance company authorized pursuant to this chapter. A risk retention group shall not be either a sponsor or a participant of a sponsored captive insurance company. The business written by a sponsored captive insurance company with respect to each protected cell shall meet at least 1 of the following:

(a) Be fronted by an insurance company authorized pursuant to the laws of any state or any jurisdiction if the insurance company is a wholly owned subsidiary of an insurance company authorized pursuant to the laws of any state or any jurisdiction.

(b) Be reinsured by a reinsurer authorized or approved by this state.

(c) Be secured by a trust fund in the United States for the benefit of policyholders and claimants funded by an irrevocable letter of credit or other asset acceptable to the commissioner. The amount of security provided by the trust fund shall not be less than the reserves associated with those liabilities, including reserves for losses, allocated loss adjustment expenses, incurred but not reported losses, and unearned premiums for business written through the participant's protected cell. The commissioner may require the sponsored captive to increase the funding of a trust established pursuant to this subdivision. A trust and trust instrument maintained pursuant to this subdivision shall be in a form and upon terms approved by the commissioner.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4667 Sponsored captive insurance companies; business entities as participants.

Sec. 4667. (1) An association, a corporation, a limited liability company, a partnership, a trust, or other business entity may be a participant in a sponsored captive insurance company authorized pursuant to this chapter.

(2) A sponsor may be a participant in a sponsored captive insurance company.

(3) A participant need not be a shareholder of the sponsored captive insurance company or an affiliate of the company.

(4) A participant shall insure only its own risks through a sponsored captive insurance company, unless otherwise approved by the commissioner.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4669 Sponsored captive insurance companies; applicability of terms and conditions in chapter 48 pertaining to protected cell insurance company.

Sec. 4669. (1) Except as otherwise provided in this chapter, the terms and conditions provided in chapter 48 relating to a protected cell insurance company apply in full to a sponsored captive insurance company.

(2) Except as otherwise provided, all of the following apply to a sponsored captive insurance company:

(a) A protected cell need not be established solely for the purpose of effecting insurance securitizations, but may be established for the purpose of isolating the expenses and claims of a sponsored captive insurance company participant.

(b) The sponsored captive insurance company shall attribute all insurance obligations, assets, and liabilities relating to a participant's risks to the participant's protected cell.

(c) Section 4805 does not apply.

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History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4673 Captive insurance regulatory and supervision fund; creation; deposit of certain money, assets, fees, and assessments; money remaining in fund at close of fiscal year; commissioner as administrator for auditing purposes.

Sec. 4673. (1) The captive insurance regulatory and supervision fund is created within the state treasury.

(2) The state treasurer may receive money or other assets from any source for deposit into the captive insurance regulatory and supervision fund. All fees and assessments received by the department of treasury or the office pursuant to the administration of this chapter and chapter 47 shall be credited to the captive insurance regulatory and supervision fund. All fees received by the department of treasury from reinsurers who assume risk only from captive insurance companies shall be deposited into the captive insurance regulatory and supervision fund. All fines and administrative penalties ordered under this chapter or chapter 47 shall be deposited directly into the captive insurance regulatory and supervision fund. The state treasurer shall direct the investment of the captive insurance regulatory and supervision fund. The state treasurer shall credit to the captive insurance regulatory and supervision fund interest and earnings from fund investments.

(3) Money in the captive insurance regulatory and supervision fund at the close of the fiscal year shall remain in the captive insurance regulatory and supervision fund and shall not lapse to the general fund.

(4) The commissioner shall be the administrator of the captive insurance regulatory and supervision fund for auditing purposes. Money in the captive insurance regulatory and supervision fund shall be expended by the commissioner, upon appropriation, for the purpose of administering chapters 18 and 47 and this chapter and for reasonable expenses incurred in promoting the captive insurance industry in this state.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

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CHAPTER 47
SPECIAL PURPOSE FINANCIAL CAPTIVES

500.4701 Definitions.

Sec. 4701. As used in this chapter:

(a) "Affiliated company" means a company in the same corporate system as a parent, by virtue of common ownership, control, operation, or management.

(b) "Captive LLC" means a limited liability company established under the Michigan limited liability company act, 1993 PA 23, MCL 450.4101 to 450.5200, or a comparable law of another state, including the District of Columbia, by a parent, counterparty, affiliated company, or SPFC for the purpose of issuing SPFC securities, entering an SPFC contract with a counterparty, or otherwise facilitating an insurance securitization.

(c) "Contested case" means a proceeding in which the legal rights, duties, obligations, or privileges of a party are required by law to be determined by the circuit court after an opportunity for hearing.

(d) "Control" including the terms "controlling", "controlled by", and "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of another person. This presumption may be rebutted by a showing that control does not exist. However, for purposes of this chapter, the fact that an SPFC exclusively provides reinsurance to a ceding insurer under an SPFC contract is not by itself sufficient grounds for a finding that the SPFC and ceding insurer are under common control.

(e) "Counterparty" means an SPFC's parent or affiliated company, or, subject to the prior approval of the director, a nonaffiliated company as ceding insurer to the SPFC contract.

(f) "Fair value" means the following:

(*i*) For cash, the amount of the cash.

(*ii*) For an asset other than cash, the amount at which the asset could be bought or sold in a current transaction between arm's length, willing parties. If available, the quoted mid-market price for the asset in active markets must be used; and if quoted mid-market prices are not available, a value must be determined using the best information available considering values of similar assets and other valuation methods, such as present value of future cash flows, historical value of the same or similar assets, or comparison to values of other asset classes, the value of which have been historically related to the subject asset.

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(g) "Foreign captive" means a captive insurer formed under the laws of the District of Columbia or a state, commonwealth, territory, or possession of the United States other than this state.

(h) "Insolvency" or "insolvent" means 1 or more of the following:

(*i*) That the SPFC is unable to pay its obligations within 30 days after they are due, unless those obligations are the subject of a bona fide dispute.

(*ii*) That the admitted assets of the SPFC do not exceed liabilities plus minimum capital and surplus for a period of time in excess of 30 days.

(*iii*) That the Ingham County circuit court has issued an order as provided for in section 8113, 8117, or 8120 in connection with a delinquency proceeding under chapter 81 instituted against the SPFC.

(i) "Insurance securitization" means a package of related risk transfer instruments, capital market offerings, and facilitating administrative agreements by which all of the following apply:

(*i*) The proceeds of the sale of SPFC securities are obtained, in a transaction that complies with applicable securities laws, by an SPFC directly through the issuance of the SPFC securities by the SPFC or indirectly through the issuance of preferred securities by the SPFC in exchange for some or all of the proceeds of the sale of SPFC securities by the SPFC's parent, an affiliated company of the SPFC, a counterparty, or a captive LLC.

(*ii*) The proceeds of the issuance of the SPFC securities secure the obligations of the SPFC under 1 or more SPFC contracts with a counterparty.

(*iii*) The obligation to the holders of the SPFC securities is secured by assets obtained with proceeds of the SPFC securities in accordance with the transaction terms.

(j) "Irrevocable letter of credit" means a letter of credit that meets the description in section 1105(c).

(k) "Management" means the board of directors, managing board, or other individual or individuals vested with overall responsibility for the management of the affairs of the SPFC, including the election and appointment of officers or other agents to act on behalf of the SPFC.

(*l*) "Office" means the department.

(m) "Organizational document" means the SPFC's articles of incorporation, articles of organization, bylaws, operating agreement, or other foundational documents that establish the SPFC as a legal entity or prescribes its existence.

(n) "Parent" means a corporation, limited liability company, partnership, or individual that directly or indirectly owns, controls, or holds with power to vote more than 50% of the outstanding voting securities of an SPFC.

(o) "Permitted investments" means those investments that meet the qualifications in section 4727(1).

(p) "Preferred securities" means securities, whether stock or debt, issued by an SPFC to the issuer of the SPFC securities in exchange for some or all of the proceeds of the issuance of the SPFC securities.

(q) "Protected cell" means a segregated account established and maintained by an SPFC for 1 or more SPFC contracts that are part of a single securitization transaction as further provided for in chapter 48.

(r) "Qualified United States financial institution" means that term as defined in section 1101.

(s) "Reserves" means that term as used in chapter 8.

(t) "Safe, reliable, and entitled to public confidence" means that term as defined in section 116.

(u) "Securities" means those different types of debt obligations, equity, surplus certificates, surplus notes, funding agreements, derivatives, and other legal forms of financial instruments.

(v) "Securities commissioner" means the securities administrator in the department of licensing and regulatory affairs.

(w) "SPFC" or "special purpose financial captive" means a captive insurance company, a captive LLC, or a company otherwise qualified as an authorized insurer that has received a limited certificate of authority from the director for the purposes provided for in this chapter.

(x) "SPFC contract" means a contract between the SPFC and the counterparty pursuant to which the SPFC agrees to provide insurance or reinsurance protection to the counterparty for risks associated with the counterparty's insurance or reinsurance business.

(y) "SPFC securities" means the securities issued pursuant to an insurance securitization, the proceeds of which are used in the manner described in subdivision (i).

(z) "Surplus note" means an unsecured subordinated debt obligation possessing characteristics consistent with accounting practices and procedures designated by the director.

(aa) "Third party" means a person unrelated to an SPFC or its counterparty, or both, that has been aggrieved by a decision of a director regarding that SPFC or its activities.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: For references to office of financial and insurance regulation to be deemed as department of insurance and financial

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services, and abolishment of office of financial and insurance regulation, see E.R.O. No. 2013-1, compiled at MCL 550.991.

For references to commissioner of office of financial and insurance regulation to be deemed as references to director of department of insurance and financial services, and abolishment of office of commissioner of office of financial and insurance regulation, see E.R.O. No. 2013-1, compiled at MCL 550.991.

Popular name: Act 218

500.4703 Conflict between provision of act and provision of chapter; chapter as controlling; sections applicable to SPFCs; exemption.

Sec. 4703. (1) No provisions of this act, other than those specifically referenced in this chapter, apply to an SPFC, and those provisions apply only as modified by this chapter. If a conflict occurs between a provision of this act and a provision of this chapter, this chapter controls.

(2) Sections 210 to 222, 226 to 238, 244 to 251, 2057 to 2062, and 4673 and chapter 45 apply to SPFCs.

(3) The commissioner, by rule, regulation, or order, may exempt an SPFC or its protected cells, on a case-by-case basis, from provisions of this chapter that the commissioner determines to be inappropriate given the nature of the risks to be insured.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4705 Limited certificate of authority to transact insurance or reinsurance; transaction of business by SPFC; limitation; requirements; submission of documents to commissioner; contents; liability of director; submission of documents to office of attorney general; evidence and documents required, considered, and reviewed by commissioner; additional filings; confidentiality; transaction of business; fees; limited certificate of authority granted after certain findings; renewal; foreign captive as SPFC.

Sec. 4705. (1) A captive insurance company, a captive LLC, or a company otherwise qualified as an authorized insurer may apply to the commissioner for a limited certificate of authority to transact insurance or reinsurance business as authorized by this chapter. An SPFC only may insure or reinsure the risks of its counterparty. Notwithstanding any other provision of this chapter, an SPFC may purchase reinsurance to cede the risks assumed under the SPFC contract as approved by the commissioner.

(2) To transact business in this state, an SPFC shall do all of the following:

(a) Obtain from the commissioner a limited certificate of authority authorizing it to conduct insurance or reinsurance business, or both, in this state.

(b) Hold at least 1 management meeting each year in this state.

(c) Maintain its principal place of business in this state.

(d) File with the commissioner the name and address of a resident registered agent designated to accept service of process and to otherwise act on its behalf in this state. The designation shall remain in force as long as any liability remains within the state.

(e) Provide such documentation of the insurance securitization as requested by the commissioner immediately upon the closing of the insurance securitization transaction, including an opinion of legal counsel with respect to compliance with this chapter and any other applicable laws as of the effective date of the insurance securitization transaction and a statement under oath of its president and secretary showing its financial condition.

(f) Provide a complete set of documentation of the insurance securitization to the commissioner shortly following closing of the insurance securitization transaction.

(3) Before granting a limited certificate of authority for an SPFC, the commissioner shall require the applicant to submit organizational documents that contain all of the following:

(a) The names and places of residence of at least 3 incorporators or organizers of whom at least 2 are residents of this state.

(b) The location of the principal office in this state.

(c) The name by which the legal entity will be known.

(d) The purposes of the creation of the entity including a reference to this chapter.

(e) The manner in which the corporate powers are to be exercised.

(f) The number of directors or managers, as applicable.

(g) The number of directors or managers, as applicable, that constitute a quorum for the purposes of doing business which consists of no fewer than 1/3 of the managers required by the organizational document.

(h) The amount and value of capital stock, if any. Each share of authorized capital stock shall have a value of not less than $1.00.

(i) The term of existence of the entity.

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(4) The organizational documents of an SPFC may contain a provision providing that a director is not personally liable to the corporation or its shareholders or policyholders for monetary damages for a breach of the director's fiduciary duty. However, the provision does not eliminate or limit the liability of a director for any of the following:

(a) A breach of the director's duty of loyalty to the corporation or its shareholders or policyholders.

(b) Acts or omissions not in good faith or that involve intentional misconduct or knowing violation of law.

(c) A transaction from which the director derived an improper personal benefit.

(5) Before the organizational documents shall be effective for the purposes of this chapter, the organizational documents shall be submitted to the office of the attorney general for examination. If such documents are found to be in compliance with this chapter, the office of the attorney general shall so certify to the commissioner. Each applicant for an SPFC limited certificate of authority that submits its organizational documents to the office of the attorney general shall pay to the attorney general the examination fee provided in section 240(2).

(6) Prior to granting a limited certificate of authority to any SPFC, the commissioner shall require, consider, and review all of the following:

(a) Evidence of all of the following:

(*i*) The amount and liquidity of its assets relative to the risks to be assumed.

(*ii*) The adequacy of the expertise, experience, and character of the person or persons who manage it.

(*iii*) The overall soundness of its plan of operation.

(*iv*) Other factors considered relevant by the commissioner in ascertaining whether the proposed SPFC is able to meet its policy obligations.

(*v*) The applicant SPFC's financial condition, including the source and form of the minimum capitalization to be contributed to the SPFC.

(b) A plan of operation, consisting of a description of or statement of intent with respect to the contemplated insurance securitization, the SPFC contract, and related transactions, which shall include all of the following:

(*i*) Draft documentation or, at the commissioner's discretion, a written summary of all material agreements that are entered into in connection with the SPFC contracts and the insurance securitization, including the names of the counterparty, the nature of the risks to be assumed, and the proposed use of protected cells, if any. The documentation or written summary shall also include the maximum amounts, purpose, nature, and the relationship between the various transactions effectuating the insurance securitization.

(*ii*) A description of any party, other than the SPFC or the counterparty, that will issue SPFC securities in an insurance securitization, including a description of its contemplated operation.

(*iii*) The source and form of additional capitalization to be contributed to the SPFC.

(*iv*) The proposed investment strategy of the SPFC.

(*v*) A description of the underwriting, reporting, and claims payment methods by which reserves covered by the SPFC contract are reported, accounted for, and settled.

(*vi*) A pro forma balance sheet and income statement illustrating various stress case scenarios for the performance of the SPFC under the SPFC contract.

(c) Biographical affidavits in a form prescribed by the commissioner of all of the prospective SPFC's officers and directors, providing their legal names, any names under which they have or are conducting their affairs, and any affiliations with other persons, together with other biographical information as the commissioner may request.

(d) An affidavit from the applicant SPFC verifying all of the following:

(*i*) The applicant SPFC meets the provisions of this chapter.

(*ii*) The applicant SPFC operates only pursuant to the provisions in this chapter.

(*iii*) The applicant SPFC's investment strategy reflects and takes into account the liquidity of assets and the reasonable preservation, administration, and asset management of such assets relative to the risks associated with the SPFC contract and the insurance securitization transaction.

(*iv*) The SPFC securities proposed to be issued are valid legal obligations that are either properly registered with the securities commissioner or constitute an exempt security or form part of an exempt transaction under section 402 of the uniform securities act, 1964 PA 265, MCL 451.802. If the issuer of the SPFC securities is not the SPFC, the SPFC shall obtain and submit an affidavit from the issuer that the securities proposed to be issued satisfy this subparagraph.

(*v*) Unless otherwise exempted by the commissioner, the trust agreement, the trusts holding assets that secure the obligations of the SPFC under the SPFC contract, and the SPFC contract with the counterparty in connection with the contemplated insurance securitization are structured pursuant to the provisions in this chapter.

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(e) Any other statements or documents required by the commissioner to evaluate and authorize the SPFC.

(7) In addition to the requirements of this section and section 4713, if a protected cell is used, an applicant SPFC shall file with the commissioner all of the following:

(a) A business plan demonstrating how the applicant accounts for the paid losses, reserves, and expenses of each protected cell at a level of detail found to be sufficient by the commissioner, and how it reports those paid losses, reserves, and expenses to the commissioner.

(b) A statement acknowledging that all financial records of the SPFC, including reports pertaining to any protected cells, shall be made available for inspection or examination by the commissioner.

(c) All contracts or sample contracts between the SPFC and any counterparty or captive LLC related to each protected cell.

(d) A description of the expenses allocated to each protected cell.

(8) Information submitted pursuant to this section is confidential and is subject to sections 4734 and 4743.

(9) To transact insurance or reinsurance business in this state, an SPFC is subject to all of the following:

(a) For an applicant not authorized under chapter 46 and not filing a concurrent application under chapter 46, a nonrefundable fee of $10,000.00 for processing its application for a limited certificate of authority. In addition, the commissioner may retain legal, financial, actuarial, and examination services from outside the office to examine and investigate the application, the reasonable cost of which may be charged against the applicant, or the commissioner may use internal resources to examine and investigate the application for a fee of $2,700.00, which is payable upon the filing of the application.

(b) An SPFC shall pay an annual renewal fee by March 1 of each calendar year. However, an SPFC that is authorized under both chapter 46 and this chapter and that pays the renewal fee provided in section 4625(5) is exempt from paying this renewal fee. The annual renewal fee shall be calculated based upon the annual volume of insurance or reinsurance premiums received by the SPFC as follows:

(*i*) For annual premiums less than $5,000,000.00, the renewal fee shall be $5,000.00.

(*ii*) For annual premiums equal to or greater than $5,000,000.00, but less than $10,000,000.00, the renewal fee shall be $10,000.00.

(*iii*) For annual premiums equal to or greater than $10,000,000.00, but less than $15,000,000.00, the renewal fee shall be $15,000.00.

(*iv*) For annual premiums equal to or greater than $15,000,000.00, but less than $25,000,000.00, the renewal fee shall be $25,000.00.

(*v*) For annual premiums equal to or greater than $25,000,000.00, but less than $40,000,000.00, the renewal fee shall be $40,000.00.

(*vi*) For annual premiums equal to or greater than $40,000,000.00, but less than $55,000,000.00, the renewal fee shall be $50,000.00.

(*vii*) For annual premiums equal to or greater than $55,000,000.00, but less than $75,000,000.00, the renewal fee shall be $75,000.00.

(*viii*) For annual premiums equal to or greater than $75,000,000.00, the renewal fee shall be $100,000.00.

(10) The commissioner may grant a limited certificate of authority authorizing the applicant to transact insurance or reinsurance business as an SPFC in this state upon finding by the commissioner of all of the following:

(a) The proposed plan of operation provides a reasonable and expected successful operation.

(b) The terms of the SPFC contract and related transactions comply with this chapter.

(c) All required fees have been paid.

(d) The commissioner of the state of domicile of each counterparty has notified the commissioner in writing or otherwise provided assurance satisfactory to the commissioner that it has approved or not disapproved the transaction.

(e) The limited certificate of authority authorizing the SPFC to transact business is limited to the insurance or reinsurance activities that the SPFC is allowed to conduct pursuant to this chapter.

(11) The limited certificate of authority shall be renewed annually upon payment of the renewal fee provided for by this section.

(12) A foreign captive, upon approval of the commissioner, may become an SPFC by complying with all of the provisions of this chapter. After this is accomplished, the foreign captive is entitled to a limited certificate of authority to transact business as an SPFC in this state and is subject to the authority and jurisdiction of this state. It is not necessary for a foreign captive redomesticating into this state to merge, consolidate, transfer assets, or otherwise engage in another reorganization, other than as specified in this section.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

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Popular name: Act 218

500.4707 SPFC; establishment; form of organization; documents; limitation; adoption of name; applicability of certain provisions in carrying out transactions; state residency; privileges and provisions applicable to limited liability company; corporate powers.

Sec. 4707. (1) An SPFC may be established as a stock corporation, limited liability company, mutual, partnership, or other form of organization approved by the commissioner.

(2) The SPFC's organizational documents shall limit the SPFC's authority to transact the business of insurance or reinsurance to those activities the SPFC conducts to accomplish its purpose as expressed in this chapter and activities it conducts pursuant to any other chapter in this act.

(3) The SPFC shall not adopt a name that is the same as, deceptively similar to, or likely to be confused with or mistaken for another existing business name registered in this state.

(4) The provisions of this act pertaining to mergers, consolidations, conversions, mutualizations, and redomestications apply in determining the procedures to be followed by an SPFC in carrying out any of the transactions described in those provisions.

(5) At least 1 of the members of the management of the SPFC shall be a resident of this state.

(6) An SPFC or captive LLC formed as a limited liability company has the privileges and is subject to the provisions of the Michigan limited liability company act, 1993 PA 23, MCL 450.4101 to 450.5200, for limited liability companies, as well as the applicable provisions contained in this chapter. Nothing contained in this provision with respect to an SPFC shall abrogate, limit, or rescind in any way the authority of the commissioner.

(7) All SPFCs formed as corporations under this chapter are considered bodies corporate and politic, in fact and in name, are subject to all of the provisions of law in relation to corporations as far as they are applicable, and have the corporate powers provided for in chapter 52.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4709 Minimum initial capitalization; additional capitalization; maintenance of deposits.

Sec. 4709. (1) An SPFC initially shall possess and after that maintain minimum capitalization of not less than $250,000.00. All of the minimum initial capitalization shall be in cash. All other funds of the SPFC in excess of its minimum initial capitalization shall be in the forms as provided in section 4727.

(2) Additional capitalization for the SPFC shall be determined, if so required, by the commissioner after giving due consideration to the SPFC's business plan, feasibility study, pro formas, and the nature of the risks being insured or reinsured, which may be prescribed in formulas approved by the commissioner.

(3) An SPFC that is authorized as an insurer other than solely pursuant to this chapter and chapter 46 initially shall possess, and after that maintain, minimum capital and surplus in compliance with sections 408 to 410a.

(4) An SPFC that is authorized as an insurer other than solely pursuant to this chapter and chapter 46 shall maintain deposits as specified in section 411.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4711 SPFC; insuring or reinsuring risks insured or reinsured by counterparty; contract for assumption of risk or indemnification of loss; related and incidental contracts; submission of actuarial opinion.

Sec. 4711. (1) An SPFC may insure or reinsure only the risks insured or reinsured by a counterparty.

(2) An SPFC shall not issue a contract for assumption of risk or indemnification of loss other than an SPFC contract. However, the SPFC may cede risks assumed through an SPFC contract to third party reinsurers through the purchase of reinsurance or retrocession protection.

(3) An SPFC may enter into contracts and conduct other commercial activities related or incidental to and necessary to fulfill the purposes of the SPFC contract, insurance securitization, and this chapter. Those activities may include, but are not limited to: entering into SPFC contracts; issuing securities of the SPFC in accordance with applicable securities law; complying with the terms of these contracts or securities; entering into trust, swap, tax, administration, reimbursement, or fiscal agent transactions; or complying with trust indenture, reinsurance, or retrocession, and other agreements necessary or incidental to effectuate an insurance securitization in compliance with this chapter or the plan of operation submitted to the commissioner.

(4) An SPFC shall annually submit to the commissioner the opinion of a qualified actuary as to whether the

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reserves and related actuarial items held in support of the reserves are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The actuarial opinion required by this section shall be submitted in a form prescribed by the commissioner. For purposes of this section, "qualified actuary" means a member of either the American academy of actuaries or the society of actuaries who also meets any other criteria that the commissioner may establish by rule, regulation, or order.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4713 Protected cells; creation and use by SPFC; written approval of commissioner; possession of minimum capitalization; fraudulent purpose not inferred.

Sec. 4713. (1) This section and section 4715 provide a basis for the creation and use of protected cells by an SPFC. If a conflict occurs between a provision of chapter 46 or chapter 48 and either this section or section 4715, this section and section 4715 control.

(2) An SPFC may establish and maintain 1 or more protected cells with prior written approval of the commissioner and subject to compliance with the applicable provisions of this chapter and the following conditions:

(a) A protected cell shall be established only for the purpose of isolating and identifying the assets and liabilities attributable to the risk ceded to the SPFC by the counterparty pursuant to 1 or more SPFC contracts and the assets and liabilities of the SPFC arising out of the related insurance securitization.

(b) Each protected cell shall be accounted for separately on the books and records of the SPFC to reflect the financial condition and results of operations of the protected cell, including income, gain, expense, or loss; dividends; other distributions to the counterparty for the SPFC contract with each cell; and other items as may be provided in the SPFC contract, insurance securitization transaction documents, plan of operation, or business plan, or as required by the commissioner.

(c) Amounts attributed to a protected cell under this chapter, including assets transferred to a protected cell account, are owned by the SPFC, and the SPFC shall not be, or shall not hold itself out to be, a trustee with respect to those protected cell assets of that protected cell account.

(d) All attributions of assets and liabilities between a protected cell and the general account shall be in accordance with the plan of operation submitted to the commissioner. No other attribution of assets or liabilities shall be made by an SPFC between the SPFC's general account and its protected cell or cells. The SPFC shall attribute all insurance obligations, assets, and liabilities relating to an SPFC contract and all obligations, assets, and liabilities of the SPFC arising out of the related insurance securitization transaction to a particular protected cell. The rights, benefits, obligations, and liabilities of any securities attributable to that protected cell, the performance under an SPFC contract and the related securitization transaction, and any tax benefits, losses, refunds, or credits allocated at any point in time pursuant to a tax allocation agreement between the SPFC and the SPFC's counterparty, parent, or affiliated company, as the case may be, including any payments made by or due to be made to the SPFC pursuant to the terms of the tax allocation agreement, shall reflect the insurance obligations, assets, and liabilities relating to the SPFC contract and proceeds of the insurance securitization transaction that are attributed to a particular protected cell.

(e) The assets of a protected cell shall not be chargeable with liabilities arising out of an SPFC contract related to or associated with another protected cell. However, 1 or more SPFC contracts may be attributed to a protected cell so long as those SPFC contracts are intended to be, and ultimately are, part of a single securitization transaction.

(f) A sale, an exchange, or another transfer of assets shall not be made by the SPFC between or among any of its protected cells without the consent of the counterparty and each protected cell.

(g) Except as otherwise contemplated in the SPFC contract or related insurance securitization transaction documents, or both, a dividend or a distribution shall not be made from a protected cell to a counterparty, captive LLC, or parent or affiliated company of the SPFC without the commissioner's approval and shall not be approved if the dividend or distribution would result in insolvency or impairment with respect to a protected cell.

(h) Except as otherwise contemplated in the SPFC contract or related insurance securitization transaction documents, or both, a sale, an exchange, or a transfer of assets shall not be made from a protected cell to a counterparty, captive LLC, or parent or affiliated company of the SPFC if the sale, exchange, or transfer would result in insolvency or impairment with respect to the protected cell.

(i) An SPFC shall pay interest or repay principal or both or make distributions or repayments of any SPFC securities issued by the SPFC or make payments of preferred securities issued to a particular protected cell from assets or cash flows relating to or emerging from the SPFC contract and the insurance securitization

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transactions that are attributable to that particular protected cell as provided in this chapter or as otherwise approved by the commissioner.

(3) An SPFC contract with or attributable to a protected cell does not take effect without the commissioner's prior written approval. The commissioner may retain legal, financial, and examination services from outside the office to examine and investigate the application for a protected cell, the reasonable cost of which may be charged against the applicant, or the commissioner may use internal resources to examine and investigate the application the reasonable cost of which may be charged against the applicant up to a maximum of $1,200.00, or may use both retained services and internal resources.

(4) An SPFC utilizing protected cells shall possess minimum capitalization for each protected cell separate and apart from the capitalization required by section 4709. For purposes of determining the capitalization of each protected cell, an SPFC initially shall capitalize and after that time maintain capitalization in each protected cell in the amount and manner required for an SPFC in section 4709.

(5) The establishment of 1 or more protected cells alone does not constitute, and shall not be considered to be, a fraudulent conveyance, an intent by the SPFC to defraud creditors, or the carrying out of business by the SPFC for any other fraudulent purpose.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4715 Protected cell; consideration as separate person; purposes; distinct name or designation; subject to orders of court; service of process; contract with third party advisor or manager; recourse by creditors; availability of assets; attachment of security interest to protected cell; identification of protected cell assets and liabilities; provisions in contracts or other documentation; income; crediting to or charging against protected cell; investment or reinvestment of amounts; annual report; notification of insolvency.

Sec. 4715. (1) The creation of a protected cell does not create, with respect to that protected cell, a legal person separate from the SPFC.

(2) Notwithstanding subsection (1), if an order of conservation, rehabilitation, or liquidation is entered for a counterparty, the SPFC and each protected cell of the SPFC shall be considered separate persons for purposes of any offset undertaken as part of the conservation, rehabilitation, or liquidation, such that any offset of mutual debts and credits between the counterparty and either the SPFC or any protected cell shall not involve the debts and credits of any other protected cell or, if the offset involves a protected cell, the SPFC.

(3) Notwithstanding subsection (1), a protected cell shall have its own distinct name or designation that includes the words "protected cell". The SPFC shall transfer all assets attributable to the protected cell to 1 or more separately established and identified protected cell accounts bearing the name or designation of that protected cell.

(4) Although the protected cell is not a separate legal person, the property of an SPFC in a protected cell is subject to orders of a court by name as it would have been if the protected cell were a separate legal person.

(5) The property of an SPFC in a protected cell shall be served in its own name with process in all civil actions or proceedings involving or relating to the activities of that protected cell or a breach by the SPFC of a duty to the protected cell or to a counterparty to a transaction linked or attributed to it by serving the SPFC in the manner described in section 1920 of the revised judicature act of 1961, 1961 PA 236, MCL 600.1920.

(6) A protected cell exists only at the pleasure of the SPFC. At the cessation of business of a protected cell in accordance with the plan of operation submitted to the commissioner, the SPFC voluntarily shall close out the protected cell account.

(7) Nothing in this section shall be construed to prohibit an SPFC from contracting with, or arranging for, an investment advisor, commodity trading advisor, or other third party to manage the assets of a protected cell, if all remuneration, expenses, and other compensation of the third party advisor or manager are payable from the assets of that protected cell and not from the assets of other protected cells or the assets of the SPFC's general account.

(8) Creditors to a protected cell are not entitled to have recourse against the protected cell assets of other protected cells or the assets of the SPFC's general account. If an obligation of an SPFC relates only to the general account, the obligation of the SPFC extends only to that creditor for that obligation and that creditor is entitled to have recourse only to the assets of the SPFC's general account.

(9) The assets of the protected cell shall not be used to pay expenses or claims other than those attributable to the protected cell. Protected cell assets are available only to the SPFC counterparty and other creditors of the SPFC that are creditors only to that protected cell and, accordingly, are entitled, in conformity with this chapter, to have recourse to the protected cell assets attributable to that protected cell. Protected cell assets are

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absolutely protected from the creditors of the SPFC that are not creditors with respect to that protected cell and who, accordingly, are not entitled to have recourse to the protected cell assets attributable to that protected cell. If an obligation of an SPFC to a person or counterparty arises from an SPFC contract or related insurance securitization transaction or is otherwise incurred for a protected cell, both of the following apply:

(a) That obligation of the SPFC extends only to the protected cell assets attributable to that protected cell, and the person or counterparty, for that obligation, is entitled to have recourse only to the protected cell assets attributable to that protected cell.

(b) That obligation of the SPFC does not extend to the protected cell assets of another protected cell or the assets of the SPFC's general account, and that person, for that obligation, is not entitled to have recourse to the protected cell assets of another protected cell or the assets of the SPFC's general account. The SPFC's capitalization of its protected cell or cells as required by section 4713(4) shall be available at all times to pay expenses of or claims against the SPFC and shall not be used to pay expenses or claims attributable to any protected cell.

(10) Notwithstanding any other provision of law, an SPFC may allow for a security interest in accordance with applicable law to attach to protected cell assets or a protected cell account when in favor of a creditor of the protected cell or to facilitate the insurance securitization, including, without limitation, the issuance of the SPFC contract, to the extent those protected cell assets are not required at all times to support the risk, but without otherwise affecting the discharge of liabilities under the SPFC contract, or as otherwise approved by the commissioner.

(11) An SPFC shall establish administrative and accounting procedures necessary to properly identify the 1 or more protected cells of the SPFC and the assets and liabilities of each protected cell. The directors of an SPFC shall keep protected cell assets and liabilities separate and separately identifiable from the assets and liabilities of the SPFC's general account. The assets and liabilities attributable to 1 protected cell shall be kept separate and separately identifiable from the assets and liabilities attributable to other protected cells.

(12) All contracts or other documentation reflecting protected cell liabilities shall indicate clearly that only the protected cell assets are available for the satisfaction of those protected cell liabilities. In all SPFC insurance securitizations involving a protected cell, including the issuance of preferred securities, the contracts or other documentation effecting the transaction shall contain provisions identifying the protected cell to which the transaction is attributed. In addition, the contracts or other documentation shall disclose clearly that the assets of that protected cell, and only those assets, are available to pay the obligations of that protected cell. Notwithstanding the provisions of this subsection and subject to the provisions of this chapter and any other applicable law or regulation, the failure to include this language in the contracts or other documentation shall not be used as the sole basis by creditors, insureds or reinsureds, insurers or reinsurers, or other claimants to circumvent this section.

(13) The income, and gains and losses, whether realized or unrealized, from protected cell assets and protected cell liabilities shall be credited to or charged against the protected cell without regard to other income and gains or losses of the SPFC, including income and gains or losses of other protected cells. Amounts attributed to any protected cell and accumulations on the attributed amounts may be invested and reinvested. The investments in a protected cell or cells shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the SPFC.

(14) An SPFC with protected cells shall file annually with the office accounting statements and financial reports required by this chapter that, among other things, shall do all of the following:

(a) Detail the financial experience of each protected cell and the SPFC separately.

(b) Provide the combined financial experience of the SPFC and all protected cells.

(c) Account for the financial experience of each protected cell and the SPFC, both separately and on a combined basis, in satisfaction of section 4731(4).

(15) An SPFC with protected cells shall notify the commissioner in writing within 10 business days of a protected cell becoming insolvent.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4717 Issuance of SPFC securities.

Sec. 4717. (1) An SPFC may issue securities, including SPFC securities and preferred securities, surplus notes, and other forms of financial instruments, subject to and in accordance with applicable law, the SPFC's approved plan of operation, and its organizational documents.

(2) An SPFC, its parent or an affiliated company, its counterparty, or a captive LLC may issue SPFC securities and any other securities necessary to implement the insurance securitization.

(3) Preferred securities may be issued by the SPFC to the issuer of the SPFC securities in connection with

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the insurance securitization in order to facilitate distributions to service SPFC securities and these preferred securities shall identify the associated protected cell. The SPFC may lawfully account for preferred securities as surplus and not as debt for purposes of statutory accounting.

(4) An SPFC, in connection with the issuance of securities, may enter into and perform all of its obligations under any required contracts to facilitate the issuance of these securities.

(5) Subject to the commissioner's approval, the issuer of the SPFC securities or, if the issuer is a captive LLC, the party controlling the captive LLC, may lawfully account for the SPFC securities as surplus and not as debt for purposes of statutory accounting and submit for the commissioner's prior approval periodic written requests for payments of interest on and repayments of principal of surplus notes.

(6) Surplus notes issued pursuant to this section constitute surplus or contribution notes of the type described in section 8142(1)(h).

(7) The commissioner, without otherwise prejudicing the commissioner's authority, may approve formulas for an ongoing plan of interest payments, principal repayments, or both interest payments and principal repayments, to provide guidance in connection with his or her ongoing reviews of requests to approve the payments on and principal repayments of the surplus notes.

(8) The obligation to repay principal or interest, or both, on the SPFC securities shall reflect, in whole or in part, the risk associated with the obligations of the SPFC to the counterparty under the SPFC contract, either directly or by being secured by assets, including the preferred securities, obtained with the proceeds of the sale of the SPFC securities.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4719 Asset management agreements.

Sec. 4719. An SPFC may enter into swap agreements, or other forms of asset management agreements, including guaranteed investment contracts, or other transactions that have the objective of leveling timing differences in funding of up front or ongoing transaction expenses or managing asset, credit, or interest rate risk of the investments in the trust to ensure that the investments are sufficient to assure payment or repayment of the securities, and related interest or principal payments, issued pursuant to an SPFC insurance securitization transaction or the obligations of the SPFC under the SPFC contract.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4721 SPFC contracts; agreements with affiliated companies and third parties; contents of contract; withdrawal of assets or income from trust and transfer to SPFC; approval from counterparty.

Sec. 4721. (1) An SPFC, at any given time, may enter into and effectuate an SPFC contract with a counterparty, provided that the SPFC contract meets all of the following:

(a) Complies with the plan of operation submitted to the commissioner.

(b) Obligates the SPFC to indemnify the counterparty for losses.

(c) Provides that contingent obligations of the SPFC under the SPFC contract are securitized through an SPFC insurance securitization and are funded and secured with assets held in trust for the benefit of the counterparty pursuant to this chapter and under agreements contemplated by this chapter and that are invested in a manner that meet the criteria under section 4727.

(2) An SPFC may enter into agreements with affiliated companies and third parties and conduct business necessary to fulfill its obligations and administrative duties incidental to the insurance securitization and the SPFC contract. The agreements may include management and administrative services agreements and other allocation and cost sharing agreements, or swap and asset management agreements, or both, or agreements for other contemplated types of transactions provided in section 4719.

(3) An SPFC contract shall contain all of the following:

(a) A requirement for the SPFC to enter into a trust agreement specifying what recoverables or reserves, or both, the agreement is to cover and to establish a trust account for the benefit of the counterparty.

(b) A stipulation that assets deposited in the trust account shall be valued according to their current fair value and shall consist only of permitted investments.

(c) A requirement for the SPFC, before depositing assets with the trustee, to execute assignments, endorsements in blank, or to transfer legal title to the trustee of all shares, obligations, or any other assets requiring assignments, in order that the counterparty, or the trustee upon the direction of the counterparty, may negotiate whenever necessary the assets without consent or signature from the SPFC or another entity.

(d) A requirement that all settlements of account between the counterparty and the SPFC be made in cash

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or its equivalent.

(e) A stipulation that the SPFC and the counterparty agree that the assets in the trust account, established pursuant to the SPFC contract, are under the control of the counterparty and may be withdrawn by the counterparty at any time, notwithstanding any other provisions in the SPFC contract, and shall be utilized and applied by the counterparty or any successor by operation of law of the counterparty, including, subject to the provisions of section 4741, but without further limitation, any liquidator, rehabilitator, receiver, or conservator of the counterparty, without diminution because of insolvency on the part of the counterparty or the SPFC, only for the following purposes:

(*i*) To transfer all of the assets into 1 or more trust accounts for the benefit of the counterparty pursuant to the terms of the SPFC contract and in compliance with this chapter.

(*ii*) To pay any other incurred and paid amounts that the counterparty claims are due pursuant to the terms of the SPFC contract and in compliance with this chapter.

(4) The SPFC contract may contain provisions that give the SPFC the right to seek approval from the counterparty to withdraw from the trust all or part of the assets, or income from them, contained in the trust and to transfer the assets to the SPFC, provided that at the time of the withdrawal, the SPFC shall replace the withdrawn assets, excluding any income withdrawn, with other assets having a fair value equal to the fair value of the assets withdrawn and that meet the provisions of section 4727; and after the withdrawals and transfer, the fair value of the assets in trust securing the obligations of the SPFC under the SPFC contract is no less than an amount needed to satisfy the funded requirement of the SPFC contract. The counterparty shall be the sole judge as to the application of these provisions but shall not unreasonably nor arbitrarily withhold its approval.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4723 Insurance securitization; not considered as insurance producers or brokers.

Sec. 4723. SPFC securities and preferred securities issued pursuant to an insurance securitization are not, and shall not be considered to be, insurance or reinsurance contracts. An investor in these securities or a holder or issuer of these securities, by sole means of this investment, holding, or issuance, is not, and shall not be considered to be, transacting the business of insurance in this state. The underwriter's placement agent or selling agent and their partners, directors, officers, members, managers, employees, agents, representatives, and advisors involved in an insurance securitization pursuant to this chapter shall not be considered to be insurance producers or brokers or conducting business as an insurance or reinsurance company or agency, brokerage, intermediary, advisory, or consulting business only by virtue of their activities in connection with them.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4725 SPFC; duty to ensure contracts fulfill certain requirements.

Sec. 4725. In fulfilling its function, the SPFC shall adhere to the following and, to the extent of its powers, shall ensure that contracts obligating other parties to perform certain functions incident to its operations are substantively and materially consistent with all of the following:

(a) The assets of an SPFC shall be preserved and administered by or on behalf of the SPFC to satisfy the liabilities and obligations of the SPFC incident to the SPFC contract with the counterparty, the issuance of preferred securities, or the insurance securitization and other related agreements.

(b) Assets held by an SPFC in trust shall be valued at their fair value.

(c) The proceeds from the sale of SPFC securities pursuant to the insurance securitization shall be deposited with the trustee to the extent required to secure the obligations of the SPFC under the SPFC contract as provided by this chapter and shall be held or invested by the trustee pursuant to section 4727 and an asset management agreement, if any.

(d) Assets of the SPFC, other than those held in trust for the counterparty, and income on trust assets received by the SPFC may be used to pay interest or other consideration on any SPFC securities or other securities or outstanding debt or payments on preferred securities or other obligation of the SPFC. Nothing in this chapter shall be construed or interpreted to prevent an SPFC from entering into a swap agreement or other asset management transaction that has the effect of hedging or guaranteeing the fixed or floating interest rate returns paid on the assets in trust or required for the securities issued by the SPFC generated from or other consideration or payment flows in the transaction.

(e) In the SPFC insurance securitization, the contracts or other relating documentation shall contain provisions identifying the SPFC.

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(f) Unless otherwise approved by the commissioner, an SPFC shall not do any of the following:

(*i*) Issue or otherwise administer primary insurance policies.

(*ii*) Enter into an SPFC contract with a person that is not licensed or otherwise authorized to transact the business of insurance or reinsurance in at least its state or country of domicile.

(*iii*) Assume or retain exposure to insurance or reinsurance losses for its own account that is not funded by proceeds from an SPFC insurance securitization that meets the provisions of this chapter. However, the SPFC may wholly or partially reinsure or retrocede the risks assumed to a third party reinsurer.

(g) An SPFC shall not do any of the following:

(*i*) Have any direct obligation to the policyholders or reinsureds of the counterparty.

(*ii*) Lend or otherwise invest, or place in custody, trust, or under management any of its assets with, or to borrow money or receive a loan from, other than by issuance of the securities pursuant to an insurance securitization, or advance from, anyone convicted of a felony, anyone who is untrustworthy or of known bad character, or anyone convicted of a criminal offense involving the conversion or misappropriation of fiduciary funds or insurance accounts, theft, deceit, fraud, misrepresentation, or corruption.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4727 Creation of trust to hold assets of SPFC.

Sec. 4727. (1) Assets of the SPFC held in trust to secure obligations under the SPFC contract shall at all times be held in cash and cash equivalents, securities listed by the securities valuation office of the national association of insurance commissioners, or another form of security acceptable to the commissioner.

(2) Assets of the SPFC that are pledged to secure obligations of the SPFC to a counterparty under an SPFC contract shall be held in trust and administered by a qualified United States financial institution that does not control, is not controlled by, or is not under common control with, the SPFC or the counterparty.

(3) The agreement governing a trust described in this section shall create 1 or more trust accounts into which all pledged assets shall be deposited and held until distributed in accordance with the trust agreement. The pledged assets shall be held by the trustee at 1 of the trustee's offices or branch offices in the United States and may be held in certificated or electronic form.

(4) The provisions for withdrawal by the counterparty of assets from the trust shall be clean and unconditional, subject only to the following:

(a) The counterparty has the right to withdraw assets from the trust account at any time, without notice to the SPFC, subject only to written notice to the trustee and the commissioner from the counterparty that funds in the amount requested are due and payable by the SPFC, pursuant to the SPFC contract.

(b) A statement or document does not need to be presented in order to withdraw assets, except the counterparty may be required to acknowledge receipt of withdrawn assets.

(c) The trust agreement shall indicate that it is not subject to any conditions or qualifications outside of the trust agreement.

(d) The trust agreement shall not contain references to any other agreements or documents.

(5) The trust agreement shall be established for the sole use and benefit of the counterparty at least to the full extent of the obligations of the SPFC to the counterparty under the SPFC contract. If there is more than 1 counterparty, or more than 1 SPFC contract with the same counterparty, a separate trust agreement shall be entered into with the counterparty and a separate trust account shall be maintained for each SPFC contract with the counterparty, unless otherwise approved by the commissioner.

(6) The trust agreement shall provide for the trustee to do all of the following:

(a) Receive assets and hold all assets in a safe place.

(b) Determine that all assets are in a form that the counterparty or the trustee, upon direction by the counterparty, may negotiate, whenever necessary, without consent or signature from the SPFC or another person or entity.

(c) Furnish to the SPFC, the commissioner, and the counterparty a statement of all assets in the trust account reported at fair value upon its inception and at intervals no less frequent than 45 days after the end of each calendar quarter.

(d) Notify the SPFC and the counterparty, within 10 days, of any deposits to or withdrawals from the trust account.

(e) Upon written demand of the counterparty, immediately take the necessary steps to transfer absolutely and unequivocally all right, title, and interest in the assets held in the trust account to the counterparty and deliver physical custody of the assets to the counterparty.

(f) Allow no substitutions or withdrawals of assets from the trust account, except pursuant to the trust agreement or SPFC contract, or as otherwise permitted by the counterparty.

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(7) The trust agreement shall provide that at least 30 days, but not more than 45 days, before termination of the trust account, written notification of termination shall be delivered by the trustee to the counterparty with a copy of the notice provided to the commissioner.

(8) In addition to the requirement for the trust as provided in this chapter, the trust agreement may be made subject to and governed by the laws of any state. The state shall be disclosed in the plan of operation submitted to the commissioner.

(9) The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.

(10) The trust agreement shall provide that the trustee is liable for its own negligence, willful misconduct, or lack of good faith.

(11) Notwithstanding subsection (4)(c) and (d), when a trust agreement is established in conjunction with an SPFC contract, then the trust agreement or SPFC contract, or both, may provide that the counterparty shall undertake to use and apply any amounts drawn upon the trust account, without diminution because of the insolvency of the counterparty or the SPFC, only for 1 or more of the following purposes:

(a) To pay or reimburse the counterparty for payment of the SPFC's share of premiums to be returned to owners of counterparty's policies covered under the SPFC contract on account of cancellations of the policies under the counterparties policies.

(b) To pay or reimburse the counterparty for payment of the SPFC's share of surrenders, benefits, losses, or other benefits covered and payable pursuant to the SPFC contract.

(c) To fund an account with the counterparty in an amount to secure the credit or reduction from liability for reinsurance coverage provided under the SPFC contract.

(d) To pay any other amounts the counterparty claims are legally and properly due under the SPFC contract.

(12) Any assets deposited into an account of the counterparty pursuant to subsection (11)(c) or withdrawn by the counterparty pursuant to subsection (11)(d) and any interest or other earnings on them, shall be held by the counterparty in trust and separate and apart from any general assets of the counterparty, for the sole purpose of funding the payments and reimbursements of the SPFC contract described in subsection (11).

(13) The counterparty shall return to the SPFC amounts withdrawn under subsection (11) in excess of actual amounts required under subsection (11)(a) to (c), and in excess of the amounts subsequently determined to be due under subsection (11)(d), plus interest at a rate not in excess of the prime rate for the amounts held pursuant to subsection (11)(c) unless a higher rate of interest has been awarded by an arbitration panel, and any net costs or expenses, including attorney fees, awarded by an arbitration panel.

(14) If the counterparty has received notification of termination of the trust account while any of the SPFC's obligations or liabilities under the SPFC contract that are secured by the trust account remain unliquidated as of 10 days prior to the termination date of the trust account, then the counterparty may withdraw amounts from the trust account equal to the unliquidated obligations and shall deposit such amounts in an account established by the counterparty, which account is separate and apart from the counterparty's general assets and is with a qualified United States financial institution, but only to the extent the obligations or liabilities have not been funded by the SPFC and only for those uses and purposes specified in subsection (11)(a) that may remain executory after the withdrawal and termination until such obligations or liabilities are discharged.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4729 Declaration and payment of dividends prohibited; exception; limitation; sufficiency of assets; provisions.

Sec. 4729. (1) An SPFC shall not declare or pay dividends in any form to its owners other than in accordance with the insurance securitization transaction agreements, and in no event shall the dividends decrease the capital of the SPFC below $250,000.00, and, after giving effect to the dividends, the assets of the SPFC, including assets held in trust pursuant to the terms of the insurance securitization, shall be sufficient to satisfy the commissioner that it can meet its obligations. Approval by the commissioner of an ongoing plan for the payment of dividends or other distribution by an SPFC with respect to securities shall be conditioned upon the retention, at the time of each payment, of capital or surplus equal to or in excess of amounts specified by, or determined in accordance with formulas approved for the SPFC by the commissioner.

(2) The dividends may be declared by the management of the SPFC if the dividends do not violate the provisions of this chapter or jeopardize the fulfillment of the obligations of the SPFC or the trustee pursuant to the SPFC insurance securitization agreements, the SPFC contract, or any related transaction and other provisions of this chapter.

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History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4731 Plan of operation; changes; filing of audited financial statements; inquiries by commissioner; filing of statement of operations; reports; preservation of books, records, documents, accounts, and vouchers; authority of securities commissioner.

Sec. 4731. (1) An SPFC may make the following material changes to its plan of operation pursuant to section 4705(6)(b), whether or not through an SPFC protected cell:

(a) If included in the initial plan of operation, securities subsequently issued to continue the securitization activities of the SPFC either during or after expiration, redemption, or satisfaction, of part or all of the securities issued pursuant to initial insurance securitization transactions, shall not be considered a material change.

(b) A change and substitution in a counterparty to a swap transaction for an existing insurance securitization as allowed pursuant to this chapter shall not be considered a material change if the replacement swap counterparty carries a similar or higher rating to its predecessor with 2 or more nationally recognized rating agencies.

(2) No later than 5 months after the fiscal year end of the SPFC, the SPFC shall file with the commissioner audited financial statements of the SPFC and the trust accounts prepared by an independent public accountant. The independent public accountant shall be an independent certified public accountant or accounting firm in good standing with the American institute of certified public accountants and in good standing in all states in which the independent public accountant is licensed to practice.

(3) The commissioner may address inquiries to any captive insurer concerning the insurer's activities or conditions or any matter connected with the insurer's transactions. An insurer so addressed shall reply in writing to each inquiry from the commissioner within 30 days of receipt of the inquiry.

(4) Each SPFC shall file by March 1 of each year a statement of operations. An SPFC with a counterparty that is authorized as an insurance company shall report using statutory accounting principles and shall value its assets and liabilities pursuant to this act and in a manner consistent with the counterparty. An SPFC with a counterparty that uses GAAP may report using either GAAP or, with the approval of the commissioner, statutory accounting principles, with useful or necessary modifications or adaptations required or approved or accepted by the commissioner for the type of insurance and kinds of insurers to be reported upon, and as supplemented by additional information required by the commissioner. The statement of operations shall include a statement of income and a balance sheet and may include a detailed listing of invested assets, including identification of assets held in trust to secure the obligations of the SPFC under the SPFC contract and additional descriptions and accounting of the reserves required or maintained by the SPFC. The SPFC also may include with the filing risk based capital calculations and other adjusted capital calculations to assist the commissioner with evaluating the levels of the surplus of the SPFC for the year ending on December 31 of the previous year. The statements shall be prepared on forms required by the commissioner. In addition, the commissioner may require the filing of performance assessments of the SPFC contract.

(5) An SPFC that is authorized as an insurer other than solely pursuant to this chapter and chapter 46 or that is reinsuring risk of a counterparty that is authorized as an insurer under this act shall file annual reports pursuant to sections 438 and 438a and chapter 10. An SPFC shall maintain its records in this state, or in 1 or more locations outside the state with the approval of the commissioner, and shall make its records available for examination by the commissioner at any time. The SPFC shall keep its books and records in such manner that its financial condition, affairs, and operations can be ascertained and so that the commissioner may readily verify its financial statements and determine its compliance with this chapter.

(6) The commissioner may require interim reporting on any or all of the SPFC's business, including any matter, condition, or requirement regulated by this chapter. The commissioner shall prescribe the format and content of the interim report.

(7) Each SPFC that fails to file a report required by this section, or fails to reply within 30 days to an inquiry of the commissioner, is subject to a civil penalty of not less than $1,000.00 or more than $5,000.00 per occurrence, and an additional $50.00 for every day that the SPFC fails to file a report or reply to the inquiry. In addition, each SPFC that fails to file a report, or fails to make a satisfactory reply to an inquiry of the commissioner concerning the SPFC's affairs, is subject to proceedings under section 4735(2).

(8) All original books, records, documents, accounts, and vouchers shall be preserved and kept available in this state for the purpose of examination. The original records, however, may be kept and maintained outside this state if, according to a plan adopted by the management of the SPFC and approved by the commissioner, it maintains suitable records. The books or records may be photographed, reproduced on film, or stored and reproduced electronically.

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(9) Nothing contained in this section with respect to an SPFC shall abrogate, limit, or rescind in any way the authority of the securities commissioner pursuant to 1935 PA 13, MCL 451.1 to 451.4.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4732 Activities requiring notice to commissioner.

Sec. 4732. An SPFC shall not enter into any of the following transactions or engage in any of the following activities unless the SPFC has notified the commissioner in writing of its intention to enter into the transaction or activity at least 30 days, or a shorter period as the commissioner allows, prior to entering into the transaction or activity and the commissioner has not disapproved of it within that period:

(a) A sale, an exchange, or another transfer of assets made by the SPFC between or among any of its protected cells.

(b) Any third party management contract or arrangement that does not meet the requirements of section 4715(7).

(c) Any material change to the SPFC's plan of operation submitted pursuant to section 4705(6)(b) except those changes listed in section 4731(1).

(d) Except as otherwise contemplated in the SPFC contract or related insurance securitization documents, or both, a sale, an exchange, or a transfer of assets from a protected cell to a counterparty, captive LLC, or parent or affiliated company of the SPFC.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4733 Captive insurance company examination; expenses and charges; payment; fee.

Sec. 4733. (1) The expenses and charges of a captive insurance company examination shall be paid to the state by the captive insurance company or companies examined, and the office shall issue warrants for the proper charges incurred in all examinations. The payments received by the state shall be deposited into the captive insurance regulatory and supervision fund.

(2) The office may charge a $15.00 fee for any document requiring certification of authenticity or the signature of the commissioner. The payments received shall be deposited into the captive insurance regulatory and supervision fund.

(3) The office may charge a fee of $25.00 payable to the attorney general for the examination of any amendment to the organizational documents.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4734 Confidentiality requirements; exception.

Sec. 4734. (1) Information and testimony submitted or furnished to the office pursuant to this chapter, examination reports, preliminary examination reports or results, and the office's work papers, correspondence, memoranda, reports, records, and other written or oral information related to an examination report or an investigation shall be confidential, shall be withheld from public inspection, shall not be subject to subpoena, and shall not be divulged to any person, except as provided in this section or with the written consent of the company. If assurances are provided that the information will be kept confidential, the commissioner may disclose confidential work papers, correspondence, memoranda, reports, records, or other information as follows:

(a) To the governor or the attorney general.

(b) To any relevant regulatory agency, including regulatory agencies of other states or the federal government.

(c) In connection with an enforcement action brought pursuant to this or another applicable act.

(d) To law enforcement officials.

(e) To persons authorized by the Ingham county circuit court to receive the information.

(f) To persons entitled to receive such information in order to discharge duties specifically provided for in this act.

(2) The confidentiality requirements of subsection (1) do not apply in any proceeding or action brought against or by the insurer under this act or any other applicable act of this state, any other state, or the United States.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

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500.4735 Cessation of business; suspension or revocation of limited certificate of authority; violations; penalties; notice.

Sec. 4735. (1) At the cessation of business of an SPFC following termination or cancellation of an SPFC contract and the redemption of any related SPFC securities issued in connection with it, the authority granted by the commissioner expires or, for retiring and surviving protected cells, is modified. The SPFC is no longer authorized to conduct activities unless and until a new or modified limited certificate of authority is issued pursuant to a new filing under section 4705 or as agreed by the commissioner.

(2) The commissioner may suspend or revoke the limited certificate of authority of an SPFC in this state for any of the following:

(a) Insolvency.

(b) Failure to meet the provisions of section 4709 or 4713(4).

(c) The SPFC is no longer safe, reliable, or entitled to public confidence or is unsound, or the SPFC is using financial methods and practices in the conduct of its business that render further transaction of insurance by the SPFC in this state hazardous to the public, the holders of the securities, or counterparties in the SPFC.

(d) Failure to respond within 30 days to an inquiry from the commissioner under section 4731(3).

(e) Failure to submit to examination or any legal obligation relative to an examination under section 4703.

(f) Refusal or failure to pay the costs of examination under section 4733.

(g) For a captive insurer formed as a limited liability company, the captive insurer is no longer in good standing under the Michigan limited liability company act, 1993 PA 23, MCL 450.4101 to 450.5200.

(h) The SPFC has failed, after written request by the commissioner, to remove or discharge an officer or director whose record of business conduct does not satisfy the requirements of section 4603 or who has been convicted of any crime involving fraud, dishonesty, or like moral turpitude.

(i) The captive insurance company has failed for an unreasonable period to pay any final judgment rendered against it in this state on any policy, bond, recognizance, or undertaking issued or guaranteed by it.

(j) Failure to otherwise comply in any material respect with applicable laws of this state.

(3) If the commissioner finds, upon examination or other evidence, that an SPFC has committed any of the acts specified in subsection (2)(b), (c), or (d), the commissioner may impose the penalties provided in section 150 if the commissioner considers it in the best interest of the public, the holders of the securities, and the policyholders of the SPFC.

(4) Unless the grounds for suspension or revocation relate only to the financial condition or soundness of the SPFC or to a deficiency in its assets, the commissioner shall notify the SPFC not less than 30 days before revoking its authority to do business in this state and shall specify in the notice the particulars of the alleged violation of the law or its organizational documents or grounds for revocation and the SPFC shall be offered the opportunity to be heard pursuant to section 437.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4741 Administrative supervision, conservation, rehabilitation, receivership, and liquidation of insurers.

Sec. 4741. (1) Except as otherwise provided in this section, the terms and conditions under chapter 81 pertaining to administrative supervision, conservation, rehabilitation, receivership, and liquidation of insurers apply in full to SPFCs or each of the SPFC's protected cells, individually or in combination, without causing or otherwise effecting an administrative supervision, conservation, rehabilitation, receivership, or liquidation of the SPFC or another protected cell.

(2) Notwithstanding any other provision of this act and without causing or otherwise affecting the conservation or rehabilitation of an otherwise solvent protected cell of an SPFC and subject to subsection (7)(e), the commissioner may petition the circuit court for an order authorizing the commissioner to conserve, rehabilitate, or liquidate an SPFC domiciled in this state on 1 or more of the following grounds:

(a) There has been embezzlement, wrongful sequestration, dissipation, or diversion of the assets of the SPFC intended to be used to pay amounts owed to the counterparty or the holders of SPFC securities.

(b) The SPFC is insolvent and the holders of a majority in outstanding principal amount of each class of SPFC securities request or consent to conservation, rehabilitation, or liquidation pursuant to this chapter.

(3) Notwithstanding any other provision of this act, the commissioner may petition the circuit court for an order authorizing the commissioner to conserve, rehabilitate, or liquidate 1 or more of an SPFC's protected cells, independently, without causing or otherwise effecting a conservation, rehabilitation, receivership, or liquidation of the SPFC generally or another of its protected cells, on 1 or more of the following grounds:

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(a) There has been embezzlement, wrongful sequestration, dissipation, or diversion of the assets of the SPFC attributable to the affected protected cell or cells intended to be used to pay amounts owed to the counterparty or the holders of SPFC securities of the affected cell or cells.

(b) The affected protected cell is insolvent and the holders of a majority in outstanding principal amount of each class of SPFC securities attributable to that particular protected cell request or consent to conservation, rehabilitation, or liquidation pursuant to this chapter.

(4) The court may not grant relief provided by subsection (2)(a) or subsection (3)(a) unless, after notice and a hearing, the commissioner, who shall have the burden of proof, establishes by the applicable rules of evidence that relief must be granted. The court's order may be made in respect of 1 or more protected cells by name, rather than the SPFC generally.

(5) Notwithstanding any other provision of this act, rules promulgated or regulations entered under this act, or other applicable law, rule, or regulation, a receiver appointed pursuant to any order or conservation, rehabilitation, or liquidation shall do all of the following:

(a) For an SPFC subject to an order of conservation, rehabilitation, or liquidation, manage the assets and liabilities of the SPFC pursuant to this chapter.

(b) For a protected cell or cells subject to an order of conservation, rehabilitation, or liquidation, manage the assets and liabilities of the protected cell or cells pursuant to this chapter and the SPFC contract.

(c) Ensure that the assets of 1 protected cell are not utilized to satisfy the liabilities of another protected cell or of the SPFC generally.

(6) With respect to amounts recoverable under an SPFC contract, the amount recoverable by the receiver, including all expenses of taking possession of the SPFC or 1 or more of the SPFC's protected cells, shall not be reduced or diminished as a result of the entry of an order of conservation, rehabilitation, or liquidation with respect to the counterparty, notwithstanding any other provision in the contracts or other documentation governing the SPFC insurance securitization.

(7) Notwithstanding any other provision of this act or other laws of this state:

(a) An application or petition, or a temporary restraining order or injunction issued pursuant to this act, with respect to a counterparty does not prohibit the transaction of a business by an SPFC, including any payment by an SPFC made pursuant to an SPFC security, or any action or proceeding against an SPFC or its assets.

(b) The commencement of a summary proceeding or other interim proceeding commenced before a formal delinquency proceeding with respect to an SPFC, and any order issued by the court does not prohibit the payment by an SPFC made pursuant to an SPFC security or SPFC contract or the SPFC from taking any action required to make the payment.

(c) A receiver of a counterparty shall not void a nonfraudulent transfer by a counterparty to an SPFC of money or other property made pursuant to an SPFC contract.

(d) A receiver of an SPFC shall not void a nonfraudulent transfer by the SPFC of money or other property made to a counterparty pursuant to an SPFC contract or made to or for the benefit of any holder of an SPFC security on account of the SPFC security.

(e) The commissioner shall not seek to have an SPFC with protected cells declared insolvent as long as at least 1 of the SPFC's protected cells remains solvent, and in the case of such an insolvency, the receiver shall handle SPFC's assets in compliance with subsection (5) and other laws of this state.

(8) Subsection (7) does not prohibit the commissioner from taking any action permitted under chapter 81 with respect only to the conservation or rehabilitation of an SPFC with protected cell or cells, provided the commissioner would have had sufficient grounds to seek to declare the SPFC insolvent, subject to and without otherwise affecting subsection (7)(e). In this case, with respect to the solvent protected cell or cells, the commissioner shall not prohibit payments made by the SPFC pursuant to an SPFC security, an SPFC contract, or otherwise made under the insurance securitization transaction that are attributable to these protected cell or cells or prohibit the SPFC from taking any action required to make these payments.

(9) With the exception of the fulfillment of the obligations under an SPFC contract, and notwithstanding any other provision of this chapter or other laws of this state, the assets of an SPFC, including assets held in trust, shall not be consolidated with or included in the estate of a counterparty in any delinquency proceeding against the counterparty pursuant to this chapter for any purpose including, without limitation, distribution to creditors of the counterparty.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4745 Contested case brought by third party; suspension, revocation, or modification of limited certificate of authority.

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Sec. 4745. (1) A contested case brought by a third party based on a decision of the commissioner pursuant to this chapter is governed by applicable law of this state except that the third party shall do all of the following:

(a) Prove its case in accordance with the applicable rules of evidence.

(b) Demonstrate irreparable harm to the SPFC or its counterparty, or both.

(c) Show that there is no other adequate remedy at law.

(d) Post a bond of sufficient surety to protect the interests of the holders of the SPFC securities and policyholders so long as it is not less than 15% of the total amount of the securitized transaction.

(2) The commissioner may suspend, revoke, or modify a limited certificate of authority issued to an SPFC or an order made in connection with a limited certificate of authority issued to an SPFC in compliance with the standards and criteria provided in subsection (1) or in conformance with section 4735(2).

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4747 Issuance of regulations; employment of legal counsel.

Sec. 4747. (1) The commissioner may issue regulations necessary to effectuate the purposes of this chapter. Regulations issued pursuant to this section do not affect an SPFC insurance securitization in effect at the time of the issuance of the regulation.

(2) Notwithstanding any other provision of law, the commissioner may employ legal counsel as he or she considers necessary to assist in his or her responsibilities under this chapter.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

CHAPTER 48
PROTECTED CELL INSURANCE COMPANIES

500.4801 Definitions.

Sec. 4801. As used in this chapter:

(a) "Domestic insurer" means an insurer domiciled in this state.

(b) "Fair value" means the following:

(*i*) For cash, the amount of the cash.

(*ii*) For assets other than cash, the amount at which that asset could be bought or sold in the current transaction between arm's length, willing parties. If available, the quoted mid-market price for the asset in active markets shall be used; and if quoted mid-market prices are not available, a value shall be determined using the best information available considering values of similar assets and other valuation methods, such as present value of future cash flows, historical value of the same and similar assets, or comparison to values of other asset classes, the value of which have been historically related to the subject asset.

(c) "Fully funded" means that, with respect to any exposure attributed to a protected cell, the fair value of the protected cell assets, on the date on which the insurance securitization is effected, equals or exceeds the maximum possible exposure attributable to the protected cell with respect to such exposures.

(d) "General account" means the assets and liabilities of a protected cell company other than protected cell assets and protected cell liabilities.

(e) "Indemnity trigger" means a transaction term by which relief of the issuer's obligation to repay investors is triggered by its incurring a specified level of losses under its insurance or reinsurance contracts.

(f) "Nonindemnity trigger" means a transaction term by which relief of the issuer's obligation to repay investors is triggered solely by some event or condition other than the individual protected cell company incurring a specified level of losses under its insurance or reinsurance contracts.

(g) "Protected cell" means an identified pool of assets and liabilities of a protected cell company segregated and insulated by means of this chapter from the remainder of the protected cell company's assets and liabilities.

(h) "Protected cell account" means a specifically identified bank or custodial account established by a protected cell company for the purpose of segregating the protected cell assets of 1 protected cell from the protected cell assets of other protected cells and from the assets of the protected cell company's general account.

(i) "Protected cell assets" means all assets, contract rights, and general intangibles, identified with and attributable to a specific protected cell of a protected cell company.

(j) "Protected cell company" means a domestic insurer or captive insurer that has 1 or more protected cells.

(k) "Protected cell company insurance securitization" means the issuance of debt instruments, the proceeds

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from which support the exposures attributed to the protected cell, by a protected cell company where repayment of principal or interest, or both, to investors pursuant to the transaction terms is contingent upon the occurrence or nonoccurrence of an event with respect to which the protected cell company is exposed to loss under insurance or reinsurance contracts it has issued.

(*l*) "Protected cell liabilities" means all liabilities and other obligations identified with and attributable to a specific protected cell of a protected cell company.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4803 Protected cells; establishment; written approval of commissioner; name or designation; attribution of assets and liabilities; attachment of security interest; contracting with third party; identification of protected cell assets and protected cell liabilities.

Sec. 4803. (1) A protected cell company may establish 1 or more protected cells with the prior written approval of the commissioner of a plan of operation or amendments submitted by the protected cell company with respect to each protected cell in connection with an insurance securitization. Upon the written approval of the commissioner of the plan of operation, which shall include, but is not limited to, the specific business objectives and investment guidelines of the protected cell, the protected cell company, in accordance with the approved plan of operation, may attribute to the protected cell insurance obligations for its insurance business and obligations relating to the insurance securitization and assets to fund the obligations. A protected cell shall have its own distinct name or designation, which shall include the words "protected cell". The protected cell company shall transfer all assets attributable to a protected cell to 1 or more separately established and identified protected cell accounts bearing the name or designation of that protected cell. Protected cell assets shall be held in the protected cell accounts for the purpose of satisfying the obligations of that protected cell.

(2) All attributions of assets and liabilities between a protected cell and the general account shall be in accordance with the plan of operation approved by the commissioner. No other attribution of assets or liabilities shall be made by a protected cell company between the protected cell company's general account and its protected cells. Any attribution of assets and liabilities between the general account and a protected cell, or from investors in the form of principal on a debt instrument issued by a protected cell company in connection with a protected cell company securitization, shall be in cash or in readily marketable securities with established fair values.

(3) The creation of a protected cell does not create, with respect to that protected cell, a legal person separate from the protected cell company. Amounts attributed to a protected cell under this chapter, including assets transferred to a protected cell account, are owned by the protected cell company, and the protected cell company shall not be, and shall not hold itself out to be, a trustee with respect to those protected cell assets of that protected cell account. Notwithstanding this subsection, the protected cell company may allow for a security interest to attach to protected cell assets or a protected cell account if in favor of a creditor of the protected cell and as otherwise allowed under applicable law.

(4) This chapter shall not be construed to prohibit the protected cell company from contracting with or arranging for an investment advisor, commodity trading advisor, or other third party to manage the protected cell assets of a protected cell, if all remuneration, expenses, and other compensation of the third party advisor or manager are payable from the protected cell assets of that protected cell and not from the protected cell assets of other protected cells or the assets of the protected cell company's general account.

(5) A protected cell company shall establish administrative and accounting procedures necessary to properly identify the 1 or more protected cells of the protected cell company and the protected cell assets and protected cell liabilities attributable to the protected cells. The directors of a protected cell company shall keep protected cell assets and protected cell liabilities separate and separately identifiable from the assets and liabilities of the protected cell company's general account and attributable to 1 protected cell separate and separately identifiable from protected cell assets and protected cell liabilities attributable to other protected cells. If this subsection is violated, the remedy of tracing is applicable to protected cell assets when commingled with protected cell assets of other protected cells or the assets of the protected cell company's general account. The remedy of tracing is not an exclusive remedy.

(6) When establishing a protected cell, the protected cell company shall attribute to the protected cell assets with a value at least equal to the reserves and other insurance liabilities attributed to that protected cell.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4805 Income credited to or charged against protected cell; insurance securitization;

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language to be contained in documentation; cessation of business of protected cell.

Sec. 4805. (1) The protected cell assets of a protected cell shall not be charged with liabilities arising out of any other business the protected cell company may conduct. All contracts or other documentation reflecting protected cell liabilities shall clearly indicate that only the protected cell assets are available for the satisfaction of those protected cell liabilities.

(2) The income, and gains and losses, whether realized or unrealized, from protected cell assets and protected cell liabilities shall be credited to or charged against the protected cell without regard to other income and gains or losses of the protected cell company, including income and gains or losses of other protected cells. Amounts attributed to any protected cell and accumulations on the attributed amounts may be invested and reinvested. The investments in a protected cell or cells shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the protected cell company.

(3) Assets attributed to a protected cell shall be valued at their fair value on the date of valuation or if there is no readily available market, as provided in the contract or the rules or other written documentation applicable to the protected cell.

(4) A protected cell company with respect to any of its protected cells shall engage in fully funded indemnity triggered insurance securitization to support in full the protected cell exposures attributable to that protected cell. A protected cell company insurance securitization that is nonindemnity triggered shall qualify as an insurance securitization under the terms of this chapter only after the commissioner by rule, regulation, or order addresses the methods of funding of the portion of this risk that is not indemnity based and addressing accounting, disclosure, risk based capital treatment, and risks associated with such securitizations. A protected cell company insurance securitization that is not fully funded, whether indemnity triggered or nonindemnity triggered, is prohibited. Protected cell assets may be used to pay interest or other consideration on any outstanding debt or other obligation attributable to that protected cell. Nothing in this subsection shall be construed or interpreted to prevent a protected cell company from entering into a swap agreement or other transaction for the account of the protected cell that has the effect of guaranteeing interest or other consideration.

(5) In all protected cell company insurance securitizations, the contracts or other documentation effecting the transaction shall contain provisions identifying the protected cell to which the transaction will be attributed. In addition, the contracts or other documentation shall clearly disclose that the assets of that protected cell, and only those assets, are available to pay the obligations of that protected cell. Notwithstanding this subsection and subject to the provisions of this chapter and any other applicable law, rule, or regulation, the failure to include such language in the contracts or other documentation shall not be used as the sole basis by creditors, reinsurers, or other claimants to circumvent this chapter.

(6) A protected cell company may attribute to a protected cell account only the insurance obligations relating to the protected cell company's general account. Under no circumstances shall a protected cell be authorized to issue insurance or reinsurance contracts directly to policyholders or reinsureds or have any obligation to the policyholders or reinsureds of the protected cell company's general account.

(7) At the cessation of business of a protected cell in accordance with the plan approved by the commissioner, the protected cell company voluntarily shall close out the protected cell account.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4807 Creditors; recourse; activities, assets, and obligations not subject to chapters 77 and 79; establishment of protected cell not considered fraudulent conveyance.

Sec. 4807. (1) Protected cell assets are only available to the creditors of the protected cell company that are creditors for that protected cell and are entitled, in conformity with this chapter, to have recourse to the protected cell assets attributable to that protected cell. Protected cell assets are absolutely protected from the creditors of the protected cell company that are not creditors for that protected cell and who, accordingly, are not entitled to have recourse to the protected cell assets attributable to that protected cell. Creditors for a protected cell are not entitled to have recourse against the protected cell assets of other protected cells or the assets of the protected cell company's general account. Protected cell assets are only available to creditors of a protected cell company after all protected cell liabilities have been extinguished or otherwise provided for in accordance with the plan of operation relating to that protected cell.

(2) When an obligation of a protected cell company to a person arises from a transaction, or is otherwise imposed, with respect to a protected cell, both of the following apply:

(a) That obligation of the protected cell company extends only to the protected cell assets attributable to that protected cell, and the person, with respect to that obligation, is entitled to have recourse only to the protected cell assets attributable to that protected cell.

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(b) That obligation of the protected cell company does not extend to the protected cell assets of any other protected cell or the assets of the protected cell company's general account, and that person, with respect to that obligation, is not entitled to have recourse to the protected cell assets of any other protected cell or the assets of the protected cell company's general account.

(3) When an obligation of a protected cell company relates solely to the general account, the obligation of the protected cell company extends only to, and that creditor, with respect to that obligation, is entitled to have recourse only to, the assets of the protected cell company's general account.

(4) The activities, assets, and obligations relating to a protected cell are not subject to the provisions of chapters 77 and 79, and neither a protected cell nor a protected cell company shall be assessed by, or otherwise be required to contribute to, any guaranty fund or guaranty association in this state with respect to the activities, assets, or obligations of a protected cell. Nothing in this subsection affects the activities or obligations of an insurer's general account.

(5) The establishment of 1 or more protected cells alone does not constitute, and shall not be considered to be, a fraudulent conveyance, an intent by the protected cell company to defraud creditors, or the carrying out of business by the protected cell company for any other fraudulent purpose.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4809 Receiver to deal with protected cell company's assets and liabilities; effect of order of conservation, rehabilitation, or liquidation.

Sec. 4809. (1) Notwithstanding any other provision of law, rule, or regulation, upon an order of conservation, rehabilitation, or liquidation of a protected cell company, the receiver shall deal with the protected cell company's assets and liabilities, including protected cell assets and protected cell liabilities, in accordance with this chapter.

(2) For amounts recoverable under a protected cell company insurance securitization, the amount recoverable by the receiver shall not be reduced or diminished as a result of the entry of an order of conservation, rehabilitation, or liquidation with respect to the protected cell company, notwithstanding any other provision to the contrary in the contracts or other documentation governing the protected cell company insurance securitization.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4811 Insurance securitization not considered insurance or reinsurance contract; investor not considered as conducting insurance business in state.

Sec. 4811. A protected cell company insurance securitization is not, and shall not be considered to be, an insurance or reinsurance contract. An investor in a protected cell company insurance securitization, by sole means of this investment, is not, and shall not be considered to be, conducting an insurance business in this state. The underwriters or selling agents and their partners, directors, officers, members, managers, employees, agents, representatives, and advisors involved in a protected cell company insurance securitization are not, and shall not be considered to be, conducting an insurance or reinsurance agency, brokerage, intermediary, advisory, or consulting business by virtue of their activities in connection with that business.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

500.4813 Rules, regulations, or orders.

Sec. 4813. The commissioner may issue rules, regulations, or orders necessary to effectuate the purposes of this chapter.

History: Add. 2008, Act 29, Imd. Eff. Mar. 13, 2008.

Popular name: Act 218

CHAPTER 50
ORGANIZATION OF DOMESTIC STOCK AND MUTUAL INSURERS

500.5000 Scope of chapter.

Sec. 5000. This chapter covers incorporation and procedures for organization of new domestic stock, mutual, and cooperative plan insurers; except, that this chapter shall apply to domestic general mutual insurers only as stated in section 5804.

History: 1956, Act 218, Eff. Jan. 1, 1957.

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Popular name: Act 218

500.5001 Compliance with chapter required.

Sec. 5001. No stock or mutual insurer or other form of corporate body, shall hereafter be incorporated in this state for the purpose of transacting any form of insurance or surety bonding business, without complying with the procedure prescribed in this chapter.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5002 Organization of insurers; definitions.

Sec. 5002. Definitions, as used in this code:

(1) Except as otherwise indicated "corporation" means a corporation formed or existing under the laws of this state.

(2) "Articles" means articles of incorporation, and all amendments thereto, and includes what has heretofore been referred to as articles of association and/or charters and amendments thereto of corporations governed by this code.

(3) "Incorporator" means a person, natural or corporate, who signs the articles.

(4) "Director" and "directors" shall be construed to be synonymous with "trustee" and "trustees" respectively. "Directors," when used in relation to any power or duty requiring collective action, shall be construed to mean "board of directors."

(5) "Registered office" means the place designated in the articles or bylaws as the office of the corporation in this state.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5006 Stock insurers; formation, number of incorporators required.

Sec. 5006. (1) Any number of persons, not less than 7, may associate together and form a stock insurer to transact any or all of the following kinds of insurance: Property, marine, inland navigation and transportation, or automobile insurance (limited), all as defined in chapter 6.

(2) Thirteen or more persons may organize a stock insurer for the purpose of transacting any of the following kinds of insurance: Life, disability, casualty, or fidelity and surety, all as defined in chapter 6 or title as defined in chapter 73.

(3) Any number of persons, not less than 20, a majority of whom shall be citizens of this state, may become together with others who may hereafter be associated with them or their successors, a body corporate for the purpose of transacting life insurance, or life and disability insurance, on the mutual plan.

(4) Any number of persons, not less than 13, may incorporate a stock insurer for the purpose of insuring railway employees against loss of position, for transacting disability and life insurance, and granting annuities, all as identified in section 6604.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1966, Act 221, Imd. Eff. July 11, 1966.

Popular name: Act 218

500.5008 Articles of incorporation; blank forms; subscribing in duplicate; contents; permissible provisions; liability of director; certificate of acknowledgment.

Sec. 5008. (1) The commissioner shall prepare and keep on hand blank forms of articles of incorporation for insurers desiring to incorporate under this act, which forms may be had on application.

(2) The incorporators shall subscribe articles of incorporation in duplicate, which articles shall contain all of the following:

(a) The names of the incorporators and their places of residence respectively.

(b) The location of the principal office for the transaction of business in this state.

(c) The name by which the incorporation shall be known, which if it be upon the mutual plan shall contain the word "mutual". However, a nonprofit mutual disability insurer into which a nonprofit health care corporation that is organized under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704, is merged or consolidated may retain and use trade names in use by the nonprofit health care corporation before the merger or consolidation.

(d) The purposes of the incorporation and the reference to the chapter of this act under which the purposes are enumerated and under which the company intends to operate.

(e) The manner in which the corporate powers are to be exercised; the number of directors and other officers; the manner of electing the directors and other officers, and how many of the directors constitute a

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quorum, and the manner of filling all vacancies; and, in the case of mutual life or life and disability insurers, the names and mailing addresses of the directors who shall serve until the first annual meeting of the corporation.

(f) The amount of capital stock, if any, what proportion is to be paid in before the corporation commences business, and the value of the stock, as provided in section 5014.

(g) The term of existence of the corporation, subject to section 5010.

(h) The time for the holding of the annual meetings of the corporation.

(i) Any terms and conditions of membership that the incorporators have agreed upon and which they consider important to have set forth in the articles.

(j) Any other terms and conditions prescribed by law for that class of insurer.

(k) If a mutual company operating on the assessment plan, the number of classes or divisions of members and the object or purpose of the classification or division, all of which shall be definitely and correctly stated; and in what manner assessments, premiums, or payments are to be required from the members, the purpose and objects for which the money so realized are to be appropriated, and the names and objects of each fund into which any the money shall be paid.

(3) The articles of any stock insurer formed or existing under this act may contain, or may be amended to contain, a provision that the shareholders shall have no preemptive rights to subscribe for any additional shares of capital stock and authorizing the board of directors to prescribe the terms and conditions upon which additional shares of capital stock shall be offered for subscription including the price of the stock, which shall not be less than the par value of the stock; and to offer shares that have not been subscribed by stockholders within the time duly fixed by the board of directors for subscription to any other person or persons at a price and upon terms not less favorable than those offered to the stockholders.

(4) The articles of incorporation may contain a provision providing that a director is not personally liable to the corporation or its shareholders or policyholders for monetary damages for a breach of the director's fiduciary duty. However, the provision does not eliminate or limit the liability of a director for any of the following:

(a) A breach of the director's duty of loyalty to the corporation or its shareholders or policyholders.

(b) Acts or omissions not in good faith or that involve intentional misconduct or knowing violation of law.

(c) A violation of section 5036, 5276, or 5280.

(d) A transaction from which the director derived an improper personal benefit.

(e) An act or omission occurring before January 1, 1989.

(5) The articles shall be acknowledged by the person signing the articles before some officer of this state authorized to take acknowledgments of deeds, who shall attach his or her certificate of acknowledgment.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1988, Act 290, Eff. Jan. 1, 1989;—Am. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 2013, Act 5, Imd. Eff. Mar. 18, 2013.

Popular name: Act 218

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500.5010 Duration of corporate existence.

Sec. 5010. The corporate existence of any company incorporated under or subject to this code shall not exceed 30 years, unless a longer term is provided in the articles of incorporation. Any company hereafter incorporated under this code may incorporate for a period of any specific number of years, not less than 30, or multiples of 30, or in perpetuity, provided that the legislature may shorten such terms by future laws.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5012 Corporate name; restrictions.

Sec. 5012. No insurer formed under this code shall assume any name which is the same as or closely resembles the name of any other corporation doing business in this state.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5014 Par value of stock; limitations.

Sec. 5014. Capital stock of domestic stock insurers incorporated under this chapter shall have value as follows:

(1) If organized to transact property, marine, inland navigation and transportation, or automobile insurance (limited), all as defined in chapter 6, each share of authorized capital stock shall have a value of not less than $1.00 or more than $100.00.

(2) If organized to transact life, disability, casualty, or fidelity and surety insurance, all as defined in

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chapter 6 or title insurance as defined in chapter 73, each share of authorized capital stock shall have a value of not less than $1.00.

(3) If organized to insure railway employees against loss of position, and to transact life and disability insurance, as identified in section 6604, each share of authorized capital stock shall have a par value of $50.00.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1966, Act 221, Imd. Eff. July 11, 1966.

Popular name: Act 218

500.5020 Examination of articles by attorney general; fee.

Sec. 5020. (1) Before such articles of incorporation shall be effective for any purpose the same shall be submitted to the attorney general for his examination, and if found by him to be in compliance with this code he shall so certify to the commissioner.

(2) Each and every insurer hereafter incorporated, where its articles of incorporation are required to be approved by the attorney general, shall pay to the attorney general for the use and benefit of the state of Michigan, the examination fee provided for in section 240 (2). It shall be unlawful for the attorney general to approve any articles of incorporation for mutual insurers until such examination fee is paid to him.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5024 Securing subscribers, stockholders, or members of insurance company; sale of capital stock; required acts of incorporators; authority of commissioner.

Sec. 5024. (1) Before securing subscribers, stockholders, or members of an insurance company, or taking subscriptions for, or negotiating for, the sale of any of the capital stock of the company or subscriptions for membership in the company, the incorporators shall do all of the following:

(a) Deliver to the commissioner such bond, deposit, or security for the protection of subscribers as the commissioner may require.

(b) Prepare and file with the commissioner duplicate copies of the articles of incorporation with the certificate of the attorney general attached, a statement showing in full detail the plan upon which the company proposes to transact business, a copy of all contracts, stocks or other instruments that it proposes to make with, or sell to, its stockholders or members, together with a copy of its prospectus and the proposed advertisements to be used in the solicitation of members or stockholders. The statement shall also show the name and location and main office of the company, the name, home and business address of each of the incorporators, the amount subscribed and paid in by each of them, and the manner in which future payments shall be made, together with 4 references as to the character and financial standing of each of the incorporators with the business address of each of the references.

(2) The commissioner shall examine the statements and documents presented and shall have power to conduct any investigation that the commissioner considers necessary and to hear the incorporators and to examine under oath any persons interested or connected with the proposed insurance company. If in the opinion of the commissioner the sale of capital stock in the proposed insurance company or soliciting of membership therein would work a fraud upon the persons subscribing to the capital stock or to such membership the commissioner may refuse to license the persons so associating to proceed in the organization and promotion of the insurance company. If, upon examination of the articles of incorporation, the documents, and instruments above mentioned and any further investigation as the commissioner may make, the commissioner is satisfied that the sale of the capital stock of the proposed insurance company or the subscription to membership therein would not work a fraud upon the persons solicited to become purchasers of such capital stock, or members of the insurance company, the commissioner shall return to the incorporators 1 copy of the articles of incorporation certified by the commissioner for the records of the company and shall retain 1 copy for the insurance bureau files. The commissioner shall then issue a certificate authorizing the incorporators to proceed with the organization of the insurance company through the sale of stock or taking of memberships.

(3) The commissioner shall have authority at any time to revoke any certificate, order, or consent made by him or her to such company to procure applications for stock or membership upon being satisfied that the further solicitation of stockholders, or members, in the corporation will work a fraud upon the persons so solicited and the commissioner may make any investigation from time to time as he or she considers best and to grant hearings to the incorporators concerning the revocation.

(4) The action of the commissioner provided for in this section shall not be in place of any action provided by law to be taken by the corporations and securities bureau of the state of Michigan in relation to the sale, taking subscriptions for, or offering for sale any stocks or securities within this state.

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History: 1956, Act 218, Eff. Jan. 1, 1955;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.5028 Completion of organization; issuance of stock certificates; mutual corporation.

Sec. 5028. (1) The incorporators shall, after the filing and approval of the required articles, proceed to the completion of organization of the proposed insurer.

(2) A stock corporation shall at once open its books of subscription to the capital stock, and a certificate of authority shall not be issued by the commissioner to the corporation until it has issued stock certificates representing the minimum capitalization under its articles of incorporation and has collected in cash both its minimum capital and any premium for surplus requirements. If capital stock is not subscribed and paid for as provided in this subsection within 1 year from the opening of the books, the corporation may only sell stock on petition to and consent by the commissioner. The commissioner, if public policy warrants, may extend this 1-year period for a period of 3 months and, after petition, for a second period of 3 months. If at the expiration of 18 months the corporation has not met the requirements of this subsection, the commissioner shall proceed to liquidate the corporation through receivership proceedings as prescribed by chapter 81.

(3) A mutual corporation shall at once open books to receive propositions and enter into agreements as specified in the chapter under which it intends to operate. The acquisition of members shall proceed for the length of time, and be subject to periods of time extension and liquidation proceedings, as provided in subsection (2).

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2001, Act 182, Imd. Eff. Dec. 21, 2001.

Popular name: Act 218

500.5036 Liability of directors for debts during organization.

Sec. 5036. The directors and incorporators of any stock company organized under this chapter, to transact property, marine, inland navigation and transportation, or automobile insurance (limited), all as defined in chapter 6, shall be jointly and severally liable for all debts or responsibilities of such company, until the whole amount of the capital of such company shall have been paid in and a certificate thereof recorded, as hereinbefore provided.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5040 Examination; certificate of authority.

Sec. 5040. Upon the petition of the incorporators of such company, the commissioner shall cause an examination to be made in respect to the capital stock and shall see that the requirements as to the same have been fully complied with; and if the company is organized to do business on the mutual or cooperative assessment plan, the commissioner shall similarly determine that the company is in the actual possession of the applications for insurance required of it, and the amount of premiums, assessments, reserve, surplus, or other resources required of it, as the case may be, and that it was shown to him by the affidavit of the president and secretary of the company that any required applications have been taken in good faith and not merely colorably. The commissioner may perform such examination by deputy or by any examiner in his office, or by the appointment of a special examiner, who shall certify to the facts as found. Upon being satisfied that all requirements of this code precedent to commencing business have been fully complied with, applicable to such company, the commissioner shall deliver to such company a certificate of authority to commence business and issue policies.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

CHAPTER 51

ORGANIZATION OF AN ACQUIRING INSURER FOR TRANSACTION OF CERTAIN TYPES OF INSURANCE

500.5100 Definitions.

Sec. 5100. As used in this chapter:

(a) "Acquiring insurer" means a domestic stock insurer, domestic mutual insurer, or reciprocal or inter-insurance exchange organized pursuant to this chapter.

(b) "Effective date of the transfer" means the date upon which a transfer occurs.

(c) "State accident fund" means the state accident fund created pursuant to the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being sections 418.101 to 418.941 of the

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(d) "Transfer" means the acquisition by an acquiring insurer of all or substantially all of the assets, and assumption by the acquiring insurer of all or substantially all of the liabilities of, the state accident fund pursuant to Act No. 317 of the Public Acts of 1969, being sections 418.101 to 418.941 of the Michigan Compiled Laws.

History: Add. 1993, Act 200, Eff. Dec. 28, 1994.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.5102 State accident fund; acquisition of assets; effect of proposed transfer.

Sec. 5102. No person other than an acquiring insurer shall acquire all or substantially all of the assets of the state accident fund. A proposed transfer shall constitute a proposed change of control of a domestic insurer within the meaning of this act and shall be subject to all the requirements of this act governing a change of control of a domestic insurer.

History: Add. 1993, Act 200, Eff. Dec. 28, 1994.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.5104 Organizing stock insurer or mutual insurer; purpose; domestic stock insurer owned by nonprofit health care corporation as acquiring insurer; limitation on transaction.

Sec. 5104. (1) Subject to the requirements of this act applicable to domestic stock insurers, domestic mutual insurers, reciprocals, or inter-insurance exchanges, and the further requirements of this chapter, 13 or more persons may organize a stock insurer or 20 or more persons may organize a mutual insurer for the purpose of transacting any or all of the following kinds of insurance: property, marine, inland navigation and transportation, casualty, or fidelity and surety, all as defined in chapter 6. Once organized and authorized, the acquiring insurer is subject to all applicable provisions of this act.

(2) During the period that the acquiring insurer is a domestic stock insurer owned by a nonprofit health care corporation formed pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704, for insurance products and services, the acquiring insurer under this chapter, whether directly or indirectly, shall only transact worker's compensation insurance and employer's liability insurance, transact disability insurance limited to replacement of loss of earnings, and act as an administrative services organization for an approved self-insured worker's compensation plan or a disability insurance plan limited to replacement of loss of earnings. This subsection does not preclude the acquiring insurer from providing either directly or indirectly noninsurance products and services as otherwise provided by law.

History: Add. 1993, Act 200, Eff. Dec. 28, 1994;—Am. 1999, Act 211, Imd. Eff. Dec. 21, 1999;—Am. 2013, Act 5, Imd. Eff. Mar. 18, 2013.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.5106 Provisions applicable to acquiring insurer.

Sec. 5106. On and after the effective date of the transfer, any acquiring insurer shall be subject to the following:

(a) The acquiring insurer shall assume, indemnify, and hold the state of Michigan and any of its subdivisions harmless from and against all existing liabilities of the state accident fund under policies of workers' compensation and employers' liability insurance issued by the state accident fund before the effective date of the transfer.

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(b) The acquiring insurer shall, in a manner similar to that of the state accident fund in the year before the effective date of the transfer, provide worker's compensation insurance to insureds with premiums less than $10,000.00 adjusted annually according to the increase or decrease in the United States department of labor consumer price index as computed for each calendar year. The acquiring insurer shall not adopt or undertake any underwriting practices or procedures in connection with workers' compensation insurance that discriminate against insureds solely on the basis of the size of the premium of the insured.

(c) The acquiring insurer shall maintain investment securities, cash, and reserve funds acquired in the transfer and those generated from doing business in Michigan, on deposit or in custody within the state of Michigan.

(d) For a period of 5 years after the effective date of the transfer, the acquiring insurer shall administer the workers' disability compensation fund of the state of Michigan at the acquiring insurer's direct cost plus reasonably allocated overhead. Any agreement evidencing such arrangement shall be terminable by the state of Michigan 1 year after the effective date of the transfer upon 6 months' written notice.

(e) For a period of at least 1 year after the effective date of the transfer, the acquiring insurer shall recognize the collective bargaining representatives of employees as constituted on the effective date of the transfer.

(f) For a period of 1 year after the effective date of the transfer, the acquiring insurer shall employ, on terms and conditions determined by the acquiring insurer, and subject to the right of the acquiring insurer to terminate employment for good cause, the employees, other than those employees also employed by the department of attorney general, on the payroll of the state accident fund as of the effective date of the transfer.

(g) Within 90 days after the effective date of the transfer, the acquiring insurer shall notify each holder of a policy of insurance, the obligations of which are assumed by the acquiring insurer that the acquiring insurer is now the insurer under the policy, that the acquiring insurer is not a state agency, and that the acquiring insurer is a member of the property and casualty guaranty association created under chapter 79.

(h) The acquiring insurer shall file the applications described in section 5108.

History: Add. 1993, Act 200, Eff. Dec. 28, 1994.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.5108 Acquiring insurer as party in place of state accident fund.

Sec. 5108. Within 90 days after the effective date of the transfer, the acquiring insurer shall apply to the court or administrative agency in this state in which an action or proceeding is pending in which the state accident fund was a party pursuant to section 731 of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.731 of the Michigan Compiled Laws, to be substituted as a party in place of the state accident fund.

History: Add. 1993, Act 200, Eff. Dec. 28, 1994.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.5110 Determining violation of MCL 500.5106.

Sec. 5110. Upon probable cause the commissioner may examine and investigate into the affairs of an acquiring insurer to determine whether the insurer has been or is engaged in any practice in violation of section 5106.

History: Add. 1993, Act 200, Eff. Dec. 28, 1994.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

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Popular name: Act 218

500.5112 Notice of violation of MCL 500.5106; hearing; findings and conclusions; order to cease and desist; additional orders.

Sec. 5112. (1) Upon probable cause to believe that an acquiring insurer has been or is engaged in any practice in violation of section 5106, the commissioner shall give notice, pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, to the acquiring insurer, setting forth the general nature of the complaint against it. Before the issuance of a notice of hearing, the commissioner or his or her designee shall give the acquiring insurer an opportunity to confer and discuss the possible complaint and proceedings with the commissioner or his or her representative and the matter may be disposed of summarily by the parties.

(2) If, after opportunity for a contested case hearing held pursuant to Act No. 306 of the Public Acts of 1969, the commissioner determines that the acquiring insurer has violated any provision of section 5106, the commissioner shall reduce his or her findings and conclusions to writing and shall issue and cause to be served upon the acquiring insurer a copy of the findings and conclusions and an order requiring the acquiring insurer to cease and desist from engaging in the violation. The commissioner may also order any of the following:

(a) Payment of a civil penalty of not more than $5,000.00 for each violation but not to exceed an aggregate penalty of $50,000.00, unless the acquiring insurer knew or reasonably should have known that it was in violation of section 5106, in which case the penalty shall not be more than $10,000.00 for each violation and shall not exceed an aggregate penalty of $100,000.00 for all violations committed in a 6-month period.

(b) Suspension or revocation of the acquiring insurer's certificate of authority if it knowingly and persistently violated section 5106.

History: Add. 1993, Act 200, Eff. Dec. 28, 1994.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.5114 Insurance agents.

Sec. 5114. (1) All agents licensed by the state of Michigan to sell property and casualty insurance shall be authorized to sell workers' compensation and employers' liability insurance issued by, and to place such business with, the acquiring insurer for a period of 3 years commencing on the effective date of the transfer. The acquiring insurer shall pay reasonable compensation for business placed with and services rendered in connection with that business.

(2) After the effective date of the transfer to an acquiring insurer, the acquiring insurer shall contract with any insurance agent association having at least 300 members, to serve as a general agent of the acquiring insurer. Any agent licensed by the state of Michigan to sell property and casualty insurance, under contract with the general agent, shall be authorized to sell worker's disability compensation and employer's liability insurance for the acquiring insurer. The general agent shall not require the agent to be a member of the association.

(3) Notwithstanding subsections (1) and (2), but subject to the remaining provisions of this section, the acquiring insurer may contract with any licensed agent to represent the acquiring insurer.

(4) The acquiring insurer shall not unfairly discriminate against any agent in providing assistance in marketing, payment, or settlement of claims, or any other matters related to marketing, placing business, or handling claims. A pilot or test program of a term not exceeding 6 months in duration shall not constitute unfair discrimination under this section.

(5) After the 3-year period provided by subsection (1), the acquiring insurer shall not withhold such appointment unreasonably and shall pay reasonable compensation for business placed with and services rendered in connection with that business. After the 3-year period provided by subsection (1), the acquiring insurer, subject to the provisions of this section and chapter 12, shall have the sole discretion to determine those agents who shall be appointed to represent the acquiring insurer.

(6) During the 3-year period, the agent's authority shall not be suspended, limited, or terminated by the acquiring insurer, except for 1 or more of the following reasons:

(a) Malfeasance.

(b) Breach of fiduciary duty or trust.

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(c) A persistent tendency to violate the procedures outlined in the acquiring insurer's basic manuals for Michigan worker's compensation and employer's liability insurance.

History: Add. 1993, Act 200, Eff. Dec. 28, 1994.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

CHAPTER 52
CORPORATE POWERS, PROCEDURES OF STOCK AND MUTUAL INSURERS

500.5200 Applicability of chapter.

Sec. 5200. (1) This chapter applies only to domestic stock, mutual, and cooperative plan insurers, including limited liability pools; except, that sections 5242 and 5252 apply also to foreign insurers, and section 5222 applies also to fraternal benefit societies.

(2) For additional provisions applicable only to:

(a) Mutual life and disability insurers, see chapter 54.

(b) General mutuals, see chapter 58.

(c) Cooperative or assessment plan life, disability, and loss of position insurers, see chapter 64.

(d) Limited liability pools, see chapter 65.

(e) Stock life, disability, and loss of position as railway employee insurers, see chapter 66.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1966, Act 140, Eff. Mar. 10, 1967;—Am. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

500.5202 Life, accident or sickness insurers; reorganization under code.

Sec. 5202. Any company organized to transact the business of life insurance or insurance against accident or sickness under any laws of this state in force prior to August 10, 1917, may reorganize under this code, and have the benefit of all its provisions, by a vote of the stockholders, or, if it be a mutual company, then by a vote of the members called for that purpose, in pursuance of its present articles, on entering into new articles of incorporation, signed by its charter officers, setting forth the particulars required under this code and filing a copy of such articles with the commissioner and the proper county clerk, after such a certificate of the attorney general has been obtained as is required when the articles are amended; and such company, in so reorganizing, shall be at liberty to make any change in its mode of doing business, not inconsistent with the provisions of this code, and to increase its capital stock, or to retire any guaranteed capital stock, as the stockholders or members may deem proper; but in so reorganizing they shall be subject to all the provisions of this code in regard to the deposit of securities, and to all its other provisions in the same manner and to the same extent as if such company had not previously had a corporate existence.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5204 Companies deemed bodies corporate and politic; corporation law applicable.

Sec. 5204. All companies formed under the insurance laws of this state shall be deemed bodies corporate and politic, in fact and in name, and shall be subject to all of the provisions of law in relation to corporations as far as they are applicable.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5205 Proof of corporate existence and authority to insure.

Sec. 5205. If it is necessary, in any legal proceedings, to prove the corporate existence of a domestic insurer, a copy of the articles of incorporation, with a certificate by the commissioner attached, that the copy is a duplicate of the copy on file in the insurance bureau and by the certificate of the state treasurer in proper cases, that the securities required to be deposited with the state treasurer have been deposited, together with a certified copy of the insurer's certificate of authority, shall be prima facie evidence of the corporate existence of the insurer; and except in proceedings by or under the authority of the state, to question its corporate right by information in the nature of quo warranto or otherwise, shall be conclusive evidence of the authority of the insurer to issue policies and transact business as contemplated by its articles, until such authority has been

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History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.5206 Corporate powers; enumeration; exercise by board of directors.

Sec. 5206. (1) Every corporation, unless otherwise provided, or inconsistent with the act under which a particular corporation is or shall have been formed shall have power:

(a) To have succession, by its corporate name, for the term stated in its articles;

(b) To sue and be sued, complain and defend, in any court of law or equity or to be a party to any proceedings before any board or commission or other public body of this state or any other state or government; suits at law may be maintained by such corporations against any of its members for any cause relating to the business of such corporation;

(c) To have a corporate seal which may be altered at pleasure and to use the same by causing it or a facsimile thereof to be impressed or affixed or reproduced, or otherwise;

(d) To acquire, purchase, hold, and convey real and personal estate and to mortgage or lease any such real or personal estate with or without any of its franchises, corporate or otherwise, subject to the provisions of this code;

(e) To appoint such officers and agents as the business of the corporation shall require and to allow them suitable compensation;

(f) To make, alter, amend and repeal bylaws for the regulation and government of its affairs, including the certification and transfer of its stock;

(g) To conduct its business in this state, other states, the District of Columbia, the territories and colonies of the United States and in foreign countries and the territories and colonies thereof and have 1 or more offices out of this state and to acquire, purchase, hold, mortgage, pledge, assign, transfer and convey real and personal property out of this state subject to the provisions of this code;

(h) To make contributions for public welfare.

(i) To have and to hold authorized but unissued shares of its own stock, which have been authorized by its stockholders as provided in section 5215 or 5218, as the case may be, for issuance at a subsequent date as the board of directors may determine, including the right for the allotment and sale of any or all of its unissued shares or of shares purchased or to be purchased, to the employees of the corporation, or to the employees of subsidiary corporations or to a trustee on their behalf, and for the payment of such shares in installments or at one time, and for the establishment of a special fund or funds in which such employees during the period of their employment or other period of time may be privileged to participate on such terms and conditions as may be imposed in respect thereof. Shares otherwise subject to pre-emptive rights under any articles of incorporation may be allotted and sold under such plan free from pre-emptive rights only with the written consent or vote of the holders of a majority of the shares entitled to exercise pre-emptive rights with respect thereto. Such allotment or sale may be cancelled by mutual agreement between the corporation or any employee or trustee, or in any other legal manner.

(2) The powers of a corporation, except as otherwise provided, shall be exercised by the board of directors.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957.

Popular name: Act 218

500.5208 Corporate powers; limitations; applicability of prohibition; services performed in connection with noninsured benefit plan; provisions; interference with rights and obligations under collective bargaining agreement prohibited; report; liability of employee covered under noninsured benefit plan; "noninsured benefit plan" or "plan" defined.

Sec. 5208. (1) The corporate powers of an insurer incorporated in this state is limited to the issuance of policies insuring persons or property or other hazards in the state of domicile and in other states from which it has received authority to transact insurance business from the insurance department of that state, and to the provision of services of the kind it performs in the normal conduct of its insurance business whether or not those services are performed in connection with an insurance contract. This section does not apply to insurers organized in compliance with the insurance laws of this state, which cannot be properly authorized in other states, because the laws of those states do not permit the writing of the class or kind of insurance written by those insurers.

(2) For services provided under subsection (1) that are performed in connection with a noninsured benefit plan, all of the following apply:

(a) An insurer's fees for services rendered shall be on a basis that precludes cost transfers between

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individuals receiving those services and policyholders of the insurer.

(b) Any insurer providing services described in subsection (1) in connection with a noninsured benefit plan shall offer a program of specific or aggregate excess loss insurance.

(c) Except as provided in subdivision (d), an insurer providing the services described in subsection (1) in connection with a noninsured benefit plan shall not enter into the service contract for a plan covering a group of less than 500 individuals. However, an insurer may continue a service contract for a plan covering a group of less than 500 individuals if the contract was in existence on December 29, 1981.

(d) An insurer may enter into a service contract for a plan covering a group of less than 500 individuals if either the insurer makes arrangements for excess loss insurance or the sponsor of the plan that covers the individuals is liable for the plan's liabilities and is a sponsor of 1 or more plans covering 500 or more individuals in the aggregate. The commissioner, upon obtaining the advice of insurers, shall establish the standards for the manner and amount of the excess loss insurance required by this subdivision. It is the intent of the legislature that the excess loss insurance requirements be uniform as between insurers and other persons authorized to provide similar services.

(e) An insurer providing the services described in subsection (1) in connection with a noninsured benefit plan shall comply with section 5208a.

(f) A service contract containing an administrative services only arrangement between an insurer and a governmental entity not subject to ERISA, whose plan provides coverage under a collective bargaining agreement utilizing a policy or certificate issued by an insurer, health care corporation, dental care corporation, or health maintenance organization before the signing of the service contract, is void unless the governmental entity has provided the notice described in section 5208a(8) to the collective bargaining agent and to the members of the collective bargaining unit not less than 30 days before signing the service contract. The voiding of a service contract under this subdivision does not relieve the governmental entity of any obligations to the insurer under the service contract.

(3) Nothing in this section shall be construed to permit an actionable interference by an insurer with the rights and obligations of the parties under a collective bargaining agreement.

(4) Services provided under subsection (1) that are performed in connection with a noninsured benefit plan shall be considered a business activity that is not an insurance carrier service and are subject to tax as authorized by the former single business tax act, 1975 PA 228, or the Michigan business tax act, 2007 PA 36, MCL 208.1101 to 208.1601.

(5) An insurer shall report with its annual statement the amount of business it has conducted as services provided under subsection (1) that are performed in connection with a noninsured benefit plan, and the commissioner shall annually transmit this information to the state commissioner of revenue.

(6) An employee covered under a noninsured benefit plan for which services are provided under a service contract authorized under subsection (1) is not liable for that portion of claims incurred and subject to payment under the plan if the service contract is entered into between an employer and insurer, unless that portion of the claim has been paid directly to the employee.

(7) As used in this section, "noninsured benefit plan" or "plan" means a benefit plan without insurance or the noninsured portion of a benefit plan that has specific or aggregate excess loss insurance.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1981, Act 189, Imd. Eff. Dec. 29, 1981;—Am. 1984, Act 267, Imd. Eff. Dec. 18, 1984;—Am. 2002, Act 146, Imd. Eff. Apr. 2, 2002;—Am. 2007, Act 187, Imd. Eff. Dec. 21, 2007.

Popular name: Act 218

500.5208a Definitions; prohibited conduct; probable cause of violation; notice of hearing; opportunity to confer and discuss complaint and proceedings; action for damages; hearing; findings and decision; cease and desist order; processing claims for benefits; interest; claim form; service contract provisions; violation of section; penalties; severability.

Sec. 5208a. (1) As used in this section:

(a) "Noninsured benefit plan" means a benefit plan without insurance or the noninsured portion of a benefit plan which has specific or aggregate excess loss insurance.

(b) "Process a claim" means the services performed in connection with a claim for benefits including the disbursement of benefit amounts.

(2) An insurer providing services under section 5208 in connection with a noninsured benefit plan, with respect to such services, shall not do any of the following:

(a) Misrepresent pertinent facts relating to coverage.

(b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to

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a claim for benefits.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim for benefits.

(d) Refuse to process claims without conducting a reasonable investigation based upon the available information.

(e) Fail to communicate affirmation or denial of coverage of a claim for benefits within a reasonable time after a claim has been received.

(f) Fail to attempt in good faith to promptly, fairly, and equitably process a claim for benefits.

(g) Knowingly compel covered individuals to institute litigation to recover amounts due under a benefit plan by offering substantially less than the amounts due.

(h) For the purpose of coercing a covered individual to accept a settlement or compromise in a claim, inform the covered individual of a policy of appealing administrative hearing decisions which are in favor of covered individuals.

(i) Delay the investigation or processing of a claim by requiring a covered individual, or the provider of services to the covered individual, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.

(j) Fail to promptly provide a reasonable explanation of the basis for denial or partial denial of a claim for benefits.

(k) Fail to promptly process a claim where liability has become reasonably clear under 1 portion of a benefit plan in order to influence a settlement under another portion of the benefit plan.

(*l*) Refuse to enter into a service contract nor refuse to provide services under a service contract because of race, color, creed, marital status, sex, national origin, residence, age, disability, or lawful occupation.

(3) An insurer providing services under section 5208 in connection with a noninsured benefit plan shall not, in order to induce a person to contract or to continue to contract with the insurer for the provision of services under a service contract offered by the insurer; to induce a person to lapse, forfeit, or surrender a policy or service contract issued by the insurer; or to induce a person to secure or terminate coverage with another insurer, health care corporation, health maintenance organization, or other person, directly or indirectly:

(a) Issue or deliver to the person money or any other valuable consideration.

(b) Offer to make or make an agreement relating to a service contract other than as plainly expressed in the service contract.

(c) Offer to give or pay, or give or pay, directly or indirectly, a rebate or adjustment of the rate payable on the service contract, or an advantage in the services thereunder, except as reflected in the rate and expressly provided in the service contract. Readjustment of the rate for services provided under the service contract may be made at the end of any contract year or contract period and may be made retroactive.

(d) Make, issue, or circulate, or cause to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of a service contract, the advantages provided thereunder, or the true nature thereof.

(e) Make a misrepresentation in a comparison, whether oral or written, between service contracts of the insurer or between service contracts of the insurer and another insurer, health care corporation, health maintenance organization, or other person.

(4) When the commissioner has probable cause to believe that an insurer is violating, or has violated subsection (2), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has probable cause to believe that an insurer is violating or has violated subsection (3), he or she shall give written notice to the insurer, pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, setting forth the general nature of the complaint against the insurer and the proceedings contemplated under this section. Before the issuance of a notice of hearing, the staff of the bureau of insurance responsible for the matters which would be at issue in the hearing shall give the insurer an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or a representative of the commissioner, and the matter may be disposed of summarily upon agreement of the parties. This subsection shall not be construed to diminish the right of a person to bring an action for damages under this section.

(5) A hearing held pursuant to subsection (4) shall be held pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. If, after the hearing, the commissioner determines that the insurer is violating, or has violated subsection (2), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has violated or is violating subsection (3), the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the insurer a copy of the findings and an order requiring the insurer to cease and desist from engaging in the prohibited activity. The commissioner may at any time, by order, and after notice and opportunity for a hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued by him or her under this subsection, when in his or

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her opinion conditions of fact or law have so changed as to require that action, or if the public interest so requires.

(6) An insurer providing services under section 5208 in connection with a noninsured benefit plan shall process claims for benefits on a timely basis. When not paid on a timely basis, benefits payable to a covered individual shall bear simple interest from a date 60 days after a satisfactory claim form was received by the insurer, at a rate of 12% interest per annum. The interest shall be paid by the noninsured benefit plan in addition to, and at the time of payment of, the claim.

(7) An insurer providing services under section 5208 in connection with a noninsured benefit plan shall specify in writing the materials which constitute a satisfactory claim form not later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form shall be considered to be paid on a timely basis if paid within 60 days after receipt of the claim form by the insurer.

(8) An insurer providing the services under section 5208 in connection with a noninsured benefit plan shall provide in its service contract a provision that the person contracting for the services in connection with a noninsured benefit plan shall notify each covered individual what services are being provided; the fact that individuals are not insured or are only partially insured, as the case may be; which party is liable for payment of benefits; and of future changes in benefits.

(9) An insurer which violates this section shall be subject to the same penalties as provided in section 2038.

(10) The sections and subsections of this act are declared to be severable and if any court of competent jurisdiction finds that any section or subsection is invalid, the remaining sections or subsections shall remain in full force and effect.

History: Add. 1981, Act 189, Imd. Eff. Dec. 29, 1981;—Am. 1998, Act 26, Imd. Eff. Mar. 12, 1998.

Popular name: Act 218

500.5209 Insurer's name; restrictions.

Sec. 5209. Except as otherwise provided in this section, an insurer shall transact its business under its own name and shall not adopt any assumed name. An insurer, by amending its articles of incorporation, may change its name or take a new name. A nonprofit mutual disability insurer into which a nonprofit health care corporation that is organized under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704, is merged or consolidated may retain and use trade names in use by the nonprofit health care corporation before the merger or consolidation.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2013, Act 5, Imd. Eff. Mar. 18, 2013.

Popular name: Act 218

500.5210 Dealing in commodities prohibited; exception.

Sec. 5210. No domestic property or marine or inland navigation and transportation, or automobile (limited) insurer shall, directly or indirectly, deal or trade in buying or selling any goods, wares, merchandise or other commodities whatever, excepting such articles as may have been insured by such insurer, and are claimed to be damaged by fire or water.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5214 Articles of incorporation; amendment.

Sec. 5214. (1) An insurer may amend its articles of incorporation at any annual meeting of the stockholders or members or at any special meeting called by the directors for that purpose.

(2) Notice of any annual or special meeting and of the purpose for which it is called shall be served on each of the stockholders, or if it is a mutual company on each of the members, in the following prescribed manner:

(a) Notice by mail shall be considered sufficient if directed to the last known address of each stockholder or member, at least 21 days immediately preceding the meeting.

(b) Notice by publication shall be considered sufficient if published in a newspaper printed and published within this state, and having general circulation within the county or counties in which the company is transacting business. The notice shall be published each week for 3 consecutive weeks immediately preceding the date of the meeting provided that the last notice must be published at least 5 days before the meeting.

(3) The insurer shall furnish the commissioner with a true copy of the notice, supported by evidence of mailing or publication and shall also furnish the commissioner with an extract subscribed to by the president and secretary from so much of the minutes of the meeting as relates to the adoption of any amendment or

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amendments.

(4) Amendments to the articles of incorporation shall not take effect until submitted to the attorney general and certified by him or her as not in conflict with the constitution or laws of this state. The insurer shall pay to the attorney general the examination fee provided for in section 240(2). The amendments shall be filed in duplicate with the commissioner, 1 copy to be retained by the commissioner and 1 copy to be returned to the insurer with a certified copy of the certificate of approval of the commissioner attached.

(5) All amendments to the articles of incorporation shall be upon the form prescribed by the commissioner.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.5215 Articles of domestic stock insurer; amendment as to increase, decrease, or reclassification of capital stock.

Sec. 5215. (1) A domestic stock insurer may increase or decrease its authorized capital stock or reclassify the same by changing the number, par value, designations, preferences or relative participating, optional or other special rights of the shares, or the qualifications, limitations, or restrictions of such rights as provided in this section. The par value of stock provided for in any amendment shall conform to the same limitations as to par value as provided for stock issued pursuant to original articles of incorporation.

(2) If a domestic stock insurer proposes to increase, decrease, or reclassify its capital stock, it shall first present its petition to the commissioner setting forth the reasons for the increase, decrease, or reclassification. The commissioner, if satisfied that the proposed increase or decrease is for the best interests of the insurer and its policyholders, and that no reasonable objection exists, may authorize and approve the proposed plan of increase or decrease, or may direct such modification of the plan as may seem proper. After the approval of the petition by the commissioner, the increase or decrease must be approved and the articles of incorporation amended in this respect, by written consent given without a meeting or by the affirmative vote in person or by proxy at a regular or special meeting of the stockholders of not less than a majority of the capital stock of the insurer having voting power. Notice of the meeting and the purpose for which the meeting is called shall be served on each of the stockholders, either personally or by mail to the last known address of each stockholder at least 3 weeks prior to the meeting. However, if any proposed amendment would alter or change the preferences, special rights, or powers given to any 1 or more classes of stock by the articles of incorporation so as to affect that class or those classes of stock adversely or would increase or decrease the amount of the authorized stock of that class or those classes of stock adversely or would increase or decrease the par value of 1 or more classes of stock, then the holders of the stock of each class of stock so affected by the amendment shall be entitled to give written consent or vote as a class upon the amendment regardless of whether the terms of the articles of incorporation entitle the class to vote or not, and the affirmative action of a majority in interest of each class of stock so affected by the amendment shall be necessary for its adoption in addition to the affirmative action of the majority of all stock entitled to vote on an amendment as is required by law for its adoption. Separate action of any class of stock proposed to be increased or decreased shall not be required if the provisions of the articles of incorporation or amendment to the articles creating the class shall have authorized the increase or decrease without separate action.

(3) An amendment to the articles of incorporation shall not become effective until finally approved by the commissioner and until submitted to the attorney general and certified by him or her as not to be in conflict with the constitution or laws of this state. Amendments to the articles of incorporation shall be filed in duplicate with the commissioner, 1 copy to be retained by the commissioner and 1 copy to be returned to the insurer with a certified copy of the certificate of the approval of the commissioner attached.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957;—Am. 1966, Act 221, Imd. Eff. July 11, 1966;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.5216 Articles; amendment as to reduction of capital; condition; methods of effecting reduction.

Sec. 5216. (1) Any such stock life, disability, casualty, title or fidelity and surety insurer may by provision in its articles of incorporation or by amendment thereto made as in section 5215 provided authorized the reduction of its capital at any time and it may reduce its capital in conformity therewith. A certificate stating the fact that such reduction has been made in conformity with the articles of incorporation or amendments thereto, giving the wording of the resolution authorizing the same and the vote thereon, specifying the manner in and the extent to which the capital of the corporation is to be reduced, shall be made and filed as provided for certificates of amendment to the articles of incorporation.

(2) No such reduction, however, shall be made in the capital of the insurer unless the assets of the insurer

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remaining after such reduction are sufficient to pay any debts of the insurer, the payment of which shall not have been otherwise provided for, nor if in the opinion of the commissioner to whom such certificate shall be submitted before being filed such reduction of capital shall endanger the protection of policyholders. Upon such certificate being so made and filed, the capital of the insurer shall thereby be so reduced.

(3) Such reduction of the capital of the insurer may be effected by retiring or reducing the outstanding shares of any class or by drawing the necessary number of the outstanding shares of any class by lot for retirement or by the exchange by the holders of outstanding shares of any class of the shares of such class held by them for a decreased number of shares of stock of the same or of a different class of stock or by reducing in the manner herein provided the par value of the shares of any class of stock having par value, or where the amount of capital represented by shares of stock having par value exceeds such par value by reducing the amount of capital represented by such shares by an amount not greater than such excess, or in case the capital shall have been increased by the transfer thereto from surplus pursuant to any provision of law so authorizing and the transfer shall not have been made in respect of any designated class or classes of stock by retransferring to surplus all or any part of the amount by which capital shall have been so increased or by the purchase of shares for retirement either pro rata from all holders of shares of that class or stock or by purchasing such shares from time to time in the open market or at private sale in both cases at not exceeding such price or prices as may be fixed or approved by the stockholders entitled to vote upon the reduction of capital to be effected in that manner or by retiring shares owned by the corporation. If such reduction of capital of the corporation be effected by retiring shares then if the consent or resolution of stockholders above referred to shall so provide an amount not exceeding that part of the capital of the insurer represented by such shares may be charged against or paid out of the capital of the insurer in respect of such shares. If such reduction of capital shall have been effected by retiring or reducing the outstanding shares of any class in any manner above mentioned including the retirement of shares already owned by the insurer, the filing of said certificate as herein provided containing a recital of such fact shall constitute an amendment to the articles of incorporation effecting a reduction of the authorized capital stock of the insurer to the extent of the aggregate par value of such shares and if such shares constitute all the outstanding shares of any particular class shall have the effect of eliminating from the articles of incorporation all reference to said particular class of stock.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1966, Act 221, Imd. Eff. July 11, 1966.

Popular name: Act 218

500.5218 Increase or decrease of capital stock; authorization by commissioner; approval by stockholders; vote; final approval; par value of stock; issuance of new stock.

Sec. 5218. (1) A domestic stock property, marine, inland navigation and transportation, or automobile (limited) insurer may increase or decrease its capital stock in the manner herein provided. When any such insurer proposes to increase or decrease its capital stock it shall first present its petition to the commissioner, setting forth the reasons for such increase or decrease. The commissioner, if satisfied that the proposed increase or decrease is for the best interests of the insurer and its policyholders, and that no reasonable objection exists thereto, may authorize and approve the proposed plan of increase or decrease, or may direct such modification thereof as may seem proper.

(2) After the approval of the petition as aforesaid, such increase or decrease must be approved, and the articles of incorporation amended in this respect, by the affirmative vote of not less than 2/3 of the capital stock of the insurer, voting in person or by proxy, at a regular or special meeting of the stockholders, but notice of such meeting, reciting the purposes thereof, shall be served on each of the stockholders, either personally or by directing same through the post office to the last known post office address of such stockholder at least 3 weeks previous to such meeting.

(3) Such increase or decrease shall not become effective until finally approved by the commissioner, and until compliance is made with the requirements of section 5214.

(4) Whenever any insurer shall increase or decrease its capital stock as herein provided, the par value of its shares shall be fixed at not less than $1.00 nor more than $100.00 each, and the directors of the insurer shall have authority to make provision for calling in the old and issuing new certificates of stock.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5220 Blank forms for amending articles.

Sec. 5220. The commissioner shall prepare and keep on hand blank forms covering the procedure for amending articles of incorporation of domestic insurers, which forms may be had on application, and shall be used by all insurers hereafter amending their articles of incorporation.

History: 1956, Act 218, Eff. Jan. 1, 1957.

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Popular name: Act 218

500.5222 Corporate life; extension.

Sec. 5222. An insurance corporation whose term is about to expire by limitation may, at any time within 2 years before the expiration of the term, by a vote of a majority of its capital stock or its members present and voting, or if a fraternal benefit society by a majority vote of its governing body or board, as the case may be, at any annual meeting or at any special meeting of its stockholders, or members, or governing body or board, as the case may be, called for that purpose, upon such notice as is provided for in the case of amendments to articles of incorporation by section 5214, direct the continuance of its corporate existence for a further term, not less than 30 years from the expiration of the existing term, as may be expressed in a resolution for that purpose. The president and secretary of the members or governing body or board or stockholders' meeting shall make and sign duplicate copies of the resolution, and its passage shall be verified by the oath of the secretary attached to each of the copies. One of the copies shall be filed in the office of the commissioner and the filed copy or a certified copy of it shall be prima facie evidence of the passage of the resolution and of the extension of the corporate life. However, the filing fee prescribed by section 240(1)(a), for insurers organized in this state, shall be paid before the term shall be extended. This action may also be taken after the expiration of a charter, with the consent in writing of the commissioner. The commissioner shall give this consent only if the commissioner has determined, after examination of the corporation, that the corporation is safe, reliable, and entitled to public confidence. The renewal term of the corporation shall begin from the expiration of the former term, and the corporation whose term has thus been renewed shall be the same corporation and own all its property, and be subject to all its liabilities, and shall have the same stockholders and members and the same officers. The rights of all persons interested in the corporation shall continue as before such extension. The articles of incorporation and bylaws shall continue the same until changed or amended by the corporation in the manner required by law.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1984, Act 365, Imd. Eff. Dec. 27, 1984;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.5224 Corporate life; expiration, liquidation.

Sec. 5224. In case the stockholders or members thereof shall not, before the expiration of the corporate existence of a domestic insurer organize a new corporation for the same purposes, on the basis of receiving the assets of the old corporation, and assuming the performance of all its existing contracts and policies, the officers of such corporation, at the expiration of its corporate life, shall be trustees for the purpose of keeping its funds invested for the security of policyholders, settling its affairs, and fulfilling and discharging its obligations, and as such, shall be under the control and direction of the proper circuit court in chancery, or other equity court, as in the case of other trustees; but the officers of such corporation shall not, at the time of the termination of the corporate existence, or in anticipation thereof, make or declare any dividend, or, except in satisfaction of the demands of creditors or policyholders, make any other disposition of the assets of the corporation, or any part thereof, which shall leave the available amount of such assets below the amount of existing debts and of the net value of outstanding policies, to be determined as hereinbefore provided; and any such attempted dividend or distribution shall be void, and may be enjoined on the application of the commissioner; and such officers, before entering upon their duties as such trustees, shall give bond to the people of the state to the satisfaction of the commissioner and to be filed with him, conditioned for the faithful discharge of their duties as such; and they shall be at all times subject to the supervision of the commissioner, in the same manner that corporations are under the provisions of this code; but such trustees shall not make dividends among stockholders, nor to members, unless in reduction of premiums on outstanding policies, except under the order of the proper court of equity; nor shall such court order any such dividends as shall at any time reduce the available assets of the company below the amount of existing debts and the net value of outstanding policies, to be determined as hereinbefore provided.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5228 Bylaws; adoption; filing.

Sec. 5228. (1) The stockholders or members of a corporation may adopt bylaws that they consider advisable. Bylaws adopted under this subsection may provide 1 or both of the following:

(a) One or more directors may participate in a regular or special meeting of the board, or a committee of the board, or conduct the meeting, by means of electronic communication devices that enable all participants in the meeting to communicate with each other. A director participating in a meeting allowed under this

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subdivision is deemed to be present in person at a meeting.

(b) Any meeting of the stockholders or members may be conducted by means of electronic communications devices by which all stockholders or members participating may simultaneously participate in the meeting. A stockholder or member participating in a meeting allowed under this subdivision is deemed to be present in person at a meeting.

(2) The directors of a domestic insurer may make bylaws, not inconsistent with the constitution and laws of this state, or with the insurer's articles of incorporation, as they consider necessary for the government of the officers and members of the insurer, and the conduct of its affairs. All bylaws and any amendments to the bylaws must be filed with the director of the department before becoming operative.

(3) If bylaws adopted under subsection (1) need to be amended to allow meetings through electronic communication devices described in subsection (1), an amendment to the bylaws may be adopted at a meeting conducted through electronic communication devices described in subsection (1).

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 2020, Act 266, Imd. Eff. Dec. 29, 2020;—Am. 2023, Act 28, Imd. Eff. May 8, 2023.

Popular name: Act 218

500.5230 Special meetings of stockholders or members; notice of meetings.

Sec. 5230. (1) A special meeting of the stockholders or members of a domestic stock or mutual insurer may be called for purposes other than amending articles of incorporation under section 5214 and extending its corporate existence under section 5222, by the directors at any time they consider advisable.

(2) Notice of a meeting of the members or stockholders must be given by mailing to each member or stockholder a copy of the notice, postage prepaid, directed to his or her last known post office address at least 21 days before the time fixed for the meeting. The notice must state the time and place, and if the meeting is a special meeting, the purpose of the special meeting. However, notice of the time and place of the annual meeting of a mutual insurer may be printed on the policy or certificate of renewal instead of mailing as required under this subsection, in which case the notice must also be printed with the annual statement of the insurer.

(3) A meeting of the stockholders or members may be conducted by means of electronic communications devices by which all stockholders or members participating may simultaneously participate in the meeting. A stockholder or member participating in a meeting allowed under this subsection is deemed to be present in person at a meeting.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2020, Act 266, Imd. Eff. Dec. 29, 2020;—Am. 2023, Act 28, Imd. Eff. May 8, 2023
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Popular name: Act 218

500.5232 Voting rights; stockholders, members, proxies, fiduciaries, pledgees.

Sec. 5232. Each stockholder or member of a domestic stock or mutual insurer shall at every meeting of the stockholders or members thereof be entitled to vote in person or by proxy in writing signed by such stockholder or member: Provided, That for insurers having only members and no stockholders, voting by proxy after June 1, 1943, shall be permitted only if provided in the articles or in any bylaw adopted by the members. Persons holding shares of the capital stock of any such insurer in a fiduciary capacity shall be entitled to vote the shares so held. Persons whose shares are pledged shall be entitled to vote, unless in the transfer by the pledgor on the books of the corporation he shall have expressly empowered the pledgee to vote thereon, in which case only the pledgee or his proxy may represent such shares and vote thereon.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5234 Stockholders and members; voting rights, quorum.

Sec. 5234. A majority of the shares entitled to vote on a particular subject matter at any meeting of the stockholders shall constitute a quorum for such vote unless otherwise provided by law or in the articles or in any bylaw adopted by the stockholders. A minimum of 10 members present in person shall constitute a quorum at any meeting of those insurers having members only and no stockholders, unless a larger number is specified in the articles or in any bylaw adopted by the members.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5236 Voting rights; inspectors of election.

Sec. 5236. Whenever any stockholder or member present at a meeting of stockholders or members of an

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insurer shall request the appointment of inspectors, the chairman of the meeting shall appoint inspectors who need not be stockholders or members. If the right of any person to vote at such meeting shall be challenged, the inspectors of election shall determine such right. The inspectors shall receive and count the votes either upon an election or the decision of any question and shall determine the result. Their certificate of any vote shall be prima facie evidence thereof.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5238 Trustees or directors; residency requirement; director as policyholder of insurer; meetings; frequency; oath.

Sec. 5238. (1) In all insurers organized under the laws of Michigan, at least 1 of the trustees or directors shall be a resident of the state of Michigan. The articles of incorporation or bylaws of an insurer other than a stock insurer may provide that a director shall be a policyholder of the insurer.

(2) The board of directors of a domestic insurer shall meet not fewer than 4 times per fiscal year in person or by means of electronic communication devices that enable all participants in a meeting to communicate with each other.

(3) Each director of a domestic insurer when elected or appointed shall take and subscribe an oath that he or she will diligently and honestly perform the duties of the office and will not knowingly violate, or knowingly permit to be violated, any provisions of this act. The oath shall be transmitted to the commissioner for filing.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1962, Act 48, Eff. Mar. 28, 1963;—Am. 1982, Act 338, Imd. Eff. Dec. 17, 1982;—Am. 1989, Act 139, Eff. July 1, 1989;—Am. 2006, Act 291, Imd. Eff. July 20, 2006.

Popular name: Act 218

500.5239 Repealed. 1988, Act 290, Eff. Jan. 1, 1989.

Compiler's note: The repealed section pertained to liability of directors for delinquency.

Popular name: Act 218

500.5240 Discharging duties of director or officer; commencement of action for failure to perform duties.

Sec. 5240. (1) A director or an officer shall discharge the duties of that position in good faith and with that degree of diligence, care, and skill which an ordinarily prudent person would exercise under similar circumstances in a like position. In discharging his or her duties, a director or an officer, when acting in good faith, may rely upon the opinion of counsel for the corporation, upon the report of an independent appraiser selected with reasonable care by the board, or upon financial statements of the corporation represented to him or her as correct by the president or the officer of the corporation having charge of its books of account, or as stated in a written report by an independent public or certified public accountant or firm of accountants fairly to reflect the financial condition of the corporation.

(2) An action against a director or officer for failure to perform the duties imposed by this section shall be commenced within 3 years after the cause of action has accrued, or within 2 years after the time when the cause of action is discovered, or should reasonably have been discovered, by the complainant, whichever occurs first.

History: Add. 1988, Act 290, Eff. Jan. 1, 1989.

Popular name: Act 218

500.5241 Indemnification against expenses of action, suit, or proceeding generally.

Sec. 5241. A corporation has the power to indemnify a person who was or is a party or is threatened to be made a party to a threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative and whether formal or informal, other than an action by or in the right of the corporation, by reason of the fact that he or she is or was a director, officer, employee, or agent of the corporation, or is or was serving at the request of the corporation as a director, officer, partner, trustee, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, or other enterprise, whether for profit or not, against expenses, including attorneys' fees, judgments, penalties, fines, and amounts paid in settlement actually and reasonably incurred by him or her in connection with the action, suit, or proceeding, if the person acted in good faith and in a manner he or she reasonably believed to be in or not opposed to the best interests of the corporation or its shareholders or policyholders, and with respect to a criminal action or proceeding, if the person had no reasonable cause to believe his or her conduct was unlawful. The termination of an action, suit, or proceeding by judgment, order, settlement, conviction, or

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upon a plea of nolo contendere or its equivalent, does not, of itself, create a presumption that the person did not act in good faith and in a manner which he or she reasonably believed to be in or not opposed to the best interests of the corporation or its shareholders or policyholders, and, with respect to a criminal action or proceeding, had reasonable cause to believe that his or her conduct was unlawful.

History: Add. 1988, Act 290, Eff. Jan. 1, 1989.

Popular name: Act 218

500.5242 Indemnification against expenses of action, suit, or proceeding; additional provisions.

Sec. 5242. A corporation has the power to indemnify a person who was or is a party to or is threatened to be made a party to a threatened, pending, or completed action or suit by or in the right of the corporation to procure a judgment in its favor by reason of the fact that he or she is or was a director, officer, employee, or agent of the corporation, or is or was serving at the request of the corporation as a director, officer, partner, trustee, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, or other enterprise, whether for profit or not, against expenses, including actual and reasonable attorneys' fees, and amounts paid in settlement incurred by the person in connection with the action or suit, if the person acted in good faith and in a manner the person reasonably believed to be in or not opposed to the best interests of the corporation or its shareholders or policyholders. However, indemnification shall not be made for a claim, issue, or matter in which the person has been found liable to the corporation unless and only to the extent that the court in which the action or suit was brought has determined upon application that, despite the adjudication of liability but in view of all circumstances of the case, the person is fairly and reasonably entitled to indemnification for the expenses which the court considers proper.

History: Add. 1988, Act 290, Eff. Jan. 1, 1989.

Compiler's note: Former MCL 500.5242, which prohibited an insurance company from controlling other insurers, was repealed by Act 91 of 1957, Eff. Sept. 27, 1957.

Popular name: Act 218

500.5242a Indemnification against expenses of action, suit, or proceeding; mandatory; standard of conduct; determination.

Sec. 5242a. (1) To the extent that a director, officer, employee, or agent of a corporation has been successful on the merits or otherwise in defense of an action, suit, or proceeding referred to in section 5241 or 5242, or in defense of a claim, issue, or matter in the action, suit, or proceeding, he or she shall be indemnified against expenses, including actual and reasonable attorneys' fees, incurred by him or her in connection with the action, suit, or proceeding and an action, suit, or proceeding brought to enforce the mandatory indemnification provided in this subsection.

(2) An indemnification under section 5241 or 5242, unless ordered by a court, shall be made by the corporation only as authorized in the specific case upon a determination that indemnification of the director, officer, employee, or agent is proper in the circumstances because he or she has met the applicable standard of conduct set forth in sections 5241 and 5242. This determination shall be made in any of the following ways:

(a) By a majority vote of a quorum of the board consisting of directors who were not parties to the action, suit, or proceeding.

(b) If the quorum described in subdivision (a) is not obtainable, then by a majority vote of a committee of directors who are not parties to the action. The committee shall consist of not less than 2 disinterested directors.

(c) By independent legal counsel in a written opinion.

(d) By the shareholders or policyholders.

(3) If a person is entitled to indemnification under section 5241 or 5242 for a portion of expenses including attorneys' fees, judgments, penalties, fines, and amounts paid in settlement, but not for the total amount thereof, the corporation may indemnify the person for the portion of the expenses, judgments, penalties, fines, or amounts paid in settlement for which the person is entitled to be indemnified.

History: Add. 1988, Act 290, Eff. Jan. 1, 1989.

Popular name: Act 218

500.5242b Payment of expenses in advance of final disposition of action, suit, or proceeding; undertaking.

Sec. 5242b. Expenses incurred in defending a civil or criminal action, suit, or proceeding described in section 5241 or 5242 may be paid by the corporation in advance of the final disposition of the action, suit, or proceeding upon receipt of an undertaking by or on behalf of the director, officer, employee, or agent to repay

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the expenses if it is ultimately determined that the person is not entitled to be indemnified by the corporation. The undertaking shall be by unlimited general obligation of the person on whose behalf advances are made but need not be secured.

History: Add. 1988, Act 290, Eff. Jan. 1, 1989.

Popular name: Act 218

500.5242c Indemnification or advancement of expenses not exclusive of other rights; indemnification inuring to benefit of heirs, executors, and administrators.

Sec. 5242c. (1) The indemnification or advancement of expenses provided under sections 5241 to 5242b is not exclusive of other rights to which a person seeking indemnification or advancement of expenses may be entitled under the articles of incorporation, bylaws, or a contractual agreement. However, the total amount of expenses advanced or indemnified from all sources combined shall not exceed the amount of actual expenses incurred by the person seeking indemnification or advancement of expenses.

(2) The indemnification provided for in sections 5241 to 5242b continues as to a person who ceases to be a director, officer, employee, or agent and shall inure to the benefit of the heirs, executors, and administrators of the person.

History: Add. 1988, Act 290, Eff. Jan. 1, 1989.

Popular name: Act 218

500.5242d "Corporation" defined for purposes of MCL 500.5241 to 500.5242c.

Sec. 5242d. For purposes of sections 5241 to 5242c, "corporation" includes all constituent corporations absorbed in a consolidation or merger and the resulting or surviving corporation, so that a person who is or was a director, officer, employee, or agent of the constituent corporation or is or was serving at the request of the constituent corporation as a director, officer, partner, trustee, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, or other enterprise whether for profit or not shall stand in the same position under the provisions of this section with respect to the resulting or surviving corporation as the person would if he or she had served the resulting or surviving corporation in the same capacity.

History: Add. 1988, Act 290, Eff. Jan. 1, 1989.

Popular name: Act 218

500.5243 Repealed. 1988, Act 290, Eff. Jan. 1, 1989.

Compiler's note: The repealed section pertained to indemnification and reimbursement of directors, officers, or employees.

Popular name: Act 218

500.5244 Liability for payment under invalid law or ordinance.

Sec. 5244. No personal liability shall arise against any director, trustee, officer, or agent of any insurer by reason of any payment made by or on behalf of such insurer on account of any taxes, licenses, or fees paid pursuant to any statute, law, or ordinance, even though the statute, law, or ordinance is subsequently declared or held to be invalid.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1966, Act 217, Eff. Mar. 10, 1967;—Am. 1988, Act 290, Eff. Jan. 1, 1989.

Popular name: Act 218

500.5245 Board of directors; quorum; special meetings; consent to action taken without meeting.

Sec. 5245. (1) A majority of the board of directors constitutes a quorum for the transaction of business, and the acts of a majority of the directors present at a meeting at which a quorum is present are the acts of the board of directors.

(2) On written notice of the time and place and purpose or purposes of any special meeting, any of the directors, in-between regular meetings of the board of directors, may consent in writing to any specific action to be taken by the corporation, and if approved by a majority of the directors at the special meeting, including those consenting in writing, the action is as valid a corporation action as though authorized at a regular meeting of the directors. The minutes of approval and action must be fully recorded, each written consent must be made a part of the minutes, and the minutes and written consent must be reviewed at the next regular meeting of the board of directors.

(3) Unless prohibited by the articles of incorporation or bylaws, action required or permitted to be taken under authorization voted at a meeting of the board or a committee of the board may be taken without a meeting if, before or after the action, all members of the board then in office or of the committee consent to the action in writing or by electronic transmission. The written consents must be filed with the minutes of the

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proceedings of the board or committee. The consent has the same effect as a vote of the board or committee for all purposes.

(4) The board of directors may permit 1 or more directors to participate in a regular or special meeting of the board, or a committee of the board, or conduct the meeting, by means of electronic communication devices that enable all participants in the meeting to communicate with each other. A director participating in a meeting under this subsection is deemed to be present in person at the meeting.

History: Add. 1966, Act 170, Eff. Mar. 10, 1967;—Am. 2006, Act 290, Imd. Eff. July 20, 2006;—Am. 2020, Act 266, Imd. Eff. Dec. 29, 2020;—Am. 2023, Act 28, Imd. Eff. May 8, 2023.

Popular name: Act 218

500.5246 Officers and agents; appointment, removal, bond.

Sec. 5246. The board of directors of a domestic insurer shall select a president, a secretary, and a treasurer, or such equivalent officers as may be designated in its articles or bylaws, and may select 1 or more vice-presidents, assistant secretaries and assistant treasurers. Any 2 of the above offices except those of president and vice-president may, unless otherwise provided by the bylaws, be held by the same person but no officer shall execute, acknowledge, or verify an instrument in more than 1 capacity. The board may also appoint such other officers and agents as they may deem necessary for the transaction of the business of the corporation. All officers and agents shall respectively have such authority and perform such duties in the management of the property and affairs of the corporation, as may be delegated by the board of directors. Any officer or agent may be removed by the board of directors whenever in their judgment the business interests of the corporation will be served thereby. The board of directors may secure the fidelity of any or all of such officers by bond or otherwise. Unless otherwise provided in the articles or bylaws, the board of directors shall have power to fill any vacancies in any offices occurring from whatever reason.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5248 Directors, officers, and employees of domestic insurer; compensation.

Sec. 5248. (1) No domestic insurer shall pay any salary, compensation, or emolument to any officer or director of the domestic insurer unless the payment is first authorized by a vote of the board of directors of the insurer.

(2) A director, officer, or employee of a domestic insurer shall not be compensated unreasonably. The compensation of any director or officer of a domestic insurer shall not be calculated, directly or indirectly, as a percentage of premiums collected or insurance written by the insurer, without the approval of the commissioner.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957;—Am. 1959, Act 30, Eff. Mar. 19, 1960;—Am. 1963, Act 69, Eff. Sept. 6, 1963;—Am. 1965, Act 243, Imd. Eff. July 21, 1965;—Am. 2006, Act 289, Imd. Eff. July 20, 2006.

Popular name: Act 218

500.5252 Director or officer of insurance corporation; receiving money or valuables for, or having pecuniary interest in, purchase, sale, or loan prohibited; certain transactions not prohibited; issuing certificate of exemption; hearing; refusal to issue certificate; order; judicial review; violation as felony; penalty.

Sec. 5252. (1) A director or officer of an insurance corporation doing business in this state shall not knowingly and intentionally, directly or indirectly, receive any money or valuable thing for negotiating, procuring, recommending, or aiding in any purchase by or sale to such corporation of any property or any loan from such corporation, or be pecuniarily interested, either as principal, co-principal, agent, or beneficiary in any such purchase, sale, or loan. This section does not:

(a) Prohibit a life insurer from making a loan upon a policy held by the borrower not in excess of the net value of the policy.

(b) Prohibit an insurer, in connection with the relocation of the place of employment of an officer, from:

(*i*) Making a loan to the officer for a mortgage on real estate which is to be used as the officer's residence as long as the loan does not exceed the fair market value of the property.

(*ii*) Acquiring the officer's residence at not more than its fair market value.

(c) Prohibit an officer of an insurer, in connection with the relocation of his or her place of employment, from:

(*i*) Accepting a loan from the insurer for a mortgage on real estate which is to be used as the officer's residence as long as the loan does not exceed the fair market value of the property.

(*ii*) Selling the officer's home to the insurer at not more than its fair market value.

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(d) Prohibit the conveyance of property between an insurer and an officer or director of an insurer if all of the following occur:

(*i*) Any interest in the conveyance on the part of any officer or director is disclosed or known to its board of directors or committee which authorizes, approves, or ratifies the conveyance, and noted in the minutes thereof, and the board or committee authorizes, approves, or ratifies the conveyance by a vote sufficient for the purpose without counting the vote or votes of any interested officer or director, however, an interested officer or director may be counted for purposes of a quorum.

(*ii*) The fact of such interest is disclosed, before or after the conveyance, to the shareholders in the case of a stock insurance company, or in the case of a mutual insurer, to the policyholders.

(*iii*) The insurer has obtained from the commissioner a certificate of exemption permitting the specific transaction. An insurer seeking to obtain a certificate of exemption shall file with the commissioner a written request for a certificate of exemption, which request shall include all of the following:

(A) A full description and disclosure of the transaction for which the certificate is sought.

(B) Copies of all contracts or other legal documents involved or to be involved in the transaction.

(C) A description of all assets involved in the transaction.

(D) The names, titles, capacities, and business relationships of all persons directly involved in the transaction.

(E) A description of any and all consideration on either or any side of the transactions.

(F) Such other information, opinions, or matters as the commissioner may reasonably require.

(2) The commissioner shall issue a certificate of exemption within 30 days after a request for a certificate of exemption has been received by him or her if the commissioner finds that the specific transaction for which the certificate of exemption is requested is fair, just, and equitable, and is not hazardous to the policyholders, stockholders, or creditors of the insurer.

(3) If the commissioner does not issue the certificate of exemption within such 30 days, the insurer seeking the certificate of exemption shall be entitled to a hearing before the commissioner pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.315 of the Michigan Compiled Laws. The hearing shall be conducted within 60 days after the request for the certificate of exemption has been received by the commissioner. The commissioner may refuse to issue a certificate of exemption if he or she finds that the specific transaction for which the certificate of exemption is requested does not meet the requirements provided in subsection (2). In the order refusing the request for a certificate of exemption, the commissioner shall set forth in what respect the specific transaction fails to meet the requirements of subsection (2). The decision of the commissioner shall be subject to judicial review as provided in the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969.

(4) Any person violating any provision of this section shall be guilty of a felony and upon conviction shall be punished by a fine not exceeding $5,000.00, or by imprisonment for a term not to exceed 5 years, or by both such fine and imprisonment, in the discretion of the court.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1968, Act 305, Eff. Nov. 15, 1968;—Am. 1982, Act 292, Imd. Eff. Oct. 7, 1982;—Am. 1984, Act 263, Imd. Eff. Dec. 14, 1984.

Popular name: Act 218

500.5256 Records relating to insurer's business or affairs; locations; production; safekeeping of securities, notes, mortgages, or other evidences of indebtedness; exceptions; holding certificates in name of nominee; indorsement; control or possession of certificate; reproduction of records; removal of records; hearing; findings, decision, and order; violation of section; liability; failure to comply with order; transfer of domicile.

Sec. 5256. (1) Each domestic insurer shall keep under its control all records relating to the insurer's business or affairs at 1 or more of the following locations:

(a) The principal place of doing business in this state.

(b) One or more locations outside the state approved for that purpose, in writing, by the commissioner.

(2) A domestic insurer shall produce those records relating to the insurer's business or affairs and personnel knowledgeable about the records at a principal place of doing business in or outside this state for examination within a reasonable time period specified by the commissioner.

(3) A domestic insurer may place for safekeeping all or any part of its securities, notes, mortgages, or other evidences of indebtedness, with any national bank, state bank, trust company, or any other United States corporation authorized as a custodian to accept and hold personal property for safekeeping. A national bank, state bank, trust company, or United States corporation authorized to accept and hold personal property for safekeeping may employ a subcustodian outside of the United States to hold assets that are not in physical form or that are customarily traded outside the United States. A statutory deposit required by any state or

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foreign country shall be excepted and any delivery and pledge or assignment of its notes, mortgages, or other securities by any such insurer, as security for money borrowed by it or as required in the regular course of its business by the laws of any state or foreign country, shall also be excepted. The insurer may hold certificates evidencing shares of stock or other registrable securities in the name of a nominee or nominees employed by the insurer and responsible to the insurer. The nominee or nominees, on the request of the insurer, shall indorse the certificate representing shares of stock or other registrable securities in blank or by assignment separate from the certificates. The insurer at all times shall maintain control or possession of the certificate representing the share of stock or other registrable securities, but, if necessary, the nominee or nominees may have access thereto for the purpose of examination under the supervision of the corporation.

(4) The records required to be retained by this section may be maintained in paper, photograph, micro process, magnetic, mechanical or electronic media, or by any process that accurately reproduces or forms a durable medium for the reproduction of a record. If the original document is unavailable, the domestic insurer may produce in an alternative format the same data that was contained on the original document.

(5) Removal of all or a material part of the records of a domestic insurer from this state, except pursuant to a plan or merger or consolidation approved by the commissioner under this act or as may be approved in writing by the commissioner, is prohibited. If after a hearing is held pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the commissioner determines that the insurer has violated this section, the commissioner shall reduce his or her findings and decision to writing and shall issue and cause to be served upon the insurer charged with the violation a copy of the findings and order requiring the insurer to return the office, records, and assets to this state. An insurer that violates this section shall be treated as a foreign insurer for the period of time the records were removed from this state, and the insurer shall be liable for both of the following:

(a) The amount of tax prescribed in section 476a and interest in the amount of 3% of the amount due and unpaid for each month or part of a month that the insurer was in violation of this section.

(b) A penalty of $5,000.00 plus an additional $50.00 for each day that the insurer was not in compliance with this section. A domestic insurer that fails to comply with an order of the commissioner issued under this section is presumed to be no longer safe, reliable, and entitled to public confidence under section 436.

(6) If an insurer fails to comply with an order issued under this section, as modified or extended, the commissioner shall suspend or revoke the insurer's certificate of authority.

(7) The commissioner may require a domestic insurer to transfer its domicile to another state if the commissioner is not satisfied with the production of the records and personnel knowledgeable about the records because all or part of the records or personnel are located outside this state.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1969, Act 318, Eff. Mar. 20, 1970;—Am. 1982, Act 338, Imd. Eff. Dec. 17, 1982;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1990, Act 256, Imd. Eff. Oct. 15, 1990;—Am. 1998, Act 121, Imd. Eff. June 10, 1998.

Popular name: Act 218

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500.5258 Acknowledgments.

Sec. 5258. A corporation may acknowledge any instrument required by law to be acknowledged, by any 1 of its officers or by its attorney appointed by instrument in writing.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5260 Stock certificates; substitutions.

Sec. 5260. (1) In case a certificate for shares of a corporation is lost, stolen or destroyed, a new certificate may be secured as provided for lost or destroyed certificates in section 17 of Act No. 106 of the Public Acts of 1913, which is known as the uniform stock transfer act.

(2) A corporation which voluntarily and in good faith issues a new certificate in lieu of one believed to have been lost, stolen or destroyed, or issues a new certificate in compliance with an order of a court of competent jurisdiction may recognize the person in whose name the new certificate or any certificate thereafter issued in exchange or substitution therefor, is issued, as the owner of the shares described therein for all purposes, including the right to vote and the right to receive payment of dividends, distribution or redemption price, until the owner of the original certificate or a transferee thereof without notice and for value shall enjoin the corporation and the holder of any new certificate or any certificate issued in exchange or substitution therefor from so acting.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Compiler's note: Act 106 of 1913, referred to in this section, was repealed by Act 174 of 1962.

Popular name: Act 218

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500.5264 Expenditures, vouchers, and affidavits.

Sec. 5264. No domestic life insurer shall make any disbursement of $100.00 or more unless the same be evidenced by a voucher signed by or on behalf of the person receiving the money and correctly describing the consideration for the payment. If the expenditure be for both services and disbursements, the voucher shall set forth the services rendered and an itemized statement of the disbursements made. If the expenditure be in connection with any matter pending before any legislative or public body, or before any department or officer of any state or government, the voucher shall correctly describe, in addition, the nature of the matter and of the interest of such insurer therein. When such voucher cannot be obtained the expenditure shall be evidenced by an affidavit describing the character and object of the expenditure and stating the reason for not obtaining the voucher.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5266 Dividends to stockholders; general provision.

Sec. 5266. No dividends shall be declared due and payable to stockholders of any stock insurance company, except out of the surplus earnings of the company unless otherwise provided for in this code.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5267 Dividends to stockholders; domestic fire insurance company.

Sec. 5267. It shall not be lawful for the directors or managers of any domestic fire insurance company to declare any dividend, except from the surplus profits arising from their business; and in estimating such profits, there shall be reserved from its admitted assets a sum equal to the amount of unearned premiums on unexpired risks and policies, and all other outstanding liabilities: Provided, always, That no company may declare dividends exceeding 10%, on its capital stock, in any 1 year, unless it shall have accumulated and be in possession of a surplus, in addition to the amount of its capital stock, and of such dividend, and all outstanding liabilities, equal to 1/4 of the amount of the unearned premiums on risks not terminated at the time of making such dividend or 1/2 of its capital stock, whichever is the greater. Any dividend made contrary to these provisions, shall subject the company making the same to a forfeiture of its corporate rights, and each stockholder receiving it to a liability to the creditors of such company to the extent of the dividend received, in addition to the other penalties and punishments in such case made and provided.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5270 Insurer's rights as stockholder in other corporations.

Sec. 5270. When an insurer shall be a stockholder in any other corporation, as provided for in sections 922 (investment in stocks and bonds), 926 (investment in insurance stocks), and 938 (collateral loans), its president and other officers or any of its directors shall be eligible to the office of director of such insurer the same as if they were individually stockholders therein and an insurer holding such stock shall possess and exercise in respect thereof, all the rights, powers, privileges and liabilities of individual owners or holders of such stock.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957.

Popular name: Act 218

500.5272 Domestic fire insurance company; deficiency of assets; notice; cessation of business; liability.

Sec. 5272. (1) Whenever it shall appear to the commissioner, from examination of any domestic fire insurance company that the assets of the company are insufficient to justify the continuance in business of such company, he may direct the officers thereof to require the stockholders to pay in the amount of such deficiency within such period as he may designate in such requisition, and in case any such company shall fail to pay in and make good the full amount of such deficiency within 30 days after such requisition and direction as aforesaid, the commissioner shall give notice of such failure in some newspaper published in the county where the office of such company is located by its charter. Such notice shall contain a brief statement of the fact of such failure to comply with this section, and shall be published in such paper once in each week for 3 successive weeks.

(2) It shall not be lawful after the first publication of such notice for such company to issue any policy of insurance, or to make any contract for the same, or to transact any business under its charter, except to close

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up its business; and all contracts of insurance and policies issued after such first publication of such notice shall be void and of no binding force, and the person or persons making such contracts or issuing such policy shall be liable, in an action of trover, to the person insured, in double the sum named as premium in such contract or policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5274 Domestic fire insurance company; assessment of stockholders.

Sec. 5274. (1) Any company receiving the requisition from the commissioner provided for in section 5272, shall forthwith call upon its stockholders for such amounts as will make its capital equal to the amount fixed by the articles of incorporation of the company; and in case any stockholder of the company shall fail to pay the amount so called for, after notice personally given or by advertisement, in such time and manner as the commissioner shall approve, it shall be lawful for the company to require the return of the original certificate of stock held by such stockholder, and in lieu thereof to issue new certificates for such number of shares as such stockholder may be entitled to in the proportion that the ascertained value of the funds of the company may be found to bear to the original capital of the company; the value of such shares, for which new certificates shall be issued, to be ascertained under the direction of the commissioner, and the company paying for the fractional parts of shares; and it shall be lawful for the directors of such company to create new stock and dispose of the same, and to issue new certificates therefor, to an amount sufficient to make up the original capital of the company.

(2) Any transfer of the stock of any such company made during the pending of any such investigation, shall not release the party making the transfer from his liability for losses which may have accrued previous to the transfer.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5276 Domestic fire insurance company; liability of directors under new risks accepted during deficiency.

Sec. 5276. In the event of any additional losses accruing upon new risks, taken after the expiration of the period limited by the commissioner in the requisition, pursuant to section 5272, for the filling up of the deficiency in the capital and assets of such company, and before said deficiency shall have been made up, the directors shall be individually liable to the extent thereof.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5280 Domestic mutual insurer; assets; deficiency; liability of director.

Sec. 5280. (1) If, upon examination, it appears to the commissioner that the assets of any domestic mutual insurer are insufficient to justify the continuance of such insurer in business, it shall be his duty to proceed in relation to such insurer in the same manner as is herein required in regard to stock companies; and the directors of such insurer are hereby made personally liable for any losses which may be sustained upon risks taken after the expiration of the period limited by the commissioner for filling up the deficiency in the capital and assets of such company, and before such deficiency shall have been made up.

(2) All the provisions of section 5272 shall apply to such a mutual insurer.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5282 Domestic stock insurer; statement of beneficial ownership of equity securities.

Sec. 5282. Every person who is directly or indirectly the beneficial owner of more than 10% of any class of any equity security of a domestic stock insurance company, or who is a director or an officer of the company, shall file in the office of the commissioner on or before January 31, 1966, or within 10 days after he becomes beneficial owner, director or officer a statement, in such form as the commissioner may prescribe, of the amount of all equity securities of the company of which he is the beneficial owner. Within 10 days after the close of each calendar month thereafter, if there has been a change in ownership during the month, every such person shall file in the office of the commissioner a statement, in such form as the commissioner may prescribe, indicating his ownership at the close of the calendar month and such changes in his ownership as have occurred during the calendar month.

History: Add. 1965, Act 377, Eff. Mar. 31, 1966.

Popular name: Act 218

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500.5283 Unfair use of information; prevention; actions for recovery of profits; limitations; exempt transactions.

Sec. 5283. For the purpose of preventing the unfair use of information which may have been obtained by the beneficial owner, director or officer by reason of his relationship to the company, any profit realized by him from any transfer of any equity security of the company within any period of less than 6 months, unless the security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the company, irrespective of any intention on the part of the beneficial owner, director or officer in entering into the transaction, of holding the security purchased, or of not repurchasing the security sold, for a period exceeding 6 months. Action to recover the profit may be instituted in any court of competent jurisdiction by the company, or by the owner of any security of the company in the name and in behalf of the company if the company fails or refuses to bring the action within 60 days after request or fails diligently to prosecute the action. No action shall be brought more than 2 years after the date the profit was realized. This section shall not be construed to cover any transaction where the beneficial owner was not such at the time the transaction dealing with the security involved, or any transaction which the commissioner by rules and regulations may exempt as not comprehended within the purpose of this section.

History: Add. 1965, Act 377, Eff. Mar. 31, 1966.

Popular name: Act 218

500.5283a Acquisition of stock or stock option; exemption from MCL 500.5283; conditions; definition.

Sec. 5283a. Any acquisition of shares of stock, other than stock acquired upon the exercise of an option, warrant, or right, pursuant to a stock bonus, profit sharing, retirement, incentive, thrift, savings, or similar plan, or any acquisition of an incentive, qualified, or restricted stock option pursuant to an incentive, qualified, or restricted stock option plan, or a stock option pursuant to an employee stock purchase plan, by a director or officer of an insurer issuing the stock or stock option is exempt from the operation of section 5283 if the plan meets the conditions provided in rules R 500.523 and R 500.526 of the Michigan Administrative Code. As used in this section and sections 5283B and 5283C, "Incentive stock option" means that term as defined in section 422A of the internal revenue code.

History: Add. 1984, Act 365, Imd. Eff. Dec. 27, 1984.

Popular name: Act 218

500.5283b Selection of director or officer to whom stock allocated or options granted; exercise of discretion; director or committee member as disinterested person; section inapplicable to certain options or equity securities.

Sec. 5283b. (1) If the selection of any director or officer of the insurer to whom stock may be allocated or to whom incentive, qualified, restricted, or employee stock purchase plan stock options may be granted pursuant to the plan, or the determination of the number or maximum number of shares of stock which may be allocated to any director or officer or which may be covered by incentive, qualified, restricted, or employee stock purchase plan stock options granted to any director or officer, is subject to the discretion of any person, then such discretion shall be exercised only as prescribed in this section.

(2) With the respect to the participation of directors:

(a) By the board of directors of the insurer, a majority of which board and a majority of the directors acting in the matter are disinterested persons.

(b) By, or only in accordance with the recommendations of, a committee of 3 or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons.

(c) In accordance with the plan, if it specifies the number or maximum number of shares of stock which directors may acquire or which may be subject to incentive, qualified, restricted, or employee stock purchase plan stock options granted to directors and the terms upon which, and the times at which, or the periods within which, such stock may be acquired or such options may be acquired and exercised; or sets forth, by formula or otherwise, effective and determinable limitations on such acquisitions or grants based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares, or percentages of outstanding shares, or similar factors.

(3) With respect to the participation of officers who are not directors:

(a) By the board of directors of the insurer or a committee of 3 or more directors.

(b) By, or only in accordance with the recommendations of, a committee of 3 or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons.

(4) For the purpose of this section, a director or committee member shall be deemed to be a disinterested

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person only if he or she is not eligible at the time the discretion is exercised and has not been eligible at any time within 1 year prior thereto for selection as a person to whom stock may be allocated or to whom incentive, qualified, restricted, or employee stock purchase plan stock options may be granted pursuant to the plan or any other plan of the insurer or any of its affiliates entitling the participants therein to acquire stock or incentive, qualified, restricted, or employee stock purchase plan stock options of the insurer or any of its affiliates.

(5) This section shall not apply with respect to any option granted, or other equity security acquired, prior to the date that sections 5282, 5283, and 5284 first become applicable with respect to any class of equity securities of any insurer.

History: Add. 1984, Act 365, Imd. Eff. Dec. 27, 1984.

Popular name: Act 218

500.5283c Stock purchase plan; limitations.

Sec. 5283c. As to each participant or as to all participants the stock purchase plan shall effectively limit the aggregate dollar amount or the aggregate number of shares of stock which may be allocated or which may be subject to incentive, qualified, restricted, or employee stock purchase plan stock options granted pursuant to the plan. The limitations may be established on an annual basis, or for the duration of the plan, whether or not the plan has a fixed termination date; and may be determined either by fixed or maximum dollar amounts or fixed or maximum numbers of shares or by formulas based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares, or percentages of outstanding shares, or similar factors which will result in an effective and determinable limitation. Such limitations may be subject to any provisions for adjustment of the plan or of stock allocable or options outstanding thereunder to prevent dilution or enlargement of rights.

History: Add. 1984, Act 365, Imd. Eff. Dec. 27, 1984.

Popular name: Act 218

500.5284 Securities not owned; sale; failure to deliver to transferee; exception.

Sec. 5284. It is unlawful for any beneficial owner, director or officer, directly or indirectly, to sell any equity security of the company if he does not own the security sold, or if owning the security, does not deliver the security to the transferee within 20 days after the sale, or does not within 5 days after the sale deposit it in the mails or other usual channels of transportation. No person shall be deemed to have violated this section if he proves that notwithstanding the exercise of good faith he was unable to make the delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.

History: Add. 1965, Act 377, Eff. Mar. 31, 1966.

Popular name: Act 218

500.5285 Nonapplication of sections to certain transactions.

Sec. 5285. The provisions of section 5283 shall not apply to any transaction, and the provisions of section 5284 shall not apply to any sale of an equity security of a domestic stock insurance company not then or previously held by the transferor in an investment account, by a dealer in the ordinary course of his business and incident to the establishment or maintenance by the dealer of a primary or secondary market, otherwise than on an exchange as defined in the securities exchange act of 1934, for the security. The commissioner, by such rules and regulations as he deems necessary or appropriate in the public interest, may define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

History: Add. 1965, Act 377, Eff. Mar. 31, 1966.

Popular name: Act 218

500.5286 Foreign or domestic arbitrage transactions; exemptions.

Sec. 5286. The provisions of sections 5282, 5283 and 5284 shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules and regulations as the commissioner may adopt in order to carry out the purposes of this act.

History: Add. 1965, Act 377, Eff. Mar. 31, 1966.

Popular name: Act 218

500.5287 Equity security; definition.

Sec. 5287. The term "equity security" means any stock or similar security; or any security convertible, with

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or without consideration into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right; or any other security which the commissioner shall deem to be of similar nature and consider necessary or appropriate, by such rules and regulations as he may prescribe in the public interest or for the protection of investors, to treat as an equity security.

History: Add. 1965, Act 377, Eff. Mar. 31, 1966.

Popular name: Act 218

500.5288 Registered equity securities; exemptions; conditions.

Sec. 5288. The provisions of sections 5282, 5283 and 5284 shall not apply to equity securities of a domestic stock insurance company if the securities shall be registered, or shall be required to be registered, pursuant to section 12 of the securities exchange act of 1934, as amended, or if the domestic stock insurance company shall not have any class of its equity securities held of record by 100 or more persons on the last business day of the year next preceding the year in which equity securities of the company would be subject to the provisions of sections 5282, 5283 and 5284 except for the provisions of this section.

History: Add. 1965, Act 377, Eff. Mar. 31, 1966.

Popular name: Act 218

500.5289 Insurance commissioner; regulatory powers; effect of good faith.

Sec. 5289. The commissioner may make such rules and regulations as may be necessary for the execution of the functions vested in him by sections 5282 to 5288, and for such purpose may classify domestic stock insurance companies, securities, and other persons or matters within his jurisdiction. No provision of sections 5282, 5283 and 5284 imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule or regulation of the commissioner, notwithstanding that the rules or regulations may be amended or rescinded or determined by judicial or other authority to be invalid for any reason, after such act or omission.

History: Add. 1965, Act 377, Eff. Mar. 31, 1966.

Popular name: Act 218

Administrative rules: R 500.402 et seq. of the Michigan Administrative Code.

500.5290 Unlawful solicitation; use of name to solicit proxies or consents.

Sec. 5290. It is unlawful for any person, in contravention of such rules and regulations as the commissioner may prescribe as necessary or appropriate in the public interest or for the protection of investors, to solicit or to permit the use of his name to solicit any proxy or consent or authorization in respect of any security of a domestic insurer not listed on a national securities exchange.

History: Add. 1965, Act 377, Eff. Mar. 31, 1966.

Popular name: Act 218

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CHAPTER 54
MUTUAL LIFE AND DISABILITY INSURERS (DOMESTIC)

500.5400 Scope of chapter.

Sec. 5400. This chapter applies only to domestic mutual life and disability insurers other than cooperative insurers as identified in chapter 64 and to mutual holding companies resulting from the reorganization of those mutual insurers.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Popular name: Act 218

500.5402 Domestic mutual insurers; formation; reorganization.

Sec. 5402. A domestic mutual insurer for the transaction of life insurance, or for the transaction of life and disability insurance, may be formed pursuant to chapter 50 and may be reorganized pursuant to chapters 59 and 60.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Popular name: Act 218

500.5403 Mutual holding company as domestic mutual insurance company.

Sec. 5403. A mutual holding company resulting from a reorganization under chapter 60 shall be considered a domestic mutual insurance company under this act except that the mutual holding company shall not be issued a certificate of authority to issue policies or transact the business of insurance.

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History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Popular name: Act 218

500.5408 Prerequisites to granting certificate of authority.

Sec. 5408. No certificate of authority shall be granted such insurer to issue policies until all of the following conditions have been met:

(a) At least 500 persons have subscribed in the aggregate for at least $1,000,000.00 of insurance if organized for the purpose of transacting life insurance, or if organized for the purpose of transacting both life and disability insurances, until 500 persons have subscribed for $1,000,000.00 of each kind of insurance as if corporations had been formed separately for each such purpose and shall each have paid in 1 full annual premium in cash upon the insurance subscribed for. No application shall exceed in amount $5,000.00 of insurance on the life of any individual or individuals jointly.

(b) The insurer has deposited with the state treasurer securities as required under section 411.

(c) The requirements of this chapter have been complied with and certified under oath to the commissioner by at least 3 of the incorporators and then not until he is satisfied that the membership list and applications are genuine and the premiums paid in cash and the applicants have agreed to accept the policies within 30 days after such certificate shall have been issued. No policy of insurance shall be issued until the commissioner has issued a certificate of authority to transact insurance.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1972, Act 360, Imd. Eff. Jan. 9, 1973.

Popular name: Act 218

500.5412 Deficiency in insurance or membership; procedure.

Sec. 5412. If at any time it appears from an examination of the insurer or from any statement filed by the insurer that the number of risks insured, the number of policies in force, or the number of members or the amount of premiums on insurance in force are below the number and amounts required under section 5408, the commissioner shall issue an order directing the insurer within a period of 90 days to secure bona fide applications for insurance in the insurer, together with the necessary premiums, from persons who, together with the existing members, shall equal the number of members required under section 5408 and whose insurance policies, together with those in force, cover the number of risks and provide for the amount of insurance required upon organization. If the insurer does not within this period become entitled to issue policies, the commissioner may in his or her discretion take proceedings for the liquidation of the insurer as provided in chapter 81.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2001, Act 182, Imd. Eff. Dec. 21, 2001.

Popular name: Act 218

500.5416 Mutual life insurer; extension of powers; procedure.

Sec. 5416. A mutual life insurer may extend its corporate powers to transact disability insurance by amending its articles of incorporation and bylaws in accordance with the provisions of section 5202: Provided, Such amendment is first approved by a vote of 2/3 of its members in person or by proxy at an annual or special meeting called for that purpose pursuant to notice given in accordance with the bylaws, which notice shall specify the additional kind of insurance which it is proposed to transact.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5420 Mutual life and disability insurers; amendment, adoption, and approval of bylaws.

Sec. 5420. Bylaws not inconsistent with the articles of association may be adopted or amended at any meeting of the directors or members of the insurer held after the receipt from the commissioner of a certified copy of the certificate of incorporation. The bylaws or amendments shall not become effective until approved by and filed with the commissioner.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1961, Act 153, Eff. Sept. 8, 1961.

Popular name: Act 218

500.5424 Directors and officers; number; election.

Sec. 5424. The management of the business and affairs of such an insurer shall be vested in a board of directors. Every such insurer shall have not less than 5 nor more than 17 directors, and such officers as shall be provided for in the articles of incorporation or in the bylaws. The directors shall be elected at the annual meetings of the members but any time after the first annual meeting the directors may be divided into 3 groups as nearly equal as possible and thereafter 1 group only elected in a manner to be provided by the

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bylaws.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1959, Act 28, Eff. Mar. 19, 1960.

Popular name: Act 218

500.5430 Capital funds; borrowing; repayment.

Sec. 5430. A mutual insurer organized under this chapter may borrow or assume liability for the repayment of a sum of money sufficient to defray the reasonable expenses of its organization or to provide the securities to be deposited with the state treasurer as required under this act, or to enable it to comply with any requirement of law, upon an agreement that has first been submitted to and approved by the commissioner, that the sum shall be repaid with interest accrued in a manner and at a rate approved by the commissioner. The agreement under which the sum is obtained shall provide that any claim for its return shall be inferior and subordinate to all claims of and reserves for policyholders and creditors. Interest shall be paid and principal shall be retired only out of the surplus earnings of the insurer and with the approval of the commissioner whenever, in his or her judgment, the financial condition of the insurer warrants it, except that approval shall be withheld if repayment will reduce the surplus to an amount that is less than the amount determined adequate to comply with section 403. Any sum advanced shall not form a part of the legal liabilities of the insurer but until repaid all statements published by the insurer or filed with the commissioner shall show the amount remaining unpaid.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

CHAPTER 55
DOMESTIC STOCK INSURER DIVISION

500.5500 Definitions.

Sec. 5500. As used in this chapter:

(a) "Assets" means property, whether real, personal, mixed, tangible, or intangible, and any right or interest in the property, including all rights under contracts and other agreements.

(b) "Capital" means the capital stock component of statutory surplus, as defined in the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, version effective January 1, 2001, and subsequent revisions.

(c) "Divide" or "division" means the act by operation of law by which a domestic stock insurer divides into 2 or more resulting insurers in accordance with a plan of division and this chapter.

(d) "Dividing insurer" means a domestic stock insurer that approves a plan of division pursuant to section 5505.

(e) "Domestic stock insurer" means a domestic stock insurer organized or created under the laws of this state.

(f) "Insurer" means a corporation engaged or attempting to engage in the business of making insurance or surety contracts.

(g) "Liability" means any liability or obligation of any kind, character, or description, whether known or unknown, absolute or contingent, accrued or unaccrued, disputed or undisputed, liquidated or unliquidated, secured or unsecured, joint or several, due or to become due, determined, determinable, or otherwise.

(h) "New insurer" means a domestic stock insurer that is created by a division occurring on or after the effective date of the amendatory act that added this chapter.

(i) "Plan of division" means a plan of division approved by a dividing insurer in accordance with section 5505.

(j) "Resulting insurer" means a domestic stock insurer created by a division or a dividing insurer that survives a division.

(k) "Shareholder" means the person in whose name a share is registered in the records of a corporation or the beneficial owner of a share to the extent of the rights granted by a nominee certificate on file with a corporation.

(*l*) "Sign" or "signature" includes a manual, facsimile, conformed, or electronic signature.

(m) "Surplus" means total statutory surplus less capital, calculated in accordance with the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, version effective January 1, 2001, and subsequent revisions.

(n) "Transfer" includes an assignment, assumption, conveyance, sale, lease, encumbrance, including a mortgage or security interest, gift, or transfer by operation of law.

History: Add. 2018, Act 421, Imd. Eff. Dec. 20, 2018.

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Popular name: Act 218

500.5503 Domestic stock insurer; division into 2 or more insurers; plan of division; requirements; amendment procedures; abandonment of plan.

Sec. 5503. (1) A domestic stock insurer may, in accordance with the requirements of this chapter, divide into 2 or more resulting insurers pursuant to a plan of division.

(2) Each plan of division must include all of the following:

(a) The name of the domestic stock insurer seeking to divide.

(b) The name of each resulting insurer that will be created by the proposed division.

(c) For each new insurer that will be created by the proposed division, a copy of both of the following:

(*i*) Its proposed articles of incorporation.

(*ii*) Its proposed bylaws.

(d) The manner of allocating between or among the resulting insurers both of the following:

(*i*) The assets of the domestic stock insurer that will not be owned by, if the dividing insurer survives the division, the dividing insurer, or, if the dividing insurer does not survive the division, all of the resulting insurers as tenants in common under section 5511.

(*ii*) The liabilities of the domestic stock insurer, including policy liabilities, to which not all of the resulting insurers will become jointly and severally liable under section 5513(1)(c).

(e) The manner of distributing shares in the new insurers to the dividing insurer or its shareholders.

(f) A reasonable description of the liabilities, including policy liabilities, and items of capital, surplus, or other assets, in each case, that the domestic stock insurer proposes to allocate to each resulting insurer, including the manner by which each reinsurance contract is to be allocated.

(g) All terms and conditions required by the laws of this state or the articles of incorporation and bylaws of the domestic stock insurer.

(h) All other terms and conditions of the division.

(3) If the domestic stock insurer will survive the division, the plan of division must include, in addition to the information required by subsection (2), all of the following:

(a) All proposed amendments to the dividing insurer's articles of incorporation and bylaws, if any.

(b) If the dividing insurer desires to cancel some, but fewer than all, shares in the dividing insurer, the manner in which it will cancel the shares.

(c) If the dividing insurer desires to convert some, but fewer than all, shares in the dividing insurer into shares, securities, obligations, money, other property, rights to acquire shares or securities, or any combination thereof, a statement disclosing the manner in which it will convert the shares.

(4) If the domestic stock insurer will not survive the proposed division, the plan of division must contain, in addition to the information required by subsection (2), the manner in which the dividing insurer will cancel or convert shares in the dividing insurer into shares, securities, obligations, money, other property, rights to acquire shares or securities, or any combination thereof.

(5) A dividing insurer may amend a plan of division in accordance with any procedures set forth in the plan of division or, if no procedures are set forth in the plan of division, in any manner determined by the board of directors of the dividing insurer, except that a shareholder that was entitled to vote on or consent to approval of the plan of division is entitled to vote on or consent to any amendment of the plan of division that will change any of the following:

(a) The amount or kind of shares, securities, obligations, money, other property, rights to acquire shares or securities, or any combination thereof, to be received by any of the shareholders of the dividing insurer under the plan of division.

(b) The articles of incorporation or bylaws of any resulting insurer that will be in effect when the division becomes effective, except for changes that do not require approval of the shareholders of the resulting insurer under its articles of incorporation or bylaws.

(c) Any other terms or conditions of the plan of division, if the change would adversely affect the shareholders in any material respect.

(6) A dividing insurer may abandon a plan of division after it has approved the plan of division without any action by the shareholders and in accordance with any procedures set forth in the plan of division or, if no procedures are set forth in the plan of division, in a manner determined by the board of directors of the dividing insurer.

(7) A dividing insurer may abandon a plan of division after it has filed a certificate of division with the department by filing with the department a notice of abandonment signed by the dividing insurer. The notice of abandonment is effective on the date it is filed with the department and the dividing insurer is considered to have abandoned its plan of division on that date.

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(8) A dividing insurer shall not abandon or amend its plan of division once the division becomes effective.

History: Add. 2018, Act 421, Imd. Eff. Dec. 20, 2018.

Popular name: Act 218

500.5505 Filing plan of division with the department; approval by board of directors and shareholders; effectiveness of certain provisions; reasonable notice.

Sec. 5505. (1) A domestic stock insurer shall not file a plan of division with the director of the department unless the plan of division has been approved in accordance with all provisions of its articles of incorporation and bylaws and by the board of directors and shareholders of the dividing insurer.

(2) If a provision of the articles of incorporation or bylaws of a domestic stock insurer adopted before the effective date of the amendatory act that added this chapter requires that a specific number or percentage of the board of directors or shareholders approve the proposal or adoption of a plan of merger, or imposes other special procedures for the proposal or adoption of a plan of merger, the domestic stock insurer shall adhere to the provision in proposing or adopting a plan of division. If a provision of the articles of incorporation or bylaws of a domestic stock insurer is amended on or after the effective date of the amendatory act that added this chapter, the provision applies to a division only in accordance with its express terms.

(3) Within 10 business days after filing the plan of division with the director of the department, the dividing insurer shall provide reasonable notice of the filing to each reinsurer that is a party to a reinsurance contract allocated in the plan of division.

History: Add. 2018, Act 421, Imd. Eff. Dec. 20, 2018.

Popular name: Act 218

500.5507 Notice and hearing of plan required; approval and filing with department; conditions of approval; confidentiality of certain financial information; payment of department expenses; order.

Sec. 5507. (1) A division does not become effective until it is approved by the director of the department after reasonable notice and a public hearing. A hearing conducted under this section must be conducted as a contested case subject to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(2) Subject to subsection (12), the director of the department shall approve a plan of division unless the director of the department finds any of the following:

(a) The interest of the policyholders of the dividing insurer that may become policyholders of a resulting insurer will not be adequately protected by the resulting insurer or acquiring party of a resulting insurer, if any.

(b) After the division, any resulting insurer would not be able to satisfy the requirements for the issuance of a certificate of authority.

(c) The division would substantially lessen competition in insurance in this state or tend to create a monopoly in this state.

(d) The financial condition of an acquiring party of a resulting insurer, if any, is such that it might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders or the interests of a remaining shareholder that is unaffiliated with the acquiring party.

(e) The terms of the plan of division are unfair and unreasonable to the dividing insurer's policyholders or shareholders.

(f) An acquiring party of a resulting insurer, if any, has plans or proposals to liquidate the resulting insurer, sell its assets, or consolidate or merge the resulting insurer with a person, or to make any other material change in its business or corporate structure or management, that are unfair and unreasonable to the resulting insurer's policyholders, and not in the public interest.

(g) The competence, experience, and integrity of the persons who would control the operation of a resulting insurer are such that it would not be in the interest of the resulting insurer's policyholders or the general public to permit the division.

(h) The division is likely to be hazardous or prejudicial to the insurance-buying public.

(i) The proposed division violates the uniform voidable transactions act, 1998 PA 434, MCL 566.31 to 566.45.

(j) The division is being made for purposes of hindering, delaying, or defrauding any policyholders or other creditors of the dividing insurer.

(k) One or more resulting insurers will not be solvent on the consummation of the division.

(*l*) The assets allocated to 1 or more resulting insurers will be, on consummation of a division, unreasonably small in relation to the business and transactions in which the resulting insurer was engaged or is about to engage.

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(3) If a division is undertaken in conjunction with the divestiture of 1 of the resulting insurers, the director shall not approve the division until the potential acquiring party has received the necessary approvals under section 1315 or 7604, as applicable.

(4) In determining whether the standards set forth in subsection (2)(i) have been satisfied, the director of the department shall only apply the uniform voidable transactions act, 1998 PA 434, MCL 566.31 to 566.45, to a dividing insurer in its capacity as a resulting insurer and shall not apply the uniform voidable transactions act, 1998 PA 434, MCL 566.31 to 566.45, to any dividing insurer that is not proposed to survive the division.

(5) In determining whether the standards set forth in subsection (2)(i), (j), (k), and (*l*) have been satisfied, the director of the department may consider, among other things, all assets, liabilities, and cash flows.

(6) In determining whether the standards set forth in subsection (2)(i) have been satisfied, with respect to each resulting insurer, the director of the department shall, in applying the uniform voidable transactions act, 1998 PA 434, MCL 566.31 to 566.45, do all of the following:

(a) Treat the resulting insurer as a debtor.

(b) Treat liabilities allocated to the resulting insurer as obligations incurred by a debtor.

(c) Treat the resulting insurer as not having received reasonably equivalent value in exchange for incurring the obligations.

(d) Treat assets allocated to the resulting insurer as remaining property.

(7) All information, documents, materials, and copies of documents and materials submitted to, obtained by, or disclosed to the director of the department in connection with a plan of division or in contemplation of a plan of division, including any information, documents, materials, or copies provided by or on behalf of a domestic stock insurer in advance of its adoption or submission of a plan of division, are confidential and are subject to the same protection and treatment in accordance with section 1355 as information and documents disclosed to or obtained by the director of the department in the course of an examination or investigation made under sections 1351 and 1357 until the time, if any, that a notice of the hearing contemplated by subsection (1) is issued.

(8) From and after the issuance of a notice of the hearing contemplated by subsection (1), all business, financial, and actuarial information for which the domestic stock insurer requests confidential treatment, other than the plan of division and any materials incorporated by reference into or otherwise made a part of the plan of division that must not be eligible for confidential treatment after the issuance of a notice of the hearing, continues to be confidential and is not available for public inspection and must be subject to the same protection and treatment in accordance with section 1355 as information and documents disclosed to or obtained by the director of the department in the course of an examination or investigation made under sections 1351 and 1357. However, if the director of the department determines that the interest of the public in making the information available for public inspection outweighs the interest of the dividing insurer in keeping the information confidential, the director of the department may, after notice and an opportunity to be heard, make the information available to public inspection in accordance with the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(9) All expenses incurred by the director of the department in connection with proceedings under this section, including expenses for the services of any attorneys, actuaries, accountants, and other experts not otherwise a part of the director's staff as may be reasonably necessary to assist the director in reviewing the proposed division, must be paid by the dividing insurer filing the plan of division. A dividing insurer may allocate expenses described in this subsection in a plan of division in the same manner as any other liability.

(10) If the director of the department approves a plan of division, the director of the department shall issue an order approving the plan of division that must be accompanied by findings of fact and conclusions of law.

(11) The conditions in this section for freeing 1 or more of the resulting insurers from the liabilities of the dividing insurer and for allocating some or all of the liabilities of the dividing insurer are conclusively satisfied if the plan of division has been approved by the director of the department in a final order, after all relevant appeals relating to the final order have been exhausted.

(12) The director may establish any additional procedures necessary or appropriate in connection with his or her review of a plan of division.

History: Add. 2018, Act 421, Imd. Eff. Dec. 20, 2018.

Popular name: Act 218

500.5509 Certificate of division; contents; effective date.

Sec. 5509. (1) After a plan of division has been adopted and approved under sections 5503 to 5507, an officer or duly authorized representative of the dividing insurer shall sign a certificate of division. The certificate of division is a public document.

(2) The certificate of division must set forth all of the following:

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(a) The name of the dividing insurer.

(b) A statement disclosing whether the dividing insurer will survive the division.

(c) The name of each new insurer that will be created by the division.

(d) The date on which the division is to be effective, which must not be more than 90 days after the dividing insurer has filed the certificate of division with the department.

(e) A statement that the division was approved by the director of the department in accordance with section 5507.

(3) The articles of incorporation and bylaws of each new insurer must satisfy the requirements of the laws of this state.

(4) A certificate of division is effective when filed with the department as provided in this section or on another date specified in the plan of division, whichever is later. However, a certificate of division must become effective not more than 90 days after the related plan of division has been approved by the department. A division is effective when the relevant certificate of division is effective.

History: Add. 2018, Act 421, Imd. Eff. Dec. 20, 2018.

Popular name: Act 218

500.5511 Division effectiveness; allocation and distribution of assets and liabilities.

Sec. 5511. (1) When a division becomes effective under section 5509(4), all of the following apply:

(a) If the dividing insurer has survived the division:

(*i*) It continues to exist.

(*ii*) Its articles of incorporation must be amended, if at all, as provided in the plan of division.

(*iii*) Its bylaws must be amended, if at all, as provided in the plan of division.

(b) If the dividing insurer has not survived the division, its separate existence ceases to exist, subject to satisfying the other requirements of this state relating to the surrender of a certificate of authority to the extent applicable.

(c) All of the following apply to each new insurer:

(*i*) It comes into existence.

(*ii*) It shall hold any capital, surplus, and other assets allocated to the new insurer by the plan of division as a successor to the dividing insurer, automatically, by operation of law and not by transfer, whether directly or indirectly.

(*iii*) Its articles of incorporation, if any, and bylaws, if any, are effective.

(*iv*) The director of the department shall issue a certificate of authority, subject to satisfying the other requirements of this state relating to the formation and licensure of new domestic stock insurers to the extent applicable.

(d) Capital, surplus, and other assets of the dividing insurer are vested as follows:

(*i*) If it is allocated by the plan of division, it vests in the applicable resulting insurer as provided in the plan of division.

(*ii*) If it is not allocated by the plan of division, it vests, if the dividing insurer survives the division, in the dividing insurer or, if the dividing insurer does not survive the division, equally in the resulting insurers as tenants in common.

(*iii*) Otherwise it vests as provided in this section without transfer, reversion, or impairment.

(e) A resulting insurer to which a cause of action is allocated as provided in subdivision (d) may be substituted or added in any pending action or proceeding to which the dividing insurer is a party when the division becomes effective.

(f) The liabilities, including policy liabilities, of the dividing insurer are allocated between or among the resulting insurers as provided in section 5513 and each resulting insurer to which liabilities are allocated is liable only for those liabilities, including policy liabilities, so allocated as successors to the dividing insurer, automatically, by operation of law, and not by transfer or assumption, whether directly or indirectly.

(g) The shares in the dividing insurer that are to be converted or canceled in the division are converted or canceled, and the shareholders of those shares are entitled only to the rights provided to them under the plan of division and any appraisal rights that they may have under section 5515.

(2) Except as provided in the articles of incorporation or bylaws of the dividing insurer, the division does not give rise to any rights that a shareholder, director of domestic stock insurer, or third party would have on a dissolution, liquidation, or winding up of the dividing insurer.

(3) The allocation to a new insurer of capital, surplus, or other assets that is collateral covered by an effective financing statement is not effective until a new financing statement naming the new insurer as a debtor is effective under the uniform commercial code, 1962 PA 174, MCL 440.1101 to 440.9994.

(4) Unless otherwise provided in the plan of division, the shares in and any securities of each new insurer

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must be distributed to either of the following:

(a) The dividing insurer, if it survives the division.

(b) Shareholders of the dividing insurer that do not assert any appraisal rights that they may have under section 5515, pro rata.

(5) A division that becomes effective under section 5509(4) is not an assignment of any insurance policy, annuity, or reinsurance agreement or any other type of contract.

History: Add. 2018, Act 421, Imd. Eff. Dec. 20, 2018.

Popular name: Act 218

500.5513 Responsibilities, liabilities, and obligations of resulting insurer.

Sec. 5513. (1) Except as otherwise expressly provided in this section, when a division becomes effective, each resulting insurer is responsible, automatically, by operation of law, for all of the following:

(a) Individually, the liabilities, including policy liabilities, that the resulting insurer issues, undertakes, or incurs in its own name after the division.

(b) Individually, the liabilities, including policy liabilities, of the dividing insurer that are allocated to the resulting insurer to the extent specified in the plan of division.

(c) Jointly and severally with the other resulting insurers, the liabilities, including policy liabilities, of the dividing insurer that are not allocated by the plan of division.

(2) Except as otherwise expressly provided in this section, when a division becomes effective, a resulting insurer is not responsible for and does not have any liability or obligation in respect of either of the following:

(a) Any liabilities, including policy liabilities, that another resulting insurer issues, undertakes, or incurs in its own name after the division.

(b) Any liabilities, including policy liabilities, of the dividing insurer that are allocated to another resulting insurer in accordance with the plan of division.

(3) If a provision of any debt security, note, or similar evidence of indebtedness for money borrowed, whether secured or unsecured, indenture, or other contract relating to indebtedness, or a provision of any other type of contract other than an insurance policy, annuity, or reinsurance agreement, that was issued, incurred, or executed by the domestic stock insurer before the effective date of the amendatory act that added this chapter requires the consent of the obligee to a merger of the dividing insurer or treats the merger as a default and does not provide that a division of the insurer does not require the consent of the obligee, as applicable, that provision applies to a division of the dividing insurer as if the division were a merger.

(4) If, after the approval of a plan of division, it is found that the act of undertaking a division itself breached a contractual obligation of the dividing insurer when the division became effective, all of the resulting insurers are liable, jointly and severally, for the contractual breach, but the validity and effectiveness of the division, including, without limitation, the allocation of liabilities in accordance with the plan of division, is not affected by the contractual breach.

(5) A direct or indirect allocation of capital, surplus, assets, or liabilities, including policy liabilities, in a division must occur automatically, by operation of law, and is not treated as a distribution or transfer for any purpose with respect to either the dividing insurer or any of the resulting insurers.

(6) Liens, security interests, and other charges on the capital, surplus, or other assets of the dividing insurer are not impaired by the division, notwithstanding any otherwise enforceable allocation of liabilities, including policy liabilities, of the dividing insurer.

(7) If the dividing insurer is bound by a security agreement under article 9 of the uniform commercial code, 1962 PA 174, MCL 440.9101 to 440.9994, or the substantial equivalent enacted in any other jurisdiction, and the security agreement provides that the security interest attaches to after-acquired collateral, each resulting insurer is bound by the security agreement.

(8) An allocation of a policy or other liability does not do either of the following:

(a) Except as provided in the plan of division and specifically approved by the director, affect the rights that a policyholder or creditor has under other law in respect of the policy or other liability, except that those rights are available only against a resulting insurer responsible for the policy or liability under this section.

(b) Release or reduce the obligation of a reinsurer, surety, or guarantor of the policy or liability.

(9) A resulting insurer is only liable for the liabilities allocated to it in accordance with the plan of division and this section and is not liable for any other liabilities under the common law doctrine of successor liability or any similar theory of liability applicable to transferees or assignees of property.

History: Add. 2018, Act 421, Imd. Eff. Dec. 20, 2018.

Popular name: Act 218

500.5515 Record shareholder of non-surviving insurer right to dissent and obtain payment.

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Sec. 5515. If the dividing insurer does not survive the division, a record shareholder of a dividing insurer is entitled to dissent from and obtain payment of the fair value of that shareholder's shares, in the same manner and to the extent provided for under sections 1762 to 1774 of the business corporation act, 1972 PA 284, MCL 450.1762 to 450.1774.

History: Add. 2018, Act 421, Imd. Eff. Dec. 20, 2018.

Popular name: Act 218

500.5517 Shareholder right to dissent and obtain payment in connection with division; application of MCL 450.1762 to shareholder actions.

Sec. 5517. (1) A shareholder of a dividing insurer is entitled to dissent from, and obtain payment of the fair value of the shareholder's shares in connection with, a division under this chapter in which the dividing insurer does not survive the division, unless the shares are converted into or canceled solely for 1 or more of the following:

(a) Cash.

(b) Shares that are listed on a national securities exchange or designated as a national market system security on an interdealer quotation system by the National Association of Securities Dealers, on the record date fixed to vote on the plan of division.

(2) Section 1762 of the business corporation act, 1972 PA 284, MCL 450.1762, applies to a shareholder exercising the rights in the same manner as would be applicable to a merger of a domestic corporation.

History: Add. 2018, Act 421, Imd. Eff. Dec. 20, 2018.

Popular name: Act 218

CHAPTER 58
GENERAL MUTUAL INSURERS (DOMESTIC)

500.5800 Applicability of chapter.

Sec. 5800. (1) This chapter applies only to domestic mutual insurers transacting property, casualty, disability, and other insurances, to mutual holding companies resulting from the reorganization of those mutual insurers, and to nonprofit mutual disability insurers.

(2) This chapter does not apply to any domestic insurer doing business on August 10, 1917, unless the insurer fully complies with this chapter and by resolution of its board of directors duly certified to by the president and secretary and filed with and approved by the commissioner elects to adopt the provisions of this chapter, in which case the insurer may thereafter effect such kind or kinds of insurance as specified in its articles of incorporation as then or thereafter amended or as may be specified in the resolution.

(3) A person incorporating under this chapter after January 1, 1984, is subject to the minimum financial requirements of sections 408 and 410. Any corporation incorporated under this chapter on or before January 1, 1984, continues to be subject to the provisions of section 5810(3).

(4) Except as otherwise provided in section 5801(2), a domestic mutual insurer transacting property, casualty, disability, and other insurances may be reorganized pursuant to chapters 59 and 60.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1970, Act 180, Imd. Eff. Aug. 3, 1970;—Am. 1984, Act 386, Eff. Mar. 29, 1985;—Am. 1998, Act 457, Imd. Eff. Jan. 4, 1999;—Am. 2000, Act 8, Imd. Eff. Feb. 25, 2000;—Am. 2013, Act 5, Imd. Eff. Mar. 18, 2013.

Popular name: Act 218

500.5801 Formation of domestic mutual insurer; nonprofit status; powers of nonprofit mutual disability insurer; limitation.

Sec. 5801. (1) A domestic mutual insurer may be formed with nonprofit status.

(2) A nonprofit mutual disability insurer has all powers of a mutual insurer organized under this chapter unless expressly reserved. A nonprofit mutual disability insurer that has merged with a nonprofit health care corporation as provided in section 5805(1) shall not convert its status to a stock insurer under chapter 59 or reorganize under chapter 60.

History: Add. 2013, Act 5, Imd. Eff. Mar. 18, 2013.

Popular name: Act 218

500.5803 Mutual holding company resulting from reorganization considered as domestic mutual insurance company.

Sec. 5803. A mutual holding company resulting from a reorganization under chapter 60 shall be considered a domestic mutual insurance company under this act except that the mutual holding company shall not be issued a certificate of authority to issue policies or transact the business of insurance.

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History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Popular name: Act 218

500.5804 Domestic mutual insurers; incorporation.

Sec. 5804. (1) Any number of persons, not less than 20, a majority of whom shall be bona fide residents of this state, by complying with the provisions of this chapter, may become together with others who may hereafter be associated with them or their successors, a body corporate, for the purpose of carrying on the business of mutual insurance as herein provided.

(2) Any persons proposing to form any such insurer shall subscribe and acknowledge articles of incorporation in accordance with chapter 50.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5805 Merger of nonprofit health care corporation with nonprofit mutual disability insurer.

Sec. 5805. (1) As set forth in section 220 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1220, a nonprofit health care corporation may merge with a nonprofit mutual disability insurer where the surviving entity is governed by this chapter. A merger described in this section is exempt from the application of sections 1311 to 1319. Notwithstanding any provision of this act to the contrary, the resulting nonprofit mutual disability insurer shall continue as a nonprofit entity and shall continue to provide coverage to the individual and small group health markets in this state.

(2) A nonprofit mutual disability insurer that has merged with a nonprofit health care corporation as described in subsection (1) may, at its option, continue to offer any product that was offered to the subscribers of the nonprofit health care corporation.

(3) A nonprofit mutual disability insurer that has merged with a nonprofit health care corporation as described in subsection (1) may offer supplemental coverage to medicare enrollees as provided in chapter 38. Notwithstanding any other provision of this act to the contrary and until July 31, 2016, both of the following apply to an insurer described in this subsection:

(a) The insurer shall continue to offer to current or new eligible policyholders who are residents of this state, at the same rates as offered to subscribers by the nonprofit health care corporation on the effective date of this section, the supplemental coverage to medicare enrollees.

(b) The insurer offering supplemental coverage under subdivision (a) shall continue all cost transfers as authorized under section 609(5) of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1609, on the effective date of this section.

(4) Benefits paid by a nonprofit mutual disability insurer that has merged with a nonprofit health care corporation as described in subsection (1) to an insured or provider by way of a check or other similar written instrument for the transmission or payment of money, that is not cashed within the period prescribed in the uniform unclaimed property act, 1995 PA 29, MCL 567.221 to 567.265, shall escheat to this state pursuant to the uniform unclaimed property act, 1995 PA 29, MCL 567.221 to 567.265.

History: Add. 2013, Act 5, Imd. Eff. Mar. 18, 2013.

Popular name: Act 218

500.5810 Domestic mutual insurers; qualification for certificate of authority.

Sec. 5810. No such insurer shall issue policies or transact any business of insurance unless it shall hold a certificate of authority from the commissioner authorizing the transaction of such business, which certificate shall not be issued until and unless the insurer shall comply with the following conditions:

(1) It shall hold bona fide applications for insurance upon which it shall issue simultaneously, or it shall have in force at least 20 policies to at least 20 members for the same kind of insurance upon not less than 200 separate risks, each within the maximum single risk described herein.

(2) The "maximum single risk" shall not exceed 20% of the admitted assets or 3 times the average risk or 1% of the insurance in force, whichever is the greater, any reinsurance taking effect simultaneously with the policy being deducted in determining such maximum single risk.

(3) It shall have collected from each applicant in cash a premium upon each application which premium shall be held in cash or securities in which insurers are authorized to invest and shall be equal to at least $25,000.00: Provided, however, The cash assets of such insurer shall be not less than $50,000.00, 1/2 of which shall be derived from cash premium payments from the original applicants, and the balance may come from premiums on additional applications or contributions as provided in section 5836, and in case of workmen's compensation insurers, the minimum premiums required to be collected from original applicants shall be $50,000.00 with minimum cash assets of $100,000.00 created as heretofore provided in this

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subdivision.

(4) For the purpose of transacting employers' liability and workmen's compensation insurance the applications shall cover not less than 20 employers having employees of not less than 5,000, each such employee being considered as a separate risk for determining the maximum single risk.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5814 Repealed. 1970, Act 180, Imd. Eff. Aug. 3, 1970.

Compiler's note: The repealed section pertained to kinds of insurance permitted mutual insurers.

Popular name: Act 218

500.5818 Domestic mutual insurers; rights of corporation and other bodies to be members.

Sec. 5818. Any public or private corporation, board or association in this state or elsewhere may make applications, enter into agreements for and hold policies in any such mutual insurance company. Any officer, stockholder, trustee or local representative of any such corporation, board, association, or estate may be recognized as acting for or on its behalf for the purpose of such membership, but shall not be personally liable upon such contract of insurance by reason of acting in such representative capacity. The right of any corporation organized under the laws of this state to participate as a member of any such mutual insurance company is hereby declared to be incidental to the purpose for which such corporation is organized and as much granted as the rights and powers expressly conferred.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5824 Voting rights of members; administrative services agreements.

Sec. 5824. Every member of the company is entitled to 1 vote, or to a number of votes based upon the insurance in force, the number of policies held, or the amount of premiums paid, as may be provided in the bylaws. A nonprofit mutual disability insurer may permit entities holding administrative services agreements with it to be members and may provide in its bylaws the basis for the number of votes the entities will have as members.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2013, Act 5, Imd. Eff. Mar. 18, 2013.

Popular name: Act 218

500.5825 Rights or interests of member of nonprofit mutual disability insurer; dissolution or winding up of nonprofit mutual disability insurer; distribution and administration of residual value; conditions requiring payments to Michigan health endowment fund; determination by independent valuation; "beneficially own" defined.

Sec. 5825. (1) A member of a nonprofit mutual disability insurer that has merged with a nonprofit health care corporation as provided in section 5805(1) shall have no interest in, or residual rights to, the assets of the nonprofit mutual disability insurer; shall not receive policy or surplus dividends; and shall not be required to pay capital assessments by the nonprofit mutual disability insurer.

(2) In the event of the dissolution or winding up of a nonprofit mutual disability insurer described in subsection (1), any residual value remaining after satisfaction of claims filed under section 8142(1)(a) to (h), shall be distributed for the benefit of the people of this state to the Michigan health endowment fund created under part 6A of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1651 to 550.1655, and shall be administered in a manner consistent with the supervision of trustees for charitable purposes act, 1961 PA 101, MCL 14.251 to 14.266.

(3) In the event of a transaction or series of transactions pursuant to which the nonprofit mutual disability insurer demutualizes under chapter 59; converts to a mutual holding company under chapter 60; sells, transfers, or otherwise disposes of all or substantially all of its assets; merges into an entity and the nonprofit mutual disability insurer is not the surviving entity; moves its principal executive office out of this state; redomesticates to another state; or allows or permits a person or a group of persons acting in concert to beneficially own greater than 50% of the voting power associated with ownership interests in the nonprofit mutual disability insurer, whether by merger, dividend, or any other means, then the nonprofit mutual disability insurer or the acquiring person or entity shall make payment for the benefit of the people of this state to the Michigan health endowment fund created under part 6A of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1651 to 550.1655, in an amount equal to the greater of the acquisition price or the fair market value of the nonprofit mutual disability insurer and its subsidiaries, considered on a consolidated holding company basis as of the time of the closing of the transaction or series of transactions, as

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determined by an independent valuation by a person or entity mutually agreed upon by the attorney general, the commissioner, and the nonprofit mutual disability insurer. The cost of the independent valuation shall be paid by the nonprofit mutual disability insurer or the acquiring person or entity. The payment for the benefit of the people of this state shall be administered in a manner consistent with the supervision of trustees for charitable purposes act, 1961 PA 101, MCL 14.251 to 14.266, and shall be in satisfaction of any claim or assertion that consideration is due with respect to the charitable assets of the nonprofit mutual disability insurer.

(4) As used in this section, "beneficially own" means actual ownership or the right, directly or indirectly, to control voting power associated with ownership interests in the nonprofit mutual disability insurer.

History: Add. 2013, Act 5, Imd. Eff. Mar. 18, 2013.

Popular name: Act 218

500.5826 Offering health care benefits to residents regardless of health status.

Sec. 5826. Until January 1, 2014, a nonprofit mutual disability insurer that has merged with a nonprofit health care corporation as described in section 5805(1) shall offer health care benefits to all residents of this state regardless of health status.

History: Add. 2013, Act 5, Imd. Eff. Mar. 18, 2013.

Popular name: Act 218

500.5828 Domestic mutual insurers; contingent liability of members; nonassessable policies.

Sec. 5828. (1) The policies shall provide for a premium or premium deposit payable in cash and, except as herein provided, for a contingent premium at least equal to the premium or premium deposit.

(2) Such mutual insurer may issue a policy without a contingent premium while it has a surplus equal to the capital required of a domestic stock insurer transacting the same kinds of insurance, and in no event shall the holder of any such policy be liable for a greater amount than the premium or premium deposit expressed in the policy.

(3) If at any time the admitted assets are less than the reserve and other liabilities, the insurer shall immediately collect upon policies with a contingent premium a sufficient proportionate part thereof to restore such assets, provided no member shall be liable for any part of such contingent premium in excess of the amount demanded within 1 year after the termination of the policy. The commissioner may, by written order, direct that proceedings to restore such assets be deferred during the time fixed in such order.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.5836 Mutual insurers; borrowed capital.

Sec. 5836. A mutual insurer organized under this chapter may borrow or assume liability for the repayment of a sum of money sufficient to defray the reasonable expenses of its organization or to provide the securities to be deposited with the state treasurer as required under this act, or to enable it to comply with any requirement of law, upon an agreement that has first been submitted to and approved by the commissioner, that the sum shall be repaid with interest accrued in a manner and at a rate approved by the commissioner. The agreement under which the sum is obtained shall provide that any claim for its return shall be inferior and subordinate to all claims of and reserves for policyholders and creditors. Interest shall be paid and principal shall be retired only out of the surplus earnings of the insurer and with the approval of the commissioner whenever, in his or her judgment, the financial condition of the insurer warrants it, except that approval shall be withheld if repayment will reduce the surplus to an amount that is less than the amount determined adequate to comply with section 403. Any sum advanced shall not form a part of the legal liabilities of the insurer but until repaid all statements published by the insurer or filed with the commissioner shall show the amount remaining unpaid.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.5840 Domestic mutual insurers; deficiency in assets; assessment of members.

Sec. 5840. Such insurer not possessed of assets at least equal to the unearned premium reserve and other liabilities shall make an assessment upon its members liable to assessment to provide for such deficiency, such assessment to be against each such member in proportion to such liability as expressed in his policy: Provided, The commissioner may, by written order, relieve the insurer from an assessment or other proceedings to restore such assets during the time fixed in such order.

History: 1956, Act 218, Eff. Jan. 1, 1957.

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Popular name: Act 218

CHAPTER 59

CONVERSION OF DOMESTIC MUTUAL INSURER TO DOMESTIC STOCK INSURER

500.5901 Definitions.

Sec. 5901. As used in this chapter:

(a) "Converted stock company" means a Michigan domiciled stock insurance company that converted from a Michigan domiciled mutual company or a stock business corporation resulting from conversion of a mutual holding company pursuant to this chapter.

(b) "Eligible member" except as otherwise provided in section 5915, means a member whose policy is in force on the date the mutual company's board of directors adopts a plan of conversion. A person insured under a group policy is not an eligible member. A person whose policy becomes effective after the board of directors adopts the plan but before the plan's effective date is not an eligible member but has the rights established under section 5919.

(c) "Plan of conversion" or "plan" means a plan adopted by a Michigan domestic mutual company's or mutual holding company's board of directors pursuant to this chapter to convert the mutual company into a Michigan domiciled stock company.

History: Add. 1987, Act 22, Imd. Eff. Apr. 24, 1987;—Am. 1995, Act 215, Imd. Eff. Nov. 29, 1995;—Am. 1998, Act 121, Imd. Eff. June 10, 1998;—Am. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Popular name: Act 218

500.5903 Conversion plan; vote to amend or withdraw; submission of documents to commissioner; time period for approval or disapproval; conditions; review by qualified expert; notice of meeting; vote; adoption; filing certain documents; confidentiality.

Sec. 5903. (1) A mutual company seeking to convert to a stock company shall adopt, by the affirmative vote of not less than 2/3 of its board of directors, a plan of conversion consistent with the requirements of sections 5905 to 5915. At any time before approval of a plan by the commissioner, the mutual company, by the affirmative vote of not less than 2/3 of its board of directors, may amend or withdraw the plan.

(2) Before a mutual company's eligible members may vote on approval of a plan, a mutual company whose board of directors has adopted a plan shall submit all of the following documents to the commissioner:

(a) The plan of conversion, including the independent evaluation of pro forma market value required by section 5905.

(b) The form of notice required by subsection (5).

(c) Any proxies to be solicited from eligible members pursuant to subsection (6).

(d) The form of notice required by section 5919(1) to persons whose policies are issued after adoption of the plan but before its effective date.

(e) The proposed articles of incorporation and bylaws of the converted stock company.

(f) A business plan for the converted company that describes anticipated changes in the postconversion business of the company, if any, and the company's plan to deploy capital acquired in the conversion.

(3) The commissioner shall approve or disapprove the plan by not later than 90 days after the filing of the documents under subsection (2). The commissioner shall approve the plan if he or she finds all of the following:

(a) The plan complies with this chapter.

(b) The plan will not prejudice the interests of the members.

(c) The plan's method of allocating subscription rights is fair and equitable.

(d) A substantial reason for and effect of the plan is to benefit the members of the company or additional capital is needed to implement the business plan filed pursuant to subsection (2)(f).

(4) The commissioner may retain, at the mutual company's expense, any qualified expert not otherwise a part of the commissioner's staff to assist in reviewing the plan and the independent evaluation of the pro forma market value required under section 5905.

(5) All eligible members shall be given notice of the members' meeting to vote upon the plan. The notice shall briefly but fairly describe the proposed conversion plan, shall inform the member of his or her right to vote upon the plan, and shall be mailed to each member's last known address, as shown on the mutual company's records, at least 21 days before the time fixed for the meeting. If the meeting to vote upon the plan is held during the mutual company's annual meeting of policyholders, only 1 combined notice of meeting is required.

(6) The plan shall be adopted upon receiving the affirmative vote of at least 2/3 of the votes cast by eligible

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members. Members entitled to vote upon the proposed plan may vote in person or by proxy. Any proxies to be solicited from eligible members shall be filed with and approved by the commissioner. The number of votes each eligible member may cast shall be determined by the mutual company's bylaws. If the bylaws are silent, each eligible member may cast 1 vote.

(7) The revised articles shall be considered at the meeting of the policyholders called for the purpose of adopting the plan of conversion and shall require for adoption the affirmative vote of at least 2/3 of the votes cast by eligible members.

(8) After the eligible members have approved the plan, the converted stock company shall file both of the following documents with the commissioner:

(a) Unless the commissioner has issued a waiver pursuant to section 5927(2), the minutes of the meeting of the members at which the plan was voted upon.

(b) The revised articles of incorporation and bylaws of the converted stock company.

(9) Upon the company's request, a business plan filed pursuant to subsection (2)(f) may be granted confidential treatment by the commissioner. A business plan granted confidential treatment is not subject to disclosure by the commissioner under the freedom of information act, Act No. 442 of the Public Acts of 1976, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

History: Add. 1995, Act 215, Imd. Eff. Nov. 29, 1995.

Popular name: Act 218

500.5904 Plan of conversion; prohibited conduct.

Sec. 5904. Prior to the completion of a plan of conversion filed by a mutual company with the commissioner, a person shall not knowingly acquire, make an offer for, or make any announcement of an offer for any security issued or to be issued by the converting mutual company in connection with its plan of conversion filed under this chapter or any security issued or to be issued by any other company authorized in section 5905(1)(c)(*i*) and organized for purposes of effecting the conversion, except in compliance with the maximum purchase limitations imposed by section 5909 or the terms of the plan of conversion as approved by the commissioner.

History: Add. 1998, Act 457, Imd. Eff. Jan. 4, 1999.

Popular name: Act 218

500.5905 Conversion plan; contents; provisions applicable to subscription rights.

Sec. 5905. (1) The following provisions shall be included in the plan:

(a) The reasons for the proposed conversion.

(b) The effect of the conversion on existing policies, including all of the following:

(*i*) A provision that all policies in force on the effective date of conversion continue to remain in force under the terms of the policies, except that any voting rights of the policyholders provided for under the policies or under this chapter are extinguished on the effective date of the conversion.

(*ii*) A provision that holders of participating policies in effect on the date of conversion continue to have the right to receive dividends as provided in the participating policies, if any.

(*iii*) A provision that, except for the mutual company's life policies, guaranteed renewable accident and health policies, and guaranteed renewable, noncancelable accident and health policies, upon the renewal date of a participating policy, the converted stock company may issue the insured a nonparticipating policy as a substitute for the participating policy.

(c) The subscription rights to eligible members, including both of the following:

(*i*) A provision that each eligible member is to receive, without payment, subscription rights to purchase a portion of the capital stock of the converted stock company. Subscription rights shall be nontransferable unless otherwise provided in the plan. A plan providing for transferable subscription rights shall include whatever terms, conditions, and restrictions on transfers that the commissioner determines are reasonably necessary to protect the member's interests. As an alternative to subscription rights in the converted stock company, the plan may provide that each eligible member is to receive, without payment, subscription rights to purchase a portion of the capital stock of 1 of the following:

(A) A corporation organized for the purpose of purchasing and holding all the stock of the converted stock company.

(B) An unaffiliated corporation that will purchase all the stock of the converted stock company.

(C) A stock insurance company into which the mutual company will be merged.

(*ii*) A provision that the subscription rights shall be allocated in whole shares among the eligible members using a fair and equitable formula. This formula may but need not take into account how the different classes of policies of the eligible members contributed to the surplus of the mutual company or any other factors that

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may be fair or equitable.

(2) The plan shall provide a fair and equitable means for allocating shares of capital stock in the event of an oversubscription to shares by eligible members exercising subscription rights received under subsection (1)(c).

(3) The plan shall provide that any shares of capital stock not subscribed to by persons exercising subscription rights received under subsection (1)(c) shall be sold in a public offering through an underwriter. If the number of shares of capital stock not subscribed by eligible members is so small in number that it does not warrant the expense of a public offering, the plan of conversion may provide for purchasing unsubscribed shares by a private placement or other alternative method approved by the commissioner that is fair and equitable to eligible members.

(4) The plan shall set the total price of the capital stock equal to the estimated pro forma market value of the converted stock company or the stock of another corporation that is participating in the conversion plan, as provided in subsection (1)(c)(*i*)(A), (B), or (C) based upon an independent evaluation by a qualified expert. This pro forma market value may be that value that is estimated to be necessary to attract full subscription for the shares, as indicated by the independent evaluation.

(5) The plan shall set the purchase price per share of capital stock equal to any reasonable amount.

(6) The plan shall provide for notice and a clear explanation to eligible members of their right to subscribe to stock of the converted stock company or the stock of another corporation that is participating in the conversion plan.

History: Add. 1995, Act 215, Imd. Eff. Nov. 29, 1995;—Am. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Popular name: Act 218

500.5907 Conversion plan; provisions applicable to operation as closed block of business.

Sec. 5907. (1) The plan shall provide that a mutual life insurance company's participating life policies in force on the effective date of the conversion shall be operated by the converted stock company for dividend purposes as a closed block of participating business, except that any and all classes of group participating policies may be excluded from the closed block.

(2) The plan shall establish 1 or more segregated accounts for the benefit of the closed block of business and shall allocate to those segregated accounts enough assets of the mutual company so that the assets together with the revenue from the closed block of business are sufficient to support the closed block, including, but not limited to, the payment of claims, expenses, taxes, and any dividends that are provided for under the terms of the participating policies, with appropriate adjustments in the dividends for experience changes. The assets allocated to the closed block of business at its establishment shall be at least equal to the amount of reserves then held in connection with the closed block of business or the minimum reserve permitted by statute or regulation for the closed block of business, whichever is greater.

(3) The amount of assets allocated to the segregated accounts of the closed block shall be based upon the mutual life insurance company's last annual statement, updated to the effective date of the conversion.

(4) The converted stock company shall keep a separate accounting for the closed block and shall make and include in the annual statement to be filed with the commissioner each year a separate statement showing the gains, losses, and expenses properly attributable to the closed block.

(5) The commissioner may waive the requirement for establishing a closed block of business if it is in the best interests of policyholders to do so. The commissioner may permit discontinuing a segregated account if its size does not warrant the expense of maintaining the segregated account.

(6) This section applies only to mutual life insurance companies.

History: Add. 1995, Act 215, Imd. Eff. Nov. 29, 1995.

Popular name: Act 218

500.5909 Acquisition of capital stock of converted stock company or stock of participating corporation; limitations; prohibitions.

Sec. 5909. (1) The plan shall provide that any person or group of persons acting in concert shall not acquire, through public offering or subscription rights, more than 5% of the capital stock of the converted stock company or the stock of another corporation that is participating in the conversion plan, as provided in section 5905(1)(c)(*i*)(A) , (B), or (C), for 5 years from the effective date of the plan, except with the approval of the commissioner. This limitation does not apply to any entity that is to purchase 100% of the capital stock of the converted company as part of the plan of conversion approved by the commissioner.

(2) The plan shall provide that no director or officer or person acting in concert with a director or officer of the mutual company shall acquire any capital stock of the converted stock company or the stock of another corporation that is participating in the conversion plan, as provided in section 5905(1)(c)(*i*)(A), (B), or (C),

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for 3 years after the effective date of the plan, except through a broker/dealer, without the permission of the commissioner. This provision does not prohibit the directors and officers from purchasing stock through subscription rights received in the plan pursuant to section 5911(1) or from participating in a tax qualified stock benefit plan pursuant to section 5913.

(3) Stock options for the converted stock insurance company or the stock of another corporation that is participating in the conversion plan, as provided in section 5905(1)(c)(*i*)(A), (B), or (C), shall not be made available to the directors or officers of the company during the 2-year period following the effective date of the plan if the aggregate stock holdings of directors and officers exceed, or would exceed if the options were exercised, 25% of the total number of shares issued by the converted company if total assets of the company are less than $50,000,000.00, or 15% of the total number of shares issued for the converted company if total assets are more than $500,000,000.00. For converted companies with total assets of or between $50,000,000.00 and $500,000,000.00, the company size threshold for limiting stock options shall be interpolated.

History: Add. 1995, Act 215, Imd. Eff. Nov. 29, 1995.

Popular name: Act 218

500.5911 Receipt of subscription rights by directors and officers of mutual company.

Sec. 5911. (1) The plan may provide that the directors and officers of the mutual company shall receive, without payment, subscription rights to purchase capital stock of the converted stock company or the stock of another corporation that is participating in the conversion plan, as provided in section 5905(1)(c)(*i*)(A), (B), or (C). These subscription rights shall be allocated among the directors and officers by a fair and equitable formula.

(2) The total number of shares that may be purchased under subsection (1) shall not exceed 25% of the total number of shares to be issued for a mutual company if total assets of the company are less than $50,000,000.00 or 15% of the total number of shares to be issued for a mutual company if total assets of the company are more than $500,000,000.00. For mutual companies with total assets of or between $50,000,000.00 and $500,000,000.00, the percentage of the total number of shares that may be purchased shall be interpolated.

(3) Stock purchased by a director or officer under subsection (1) may not be sold within 1 year after the effective date of the conversion.

History: Add. 1995, Act 215, Imd. Eff. Nov. 29, 1995;—Am. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Popular name: Act 218

500.5913 Allocation of subscription rights to employee benefit plan.

Sec. 5913. The plan may allocate to a tax-qualified employee benefit plan subscription rights to purchase up to 10% of the capital stock of the converted stock company or the stock of another corporation that is participating in the conversion plan, as provided in section 5905(1)(c)(*i*)(A), (B), or (C). This employee benefit plan is entitled to exercise its subscription rights regardless of the total number of shares purchased by other persons.

History: Add. 1995, Act 215, Imd. Eff. Nov. 29, 1995;—Am. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Popular name: Act 218

500.5915 Adoption of plan not relying on issuance of subscription rights; alternative plan; retaining qualified expert; “eligible member” and “U.S. branch” defined.

Sec. 5915. (1) The board of directors may adopt a plan of conversion that does not rely in whole or in part upon issuing subscription rights to members to purchase stock of the converted stock company if the commissioner finds that the plan does not prejudice the interests of the members, is fair and equitable, and is not inconsistent with the purpose and intent of this chapter. An alternative plan may include the merger of a domestic mutual insurer into a domestic or foreign stock insurer, issuing stock or cash to policyholders instead of subscription rights, or another plan approved by the commissioner. The commissioner may retain, at the mutual company's expense, any qualified expert not otherwise a part of the commissioner's staff to assist in reviewing whether the plan may be approved by the commissioner.

(2) For an alternative plan submitted under subsection (1) by a U.S. branch of an alien insurer, "eligible member" means a policyholder eligible to receive a benefit upon demutualization in accordance with the plan of demutualization approved in, and the demutualization statute and regulations of, the jurisdiction in which the alien insurer is domiciled, and approved by the commissioner as consistent with the purposes of this chapter. As used in this subsection, "U.S. branch" means a business unit through which insurance is transacted within the United States by an alien insurer that uses this state as a state of entry.

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History: Add. 1995, Act 215, Imd. Eff. Nov. 29, 1995;—Am. 1998, Act 121, Imd. Eff. June 10, 1998;—Am. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Popular name: Act 218

500.5917 Effectiveness of plan; conditions.

Sec. 5917. A plan is effective when the commissioner has approved the plan, the eligible members have approved the plan, and the revised articles of incorporation have been adopted.

History: Add. 1995, Act 215, Imd. Eff. Nov. 29, 1995.

Popular name: Act 218

500.5919 Notice of adoption of conversion plan; right of member to rescind or cancel policy.

Sec. 5919. (1) All members whose policies become effective after the proposed plan has been adopted by the board of directors and before the effective date of the plan shall be given written notice of the plan of conversion on or before the forty-fifth day after the effective date of the plan. The notice shall specify the member's right to rescind or cancel the member's policy, as provided in subsection (2). A copy of the description of the plan provided to members pursuant to section 5903(5) shall accompany the notice. The form of the notice shall be filed with and approved by the commissioner.

(2) A member of a life or health insurance company entitled to receive the notice described in subsection (1) is entitled to rescind the member's policy and receive a full refund of any amounts paid for the policy or contract within 10 days after he or she has received the notice. Each member of a property or casualty insurance company entitled to receive the notice provided for in subsection (1) shall be advised of the member's right of cancellation and to a pro rata refund of unearned premiums.

History: Add. 1995, Act 215, Imd. Eff. Nov. 29, 1995.

Popular name: Act 218

500.5921 Conversion plan; continuation of corporate existence; transfer of rights, franchises, and interests; assumption of obligations and liabilities; service and election of directors and officers.

Sec. 5921. (1) Upon converting a mutual company to a converted stock company under this chapter, the corporate existence of the mutual company is continued in the converted stock company. All the rights, franchises, and interests of the mutual company in and to every species of property, real, personal, and mixed, and any accompanying things in action, are transferred to and vested in the converted stock company, without any deed or transfer. In addition, the converted stock company has assumed all the obligations and liabilities of the mutual company.

(2) The directors and officers of the mutual company, unless otherwise specified in the plan of conversion, shall serve as directors and officers of the converted stock company until new directors and officers of the converted stock company are duly elected pursuant to the articles of incorporation and bylaws of the converted stock company.

History: Add. 1995, Act 215, Imd. Eff. Nov. 29, 1995.

Popular name: Act 218

500.5923 Payment of fee, commission, or consideration to director, officer, agent, or employee; costs and expenses.

Sec. 5923. (1) A director, officer, agent, or employee of the mutual company or any other person shall not receive any fee, commission, or other valuable consideration, other than his or her usual regular salary or compensation, for aiding, promoting, or assisting in a conversion under this chapter except as provided for in the plan approved by the commissioner.

(2) All the costs and expenses connected with a plan of conversion shall be paid for or reimbursed by the mutual company or the converted stock company. However, if the plan provides either for an unaffiliated corporation to purchase and hold all the stock of the converted stock company or for the merger of the mutual company into a stock company, the unaffiliated corporation or stock company shall pay for or reimburse all the costs and expenses connected with the plan.

History: Add. 1995, Act 215, Imd. Eff. Nov. 29, 1995.

Popular name: Act 218

500.5925 Validity of actions.

Sec. 5925. (1) If the mutual company complies substantially and in good faith with the notice requirements of this chapter, the mutual company's failure to give a member the required notice does not impair the validity

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of any action taken under this chapter.

(2) Except as otherwise provided, an action challenging the validity of or arising out of acts taken or proposed to be taken under this chapter, other than an action challenging the commissioner's decision approving or disapproving the plan, shall be commenced within 30 days after the eligible members have approved the plan. An action based upon noncompliance with a business plan submitted under section 5903(2)(f) shall be commenced in Ingham county circuit court within 3 years after the cause of action has accrued, or within 2 years after the time when the cause of action is discovered or should reasonably have been discovered by the complainant, whichever occurs first.

(3) Notwithstanding section 244, an action challenging the validity of the commissioner's decision approving or disapproving the plan shall be commenced within 30 days after the commissioner's decision.

History: Add. 1995, Act 215, Imd. Eff. Nov. 29, 1995;—Am. 1998, Act 121, Imd. Eff. June 10, 1998.

Popular name: Act 218

500.5927 Petition to waive notice and approval requirements.

Sec. 5927. (1) If a mutual insurer becomes insolvent, its board of directors by a majority vote may request in its petition that the commissioner waive the requirements imposing notice to and policyholder approval of the planned conversion. The petition shall specify both of the following:

(a) The method and basis for the issuance of the converted insurer's shares of its capital stock to an independent party in connection with an investment by the independent party in an amount sufficient to restore the insurer to a sound financial condition.

(b) That the conversion shall be accomplished without consideration to the past, present, or future policyholders, if the commissioner finds that the value of the insurer, due to the insolvency, is insufficient to warrant consideration.

(2) If the commissioner, upon review of the plan of conversion and after a financial examination, finds that the mutual insurer no longer meets statutory requirements with respect to capital, surplus, deposits, and assets, the commissioner may waive, by a written order, the requirements of section 5903(6).

History: Add. 1995, Act 215, Imd. Eff. Nov. 29, 1995.

Popular name: Act 218

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CHAPTER 60

Reorganization of Mutual Insurers

500.6001 Definitions.

Sec. 6001. As used in this chapter:

(a) "Converted company" means a Michigan domiciled stock insurance company that results from the reorganization of a mutual company under this chapter.

(b) "Eligible member" means a member whose policy is in force on the date the mutual company's board of directors adopts a plan of reorganization under this chapter.

(c) "Intermediate holding company" means a business corporation subsidiary of a mutual holding company domiciled in this state, any other state, or the District of Columbia that is authorized to issue 1 or more classes of capital stock, the corporate purposes of which include holding directly or indirectly the voting stock of a converted company.

(d) "Member" means a person who, on the records of the mutual company and pursuant to its articles of incorporation or bylaws, is considered to be a holder of a membership interest in the mutual company. A person insured under a group policy is not a member. On and after the effective date of a reorganization under this chapter, member means a member of the mutual holding company created in the reorganization.

(e) "Mutual holding company" or "MHC" means a mutual corporation resulting from a reorganization of a mutual company under this chapter.

(f) "Mutual company" means a domestic mutual insurance company organized under chapter 50, 54, or 58.

(g) "Plan of reorganization" or "plan" means a plan adopted pursuant to this chapter by the board of directors of a mutual company for the reorganization of the mutual company simultaneously into both a mutual holding company and a converted company existing as a direct or indirect stock subsidiary of the mutual holding company.

(h) "Policy" means a group or individual insurance policy or contract issued by a mutual company. The term policy does not include a certificate of insurance issued in connection with a group policy or contract.

(i) "Policyholder" means the holder of a policy other than a reinsurance contract.

History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Compiler's note: Former Chapter 60, being MCL 500.6000-500.6034, was repealed by Act 256 of 1964, Eff. Aug. 28, 1964.

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Popular name: Act 218

500.6003 Reorganization of mutual company; formation.

Sec. 6003. (1) Upon approval of the commissioner, a mutual company may reorganize by forming simultaneously a mutual holding company and converting the mutual company into a direct or indirect stock subsidiary of the mutual holding company. Unless otherwise specifically requested in a plan of reorganization filed with the commissioner, reorganization under this chapter is not a full conversion of a mutual company or of a mutual holding company, as otherwise available under chapter 59. Chapter 59 conversions are separate transactions from a reorganization under this chapter, but may occur with or as a result of a reorganization under this chapter if so requested in a plan approved by the commissioner under chapter 59.

(2) A mutual holding company formed under this chapter may demutualize by complying with the applicable provisions of chapter 59.

History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Compiler's note: Former Chapter 60, being MCL 500.6000-500.6034, was repealed by Act 256 of 1964, Eff. Aug. 28, 1964.

Popular name: Act 218

500.6005 Reorganization plan; adoption; amendment; withdrawal.

Sec. 6005. (1) A mutual company seeking to reorganize to a mutual holding company structure shall adopt, by the affirmative vote of not less than 2/3 of its board of directors, a plan of reorganization under this chapter.

(2) At any time before approval of a plan of reorganization by eligible members, the mutual company, by the affirmative vote of not less than 2/3 of its board of directors, may amend or withdraw the plan.

History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Compiler's note: Former Chapter 60, being MCL 500.6000-500.6034, was repealed by Act 256 of 1964, Eff. Aug. 28, 1964.

Popular name: Act 218

500.6007 Reorganization plan; contents.

Sec. 6007. A plan of reorganization shall include all of the following:

(a) The reasons for the proposed reorganization.

(b) The effect of the reorganization on existing policies including all of the following:

(*i*) A provision that all policies in force on the effective date of the reorganization continue to remain in force under the terms of those policies, except that any voting or other membership rights of the policyholders provided for under the policies or under this act, and any contingent liability policy provisions permitted by this act are extinguished on the effective date of the reorganization.

(*ii*) A provision that holders of participating policies in effect on the date of reorganization continue to have the right to receive dividends as provided in the participating policies, if any.

(*iii*) A provision that, except for a mutual company's life policies, guaranteed renewable accident and health policies, and noncancelable accident and health policies, the converted company may issue the insured a nonparticipating policy as a substitute for the participating policy upon the renewal date of a participating policy.

(c) The detailed plans for granting membership interests to current and future policyholders of the converted company.

(d) Information sufficient to demonstrate that the financial condition of the converted company will not be diminished by the plan.

(e) A description of any current plans or any proposal approved by the mutual company board to issue shares of an intermediate holding company or shares of the converted company to the public or to other persons who are not direct or indirect subsidiaries of the mutual holding company.

(f) The identity of the proposed officers and directors of the mutual holding company and each intermediate holding company, if any, together with other biographical information as the commissioner requests.

(g) Other information as the commissioner requests or prescribes by rule.

History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Compiler's note: Former Chapter 60, being MCL 500.6000-500.6034, was repealed by Act 256 of 1964, Eff. Aug. 28, 1964.

Popular name: Act 218

500.6009 Reorganization plan; operation and support of closed block of business.

Sec. 6009. (1) A plan of reorganization shall provide that a mutual life insurance company's participating life policies in force on the effective date of the conversion shall be operated by the converted company for

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dividend purposes as a closed block of participating business except that any or all classes of group participating policies may be excluded from the closed block.

(2) The plan shall establish 1 or more segregated accounts for the benefit of the closed block of business and shall allocate to those segregated accounts enough assets of the mutual company so that the assets together with the revenue from the closed block of business are sufficient to support the closed block including, but not limited to, the payment of claims, expenses, taxes, and any dividends that are provided for under the terms of the participating policies, with appropriate adjustments in the dividends for experience changes.

(3) The plan shall be accompanied by an actuarial opinion as to the adequacy of reserves or assets by a qualified actuary or an appointed actuary who meets the standards required under this act or under regulations established under this act for the submission of actuarial opinions. The actuarial opinion shall relate to the adequacy of the assets allocated to the segregated accounts in support of the closed block of business. The actuarial opinion shall be based on methods of analysis considered appropriate for those purposes by the actuarial standards board and as certified by the commissioner. The amount of assets allocated to the segregated accounts of the closed block shall be based upon the mutual life insurance company's last annual statement that is updated to the effective date of the reorganization.

(4) The converted company shall keep a separate accounting for the closed block and shall make and include in the annual statement to be filed with the commissioner each year a separate statement showing the gains, losses, and expenses properly attributable to the closed block.

(5) Upon the commissioner's approval, assets allocated to the closed block that are in excess of the amount of assets necessary to support the remaining policies in the closed block shall periodically revert to the benefit of the converted company.

(6) The commissioner may waive the requirement for the establishment or continuation of a closed block of business if the commissioner considers it to be in the best interest of the participating policyholders of a converted company to do so.

(7) This section applies only to mutual life insurance companies.

History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Compiler's note: Former Chapter 60, being MCL 500.6000-500.6034, was repealed by Act 256 of 1964, Eff. Aug. 28, 1964.

Popular name: Act 218

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500.6011 Reorganization plan; filing of documents; hearing; approval or disapproval of plan by commissioner; conditions for approval; retention and assistance of qualified expert.

Sec. 6011. (1) After adoption by the mutual company's board of directors and prior to the members' approval of the plan of reorganization, a mutual company shall file all of the following documents with the commissioner for review and approval:

(a) The plan of reorganization.

(b) The form of notice required by section 6013 for eligible members to vote on the plan.

(c) Any proxies to be solicited from eligible members and any other soliciting materials.

(d) The proposed articles of incorporation and bylaws of the mutual holding company, each intermediate holding company, if any, and the revised articles of incorporation and bylaws of the converted company.

(2) The commissioner may hold a hearing to review a plan of reorganization. The commissioner shall approve the plan upon finding both of the following:

(a) The plan complies with this chapter.

(b) The plan is fair and equitable to the interests of the policyholders.

(3) The commissioner shall approve or disapprove a plan by not later than 90 days after the filing of the documents under subsection (1).

(4) The commissioner may conditionally approve a plan if he or she determines that conditions are reasonably necessary to protect policyholder interests. The conditions may include, but are not limited to, the following:

(a) Prior approval of any concurrent or subsequent acquisition, merger, or formation of affiliate entities of the mutual holding company.

(b) Prior approval of the capital structure of or any changes to the capital structure of any intermediate holding company.

(c) Prior approval of any initial public offering or of any other issuance of equity or debt securities of an intermediate holding company or of the converted company in a private sale or public offering.

(d) Prior approval of the expansion of the mutual holding insurance company system into lines of business, industries, or operations for which it was not licensed or authorized at the time of the reorganization.

(e) Limitations on dividends and distributions if the effect would be to reduce capital and surplus of the

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converted company, in addition to any limitations that may otherwise be authorized by law.

(f) Limitations on the pledge or encumbrance of the stock of the converted company.

(5) The commissioner may retain, at the mutual company's expense, any qualified expert not otherwise a part of the commissioner's staff to assist in reviewing the plan of reorganization.

History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Compiler's note: Former Chapter 60, being MCL 500.6000-500.6034, was repealed by Act 256 of 1964, Eff. Aug. 28, 1964.

Popular name: Act 218

500.6013 Reorganization plan; membership meeting; notice; quorum; vote; proxy; voter eligibility.

Sec. 6013. (1) All eligible members shall be given notice of the members' meeting to vote upon the plan of reorganization. The notice shall briefly but fairly describe the proposed plan, including identifying in reasonable detail the benefits and risks, and shall inform the member of member rights to vote on the plan. A plan summary or copy of the plan shall accompany the notice. The notice shall be mailed to each member's last known address shown on the mutual company's records, within 45 days after the commissioner's approval of the plan. The meeting to vote upon the plan shall be set for a date that is not less than 45 days after the date when the notice of the members' meeting is mailed by the mutual company. If the meeting to vote upon the plan is held during the mutual company's annual meeting of policyholders, only 1 combined notice of meeting is required.

(2) The plan of reorganization shall be adopted at a meeting with a quorum present upon receiving the affirmative vote of at least 2/3 of the votes cast by eligible members.

(3) Members entitled to vote upon the proposed plan may vote in person or by proxy. Certified copies of any forms of proxies to be solicited from eligible members, together with the related proxy statement and any other soliciting materials, shall be filed with the plan and approved by the commissioner before their use.

(4) Each eligible member may cast votes upon each matter coming to a vote in accordance with any rights or classifications of members as provided in the mutual insurer's articles of incorporation or bylaws. If the articles of incorporation or bylaws are silent, each eligible member may cast 1 vote.

History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Compiler's note: Former Chapter 60, being MCL 500.6000-500.6034, was repealed by Act 256 of 1964, Eff. Aug. 28, 1964.

Popular name: Act 218

500.6015 Documents to be filed after plan approval.

Sec. 6015. After the eligible members have approved a plan of reorganization, the converted company shall file all of the following documents with the commissioner:

(a) The minutes of the members' meeting at which the plan of reorganization was voted upon.

(b) The articles and bylaws of the mutual holding company and each intermediate holding company, if any, and the revised articles of incorporation and bylaws of the converted company.

History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Compiler's note: Former Chapter 60, being MCL 500.6000-500.6034, was repealed by Act 256 of 1964, Eff. Aug. 28, 1964.

Popular name: Act 218

500.6017 Mutual holding company; articles of incorporation.

Sec. 6017. (1) Adoption of articles of incorporation for the mutual holding company, each intermediate holding company, if any, and revised articles of incorporation for the converted company is necessary to implement the plan of reorganization. Procedures for adoption or revision of these articles are governed by the applicable provisions of this act or, in the case of an intermediate holding company, the business corporation law of the state in which the intermediate holding company is incorporated. The members may adopt revised articles of incorporation at the same meeting at which the members approve the plan.

(2) The articles of incorporation of a mutual holding company shall include all of the following:

(a) That it is a mutual holding company organized as an insurer under chapter 50, 54, or 58.

(b) That the mutual holding company may hold not less than a majority of the shares of voting stock of a converted company or an intermediate holding company, which in turn holds directly or indirectly all of the voting stock of a converted company.

(c) That it is not authorized to issue any capital stock except pursuant to a conversion in accordance with chapter 59.

(d) That its members shall have the rights specified in this chapter and in its articles of incorporation and bylaws.

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History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Compiler's note: Former Chapter 60, being MCL 500.6000-500.6034, was repealed by Act 256 of 1964, Eff. Aug. 28, 1964.

Popular name: Act 218

500.6019 Reorganization plan; conditions for plan to take effect.

Sec. 6019. (1) A plan becomes effective when the commissioner has approved the plan, the members have approved the plan, and the articles of incorporation of the mutual holding company, each intermediate holding company, if any, and the revised articles of incorporation of the converted company have been adopted and filed with the commissioner.

(2) All of the following simultaneously occur when a plan of reorganization becomes effective under this chapter:

(a) The mutual company becomes a converted company and the corporate existence of the mutual company continues in the converted company with the original date of incorporation of the mutual company.

(b) The membership interests of the mutual company's policyholders are extinguished, and all of the mutual company's eligible members become members of the mutual holding company by and in accordance with the articles of incorporation and bylaws of the mutual holding company and applicable provisions of this chapter and chapters 50, 54, and 58.

(c) All the rights, franchises, and interests of the mutual company in and to every type of property, real, personal, and mixed, and any things in action belonging to it, are transferred to and vested in the converted company without any deed or transfer.

(d) All the obligations and liabilities of the mutual company are assumed by the converted company.

(e) All of the shares of the capital stock of the converted company shall be issued to the mutual holding company, which at all times shall own a majority of the shares of the voting stock of the converted company, except that either at the time a plan is effective, or at a later time with the commissioner's approval, 1 or more intermediate holding companies may be created, so long as the mutual holding company at all times owns directly or indirectly a majority of the shares of the voting stock of the converted company.

(f) Unless otherwise specified in the plan, the directors and officers of the mutual company serve as directors and officers of the converted company until new directors and officers of the converted company are duly elected pursuant to the articles of incorporation and bylaws of the converted company.

History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Compiler's note: Former Chapter 60, being MCL 500.6000-500.6034, was repealed by Act 256 of 1964, Eff. Aug. 28, 1964.

Popular name: Act 218

500.6023 Membership interest in mutual holding company.

Sec. 6023. (1) No member of a mutual holding company may transfer membership in the mutual holding company.

(2) A member of a mutual holding company is not personally liable for the acts, debts, liabilities, or obligations of the mutual holding company solely because of his or her membership status.

(3) No assessments of any kind may be imposed upon the members of a mutual holding company by the directors or members, or because of any liability, act, debt, or obligation of the mutual holding company or of any company owned or controlled by the mutual holding company.

(4) Neither a membership interest in a domestic mutual holding company nor any intermediate or transitional stages taken pursuant to a plan constitutes the creation, issuance, offer to sell, solicitation of an offer to buy, or the sale of a security under the laws of this state.

(5) A membership interest in the mutual holding company automatically terminates if the policy that gave rise to the membership interest is canceled, nonrenewed, terminated, or expires.

(6) Except as otherwise approved by the commissioner, a membership interest in the mutual holding company shall be automatically created with a new policy issued by the converted company.

History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Compiler's note: Former Chapter 60, being MCL 500.6000-500.6034, was repealed by Act 256 of 1964, Eff. Aug. 28, 1964.

Popular name: Act 218

500.6025 Mutual holding company; powers and duties.

Sec. 6025. (1) A mutual holding company has the same powers granted to domestic mutual insurance companies and is subject to the same requirements of this act applicable to mutual companies that are not inconsistent with the provisions of this chapter except that a mutual holding company does not have authority to transact an insurance business. The commissioner may exempt a mutual holding company from any requirement of this act that the commissioner finds inapplicable to a company that is not issuing policies of

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insurance or reinsurance.

(2) Neither the mutual holding company nor any intermediate holding company shall issue or reinsure policies of insurance.

(3) With the commissioner's approval and as provided under this act, a mutual holding company may enter into an affiliation, consolidation, merger, or acquisition agreement either at or after the effective date of a reorganization under this chapter with any mutual insurance company authorized to do business in this state or with any mutual holding company organized in this state or any other state or the District of Columbia.

(4) The assets of a mutual holding company organized under this chapter are subject to a lien in favor of the policyholders of the converted company under such terms as the commissioner may approve.

History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Compiler's note: Former Chapter 60, being MCL 500.6000-500.6034, was repealed by Act 256 of 1964, Eff. Aug. 28, 1964.

Popular name: Act 218

500.6027 Transfer, assignment, or diversion of business from converted business.

Sec. 6027. Without the commissioner's prior approval, neither the converted company nor any other person affiliated with or controlling the converted company shall transfer, assign, or divert business from the converted company to any other insurance company or affiliate if the purpose or effect of doing so would be to reduce significantly the number of members of the mutual holding company. What is a significant reduction shall be determined by the commissioner after examination of the converted company's business reasons for effecting any such transfer, assignment, or diversion.

History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Compiler's note: Former Chapter 60, being MCL 500.6000-500.6034, was repealed by Act 256 of 1964, Eff. Aug. 28, 1964.

Popular name: Act 218

500.6029 Receipt of fee, commission, or other consideration; payment of costs and expenses.

Sec. 6029. (1) A director, officer, agent, or employee of the mutual company or any other person shall not receive any fee, commission, or other valuable consideration, other than his or her usual salary and compensation, for aiding, promoting, or assisting in a reorganization under this chapter, except as provided for in the plan approved by the commissioner.

(2) All the costs and expenses connected with a plan of reorganization shall be paid for or reimbursed by the mutual company or the converted company.

History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Compiler's note: Former Chapter 60, being MCL 500.6000-500.6034, was repealed by Act 256 of 1964, Eff. Aug. 28, 1964.

Popular name: Act 218

500.6031 Substantial compliance with notice requirements; commencement of action challenging validity of certain acts or commissioner's decision.

Sec. 6031. (1) If a mutual company complies substantially and in good faith with the notice requirements of this chapter, the mutual company's failure to give a member any required notice does not impair the validity of any action taken under this chapter. The commissioner may convene an appropriate hearing at any time for purposes of determining the existence of good faith and substantial compliance by the mutual company.

(2) An action challenging the validity of or arising out of acts taken or proposed to be taken under this chapter, other than an action challenging the commissioner's decision approving or disapproving the plan, shall be commenced within 30 days after the eligible members have approved the plan. An action challenging the validity of the commissioner's decision approving or disapproving the plan shall be commenced within 30 days after the commissioner's decision is announced.

History: Add. 2000, Act 8, Imd. Eff. Feb. 25, 2000.

Compiler's note: Former Chapter 60, being MCL 500.6000-500.6034, was repealed by Act 256 of 1964, Eff. Aug. 28, 1964.

Popular name: Act 218

CHAPTER 61
AUTOMOBILE THEFT PREVENTION AUTHORITY

500.6101 Definitions.

Sec. 6101. As used in this chapter:

(a) "Authority" means the automobile theft prevention authority.

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(b) "Board" means the board of directors of the automobile theft prevention authority.

(c) "Economic automobile theft" means automobile theft perpetrated for financial gain.

History: Add. 1992, Act 174, Imd. Eff. July 23, 1992.

Compiler's note: Enacting section 2 of Act 174 of 1992 provides:

"Section 2. Chapter 61 of Act No. 218 of the Public Acts of 1956, as added by this amendatory act, is retroactive and applies effective April 1, 1992."

Former MCL 500.6101, which pertained to definitions, was repealed by Act 191 of 1991 , Eff. Apr. 1, 1992.

Popular name: Act 218

500.6103 Automobile theft prevention authority; creation; board of directors; appointment, qualifications, and terms of members; compensation and expenses; quorum; meetings; exercising powers, duties, and functions.

Sec. 6103. (1) There is hereby created a public body corporate and politic to be known as the automobile theft prevention authority.

(2) The purposes, powers, and duties of the authority shall be vested in and exercised by a board of directors.

(3) The board of directors shall consist of 7 members, appointed by the governor, with the advice and consent of the senate, 2 of whom shall be representative of purchasers of automobile insurance in this state, 2 of whom shall be representative of automobile insurers doing business in this state, 2 of whom shall be representative of law enforcement officials in this state, and 1 of whom shall be the director of the department of state police or his or her designee. The governor shall designate 1 member to serve as the chairperson of the authority.

(4) Members of the board shall serve for a term of 4 years.

(5) Members of the board shall serve without compensation for their membership on the board, except that members of the board shall receive reasonable reimbursement for necessary travel and expenses.

(6) A majority of the members of the board shall constitute a quorum for the transaction of business at a meeting, or the exercise of a power or function of the authority, notwithstanding the existence of 1 or more vacancies. Notwithstanding any other provision of law, action may be taken by the authority at a meeting upon a vote of the majority of its members present in person or through the use of amplified telephonic equipment, if authorized by the bylaws of the board. The authority shall meet at the call of the chair or as may be provided in the bylaws of the authority. Meetings of the authority may be held anywhere within the state of Michigan.

(7) The authority shall be within the department of state police and shall exercise its prescribed statutory powers, duties, and functions independently of the head of that department. The budgeting, procurement, and related functions of the authority, and administrative responsibilities for employees of the authority, shall be performed under the direction and supervision of the director of the department of state police.

History: Add. 1992, Act 174, Imd. Eff. July 23, 1992.

Compiler's note: Enacting section 2 of Act 174 of 1992 provides:

"Section 2. Chapter 61 of Act No. 218 of the Public Acts of 1956, as added by this amendatory act, is retroactive and applies effective April 1, 1992."

Former MCL 500.6103, which pertained to creation of the automobile theft prevention authority, was repealed by Act 191 of 1991, Eff. Apr. 1, 1992.

Popular name: Act 218

500.6105 Authority; powers.

Sec. 6105. The authority shall have the powers necessary or convenient to carry out and effectuate the purposes and provisions of this chapter and the purposes of the authority and the powers delegated by other laws, including, but not limited to, the power to:

(a) Sue and be sued; to have a seal and alter the same at pleasure; to have perpetual succession; to make, execute, and deliver contracts, conveyances, and other instruments necessary or convenient to the exercise of its powers; and to make and amend bylaws.

(b) Solicit and accept gifts, grants, loans, funds collected and placed in the automobile theft prevention fund, and other aids from any person or the federal, state, or a local government or any agency thereof.

(c) Make grants and investments.

(d) Procure insurance against any loss in connection with its property, assets, or activities.

(e) Invest any money held in reserve or sinking funds, or any money not required for immediate use or disbursement, at its discretion and to name and use depositories for its money.

(f) Contract for goods and services and engage personnel as is necessary, including the services of private consultants, managers, counsel, auditors, and others for rendering professional, management, and technical

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assistance and advice, payable out of any money of the fund legally available for this purpose.

(g) Indemnify and procure insurance indemnifying any member of the board from personal loss or accountability from liability resulting from a member's action or inaction as a member of the board.

(h) Do all other things necessary or convenient to achieve the objectives and purposes of the authority, this chapter, or other laws.

History: Add. 1992, Act 174, Imd. Eff. July 23, 1992.

Compiler's note: Enacting section 2 of Act 174 of 1992 provides:

"Section 2. Chapter 61 of Act No. 218 of the Public Acts of 1956, as added by this amendatory act, is retroactive and applies effective April 1, 1992."

Former MCL 500.6105, which pertained to powers of authority, was repealed by Act 191 of 1991, Eff. Apr. 1, 1992.

Popular name: Act 218

500.6107 Automobile theft prevention fund; payment of assessment by certain insurers; administration of fund; priority of expenditures; use and distribution of fund; fund not considered state money; "written car year" defined.

Sec. 6107. (1) Before April 1 of each year, each insurer engaged in writing insurance coverages that provide the security required by section 3101(1) in this state, as a condition of its authority to transact insurance in this state, shall pay to the authority an assessment equal to $1.00 multiplied by the insurer's total written car years of insurance providing the security required by section 3101(1) written in this state during the preceding year.

(2) The authority shall segregate and deposit money received under subsection (1), and all other money received by the authority, in a fund to be known as the automobile theft prevention fund. The authority shall administer the automobile theft prevention fund.

(3) The authority shall expend money in the automobile theft prevention fund in the following order of priority:

(a) To pay the costs of administration of the authority.

(b) To achieve the purposes and objectives of this chapter, which may include, but not be limited to, the following:

(*i*) Providing financial support to the department of state police and local law enforcement agencies for economic automobile theft enforcement teams.

(*ii*) Providing financial support to state or local law enforcement agencies for programs designed to reduce the incidence of economic automobile theft.

(*iii*) Providing financial support to local prosecutors for programs designed to reduce the incidence of economic automobile theft.

(*iv*) Providing financial support to judicial agencies for programs designed to reduce the incidence of economic automobile theft.

(*v*) Providing financial support for neighborhood or community organizations or business organizations for programs designed to reduce the incidence of automobile theft.

(*vi*) Conducting educational programs designed to inform automobile owners of methods of preventing automobile theft and to provide equipment, for experimental purposes, to enable automobile owners to prevent automobile theft.

(4) Money in the automobile theft prevention fund must only be used for automobile theft prevention efforts and must be distributed based on need and efficacy as determined by the authority.

(5) Money in the automobile theft prevention fund is not state money.

(6) As used in this section, "written car year" means the portion of a year during which a vehicle is insured as determined by the catastrophic claims association and used to calculate premium charges under section 3104.

History: Add. 1992, Act 174, Imd. Eff. July 23, 1992;—Am. 2017, Act 58, Imd. Eff. June 15, 2017.

Compiler's note: Enacting section 2 of Act 174 of 1992 provides:

"Section 2. Chapter 61 of Act No. 218 of the Public Acts of 1956, as added by this amendatory act, is retroactive and applies effective April 1, 1992."

Former MCL 500.6107, which pertained to automobile prevention fund, was repealed by Act 191 of 1991, Eff. Apr. 1, 1992.

Popular name: Act 218

500.6110 Authority; plan of operation; report.

Sec. 6110. (1) The authority shall develop and implement a plan of operation.

(2) The plan of operation shall include an assessment of the scope of the problem of automobile theft, including particular areas of the state where the problem is greatest; an analysis of various methods of combating the problem of automobile theft and economic automobile theft; a plan for providing financial

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support to combat automobile theft and economic automobile theft; and an estimate of the funds required to implement the plan.

(3) The authority shall report annually on or before February 1 to the governor and the legislature on its activities in the preceding year.

History: Add. 1992, Act 174, Imd. Eff. July 23, 1992.

Compiler's note: Enacting section 2 of Act 174 of 1992 provides:

"Section 2. Chapter 61 of Act No. 218 of the Public Acts of 1956, as added by this amendatory act, is retroactive and applies effective April 1, 1992."

Former MCL 500.6110, which pertained to plan of operation and annual report, was repealed by Act 191 of 1991, Eff. Apr. 1, 1992.

Popular name: Act 218

500.6111 Automobile theft prevention authority; report.

Sec. 6111. By July 1 of every odd numbered year, the automobile theft prevention authority shall prepare a report that details the theft of automobiles occurring in this state for the previous 2 years, assesses the impact of the thefts on rates charged for automobile insurance, summarizes prevention programs, and outlines allocations made by the authority. The director of the department of state police, insurers, and the commissioner shall cooperate in the development of the report as requested by the automobile theft prevention authority and shall make available records and statistics concerning automobile thefts, including the number of automobile thefts, number of prosecutions and convictions involving automobile thefts, and automobile theft recidivism. The automobile theft prevention authority shall evaluate the impact automobile theft has on the citizens of this state and the costs incurred by the citizens through insurance, police enforcement, prosecution, and incarceration due to automobile thefts. The report required by this section shall be submitted to the senate and house of representatives standing committees on insurance issues and the commissioner.

History: Add. 1992, Act 174, Imd. Eff. July 23, 1992;—Am. 2004, Act 316, Imd. Eff. Aug. 27, 2004.

Compiler's note: Section 2 of Act 174 of 1992 provides:

"Section 2. Chapter 61 of Act No. 218 of the Public Acts of 1956, as added by this amendatory act, is retroactive and applies effective April 1, 1992."

Popular name: Act 218

500.6115, 500.6125 Repealed. 1991, Act 191, Eff. Apr. 1, 1992.

Compiler's note: The repealed sections pertained to dissolution of authority, liquidation of assets, and repeal of chapter.

Popular name: Act 218

CHAPTER 62
MUTUAL EMPLOYERS' LIABILITY INSURERS (DOMESTIC)

500.6200-500.6236 Repealed. 1964, Act 256, Eff. Aug. 28, 1964.

Compiler's note: The repealed sections regulated domestic mutual employers' liability and workmen's compensation insurers.

Popular name: Act 218

CHAPTER 63
ANTI-FRAUD UNIT

500.6301 Establishment of anti-fraud unit; powers and duties.

Sec. 6301. (1) An anti-fraud unit is established as a criminal justice agency in the department, dedicated to prevention and investigation of criminal and fraudulent activities in the insurance market.

(2) The anti-fraud unit is a criminal justice agency with full access to criminal justice information and criminal justice information systems. The anti-fraud unit may investigate all persons, including, but not limited to, persons subject to the department's regulatory authority, consumers, insureds, and any other persons allegedly engaged in criminal and fraudulent activities in the insurance market. The anti-fraud unit may investigate criminal and fraudulent activity related to any matter under the jurisdiction and authority of the department under Executive Reorganization Order No. 2013-1, MCL 550.991.

(3) The anti-fraud unit may do any of the following:

(a) Conduct criminal background checks on applicants for licenses and current licensees in accordance with state and federal law.

(b) Collect and maintain claims of criminal and fraudulent activities in the insurance industry.

(c) Investigate claims of criminal and fraudulent activity in the insurance market that, if true, would constitute a violation of applicable state or federal law, including, but not limited to, the Michigan penal code,

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1931 PA 328, MCL 750.1 to 750.568, and this act.

(d) Maintain records of criminal investigations.

(e) Share records of its investigations with other criminal justice agencies.

(f) Review information from other criminal justice agencies to assist in the enforcement and investigation of all matters under the authority of the director.

(g) Conduct outreach and coordination efforts with local, state, and federal law enforcement and regulatory agencies to promote investigation and prosecution of criminal and fraudulent activities in the insurance market.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.6302 Anti-fraud unit; records and information; exempt from freedom of information act; duties of director; disclosure; waiver.

Sec. 6302. (1) A document, material, or information related to an investigation of the anti-fraud unit is confidential by law and privileged, is not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, is not subject to subpoena, and is not subject to discovery or admissible in evidence in any private civil action. However, the director may use the documents, materials, or information in the furtherance of any supervisory activity or legal action brought as part of the director's duties.

(2) The director, or any person that received documents, materials, or information while acting on behalf of the anti-fraud unit, is not permitted and may not be required to testify in any private civil action concerning any confidential documents, materials, or information described in subsection (1).

(3) To assist in the performance of the anti-fraud unit's duties, the director may do any of the following:

(a) Share documents, materials, or information, including the confidential and privileged documents, materials, or information that is subject to subsection (1), with any of the following:

(*i*) Other state, federal, and international regulatory agencies.

(*ii*) Other state, federal, and international law enforcement authorities, if the recipient agrees to maintain the confidentiality and privileged status of the documents, materials, or information.

(*iii*) Any other person as the director considers necessary to discharge the anti-fraud unit's duties under section 6301 or other applicable law.

(b) Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from any of the following:

(*i*) Other state, federal, and international regulatory agencies.

(*ii*) Other state, federal, and international law enforcement authorities, if the recipient agrees to maintain the confidentiality and privileged status of the documents, materials, or information.

(*iii*) Any other person as the director considers necessary to discharge his or her duties under this act or any other applicable act.

(c) Enter into agreements governing the sharing and use of information that are consistent with this section.

(4) The director shall maintain as confidential and privileged any documents, materials, or information received under subsection (3)(b) with notice or the understanding that the documents, materials, or information is confidential and privileged under the laws of the jurisdiction that is the source of the documents, materials, or information.

(5) The disclosure of any documents, materials, or information to the director, or the sharing of documents, materials, or information under subsection (3), is not a waiver of, and must not be construed as a waiver of, any privilege applicable to or claim of confidentiality in those documents, materials, or information.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.6303 Annual report to legislature.

Sec. 6303. (1) Beginning July 1 of the year after the effective date of the amendatory act that added this section, the anti-fraud unit shall prepare and publish an annual report to the legislature on the anti-fraud unit's efforts to prevent automobile insurance fraud.

(2) The anti-fraud unit shall submit the annual report to the legislature required by this section to the standing committees of the senate and house of representatives with primary jurisdiction over insurance issues and the director.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

500.6304 Effect of chapter; limitation of power.

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Sec. 6304. This chapter does not limit the power of the anti-fraud unit to conduct activities under Executive Order No. 2018-9 with respect to the financial services industry or markets.

History: Add. 2019, Act 21, Imd. Eff. June 11, 2019.

Popular name: Act 218

CHAPTER 64
COOPERATIVE PLAN INSURERS (DOMESTIC)

500.6400 Scope of chapter.

Sec. 6400. (1) This chapter applies only to domestic insurers transacting life, disability, or loss of position insurances, as defined in section 6406, on the cooperative or assessment plan.

(2) Corporations heretofore organized and/or doing business under the provisions of Act No. 339 of the Public Acts of 1937, as amended, shall hereafter be subject to the provisions of this chapter and shall hereafter be classified as insurers doing business under this chapter.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Compiler's note: Act 339 of 1937, referred to in this section, amended Act 256 of 1917 which was repealed by Act 218 of 1956.

Popular name: Act 218

500.6402 Domestic cooperative plan insurers; organization.

Sec. 6402. Subject to the requirements of chapter 50 (organization of domestic insurers) and 52 (corporate powers, procedures of domestic insurers), any number of persons, not less than 7, residents of this state, may incorporate for the purpose of carrying on upon the assessment or cooperative plan, the kind or kinds of insurance enumerated in any 1 or more subdivisions of section 6406.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6406 Domestic cooperative plan insurers; authorized kinds of insurance.

Sec. 6406. The kinds of insurance which may be carried on by insurers incorporated under this chapter shall be as follows:

(1) To insure persons against bodily injury or death by accident or against disability on account of sickness or accident and also to grant specific hospital benefits and medical, surgical and sick-care benefits to persons and their families, subject to such limitations as the commissioner may prescribe with respect thereto; and to provide reimbursement of funeral expenses, not exceeding $200.00 to any person in conjunction therewith.

(2) To provide indemnity to conductors, engineers and motormen of steam and electric railways, and to persons engaged in other similar trades or occupations, for loss of position arising from discharge or suspension, which indemnity shall be payable in installments which do not exceed the average monthly wage of the member, and which, in the aggregate upon any 1 risk, shall not exceed 15% of the contingency reserve deposit provided in sections 6434 and 6446, and to provide indemnity for loss of position arising from retirement.

(3) To insure the lives of persons and to grant every insurance pertaining thereto. Such policies of life insurance may provide for total and permanent disability benefits and accidental death benefits.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6410 Domestic cooperative plan insurers; qualifications for certificate of authority; issuance of policies.

Sec. 6410. No insurer shall commence business under this chapter until it shall have procured bona fide applications for insurance therein together with the first premium in cash from at least 300 eligible persons for each class of risk as defined in section 6406 which the insurer undertakes to write; nor until the secretary and treasurer shall have given good and sufficient bonds to the insurer to be held by the president of the insurer, for the faithful performance of their duties, which bonds shall each be in amount at least twice the amount of money liable to come into the hands of such officer at any 1 time, said bonds to be approved by the commissioner; nor until the commissioner, after receipt of satisfactory proof as to compliance with these and such other requirements as he shall deem essential, shall have issued a certificate of authority to such insurer, then, and not before, the insurer may issue its policies of insurance.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

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500.6412 Domestic cooperative plan insurers; life insurer; qualifications to write annuity contracts.

Sec. 6412. No insurer subject to subdivision (3) of section 6406 (transaction of life insurance) shall write in Michigan any contract of annuity, or retain by virtue of supplemental agreement any proceeds of any policy or contract of insurance upon deposit with such insurer at interest or upon settlement option, until it shall have a contingency reserve deposit as defined and described in section 6434, in the amount of $100,000.00, and shall have obtained from the commissioner a certificate of authority to write such contracts of annuity or supplemental agreements.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6414 Domestic cooperative plan insurers; qualifications to write group insurance.

Sec. 6414. No such insurer shall do a business of group insurance in Michigan until it shall have accrued a contingency reserve deposit as defined and described in section 6434 in the amount of $100,000.00, and shall have obtained from the commissioner a certificate of authority to write group insurance.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6418 Domestic cooperative plan insurers; directors; selection at annual meetings; first annual meeting.

Sec. 6418. (1) The property, business and affairs of such insurer, shall be managed by not less than 5 nor more than 20 directors to be chosen by the members at the annual meeting of members, to serve until the next annual meeting and until their successors be qualified. The directors may be divided into 3 groups as nearly equal as possible and in such case only 1 group shall be elected at each annual meeting in a manner to be prescribed by the bylaws.

(2) The first annual meeting of members shall take place within 12 months following the date of execution of the articles of incorporation. During the interim between the execution of the articles of incorporation and the first annual meeting of members, the affairs of the insurer may be administered by such directors, officers or trustees as shall be vested with such interim authority by the terms of the articles of incorporation.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6422 Domestic cooperative plan insurers; members; voting; quorum; inspection of books.

Sec. 6422. Every person insured in any insurer organized under this chapter shall be a member of such insurer, and shall be entitled to 1 vote at all meetings of the members, and may vote in person or by proxy under such rules and regulations as may be provided in the bylaws of such insurer: Provided, however, That a minimum of 10 members shall be present in person to constitute a quorum. The books of such insurer shall be open for inspection by any member of such insurer at any of its meetings.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6428 Insurer transacting business under MCL 500.6406 subject to certain provisions.

Sec. 6428. (1) An insurer transacting business under section 6406(1) is subject to section 2260 and chapter 34.

(2) An insurer transacting business under section 6406(2) is subject to section 6616, and all policies must grant the nonforfeiture values under annuity contracts that are required of life insurers under this act.

(3) An insurer transacting business under section 6406(3) is subject to chapters 40 and 42.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.6432 Domestic cooperative plan insurers; reserves; standards applicable.

Sec. 6432. (1) Every insurer transacting the kind or kinds of insurance described in subdivisions (1) and (2) of section 6406 (disability and loss of position insurances) shall maintain reserves for unearned premiums in accordance with the standards prescribed from time to time by the commissioner, which standards shall conform to those required of other insurers authorized to insure similar risks under the provisions of this code.

(2) Every insurer transacting the business of life insurance, endowment and/or annuity on or after January 1, 1948, shall maintain the reserves required by section 834 (standard valuation law); for all contracts issued

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between January 1, 1940, and December 31, 1947, inclusive, reserves not less than that determined by the national fraternal congress table of mortality as adopted by the national fraternal congress, August 23, 1899, with interest assumption not more than 4% per annum, or such other reserve as shall be provided by the certificate or contract of insurance, whichever may be the greater; and for all contracts issued prior to January 1, 1940, premiums shall be segregated as a separate fund or funds to be held in trust solely for the benefit of such contract, for which fund a separate accounting shall be made, unless or until the insurer shall be able to and shall elect to transfer said contracts or policies, with the reserves herein required, into 1 of the preceding 2 classes.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6434 Contingency reserve; deposit.

Sec. 6434. Every domestic insurer subject to this chapter shall maintain a contingency reserve at all times at least equal to 1/10 of the total premium income for the preceding calendar year but not less than $5,000.00 for each kind of insurance enumerated in section 6406 which the insurer undertakes to issue and shall maintain a deposit with the state treasurer, of the kind and amount and for the purposes specified in section 411.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1972, Act 360, Imd. Eff. Jan. 9, 1973.

Popular name: Act 218

500.6436 Domestic cooperative plan insurers; unlawful use of reserve funds; penalty.

Sec. 6436. (1) It shall be unlawful for any officer or agent of a cooperative mutual life insurance company doing business in this state to appropriate or use any portion of the reserve or mortality funds of such company for any other purpose than such as the articles of incorporation, bylaws and contracts with members prescribe.

(2) Any officer or agent guilty of any intentional violation of this section, or who shall aid or abet others in any such violation, shall be deemed guilty of a misdemeanor and upon conviction thereof shall be punished by a fine not exceeding $1,000.00, or by imprisonment not exceeding 6 months, or by both such fine and imprisonment, in the discretion of the court.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6440 Domestic cooperative plan insurers; assessment of members; nonassessable policies.

Sec. 6440. On and after January 1, 1948, every policy issued or delivered in this state by any domestic insurer subject to this chapter, shall set forth on the first page thereof, in addition to the regular specified premiums, the fact that the member is liable to be assessed to the extent needed to pay said member's aliquot share of claims and expenses, and to maintain the reserves required by this chapter. No such assessment shall be levied against any policyholder except upon due notice to such policyholder. Every policyholder shall be entitled to elect that his or her policy reserves, or the required portion thereof, shall be applied against such assessment. If any member shall fail to pay such assessment in cash within 30 days after notice, said assessment shall become a lien upon his or her policy or policies. Whenever the amount of liens upon any policy shall equal its reserve, the policy shall become void without further action and no further liability shall attach to the insurer. No assessment shall be made until the method of determining and spreading the assessment shall have been approved by the commissioner. The commissioner may authorize the prosecution of suits to collect assessments when he shall deem such action equitable and practicable: Provided, That any insurer issuing the kinds of insurance in subdivisions (1) (disability) and/or (2) (loss of position) of section 6406 may issue a nonassessable policy, which may be so described on the face of the policy, while it has contingency reserves in the amount of at least $200,000.00, and in no event shall the holder of any such policy, or any renewal thereof, be liable for a greater amount than the premiums expressed in the policy: Provided further, That no such nonassessable policy shall be issued until the commissioner shall, after examination of the insurer, determine that the insurer has contingency reserves of at least $200,000.00, and authorizes the insurer, in writing, to issue such nonassessable policies.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6446 Domestic cooperative plan insurers; limits of risk; increased reserve; reinsurance.

Sec. 6446. No such insurer shall expose itself to loss from all causes, on any 1 risk, in a total principal sum

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exceeding 10% of its contingency reserve deposit as defined in section 6434: Provided, That insurers may establish, make and maintain a larger contingency reserve deposit than is required by said section 6434, and thereafter the limits of exposure as herein defined shall be increased by 10% of any such excess deposit: Provided further, That insurers transacting business under this chapter may issue policies under which the amount insured exceeds the foregoing limitations, if the said insurers shall, at the time of issuance of said policy or policies, have in force, and shall maintain in force throughout the continuance of such policies, a good and enforceable contract or contracts of reinsurance ceding of said individual risks not less than the excess over the permissible retention as herein provided, which reinsurance shall be ceded only to insurers authorized under the provisions of this code to transact business of a similar class in this state, and to accept reinsurance: Provided, however, That no reinsurance shall be ceded to or accepted by any insurer operating under the cooperative or assessment plan: Provided further, That this section shall not reduce the limits of exposure to loss for insurers legally operating in this state under the cooperative or assessment plan on January 1, 1947.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6450 Guaranty fund; agreement; terms; repayment; other borrowed money.

Sec. 6450. Any insurer may secure its required funds for reserve purposes by means of contributions or loans, but subject to the limitations set forth in this section. Any fund so secured is hereinafter described as a guaranty fund. The agreement upon which a guaranty fund is secured shall provide that any claim for its return is inferior and subordinate to all claims of and reserves for policyholders and insured members and to the statutory required contingency reserve deposit and is subject to the approval of the commissioner. The guaranty fund and agreed interest on the guaranty fund accrued in a manner and at a rate approved by the commissioner shall not be liabilities or claims against the insurer or any of its assets except as provided in this section. Interest shall be paid and principal shall be retired only out of surplus of the insurer in excess of current obligations and of reserves required by this chapter. No part of principal shall be retired or interest paid unless the surplus remaining after repayment is determined adequate to comply with section 403 and the insurer has received the written consent of the commissioner. No commission or promotion expense of any kind shall be paid or allowed in connection with the raising of the guaranty fund, and the amount of the guaranty fund together with interest on the fund and any portion of the fund retired during any year shall be reported in the insurer's annual statement. This section does not bar any insurer subject to this section from borrowing money, but the amount borrowed with accrued interest shall be carried by the insurer as an immediate liability, as distinguished from the deferred or contingent liability status of the guaranty fund.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.6456 Domestic cooperative plan insurers; conversion into mutual insurer; procedure.

Sec. 6456. (1) Any insurer transacting business under subdivisions (1) (disability) or (3) (life) of section 6406, or under both such subdivisions, may, at its option, convert itself without reincorporation into a mutual insurance company transacting the corresponding kind or kinds of business, and become subject to the provisions of sections 5408 through 5430 (provisions applicable to domestic mutual life and disability insurers) and the applicable portions of sections 408 (capital, surplus, assets required) and 412 (deposit requirement), upon meeting the surplus and other requirements of said sections. Any insurer transacting only the kinds of business specified in subdivisions (1) (disability) and/or (2) (loss of position) of section 6406, may, at its option, convert itself without reincorporation into a mutual company and continue to transact the said kind or kinds of business, and become subject in all other respects to the provisions of chapter 58 (domestic general mutual insurers) upon meeting the requirements of said chapter.

(2) The board of directors, trustees, or managers, shall adopt, in the manner provided by law, such amendments to the articles of incorporation and the bylaws of the insurer as shall be necessary to make the same conform to the articles of incorporation and bylaws of a mutual insurance company, as above limited. Upon approval by the commissioner of such amendments, and the filing of a certified copy of the amendments to the articles of incorporation with the county clerk of the county in which the principal office of the insurer is located, such insurer shall be subject to the provisions and entitled to the benefits of the sections or chapter above designated, as the case may be.

(3) Such conversion into a mutual insurance company shall not affect the rights or obligations of the insurer or its members on any contract theretofore made.

History: 1956, Act 218, Eff. Jan. 1, 1957.

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Popular name: Act 218

500.6460 New insurers organized after December 31, 1993.

Sec. 6460. No new insurer shall be organized under this chapter after December 31, 1993.

History: Add. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

CHAPTER 65
LIMITED LIABILITY POOLS

500.6500 Applicability of chapter.

Sec. 6500. This chapter applies only to pools formed to transact liability insurance as defined in section 6506, on the cooperative or assessment plan.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

500.6502 Formation of limited liability pool; purpose.

Sec. 6502. Subject to the requirements of chapters 50 and 52, any number of persons, not less than 7, who are residents of this state, may form a limited liability pool for the purpose of carrying on upon the assessment or cooperative plan, liability insurance as provided in section 6506.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

500.6506 Powers of limited liability pool; limitation.

Sec. 6506. The powers of a limited liability pool formed pursuant to this chapter shall be limited to the issuance of liability insurance policies for commercial, or other industrial, professional, or business liabilities as designated by the commissioner pursuant to this section. If, after holding a public hearing, the commissioner determines that liability insurance for a business or class of businesses, including, but not limited to, 4-year institutions of higher learning, child day care centers, nonprofit organizations, or a profession or class of professions is not readily available or is not available at a reasonable premium, the commissioner shall designate that business or class of businesses or profession or class of professions as eligible to be issued liability insurance policies by a limited liability pool formed pursuant to this chapter.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

500.6510 Commencement of business; pool not subject to MCL 500.410.

Sec. 6510. (1) A limited liability pool shall not commence business under this chapter until all of the following are met:

(a) The pool has procured bona fide applications for insurance together with the first premium in cash from at least 50 eligible persons for the business or class of businesses or profession or class of professions as defined in section 6506 which the pool undertakes to write.

(b) The secretary and treasurer have given good and sufficient bonds, approved by the commissioner, to the pool to be held by the president of the pool, for the faithful performance of their duties, which bonds shall each be in an amount at least twice the amount of money liable to come into the hands of such officer at any 1 time.

(c) The pool has accrued a contingency reserve deposit as defined and described in section 6534.

(d) The pool has met the insurer requirements provided in section 411.

(e) The commissioner, after receipt of satisfactory proof as to compliance with these and such other requirements as he or she considers essential, has issued a certificate of authority to the pool.

(2) A limited liability pool formed under this chapter shall not be subject to the requirement provided in section 410.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

500.6512 Limited liability pool; formation; purpose.

Sec. 6512. The commissioner shall require a limited liability pool formed under this chapter to certify annually the loss reserves of the pool by an actuary approved by the commissioner.

History: Add. 1990, Act 350, Imd. Eff. Dec. 26, 1990.

Popular name: Act 218

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500.6514 Limited liability pool; rates.

Sec. 6514. The rates charged by a limited liability pool formed under this chapter shall be filed in accordance with section 2408 and shall be subject to the prior approval of the commissioner.

History: Add. 1990, Act 350, Imd. Eff. Dec. 26, 1990.

Popular name: Act 218

500.6516 Limited liability pool; underwriting rules.

Sec. 6516. (1) A limited liability pool formed under this chapter shall put in writing all underwriting rules used by the insurer and shall file its underwriting rules with the commissioner prior to their use in this state.

(2) As used in this section, "underwriting rules" means the written statements, guidelines, or criteria of a limited liability pool, that describe the standards under which the limited liability pool issues, refuses to issue, renews, refuses to renew, or limits coverage for liability insurance under this chapter.

History: Add. 1990, Act 350, Imd. Eff. Dec. 26, 1990.

Popular name: Act 218

500.6517 Limited liability pool; reinsurance.

Sec. 6517. A limited liability pool formed under this chapter may reinsure all or any portion of its potential liability with reinsurers licensed to transact insurance in this state or approved by the commissioner. A limited liability pool shall not directly or indirectly reinsure all or any portion of its potential liability with an insurer not authorized to transact insurance in this state without approval by the commissioner.

History: Add. 1990, Act 350, Imd. Eff. Dec. 26, 1990.

Popular name: Act 218

500.6518 Management of property, business, and affairs of pool by directors; selection and term of directors; first annual meeting; interim authority.

Sec. 6518. (1) The property, business, and affairs of a pool authorized under this chapter shall be managed by not less than 5 nor more than 20 directors to be chosen by the members at the annual meeting of members, to serve until the next annual meeting and until their successors be qualified.

(2) The first annual meeting of members shall take place within 12 months following the date of execution of the articles of incorporation. During the interim between the execution of the articles of incorporation and the first annual meeting of members, the affairs of the pool may be administered by such directors, officers, or trustees as shall be vested with such interim authority by the terms of the articles of incorporation.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

500.6522 Insured person as member of pool; voting rights; quorum; inspection of books.

Sec. 6522. Every person insured in any pool formed under this chapter shall be a member of the pool, and shall be entitled to 1 vote at all meetings of the members, and may vote in person or by proxy under such rules and regulations as may be provided in the bylaws of the pool. A minimum of 10 members shall be present in person to constitute a quorum. The books of the pool shall be open for inspection by any member of the insurer at any of its meetings.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

500.6532 Reserves for unearned premiums.

Sec. 6532. Every pool transacting insurance under this chapter shall maintain reserves for unearned premiums in accordance with the standards prescribed from time to time by the commissioner, which standards shall conform to those required of other insurers authorized to insure similar risks under the provisions of this code.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

500.6534 Contingency reserve; deposit with state treasurer; use of deposit.

Sec. 6534. Every pool subject to this chapter shall maintain a contingency reserve at all times at least equal to 2/7 of the total premium income for the preceding calendar year but not less than $300,000.00 and shall maintain a deposit with the state treasurer of the kind and amount and for the purposes specified in section 411. The deposit with the state treasurer may be used by the pool for purposes of calculating the contingency

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reserve. This contingency reserve shall be in addition to the ordinary reserves maintained for unpaid losses and loss adjustment expenses, including those claims which have been incurred but not reported and the reserve required under section 6532.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986;—Am. 1990, Act 350, Imd. Eff. Dec. 26, 1990.

Popular name: Act 218

500.6540 Assessment of member.

Sec. 6540. Every policy issued or delivered in this state by any pool subject to this chapter shall set forth on the first page thereof, in addition to the regular specified premiums, the fact that the member is liable to be assessed to the extent needed to pay that member's proportional share of claims and expenses, and to maintain the reserves required by this chapter. However, in no event shall a member be liable for an assessment under this section which is greater than the annual premium expressed in the policy. An assessment shall not be levied against any member except upon due notice to the member. If any member shall fail to pay the assessment in cash within 30 days after notice, the assessment shall become a lien upon his or her policy. Whenever an assessment becomes a lien upon a policy, the policy shall become void without further action and no further liability shall attach to the pool. An assessment shall not be made until the method of determining and spreading the assessment has been approved by the commissioner. The commissioner may authorize the prosecution of suits to collect assessments when he or she deems that action equitable and practicable.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

500.6550 Loans.

Sec. 6550. Any pool organized under this chapter may secure its required funds for the deposit required under section 411, contingency reserve and other reserve purposes, and to defray the reasonable expenses of its organization by means of loans, upon an agreement that has first been submitted to and approved by the commissioner, that the funds shall be repaid with interest accrued in a manner and at a rate approved by the commissioner. The agreement under which the funds are obtained shall provide that any claim for their return shall be inferior and subordinate to all claims of and reserves for policyholders and creditors and shall not be liabilities or claims against the pool or any of its assets except as provided in this section. Interest shall be paid and principal shall be retired only out of surplus of the pool in excess of current obligations and of reserves required by this chapter. No part of principal shall be retired or interest paid unless the surplus remaining after repayment is determined adequate to comply with section 403 and the pool has received the written consent of the commissioner. The amount of funds obtained pursuant to this section and any portion retired during any year shall be reported in the pool's annual statement.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

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CHAPTER 66

RAILWAY EMPLOYEES, AND LIFE, DISABILITY INSURERS (DOMESTIC, STOCK)

500.6600 Scope of chapter.

Sec. 6600. This chapter applies only to domestic stock insurers formed for the purpose of transacting insurance as provided in section 6604.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6604 Railway employees' loss of position; accident or disability; health and life insurance; annuities.

Sec. 6604. Any number of persons, not less than 13, may associate together and form an incorporated company for the following purposes, to wit:

First, To insure railway employees against loss of position resulting from discharge, suspension or retirement;

Second, To insure any person against bodily injury or death by accident, or against disability on account of sickness;

Third, To insure the lives and health of persons and every insurance pertaining thereto, and to grant, purchase or dispose of annuities.

History: 1956, Act 218, Eff. Jan. 1, 1957.

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Popular name: Act 218

500.6608 Capital stock issuance limitations; par value.

Sec. 6608. The amount of capital stock of any company organized under the provisions of this chapter shall not be less than $200,000.00, in shares of the par value of $50.00 each.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6612 Applicability of chapter.

Sec. 6612. Such provisions of this code as are applicable to domestic stock insurers transacting life, disability, or casualty insurances as are not inconsistent with, or in conflict with provisions of this chapter are hereby made applicable to the operation of any insurer organized under the provisions of this chapter.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6616 Railway employees' loss of position insurance; limit of liability; application.

Sec. 6616. (1) All contracts insuring railway employees against loss of position or of wages resulting from discharge, suspension or retirement shall contain a provision, in form approved by the commissioner, limiting the liability under said contract to an amount not greater than the average monthly wages earned at the effective date of the policy contract, and in the event that more than 1 contract shall be in force, to its pro rata share of said loss. No insurer shall solicit, by advertising or otherwise, where the risk to be insured against is covered by a prior policy in force with another insurer, the writing of a contract wherein the insured shall recover under its contract any more than the pro rata share of the loss as herein provided.

(2) All contracts providing for such insurance shall be written only after a written application therefor shall be signed by the applicant wherein he shall be required to state whether he has similar coverage with another company and the amount of his average monthly wages.

(3) The provisions of this section shall be applicable to all insurers organized under or admitted to do business within the state of Michigan under the provisions of Act No. 256 of the Public Acts of 1917, as amended, or under the provisions of this code: Provided, That contracts of insurance, in force as of July 30, 1943, shall not be altered, amended or affected in any way by reason of the provisions of this section.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Compiler's note: Act 256 of 1917, referred to in this section, was repealed by Act 218 of 1956 .

Popular name: Act 218

CHAPTER 68
FARMERS' AND OTHER SPECIAL MUTUAL PROPERTY INSURERS (DOMESTIC)

500.6800 Scope of chapter; code applicability to domestic farmers' mutual insurers.

Sec. 6800. (1) This chapter applies only to domestic farmers' mutual insurers and to the other domestic mutual insurers organized and transacting insurance upon property under this chapter.

(2) No provision or provisions of this insurance code not contained in or referred to in this chapter shall be applicable as to any such insurer.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6802 Formation of mutual plan insurers.

Sec. 6802. Companies may be incorporated upon the mutual plan to insure against loss and damage by fire, lightning, cyclones, windstorms, tornadoes, hail, riot, riot attending a strike, aircraft, smoke, vehicles and death of livestock from any cause, by complying with the provisions of this chapter as provided in the succeeding sections.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6804 Farmers' mutuals; organization; insuring powers.

Sec. 6804. Any number of persons not less than 25 may associate together for the purpose of mutual insurance of the property of its members against loss or damage by inherent explosion, fire, lightning, riot, riot attending a strike, aircraft, smoke or vehicles, which property to be insured by companies organized or operating under this section shall embrace only farm property or property located in a village or city of less than 5,500 inhabitants used by a farmer exclusively for his own storage purposes, which property is not

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associated in any way with any retail, wholesale or processing operation, country churches, schoolhouses, lodge halls and town halls and their contents, in any township; and churches, schoolhouses and dwellings and accompanying outbuildings and their contents situated within the corporate limits of cities or villages having a population not in excess of 5,500 inhabitants; and any buildings and contents, located on county agricultural fairgrounds, used for fair purposes or for boys and girls club work: Provided, That such property has adequate fire protection.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 168, Eff. Sept. 27, 1957.

Popular name: Act 218

500.6806 Company organized or operating under MCL 500.6804; limit of risk.

Sec. 6806. No company organized or operating under section 6804 shall carry an insurance or assume a liability on any single hazard in excess of the amount set forth in section 640.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.6807 Farmers' mutuals; coverage of property while off insured premises.

Sec. 6807. In the absence of any charter provision or bylaw to the contrary, the terms of a policy issued by any company organized or operating under section 6804 shall be construed to cover any loss or damage by fire or lightning to any insured farm vehicle and its contents while located in any building not insurable by said company, provided said property shall have been absent from the insured owners' premises not more than 10 days and continuously in said uninsurable building not more than 48 hours.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6810-500.6820 Repealed. 1994, Act 226, Imd. Eff. June 27, 1994.

Compiler's note: The repealed sections pertained to organization and insuring powers of certain mutuals.

Popular name: Act 218

500.6822 Certificate of authority; required to transact business; expiration; renewal; revocation; qualification for certificate of authority or commencing business.

Sec. 6822. (1) An insurance company organized or operating under this chapter shall not transact any business without a certificate of authority from the commissioner.

(2) All such certificates of authority shall expire on the last day of June of each year and shall be renewed annually upon full compliance with the provisions of this chapter, and such certificates of authority shall be revocable by the commissioner for violation of any of the provisions of this chapter after due notice to the company and a hearing on the question of the violation.

(3) An insurance company hereafter organized under this chapter shall not be granted a certificate of authority and shall not commence business until bona fide agreements have been entered into for insurance with at least 200 individuals covering property to be insured to the amount of not less than $500,000.00.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.6823 Property insurance; territorial limitations.

Sec. 6823. No company shall hereafter be organized under the provisions of this chapter for the purpose of insuring property other than that mentioned in section 6804. Any mutual insurance company whose business is limited by law or its charter to 1 or more counties, may provide in its charter or by amendment to its charter for insuring for its resident members any real or personal property owned by them and situated outside the county or counties in which the company is authorized to insure but in an adjoining county and may also provide for extending the insurance on personal property that may be temporarily absent not to exceed 6 months in a county adjoining a county or counties in which the company is authorized to do business, during which time the insurance on the personal property shall be in force as fixed in the company's charter or bylaws, so long as upon the adoption of any such article or amendment, the same shall automatically extend to all existing policies of the company, and that the insurance is subject to the same limitations as provided in section 6804.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.6824 Reinsurance; limitations.

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Sec. 6824. Any company organized or operating under this chapter whose business is limited by law or by its charter to 1 or more counties may provide in its charter or by amendment to its charter for assuming reinsurance from other companies on property located anywhere within the state: Provided, however, That no reinsurance shall be accepted of a different kind or on a different class of property than the company is by its charter permitted to write direct. The company ceding such reinsurance shall not, by virtue of such reinsurance, become a member of the company assuming the reinsurance nor shall the ceding company assume any contingent liability for assessment unless otherwise provided by written agreement.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6826 Records and reports; requirements.

Sec. 6826. All companies organized or operating under this chapter shall keep such reasonable records and make such reports as the commissioner shall require.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6828 Financial report to members; penalty for violations.

Sec. 6828. (1) It shall be the duty of the secretary of each mutual insurance company doing business in this state under the authority of this chapter to make out and deliver by mail or otherwise to the last known post office address as shown by the company's records each year to each individual member of such company a copy of the financial report required by law to be made by such company to the commissioner.

(2) Any person, being a resident of this state, acting as secretary of any such mutual insurance companies, doing business in this state, who shall wilfully refuse, or neglect to make out and deliver the reports, as provided in subsection (1), above, shall be deemed guilty of a misdemeanor, and on conviction thereof, shall be subject to a fine of not more than $100.00.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6830 Directors and officers; election.

Sec. 6830. A company hereafter organized under this chapter shall provide in its articles of incorporation that its directors shall be elected by its members and that its officers shall be elected by its board of directors. The secretary or manager of the company may or may not be a member of the board of directors or a member of the company.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6834 Corporation, board, or association as member.

Sec. 6834. Whenever any public or private corporation, board or association in this state has entered into an agreement for and holds a policy in any mutual insurance company operating under this chapter, any officer, stockholder, or trustee of any such corporation, board or association who may be designated by such corporation, board or association, may be recognized as acting for or on its behalf for the purpose of such membership, but shall not be personally liable upon such contract of insurance by reason of acting in such representative capacity. The right of any corporation organized under the laws of this state to participate as a member of any such mutual insurance company is hereby declared to be incidental to the purpose for which such corporation is organized and as much granted as the rights and powers expressly conferred.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6838 Premium notes and assessments; liens.

Sec. 6838. The articles of incorporation and bylaws of any such company organized under or subject to the provisions of this chapter, may provide for the receiving of applications or agreements from its members for insurance, with or without taking from the insured any premium note or notes; and it shall be lawful for such mutual insurance companies, to make assessments upon such agreements, or policies issued thereon, or upon the premium note or notes, as the case may be, pro rata, according to the amount of such agreement or policies, or premium note or notes for the payment of the losses and expense incurred by such companies, and all such premium notes, or agreements, or assessments, shall be a lien upon the property insured to the amount of such note, notes, agreements, assessments, costs and interest thereon.

History: 1956, Act 218, Eff. Jan. 1, 1957.

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Popular name: Act 218

500.6840 Levy of assessment; deficit; farmers' mutuals; advance premiums; surplus; membership fees; nonassignable policies.

Sec. 6840. (1) It shall be the duty of the president and secretary or other executive officer or officers having power to levy assessments, of each and every mutual insurance company doing business in this state under authority of this chapter to levy an assessment on the members according to classification thereof, sufficient to cover all liability of the company at each and every assessment: Provided, however, That the commissioner may if he deems it advisable grant authority to carry forward a portion of any deficit. Any deficit carried over must be included in the assessment levied during the year immediately following.

(2) It shall be unlawful for any mutual fire insurance company incorporated under the provisions of section 6804 (farmers' mutuals) to conduct its business on the delayed assessment plan and authority is hereby given for mutual insurance companies incorporated under this chapter to collect an advance premium ratably assessed against the membership of an amount which shall be estimated as sufficient to pay each member's proportionate share of the losses and expenses of the company for the ensuing 12 months or lesser period as prescribed by the articles of incorporation of the company, and to provide for surplus funds as permitted in section 6844.

(3) The amount of membership fee collected per $100.00 of insurance by a mutual insurance company incorporated under the provisions of this chapter at the time of issuing a policy for a new member or increasing a policy shall be uniform for all companies on the same class of business and shall be prescribed by the commissioner upon agreement on the amount of such membership fee by a majority of the companies writing each separate class. Such fee shall be the only fee collected in addition to the advance premium. No new membership fee shall be charged for a policy reinstated within 6 months of the date such policy was cancelled: Provided further, That any mutual fire insurance company doing business in this state under authority of this chapter and operating upon the advance premium plan while having a surplus at least equal to $200,000.00 may issue an insurance policy which shall provide that the member insured shall not be liable for an additional assessment during the period for which an advance premium has been paid, and in no event shall the holder of any such policy be liable to the company for a greater amount than the advance premium charged for that period.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6842 Failure to make assessment; penalty.

Sec. 6842. Any person being a resident of this state, acting as president, secretary or other officer of any such mutual insurance company, doing business in this state under authority of this chapter, who shall wilfully refuse, or neglect to make assessments as provided in section 6840 shall be deemed guilty of a misdemeanor, and upon conviction thereof shall be punished by a fine not exceeding $1,000.00 nor less than $500.00, or by imprisonment in the county jail not less than 6 months nor more than 1 year, or both such fine and imprisonment in the discretion of the court.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6844 Surplus fund; accumulation.

Sec. 6844. Any company organized or operating under this chapter may provide in its charter or by amendment to its charter for the collection of assessments and/or premiums in excess of the amount required to cover current losses and expenses, for the purpose of accumulating a surplus fund.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6846 Board of directors; borrowing power.

Sec. 6846. The board of directors of any company organized or operating under this chapter may borrow money for the purpose of paying losses and expenses.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6848 Unearned premium reserve; refund.

Sec. 6848. Any company organized or operating under this chapter upon the advance premium plan, shall maintain and set aside as a liability an unearned premium reserve upon the same basis as that required of

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domestic stock insurance companies transacting the same kind of business. Such companies shall provide in their policy for the refund of the unearned premium in case of cancellation for any cause.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6850 Investments; real estate; agricultural credit corporation membership.

Sec. 6850. No company organized or operating under this chapter shall invest any of its assets until it has cash in state or national banks of Michigan of $20,000.00 in excess of the estimated amount of all unpaid losses of which the company has received notice. Should any company's cash in such banks fall below the required amount after investments have been made, the commissioner may if he deem it necessary for the protection of the policyholders of the company require such company to convert a part or all of its investments into cash. Funds available for investment may be invested in accordance with the laws of this state relating to the investment of the assets of domestic stock companies transacting the same kind of business except that companies organized or operating under this chapter are prohibited from investing in or owning corporation stocks, or investing in or owning real estate, except as follows:

(1) Such as shall be necessary for its immediate accommodation in transacting business, or

(2) Such as shall have been conveyed or mortgaged to the company in good faith, by way of security for debts, or

(3) Such as shall have been conveyed to the company in satisfaction for debts or subrogation of claims, or

(4) Such as shall have been purchased at sales upon judgments, decrees or mortgages in favor of such company, or held by or owned by it; and all real estate obtained by virtue of any provisions of this section, except that mentioned in the first subdivision, shall be sold or disposed of within 5 years after the title has been perfected in such company, unless the company shall procure a certificate from the commissioner that the interest of such company will materially suffer by a forced sale, in which event the sale may be postponed for such period as the commissioner shall direct in such certificate, not to exceed 10 years in all, or

(5) Any company organized or operating under this chapter is hereby authorized, upon the consent and approval of the commissioner, and in accordance with the rules and regulations promulgated by the commissioner, to purchase and own stock in or become a member of any agricultural credit corporation, or similar corporation, formed for the purpose of financing and/or lending money to any such company. Any such company purchasing and owning stock in or becoming a member of any such corporation is hereby authorized, upon the consent and approval of the commissioner, to borrow money for the purpose of paying losses and to pledge for the payment thereof the assets of such company. If the delinquency in collection of assessments levied by any such company, purchasing and owning stock in or becoming a member of any such corporation, at the end of the fiscal year of such company shall exceed 15%, the commissioner shall be empowered to take steps for the collection of such assessments, including the power to bring suit on behalf of such company, and/or to order such additional assessments as may be found to be necessary to remove such deficiency.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6854 Insurance in excess of fair value prohibited.

Sec. 6854. No company organized or operating under this chapter shall issue a policy for an amount in excess of a fair value of the property insured.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6856 Maximum amount recoverable on face of policy; premium, assessments.

Sec. 6856. No company organized or operating under this chapter shall issue any policy which provides that the maximum amount recoverable is less than the amount stated on the face of the policy, and no assessment shall be levied or premium collected on any amount larger than that so stated on such policy face.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6858 Adjustment or arbitration of losses; subpoenas to witnesses; notice.

Sec. 6858. That any district or municipal court of a judicial district or municipality of this state is authorized and required to issue subpoenas, and compel the attendance of witnesses before the president, vice-president, secretary, board of directors, or either of the directors, or the auditor or board of auditors of any mutual insurance company organized under the laws of this state, whenever requested so to do by said

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officers of the insurance companies, or any 1 of them, or the insured, to give evidence in any matter touching the adjustment or arbitration of losses by fire or other cause which may come before such officer or officers; and the subpoena shall be valid to compel the attendance of a witness within the same county where such matter is to be tried, and within 30 miles of the place of such trial. The opposite party interested in the adjustment or arbitration shall be notified, without cost to him, her, or them, at least 24 hours in advance, of the time and place where such witnesses are to be examined, and he, she, or they shall have the right to appear by attorney or in person, and cross-examine all witnesses produced.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1991, Act 141, Imd. Eff. Nov. 25, 1991.

Popular name: Act 218

500.6859 Adjustment or arbitration of losses; service of subpoenas; fees.

Sec. 6859. Any subpoena may be served by a sheriff, constable or any other person, and it shall be served by delivering a copy of the subpoena, and by paying or tendering to him or her the same fees for traveling and 1 day's attendance as are allowed by law.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1991, Act 141, Imd. Eff. Nov. 25, 1991.

Popular name: Act 218

500.6860 Adjustment or arbitration of losses; compelling attendance of witness; costs.

Sec. 6860. Whenever it shall appear to the satisfaction of the judge, by affidavit of a party interested in said adjustment or arbitration, or by other competent testimony, that any person duly subpoenaed to appear as required by subpoena, shall have refused or neglected without just cause to attend as a witness in conformity to the subpoena, and the testimony of such witnesses is material, as the deponent verily believes, the judge shall have power to issue an attachment to compel the attendance of the witness, and the witness shall be liable for the cost of such attachment for the service of the same, which costs may be recovered in an action of assumpsit at the suit of the party injured by such neglect or refusal, before any court having competent jurisdiction in like cases, and shall moreover be liable to the injured party in damages.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1991, Act 141, Imd. Eff. Nov. 25, 1991.

Popular name: Act 218

500.6862 Adjustment or arbitration of losses; administration of oath to witness; perjury.

Sec. 6862. Any 1 of said officers or directors of such insurance companies shall have the power, and they are hereby authorized to administer an oath to said witnesses or parties so testifying before them in the adjustment or arbitration of such losses, and said witnesses shall be liable to the same pains and penalties for perjury as are now provided by law.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6864 Limitation of actions.

Sec. 6864. No suit or action at law for the recovery of any claim for loss or damage under a policy issued by any company organized or operating under this chapter shall be sustainable in any court of law or equity unless commenced within 12 months next after the liability shall have accrued.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6866 Uniform farm mutual fire policy.

Sec. 6866. On and after January 1, 1946, no company organized or operating under the provisions of this chapter shall issue fire insurance policies on farm property in this state other than those of the standard form as set forth in section 6868.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6868 Uniform farm mutual fire policy; required form.

Sec. 6868. Uniform Farm Mutual Fire Insurance

Policy No. $

(Name of company)

Organized Charter expires

In consideration of the provisions and stipulations herein or added hereto and of the warranties contained

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in the application (if any) for insurance, and subject to the tenor, terms, provisions and stipulations of its charter and bylaws and any amendment thereto hereafter made, does hereby insure ..... and legal representatives, to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss, without allowance for any increased cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair, and without compensation for loss resulting from interruption of business, nor in any event for more than the interest of the insured, commencing the ..... day of ..... 19..... at noon, standard time, at location of property involved, against all direct loss by fire and lightning and by removal from premises endangered by the perils insured against in this policy, except as hereinafter provided, to the property described hereinafter while located or contained as described in this policy, or pro rata for 5 days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy, but not elsewhere, to an amount not exceeding the sums hereinafter stated upon the following described property, to-wit: (space for policy form) Assignment of this policy shall not be valid except with the written consent of this company.

This policy is made and accepted subject to the foregoing provisions and stipulations and those hereinafter stated, and to the charter and bylaws of said company not inconsistent therewith and to any amendment thereto hereafter made during the term hereof, which are hereby made a part of this policy, together with such other provisions, stipulations and agreements as may be added hereto, as provided in this policy.

In witness whereof, this company has caused these presents to be executed and attested by its president and secretary this ..... day of ..... A.D. 19 .....

..... President ..... Secretary

(All that appears above shall appear upon the first page of the policy.)

1.	Concealment, Fraud	This entire policy shall be void if whether before or after a loss, the insured has wilfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.
2.	Uninsurable and Excepted Property	This policy shall not cover accounts, bills, currency, deeds, evidences of debt, money or securities; nor, unless specifically named hereon in writing, bullion, manuscripts, photos, pictures, jewelry, sporting goods or antiques.
3.	Perils Not Included	This company shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly, by: (a) enemy attack by armed forces, including action taken by military, naval or air forces in resisting an actual or an immediately impending enemy attack; (b) invasion; (c) insurrection; (d) rebellion; (e) revolution; (f) civil war; (g) usurped power; (h) order of any civil authority except acts of destruction at the time of and for the purpose of preventing the spread of fire: Provided, That such fire did not originate from any of the perils excluded by this policy; (i) neglect of the insured to use all reasonable means to save and preserve the property at and after a loss or when the property is endangered by fire in neighboring premises; (j) nor shall this company be liable for loss by theft.
4.	Other Insurance	Other insurance may be prohibited or the amount of insurance may be limited by endorsement attached hereto.
5.	Conditions Suspending or Restricting Insurance	Unless otherwise provided in writing added hereto this company shall not be liable for loss occurring: (a) while the hazard is increased by any means within the control or knowledge of the insured; or (b) while a described building, whether intended for occupancy by owner or tenant, is vacant or unoccupied beyond a period of 60 consecutive days; or (c) as a result of explosion or riot, unless fire ensue, and in that event for loss by fire only; (d) if, with the knowledge of the insured foreclosure proceedings be commenced or notice given of sale of any property insured hereunder by reason of any mortgage or trust deed; or (e) if any change, other than by the death of an insured, takes place in the interest (except increase of insured's interest), title or possession of the subject of insurance (except change of occupants without increase of hazard); or (f) while the insured shall have any other contract of fire insurance covering in whole or in part on property covered by this policy without the knowledge of this company.
6.	Other Perils or Subjects	Any other peril to be insured against or subject of insurance to be covered in this policy shall be by endorsement in writing hereon or added hereto.

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7. Added Provisions — The extent of the application of insurance under this policy and of the contribution to be made by this company in case of loss, and any other provisions or agreement not inconsistent with the provisions of this policy, may be provided for in writing added hereto, or by duly adopted articles of association or bylaws of the company, but no provision may be waived except such as by the terms of this policy is subject to change.

8. Waiver Provisions — No permission affecting this insurance shall exist, or waiver of any provision by valid, unless granted herein or expressed in writing added hereto, or by duly adopted articles of association or bylaws of the company.

9. Cancellation of Policy — This policy shall be cancelled at any time at the request of the insured, in which case this company shall, upon demand and surrender of this policy, refund the excess of paid premium above the customary short rates for the expired time. This policy may be cancelled at any time by this company by giving to the insured a 5 days' written notice of cancellation, delivered personally or mailed to the insured at the last known post office address as shown by the company's records, with or without tender of the excess of paid premium above the pro rata premium for the expired time, which excess, if not tendered, shall be refunded on demand. Notice of cancellation shall state that said excess premium (if not tendered) will be refunded on demand.

10. Mortgagee Interest and Obligations — If loss hereunder is made payable, in whole or in part, to a designated mortgagee not named herein as the insured, such interest in this policy may be cancelled by giving to such mortgagee a 10 days' written notice of cancellation delivered personally or mailed to such mortgagee at the last known post office address as shown by the company's records.

If the insured fails to render proof of loss such mortgagee, upon notice, shall render proof of loss in the form herein specified within 60 days thereafter and shall be subject to the provisions hereof relating to appraisal and time of payment and of bringing suit. If this company shall claim that no liability existed as to the mortgagor or owner, it shall, to the extent of payment of loss to the mortgagee, be subrogated to all the mortgagee's right of recovery, but without impairing mortgagee's right to sue; or it may pay off the mortgage debt and require an assignment thereof and of the mortgage. Other provisions relating to the interests and obligations of such mortgagee may be added hereto by agreement in writing, or may be provided for by the bylaws of the company.

11. Pro Rata Liability — This company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not.

12. Requirements In Case Loss Occurs — The insured shall give immediate written notice to this company of any loss, protect the property from further damage, forthwith separate the damaged and undamaged personal property, put it in the best possible order, furnish a complete inventory of the destroyed, damaged and undamaged property, showing in detail quantities, costs, actual cash value and amount of loss claimed; and within 60 days after the loss, unless such time is extended in writing by the company, the insured shall render to this company a proof of loss, signed and sworn to by the insured, stating the knowledge and belief of the insured as to the following:

The time and origin of the loss, the interest of the insured and of all others in the property, the actual cash value of each item thereof and the amount of loss thereto, all encumbrances thereon, all other contracts of insurance, whether valid or not, covering any of said property, any changes in the title, use, occupation, location, possession or exposures of said property, since the issuing of this policy, by whom and for what purpose any building herein described and the several parts thereof were occupied at the time of loss and whether or not it then stood on leased ground, and shall furnish a copy of all the descriptions and schedules in all policies and, if required, verified plans and specifications of any building, fixtures or machinery destroyed or damaged.

The insured, as often as may be reasonably required, shall exhibit to any person designated by this company all that remains of any property herein described, and submit to examinations under oath by any person named by this company, and subscribe the same; and, as often as may be reasonably required, shall produce for examination all books of account, bills, invoices, and other vouchers, or certified copies thereof if originals be lost, at such reasonable time and place as may be designated by this company or its representative, and shall permit extracts and copies thereof to be made.

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13.Appraisal	In case the insured and this company shall fail to agree as to the actual cash value or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within 20 days of such demand. The appraisers shall first select a competent and disinterested umpire; and failing for 15 days to agree upon such umpire, then, on request of the insured or this company, such umpire shall be selected by a circuit judge of the judicial circuit of this state in which the property covered is located. The appraisers shall then appraise the loss, stating separately actual cash value and loss to each item; and, failing to agree, shall submit their differences, only, to the umpire. An award in writing, so itemized, of any 2 when filed with this company shall determine the amount of actual cash value and loss. Each appraiser shall be paid by the party selecting him and the expenses of appraisal and umpire shall be paid by the parties equally.
14.Company's Options	It shall be optional with this company to take all, or any part, of the property at the agreed or appraised value, and also to pay its proper share of repairing, rebuilding or replacing the property destroyed or damaged with other of like kind and quality within a reasonable time, on giving notice of its intention so to do within 30 days after the receipt of the proof of loss herein required.
15.Abandonment	There can be no abandonment to this company of any property.
16.When Loss Payable	The amount of loss for which this company may be liable shall be payable 60 days after proof of loss, as herein provided, is received by this company and ascertainment of the loss is made either by agreement between the insured and this company expressed in writing or by the filing with this company of an award as herein provided.
17.Suit	No suit or action on this policy, for the recovery of any claim, shall be sustainable in any court of law or equity unless all the requirements of this policy shall have been complied with, nor unless commenced within 12 months next after the loss shall have occurred.
18.Subrogation	This company may require from the insured an assignment of all right of recovery against any party for loss or damage to the extent that payment therefor is made by this company, and of all contractual rights against any third party (but without impairment of insured's right to sue for the full amount due such insured), to the extent that payment for loss or damage is made by this company. Suit for recovery under any assignment made to this company may be brought in the name of the insured or this company or both, but without cost to the insured.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6869 Uniform farm mutual fire policy; conflicting bylaws, riders.

Sec. 6869. No bylaw of any company authorized under the provisions of this chapter or any rider attached to a "uniform farm mutual fire insurance policy" shall restrict or nullify paragraphs number 12, 13, 16 or 17 of such policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6870 Uniform farm mutual fire policy; optional provisions.

Sec. 6870. A company may print on or in its policies its name, location, date of organization and date of expiration of its charter, articles of incorporation and/or bylaws, the names of its officers and agents, the number and date of the policy and, if it is issued through an agent, the words "this policy shall not be valid until countersigned by the duly authorized agent of the company at ..... ."

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6872 Uniform farm mutual fire policy; rate, premium, assessment, expiration.

Sec. 6872. If a company issues its policies for a specified term and/or charges an advance premium or assessment, the form set forth for the face of the policy may be altered to show rate, premium or assessment and expiration date of policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6874 Uniform farm mutual fire policy; printed descriptions and specifications of

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property.

Sec. 6874. A company may print or use in its policies printed forms of description and specifications of the property insured.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.6876 Repealed. 1963, Act 53, Eff. Sept. 6, 1963.

Compiler's note: The repealed section regulated attachment of riders to uniform farm mutual fire policy.

Popular name: Act 218

500.6886 Additional provisions of code applicable to domestic mutual insurers.

Sec. 6886. Domestic mutual insurers transacting insurance under this chapter are also subject to the following additional chapters and provisions of this act as applicable:

(a) Chapter 1.
(b) Chapter 2.
(c) Sections 403, 454, 460, and 476a.
(d) Chapter 9.
(e) Chapter 12.
(f) Chapter 20.
(g) Section 2236.
(h) Chapter 50.
(i) Chapter 52.
(j) Chapter 76.
(k) Chapter 81.
(*l*) Chapter 83.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1972, Act 133, Eff. Mar. 30, 1973;—Am. 1987, Act 261, Imd. Eff. Dec. 28, 1987;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

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CHAPTER 70
MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

500.7001 Definitions.

Sec. 7001. As used in this chapter:

(a) "Board" means the board of trustees of the multiple employer welfare arrangement security fund.

(b) "Cash reserves" means federally guaranteed obligations that have a fixed recoverable principal amount or an irrevocable and unconditional letter of credit.

(c) "Covered claim" means an obligation of an insolvent MEWA to pay a claim that is covered by the MEWA to a covered employee or dependent who is a resident of this state.

(d) "Employee welfare benefit plan" means that term as defined in section 3 of the employee retirement income security act of 1974, Public Law 93-406, 88 Stat. 829, 29 U.S.C. 1002.

(e) "Fund" means the multiple employer welfare arrangement security fund.

(f) "Insolvent MEWA" means a MEWA authorized to do business in this state for which a domiciliary or ancillary receiver has been appointed in this state.

(g) "Letter of credit" means a letter of credit that meets all of the following requirements:

(*i*) Is issued by a federally insured financial institution.

(*ii*) Is issued upon such terms and in a form approved by the commissioner.

(*iii*) Is subject to draw by the commissioner, upon giving 5 business days' written notice to the MEWA, or by the MEWA for the subscriber's benefit if the MEWA is unable to pay claims as they come due.

(h) "Multiple employer welfare arrangement" or "MEWA" means that term as defined in section 3 of the employee retirement income security act of 1974, Public Law 93-406, 88 Stat. 829, 29 U.S.C. 1002, which meets either or both of the following criteria:

(*i*) One or more of the employer members in the MEWA is either domiciled in this state or has its principal headquarters or principal administrative office in this state.

(*ii*) The MEWA solicits an employer that is domiciled in this state or has its principal headquarters or principal administrative office in this state.

History: Add. 1986, Act 121, Eff. July 1, 1986;—Am. 1990, Act 126, Imd. Eff. June 26, 1990.

Popular name: Act 218

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500.7004 Employee welfare benefit plan as multiple employer welfare arrangement; certificate of authority required; applicability of chapter.

Sec. 7004. A person shall not establish or maintain an employee welfare benefit plan which is a multiple employer welfare arrangement in this state unless the MEWA obtains and maintains a certificate of authority pursuant to this chapter. This chapter shall not apply to an employee welfare benefit plan or MEWA that is fully insured.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7006 Benefits to which authorized MEWA limited.

Sec. 7006. A MEWA authorized under this chapter shall be limited to providing the following benefits:

(a) Medical, dental, optical, surgical, or hospital care benefits.

(b) Benefits in event of sickness, accident, disability, or death.

(c) Prepaid legal services.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7010 Application for certificate of authority; form; submission of application and other documents to commissioner; examination of application and documents; investigation; examination under oath of certain persons.

Sec. 7010. (1) A person wishing to establish an employee welfare benefit plan which is a multiple employer welfare arrangement shall apply for a certificate of authority on a form prescribed by the commissioner. The application shall be completed and submitted to the commissioner along with all of the following:

(a) Copies of all articles, bylaws, agreements, or other documents or instruments describing the rights and obligations of employers, employees, and beneficiaries with respect to the MEWA.

(b) Current financial statements of the MEWA.

(c) Proof of a fidelity bond in a form and amount approved by the commissioner.

(d) A statement showing in full detail the plan upon which the MEWA proposes to transact business, a copy of all contracts, or other instruments which it proposes to make with or sell to its members, together with a copy of its plan description and the proposed printed matter to be used in the solicitation of members.

(2) The commissioner shall promptly examine the application and documents submitted by the applicant and shall have the power to conduct any investigation which the commissioner may deem necessary and to examine under oath any persons interested or connected with the MEWA.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7011 Conditions to issuance of certificate of authority.

Sec. 7011. The commissioner shall not issue a certificate of authority to a MEWA unless all of the following conditions have been met:

(a) The commissioner is satisfied that:

(*i*) The employers in the MEWA are members of an association or group of 2 or more businesses or entities that are in the same trade or industry or same type of service, including closely related businesses that provide support, services, or supplies primarily to that trade, service, or industry.

(*ii*) The association or group of employers in the MEWA is engaged in substantial activity for its members other than sponsorship of an employee welfare benefit plan.

(*iii*) The association or group of employers in the MEWA has been in existence for a period of not less than 2 years.

(*iv*) The employee welfare benefit plan of the association or group is controlled and sponsored directly by participating employers or employee members, or both.

(*v*) The MEWA has within its own organization adequate facilities and competent personnel to service the employee benefit plan or has contracted with an authorized third party administrator to provide services. A third party administrator contracting with a MEWA pursuant to this subparagraph shall deliver a fidelity bond to the MEWA in an amount approved by the commissioner to protect against the misappropriation or misuse of any money handled by the third party administrator.

(b) The MEWA has applications from not less than 2 employers and will provide similar benefits for not less than 200 separate participating employees. The annual gross premiums of or contributions to the plan will

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be not less than $20,000.00 for a plan that provides only vision benefits, $75,000.00 for a plan that provides only dental benefits, and $200,000.00 for all other plans.

(c) The MEWA possesses a written commitment, binder, or policy for excess loss insurance issued by an insurer authorized to do business in this state, in an amount approved by the commissioner. The binder or policy shall provide not less than 30 days' notice of cancellation to the commissioner.

(d) The MEWA has established a procedure, to the satisfaction of the commissioner, for handling claims for benefits in the event of dissolution of the MEWA.

(e) The MEWA has delivered to the commissioner a bond, deposit, or security for the protection of subscribers as the commissioner requires.

History: Add. 1986, Act 121, Eff. July 1, 1986;—Am. 1999, Act 82, Imd. Eff. June 28, 1999.

Popular name: Act 218

500.7012 Fees; payment and collection; service of process; designation and purpose of fees.

Sec. 7012. (1) The commissioner shall collect, and the persons affected shall pay to the commissioner, the following fees:

(a)	Filing fee to accompany application for certificate of authority.....	$	200.00.
(b)	Certificate of authority.....	$	25.00.
(c)	Filing fee for annual statement each year.....	$	25.00.

(2) Each MEWA shall appoint the commissioner as its resident agent for purposes of service of process. The fee for such service shall be in the amount of $5.00, payable at the time of service.

(3) Fees paid under this section shall be designated for the insurance bureau to cover the additional costs incurred as a result of this chapter.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7014 Issuance of certificate of authority; refusal to grant certificate; notice of refusal; request for and conduct of hearing.

Sec. 7014. After examination and investigation, the commissioner shall issue a certificate of authority to the MEWA if the commissioner is satisfied that the MEWA is in a stable and unimpaired financial condition and that the MEWA is qualified to maintain an employee welfare benefit plan in compliance with this chapter. The commissioner shall refuse to grant a certificate of authority to an applicant who fails to meet the requirements of this chapter. Notice of refusal shall be in writing and shall set forth the basis for the refusal. If the applicant submits a written request within 30 days after mailing of the notice of refusal, the commissioner shall promptly conduct a hearing pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, in which the applicant shall be given an opportunity to show compliance with the requirements of this chapter.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7018 Temporary certificate; organization of proposed MEWA; opening books to commissioner; condition to issuance of final certificate.

Sec. 7018. (1) The MEWA, upon receipt of its initial certificate of authority, which shall be a temporary certificate, shall proceed to the completion of organization of the proposed MEWA.

(2) A MEWA shall open its books to the commissioner, and a final certificate of authority shall not be issued by the commissioner to any MEWA until it has collected in cash reserves as provided in section 7040.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7020 Issuance of policies by MEWA; premium or premium deposit; contingent premium; restoration of cash reserves.

Sec. 7020. (1) The policies issued by the MEWA shall provide for a premium or premium deposit payable in cash and, except as herein provided, for a contingent premium at least equal to 1 month's premium or premium deposit, which may be prefunded, and in no event shall a member be liable for a greater amount than the premium or premium deposit expressed in the policy.

(2) The MEWA may issue its policy without a contingent premium when it has cash reserves as provided in section 7040.

(3) If at any time the cash reserves are less than the requirement of section 7040, the MEWA shall immediately collect upon policies with a contingent premium a sufficient proportionate part thereof to restore

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the cash reserves, provided no member shall be liable for any part of the contingent premium in excess of the amount demanded within 1 year after the termination of the policy. The commissioner may by written order direct that proceedings to restore the reserves be deferred during the time fixed in the order.

History: Add. 1986, Act 121, Eff. July 1, 1986;—Am. 1990, Act 126, Imd. Eff. June 26, 1990.

Popular name: Act 218

500.7022 Name of MEWA; proof of existence of MEWA.

Sec. 7022. No MEWA authorized under this chapter shall take any name which is the same as or closely resembles the name of any other MEWA doing business in this state. A MEWA shall transact its business under its own name, and shall not adopt any assumed name: excepting that a MEWA, by amending its articles, may change its name or take a new name with the approval of the commissioner. Whenever it shall be necessary, in any legal proceedings, to prove the existence of a MEWA, a certified copy of such MEWA's certificate of authority shall be prima facie evidence of the existence of the MEWA.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7024 Powers of MEWA.

Sec. 7024. Every MEWA, unless otherwise provided, or inconsistent with this chapter, shall have power:

(a) To have succession, by its name, for the term stated in its trust agreement, which shall be in perpetuity unless otherwise specified.

(b) To sue and be sued, complain and defend, in any court of law or equity or to be a party to any proceedings before any board or commission or other public body of this state or any other state or government; suits at law may be maintained by the MEWA against any of its members for any cause relating to the business of the MEWA.

(c) To have a seal which may be altered at pleasure and to use the seal by causing it or a facsimile of the seal to be impressed or affixed or reproduced, or otherwise.

(d) To appoint such officers and agents as the business of the MEWA shall require and to allow them suitable compensation.

(e) To make, alter, amend, and repeal bylaws for the regulation and government of its affairs.

(f) To conduct its business in this state, other states, the District of Columbia, the territories and colonies of the United States and in foreign countries and the territories and colonies thereof and have 1 or more offices out of this state and to acquire, purchase, hold, mortgage, pledge, assign, transfer and convey real and personal property out of this state subject to the provisions of this chapter.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7026 Articles, bylaws, and trust agreement of MEWA and amendments thereto; filing; approval; form for trust agreement; notice of meeting; voting rights; powers to be exercised by board of trustees; restrictions on trustees.

Sec. 7026. (1) The articles, bylaws, and trust agreement of the MEWA and all amendments thereto shall be filed with and approved by the commissioner before becoming operative. The trust agreement shall be filed on a form prescribed by the commissioner.

(2) Each member employer of a MEWA shall be given notice of every meeting of the members and shall be entitled to an equal vote, either in person or by proxy in writing by such member.

(3) The powers of a MEWA, except as otherwise provided, shall be exercised by the board of trustees chosen to carry out the purposes of the trust agreement. Not less than 50% of the trustees shall be persons who are covered under the MEWA and no trustee shall be an owner, officer, or employee of a third party administrator who provides services to the MEWA.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7028 Duties of trustees; limitation on liability of trustee.

Sec. 7028. The trustees of a MEWA shall give the attention and exercise the vigilance, diligence, care, and skill that prudent persons use in like or similar circumstances. Trustees shall be responsible for all operations of the MEWA and shall take all necessary precautions to safeguard the assets of the MEWA. No trustee shall be held liable for any delinquency under this section after 6 years from the date of the delinquency, or after 2 years from the time when the delinquency is discovered by a person complaining of the delinquency, whichever occurs sooner.

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History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7030 Officers and agents; selection and appointment; authority and duties; removal; bond.

Sec. 7030. The board of trustees shall select such officers as designated in the articles or bylaws and may appoint agents as they may deem necessary for the transaction of the business of the MEWA. All officers and agents shall respectively have such authority and perform such duties in the management of the property and affairs of the MEWA, as may be delegated by the board of trustees. Any officer or agent may be removed by the board of trustees whenever in their judgment the business interests of the MEWA will be served thereby. The board of trustees shall secure the fidelity of any or all of such officers or agents who handle the funds of the MEWA by bond or otherwise.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7032 Compensation of trustee, officer, or employee.

Sec. 7032. (1) A MEWA shall not pay any salary, compensation, or emolument to any officer or trustee of the MEWA, unless the payment is first authorized by a majority vote of the board of trustees of the MEWA.

(2) A trustee, officer, or employee of a MEWA shall not be compensated unreasonably. The compensation of any trustee or officer of a MEWA shall not be calculated, directly or indirectly, as a percentage of money or premiums collected, without the approval of the commissioner.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7034 Trustee or officer; prohibited conduct; violation as felony; penalty.

Sec. 7034. (1) A trustee or officer of a MEWA shall not knowingly and intentionally, directly or indirectly, receive any money or valuable thing for negotiating, procuring, recommending, or aiding in any purchase by or sale to the MEWA of any property or any loan from the MEWA, or be pecuniarily interested, either as principal, co-principal, agent, or beneficiary in any such purchase, sale, or loan.

(2) A person who violates this section is guilty of a felony punishable by a fine of not more than $10,000.00, or by imprisonment for not more than 10 years, or both.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7040 Financial statements and reports required to be filed; commingling of cash reserves prohibited.

Sec. 7040. (1) Each MEWA transacting business in this state shall file all of the following with the director:

(a) Within 180 days after the end of each fiscal year, financial statements audited by a certified public accountant. An actuarial opinion regarding reserves for known claims and associated expenses and incurred but not reported claims and associated expenses, in accordance with subdivision (c), must be included in the audited financial statement. The opinion must be rendered by an actuary approved by the director or who has 5 or more years of experience in this field.

(b) Within 60 days after the end of each fiscal quarter, unaudited financial statements, affirmed by an appropriate officer or agent of the MEWA.

(c) Within 60 days after the end of each fiscal quarter, a report certifying that the MEWA maintains reserves that are sufficient to meet its contractual obligations, and that it maintains a policy for excess loss insurance issued by an insurer authorized to do business in this state. The director, after hearing, shall establish general standards for the manner and amount of the excess loss insurance required by this subdivision. A MEWA shall maintain minimum cash reserves of not less than 25% of the aggregate contributions in the current fiscal year or not less than 35% of the claims paid in the preceding fiscal year, whichever is greater. Reserves must be calculated with proper actuarial calculations of all of the following:

(*i*) Known claims, paid and outstanding.

(*ii*) A history of incurred but not reported claims.

(*iii*) Claims handling expenses.

(*iv*) Unearned premiums.

(*v*) An estimate for bad debts.

(*vi*) A trend factor.

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(d) A schedule of premium contributions, rates, and renewal projections.

(2) Cash reserves established under this section must be maintained in a separate, identifiable account and must not be commingled with other funds of the MEWA.

History: Add. 1986, Act 121, Eff. July 1, 1986;—Am. 2022, Act 278, Eff. Mar. 29, 2023.

Popular name: Act 218

500.7044 Notice to individual covered by plan.

Sec. 7044. A MEWA, in connection with an employee welfare benefit plan, shall provide the following written notice to each individual covered by the plan:

(a) The fact that individuals covered by the plan are only partially insured.

(b) The fact that in the event the plan or the MEWA does not ultimately pay medical expenses that are eligible for payment under the plan for any reason, the individuals covered by the plan may be liable for those expenses.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7050 Examination of affairs of MEWA; access to books, records, and documents; examination of trustees, officers, agents, and employees; payment and disposition of assessment.

Sec. 7050. The commissioner, or any person appointed by the commissioner, shall have the power to examine the affairs of any MEWA, and for such purposes shall have free access to all the books, records, and documents that relate to the business of the plan, and may examine under oath its trustees, officers, agents, and employees in relation to the affairs, transactions, and condition of the MEWA. Each authorized MEWA shall pay an assessment annually to the commissioner in an amount equal to 1/4 of 1% of the annual self-funded contributions made to the MEWA for that year. The assessments paid under this section shall be appropriated to the insurance bureau to cover the additional costs incurred by the insurance bureau in the examination and regulation of MEWAs under this chapter.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7060 Additional provisions to which MEWA subject.

Sec. 7060. A MEWA transacting business in this state is also subject to the following additional sections and chapters of this act, as applicable, in the same manner as an insurer authorized to transact insurance in this state:

(a) Section 240(1)(c), (d), and (h).

(b) Chapter 12.

(c) Chapter 20.

(d) Chapter 22.

(e) Chapter 34.

(f) Chapter 44.

(g) Chapter 81.

History: Add. 1986, Act 121, Eff. July 1, 1986;—Am. 1999, Act 82, Imd. Eff. June 28, 1999;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.7070 Certificate of authority; grounds for suspension, revocation, or limitation.

Sec. 7070. The commissioner may suspend, revoke, or limit the certificate of authority of a MEWA if the commissioner determines that any of the following conditions exists:

(a) The MEWA has failed to maintain a policy for excess insurance as required by section 7011.

(b) The MEWA is using financial methods and practices in the conduct of its business which render further transaction of business in this state hazardous or injurious to its members, employees, beneficiaries, or to the public.

(c) The MEWA has failed, after written request by the commissioner, to remove or discharge an officer, director, trustee, or other employee who has been convicted of any crime involving fraud, dishonesty, or moral turpitude.

(d) The MEWA has failed or refused to furnish any report or statement required under section 7040.

(e) The MEWA has failed for an unreasonable period to pay any final judgment rendered against it in this state on any contractual obligation.

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(f) The commissioner, upon investigation, determines that the MEWA is conducting business fraudulently, or is not meeting its contractual obligations in good faith.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7074 Written findings of violation; issuance and service of findings and cease and desist order; additional orders.

Sec. 7074. If, after a hearing, the commissioner determines that a MEWA is violating or has violated a provision of this chapter, the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the MEWA a copy of the findings and an order requiring the MEWA to cease and desist from engaging in the prohibited activity, and the commissioner may order any of the following:

(a) Payment of a monetary penalty of not more than $500.00 for each violation but not to exceed an aggregate penalty of $5,000.00, unless the MEWA knew or reasonably should have known it was in violation of this chapter, in which case the penalty shall not be more than $2,500.00 for each violation and shall not exceed an aggregate penalty of $25,000.00 for all violations committed in a 6-month period.

(b) Suspension or revocation of the MEWA's certificate of authority if the plan knowingly and persistently violated a provision of this chapter.

(c) Restitution or refund to an aggrieved person.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7076 Violation of cease and desist order; notice; hearing; civil fine; suspension or revocation of certificate of authority.

Sec. 7076. If a MEWA violates a cease and desist order under this chapter and has been given notice and an opportunity for a hearing, the commissioner may order a civil fine of not more than $10,000.00 for each violation, or a suspension or revocation of the MEWA's certificate of authority, or both the fine and suspension or revocation.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7078 Conduct of proceedings for payment of fines or for suspension, revocation, or limitation of certificate of authority; appeal of disputed claim; hearing.

Sec. 7078. (1) Proceedings for the payment of fines or for suspension, revocation, or limitation of a certificate of authority shall be conducted under the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws.

(2) Any employer in the MEWA or any employee covered under the MEWA may appeal a disputed claim to the commissioner. If the commissioner determines that there is a legitimate dispute, the commissioner or the commissioner's designee shall conduct a hearing pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7080 Multiple employer welfare arrangement security fund; creation; administration; use; appointment, qualifications, terms, and compensation of board of trustees; powers of board of trustees; payment of and accounting for expenses.

Sec. 7080. (1) A multiple employer welfare arrangement security fund is created within the state treasury. The fund shall be administered by a board of trustees and shall be used solely to pay and discharge covered claims against insolvent MEWAs authorized to do business in this state.

(2) The board of trustees of the fund shall consist of 3 members. The commissioner shall be an ex officio member and the remaining 2 members shall be representatives of authorized MEWAs, who shall be appointed by the governor with the advice and consent of the senate. The 2 appointive members shall serve terms of 4 years and shall serve without compensation, except for actual and necessary expenses.

(3) The board may:

(a) If a MEWA becomes insolvent, appoint a person to act as a fund administrator. The fund administrator shall:

(*i*) Supervise disbursements for covered claims of the insolvent MEWA.

(*ii*) Request payments from the fund for covered claims.

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(*iii*) Perform such other duties as are designated by the board.

(b) Authorize payments from the fund for covered claims upon request to the fund administrator by a covered employee or dependent who is a Michigan resident and who is receiving or is entitled to receive benefits from an insolvent MEWA that is unable to continue paying benefits. All payments from the fund shall be determined by the board and made upon an order signed by a trustee.

(c) Promulgate rules as it deems necessary to carry out the purposes of the fund pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws.

(d) Maintain records, institute systems and procedures, and take any other administrative action as it deems necessary to carry out the purposes of the fund.

(e) Secure legal advice and be represented by the attorney general or any assistant designated by him or her in any matter involving the affairs of the fund.

(4) All expenses authorized by the board for the proper administration of the fund, including, but not limited to, the salary and expenses of the fund administrator and the investigation, determination, and defense of claims against the fund shall be borne by and paid from the assets of the fund. All expenses incurred and charged to the fund shall be accounted for on a fiscal year basis.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Compiler's note: For transfer of position of commissioner of office of financial and insurance regulation as member or chairperson of board or commission to director of department of insurance and financial services, see E.R.O. No. 2013-1, compiled at MCL 550.991.

Popular name: Act 218

500.7084 Assessments; purpose; limitation; notice; payment; assessments as elements of loss for purpose of establishing rates; liability of employer ceasing to participate in MEWA; certification of collection and receipt of money from assessments; noting delinquencies; collection of delinquent assessment; transfer of money to state treasurer; treasurer or custodian of fund; investments; crediting earnings from investment.

Sec. 7084. (1) To the extent necessary for payment of covered claims and for payments of reasonable costs of administering the fund, the commissioner shall assess upon and collect from each MEWA an amount which is in the proportion that the benefits the MEWA paid to Michigan employees and their dependents in the preceding calendar year bears to the total benefits paid by all authorized MEWAs to Michigan employees and dependents in the preceding calendar year. The commissioner, upon the advice of the trustees, may make additional assessments as the board considers necessary to keep the security fund solvent. The total assessment under this section shall not exceed 2% of benefits the MEWA paid on behalf of the Michigan employees and their dependents in any calendar year. Assessments shall not be collected until a MEWA's insolvency necessitates a payment from the fund.

(2) Notice of the assessments shall be sent by the commissioner by registered mail to each MEWA. Payment of assessments shall be made so as to be received in the office of the commissioner on or before a date specified uniformly in the notice, but not less than 90 days after the date of mailing.

(3) Assessments under this section shall constitute elements of loss for the purpose of establishing rates.

(4) If an employer ceases to participate in a MEWA, the employer shall continue to be liable to the MEWA for the security fund assessment for any benefits paid by the MEWA to Michigan employees and their dependents during the previous calendar year.

(5) The commissioner shall certify to the trustees the collection and receipt of all money from assessments, noting any delinquencies. The board shall take such action as in its judgment is proper to effect collection of any delinquent assessment. All money received from assessments pursuant to this section shall be transferred to the state treasurer who shall be the custodian of the fund. The treasurer may make those investments as in the treasurer's judgment are in the best interest of the fund. The earnings from the investment of the money from the fund shall be credited to the fund.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7086 Security fund as creditor of insolvent MEWA; reimbursement from insolvent MEWA.

Sec. 7086. The security fund after paying a covered claim to an employee or dependent shall have all the rights of a creditor of the insolvent MEWA to the extent of benefits it paid. The board shall have the right and obligation to obtain reimbursement from an insolvent MEWA for any money paid out as benefits to the covered participants of the insolvent MEWA, including expenses pertinent to payments or recovery thereof.

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History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

500.7090 Effective date of chapter.

Sec. 7090. This chapter shall take effect July 1, 1986.

History: Add. 1986, Act 121, Eff. July 1, 1986.

Popular name: Act 218

CHAPTER 72
RECIPROCAL INSURANCE EXCHANGES

500.7200 Scope of chapter.

Sec. 7200. This chapter applies only to reciprocal insurers.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.7202 Reciprocal insurance exchanges; insuring powers.

Sec. 7202. Individuals, partnerships and public or private corporations of this state, hereby designated subscribers, are hereby authorized to exchange reciprocal or interinsurance contracts with each other or with individuals, partnerships and corporations of other states and countries providing indemnity among themselves and from any loss which may be insured against under other provisions of the laws, including employers' liability, workmen's compensation and accident insurance, and excepting life and health insurance.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957.

Popular name: Act 218

500.7206 Reciprocal insurance exchanges; execution of contract by attorney.

Sec. 7206. Such contracts may be executed by an attorney, agent or other representative, herein designated as attorney. Such attorney may be an individual, individuals, firm or corporation.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.7210 Declaration; bond.

Sec. 7210. (1) The subscribers, through their attorney, shall file with the commissioner a declaration, verified by the oath of such attorney, setting forth:

(a) The name or title of the exchange.

(b) The location of the principal office of the exchange.

(c) The kind or kinds of insurance risks to be exchanged. The classes of risks to be written shall be those authorized by section 7202.

(d) A copy of common contract entered into between the members of the exchange and the attorney.

(e) A copy of the policy or agreement wherein contracts of insurance are exchanged among the subscribers.

(f) That applications have been made for insurance upon at least 200 risks aggregating not less than $3,000,000.00, as represented by bona fide applications, or in case of employers' liability or compensation insurance covering a total payroll of not less than $3,000,000.00, such applications to be concurrently effective when such reciprocal exchange is authorized to commence business by the commissioner. In the case of automobile insurance, applications shall have been made upon at least 1,000 automobiles represented by contracts to be effective concurrently and covering any or all classes of automobile insurance.

(g) That there has been deposited and shall be maintained at all times with the state treasurer cash or securities in satisfaction of the requirements of section 411.

(2) There shall be filed a copy of a bond of $50,000.00 with the commissioner conditioned that the attorney will faithfully carry out the contract or agreement made between the attorney and the subscribers, guaranteeing the subscribers against any loss to them by reason of any illegal or dishonest acts on the part of such attorney. Such bond may be a bond of an authorized surety company or a personal bond with 2 sureties approved by the commissioner. The bond shall run in favor of the board of trustees or advisory committee of the reciprocal exchange and shall be for the benefit of all subscribers wherever located.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1972, Act 360, Imd. Eff. Jan. 9, 1973.

Popular name: Act 218

500.7214 Reciprocal insurance exchanges; actions and suits.

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Sec. 7214. Subscribers at a reciprocal or interinsurance exchange shall only sue or be sued in the name or designation adopted by them.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992.

Popular name: Act 218

500.7218 Reciprocal insurance exchanges; limit of risk; statement of maximum assumed by subscriber.

Sec. 7218. There shall be filed with the commissioner by such attorney a statement under the oath of such attorney, showing the maximum amount of indemnity upon any single risk, and such attorney shall, whenever and as often as the same shall be required, file with the commissioner a statement verified by his oath to the effect that he has examined the commercial rating of such subscribers as shown by the reference book of a commercial agency having at least 100,000 subscribers, and that from such examination or from other information in his possession it appears that no subscriber has assumed on any single risk an amount greater than 10% of the net worth of such subscriber.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.7222 Repealed. 1994, Act 226, Imd. Eff. June 27, 1994.

Compiler's note: The repealed section pertained to certificates of authority relating to reciprocal insurance exchanges.

Popular name: Act 218

500.7226 Reciprocal insurance exchanges; corporation empowered to exchange contracts.

Sec. 7226. Any public or private corporation now or hereafter organized under the laws of this state shall, in addition to the rights, powers and franchises specified in its articles of incorporation, have full power and authority to exchange insurance contracts of the kind and character herein mentioned. The right to exchange such contracts is hereby declared to be incidental to the purposes for which such corporations are organized, and as much granted as the rights and powers expressly conferred.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957.

Popular name: Act 218

500.7230 Reciprocal insurance exchanges; records and securities of domestic insurers; safekeeping.

Sec. 7230. Section 5256 shall apply to domestic reciprocal insurers.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.7234 Reciprocal insurance exchanges; filing of fire, lightning, or windstorm rates.

Sec. 7234. Any reciprocal or interinsurance exchange exchanging contracts of indemnity between its subscribers and providing coverage for loss by fire, lightning or windstorm and which maintains its own rates and schedule of rates shall not be required to join or become a member of a fire insurance rating bureau but may, in lieu of joining such bureau, file with the commissioner its schedule of rates.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

CHAPTER 73
TITLE INSURERS

500.7300 Scope of chapter.

Sec. 7300. This chapter applies only to domestic, foreign and alien insurers transacting title insurance.

History: Add. 1966, Act 221, Imd. Eff. July 11, 1966.

Popular name: Act 218

500.7301 Definitions.

Sec. 7301. As used in this chapter:

(a) "Title insurance" means the insuring, guaranteeing, or indemnifying of designated owners of real estate or any interest in real estate against loss or damage that may result because the title is vested in a manner otherwise than as stated in the title insurance policy, because the title is unmarketable, or because the title is subject to liens, encumbrances, or other matters adversely affecting the rights of use, enjoyment, or

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disposition of the real estate, and not excepted in the policy, all in accordance with the terms of a title insurance policy approved as to substance and form, or doing anything equivalent in substance to any of the foregoing in a manner designed to evade the provisions of this chapter.

(b) "Title insurer" means any domestic, foreign, or alien insurer issuing title insurance, either directly or indirectly, other than reinsurance or coinsurance or both as referred to in section 7308, with respect to any real estate located in this state.

(c) "Title insurance policy" means any policy or contract insuring, guaranteeing, or indemnifying against loss or damage suffered by owners of real estate or by other persons interested in the real estate by reason of liens, encumbrances upon, defects in, or the unmarketability of the title to the real estate, or other matters affecting the title to real estate or the right to the use and enjoyment of the real estate, and insuring, guaranteeing, or indemnifying the condition of the title to real estate or the status of any lien on the real estate.

(d) "Title insurance commitment" means a document issued by a duly authorized title insurer offering to issue a title insurance policy upon performance of the conditions set forth in the document.

(e) "Property title information report" means information regarding matters of public record affecting legal title to real property that satisfies both of the following:

(*i*) Is provided upon request to a real property owner, a financial institution, a person with a contractual interest in the real property, or to a person licensed under article 25 of the occupational code, Act No. 299 of the Public Acts of 1980, being sections 339.2501 to 339.2518 of the Michigan Compiled Laws, in connection with the marketing of real estate.

(*ii*) Is provided on a form other than a commitment of title insurance.

History: Add. 1966, Act 221, Imd. Eff. July 11, 1966;—Am. 1996, Act 566, Imd. Eff. Jan. 16, 1997.

Popular name: Act 218

500.7302 Corporations authorized to transact title insurance.

Sec. 7302. Only a domestic, foreign or alien corporation organized on the stock plan and authorized by the commissioner pursuant to section 7303 shall transact or attempt to transact a title insurance business in this state or issue title insurance with respect to real estate located in this state.

History: Add. 1966, Act 221, Imd. Eff. July 11, 1966.

Popular name: Act 218

500.7303 Prerequisites to issuance of certificate of authority.

Sec. 7303. No corporation shall issue title insurance policies, contracts or commitments with respect to real estate located in this state or otherwise transact any business of title insurance in this state unless it holds a certificate of authority from the commissioner, pursuant to section 402, authorizing the transaction of the business, which certificate shall not be issued until the title insurer has complied with the following conditions:

(a) The insurer shall comply with the deposit requirements of section 411.

(b) A domestic, foreign or alien title insurer shall have completed its rate filing pursuant to section 7312.

(c) A domestic, foreign or alien title insurer shall have filed its forms of policies pursuant to section 7313.

History: Add. 1966, Act 221, Imd. Eff. July 11, 1966;—Am. 1972, Act 360, Imd. Eff. Jan. 9, 1973.

Popular name: Act 218

500.7304 Title insurers; powers.

Sec. 7304. Every title insurer authorized to do business pursuant to this code may issue title insurance; make, execute and perfect such contracts, agreements, policies and other instruments as may be required therefor; examine titles to real estate in connection with any transaction in which a policy of title insurance or commitment therefor is being issued and report thereon; issue commitments for title insurance policies specifying the requirements for the issuance of such policies; act as escrow agent in any transaction involving the issuance of a title insurance policy. Nothing contained in this chapter shall be construed to authorize any title insurer, or any officer, director, employee, trustee, agent or solicitor thereof, to engage in any act or practice prohibited by Act No. 354 of the Public Acts of 1917, being section 450.681 of the Compiled Laws of 1948, under a claim that the act or practice is incidental to the conduct of a business authorized by this chapter, whether or not a separate charge is made therefor. It shall be unlawful for any title insurer, or any such person, to suggest to any party to a transaction involving the examination, insuring and conveyancing of titles to real estate that the party does not need to retain for the transaction the professional services of an independent attorney duly licensed to practice law in this state.

History: Add. 1966, Act 221, Imd. Eff. July 11, 1966.

Popular name: Act 218

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500.7305 Unearned premium reserves.

Sec. 7305. (1) Every title insurer authorized to transact title insurance in this state shall establish and maintain, except as provided in subsection (4), an unearned premium reserve on business done in this state which at all times and for all purposes shall be deemed and constitute unearned portions of the risk premiums and shall be charged as a reserve liability for the title insurer in determining its financial condition.

(2) The unearned premium reserve shall be cumulative and shall consist of the following:

(a) The unearned premium reserve established by each title insurer pursuant to section 817, in respect to gross premiums received prior to January 1, 1967.

(b) Five percent of the gross premiums received by it in each month commencing with January 1, 1967, for all policies of title insurance and reinsurance and coinsurance agreements.

(3) Commencing January 1, 1969, and on January 1 of each year thereafter, there shall be released from the unearned premium reserve an amount equal to 1/10 of that portion thereof originally placed therein in respect to each year more than 10 in the past. The amounts so released from the unearned premium reserve shall no longer constitute a part thereof and may be used for any lawful purposes.

(4) A foreign title insurer authorized to transact title insurance in this state may establish an unearned premium reserve on its title insurance done in this state in accordance with the laws of the state under which the insurer is organized, if the reserves are mandatory under such laws and are substantially equivalent to the requirements of this section.

History: Add. 1966, Act 221, Imd. Eff. July 11, 1966.

Popular name: Act 218

500.7306 Claim reserves; requirements.

Sec. 7306. (1) Every title insurer shall establish and maintain, in addition to other reserves, a reserve against unpaid claims and claim expense, herein known as the claim reserve. The reserve shall be in an amount estimated in the aggregate as being sufficient to provide for payment of all claim and claim expense likely to be incurred by reason of every claim presented pursuant to written notice from or on behalf of an insured of a title defect in or lien on or adverse claim against the title insured, that may result in a claim being paid or cause expense to be incurred for the proper disposition of the claim.

(2) The amounts so estimated shall be revised from time to time as circumstances require, but shall be redetermined at least once each year.

History: Add. 1966, Act 221, Imd. Eff. July 11, 1966.

Popular name: Act 218

500.7308 Reinsurance; authorization.

Sec. 7308. (1) Any title insurer may reinsure a part of its liability under 1 or more of its title insurance policies, reinsurance or coinsurance agreements by ceding a part of the liability to any company authorized to engage in the title insurance business in this state or in any other of the states of the United States. No title insurer shall effect reinsurance with an insurer not authorized to do business in this state unless the assuming insurer has been approved by the commissioner.

(2) Any title insurer may reinsure title insurance policies, reinsurance or coinsurance agreements issued or entered into by any other company authorized to engage in the business of title insurance in this state or any other state of the United States regardless of the location of the land, an interest in which is being insured.

(3) The ceding of reinsurance to other companies and the reinsurance of other companies authorized by this section may be effected by facultative treaty or contract or, subject to the approval of the commissioner, pursuant to an automatic reinsurance treaty or contract.

(4) No title insurer shall directly or indirectly contract for or effect reinsurance of any risk in this state except with an insurer authorized by the commissioner to transact business in this state or in an insurer authorized to transact business in any other state or the District of Columbia, who meets the same standard of solvency as is required by the laws of this state for insurers of the same class transacting business in this state. No title insurer shall directly or indirectly contract for or effect reinsurance with an insurer not authorized to transact insurance in this state without approval of the commissioner.

History: Add. 1966, Act 221, Imd. Eff. July 11, 1966.

Popular name: Act 218

500.7310 Rating organizations; formation; operation.

Sec. 7310. Rating organizations for title insurance may be formed and may operate pursuant to the applicable provisions of chapter 24.

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History: Add. 1966, Act 221, Imd. Eff. July 11, 1966.

Popular name: Act 218

500.7312 Rates; filing.

Sec. 7312. The rates of every title insurer shall be filed pursuant to the applicable provisions of chapter 24.

History: Add. 1966, Act 221, Imd. Eff. July 11, 1966.

Popular name: Act 218

500.7313 Filing of basic forms of policies; policy commitments and other contracts or agreements.

Sec. 7313. The basic form of title policies, title policy commitments and other contracts or agreements of title insurance shall be subject to the filing and other provisions of section 2236.

History: Add. 1966, Act 221, Imd. Eff. July 11, 1966.

Popular name: Act 218

500.7315 Investments; interests in realty.

Sec. 7315. In addition to the classes of investments authorized by chapter 9, any title insurer may invest in and hold interests in real estate acquired in the process of settling claims asserted under its title policies subject to the provisions of subsection (4) of section 948.

History: Add. 1966, Act 221, Imd. Eff. July 11, 1966.

Popular name: Act 218

500.7316 Property title information report.

Sec. 7316. A title agency or insurer may provide a property title information report. A property title information report shall be provided without payment or consideration of any kind and without any promise to obtain from the title insurer a title insurance policy for the property for which the title insurance report was prepared. If a property title information report is provided under this section, the property title information report shall disclose that it was provided without payment or consideration of any kind and that it was provided without any promise to obtain from the title insurer a title insurance policy.

History: Add. 1996, Act 566, Imd. Eff. Jan. 16, 1997.

Popular name: Act 218

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500.7317 Licensing of agents or solicitors.

Sec. 7317. Persons acting as agents or solicitors for a title insurer shall be licensed in such capacities and subject to the applicable provisions of chapter 12.

History: Add. 1966, Act 221, Imd. Eff. July 11, 1966;—Am. 1972, Act 133, Eff. Mar. 30, 1973.

Popular name: Act 218

500.7318 Effect of act on prior act; liabilities; penalties.

Sec. 7318. (1) This chapter shall not impair or affect any act done, offense committed or right accruing, accrued or acquired or liability, penalty, forfeiture or punishment incurred prior to the time it takes effect, but the same may be enjoyed, asserted, enforced, prosecuted or inflicted, as fully and to the same extent as if this chapter had not been passed.

History: Add. 1966, Act 221, Imd. Eff. July 11, 1966.

Popular name: Act 218

CHAPTER 76
CONSOLIDATION OR MERGER OF DOMESTIC INSURERS

500.7604 Procedure for consolidation, merger, or reinsurance of risks; waiver for domestic stock insurers; dissolution of corporation; cessation of liability; reinsurance of individual risks; fraternal benefit societies; acquisition of general abstract business; notice of merger of farmers mutual insurer with other mutual insurer.

Sec. 7604. (1) An insurer organized under the laws of this state and transacting business under this act may consolidate or merge with or reinsure all or any part of its outstanding risks for the purpose of effecting a merger or consolidating with an insurer of generally like character authorized to transact business in this state under terms that are reasonable and just. "Consolidation" and "merger", as used in this chapter, include a transaction in which an authorized insurer that is a wholly-owned subsidiary of a controlling corporation,

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which need not be an insurer, distributes shares of the capital stock of the controlling corporation in merging another insurer into the subsidiary or in merging the subsidiary into another insurer. If an insurer proposes to consolidate or merge with, or reinsure all of its outstanding risk with, another insurer for the purpose of effecting a merger or consolidation, the following procedure must be followed:

(a) The insurers shall petition the director, setting forth the terms and conditions of the proposed consolidation, merger, or agreement of reinsurance, to which the director may grant preliminary, tentative, or conditional approval.

(b) After securing the approval from the director, the insurers shall give notice, either personally or through mailing at least 21 days before the time fixed for the meeting, to the last known postal address of each stockholder, subscriber, or member, that the question of the consolidation, merger, or reinsurance will be voted on at a regular or special meeting of the stockholders, subscribers, or members, which notice must fairly but briefly describe the proposed procedure.

(c) The consolidation, merger, or contract of reinsurance for the purpose of effecting a merger or consolidation must be approved at the regular or special meeting held in pursuance of the call and notice, by the affirmative vote of not less than a majority of the members or subscribers voting in person or by proxy if it is a mutual or a cooperative or assessment corporation or a reciprocal or interinsurance exchange, or not less than a majority of the outstanding capital stock, if it is a stock company.

(d) The consolidation or merger agreement or contract of reinsurance for the purpose of effecting a merger or consolidation, together with proper proof that it has been approved by the stockholders, subscribers, or members as provided in this section, must be submitted to the director for final approval. This contract is not effective until the director, in his or her discretion, issues a certificate of final approval to the petitioner. If the terms of the consolidation or merger or reinsurance contract for the purpose of effecting the merger or consolidation provide that securities must pass to an insurer assuming the liabilities for which the securities are held, a public official, or other person or company holding the securities, shall, on the written order of the director, deliver the securities to or credit the securities to the account of the corporation, corporations, person, or persons entitled to the securities by the terms of the contract and the order of the director.

(2) To facilitate the merger of any resulting insurer with and into another company simultaneously with the effectiveness of a division authorized by this act, a dividing insurer, including its officers, directors, and shareholders, may adopt and execute a plan of merger or consolidation on behalf of a resulting insurer and may execute and deliver documents, plans, certificates, and resolutions, and may make any filings, in each case, on behalf of the resulting insurer. If provided in a plan of merger or consolidation described in this subsection, the merger or consolidation is effective simultaneously with the effectiveness of a division authorized by this act. On request of the dividing insurer, the director may waive the other requirements of this section with respect to any merger or consolidation involving only domestic stock insurers and may issue its final approval of the merger or consolidation as part of its approval of a plan of division under this act.

(3) Consolidation, merger, or reinsurance for the purpose of effecting a merger or consolidation of all of the insurance risk of any membership corporation under this section, acts as a dissolution of the corporation except for a stock company, which must be dissolved in accordance with the business corporation act, 1972 PA 284, MCL 450.1101 to 450.2098. All liability on a stock company's certificates or contracts ceases on the expiration of 5 days after the consolidation, merger, or reinsurance for the purpose of effecting a merger or consolidation, but its officers may thereafter perform any act or acts necessary to close its affairs with the approval of the director.

(4) This section does not prohibit an insurer from reinsuring a fractional part or all of an individual risk in the usual or incidental conduct of its business.

(5) Consolidation, merger, or reinsurance for the purpose of effecting a merger or consolidation of all or a substantial portion of the risks of a fraternal benefit society is governed by this section insofar as not otherwise regulated by chapter 81a, specifically governing fraternal benefit societies.

(6) This section does not prohibit a title insurance corporation from acquiring by merger, exchange of stock, or otherwise, if permitted by and under the business corporation act, 1972 PA 284, MCL 450.1101 to 450.2098, a corporation engaged in the general abstract business or the assets of a corporation engaged in the general abstract business.

(7) Notwithstanding subsection (1), if a farmers mutual insurer organized under chapter 68 proposes to merge with any other mutual insurer, the surviving insurer may give notice to its members by publication as provided in section 5214(2).

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1961, Act 104, Eff. Sept. 8, 1961;—Am. 1969, Act 194, Imd. Eff. Aug. 6, 1969;—Am. 1977, Act 46, Imd. Eff. July 5, 1977;—Am. 1981, Act 66, Imd. Eff. June 16, 1981;—Am. 1990, Act 1, Eff. Apr. 1, 1990;—Am. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 2018, Act 421, Imd. Eff. Dec. 20, 2018.

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Popular name: Act 218

500.7606 Insurers; retention of names.

Sec. 7606. When an insurer is consolidated or merged under the provisions of this chapter, the name of the insurer may be retained for a period of 5 years after the effective date of the consolidation or merger for the use of the resulting insurer and no other domestic or foreign insurer shall be authorized to do business under such name or any other name that closely resembles such name during the 5-year period.

History: Add. 1957, Act 91, Eff. Sept. 27, 1957.

Popular name: Act 218

CHAPTER 77

500.7701 Short title of chapter.

Sec. 7701. This chapter shall be known and may be cited as the "Michigan life and health insurance guaranty association act".

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982.

Popular name: Act 218

500.7702 Purpose and construction of chapter.

Sec. 7702. (1) The purpose of this chapter is to protect, subject to certain limitations, persons specified in section 7704(1) against failure in the performance of contractual obligations under insurance policies and annuity contracts specified in section 7704(2) because of the impairment or insolvency of the insurer issuing the policies or contracts. To provide this protection:

(a) An association of insurers is created to enable the guaranty of payment of benefits and continuation of coverages as limited in this chapter.

(b) Members of the association are subject to assessment to provide funds to carry out the purpose of this chapter.

(c) The association is authorized to assist the commissioner, in the prescribed manner, in the detection and prevention of insurer impairments or insolvencies.

(2) This chapter shall be construed to execute the purposes provided in subsection (1).

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982;—Am. 1982, Act 501, Imd. Eff. Dec. 31, 1982;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 2006, Act 671, Imd. Eff. Jan. 10, 2007.

Compiler's note: Enacting section 1(1) of Act 671 of 2006 provides:

"Enacting section 1. (1) Sections 7702, 7704, 7705, 7706, 7707, 7708, 7709, 7711, 7712, 7714, and 7717 of the insurance code of 1956, 1956 PA 218, MCL 500.7702, 500.7704, 500.7705, 500.7706, 500.7707, 500.7708, 500.7709, 500.7711, 500.7712, 500.7714, and 500.7717, as amended by this amendatory act, apply to an insurer impairment or insurer insolvency proceeding commenced on or after the effective date of this amendatory act for which guaranty association coverage obligations are incurred."

Popular name: Act 218

500.7704 Coverages; liability of association; limitations.

Sec. 7704. (1) This chapter shall provide coverage for the policies and contracts specified in subsection (2) to the following persons:

(a) To a person, other than nonresident certificate holders under group policies or contracts, who, regardless of where he or she resides, is the beneficiary, assignee, or payee of a person covered under subdivision (b).

(b) To a person who is an owner of, or certificate holder under, a policy or contract described in subsection (2), other than an unallocated annuity contract or structured settlement contract, and which owner or certificate holder is 1 of the following:

(*i*) A resident.

(*ii*) Not a resident, if all of the following conditions are met:

(A) The insurer that issued the policy or contract is domiciled in this state.

(B) The state in which the person resides has an association similar to the association created by this chapter.

(C) The person is not eligible for coverage by an association in any other state because the insurer was not licensed in that state at the time specified in the state's guaranty association law.

(*iii*) Not a resident, if both of the following conditions are met:

(A) The person would have been considered a resident at the time the contract was obtained by the person.

(B) The person is not eligible for coverage by another guaranty association.

(c) For an unallocated annuity contract, except as provided in subsection (3), to either of the following:

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(*i*) To a person who is the owner of an unallocated annuity contract if the contract is issued to or in connection with a specific plan whose sponsor has its principal place of business in this state.

(*ii*) To a person who is the owner of an unallocated annuity contract issued to or in connection with a government lottery if the owner is a resident of this state.

(d) For a structured settlement annuity, except as provided in subsection (3), to a person who is a payee under a structured settlement annuity, or a beneficiary of a payee if the payee is deceased, and the payee is either of the following:

(*i*) A resident, regardless of where the contract owner resides.

(*ii*) Not a resident, if either of the following conditions is met:

(A) The contract owner of the structured settlement annuity is a resident, and the payee or beneficiary is not eligible for coverage from the association where the payee or beneficiary resides.

(B) The contract owner of the structured settlement annuity is not a resident, and both of the following conditions are met:

(I) The insurer that issued the structured settlement annuity is domiciled in this state, and the state in which the contract owner resides has an association similar to the association created by this chapter.

(II) Neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(2) Except as provided in subsections (3), (4), and (5), this chapter provides coverage to a person specified in subsection (1) for direct, nongroup life, health, annuity, and supplemental policies or contracts, for certificates under direct group life, health, annuity, and supplemental policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this chapter.

(3) This chapter does not provide coverage to a person who is a payee or beneficiary of a contract owner that is a resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state or to a person otherwise covered under subsection (1)(c), if any coverage is provided by the association of another state to that person.

(4) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. To avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this chapter in situations where a person could be covered by the association of more than 1 state, whether as an owner, payee, beneficiary, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only 1 association.

(5) This chapter does not provide coverage for the following:

(a) A portion of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy or contract owner, including, but not limited to, the nonguaranteed portion of a variable or separate account product.

(b) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract.

(c) A portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value exceeds the following:

(*i*) Averaged over the period of 4 years prior to the date on which the member insurer becomes an impaired insurer or an insolvent insurer, whichever occurs first, the rate of interest determined by subtracting 2 percentage points from Moody's corporate bond yield average averaged for that same 4-year period or for a lesser period if the policy or contract was issued less than 4 years before the member insurer becomes an impaired insurer or an insolvent insurer, whichever occurs first.

(*ii*) On and after the date on which the member insurer becomes an impaired insurer or an insolvent insurer, whichever occurs first, the rate of interest determined by subtracting 3 percentage points from Moody's corporate bond yield average as most recently available.

(d) A portion of a plan or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or other person under any of the following:

(*i*) A multiple employer welfare arrangement as defined in section 7001.

(*ii*) A minimum premium group insurance plan.

(*iii*) A stop-loss or excess-loss group insurance plan. This subparagraph does not apply to the insured portion of a stop-loss or excess-loss group insurance plan written pursuant to section 407a or 5208 or written by a member property casualty insurer if the premiums were identified as disability insurance premiums in its

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annual statement.

(*iv*) An administrative services only contract.

(e) A portion of a policy or contract to the extent that it provides dividends or experience rating credits, voting rights, or payment of any fees or allowances be paid to a person, including the policy or contract owner, in connection with the service to or administration of the policy or contract.

(f) A policy or contract issued in this state by an insurer at a time when it did not have a certificate of authority to issue the policy or contract in this state.

(g) An unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension benefit guaranty corporation regardless of whether the federal pension benefit guaranty corporation has become liable to make any payments with respect to the benefit plan.

(h) A portion of an unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery.

(i) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including, but not limited to, any of the following:

(*i*) A claim based on marketing materials.

(*ii*) A claim based on side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements.

(*iii*) A claim based on misrepresentations of or regarding policy benefits.

(*iv*) An award of exemplary or punitive damages or statutory interest and claims related to bad faith in the payment of claims, and attorney fees and costs.

(*v*) A claim for penalties or consequential or incidental damages.

(j) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer.

(k) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired insurer or an insolvent insurer, whichever occurs first. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subdivision, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and is not subject to forfeiture.

(*l*) A portion of a policy or contract to the extent that the assessments required by section 7709 for the policy or contract are preempted by federal or state law.

(m) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits under part C or part D of title XVIII of the social security act, 42 USC 1395w-21 to 1395w-29 and 42 USC 1395w-101 to 1395w-152, or under regulations issued under part C or part D of title XVIII of the social security act, 42 USC 1395w-21 to 1395w-29 and 42 USC 1395w-101 to 1395w-152.

(6) The benefits that the association may become obligated to cover shall not exceed the lesser of the following:

(a) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired insurer or an insolvent insurer.

(b) With respect to 1 life, regardless of the number of policies or contracts:

(*i*) $300,000.00 in life insurance death benefits, but not more than $100,000.00 in net cash surrender and net cash withdrawal values for life insurance.

(*ii*) Except as otherwise provided in subparagraphs (*iv*) and (*v*), $100,000.00 in health insurance benefits, including any net cash surrender and net cash withdrawal values.

(*iii*) $250,000.00 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

(*iv*) $300,000.00 in disability income insurance benefits or long-term care benefits.

(*v*) $500,000.00 in basic hospital, medical, and surgical insurance benefits.

(c) With respect to each individual participating in a governmental retirement benefit plan established under section 401(k), 403(b), or 457 of the internal revenue code of 1986, 26 USC 401, 403, and 457, covered by an unallocated annuity contract or the beneficiaries of each such individual, if deceased, in the aggregate, $250,000.00 in present value annuity benefits, including net cash surrender and net cash withdrawal values.

(d) With respect to each payee of a structured settlement annuity, or the beneficiary or beneficiaries of a deceased payee, $250,000.00 in present value annuity benefits, in the aggregate, including net cash surrender

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and net cash withdrawal values, if any.

(e) For either 1 contract owner provided coverage under subsection (1)(c)(*ii*) or 1 plan sponsor whose plans own directly or in trust 1 or more unallocated annuity contracts not included in subdivision (C), $5,000,000.00 in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, if 1 or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of 2 or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state, but in no event is the association obligated to cover more than $5,000,000.00 in benefits for all those unallocated contracts.

(7) In no event is the association obligated to cover more than the following:

(a) An aggregate of $300,000.00 in benefits for any 1 life under subsection (6)(b)(*i*), (*ii*), (*iii*), and (*iv*), (c), and (d).

(b) An aggregate of $500,000.00 in benefits for any 1 life under subsection (6)(b)(*v*).

(c) For 1 owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, $5,000,000.00 in benefits, regardless of the number of policies and contracts held by the owner.

(8) The limitations under subsections (6) and (7) are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired insurer or insolvent insurer attributable to covered policies. The costs of the association's obligations under this act may be satisfied by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(9) In performing its obligations to provide coverage under section 7708, the association is not required to guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, contractual obligations of the insolvent insurer or impaired insurer under a covered policy or contract that do not materially affect the economic benefits of the covered policy or contract.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982;—Am. 1982, Act 501, Imd. Eff. Dec. 31, 1982;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1996, Act 548, Imd. Eff. Jan. 15, 1997;—Am. 2006, Act 671, Imd. Eff. Jan. 10, 2007;—Am. 2010, Act 157, Imd. Eff. Sept. 2, 2010.

Compiler's note: Enacting section 1(1) of Act 671 of 2006 provides:

"Enacting section 1. (1) Sections 7702, 7704, 7705, 7706, 7707, 7708, 7709, 7711, 7712, 7714, and 7717 of the insurance code of 1956, 1956 PA 218, MCL 500.7702, 500.7704, 500.7705, 500.7706, 500.7707, 500.7708, 500.7709, 500.7711, 500.7712, 500.7714, and 500.7717, as amended by this amendatory act, apply to an insurer impairment or insurer insolvency proceeding commenced on or after the effective date of this amendatory act for which guaranty association coverage obligations are incurred."

Enacting section 1 of Act 157 of 2010 provides:

"Enacting section 1. This amendatory act's increase in the maximum benefits under section 7704(6)(b)(iii), (c), and (d) of the insurance code of 1956, 1956 PA 218, MCL 500.7704, does not apply to a member insurer that is under either a rehabilitation or liquidation order on the effective date of this amendatory act."

Popular name: Act 218

500.7705 Definitions.

Sec. 7705. As used in this chapter:

(a) "Account" means either of the 2 accounts created under section 7706.

(b) "Association" means the Michigan life and health insurance guaranty association created under section 7706.

(c) "Authorized assessment" or "authorized" when used in the context of assessments means a resolution or motion passed by the association's board of directors that directs that an assessment be called immediately or in the future from member insurers for a specific amount. An assessment is authorized when the resolution or motion is passed.

(d) "Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

(e) "Called assessment" or "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(f) "Contractual obligation" means an obligation under covered policies.

(g) "Covered policy" means a policy, contract, or certificate under a group policy or contract, or portion of a group policy or contract, for which coverage is provided under section 7704.

(h) "Health insurance" means disability insurance as described in section 606.

(i) "Impaired insurer" means a member insurer considered by the director to be potentially unable to fulfill

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the insurer's contractual obligations or that is placed under an order of rehabilitation or conservation by a court of competent jurisdiction. Impaired insurer does not mean an insolvent insurer.

(j) "Insolvent insurer" means a member insurer that becomes insolvent and is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(k) "Member insurer" means a person authorized to transact a kind of insurance or annuity business in this state for which coverage is provided under section 7704 and includes an insurer whose certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn. Member insurer does not include the following:

(*i*) A fraternal benefit society.

(*ii*) A cooperative plan insurer authorized under chapter 64.

(*iii*) A health maintenance organization authorized or licensed under chapter 35.

(*iv*) A mandatory state pooling plan.

(*v*) A mutual assessment or any person that operates on an assessment basis.

(*vi*) A nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

(*vii*) An insurance exchange.

(*viii*) An organization that has a certificate or license limited to the issuance of charitable gift annuities.

(*ix*) Any entity similar to the entities described in this subdivision.

(*l*) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's Investors Service, Inc., or a successor to that service.

(m) "Owner" of a contract or policy and "contract owner" and "policy owner" mean the person who is identified as the legal owner under the terms of the contract or policy or who is otherwise vested with the legal title to the contract or policy through a valid assignment completed in accordance with the terms of the contract or policy and properly recorded as the owner on the books of the insurer. The terms owner, contract owner, and policy owner do not include persons with a mere beneficial interest in a contract or policy.

(n) "Person" means an individual, corporation, partnership, association, or voluntary organization.

(o) "Plan sponsor" means the following:

(*i*) For a benefit plan established or maintained by a single employer, the single employer.

(*ii*) For a benefit plan established or maintained by an employee organization, the employee or organization.

(*iii*) For a benefit plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(p) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations, and deposits and less dividends and experience credits. The term "premiums" does not include an amount or consideration received for a policy or contract, or a portion of a policy or contract for which coverage is not provided under section 7704. However, accessible premiums must not be reduced because of sections 7704(5)(c) relating to interest limitations and 7704(6)(b), (c), and (e) relating to limitations with respect to any 1 individual, any 1 participant, and any 1 contract holder. Premiums do not include premiums in excess of the following:

(*i*) $5,000,000.00 on an unallocated annuity contract not issued under a governmental retirement plan established under section 401(k), 403(b), or 457 of the internal revenue code of 1986, 26 USC 401, 403, and 457.

(*ii*) For multiple nongroup policies of life insurance owned by 1 owner, whether the policyowner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, $5,000,000.00 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(q) "Principal place of business" of a plan sponsor or a person other than a natural person means the state in which the natural persons who establish policy for the direction, control, and coordination of the entity as a whole primarily exercise that function. In making this determination, the association, in its reasonable judgment, shall consider all of the following factors:

(*i*) The state in which the primary executive and administrative headquarters of the entity is located.

(*ii*) The state in which the principal office of the chief executive officer of the entity is located.

(*iii*) The state in which the board of directors, or the entity's similar governing person or persons, conducts the majority of its meetings.

(*iv*) The state in which the executive or management committee of the board of directors, or the entity's similar governing person or persons, conducts the majority of its meetings.

(*v*) The state from which the management of the overall operations of the entity is directed.

(*vi*) For a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state

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in which the holding company or controlling affiliate has its principal place of business as determined using subparagraphs (*i*) to (*v*). However, for a plan sponsor, if more than 50% of the participants in the benefit plan are employed in a single state, that state is the principal place of business of the plan sponsor.

(*vii*) For a plan sponsor of a benefit plan, the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan is based on the location of the principal place of business of the employer or employee organization that has the largest investment in the benefit plan instead of a specific or clear designation of a principal place of business.

(r) "Receivership court" means the court in the insolvent insurer's or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer.

(s) "Resident" means a person who resides in this state at the time a member insurer is determined to be an impaired insurer or insolvent insurer and to whom contractual obligations are owed. A person may be considered a resident of only 1 state, which, for a person other than a natural person, is its principal place of business. Citizens of the United States who are either residents of foreign countries or residents of the United States possessions, territories, or protectorates that do not have an association similar to the association created by this chapter are considered residents of this state if the insurer that issued the policies or contracts is domiciled in this state.

(t) "State" means a state, the District of Columbia, Puerto Rico, or a United States possession, territory, or protectorate.

(u) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(v) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract.

(w) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of an annuity benefit guaranteed to an individual by an insurer under the contract or certificate. Unallocated annuity contract includes, but is not limited to, a guaranteed investment contract or a deposit administration contract.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982;—Am. 1982, Act 501, Imd. Eff. Dec. 31, 1982;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1996, Act 548, Imd. Eff. Jan. 15, 1997;—Am. 2006, Act 671, Imd. Eff. Jan. 10, 2007;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Enacting section 1(1) of Act 671 of 2006 provides:

"Enacting section 1. (1) Sections 7702, 7704, 7705, 7706, 7707, 7708, 7709, 7711, 7712, 7714, and 7717 of the insurance code of 1956, 1956 PA 218, MCL 500.7702, 500.7704, 500.7705, 500.7706, 500.7707, 500.7708, 500.7709, 500.7711, 500.7712, 500.7714, and 500.7717, as amended by this amendatory act, apply to an insurer impairment or insurer insolvency proceeding commenced on or after the effective date of this amendatory act for which guaranty association coverage obligations are incurred."

Popular name: Act 218

500.7706 Michigan life and health insurance guaranty association; creation; membership requirement; performance of functions; exercise of powers; accounts; supervision of commissioner; applicability of insurance laws; meetings.

Sec. 7706. (1) There is created a nonprofit legal entity to be known as the Michigan life and health insurance guaranty association. A member insurer shall be and remain a member of the association as a condition of authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under section 7710 and shall exercise its powers through a board of directors established under section 7707. For purposes of administration and assessment the association shall maintain the following 2 accounts:

(a) The health insurance account.

(b) The life insurance and annuity account which includes the following subaccounts:

(*i*) A life insurance subaccount.

(*ii*) An annuity subaccount, which shall include unallocated annuity contracts owned by a governmental retirement plan, or its trustee, established under section 401, 403(b), or 457 of the internal revenue code of 1986, 26 USC 401, 403, and 457, but shall not include other unallocated annuities.

(*iii*) An unallocated annuity subaccount, which shall not include unallocated annuity contracts owned by a governmental retirement benefit plan, or its trustee, established under section 401, 403(b), or 457 of the internal revenue code of 1986, 26 USC 401, 403, and 457.

(2) The association is under the immediate supervision of the commissioner and is subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be open to the public

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upon majority vote of the board of directors of the association.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982;—Am. 1982, Act 501, Imd. Eff. Dec. 31, 1982;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1996, Act 548, Imd. Eff. Jan. 15, 1997;—Am. 2006, Act 671, Imd. Eff. Jan. 10, 2007.

Compiler's note: Enacting section 1(1) of Act 671 of 2006 provides:

"Enacting section 1. (1) Sections 7702, 7704, 7705, 7706, 7707, 7708, 7709, 7711, 7712, 7714, and 7717 of the insurance code of 1956, 1956 PA 218, MCL 500.7702, 500.7704, 500.7705, 500.7706, 500.7707, 500.7708, 500.7709, 500.7711, 500.7712, 500.7714, and 500.7717, as amended by this amendatory act, apply to an insurer impairment or insurer insolvency proceeding commenced on or after the effective date of this amendatory act for which guaranty association coverage obligations are incurred."

Popular name: Act 218

500.7707 Board of directors; appointment and election of members; vacancy; notice of organizational meeting; voting rights; approval of election or appointment; fair representation required; reimbursement for expenses.

Sec. 7707. (1) The board of directors of the association shall consist of not less than 5 nor more than 9 member insurers and 2 persons representing the general public serving terms as established in the plan of operation. The 2 members of the board representing the general public shall be appointed by the commissioner, shall not be engaged in the business of insurance, and shall not be officers, directors, or employees of an insurance company. The remaining members of the board shall be elected by member insurers subject to the approval of the commissioner. A vacancy on the board for a member representing the general public shall be filled for the remaining period of the term by appointment by the commissioner. A vacancy on the board for a member representing member insurers shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner. To elect the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to 1 vote in person or by proxy.

(2) In approving an election or in appointing a member to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(3) A member of the board may be reimbursed from the assets of the association for expenses incurred by the member as a member of the board of directors but a member of the board shall not otherwise be compensated by the association for his or her services.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982;—Am. 2006, Act 671, Imd. Eff. Jan. 10, 2007.

Compiler's note: Enacting section 1(1) of Act 671 of 2006 provides:

"Enacting section 1. (1) Sections 7702, 7704, 7705, 7706, 7707, 7708, 7709, 7711, 7712, 7714, and 7717 of the insurance code of 1956, 1956 PA 218, MCL 500.7702, 500.7704, 500.7705, 500.7706, 500.7707, 500.7708, 500.7709, 500.7711, 500.7712, 500.7714, and 500.7717, as amended by this amendatory act, apply to an insurer impairment or insurer insolvency proceeding commenced on or after the effective date of this amendatory act for which guaranty association coverage obligations are incurred."

Popular name: Act 218

500.7708 Powers and duties of association as to impaired or insolvent insurers; proceeding under subsection (3)(b) or (5)(b); paying or crediting rate of interest; nonpayment of premiums; premiums due and liability for unearned premiums; applicability of protection; additional powers of association; transfer of amount to association; failure of association to act; rendering assistance and advice to commissioner; standing; appearance; intervention; assignment of rights and causes of action; subrogation; reduced amounts; additional powers of association; reinsurance agreement; substitute coverage.

Sec. 7708. (1) In addition to the powers and duties enumerated in other sections of this chapter, the association has the powers and duties provided in this section.

(2) If a member insurer is an impaired insurer, the association, subject to conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, and that are approved by the commissioner, may do any of the following:

(a) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the covered policies of the impaired insurer.

(b) Provide money, pledges, notes, guarantees, or other means as are proper to effectuate subdivision (a), and to assure payment of the contractual obligations of the impaired insurer pending action under subdivision (a).

(c) Loan money to the impaired insurer.

(3) Subject to the conditions specified in subsection (4), if a member insurer is an impaired insurer, whether domestic, foreign, or alien, and the insurer is not paying claims timely, the association shall do either of the following:

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(a) Take any of the actions specified in subsection (2).

(b) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition for them under claims of emergency or hardship in accordance with standards proposed by the association and approved by the commissioner.

(4) The association is subject to subsection (3) only if the following are met:

(a) The laws of the impaired insurer's state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations:

(*i*) The delinquency proceeding shall not be dismissed.

(*ii*) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management.

(*iii*) It shall not be permitted to solicit or accept new business or have any suspended or revoked license restored.

(b) If the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in this state.

(c) If the impaired insurer is a foreign or alien insurer, any of the following has occurred:

(*i*) It has been prohibited from soliciting or accepting new business in this state.

(*ii*) Its certificate of authority has been suspended or revoked in this state.

(*iii*) A petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of that state.

(5) If a member insurer is an insolvent insurer, the association shall do either of the following:

(a) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies of the insolvent insurer or assure payment of the contractual obligations of the insolvent insurer; and provide money, pledges, notes, guarantees, or other means as are reasonably necessary to effectuate this subdivision.

(b) Provide benefits and coverage pursuant to subsection (6).

(6) If proceeding under subsection (3)(b) or (5)(b), all of the following apply:

(a) The association shall assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred as follows:

(*i*) For group policies or contracts, not later than the earlier of the next renewal date under the policy or contract or 45 days, but not less than 30 days, after the date on which the association becomes obligated with respect to the policies and contracts.

(*ii*) With respect to nongroup policies, contracts, and annuities, not later than the earlier of the next renewal date, if any, under the policies or contracts or 1 year, but not less than 30 days, from the date on which the association becomes obligated with respect to the policies or contracts.

(b) The association shall make diligent efforts to provide all known insureds or annuitants of nongroup contracts, or group policyholders of group policies and contracts, 30 days' notice of the termination of the benefits provided pursuant to subdivision (a).

(c) The association shall make available substitute coverage on an individual basis in accordance with the provisions of subdivision (d), to each known insured or an annuitant under nongroup life and health insurance policies and annuities covered by the association, or owner if other than the insured or annuitant, and to each individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, if the insured or annuitant had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class.

(d) In providing the substitute coverage required under subdivision (c), all of the following apply:

(*i*) The association may offer either to reissue the terminated coverage or to issue an alternative policy.

(*ii*) Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.

(*iii*) The association may reinsure an alternative or reissued policy.

(e) An alternative policy adopted by the association shall be subject to the approval of the commissioner. The association may adopt an alternative policy for future issuance without regard to any particular impairment or insolvency. An alternative policy shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium

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shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten. An alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(f) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the commissioner or by a court of competent jurisdiction.

(g) The association's obligations with respect to coverage under a policy of the impaired or insolvent insurer or under a reissued or alternative policy shall cease on the date the coverage or policy is replaced by another similar policy by the policyholder, the insured, or the association.

(7) If proceeding under subsection (3)(b) or (5) for a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 7704(5)(c).

(8) Nonpayment of premiums within 31 days after the date required under the terms of a guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the association's obligations under the policy or coverage under this chapter with respect to the policy or coverage, except for a claim incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter.

(9) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the association, and the association is liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(10) The protection provided by this chapter does not apply if guaranty protection is also provided to residents of this state by the laws of the domiciliary state of the impaired insurer or insolvent insurer.

(11) In carrying out its duties under this section, the association, subject to approval by a court in this state, may do the following:

(a) Impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the association finds that the amounts that can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of the permanent policy or contract liens to be in the public interest.

(b) Impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, if the receivership court imposes a temporary moratorium or moratorium charge on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired insurer or insolvent insurer, the association may defer the payment of the cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, but not for claims covered by the association that are to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(12) A deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to section 8153, shall be promptly transferred to the association in accordance with section 8141a. The association may apply a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of all policy owners' claims related to that insolvency for which the association has provided or will provide statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency with the remainder used to pay claims pursuant to section 8141a(1)(a) to (e). Any amount remaining after the payment of claims under section 8141a(1)(a) to (e) shall be transferred to the domiciliary receiver.

(13) If the association fails to act as provided in subsections (3) and (5) within a reasonable period of time, the commissioner shall have the powers and duties of the association under this chapter with respect to impaired insurers or insolvent insurers.

(14) The association may render assistance and advice to the commissioner, upon his or her request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired insurer or insolvent insurer.

(15) The association has standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired insurer or insolvent insurer concerning which the association is or may become

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obligated under this chapter or with jurisdiction over any person or property that the association may have rights to through subrogation or otherwise. The standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying, or guaranteeing the covered policies or contracts of the impaired insurer or insolvent insurer and the determination of the covered policies and contractual obligations. The association may also appear or intervene before a court in another state with jurisdiction over an impaired insurer or insolvent insurer for which the association is or may become obligated or with jurisdiction over a third party against whom the association may have rights through subrogation of the insurer's policyholders.

(16) A person receiving benefits under this chapter shall be considered to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this chapter whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The association may require an assignment to the association of such rights and causes of action by a payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of rights or benefits conferred by this chapter upon that person. The association shall be subrogated to these rights against the assets of an impaired insurer or insolvent insurer. The subrogation rights of the association under this subsection has the same priority against the assets of the impaired insurer or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter. In addition, the association has all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired insurer or insolvent insurer or owner, beneficiary, or payee of a policy or contract with respect to the policy or contract, including without limitation for a structured settlement annuity, any right of the owner, beneficiary, or payee of the annuity, to the extent of benefits received pursuant to this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment of the annuity.

(17) If subsection (16) is invalid or ineffective for any person or claim for any reason, the amount payable by the association for the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portions thereof, covered by the association.

(18) If the association has provided benefits for a covered obligation and a person recovers an amount that the association has rights to as described in subsection (16), the person shall pay to the association the portion of the recovery attributable to the policies, or portion thereof, covered by the association.

(19) In addition to other rights and powers under this chapter, the association may do the following:

(a) Enter into contracts necessary or proper to carry out the provisions and purposes of this chapter.

(b) Sue or be sued, including taking legal actions necessary or proper for recovery of unpaid assessments levied under section 7709 and to settle claims or potential claims against it.

(c) Borrow money to effect the purposes of this chapter. Notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets.

(d) Employ or retain the people necessary to handle the financial transactions of the association and to perform other functions that become necessary or proper under this chapter.

(e) Negotiate and contract with a liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association.

(f) Take legal action necessary to avoid or recover payment of improper claims.

(g) Exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this chapter.

(h) Join an organization of 1 or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(i) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter to the person, and the person shall promptly comply with the request.

(j) Take other necessary or appropriate action to discharge its duties and obligations and to exercise its powers under this chapter.

(20) At any time within 1 year after the coverage date, the association may elect to succeed to the rights and obligations of the member insurer, that accrue on or after the coverage date and that relate to contracts, in whole or in part, by the association, under any 1 or more indemnity reinsurance agreements entered into by the member insurer as a ceding insurer and selected by the association; provided, however, that the association shall not exercise this election for a reinsurance agreement if the receiver, rehabilitator, or

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liquidator of the member insurer has previously and expressly disaffirmed the reinsurance agreement on which the association becomes responsible for the obligations of a member insurer. The association shall make an election under this subsection by providing a notice to the receiver, rehabilitator, or liquidator and to the affected reinsurer. If the association makes an election, all of the following apply with respect to the agreements selected by the association:

(a) The association is responsible for all unpaid premiums due under the agreements for periods both before and after the coverage date, and for the performance of all other obligations to be performed after the coverage date, for contracts covered, in whole or in part, by the association. The association may charge contracts covered in part by the association, through reasonable allocation methods, the cost for reinsurance in excess of the obligations of the association.

(b) The association is entitled to any amounts payable by the reinsurer under the agreements for losses or events that occur in periods after the coverage date and that relate to contracts covered by the association, in whole or in part, provided that the association is obligated upon receipt of this amount to pay to the beneficiary under the policy or contract on account of which they were paid the amount received by the association that is in excess of the benefits paid by the association on account of the policy or contract less the retention of the impaired member insurer or insolvent member insurer applicable to the loss or event.

(c) Within 30 days following the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each such reinsurance agreement as of the date of the association's election, which calculation shall give full credit to all items paid by either the member insurer or its receiver, rehabilitator, or liquidator or the indemnity reinsurer during the period between the coverage date and the date of the association's election. Either the association or the indemnity reinsurer shall pay the net balance due the other within 5 days of the completion of this calculation. If the receiver, rehabilitator, or liquidator has received any amounts due the association pursuant to subdivision (b), the receiver, rehabilitator, or liquidator shall remit this amount to the association as promptly as practicable.

(d) If, within 60 days of the election, the association pays the premiums due for periods both before and after the coverage date that relate to contracts covered by the association, in whole or in part, the reinsurer shall not terminate the reinsurance agreements insofar as the agreements relate to contracts covered by the association in whole or in part and shall not set off any unpaid premiums due for periods prior to the coverage date against amounts due the association.

(e) As used in this subsection, "coverage date" means the date on which the association becomes responsible for the obligations of the member insurer.

(21) If the association transfers its obligations to another insurer, and if the association and the other insurer agree, the other insurer shall succeed to the rights and obligations of the association under subsection (20) effective on the date agreed to by the association and the other insurer and regardless of whether the association has made the election referred to in subsection (20). If this occurs, the indemnity reinsurance agreement automatically terminates for new reinsurance unless the indemnity reinsurer and other insurer agree to the contrary and the obligations described in subsection (20)(b) no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third party insurer. This subsection does not apply if the association has previously expressly determined in writing that it will not exercise the election referred to in subsection (20).

(22) Subsections (20) and (21) shall be applied consistently with section 8132 and shall supersede the provisions of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the coverage date, to the receiver, liquidator, or rehabilitator or the insolvent member insurer. The receiver, rehabilitator, or liquidator remain entitled to any amounts payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur in periods prior to the coverage date, subject to applicable setoff provisions.

(23) Except as otherwise expressly provided in subsections (20) to (22), this section does not do any of the following:

(a) Alter or modify the terms and conditions of the indemnity reinsurance agreements of the insolvent member insurer.

(b) Abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement.

(c) Give a policy owner or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

(24) The board of directors of the association, in the exercise of reasonable business judgment, may determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner.

(25) If the association has arranged or offered to provide the benefits of this chapter to a covered person

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under a plan or arrangement that fulfills the association's obligations under this chapter, the person is not entitled to benefits from the association in addition to, or other than those provided under, the plan or arrangement.

(26) Venue in a suit against the association arising under this chapter shall be in Ingham county. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

(27) In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under subsection (3) or (5), the association may, subject to the commissioner's or the receivership court's approval, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value, by issuing an alternative policy or contract in accordance with the following provisions:

(a) Instead of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value.

(b) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract.

(c) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 2006, Act 671, Imd. Eff. Jan. 10, 2007.

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Popular name: Act 218

500.7709 Assessments.

Sec. 7709. (1) Except as otherwise provided in this section, for the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than 30 days after written notice to the member insurers and shall accrue interest at 12% per annum on and after the due date.

(2) There shall be 2 classes of assessments, as follows:

(a) Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other general expenses and may be authorized and called whether or not the assessment relates to a particular impaired insurer or insolvent insurer.

(b) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under section 7708 for an impaired insurer or insolvent insurer.

(3) The amount of a class A assessment shall be determined by the board and may be authorized and called on a pro rata or nonpro rata basis. If pro rata, the board may provide that it be credited against future class B assessments. The total of all nonpro rata assessments shall not exceed $150.00 per member insurer in 1 calendar year.

(4) The amount of a class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula that may be based on the premiums or reserves of the impaired insurer or insolvent insurer or any other standard considered by the board in its sole discretion as being fair and reasonable under the circumstances.

(5) A class B assessment against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the 3 most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent bears to such premiums received on business in this state for those 3 most recent calendar years by all assessed member insurers.

(6) An assessment for funds to meet the requirements of the association with respect to an impaired insurer or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection (2) and computation of assessments under this section shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized

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assessment not yet called within 180 days after the assessment is authorized.

(7) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill that insurer's contractual obligations. If an assessment against a member insurer is abated or deferred, in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(8) The total of all assessments authorized by the association for a member insurer for each subaccount of the life insurance and annuity account and for the health account shall not in 1 calendar year exceed 2% of that member insurer's average annual premiums received in this state on the policies and contracts covered by the account or subaccount during the 3 calendar years preceding the year in which the insurer became an impaired insurer or insolvent insurer, subject to the following:

(a) If 2 or more assessments are authorized in 1 calendar year for insurers that become impaired insurers or insolvent insurers in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation under this subsection are equal and limited to the higher of the 3-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

(b) If the maximum assessment, together with the other assets of the association in an account, does not provide in 1 year, in either account, an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this chapter.

(9) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to 1 or more impaired insurers or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(10) If the maximum assessment for a subaccount of the life insurance and annuity account in any 1 year does not provide an amount sufficient to carry out the responsibilities of the association, then, pursuant to subsection (5), the board shall access the other subaccounts of the life insurance and annuity account for the necessary additional amount, subject to the maximum stated in subsection (8).

(11) The board may refund to member insurers, by an equitable method as established in the plan of operation and in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out future obligations of the association with regard to that account, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained in an account to provide funds for the continuing expenses of the association and for future claims. Instead of a class A assessment, the board may transfer on an equitable pro rata basis excess amounts from class B accounts to the class A account.

(12) In determining premium rates and policy owner dividends as to any kind of insurance within the scope of this chapter, a member insurer may consider the amount reasonably necessary to meet assessment obligations under this chapter.

(13) The association shall issue to an insurer paying an assessment under this chapter, other than a class A assessment, a certificate of contribution in a form prescribed by the commissioner for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in the insurer's financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

(14) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as stated in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest. Within 60 days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest. Within 30 days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within 60 days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner. Instead of rendering a final decision on a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association. If the protest or appeal is resolved in the member insurer's favor, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the association.

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(15) The association may request information of member insurers in order to aid in the exercise of its power under this section, and member insurers shall promptly comply with this request.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982;—Am. 1986, Act 121, Imd. Eff. May 28, 1986;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 2006, Act 671, Imd. Eff. Jan. 10, 2007.

Compiler's note: Enacting section 1(1) of Act 671 of 2006 provides:

"Enacting section 1. (1) Sections 7702, 7704, 7705, 7706, 7707, 7708, 7709, 7711, 7712, 7714, and 7717 of the insurance code of 1956, 1956 PA 218, MCL 500.7702, 500.7704, 500.7705, 500.7706, 500.7707, 500.7708, 500.7709, 500.7711, 500.7712, 500.7714, and 500.7717, as amended by this amendatory act, apply to an insurer impairment or insurer insolvency proceeding commenced on or after the effective date of this amendatory act for which guaranty association coverage obligations are incurred."

Popular name: Act 218

500.7710 Plan of operation and amendments; submission to commissioner; effective date; failure to submit suitable plan or amendments; rules; compliance by member insurers; contents of plan; providing for delegation of powers and duties of association to other organization.

Sec. 7710. (1) The association shall submit to the commissioner a plan of operation and amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and amendments to the plan shall become effective upon approval in writing by the commissioner or if he or she has not disapproved it within 30 days after submission.

(2) If the association fails to submit a suitable plan of operation within 60 days following the effective date of this chapter or if at any time the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, promulgate rules reasonably necessary or advisable to effectuate this chapter. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(3) All member insurers shall comply with the plan of operation.

(4) In addition to requirements enumerated elsewhere in this chapter, the plan of operation shall contain the following:

(a) Procedures for handling the assets of the association.

(b) The amount and method of reimbursing members of the board of directors under section 7707.

(c) Regular places and times for meetings of the board of directors.

(d) Procedures for records to be kept of financial transactions of the association, the association's agents, and the board of directors.

(e) Procedures for election of the board of directors and for submission of board members to the commissioner.

(f) Additional procedures for assessments under section 7709.

(g) Additional provisions necessary or proper for the execution of the powers and duties of the association.

(5) The plan of operation may provide that any or all powers and duties of the association, except those under sections 7708(16)(c) and 7709, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of the association, or the association's equivalent, in 2 or more states.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.7711 Additional duties of commissioner; suspension or revocation of certificate of authority; forfeiture; appeal; judicial review; notice by liquidator, rehabilitator, or conservator.

Sec. 7711. (1) In addition to the duties enumerated elsewhere in this chapter, the commissioner shall:

(a) Upon request of the board of directors, provide the association with a statement of the premiums in the appropriate states for each member insurer.

(b) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer constitutes notice to that insurer's shareholders, if any. The failure of the insurer to promptly comply with the demand does not excuse the association from the performance of the association's powers and duties under this chapter.

(c) In a liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

(2) In addition to the powers enumerated elsewhere in this chapter, the commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of a member

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insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture on a member insurer that fails to pay an assessment when due. The forfeiture shall not exceed 5% of the unpaid assessment per month, but forfeiture shall not be less than $100.00 per month.

(3) A final action by the board of directors or the association may be appealed to the commissioner by a member insurer if the appeal is taken within 60 days of its receipt of notice of the final action being appealed. A final action or order of the commissioner is subject to judicial review in a court of competent jurisdiction in accordance with this state's laws applying to actions or orders of the commissioner.

(4) The liquidator, rehabilitator, or conservator of an impaired insurer may notify all interested persons of the effect of this chapter.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 2006, Act 671, Imd. Eff. Jan. 10, 2007.

Compiler's note: Enacting section 1(1) of Act 671 of 2006 provides:

"Enacting section 1. (1) Sections 7702, 7704, 7705, 7706, 7707, 7708, 7709, 7711, 7712, 7714, and 7717 of the insurance code of 1956, 1956 PA 218, MCL 500.7702, 500.7704, 500.7705, 500.7706, 500.7707, 500.7708, 500.7709, 500.7711, 500.7712, 500.7714, and 500.7717, as amended by this amendatory act, apply to an insurer impairment or insurer insolvency proceeding commenced on or after the effective date of this amendatory act for which guaranty association coverage obligations are incurred."

Popular name: Act 218

500.7712 Detection and prevention of insurer insolvencies or impairments; powers and duties of commissioner and board of directors; reports and recommendations.

Sec. 7712. (1) To aid in the detection and prevention of insurer insolvencies or impairments, the commissioner shall do the following:

(a) Notify the commissioners of all the other states, territories of the United States, and the District of Columbia when he or she takes any of the following actions against a member insurer:

(*i*) Revokes a certificate of authority.

(*ii*) Suspends a certificate of authority.

(*iii*) Makes a formal order that the company restricts its premium writing, obtains additional contributions to surplus, withdraws from the state, reinsures all or a part of its business, or increases capital, surplus, or any other account for the security of policyholders or creditors.

(b) Mail the notice under subdivision (a) to all commissioners within 30 days following the action taken.

(c) Report to the board of directors when he or she has taken any of the actions set forth in subdivision (a) or has received a report from any other commissioner indicating that such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(d) Report to the board of directors when the commissioner has reasonable cause to believe from an examination, whether completed or in process, of a member insurer that the insurer may be an impaired insurer or insolvent insurer.

(e) Furnish to the board of directors the NAIC insurance regulatory information system (IRIS) ratios and listings of companies not included in the ratios developed by the national association of insurance commissioners. The board may use that information in carrying out its duties and responsibilities under this section.

(f) The report and the information furnished pursuant to this subsection shall be kept confidential by the board of directors until made public by the commissioner or other lawful authority.

(2) The commissioner may seek the advice and recommendations of the board of directors concerning a matter affecting his or her duties and responsibilities regarding the financial condition of a member company seeking to transact insurance business in this state.

(3) The board of directors, upon majority vote, may make reports and recommendations to the commissioner upon a matter germane to the solvency, liquidation, rehabilitation, or conservation of a member insurer or germane to the solvency of a company seeking to transact insurance business in this state. The reports and recommendations shall not be considered public documents.

(4) The board of directors, upon majority vote, may notify the commissioner of information indicating that a member insurer may be an impaired insurer or insolvent insurer.

(5) The board of directors, upon majority vote, may request that the commissioner order an examination of a member insurer that the board in good faith believes may be an impaired insurer or insolvent insurer. Within 30 days after the receipt of the request, the commissioner shall begin the examination. The examination may be conducted as a national association of insurance commissioners examination or may be conducted by a person whom the commissioner designates. The cost of the examination shall be paid by the association, and

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the examination report shall be treated in the same manner as other examination reports. An examination report shall not be released to the board of directors before release to the public, but this does not preclude the commissioner from complying with subsection (1). The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but shall not be open to public inspection before release of the examination report to the public.

(6) The board of directors, upon majority vote, may make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(7) At the conclusion of an insurer insolvency in which the association was obligated to pay covered claims, the board of directors shall prepare a report to the commissioner containing information in the board's possession bearing on the history and causes of the insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes for insolvency of a particular insurer and may adopt by reference a report prepared by such other associations.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 2006, Act 671, Imd. Eff. Jan. 10, 2007.

Compiler's note: Enacting section 1(1) of Act 671 of 2006 provides:

"Enacting section 1. (1) Sections 7702, 7704, 7705, 7706, 7707, 7708, 7709, 7711, 7712, 7714, and 7717 of the insurance code of 1956, 1956 PA 218, MCL 500.7702, 500.7704, 500.7705, 500.7706, 500.7707, 500.7708, 500.7709, 500.7711, 500.7712, 500.7714, and 500.7717, as amended by this amendatory act, apply to an insurer impairment or insurer insolvency proceeding commenced on or after the effective date of this amendatory act for which guaranty association coverage obligations are incurred."

Popular name: Act 218

500.7714 Liability for unpaid assessments of insureds on impaired or insolvent insurer operating under plan with assessment liability; records of negotiations and meetings; report; association as creditor of impaired or insolvent insurer; "assets attributable to covered policies" defined; disbursement of assets.

Sec. 7714. (1) This chapter shall not be construed to reduce the liability for unpaid assessments of the insureds on an impaired insurer or insolvent insurer operating under a plan with assessment liability.

(2) Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out powers and duties under section 7708. Association records concerning an impaired insurer or an insolvent insurer shall not be disclosed before the termination of a liquidation, rehabilitation, or conservation proceeding involving an impaired insurer or insolvent insurer, or before the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. This subsection does not limit the duty of the association to render a report of association activities under section 7715.

(3) For the purpose of carrying out obligations under this chapter, the association shall be considered a creditor of the impaired insurer or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to section 7708(16). Assets of the impaired insurer or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired insurer or insolvent insurer as required by this chapter. As used in this subsection, "assets attributable to covered policies" means that proportion of the assets which the reserves that should have been established for the covered policies bear to the reserves that should have been established for all policies of insurance written by the impaired insurer or insolvent insurer.

(4) As a creditor of an impaired insurer or insolvent insurer as provided in subsection (3) and consistent with chapter 81, the association and other similar associations are entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this act. If the liquidator has not, within 120 days of a final determination of insolvency of an insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association may make application to the receivership court for approval of its own proposal to disburse assets.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 2006, Act 671, Imd. Eff. Jan. 10, 2007.

Compiler's note: Enacting section 1(1) of Act 671 of 2006 provides:

"Enacting section 1. (1) Sections 7702, 7704, 7705, 7706, 7707, 7708, 7709, 7711, 7712, 7714, and 7717 of the insurance code of 1956, 1956 PA 218, MCL 500.7702, 500.7704, 500.7705, 500.7706, 500.7707, 500.7708, 500.7709, 500.7711, 500.7712, 500.7714, and 500.7717, as amended by this amendatory act, apply to an insurer impairment or insurer insolvency proceeding commenced on or after the effective date of this amendatory act for which guaranty association coverage obligations are incurred."

Popular name: Act 218

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500.7715 Examination and regulation of association by commissioner; financial report; report of activities.

Sec. 7715. The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the commissioner and a report of the association's activities during the preceding calendar year.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982.

Popular name: Act 218

500.7716 Association exempt from fees and taxes; exception.

Sec. 7716. The association shall be exempt from payment of fees and taxes levied by this state or its political subdivisions, except taxes levied on real property.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982.

Popular name: Act 218

500.7717 Nonliability of member insurer, association, board of directors, or commissioner in performance of powers and duties.

Sec. 7717. There is no liability on the part of and a cause of action does not arise against a member insurer or an insurer's agents or employees, the association or the association's agents or employees, members of the board of directors, or the commissioner or his or her representatives for any action or omission by them in the performance of powers and duties under this act. This immunity shall extend to the participation in an organization of 1 or more other state associations of similar purposes and to the organization and its agents or employees.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 2006, Act 671, Imd. Eff. Jan. 10, 2007.

Popular name: Act 218

Compiler's note: Enacting section 1(1) of Act 671 of 2006 provides:

"Enacting section 1. (1) Sections 7702, 7704, 7705, 7706, 7707, 7708, 7709, 7711, 7712, 7714, and 7717 of the insurance code of 1956, 1956 PA 218, MCL 500.7702, 500.7704, 500.7705, 500.7706, 500.7707, 500.7708, 500.7709, 500.7711, 500.7712, 500.7714, and 500.7717, as amended by this amendatory act, apply to an insurer impairment or insurer insolvency proceeding commenced on or after the effective date of this amendatory act for which guaranty association coverage obligations are incurred."

500.7718 Stay of proceedings in which insolvent insurer party; setting aside default judgment; defense.

Sec. 7718. All proceedings in which an insolvent insurer is a party in a court in this state shall be stayed 60 days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on a matter germane to the association's powers or duties. If a judgment under a decision, order, verdict, or finding is based on default, the association may apply to have the judgment set aside by the same court that made the judgment and shall be permitted to defend in the action on the merits.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982.

Popular name: Act 218

500.7719 Repealed. 1989, Act 302, Eff. Jan. 3, 1990.

Compiler's note: The repealed section pertained to prohibited advertisement, announcement, or statement.

Popular name: Act 218

500.7780 Applicability of chapter to delinquent insurer.

Sec. 7780. This chapter applies to a delinquent insurer for which delinquency proceedings have been commenced on or after May 1, 1982.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982.

Popular name: Act 218

CHAPTER 78
LIQUIDATIONS AND RECEIVERSHIPS

500.7800-500.7868 Repealed. 1989, Act 302, Eff. Jan. 3, 1990.

Popular name: Act 218

CHAPTER 79

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500.7901 Property and casualty guaranty association act; short title.

Sec. 7901. This chapter constitutes, and may be cited as the "property and casualty guaranty association act".

History: Add. 1969, Act 277, Imd. Eff. Aug. 11, 1969.

Popular name: Act 218

500.7911 Property and casualty guaranty association; membership; exception; laws to which association subject.

Sec. 7911. (1) To implement this chapter, there shall be maintained within this state, by all insurers authorized to transact in this state insurance other than life or disability insurance, except the Michigan basic property insurance association created pursuant to section 2920, an association of those insurers to be known as the property and casualty guaranty association, hereafter referred to as the "association". Each insurer shall be a member of the association as a condition of its authority to continue to transact insurance in this state.

(2) An insurer from which insurance has been or may be procured in this state solely by virtue of chapter 19 shall not be considered to be an insurer authorized to transact insurance in this state for the purposes of this chapter.

(3) The association is subject to the requirements of this chapter and chapter 81 but is not subject to the other chapters of this act. The association shall be subject to other laws of this state to the extent that it would be subject to those laws if it were an insurer organized and operating under chapter 50, to the extent that those other laws are consistent with this chapter.

History: Add. 1969, Act 277, Imd. Eff. Aug. 11, 1969;—Am. 1972, Act 207, Imd. Eff. June 30, 1972;—Am. 1980, Act 41, Imd. Eff. Mar. 17, 1980;—Am. 1982, Act 502, Eff. Mar. 30, 1983;—Am. 1990, Act 137, Eff. June 29, 1990;—Am. 1993, Act 200, Eff. Dec. 28, 1994;—Am. 2006, Act 365, Imd. Eff. Sept. 18, 2006.

Compiler's note: Act 143 of 1993, which amended this section, was submitted to the people by referendum petition (as Proposal C) and rejected by a majority of the votes cast at the November 8, 1994, general election.

Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.7911a Life or disability insurer not to be member of association.

Sec. 7911a. Notwithstanding section 7911, a life or disability insurer shall not be a member of the association.

History: Add. 1982, Act 501, Imd. Eff. Dec. 31, 1982;—Am. 1996, Act 548, Imd. Eff. Jan. 15, 1997.

Popular name: Act 218

500.7912 Property and casualty guaranty association; board of governors; appointment, terms, and qualifications of members; vacancy.

Sec. 7912. (1) The association shall be managed by a board of governors, composed of 5 member insurers and 2 persons representing the general public, each of whom shall be appointed by the commissioner to serve for terms of 3 years and until their successors are appointed and qualified. Three of the governors who are member insurers shall be domestic insurers and 2 shall be foreign insurers. At least 2 governors who are member insurers shall be stock insurers and at least 2 shall be nonstock insurers. The 5 governors who are member insurers shall be representative, as nearly as possible, of all the kinds of insurance covered by this chapter.

(2) In case of a vacancy for any reason in the office of any governor, the commissioner shall appoint a person to fill the unexpired term of the vacant office to maintain the membership of the board as required in subsection (1).

History: Add. 1969, Act 277, Imd. Eff. Aug. 11, 1969;—Am. 1982, Act 502, Eff. Mar. 30, 1983.

Popular name: Act 218

500.7914 Property and casualty guaranty association; plan of operation, adoption, amendment, approval; failure to adopt operation plan.

Sec. 7914. (1) The association shall adopt a plan of operation and any amendments thereof, not

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inconsistent with the provisions of this chapter, necessary to assure the fair, reasonable and equitable manner of administering the association, and to provide for such other matters as are necessary or advisable to implement the provisions of this chapter. The plan of operation and any amendments thereof shall be subject to prior written approval by the commissioner. All members of the association shall adhere to the plan of operation.

(2) If for any reason the association fails to adopt a suitable plan of operation within 6 months following the effective date of this chapter, or if at any time thereafter the association fails to adopt suitable amendments to the plan of operation, the commissioner shall adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this act. Such rules shall continue in force until modified by the commissioner or superseded by a plan of operation adopted by the association and approved by the commissioner.

History: Add. 1969, Act 277, Imd. Eff. Aug. 11, 1969.

Popular name: Act 218

500.7916 Property and casualty guaranty association; servicing facilities; designation; reimbursement; authority; approval.

Sec. 7916. In accordance with its plan of operation the association may designate 1 or more of its members as servicing facilities but a member may decline such designation. Each servicing facility shall be reimbursed by the association for any expenses it incurs and for any payments it makes on behalf of the association. Each servicing facility shall have authority to perform any functions of the association that the governors lawfully may delegate to it and to do so on behalf of and in the name of the association. The designation of servicing facilities shall be subject to the approval of the commissioner.

History: Add. 1969, Act 277, Imd. Eff. Aug. 11, 1969.

Popular name: Act 218

500.7918 Property and casualty guaranty association; powers generally.

Sec. 7918. (1) The association may borrow funds when necessary to implement this act.

(2) The association, either in its own name or through a servicing facility, may sue or be sued, and may use the courts to assert or defend any rights the association may have under this chapter, to the extent necessary to fully exercise its rights and perform its duties under, and to implement, this chapter.

(3) The association may retain and employ legal counsel in its discretion to represent the association in all respects.

(4) The association may bring an action against any third party administrator, agent, attorney, or other representative of the insolvent insurer to obtain custody and control of all claims information, including all files, records, and electronic data related to an insolvent company that are appropriate or necessary for the association, or a similar association in other states, to carry out its duties under this act. The association shall have the absolute right through emergency equitable relief to obtain custody and control of all claims information in the custody or control of the third party administrator, agent, attorney, or other representative of the insolvent insurer, regardless of where the information may be physically located. In bringing the action, the association is not subject to any defense, lien, possessory or otherwise, or other legal or equitable ground for refusal to surrender claims information that might be asserted against the liquidator of the insolvent insurers. If litigation is necessary for the association to obtain custody of the claims information requested and it results in the relinquishment of claims information to the association after refusal to provide the information in response to a written demand, the court shall award the association its costs, expenses, and reasonable attorney fees incurred in bringing the action. This section does not affect the rights and remedies that the custodian of the claims information may have against the insolvent insurers, so long as those rights and remedies do not conflict with the rights of the association to custody and control of the claims information under this act.

(5) Upon request of the commissioner, consent of the association, and appointment by the court, the association may act as deputy receiver in delinquency proceedings under chapter 81.

History: Add. 1969, Act 277, Imd. Eff. Aug. 11, 1969;—Am. 1980, Act 41, Imd. Eff. Mar. 17, 1980;—Am. 2001, Act 182, Imd. Eff. Dec. 21, 2001;—Am. 2006, Act 364, Imd. Eff. Sept. 18, 2006.

Popular name: Act 218

500.7921 "Insolvent insurer" and "member insurer" defined.

Sec. 7921. As used in this chapter:

(a) "Insolvent insurer" means an insurer which has been a member insurer and against whom a final order of liquidation has been entered with a finding of insolvency by a court of competent jurisdiction in the

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insurer's state of domicile. The date on which the order becomes final shall be the date on which all appeals of the finding of insolvency are exhausted. If the finding of insolvency in the order of liquidation is not appealed, the order of liquidation shall be considered final on the date the order was issued.

(b) "Member insurer" means an insurer required to be a member of the association pursuant to section 7911.

History: Add. 1969, Act 277, Imd. Eff. Aug. 11, 1969;—Am. 1980, Act 41, Imd. Eff. Mar. 17, 1980;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1990, Act 137, Eff. June 29, 1990;—Am. 1993, Act 200, Eff. Dec. 28, 1994;—Am. 2006, Act 363, Imd. Eff. Sept. 18, 2006.

Compiler's note: Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.7925 "Covered claims" defined; definitions.

Sec. 7925. (1) "Covered claims" means obligations of an insolvent insurer that meet all of the following requirements:

(a) Arise out of the insurance policy contracts of the insolvent insurer issued to residents of this state or are payable to residents of this state on behalf of insureds of the insolvent insurer.

(b) Were unpaid by the insolvent insurer.

(c) Are presented as a claim to the receiver in this state or the association on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

(d) Were incurred or existed before, at the time of, or within 30 days after the date the receiver was appointed.

(e) Arise out of policy contracts of the insolvent insurer issued for all kinds of insurance except life and disability insurance.

(f) Arise out of insurance policy contracts issued on or before the last date on which the insolvent insurer was a member insurer.

(2) Covered claims shall not include any of the following:

(a) Obligations to refund unearned premiums above the first $500.00 of unearned premiums from each person from any 1 insolvent insurer. The maximum amount of unearned premiums which shall constitute a covered claim shall be adjusted annually to reflect changes in the cost of living under rules prescribed by the commissioner. A refund in an amount less than $50.00 shall not be made for unearned premiums.

(b) Obligations incurred after the expiration date of the insurance policy, after the insurance policy has been replaced by the insured, or after the insurance policy has been canceled by the association as provided in this chapter.

(c) Obligations arising out of sections 2001 to 2050, or similar provisions of law in another jurisdiction.

(3) Covered claims shall not include any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, or health care corporation as subrogation recoveries, contribution, indemnification, or other obligation. A claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, or health care corporation shall not be brought against an insured or claimant under a policy issued by the insolvent insurer unless the claim exceeds the association's obligation limitations under subsection (6).

(4) Covered claims shall not include obligations for any first party or third party claim by or against an insured whose net worth exceeds $25,000,000.00 on December 31, or on the last date of the insured's fiscal period if that is other than December 31, of the year immediately preceding the date the insurer becomes an insolvent insurer. In determining net worth on this date, an insured's net worth shall include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis. The $25,000,000.00 net worth limit shall be adjusted annually to reflect the aggregate annual percentage change in the consumer price index since the previous adjustment, rounded to the nearest $10,000.00. The effective date of the adjustment shall be January 1 of each year. This subsection applies to an insolvency that occurs on or after the effective date of the amendatory act that added this subsection.

(5) Covered claims shall not include any portion of a claim that is in excess of an applicable limit provided in the insurance policy.

(6) Covered claims shall not include that portion of a claim, other than a worker's compensation claim or a claim for personal protection insurance benefits under section 3107, that is in excess of $5,000,000.00. The $5,000,000.00 claim cap shall be adjusted annually to reflect the aggregate annual percentage change in the

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consumer price index since the previous adjustment, rounded to the nearest $10,000.00. The effective date of the adjustment shall be January 1 of each year and shall apply to claims made on or after that date. The claim cap in effect at the time of payment of a claim shall apply.

(7) Covered claims shall not include adjustment fees and expenses, attorneys' fees and expenses, court costs, interest, or bond premiums if the fees, expenses, costs, interest, or premiums were incurred by the insolvent insurer before the receiver was appointed.

(8) As used in this section:

(a) "Consumer price index" means the consumer price index for all urban consumers in the U.S. city average, as most recently reported by the United States department of labor, bureau of labor statistics, and as certified by the commissioner.

(b) "Control" means that term as defined in section 115(b)(*i*).

(c) "Health care corporation" means that term as defined in section 105 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1105.

History: Add. 1969, Act 277, Imd. Eff. Aug. 11, 1969;—Am. 1972, Act 207, Imd. Eff. June 30, 1972;—Am. 1980, Act 41, Imd. Eff. Mar. 17, 1980;—Am. 2006, Act 362, Imd. Eff. Sept. 18, 2006.

Popular name: Act 218

Administrative rules: R 500.351 of the Michigan Administrative Code.

500.7931 Payment and discharge of covered claims; association as party in interest; rights of association; cause of action against insureds; recoverable damages or benefits as credit against covered claim; action to recover excess payment; claims made under worker's disability compensation act; continuation and duration of coverage for covered claims; cancellation of insurance policies; notice; definitions.

Sec. 7931. (1) The association may pay or discharge covered claims directly, through a servicing facility, or through a contract for reinsurance or transfer of liabilities with a member insurer, in accordance with the plan of operation.

(2) The association shall be a party in interest in all proceedings involving a covered claim and shall have the same rights as the insolvent insurer would have had if not in receivership, including the right to appear, defend, and appeal a claim in a court of competent jurisdiction; to receive notice of, investigate, adjust, compromise, settle, and pay a covered claim; and to investigate, handle, and deny a noncovered claim. The association shall not have a cause of action against the insureds of the insolvent insurer for any sums it has paid out, except those causes of action that the insolvent insurer would have had if the sums had been paid by the insolvent insurer, or except as otherwise provided by this chapter.

(3) If damages or benefits are recoverable by a claimant other than from any disability policy or life insurance policy owned or paid for by the claimant or by a claimant or insured under an insurance policy other than a policy of the insolvent insurer, or under a self-insured program of a self-insured entity, the damages or benefits recoverable shall be a credit against a covered claim payable under this chapter. The claimant, insured, or self-insured entity shall first exhaust all coverage provided by any policy or the self-insured retention of an excess insurance policy. If damages against an insured who is not a resident of this state are recoverable by a claimant who is a resident of this state, in whole or in part, from any insurance guaranty association or fund or its equivalent in the state where the insured is a resident, the damages recoverable shall be a credit against a covered claim payable under this chapter. To the extent that the association's obligation is reduced by this section, the liability of the person insured by the insolvent insurer's policy shall be reduced in the same amount. An insurer, self-insured entity, or any other person shall not maintain an action against an insured of the insolvent insurer to recover an amount that constitutes a credit against a covered claim under this section. An amount paid to a claimant in excess of the amount authorized by this section may be recovered by an action brought by the association. If the claims made arise under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, this subsection does not provide credits in excess of those specified in section 354 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.354, and does not limit the liability of the guaranty association or the insured under a policy of the insolvent insurer for benefits provided under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941.

(4) The association shall continue coverage for covered claims under each insurance policy of the insolvent insurer that was in force on the date the receiver was appointed until the insurance policy has expired in accordance with its terms, has been replaced by the insured, or has been canceled by the association as provided in this chapter, but in no event for more than 30 days after the date the receiver was appointed.

(5) The association may cancel insurance policies of the insolvent insurer by mailing or delivering to the

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insured at the last known address within this state a 10 days' written notice of cancellation, notwithstanding a statute or policy provision to the contrary.

(6) As used in this section:

(a) "Self-insured entity" means a person or employer that covers its liability through a qualified individual or group self-insurance program.

(b) "Self-insured program" means any formal program created for the specific purpose of covering liabilities typically covered by insurance.

History: Add. 1969, Act 277, Imd. Eff. Aug. 11, 1969;—Am. 1980, Act 41, Imd. Eff. Mar. 17, 1980;—Am. 2006, Act 361, Imd. Eff. Sept. 18, 2006.

Popular name: Act 218

500.7933 Financial condition of member insurer; reports and recommendations; advice to commissioner; exemption from public disclosure.

Sec. 7933. (1) The association may submit reports and make recommendations to the commissioner regarding the financial condition of any member insurer. The reports and recommendations shall not be considered public documents.

(2) After the commissioner has entered an order restricting the certificate of authority of an insurer, the association shall render advice to the commissioner, upon his or her request, concerning rehabilitation, payment of claims, continuation of coverage, or the performance of other obligations of the insurer.

(3) Any reports, recommendations, and advice prepared in compliance with this section shall be exempt from public disclosure.

History: Add. 1969, Act 277, Imd. Eff. Aug. 11, 1969;—Am. 1980, Act 41, Imd. Eff. Mar. 17, 1980.

Popular name: Act 218

500.7935 Cooperation of insured with association; assignment of rights; indemnification from catastrophic claims association; options.

Sec. 7935. (1) Each insured entitled to the protection of this chapter shall cooperate with the association in accordance with the insured's policy in the same manner as the insured would have been required to cooperate with his or her insurer if it were not in receivership. Each insured shall be considered to have assigned to the association any right to make claim against the receiver for a refund of unearned premium for the period of coverage provided by the association beginning on the date of receivership.

(2) An insured or claimant entitled to the benefits of this chapter shall be considered to have assigned to the association, to the extent of any payment received from the association, his or her rights against the estate of the insolvent insurer, rights under the policy under which his or her claim arose, and any other rights the insured or claimant may have against another person for payment of the covered claim paid by the association.

(3) The association shall be entitled to receive, to the extent of the amount paid or payable by the association by reason of a covered claim, any amount recoverable by the receiver or the insolvent insurer by way of right of indemnification from the catastrophic claims association created in section 3104.

(4) The association shall be entitled to any option to take possession of, right of salvage in, or other right to proceeds from the sale or disposition of insured property which is the subject matter of a covered claim, to which the insolvent insurer would have been entitled had it paid the claim.

History: Add. 1969, Act 277, Imd. Eff. Aug. 11, 1969;—Am. 1980, Act 41, Imd. Eff. Mar. 17, 1980.

Popular name: Act 218

500.7941 Assessments on member insurers; purpose; allocation of claim payments and costs to categories; separate assessments for each category; use, amount, and rate of assessment; remittance and administration of assessments; notice; limitation; exemption or deferment; recognition of assessments in rate-making procedures; refunds; revocation of certificate of authority.

Sec. 7941. (1) To the extent necessary to secure funds for the association for payment of covered claims and for payment of reasonable costs of administering the association, including the cost of indemnifying members of the board of governors, other member insurers, officers, employees, and other persons acting on behalf of the association to the extent permitted by law and the plan of operation, the association shall levy assessments upon all member insurers. The association shall allocate its claim payments and costs to the following 5 categories:

(a) Worker's compensation insurance.

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(b) Automobile insurance.

(c) Title insurance.

(d) Fire, allied lines, farm owner's multiple peril, homeowner's multiple peril, inland marine, earthquake, and credit insurance.

(e) All other kinds of insurance except life and disability insurance.

(2) Separate assessments shall be made for each category prescribed in subsection (1). The assessment for each category shall be used to pay the claim payments and costs allocated to that category. The assessment for each category shall be in proportion to the net direct premiums written, after deducting dividends paid or credited to policyholders, by each member insurer in this state for kinds of insurance included within each category, as reported in the most recent annual statement available at the time of assessment. The rate of assessment shall be a uniform percentage of the premiums for all member insurers. The assessments shall be remitted to and administered by the association in accordance with the plan of operation. Each member insurer assessed shall have not less than 30 days' advance written notice of the date the assessment is due and payable.

(3) A member insurer shall not be assessed during a calendar year for more than 1% of its net direct premiums written in this state during the previous calendar year. The commissioner may exempt a member insurer from all or part of an assessment or may defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of exemption or deferment, dividends shall not be declared or paid to shareholders or policyholders. If a member insurer is exempted from all or part of an assessment, or if an assessment against a member insurer is deferred in whole or in part, the amount of the exemption or deferred assessment may be assessed against the other member insurers in a manner consistent with the basis for assessments prescribed in this section. The commissioner may impose conditions on an exemption or deferral which he or she considers reasonable and necessary.

(4) The assessments shall be recognized in the rate-making procedures for insurance rates in the same manner that expenses and premium taxes are recognized. Unused assessments and reimbursements from the receiver remaining in a category in excess of covered claims and expenses allocated to that category shall be refunded by the association to each member insurer who paid the assessments for that category in proportion to its assessments paid. An insurer that ceases to be a member of the association shall not have a right to a refund of an assessment previously remitted to the association. The commissioner may revoke the certificate of authority to transact business in this state of a member insurer that fails to pay an assessment when due as provided in this act and after a demand has been made.

History: Add. 1969, Act 277, Imd. Eff. Aug. 11, 1969;—Am. 1972, Act 207, Imd. Eff. June 30, 1972;—Am. 1980, Act 41, Imd. Eff. Mar. 17, 1980;—Am. 1982, Act 502, Eff. Mar. 30, 1983;—Am. 1990, Act 137, Eff. June 29, 1990;—Am. 2006, Act 360, Imd. Eff. Sept. 18, 2006.

Popular name: Act 218

500.7945 Stay of proceedings.

Sec. 7945. (1) All proceedings in any court of law of this state to which the insolvent insurer is a party, or in which the insolvent insurer is obligated to defend or has assumed the defense of a party, shall be stayed for 6 months after the date a receiver is appointed, and for any additional time as determined by the court that has jurisdiction over those proceedings, to permit proper defense of all pending causes of action.

(2) All proceedings in any administrative tribunal, including worker's compensation proceedings, to which the insolvent insurer is a party, or in which the insolvent insurer is obligated to defend or has assumed the defense of a party, shall be stayed for such length of time after the date a receiver is appointed, as determined by the administrative tribunal that has jurisdiction over those proceedings. The administrative tribunal shall grant a stay for each affected proceeding, as necessary, to provide the association with sufficient time to prepare a proper defense in the proceeding.

History: Add. 1969, Act 277, Imd. Eff. Aug. 11, 1969;—Am. 1980, Act 41, Imd. Eff. Mar. 17, 1980;—Am. 2006, Act 359, Imd. Eff. Sept. 18, 2006.

Popular name: Act 218

500.7947 Tax exemption.

Sec. 7947. The association shall be exempt from all license fees, income, franchise, privilege or occupation taxes levied or assessed by this state, any municipality, county or other political subdivision of the state, except state, county or municipal taxes upon the real or personal property of the association, which is to be assessed and taxed in the same manner as real property and personal property of other nonexempt persons.

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History: Add. 1969, Act 277, Imd. Eff. Aug. 11, 1969.

Popular name: Act 218

500.7948 Liability.

Sec. 7948. There shall not be liability on the part of and a cause of action of any nature shall not arise against any member insurer, the association, agents or employees of the association, the board of governors, or the commissioner or representatives of the commissioner for any action taken by them in the exercise of their powers and performance of their duties under this chapter.

History: Add. 1980, Act 41, Imd. Eff. Mar. 17, 1980.

Popular name: Act 218

500.7949 Insurance commissioner; regulatory powers; visitation; examination; hearings.

Sec. 7949. (1) The operation of the association at all times shall be subject to the regulation of the commissioner. The commissioner, or any deputy or examiner, or any person whom the commissioner appoints, shall have the power of visitation and examination into the affairs of the association and free access to all books, papers and documents that relate to the business of the association, may summon and qualify witnesses under oath, and may examine officers, agents or employees or any other person having knowledge of the affairs, transactions or conditions of the association.

(2) Any member insurer aggrieved by any action or decision of the association may appeal to the commissioner within 30 days from the action or decision. Proceedings under this section are subject to the provisions of Act No. 197 of the Public Acts of 1952, as amended, being sections 24.101 to 24.110 of the Compiled Laws of 1948.

History: Add. 1969, Act 277, Imd. Eff. Aug. 11, 1969.

Popular name: Act 218

CHAPTER 80
FRATERNAL BENEFIT SOCIETIES

500.8000-500.8095 Repealed. 1969, Act 318, Eff. Mar. 20, 1970;—1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

CHAPTER 81
SUPERVISION, REHABILITATION, AND LIQUIDATION

500.8101 Construction and purpose of chapter.

Sec. 8101. (1) This chapter shall not be interpreted to limit the powers granted the commissioner by other provisions of this code.

(2) This chapter shall be liberally construed to effect the purpose stated in subsection (3).

(3) The purpose of this chapter is the protection of the interests of insureds, claimants, creditors, and the public with minimum interference with the normal prerogatives of the owners and managers of insurers, through the following:

(a) Early detection of potentially dangerous conditions in an insurer and prompt application of appropriate corrective measures.

(b) Improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry.

(c) Enhanced efficiency and economy of liquidation to minimize legal uncertainty and litigation.

(d) Equitable apportionment of unavoidable loss.

(e) Lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process and by extending the scope of personal jurisdiction over debtors of the insurer outside this state.

(f) Regulation of the insurance business relating to delinquency procedures and rules on the entire insurance business.

(4) This chapter does not apply to insurers that are subject to delinquency proceedings commenced prior to January 1, 1990. Delinquency proceedings commenced prior to January 1, 1990, shall be conducted pursuant to former chapter 78.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8102 Applicability of proceedings authorized by chapter.

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Sec. 8102. The proceedings authorized by this chapter may be applied to:

(a) An insurer who is transacting, or has transacted, insurance business in this state, and against whom claims arising from that business may exist now or in the future.

(b) An insurer who purports to transact an insurance business in this state.

(c) An insurer who has insureds resident in this state.

(d) All other persons organized or in the process of organizing with the intent to transact an insurance business in this state.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8103 Definitions.

Sec. 8103. As used in this chapter:

(a) "Ancillary state" means any state other than a domiciliary state.

(b) "Creditor" is a person having a claim against the insurer, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed, or contingent.

(c) "Delinquency proceeding" means a proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving such insurer, and a summary proceeding under section 8109 or 8110. "Formal delinquency proceeding" means any liquidation or rehabilitation proceeding.

(d) "Domiciliary state" means the state in which an insurer is incorporated or organized, or, in the case of an alien insurer, its state of entry.

(e) "Fair consideration" is given for property or an obligation pursuant to either of the following:

(*i*) If in exchange for the property or obligation, as a fair equivalent of the property or obligation and in good faith, property is conveyed or services are rendered or an obligation is incurred or an antecedent debt is satisfied.

(*ii*) If the property or obligation is received in good faith to secure a present advance or antecedent debt in an amount not disproportionately small as compared to the value of the property or obligation obtained.

(f) "Foreign country" means any other jurisdiction not in any state.

(g) "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered, for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, "general assets" includes all property or its proceeds in excess of the amount necessary to discharge the sum or sums secured by the property. Assets held in trust and on deposit for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as general assets. Amounts due an insolvent insurer as indemnification from the catastrophic claims association created in section 3104 shall not be considered to be assets of the receivership, but shall be paid directly to the property and casualty guaranty association under section 7935.

(h) "Guaranty association" means the Michigan property and casualty guaranty association, the worker's compensation self-insurance security fund, the Michigan life and health insurance guaranty association, and any other similar entity now or hereafter created by the legislature of this state for the payment of claims of insolvent insurers. "Foreign guaranty association" means any similar entities now in existence or hereafter created by the legislature of any other state.

(i) "Insolvency" or "insolvent" means:

(*i*) For an insurer issuing only assessable fire insurance policies:

(A) The inability to pay an obligation within 30 days after it becomes payable.

(B) If an assessment is made within 30 days after the date in subparagraph (*i*)(A), the inability to pay an obligation 30 days following the date specified in the first assessment notice issued after the date of loss.

(*ii*) For an insurer, other than an insurer under subparagraph (*i*), the inability to pay its obligations when they are due or when admitted assets do not exceed liabilities plus the greater of either of the following:

(A) Any capital and surplus required by law for its organization.

(B) The total par or stated value of its authorized and issued capital stock.

(*iii*) For purposes of this subdivision, "liabilities" shall include, but not be limited to, reserves required by statute or by rule or specific requirements imposed by the commissioner upon an insurer at the time of admission or subsequent to admission.

(j) "Preferred claim" means a claim that receives priority of payment from the general assets of the insurer under this chapter.

(k) "Receiver" means receiver, liquidator, rehabilitator, or conservator as the context requires.

(*l*) "Reciprocal state" means a state other than this state in which all of the following occurs:

(*i*) In substance and effect sections 8118(1), 8152, 8153, 8155, 8156, and 8157 are in force.

(*ii*) Provisions requiring that the commissioner or equivalent official be the receiver of a delinquent insurer

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are in force.

(*iii*) Some provision for the avoidance of fraudulent conveyances and preferential transfers are in force.

(m) "Secured claim" means a claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise, but not including a special deposit claim or claim against general assets. The term also includes claims that have become liens upon specific assets by reason of judicial process.

(n) "Special deposit claim" means a claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including a claim secured by general assets.

(o) "State" means a state, district, or territory of the United States.

(p) "Transacting business" includes any of the following acts, whether effected by mail or otherwise:

(*i*) The issuance or delivery of contracts of insurance to persons resident in this state.

(*ii*) The solicitation of applications for insurance contracts or other negotiations preliminary to the execution of insurance contracts.

(*iii*) The collection of premiums, membership fees, assessments, or other consideration for insurance contracts.

(*iv*) The transaction of matters subsequent to execution of insurance contracts and arising out of them.

(*v*) Operating under a certificate of authority, as an insurer, issued by the commissioner.

(q) "Transfer" shall include the sale and every other and different mode, direct or indirect, of disposing of or of parting with property or with an interest in property or with the possession of property or of fixing a lien upon property or upon an interest in property, absolutely or conditionally, voluntarily, by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be considered a transfer suffered by the debtor.

(r) "Trusteed assets" means the assets of an alien insurer and U.S. branch domiciled in this state and maintained in trust pursuant to section 411(4).

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1994, Act 227, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.8104 Commencement of delinquency proceeding; jurisdiction; stay of proceedings.

Sec. 8104. (1) A delinquency proceeding shall not be commenced under this chapter by anyone other than the commissioner of this state and a court shall not have jurisdiction to entertain, hear, or determine a proceeding commenced by any other person.

(2) A court of this state shall not have jurisdiction to entertain, hear, or determine a complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of an insurer; or praying for an injunction or restraining order or other relief preliminary to, incidental to, or relating to such proceedings other than in accordance with this chapter.

(3) The circuit court for Ingham county shall have sole jurisdiction of a delinquency proceeding commenced under this chapter. In addition to other grounds for jurisdiction provided by the law of this state, the circuit court for Ingham county shall also have jurisdiction over a person served pursuant to the applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this state, if any of the following apply:

(a) The person served is obligated to the insurer as incident to an agency or brokerage arrangement that may exist or has existed between the insurer and the agent or broker, in an action on or incident to the obligation.

(b) The person served is a reinsurer who has at any time written a policy of reinsurance for an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced, or is an agent or broker of or for the reinsurer, in an action on or incident to the reinsurance contract.

(c) The person served is or has been an officer, manager, trustee, organizer, promoter, or person in a position of comparable authority or influence on an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced, in an action resulting from such a relationship with the insurer.

(4) If the court on motion of any party finds that any action should as a matter of substantial justice be tried in a forum outside this state, the court may enter an appropriate order to stay further proceedings on the action in this state.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8105 Receiver; application for relief.

Sec. 8105. (1) A receiver appointed in a proceeding under this chapter may at any time apply for, and the circuit court for Ingham county may grant, a restraining order, preliminary injunction, permanent injunction, and any other order as may be considered necessary and proper to prevent any of the following:

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(a) The transaction of further business by the insurer.

(b) The transfer of property.

(c) Interference with the receiver or with a proceeding under this chapter.

(d) Waste of the insurer's assets.

(e) Dissipation and transfer of bank accounts.

(f) The institution or further prosecution of any actions or proceedings.

(g) The obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets, or its policyholders.

(h) The levying of execution against the insurer, its assets, or its policyholders.

(i) The making of a sale or deed for nonpayment of taxes or assessments that would lessen the value of the insurer's assets.

(j) The withholding from the receiver of books, accounts, documents, or other records relating to the insurer's business.

(k) Other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors, or shareholders, or the administration of a proceeding under this chapter.

(2) The receiver may apply to a court outside of the state for the relief described in subsection (1).

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8106 Cooperation with commissioner; obstruction or interference prohibited; existing legal rights not abridged; penalties; petition for relief.

Sec. 8106. (1) An officer, manager, director, trustee, owner, employee, or agent of an insurer, or any other persons with authority over or in charge of any segment of the insurer's affairs, shall cooperate with the commissioner in a proceeding under this chapter or an investigation preliminary to the proceeding. The term "person" as used in this section shall include a person who exercises control directly or indirectly over activities of the insurer through a holding company or other affiliate of the insurer. As used in this section, "to cooperate" shall include, but shall not be limited to, the following:

(a) To reply promptly in writing to any inquiry from the commissioner requesting such a reply.

(b) To make available to the commissioner books, accounts, documents, or other records, information, or property of, or pertaining to, the insurer and in his or her possession, custody, or control.

(2) A person shall not obstruct or interfere with the commissioner in the conduct of a delinquency proceeding or an investigation preliminary or incidental to a delinquency proceeding.

(3) This section shall not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation or other delinquency proceedings or orders.

(4) A person included within subsection (1) who fails to cooperate with the commissioner, or a person who obstructs or interferes with the commissioner in the conduct of a delinquency proceeding or an investigation preliminary or incidental to a delinquency proceeding, or who violates an order the commissioner issued validly under this chapter may:

(a) Be sentenced to pay a fine not exceeding $10,000.00, or imprisonment for a term of not more than 1 year, or both.

(b) After a hearing, be subject to the imposition by the commissioner of a civil penalty not to exceed $10,000.00, or the revocation or suspension of any insurance licenses issued by the commissioner, or both.

(5) An insurer subject to a delinquency proceeding pursuant to this chapter shall have the right to petition the court for relief from the actions of the commissioner or other person involved with the delinquency proceeding, including but not limited to the following:

(a) To review the expenses of the receivership in the event that the insurer claims the expenses are excessive or unreasonable.

(b) To review the actions of the receiver, commissioner, or other person involved in the delinquency proceeding, in the event the insurer claims the receiver, commissioner, or other person is abusing his or her authority under this chapter or is causing financial or administrative harm to the insurer.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8107 Official bonds.

Sec. 8107. In a proceeding under this chapter, the commissioner and his or her deputies shall be responsible on their official bonds for the faithful performance of their duties. If the court considers it desirable for the protection of the assets, the court may at any time require an additional bond from the commissioner or his or her deputies, and the bond shall be paid for out of the assets of the insurer as a cost of

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administration.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8108a Prohibited conduct by insurer.

Sec. 8108a. Until all payments of or on account of the insurer's contractual obligations by all guaranty associations and all expenses and interest on the payments and expenses are repaid to the guaranty associations or a plan of repayment by the insurer is approved by the guaranty associations, an insurer that is subject to any delinquency proceedings, whether formal or informal, administrative or judicial, shall not:

(a) Be released from the proceeding, unless the proceeding is converted into a judicial rehabilitation or liquidation proceeding.

(b) Be permitted to solicit or accept new business or request or accept the restoration of a suspended or revoked license or certificate of authority.

(c) Be returned to the control of its shareholders or private management.

(d) Have its assets returned to the control of its shareholders or private management.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8109 Orders; determination; supervision of insurer; restrictions; compliance; hearings; notice; time; judicial review; review of supervisor's action; violation of supervision order; penalty; enforcement of supervision order; personal liability to insurer for reduction of net worth or loss; action; costs and expenses.

Sec. 8109. (1) If the commissioner has reasonable cause to believe and determines after a hearing held under subsection (5) that a domestic insurer has committed or engaged in, or is about to commit or engage in, an act, practice, or transaction that would subject it to delinquency proceedings under this chapter, the commissioner may make and serve upon the insurer and any other persons involved any order as is reasonably necessary to correct, eliminate, or remedy the conduct, condition, or ground.

(2) If upon examination or at any other time the commissioner has reasonable cause to believe that a domestic insurer is in such condition as to render the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance, or if the domestic insurer gives its consent, then the commissioner shall upon his or her determination:

(a) Notify the insurer of his or her determination.

(b) Furnish to the insurer a written list of the commissioner's requirements to abate his or her determination.

(3) If the commissioner makes a determination to supervise an insurer subject to an order under subsection (1) or (2), the commissioner shall notify the insurer that it is under the supervision of the commissioner. During the period of supervision, the commissioner may appoint a supervisor to supervise the insurer. The order appointing a supervisor shall direct the supervisor to enforce orders issued under subsections (1) and (2) and may also require the following:

(a) That the insurer shall not do any of the following things during the period of supervision, without the prior approval of the commissioner or his or her supervisor:

(*i*) Dispose of, convey, or encumber any of its assets or its business in force including disposing, conveying, or encumbering its assets or business to affiliated companies, either domestic, foreign, or alien.

(*ii*) Withdraw from any of its bank accounts.

(*iii*) Lend any of its funds.

(*iv*) Invest any of its funds.

(*v*) Transfer any of its property.

(*vi*) Incur any debt, obligation, or liability.

(*vii*) Merge or consolidate with another company.

(*viii*) Enter into any new reinsurance contract or treaty or cancel any existing reinsurance contract or treaty.

(*ix*) Engage in any other activity that the commissioner or his or her supervisor considers hazardous to the insurer.

(b) That upon the written instruction of the commissioner or his or her supervisor the insurer shall do the following during the period of supervision:

(*i*) Produce all books, accounts, and records of affiliated companies, as required to be maintained by section 1341(1)(d), including affiliated foreign or alien insurers, for review by the commissioner or his or her supervisor.

(*ii*) Dispose of, convey, or encumber any of its assets or its business in force.

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(*iii*) Deposit any funds or assets in any of its bank accounts or depositories.

(*iv*) Collect or enforce provisions of any of its loans, security agreements, mortgages, hypothecations, contracts, or like obligations.

(*v*) Invest any of its funds.

(*vi*) Transfer any of its property.

(*vii*) Incur any debt, obligation, or liability.

(*viii*) Enter into any new reinsurance contract or treaty.

(*ix*) Engage in any other activity that the commissioner, or his or her supervisor after review by the commissioner, considers reasonably necessary to insuring compliance by the insurer with the supervision order.

(4) An insurer subject to an order under this section shall comply with the lawful requirements of the commissioner and his or her supervisor and, if placed under supervision, shall have 60 days from the date the supervision order is served within which to comply with the commissioner's requirements. If the insurer fails to comply within that time, the commissioner may institute proceedings to have a rehabilitator or liquidator appointed under section 8112 or 8117, to extend the period of supervision pursuant to the commissioner's written order, or to suspend, revoke, or limit the insurer's certificate of authority to do business in accordance with section 437.

(5) The notice of hearing under subsection (1) and an order issued pursuant to subsection (1) shall be served upon the insurer pursuant to the applicable rules of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws. The notice of hearing shall state the time and place of hearing, and the conduct, condition, or ground upon which the commissioner would base his or her order. Unless mutually agreed between the commissioner and the insurer, the hearing shall occur not less than 10 days or more than 30 days after notice is served and shall be either in Ingham county or in some other place convenient to the parties to be designated by the commissioner. The commissioner shall hold all hearings under subsection (1) privately unless the insurer requests a public hearing, in which case the hearing shall be public.

(6) An insurer subject to an order under subsection (2) may request a hearing to review that order. Such a hearing shall be held as provided in subsection (5), but the request for a hearing shall not stay the effect of the order. If the commissioner issues an order under subsection (2), the insurer, at any time, may waive a commissioner's hearing and apply for immediate judicial relief by means of any remedy afforded by law without first exhausting administrative remedies. Subsequent to a hearing, a party to the proceedings whose interests are substantially affected shall be entitled to judicial review of an order issued by the commissioner.

(7) During the period of supervision, the insurer may request the commissioner to review an action taken or proposed to be taken by the supervisor, specifying wherein the action complained of is believed not to be in the best interest of the insurer.

(8) If a person has violated a supervision order issued under this section which as to him or her was then still in effect, he or she may be sentenced by the court to pay a fine not exceeding $10,000.00.

(9) The commissioner may apply for, and the circuit court may grant, a restraining order, preliminary injunction, permanent injunction, and any other order as may be considered necessary and proper to enforce a supervision order, including an order precluding a person or domestic insurer from transferring business to or writing new business with an affiliated domestic, foreign, or alien insurer so as to avoid the effects of a supervision as provided in subsections (3) and (4).

(10) If a person subject to the provisions of this chapter, including those persons described in section 8106(1), knowingly violates a valid order of the commissioner issued under the provisions of this section and, as a result of the violation, the net worth of the insurer is reduced or the insurer suffers loss it would not otherwise have suffered, that person is personally liable to the insurer for the amount of the reduction or loss. The commissioner or supervisor is authorized to bring an action on behalf of the insurer in the circuit court for Ingham county to recover the amount of the reduction or loss, together with cost.

(11) Reasonable costs and expenses incurred by the commissioner in conducting a supervision of an alien insurer or any investigation preliminary to that supervision under this chapter are an expense of administering a delinquency proceeding and are payable from the assets of the trust established pursuant to section 411(4).

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 1994, Act 227, Imd. Eff. June 27, 1994.

Compiler's note: Section 3 of Act 182 of 1992 reads as follows:

"Section 8109 of Act No. 218 of the Public Acts of 1956, being section 500.8109 of the Michigan Compiled Laws, as amended by this 1992 amendatory act is remedial and applies to all supervisions in effect 90 calendar days prior to the enactment of this amendatory act."

Popular name: Act 218

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500.8110 Seizure order.

Sec. 8110. (1) The commissioner may file in the circuit court for Ingham county a petition alleging, with respect to a domestic insurer:

(a) That there exists grounds justifying a court order for a formal delinquency proceeding against an insurer under this chapter.

(b) That the interests of policyholders, creditors, or the public will be endangered by delay.

(c) The contents of an order considered necessary by the commissioner.

(2) Upon a filing under subsection (1), the court may issue immediately and without a hearing the requested order directing the commissioner to take possession and control of all or a part of the property, books, accounts, documents, and other records of an insurer, and of the premises occupied by the insurer for the transaction of its business; and until further order of the court enjoin the insurer and its officers, managers, agents, and employees from disposition of its property and from the transaction of its business except with the commissioner's written consent.

(3) The court shall specify in the order the duration of the order, which shall be such time as the court considers necessary for the commissioner to ascertain the condition of the insurer. On motion of either party or in its own discretion, the court may hold hearings, from time to time, as it considers desirable after such notice as it considers appropriate, and may extend, shorten, or modify the terms of the seizure order. The court shall vacate the seizure order if the commissioner fails to commence a formal proceeding under this chapter after having had a reasonable opportunity to do so. An order of the court pursuant to a formal proceeding under this act shall vacate the seizure order.

(4) Entry of a seizure order under this section shall not constitute an anticipatory breach of any insurer contract.

(5) An insurer, subject to an ex parte order under this section, may petition the circuit court for Ingham county at any time after the order is issued, for a hearing and review of the order. The court shall hold a hearing and review not more than 15 days after the request. A hearing under this subsection may be held privately in chambers and shall be held privately in chambers if so requested by the insurer proceeded against.

(6) If, at any time after the issuance of an ex parte order, it appears to the court that a person whose interest is or will be substantially affected by the order did not appear at the hearing and has not been served, the court may order that notice be given. An order that notice be given shall not stay the effect of an order previously issued by the court.

(7) If a visiting or retired judge is assigned to the circuit court for Ingham county in any proceeding filed under this section or in any formal delinquency proceeding brought under this chapter because the estate of the insurer against which the proceeding has been brought is of such size or complexity that additional judicial resources are necessary to conduct the proceeding expeditiously so as to protect to the fullest extent possible the interests of the insurer, its policyholders and creditors, and the public, the expense of the assigned judge shall be an expense of administration of the proceeding and shall be reimbursable from the estate of the insurer against which the proceeding has been brought.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1994, Act 443, Imd. Eff. Jan. 10, 1995.

Popular name: Act 218

500.8111 Confidentiality; exception; “third parties” defined.

Sec. 8111. (1) Except as provided in subsection (2), in all proceedings and judicial review of these proceedings under sections 8109 and 8110, all records of the insurer, other documents, office of financial and insurance services files, and court records and papers, so far as they pertain to or are a part of the record of the proceedings, are confidential and shall be held by the clerk of the court in a confidential file except as is necessary to obtain compliance therewith, unless the court, after hearing arguments from the parties in chambers, orders otherwise or the insurer requests that the matter be made public.

(2) Without compromising the confidentiality of the records of the commissioner, office of financial and insurance services, or supervisor, the commissioner or his or her supervisor may advise third parties of the existence of a supervision order and of the supervisor's authority if considered by either of them necessary to further the insurer's compliance with the supervision order. The commissioner may advise third parties of the existence of a supervision order and of facts pertaining to the supervision order if considered necessary by the commissioner with regard to other regulatory matters affecting the insurer or a person or entity related to the insurer. Third parties advised under this subsection are required to keep the existence of a supervision confidential. As used in this subsection, "third parties" means the following persons:

(a) Debtors and creditors of the insurer and its affiliates.

(b) Persons who hold or control assets of the insurer and its affiliates.

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(c) Reinsurers of the insurer and its affiliates.

(d) Insurance regulatory officials.

(e) Law enforcement agencies.

(f) The workers' compensation agency.

(g) Representatives of a guaranty association or foreign guaranty association that may become obligated as a result of the insolvency of the insurer. Confidentiality obligations of a guaranty association or foreign guaranty association to the receiver end upon the entry of an order of liquidation with a finding of insolvency against the insurer.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1992, Act 182, Imd. Eff. Oct. 1, 1992;—Am. 2006, Act 358, Imd. Eff. Sept. 18, 2006.

Popular name: Act 218

500.8112 Rehabilitation of insurer; petition; grounds.

Sec. 8112. The commissioner may apply by petition to the circuit court for Ingham county for an order authorizing the commissioner to rehabilitate a domestic insurer or an alien insurer domiciled in this state on 1 or more of the following grounds:

(a) The insurer is in such condition that the further transaction of business would be hazardous financially to its policyholders, creditors, or the public.

(b) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that, if established, would endanger assets in an amount threatening the insurer's solvency.

(c) The insurer has failed to remove a person who in fact has executive authority with the insurer, whether an officer, manager, general agent, employee, or other person, if the person has been found after notice and hearing by the commissioner to be dishonest or untrustworthy in a way affecting the insurer's business.

(d) Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be untrustworthy.

(e) A person who in fact has executive authority with the insurer, whether an officer, manager, general agent, director or trustee, employee, or other person, has refused to be examined under oath by the commissioner concerning its affairs, whether in this state or elsewhere, and after reasonable notice of the fact, the insurer has failed promptly and effectively to terminate the employment and status of the person and all of his or her influence on management.

(f) After demand by the commissioner, the insurer has failed to promptly make available for examination its property, books, accounts, documents, or other records, or those of a subsidiary or related company within the control of the insurer, or those of a person having executive authority with the insurer and pertaining to the insurer.

(g) Without first obtaining the commissioner's written consent, the insurer has transferred, or attempted to transfer, in a manner contrary to law, substantially its entire property or business, or has entered into a transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person.

(h) The insurer or its property has been or is the subject of an application for the appointment or a receiver, trustee, custodian, conservator, or sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this state, and the appointment has been made or is imminent, and the appointment may deny the courts of this state of jurisdiction or might prejudice orderly delinquency proceedings under this chapter.

(i) Within the previous 4 years the insurer has willfully violated its charter or articles of incorporation, its bylaws, an insurance law of this state, or a valid order of the commissioner under section 8109.

(j) The insurer has failed to pay within 60 days after due date an obligation to a state or a subdivision of a state or a judgment entered in a state, if the court in which the judgment was entered had jurisdiction over the subject matter. However, nonpayment shall not be a ground until 60 days after a good faith effort by the insurer to contest the obligation has been terminated, whether it is before the commissioner or the court, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full.

(k) The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law and, after written demand by the commissioner, has failed to give immediately an adequate explanation.

(*l*) The board of directors or the holders of a majority of the shares entitled to vote request or consent to rehabilitation under this chapter.

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(m) Is found, after examination, to be in a condition so that it could not presently meet the requirements for incorporation and authorization.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8113 Order to rehabilitate insurer; provisions; filing as notice; title to assets vested in rehabilitator; accounting.

Sec. 8113. (1) An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in this state, shall appoint the commissioner and his or her successors in office as the rehabilitator, and shall direct the rehabilitator to take immediate possession of the assets of the insurer, and to administer them under the court's general supervision. The filing or recording of the order with the clerk of the circuit court or register of deeds for the county in which the principal business of the company is conducted, or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that register of deeds would have imparted. The order to rehabilitate the insurer shall by operation of law vest title to all assets of the insurer in the rehabilitator.

(2) An order issued under this section shall require accounting to the court by the rehabilitator. Accountings shall be at such intervals as the court specifies in the order.

(3) Entry of an order of rehabilitation shall not constitute an anticipatory breach of any insurer contracts.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8114 Commissioner as rehabilitator; appointment of special deputies; employment of counsel, clerks, and assistants; compensation; terms; expenses; powers of rehabilitator; criminal or tortious conduct; breach of contractual or fiduciary obligation; plan to effect changes; avoidance of fraudulent transfers.

Sec. 8114. (1) The commissioner as rehabilitator may appoint 1 or more special deputies, including but not limited to the Michigan life and health insurance guaranty association and the Michigan property and casualty guaranty association, who shall have all the powers and responsibilities of the rehabilitator granted under this section, and the commissioner may employ such counsel, clerks, and assistants as considered necessary. The compensation of the special deputy, counsel, clerks, and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the commissioner, with the approval of the court and shall be paid out of the funds or assets of the insurer. The persons appointed under this section shall serve at the pleasure of the commissioner. If the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner may advance the incurred costs out of an appropriation for the maintenance of the insurance bureau. Amounts advanced for expenses of administration shall be repaid to the commissioner for the use of the insurance bureau out of the first available money of the insurer.

(2) The rehabilitator may take such action as he or she considers necessary or appropriate to reform and revitalize the insurer including, but not limited to, the powers in section 8121(1)(f), (*l*), (m), (r), and (u). The rehabilitator has all the powers of the directors, officers, and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. The rehabilitator has full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

(3) If it appears to the rehabilitator that there has been criminal or tortious conduct or breach of a contractual or fiduciary obligation detrimental to the insurer by an officer, manager, agent, broker, employee, or other person, he or she may pursue all appropriate legal remedies.

(4) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, he or she shall prepare a plan to effect those changes. Upon application of the rehabilitator for approval of the plan, and after notice and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. A plan approved under this section shall be, in the court's judgment, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall implement the plan. For a life insurer, the plan proposed may include the imposition of liens upon the policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

(5) The rehabilitator shall have the power under sections 8126 and 8127 to avoid fraudulent transfers.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1996, Act 117, Imd. Eff. Mar. 6, 1996.

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Popular name: Act 218

500.8115 Stay of action or proceeding; purpose; duties of rehabilitator; statute of limitations; laches; standing of guaranty association.

Sec. 8115. (1) A court in this state before which an action or proceeding in which the insurer is a party, or is obligated to defend a party, is pending when a rehabilitation order against the insurer is entered shall stay the action or proceeding for 90 days and such additional time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take action respecting the pending litigation as he or she considers necessary in the interests of justice and for the protection of creditors, policyholders, and the public. The rehabilitator shall consider immediately all litigation pending outside this state and shall petition the courts having jurisdiction over that litigation for stays if necessary to protect the insurer's estate.

(2) A statute of limitations or defense of laches shall not run with respect to an action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. An action by or against the insurer that might have been commenced when the petition was filed may be commenced for at least 60 days after the order of rehabilitation is entered or the petition is denied.

(3) A guaranty association or foreign guaranty association covering life or health insurance or annuities shall have standing to appear in a court proceeding concerning the rehabilitation of a life or health insurer if the association is or may become liable to act as a result of the rehabilitation.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8115a Netting agreement or qualified financial contract; rights; transfer; duties of receiver; exception; rights of counterparties; definitions.

Sec. 8115a. (1) Notwithstanding any other provision of this act, including section 8141, any provision of this act permitting the modification of contracts, or other law of this state, a person shall not be stayed or prohibited under this chapter from exercising any of the following:

(a) A contractual right to terminate, liquidate, or close out any netting agreement or qualified financial contract with an insurer because of the commencement of a formal delinquency proceeding under this chapter or the insolvency, financial condition, or default of the insurer at any time, provided that the right is enforceable under applicable law other than this act.

(b) Any right under any of the following:

(*i*) A pledge, security, collateral, reimbursement, or guarantee agreement or any similar security agreement with a bank established under the authority of the federal home loan bank act, 12 USC 1421 to 1449.

(*ii*) A pledge, security, collateral, reimbursement, or guarantee agreement or any similar security agreement or credit enhancement relating to at least 1 netting agreement or qualified financial contract.

(c) Subject to section 8130(2), any right to set off or net out any termination value, payment amount, or other transfer obligation arising under or in connection with a netting agreement or qualified financial contract where the counterparty or its guarantor is organized under the laws of the United States or a state or foreign jurisdiction approved by the securities valuation office of the national association of insurance commissioners and approved by the commissioner as eligible for netting.

(2) Upon termination of a netting agreement, the net or settlement amount, if any, owed by a nondefaulting party to an insurer against which an application or petition has been filed under this chapter shall be transferred to or on the order of the receiver for the insurer, even if the insurer is the defaulting party, notwithstanding any provision in the netting agreement that may provide that the nondefaulting party is not required to pay any net or settlement amount due to the defaulting party upon termination. Any limited 2-way payment provision in a netting agreement with an insurer that has defaulted shall be considered to be a full 2-way payment provision as against the defaulting insurer. Any such property or amount shall, except to the extent it is subject to 1 or more secondary liens or encumbrances, be a general asset of the insurer.

(3) In making any transfer of a netting agreement or qualified financial contract of an insurer subject to a proceeding under this chapter, the receiver shall do either of the following:

(a) Transfer to 1 party, other than an insurer subject to a proceeding under this chapter, all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer that is the subject of the proceeding, including all rights and obligations of each party under each such netting agreement and qualified financial contract and all property, including any guarantees or credit support documents, securing any claims of each party under each such netting agreement and qualified financial contract.

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(b) Transfer none of the netting agreements, qualified financial contracts, rights, obligations, or property referred to in subdivision (a) with respect to the counterparty and any affiliate of the counterparty.

(4) If a receiver for an insurer makes a transfer of 1 or more netting agreements or qualified financial contracts, the receiver shall use its best efforts to notify any person who is party to the netting agreements or qualified financial contracts of the transfer by 12 noon of the receiver's local time on the business day following the transfer. For purposes of this subsection, "business day" means a day other than a Saturday, Sunday, or any day on which either the New York stock exchange or the federal reserve bank of New York is closed.

(5) Except as provided in subsection (6), notwithstanding any other provision of this act, a receiver may not avoid a transfer of money or other property arising in connection with any of the following that is made before the commencement of a formal delinquency proceeding under this chapter:

(a) A netting agreement or qualified financial contract.

(b) A pledge, security, collateral, reimbursement, or guarantee agreement or similar security agreement with a bank established under the authority of the federal home loan bank act, 12 USC 1421 to 1449.

(c) A pledge, security, collateral, reimbursement, or guarantee agreement or any similar security agreement or credit enhancement relating to a netting agreement or qualified financial contract.

(6) Notwithstanding subsection (5), a transfer may be avoided under section 8126 if the transfer was made with actual intent to hinder, delay, or defraud the insurer, a receiver appointed for the insurer, or existing or future creditors.

(7) In exercising any of its powers under this chapter to disaffirm or repudiate a netting agreement or qualified financial contract, the receiver shall take action with respect to each netting agreement or qualified financial contract and all transactions entered into in connection with the netting agreement or qualified financial contract in its entirety. Notwithstanding any other provision of this chapter, any claim of a counterparty against the estate arising from the receiver's disaffirmance or repudiation of a netting agreement or qualified financial contract that has not been previously affirmed in the liquidation or immediately preceding rehabilitation case shall be determined and shall be allowed or disallowed as if the claim had arisen before the date of the filing of the petition for liquidation or, if a rehabilitation proceeding is converted to a liquidation proceeding, as if the claim had arisen before the date of the filing of the petition for rehabilitation. The amount of the claim shall be the actual direct compensatory damages determined as of the date of the disaffirmance or repudiation of the netting agreement or qualified financial contract.

(8) This section does not apply to persons who are affiliates of the insurer that is the subject of the proceeding.

(9) All rights of counterparties under this act apply to netting agreements and qualified financial contracts entered into on behalf of the general account or separate accounts if the assets of each separate account are available only to counterparties to netting agreements and qualified financial contracts entered into on behalf of that separate account.

(10) As used in this section:

(a) "Actual direct compensatory damages" includes normal and reasonable costs of cover or other reasonable measures of damages utilized in the derivatives market for the contract and agreement claims, but does not include punitive and exemplary damages, damages for lost profit or lost opportunity, or damages for pain and suffering.

(b) "Commodity contract" means any of the following:

(*i*) A contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of, a board of trade designated as a contract market by the commodity futures trading commission under the commodity exchange act, 7 USC 1 to 27f, or board of trade outside the United States.

(*ii*) An agreement that is subject to regulation under section 23 of the commodity exchange act, 7 USC 23, and that is commonly known to the commodities trade as a margin account, margin contract, leverage account, or leverage contract.

(*iii*) An agreement or transaction that is subject to regulation under section 6c of the commodity exchange act, 7 USC 6c, and that is commonly known to the commodities trade as a commodity option.

(c) "Contractual right" includes any right, whether or not evidenced in writing, arising under statutory or common law, a rule or bylaw of a national securities exchange, national securities clearing organization, or securities clearing agency, a rule or bylaw, or a resolution of the governing body, of a contract market or its clearing organization, or under law merchant.

(d) "Forward contract" means a contract for the purchase, sale, or transfer of a commodity, as defined in section 1a of the commodity exchange act, 7 USC 1a, or any similar good, article, service, right, or interest that is presently or in the future becomes the subject of dealing in the forward contract trade, or product or by-product thereof, with a maturity date more than 2 days after the date the contract is entered into, including,

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but not limited to, a repurchase transaction, reverse repurchase transaction, consignment, lease, swap, hedge transaction, deposit, loan, option, allocated transaction, unallocated transaction, or a combination of these or option on any of them. Forward contract does not include a commodity contract.

(e) "Netting agreement" means a contract or agreement, including terms and conditions incorporated by reference in the contract or agreement, that documents 1 or more transactions between the parties to the agreement for or involving 1 or more qualified financial contracts and that provides for the netting or liquidation of qualified financial contracts or present or future payment obligations or payment entitlements thereunder, including liquidation or close-out values relating to those obligations or entitlements, among the parties to the netting agreement. Netting agreement includes a master agreement that otherwise meets this definition. A master agreement includes all schedules, confirmations, definitions, and addenda to it and transactions under it, which shall be treated as 1 netting agreement.

(f) "Qualified financial contract" means a commodity contract, forward contract, repurchase agreement, securities contract, swap agreement, and any similar agreement that the commissioner determines by regulation, resolution, or order to be a qualified financial contract for the purposes of this chapter.

(g) "Repurchase agreement", including a reverse repurchase agreement, means an agreement, including related terms, that provides for the transfer of certificates of deposit, eligible bankers' acceptances, or securities that are direct obligations of, or that are fully guaranteed as to principal and interest by, the United States or an agency of the United States against the transfer of funds by the transferee of the certificates of deposit, eligible bankers' acceptances, or securities with a simultaneous agreement by the transferee to transfer to the transferor certificates of deposit, eligible bankers' acceptances, or securities as described above, at a date certain not later than 1 year after the transfers or on demand, against the transfer of funds. For the purposes of this definition, the items that may be subject to an agreement include mortgage-related securities, a mortgage loan, and an interest in a mortgage loan, and shall not include any participation in a commercial mortgage loan, unless the commissioner determines by regulation, resolution, or order to include the participation within the meaning of the term.

(h) "Securities contract" means a contract for the purchase, sale, or loan of a security, including an option for the repurchase or sale of a security, certificate of deposit, or group or index of securities, including an interest therein or based on the value thereof, or an option entered into on a national securities exchange relating to foreign currencies, or the guarantee of a settlement of cash or securities by or to a securities clearing agency. As used in this definition, "security" includes a mortgage loan, mortgage-related securities, and an interest in any mortgage loan or mortgage-related security.

(i) "Swap agreement" means an agreement, including the terms and conditions incorporated by reference in an agreement, that is a rate swap agreement, basis swap, commodity swap, forward rate agreement, interest rate future, interest rate option, forward foreign exchange agreement, spot foreign exchange agreement, rate cap agreement, rate floor agreement, rate collar agreement, currency swap agreement, cross-currency rate swap agreement, currency future, or currency option or any other similar agreement, and includes any combination of agreements and an option to enter into an agreement.

History: Add. 2004, Act 217, Imd. Eff. July 14, 2004;—Am. 2012, Act 166, Imd. Eff. June 14, 2012.

Popular name: Act 218

500.8116 Order of liquidation; petition; duties of circuit court; order terminating rehabilitation; restoration to possession of property and control of business.

Sec. 8116. (1) If the commissioner believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders, or the public, or would be futile, the commissioner may petition the circuit court for Ingham county for an order of liquidation. A petition under this subsection shall have the same effect as a petition under section 8117. The circuit court shall permit the directors of the insurer to take such actions as are reasonably necessary to defend against the petition and may order payment from the insurer's estate for costs and other defense expenses as justice may require.

(2) The rehabilitator may petition at any time the circuit court for Ingham county for an order terminating rehabilitation of an insurer. The court shall also permit the insurer's directors to petition the court for an order terminating rehabilitation of the insurer and may order payment from the insurer's estate for costs and other expenses of the petition as justice may require. If the court finds that rehabilitation has been accomplished and that grounds for rehabilitation under section 8112 no longer exist, it shall order that the insurer be restored to possession of its property and the control of the business. The court may also make that finding and issue that order at any time upon its own motion.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

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500.8117 Liquidation of domestic or alien insurer; basis.

Sec. 8117. The commissioner may petition the circuit court for Ingham county for an order directing him or her to liquidate a domestic insurer or an alien insurer domiciled in this state on the following basis:

(a) Any ground for an order of rehabilitation as specified in section 8112, whether or not there has been a prior order directing the rehabilitation of the insurer.

(b) That the insurer is insolvent.

(c) That the insurer is in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors, or the public.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8118 Order of liquidation; provisions; filing as notice; rights and liabilities; judicial declaration of insolvency; accounting.

Sec. 8118. (1) An order to liquidate the business of a domestic insurer shall appoint the commissioner and his or her successors in office as liquidator and shall direct the liquidator to take possession immediately of the insurer's assets and to administer them under the court's general supervision. The liquidator shall be vested by operation of law with the title to all of the property, contracts, and rights of action, and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation. The filing or recording of the order with the clerk of the circuit court and the register of deeds of the county in which its principal office or place of business is located or, in the case of real estate, with the register of deeds of the county where the property is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded which the register of deeds would have imparted.

(2) Upon issuance of the order, the rights and liabilities of the insurer and of its creditors, policyholders, shareholders, members, and all other persons interested in its estate shall become fixed as of the date of entry of the order of liquidation, except as provided in sections 8119 and 8137.

(3) An order to liquidate the business of an alien insurer domiciled in this state shall be in the same terms and have the same legal effect as an order to liquidate a domestic insurer, except that the court is vested by operation of law with titles to the trusteed assets of the alien insurer and that the assets and business of the insurer in the United States shall be the only assets and business included in the order. The liquidator shall administer the trusteed assets in accordance with this chapter, subject at all times to the court's direction and supervision.

(4) At the time of petitioning for an order of liquidation, or at any time thereafter, the commissioner, after making appropriate findings of an insurer's insolvency, may petition the court for a judicial declaration of insolvency. After providing notice and hearing as it considers proper, the court may make the declaration.

(5) An order issued under this section shall require accounting to the court by the liquidator. Accountings shall be at intervals as the court specifies in its order.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1994, Act 227, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.8118a Order transferring title to and possession of trusteed assets; actions of court; considerations.

Sec. 8118a. (1) For an alien insurer domiciled in this state, at any time after the court grants an order pursuant to section 8118, any person having an interest in the trusteed assets of the insurer or in their due administration or in the due administration of the insurer's estate and seeking to have all or part of the trusteed assets transferred to that person shall do so by petitioning the court for an order directing that title to and possession of all or part of the trusteed assets be transferred to that person.

(2) After providing notice and hearing as it considers proper, the court may grant, deny, or suspend a petition made pursuant to subsection (1) on terms and conditions, or make such other order, as the court considers appropriate, considering the following:

(a) The interests of policyholders, other claimants and creditors of the insurer, and the public.

(b) Whether the order requested, and any governing legislation upon which it is based, is conducive to or contrary to the objectives of this chapter.

(c) Whether the order requested is consistent with the terms, conditions, and objectives of the trust agreement or agreements referred to in section 411(4).

(d) The effect the order requested would have or could reasonably be expected to have on the ability of the liquidator to use assets of the insurer's estate under the liquidation order to transfer policy obligations to a solvent assuming insurer.

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(e) Any agreements with a receiver or commissioner or like official of another state in which the insurer was doing business, or of the country under the laws of which the insurer was formed, relating to the rehabilitation, liquidation, conservation, or dissolution of the insurer.

(f) The adequacy of information available to the court upon which to make a determination.

(g) The costs that could reasonably be expected to be incurred as a result of the order.

History: Add. 1994, Act 227, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.8119 Order of liquidation; continuation of policies in force; termination of coverages.

Sec. 8119. (1) All policies, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force only for the lesser of:

(a) A period of 30 days from the date of entry of the liquidation order.

(b) The expiration of the policy coverage.

(c) The date the insured replaces the insurance coverage with equivalent insurance in another insurer or otherwise terminates the policy.

(d) The date the liquidator effects a transfer of the policy obligation pursuant to section 8121(1)(h).

(2) An order of liquidation under section 8118 shall terminate coverages at the time specified in subsection (1) for purposes of any other statute.

(3) Policies of life or health insurance or annuities shall continue in force for such period and under such terms as is provided for by an applicable guaranty association or foreign guaranty association.

(4) Policies of life or health insurance or annuities or any period or coverage of such policies not covered by a guaranty association or foreign guaranty association shall terminate under subsections (1) and (2).

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8120 Dissolution of corporation.

Sec. 8120. The commissioner may petition for an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in this state at the time he or she applies for a liquidation order. The court shall order dissolution of the corporation upon petition by the commissioner upon or after the granting of a liquidation order. If the dissolution has not previously been ordered, it shall be effected by operation of law upon the discharge of the liquidator if the insurer is insolvent and may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8121 Powers of liquidator; extended reporting period; powers and authority not exclusive; delaying sale of assets.

Sec. 8121. (1) The liquidator shall have the power to do the following:

(a) To appoint a special deputy, including, but not limited to, the Michigan life and health insurance guaranty association with its consent or the Michigan property and casualty guaranty association with its consent to act for him or her under this chapter and to determine the special deputy's reasonable compensation. The special deputy shall have all powers of the liquidator granted by this chapter and shall serve at the pleasure of the liquidator.

(b) To employ employees and agents, legal counsel, actuaries, accountants, appraisers, consultants, and such other personnel as he or she considers necessary to assist in the liquidation.

(c) To fix the reasonable compensation of employees and agents, legal counsel, actuaries, accountants, court's appraisers, and consultants with the court's approval.

(d) To pay reasonable compensation to persons appointed and to defray from the funds or assets of the insurer all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with, the insurer's business and property. If the insurer's property does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner may advance the incurred costs out of an appropriation for the maintenance of the insurance bureau. Amounts advanced for expenses of administration shall be repaid to the commissioner for the use of the insurance bureau out of the first available money of the insurer.

(e) To hold hearings, to subpoena witnesses to compel their attendance, to administer oaths, to examine a person under oath, and to compel a person to subscribe to his or her testimony after it has been correctly reduced to writing; and in connection with these powers to require the production of books, papers, records,

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or other documents that he or she considers relevant to the inquiry.

(f) To collect all debts and money due and claims belonging to the insurer, wherever located, and for the following purposes:

(*i*) To institute timely action in other jurisdictions to forestall garnishment and attachment proceedings against debts.

(*ii*) To do other acts as are necessary or expedient to collect, conserve, or protect the assets or property, including the power to sell, compound, compromise, or assign debts for purposes of collection upon terms and conditions as he or she considers best.

(*iii*) To pursue a creditor's remedies available to enforce the creditor's claims.

(g) To conduct public and private sales of the insurer's property.

(h) To use assets of the insurer's estate under a liquidation order to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under section 8142.

(i) To acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of, or deal with, insurer property at its market value or upon terms and conditions as are fair and reasonable. He or she shall also have power to execute, acknowledge, and deliver any and all deeds, assignments, releases, and other instruments necessary or proper to effectuate the sale of property or other transaction in connection with the liquidation except that for trusteed assets, any instruments necessary or proper shall be executed only pursuant to court order.

(j) To borrow money on the security of the insurer's assets or to borrow money without security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation.

(k) To enter into contracts necessary to carry out the order to liquidate, and to affirm or disavow any contracts to which the insurer is a party.

(*l*) To continue to prosecute and to institute in the name of the insurer or in his or her own name suits and other legal proceedings, in this state or elsewhere, and to abandon the prosecution of claims he or she considers unprofitable to pursue further. If the insurer is dissolved under section 8120, he or she shall have the power to apply to any court in this state or elsewhere for leave to substitute himself or herself for the insurer as plaintiff.

(m) To prosecute an action that may exist on behalf of the creditors, members, policyholders, or shareholders of the insurer against an officer of the insurer or another person.

(n) To remove records and property of the insurer to the commissioner's offices or to such other place as may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations and foreign guaranty associations shall have such reasonable access to the records of the insurer as is necessary for them to carry out their statutory obligations.

(o) To deposit in 1 or more banks in this state such sums as are required for meeting current administration expenses and dividend distributions.

(p) To invest all sums not currently needed, unless the court orders otherwise.

(q) To file any necessary documents for recording in the office of any register of deeds in this state or elsewhere where property of the insurer is located.

(r) To assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds, and the defense of usury. A waiver of a defense by the insurer after a petition in liquidation has been filed does not bind the liquidator. If a guaranty association or foreign guaranty association has an obligation to defend a suit, the liquidator shall give precedence to that obligation and may defend only in the absence of a defense by the guaranty associations.

(s) To exercise and enforce all the rights, remedies, and powers of a creditor, shareholder, policyholder, or member, including the power to avoid a transfer or lien that may be given by the general law and that is not included in sections 8126 to 8128.

(t) To intervene in a proceeding wherever instituted that might lead to the appointment of a receiver or trustee and to act as the receiver or trustee whenever the appointment is offered.

(u) To enter into agreements with a receiver or commissioner of another state or country relating to the rehabilitation, liquidation, conservation, or dissolution of an insurer doing business in both states or countries.

(v) To exercise all powers now held or hereafter conferred upon receivers by the laws of this state not inconsistent with the provisions of this chapter.

(2) If a company placed in liquidation issued liability policies on a claims made basis, which provided an option to purchase an extended period to report claims, then the liquidator may make available to holders of those policies, for a charge, an extended period to report claims as stated in this chapter. The extended reporting period shall be made available only to those insureds who have not secured substitute coverage. The extended period made available by the liquidator shall begin upon termination of an extended period to report claims in the basic policy and shall end at the earlier of the final date for filing of claims in the liquidation

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proceeding or 18 months from the order of liquidation.

(3) The extended period to report claims made available by the liquidator is subject to the terms of the policy to which it relates. The liquidator shall make available the extended period within 60 days after the order of liquidation at a charge to be determined by the liquidator subject to the court's approval. The offer shall be considered rejected unless the offer is accepted in writing and the charge is paid within 90 days after the order of liquidation. Commissions, premium taxes, assessments, or other fees shall not be due on the charge pertaining to the extended period to report claims.

(4) The enumeration in this section of the powers and authority of the liquidator shall not be construed as a limitation upon him or her, and it shall not exclude in any manner his or her right to do other acts not specifically enumerated in this section or otherwise provided for if necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation.

(5) The liquidator may delay the sale of the assets of the company if the liquidator determines a delay in the sale would be prudent in order to obtain a more favorable rate of return on the sale of the assets.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1994, Act 227, Imd. Eff. June 27, 1994;—Am. 1996, Act 117, Imd. Eff. Mar. 6, 1996.

Popular name: Act 218

500.8122 Notice of liquidation; filing claims; changes of address.

Sec. 8122. (1) Unless the court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible as follows:

(a) By first-class mail and either by telegram or telephone to the insurance commissioner of each jurisdiction in which the insurer is doing business.

(b) By first-class mail to each guaranty association or foreign guaranty association which is or may become obligated as a result of the liquidation.

(c) By first class mail to all insurance agents of the insurer.

(d) By first class mail to all persons known or reasonably expected to have claims against the insurer including all policyholders, at their last known address as indicated by the records of the insurer.

(e) By publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in other locations as the liquidator considers appropriate.

(2) Notice to potential claimants under subsection (1) shall require claimants to file with the liquidator their claims together with proper proofs as required under section 8136 on or before a date the liquidator shall specify in the notice. Although an earlier date may be set by the liquidator, the last day to file claims shall be not later than 18 months following the order of liquidation. The liquidator need not require persons claiming cash surrender values or other investment values in life insurance and annuities to file a claim. All claimants shall have a duty to keep the liquidator informed of any changes of address.

(3) If notice is given in accordance with this section, the distribution of assets of the insurer under this chapter shall be conclusive with respect to all claimants, whether or not they received notice.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8123 Notice by agent to policyholder; report of compliance; penalty; waiver.

Sec. 8123. (1) Every agent who receives notice in the form prescribed in section 8122 that an insurer which he or she represents as an agent is the subject of a liquidation order shall within 15 days of the notice give notice of the liquidation order to each policyholder or other person named in a policy issued through the agent by the insured. The notice shall be sent by first class mail to the last address contained in the agent's records for each policyholder or other person named in the policy issued through the agent by the insurer, if the agent has a record of the address of the policyholder or other person. A policy shall be considered issued through an agent, if the agent has a property interest in the expiration of the policy or if the agent has had in his or her possession a copy of the declarations of the policy at any time during the life of the policy, unless the property interest or the files of the insured have been transferred to another. The written notice shall include the name and address of the insurer, the name and address of the agent, identification of the policy impaired, and the nature of the impairment including termination of coverage, as described in section 8119. Notice by a general agent satisfies the notice requirement for an agent under contract to the general agent. Each agent obligated to give notice under this section shall file a report of compliance with the liquidator.

(2) An agent failing to give notice or file a report of compliance as required in subsection (1) may be subject to payment of a penalty of not more than $1,000.00 and may have his or her license suspended after a hearing held by the commissioner.

(3) The liquidator may waive the duties imposed by this section if he or she determines that other notice to

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the policyholders of the insurer under liquidation is adequate.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8124 Order appointing liquidator as bar to action at law or equity; full faith and credit to injunctions; intervention; expense; institution of action or proceeding on behalf of estate of insurer; period of limitation; statute of limitation or defense of laches.

Sec. 8124. (1) Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in this state, an action at law or equity shall not be brought against the insurer or liquidator, whether in this state or elsewhere, and any such existing action shall not be maintained or further presented after issuance of such order. The courts of this state shall give full faith and credit to injunctions against the liquidator or the company or the continuation of existing actions against the liquidator or the company, if such injunctions are included in an order to liquidate an insurer issued pursuant to corresponding provisions in other states. If, in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside this state, he or she may intervene in the action. The liquidator may defend an action in which he or she intervenes under this section at the expense of the estate of the insurer.

(2) The liquidator may, upon or after an order for liquidation, within 2 years or such time in addition to 2 years as applicable law may permit, institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which the order is entered. If, by agreement, a period of limitation is fixed for instituting a suit or proceeding upon a claim, or for filing a claim, proof of claim, proof of loss, demand, notice, or the like, or if in a proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for taking action, filing a claim or pleading, or doing any act, and the period had not expired at the date of the filing of the petition, the liquidator may, for the benefit of the estate, take action or do an act required of or permitted to the insurer within a period of 180 days subsequent to the entry of an order for liquidation, or within such further period as is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

(3) A statute of limitation or defense of laches shall not run with respect to an action against an insurer between the filing of a petition for liquidation against an insurer and the denial of the petition. An action against the insurer that might have been commenced when the petition was filed may be commenced at least within 60 days after the petition is denied.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 2006, Act 357, Imd. Eff. Sept. 18, 2006.

Popular name: Act 218

500.8124a Guaranty association or foreign guaranty association; court standing; right to intervene; jurisdiction.

Sec. 8124a. Any guaranty association or foreign guaranty association has standing to appear and may intervene as a party as a matter of right or otherwise appear and participate in any court proceeding concerning the rehabilitation or liquidation of an insurer if the association is or may become liable to act as a result of the liquidation. Exercise by any guaranty association or its designated representative of the right to intervene conferred under this subsection does not constitute grounds to establish general personal jurisdiction by the courts of this state. The intervening guaranty association or foreign guaranty association is subject to the court's jurisdiction only for the limited purpose for which it intervenes.

History: Add. 2006, Act 356, Imd. Eff. Sept. 18, 2006.

Compiler's note: Act 218

500.8125 List of insurer's assets; amendments and supplements; filing; reduction of assets to liquidity; submission of assets for disbursement.

Sec. 8125. (1) As soon as practicable after the liquidation order but not later than 120 days after the liquidation order, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended or supplemented from time to time as the liquidator may determine. One copy shall be filed in the office of the clerk of the circuit court and 1 copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

(2) The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation.

(3) A submission to the court for disbursement of assets in accordance with section 8134 fulfills the requirements of subsection (1).

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History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8126 Transfers and obligations as fraudulent; avoidance by receiver; retention of property, lien, or obligation as security for repayment; preservation of transfer or obligation; perfection of transfer; transfer creating equitable lien; fraudulent transaction of insurer with reinsurer.

Sec. 8126. (1) Every transfer made or suffered and every obligation incurred by an insurer within 1 year prior to the filing of a successful petition for rehabilitation or liquidation under this chapter is fraudulent as to then existing and future creditors, if made or incurred without fair consideration or with actual intent to hinder, delay, or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this chapter, which is fraudulent under this section, may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee, for a present fair equivalent value, and except that a purchaser, lienor, or obligee, who in good faith has given a consideration less than fair equivalent value for the transfer, lien, or obligation may retain the property, lien, or obligation as security for repayment. The court, on due notice, may order the transfer or obligation to be preserved for the benefit of the estate, and if so ordered, the receiver shall succeed to and may enforce the rights of the purchaser, lienor, or obligee.

(2) A transfer of property other than real property shall be considered to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceeding on a simple contract could become superior to the rights of the transferee under section 8128(5) and (6). A transfer of real property shall be considered to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee. A transfer which creates an equitable lien shall not be considered to be perfected if there are available means by which a legal lien could be created. A transfer not perfected prior to the filing of a petition for liquidation shall be considered to be made immediately before the filing of the successful petition. The provisions of this subsection apply whether or not there are or were creditors who might have obtained a lien or persons who might have become bona fide purchasers.

(3) A transaction of the insurer with a reinsurer shall be considered fraudulent and may be avoided by the receiver under subsection (1) if both of the following occur:

(a) The transaction consists of the termination, adjustment, or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transactions, unless the reinsurer gives a present fair equivalent value for the release.

(b) Any part of the transaction took place within 1 year prior to the date of filing of the petition through which the receivership was commenced.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8127 Transfer of insurer's real property; validity; constructive notice of commencement of proceeding in rehabilitation or liquidation; judicial sale of real property of insurer; validity of transfer against receiver; payment of indebtedness or delivery of property to insurer; knowledge of pending rehabilitation or liquidation; burden of proof; currency or negotiable instruments not impaired.

Sec. 8127. (1) After a petition for rehabilitation or liquidation has been filed, a transfer of the insurer's real property made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or if not made for a present fair equivalent value, then to the extent of the present consideration actually paid for the property for which amount the transferee shall have a lien on the transferred property. Constructive notice of the commencement of a proceeding in rehabilitation or liquidation shall be given upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the register of deeds in the county where any real property in question is located. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

(2) After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the insurer's property or an order of rehabilitation or liquidation is granted:

(a) A transfer of the insurer's property, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or if not made for a present fair

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equivalent value, then to the extent of the present consideration actually paid for the property for which amount the transferee shall have a lien on the transferred property.

(b) A person indebted to the insurer or holding property of the insurer, if acting in good faith, may pay all or part of the indebtedness or deliver all or part of the property to the insurer or upon his or her order, with the same effect as if the petition were not pending.

(c) A person having actual knowledge of the pending rehabilitation or liquidation shall be considered not to act in good faith.

(d) A person asserting the validity of a transfer under this section shall have the burden of proof. Except as elsewhere provided in this section, no transfer by or on behalf of the insurer after the date of the petition for liquidation by a person other than the liquidator shall be valid against the liquidator.

(3) Nothing in this chapter shall impair the negotiability of currency or negotiable instruments.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8128 Preference generally; transfers considered made or suffered; lien obtainable by legal or equitable proceedings; dissolution of voidable lien; discharge of property from lien; summary jurisdiction; hearing; notice; order; liability of surety; set off against preference; examination of transactions; payment of attorney; personal liability; recovery of certain commissions in delinquency proceedings.

Sec. 8128. (1) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within 1 year before the filing of a successful petition for liquidation under this chapter, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then a transfer shall be considered a preference if made or suffered within 1 year before the filing of the successful petition for rehabilitation, or within 2 years before the filing of the successful petition for liquidation, whichever time is shorter.

(2) A preference may be avoided by the liquidator if any of the following occurs:

(a) The insurer was insolvent at the time of the transfer.

(b) The transfer was made within 4 months before the filing of the petition.

(c) The creditor receiving the transfer or benefited by the transfer or his or her agent acting with reference to the transfer had, at the time the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent.

(d) The creditor receiving the transfer was any of the following:

(*i*) An officer of the insurer.

(*ii*) An employee, attorney, or other person who was in fact in a position of comparable influence with the insurer as an officer whether or not he or she held an officer position.

(*iii*) A shareholder holding directly or indirectly more than 5% of any class of any equity security issued by the insurer.

(*iv*) Another person, firm, corporation, or association with whom the insurer did not deal at arm's length.

(3) If the preference is voidable, the liquidator may recover the property or, if the property has not been converted, the property's value from a person who has received or converted the property. However, if a bona fide purchaser or lienor has given less than fair equivalent value, he or she shall have a lien upon the property to the extent of the consideration actually given by him or her. If a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate and if so ordered, the lien or title shall pass to the liquidator.

(4) A transfer of property other than real property shall be considered to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee. A transfer of real property shall be considered to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee. A transfer that creates an equitable lien shall not be considered to be perfected if there are available means by which a legal lien could be created. A transfer not perfected prior to the filing of a petition for liquidation shall be considered to be made immediately before the filing of the successful petition. The provisions of this subsection apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

(5) A lien obtainable by legal or equitable proceedings upon a simple contract is a lien arising in the

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ordinary course of such proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens that under applicable law are given a special priority over other liens that are prior in time.

(6) A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee within the meaning of subsection (4), if that superiority would follow only from the lien or purchase itself or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. Such a lien could not, however, become superior and such a purchase could not create superior rights for the purpose of subsection (4) through any acts subsequent to the obtaining of the lien or subsequent to the purchase which require the agreement or concurrence of a third party or which require further judicial action or ruling.

(7) A transfer of property for or on account of a new and contemporaneous consideration which is considered under subsection (4) to be made or suffered after the transfer because of delay in perfecting it does not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within 21 days, or a period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if the loan is actually made, or a transfer that becomes security for a future loan, shall have the same effect as a transfer for or on account of a new and contemporaneous consideration.

(8) If a lien considered voidable under subsection (2) has been dissolved by the furnishing of a bond or other obligation and the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon the insurer's property before the filing of a petition under this chapter which results in a liquidation order, then that indemnifying transfer or lien shall also be considered voidable.

(9) The property affected by a lien considered voidable under subsections (1) and (8) shall be discharged from the lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator, except that the court, upon due notice, may order the lien to be preserved for the estate's benefit and the court may direct that a conveyance be executed as may be proper or adequate to evidence the liquidator's title.

(10) The circuit court shall have summary jurisdiction of a proceeding by the liquidator to hear and determine the rights of parties under this section. Reasonable notice of each hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. If an order is entered for the recovery of indemnifying property or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall ascertain in the same proceeding the value of the property or lien, and if the value is less than the amount for which the property is indemnity or than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the court, to the liquidator, within such reasonable times as the court shall fix.

(11) The liability of the surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the liquidator, or if the property is retained under subsection (10), to the extent of the amount paid to the liquidator.

(12) If a creditor has been preferred, and afterward in good faith gives the insurer further credit without security of any kind for property that becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition may be set off against the preference that would otherwise be recoverable from him or her.

(13) If an insurer, directly or indirectly, within 4 months before the filing of a successful petition for liquidation under this chapter or at any time in contemplation of a proceeding to liquidate, pays money or transfers property to an attorney for services rendered or to be rendered, the transactions may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court and the excess may be recovered by the liquidator for the estate's benefit. If the attorney is in a position of influence with the insurer or an affiliate of the insurer, payment of any money or the transfer of any property to the attorney for services rendered or to be rendered shall be governed by the provision of subsection (2)(d).

(14) An officer, manager, employee, shareholder, member, subscriber, attorney, or other person acting on behalf of the insurer who knowingly participates in giving a preference if he or she has reasonable cause to believe the insurer is or is about to become insolvent at the time of the preference shall be personally liable to the liquidator for the amount of the preference. If a transfer was made within 4 months before the date of filing of a successful petition for liquidation, an inference may be made that reasonable cause existed to believe the insurer was or was about to become insolvent at the time of the preference. A person receiving

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property or the benefit of the property from the insurer as a preference voidable under subsection (1) shall be personally liable for the property or benefit and shall be bound to account to the liquidator. Nothing in this subsection shall prejudice any other claim by the liquidator against any person.

(15) For delinquency proceedings commenced after January 1, 1990, and notwithstanding any other provision of law, commissions paid to insurance agents or agencies by an insurer in the ordinary course of business at a time when the insurer was authorized to transact such business are not recoverable unless the agent or agency is affiliated with the insurer or produces more than 10% of the insurer's premium.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.8129 Claim of creditor; allowance; excused late filing.

Sec. 8129. (1) A claim of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment, or encumbrance voidable under this chapter shall not be allowed unless the creditor surrenders the preference, lien, conveyance, transfer, assignment, or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within 30 days from the date of the entering of the final judgment, unless the court having jurisdiction over the liquidation allows further time for an appeal or other continuation of the proceeding.

(2) A claim allowable under subsection (1) by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment, or encumbrance, may be filed as an excused late filing under section 8135 if filed within 30 days from the date of the avoidance or within the further time allowed by the court under subsection (1).

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8130 Setoff or counterclaim.

Sec. 8130. (1) Mutual debts or mutual credits, whether arising out of 1 or more contracts, between the insurer and another person in connection with an action or proceeding under this chapter shall be set off and the balance only shall be allowed or paid, except as provided in subsection (2) and section 8133.

(2) A setoff or counterclaim shall not be allowed in favor of a person if:

(a) The insurer's obligation to the person would not at the date of the filing of a petition for receivership entitle the person to share as a claimant in the assets of the insurer.

(b) The insurer's obligation to the person was purchased by or transferred to the person with a view to its being used as a setoff.

(c) The insurer's obligation is owed to an affiliate of the person or any other entity or association other than the person.

(d) The person's obligation is owed to an affiliate of the insurer or any other entity or association other than the insurer.

(e) The person's obligation is to pay an assessment levied against the insurer's members or subscribers, is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution.

(f) The obligations between the person and the insurer arise from business where either the person or the insurer has assumed risks and obligations from the other party and then has ceded back to that party substantially the same risks and obligations.

(3) The receiver shall provide persons with accounting statements identifying all debts that are due and payable. If a person owes to the insurer amounts that are due and payable, against which the person asserts setoff of mutual credits that may become due and payable from the insurer in the future, the person shall promptly pay to the receiver the amounts due and payable, provided that, notwithstanding section 8142 or any other provision of this chapter, the receiver shall promptly and fully refund, to the extent of the person's prior payments, any mutual credits that become due and payable to the person by the insurer. Prior to the termination of any proceeding under this chapter, the amount due the person shall be determined for the purpose of the receiver making a final refund, if any.

(4) Subsections (2)(c), (d), and (f) and (3) apply to all contracts entered into, renewed, extended, or amended on or after 1 year after the effective date of this subsection and to debts or credits arising from any business written or transactions occurring after the effective date of this subsection pursuant to any such contract. For purposes of this section any change in the terms of, or consideration for, any such contract shall be considered an amendment.

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History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.8130a Contributions of parties; determination by court; distribution to stockholders; recovery of distributions; limitations.

Sec. 8130a. (1) Prior to the termination of a liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, and policyowners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In making a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) A distribution to stockholders, if any, of an impaired or insolvent insurer shall not be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under section 7708 with respect to the insurer have been fully recovered by the association.

(3) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer or from any affiliate that controlled it the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the 5 years preceding the petition for liquidation or rehabilitation subject to the following limitations:

(a) A distribution shall not be recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(b) A person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions he or she received. A person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions he or she would have received if they had been paid immediately. If 2 or more persons are liable with respect to the same distributions, they shall be jointly and severally liable. If a person liable under this subdivision is insolvent, all controlling affiliates at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

(c) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8131 Report of liquidator to court; levy of assessment; order to show cause; notice; hearing; determination; enforcement.

Sec. 8131. (1) As soon as practicable but not more than 2 years from the date of an order of liquidation under section 8118 of an insurer issuing assessable policies, the liquidator shall report to the court on all of the following:

(a) The reasonable value of the insurer's assets.

(b) The insurer's probable total liabilities.

(c) The probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment.

(d) A recommendation as to whether or not an assessment should be made and in what amount.

(2) Upon the basis of the report provided in subsection (1), including supplements and amendments to the report, the circuit court may levy 1 or more assessments against all members of the insurer who are subject to assessment. Subject to applicable legal limits on assessability, the aggregate assessment shall be for the amount that the sum of the probable liabilities, the expenses of administration, and the estimated cost of collection of the assessment, exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

(3) After levy of assessment under subsection (2), the liquidator shall issue an order directing each member who has not paid the assessment pursuant to the order to show cause why the liquidator should not pursue a judgment against the respective members.

(4) The liquidator shall give notice of the order to show cause by publication and by first-class mail to each liable member, mailed to his or her last known address as it appears on the insurer's records, at least 20 days before the return day of the order to show cause.

(5) If a member does not appear and serve duly verified objections upon the liquidator on or before the return day of the order to show cause under subsection (3), the court shall make an order adjudging the

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member liable for the amount of the assessment against him or her pursuant to subsection (3), together with costs, and the liquidator shall have a judgment against the member therefor. If on or before the return day the member appears and serves duly verified objections upon the liquidator, the commissioner may hear and determine the matter or may appoint a referee to hear the matter and make such order as the facts warrant. If the commissioner determines that the objections do not warrant relief from assessment, the member may request the court to review the matter and vacate the order to show cause.

(6) The liquidator may enforce any order or collect any judgment under subsection (5) by any lawful means.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8132 Amount recoverable by liquidator from reinsurers; reduction prohibited; reinsurer's obligation to insurer's estate; assumption of obligations by life and health insurance guaranty association.

Sec. 8132. (1) The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of the delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement. The reinsurance shall be payable pursuant to the terms of the reinsurance contract by the assuming insurer on the basis of reported claims allowed by the liquidation court, except as provided in subsection (2), without diminution because of the insolvency of the ceding insurer. Payment made directly to an insured or other creditor shall not diminish the reinsurer's obligation to the insurer's estate unless the reinsurance contract requires or an endorsement signed by the reinsurer to the policies reinsured requires the reinsurer to make payment to the payees under the policies reinsured if the ceding insurer became insolvent.

(2) If a life and health insurance guaranty association or its designated successor life or health insurer has assumed policy obligations as direct obligations of the insolvent ceding insurer and has succeeded to the rights of the insolvent insurer under the contract of reinsurance, then the reinsurer's liability shall continue under the contract of reinsurance and shall be payable pursuant to the direction of the guaranty association or its designated successor. As a condition to succeeding to the insolvent insurer's rights under the contract, the guaranty association or successor life or health insurer shall be responsible for premiums payable under the reinsurance contract for periods after the date of liquidation.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 2000, Act 283, Imd. Eff. July 10, 2000.

Compiler's note: Enacting section 1 of Act 283 of 2000 provides:

"Enacting section 1. The legislature declares that the provisions of this amendatory act are fundamental to the business of insurance as provided in sections 1 and 2 of chapter 20, popularly known as the McCarran-Ferguson act, 59 Stat. 33 and 34, 15 U.S.C. 1011 and 1012. It is the intent of this amendatory act that upon the insolvency of an alien insurer or reinsurer that provides security to fund its United States obligations under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, the assets representing the security shall be maintained in the United States and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets shall be distributed under the insurance laws of the state where the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies."

Popular name: Act 218

500.8133 Payment of unpaid earned premium; recovery of unearned premium; prohibited credits and setoffs; violation; penalty; notice; hearing; appeal.

Sec. 8133. (1) An agent, premium finance company, or any other person, other than the insured, responsible for the payment of a premium held by him or her shall be obligated to pay any unpaid earned premium due the insurer at the time of the declaration of insolvency. The liquidator shall also have the right to recover from that person any part of an unearned premium that represents that person's commission. Credits, setoffs, or both, shall not be allowed to an agent, broker, or premium finance company for an amount advanced to the insurer by the agent, broker, or premium finance company on behalf of, but in the absence of a payment by, the insured. An insured shall be obligated to pay any unpaid earned premium due the insurer at the time of the declaration of insolvency, as shown on the insurer's records.

(2) Upon satisfactory evidence of a violation of this section, the commissioner may pursue either 1 or both of the following courses of action:

(a) Suspend or revoke or refuse to renew the licenses of each offending party.

(b) Impose a penalty of not more than $1,000.00 for each and every act in violation of this section by each offending party.

(3) Before the commissioner takes action under subsection (2), the commissioner shall give written notice to the person, company, association, or exchange accused of violating the law, stating specifically the nature of the alleged violation and fixing a time and place, at least 10 days thereafter, for a hearing on the matter. After the hearing, or upon failure of the accused to appear at the hearing, the commissioner, if he or she finds

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a violation, shall impose the penalties under subsection (2) as he or she considers advisable.

(4) If the commissioner takes action under subsection (2), the party aggrieved may appeal from that action to the circuit court.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8133a Deductible agreement; collateral as asset maintained and administered by receiver; jurisdiction of circuit court; rights of guaranty association or foreign guaranty association; applicability to delinquency proceedings; applicability to first party claims; definitions.

Sec. 8133a. (1) Notwithstanding any other law or contract to the contrary, any collateral held by or for the benefit of or assigned to the insurer or subsequently the receiver in order to secure the obligations of a policyholder under a deductible agreement shall not be considered an asset of the estate and shall be maintained and administered by the receiver as provided in this section.

(2) If collateral is being held by or for the benefit of or assigned to the insurer or subsequently the receiver to secure obligations under a deductible agreement with a policyholder, the collateral shall be used to secure the policyholder's obligation to fund or reimburse claims payment within the agreed deductible amount as provided in this section.

(3) If a claim that is subject to a deductible agreement and secured by collateral is not covered by any guaranty association or foreign guaranty association and the policyholder is unwilling or unable to take over the handling and payment of the noncovered claims, the receiver shall adjust and pay the noncovered claims using the collateral but only to the extent the available collateral after allocation under subsection (4) is sufficient to pay all outstanding and anticipated claims. If the collateral is exhausted and the insured is not able to provide funds to pay the remaining claims within the deductible after all reasonable means of collection against the insured have been exhausted, the receiver's obligation to pay the claims from the collateral terminates and the remaining claims shall be claims against the insurer's estate subject to complying with other provisions in this chapter for the filing and allowance of those claims. If the liquidator determines that the collateral is insufficient to pay all additional and anticipated claims, the liquidator may file a plan, subject to court approval, for equitably allocating the collateral among claimants.

(4) To the extent that the receiver is holding collateral provided by a policyholder that was obtained to secure a deductible agreement and to secure other obligations of the policyholder to pay the insurer directly or indirectly amounts that become assets of the estate, such as reinsurance obligations under a captive reinsurance program or adjustable premium obligations under a retrospectively rated insurance policy where the premium due is subject to adjustment based upon actual loss experience, the receiver shall equitably allocate the collateral among those obligations and administer the collateral allocated to the deductible agreement as provided in this section. For collateral allocated to obligations under the deductible agreement, if the collateral secured reimbursement obligation under more than 1 line of insurance, then the collateral shall be equitably allocated among the various lines based upon the estimated ultimate exposure within the deductible amount for each line. The receiver shall inform the guaranty associations and foreign guaranty associations of the method and details of all the foregoing allocations.

(5) Regardless of whether there is collateral, if the insurer has contractually agreed to allow the policyholder to fund its own claims within the deductible amount pursuant to a deductible agreement, either through the policyholder's own administration of its claims or through the policyholder providing funds directly to a third party administrator who administers the claims, the receiver shall allow this funding arrangement to continue and, where applicable, will enforce the arrangement to the fullest extent possible. The funding of these claims by the policyholder within the deductible amount will act as a bar to any claim for such amount in the liquidation proceeding, including, but not limited to, any claim by the policyholder or the third party claimant. This funding arrangement extinguishes both the obligation, if any, of any guaranty association to pay those claims within the deductible amount, as well as the obligations, if any, of the policyholder or third party administrator to reimburse the guaranty association. If a policyholder has entered into an agreement to which this subsection applies and is prevented from funding its own claims due to any proceeding under 11 USC 101 to 1330 and 1501 to 1532, then the guaranty funds that would otherwise be obligated to pay the claims shall pay the claims to the extent required by applicable state law and, in addition to any other rights of recovery arising from payment of the claims, shall have the full benefit of all collateral and other rights of reimbursement and recovery under this section from the bankruptcy court, liquidator, or receiver. No charge of any kind shall be made against any guaranty association on the basis of the policyholder funding of claim payments made pursuant to an arrangement described in this subsection.

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(6) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount, to the extent a guaranty association or foreign guaranty association is required by applicable state law to pay any claims for which the insurer would have been entitled to reimbursement from the policyholder under the terms of the deductible agreement and to the extent the claims have not been paid by a policyholder or third party, the receiver shall promptly bill the policyholder for reimbursement and the policyholder is obligated to pay the reimbursement amount to the receiver for the benefit of the guaranty association or foreign guaranty associations who paid the claims. Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the deductible agreement, is a defense to the policyholder's reimbursement obligation under the deductible agreement. The receiver shall promptly reimburse the guaranty association or foreign guaranty association for claims paid that were subject to the deductible when the policyholder reimbursements are collected. If the policyholder fails to pay the amounts due within 60 days after the bill for the reimbursement is due, the receiver shall use the collateral to the extent necessary to reimburse the guaranty association or foreign guaranty associations, and, at the same time, may pursue other collections efforts against the policyholder. If more than 1 guaranty association or foreign guaranty association has a claim against the same collateral and the available collateral, after allocation under subsection (4), along with billing and collection efforts, are together insufficient to pay each guaranty association and foreign guaranty association in full, then the receiver will prorate payments to each guaranty association and foreign guaranty association based upon the relationship the amount of claims each guaranty association and foreign guaranty association has paid bears to the total of all claims paid by the guaranty association and foreign guaranty associations.

(7) The receiver is entitled to deduct from reimbursements owed to a guaranty association or foreign guaranty association or collateral to be returned to a policyholder reasonable actual expenses incurred in fulfilling the responsibilities under this section, not to exceed 3% of the collateral or the total deductible reimbursements actually collected by the receiver. For claim payments made by a guaranty association or foreign guaranty association, the receiver shall promptly provide the guaranty association or foreign guaranty association with a complete accounting of the receiver's deductible billing and collection activities, including copies of the policyholder billings when rendered, the reimbursements collected, the available amounts and use of collateral for each account, and any proration of payments when it occurs. If the receiver fails to make a good faith effort within 120 days of receipt of claims payment reports to collect reimbursements due from a policyholder under a deductible agreement based on claim payments made by the guaranty association or foreign guaranty association, the guaranty association or foreign guaranty association may pursue collection from the policyholders directly on the same basis as the receiver, and with the same rights and remedies, and shall report any amounts collected from each policyholder to the receiver. To the extent that a guaranty association or foreign guaranty association pays claims within the deductible amount, but is not reimbursed by either the receiver under this section or by policyholder payments from the guaranty association's or foreign guaranty association's own collection efforts, the guaranty association or foreign guaranty association shall have a claim in the insolvent insurer's estate for unreimbursed claims payments.

(8) The receiver shall adjust the collateral being held as the claims subject to the deductible agreement are run off, so long as adequate collateral is maintained to secure the entire estimated ultimate obligation of the policyholder plus a reasonable safety factor. The receiver shall make these adjustments periodically, but is not required to adjust the collateral more than once a year. The guaranty association and any foreign guaranty association shall be informed of all such collateral reviews, including, but not limited to, the basis for the adjustment. Once all claims covered by the collateral have been paid and the receiver is satisfied that no new claims can be presented, the receiver will release any remaining collateral to the policyholder.

(9) The Ingham county circuit court having jurisdiction over the liquidation proceedings shall have jurisdiction to resolve disputes arising under this section.

(10) This section does not limit or adversely affect any right a guaranty association or foreign guaranty association may have under applicable state law to obtain reimbursement from certain classes of policyholders for claims payments made by the guaranty association or foreign guaranty association under policies of the insolvent insurer or for related expenses the guaranty association or foreign guaranty association incurs.

(11) This section applies to all delinquency proceedings that are open and pending on the effective date of this section.

(12) This section does not apply to first party claims or to claims funded by a guaranty association or foreign guaranty association net of the deductible unless subsection (5) applies.

(13) As used in this section:

(a) "Deductible agreement" means any combination of 1 or more policies, endorsements, contracts, or security agreements that provide for the policyholder to bear the risk of loss within a specified amount per

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claim or occurrence covered under a policy of insurance and may be subject to aggregate limit of policyholder reimbursement obligations.

(b) "Noncovered claim" means a claim that is subject to a deductible agreement, may be secured by collateral, and is not covered by a guaranty association or foreign guaranty association.

History: Add. 2006, Act 355, Imd. Eff. Sept. 18, 2006.

Compiler's note: Act 218

500.8134 Proposal to make early access disbursements; effect of insufficient assets; report; provisions of proposal; notice of application; action on application; return of early access funds; limitation.

Sec. 8134. (1) Within 120 days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this state, the liquidator shall make application to the court for approval of a proposal to make early access disbursements out of marshaled assets, to any guaranty association or foreign guaranty association having obligations because of the insolvency. If the liquidator determines that the estate will not have sufficient assets to make any early access disbursements to a guaranty association or foreign guaranty association under this section, the liquidator shall file a report with the court supporting this determination. Notice to the state insurance commissioners, guaranty associations, and foreign guaranty associations and court review of the report shall be provided under subsection (5). This report may be given instead of an application for a proposal to make early access disbursements. However, if at any time the estate obtains sufficient assets to support an early access disbursement under this section, the liquidator shall file an application for a proposal to make early access disbursements within 60 days of the estate obtaining those assets. If, within 120 days of a final determination of insolvency, the liquidator fails to file an application with the court for approval of a proposal to make early access disbursements or, alternatively, fails to file a report with the court supporting the determination that the estate will not have sufficient assets to make early access disbursements, any guaranty association or foreign guaranty association that may become obligated to pay claims as a result of the insolvency may file this application. An application filed by an association shall be reviewed by the court and, if the proposal submitted by the association meets the requirements set out in this section, the application shall be approved by the court. Upon court approval of the guaranty association or foreign guaranty association proposal, the liquidator shall begin making early access disbursements in accordance with the proposal.

(2) A proposal under subsection (1) shall at least include provisions for all of the following:

(a) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and claims falling within the priorities established in section 8142(1)(a) and (b) and (2). When a reserve for uncovered claims under section 8142(2) is appropriate, the amount of estate assets to be reserved for those claims shall be a percentage of the uncovered claims under section 8142(2), equal in proportion to the percentage of assets distributed, or proposed for distribution, to the guaranty association or foreign guaranty association with respect to covered obligations at the time the reserve for uncovered claims is calculated. Reserves shall be established based on the best available information at the time the distribution is calculated and modified from time to time as more refined information becomes available.

(b) Disbursement of the assets marshaled to date and subsequent disbursement of assets as they become available.

(c) Equitable allocation of disbursements to each of the guaranty associations and foreign guaranty associations entitled to disbursements.

(d) The securing by the liquidator from each of the associations entitled to disbursements pursuant to this section of an agreement to return to the liquidator such assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in section 8142 in accordance with those priorities. A bond shall not be required of any such association.

(e) A full report to be made by each association to the liquidator accounting for assets disbursed to the association, all disbursements made from the assets, interest earned by the association on the assets, and any other matter as the court directs.

(3) The liquidator's proposal shall provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made thereby for which the associations could assert a claim against the liquidator, and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of claim payments made or to be made by the association, then disbursements shall be in the amount of available assets.

(4) The liquidator's proposal shall, with respect to an insolvent insurer writing life or health insurance or

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annuities, provide for disbursements of assets to any guaranty association or any foreign guaranty association covering life or health insurance or annuities or to any other entity or organization reinsuring, assuming, or guaranteeing policies or contracts of insurance under the acts creating the associations.

(5) Notice of application shall be given to the association in each state and to the commissioners of insurance of each state. Notice shall be considered to have been given when deposited in the United States certified mails, first-class postage prepaid, at least 30 days before submission of the application to the court. Action on the application may be taken by the court if the notice under this subsection has been given and if the liquidator's proposal complies with subsection (2)(a) and (b).

(6) The liquidator shall not offset the amount to be disbursed to any guaranty association or foreign guaranty association by any special or statutory deposit or any other asset of the insolvent insurer except to the extent the deposit or asset has been paid to the association for the purpose of satisfying the association's claims. If a guaranty association or foreign guaranty association has received an early access distribution and thereafter also receives a special or statutory deposit or any other asset of the insolvent insurer, the liquidator may request the return of the early access funds up to the amount of the special or statutory deposit or other asset of the insolvent insurer.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1998, Act 279, Imd. Eff. July 27, 1998;—Am. 2006, Act 354, Imd. Eff. Sept. 18, 2006.

Popular name: Act 218

500.8135 Proof of claims; filing; circumstances permitting late filing; receipt of distributions by late filing claimants.

Sec. 8135. (1) Proof of all claims shall be filed with the liquidator in the form required by section 8136 on or before the last day for filing specified in the notice required under section 8122, except that proof of claims for cash surrender values or other investment values in life insurance and annuities need not be filed unless the liquidator expressly so requires.

(2) The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if he or she were not late, to the extent that the payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

(a) The existence of the claim was not known to the claimant and that he or she filed his or her claim as promptly thereafter as reasonably possible after learning of it.

(b) A transfer to a creditor was avoided under sections 8126 to 8128, or was voluntarily surrendered under section 8129, and that the filing satisfies the conditions of section 8129.

(c) The valuation under section 8141 of security held by a secured creditor shows a deficiency, which is filed within 30 days after the valuation.

(3) The liquidator shall permit late filing claims to share in distributions, whether past or future, as if they were not late, if those claims are claims of a guaranty association or foreign guaranty association for reimbursement of covered claims paid, expenses incurred, or both, after the last day for filing and if the payments were made and expenses incurred as provided by law.

(4) The liquidator may consider a claim filed late which is not covered by subsection (2) and permit it to receive distributions which are subsequently declared on any claims of the same or lower priority if the payment does not prejudice the orderly administration of the liquidation. The late filing claimant shall receive, at each distribution, the same percentage of the amount allowed on his or her claim as is then being paid to claimants of any lower priority. This shall continue until his or her claim has been paid in full.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8136 Proof of claim; statement; form; additional information or evidence; judgment or order entered by default or collusion; judgment or order as evidence of liability or quantum of damages; claims of guaranty association.

Sec. 8136. (1) Proof of claim shall consist of a statement signed by the claimant or other authorized person that includes all of the following that are applicable:

(a) The particulars of the claim, including the consideration given for it.

(b) The identity and amount of the security on the claim.

(c) The payments made on the debt, if any.

(d) That the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to the claim.

(e) Any right of priority of payment or other specific right asserted by the claimants.

(f) A copy of the written instrument which is the foundation of the claim.

(g) The name and address of the claimant and the attorney who represents him or her, if any.

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(2) A claim need not be considered or allowed if it does not contain all the information in subsection (1) which may be applicable. The liquidator may require that a prescribed form be used and may require that other information and documents be included.

(3) The liquidator may request the claimant to present information or evidence supplementary to that required under subsection (1) at any time and may take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

(4) A judgment or order against an insured or the insurer entered after the date of filing of a successful petition for liquidation and a judgment or order against an insured or the insurer entered at any time by default or by collusion need not be considered as evidence of liability or of quantum of damages. A judgment or order against an insured or the insurer entered within 4 months before the filing of the petition need not be considered as evidence of liability or of the quantum of damages.

(5) All claims of a guaranty association or foreign guaranty association shall be in the form and contain the substantiation agreed to by the association and the liquidator.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8137 Contingent claims; discounting claims at legal rate of interest; claims made under employment contracts.

Sec. 8137. (1) The claim of a third party which is contingent only on his or her first obtaining a judgment against the insured shall be considered and allowed as if there were no such contingency.

(2) A claim may be allowed even if contingent, if it is filed in accordance with section 8135. It may be allowed and may participate in all distributions declared after it is filed to the extent that it does not prejudice the orderly administration of the liquidation.

(3) Claims that are due except for the passage of time shall be treated as absolute claims are treated, except that those claims may be discounted at the legal rate of interest.

(4) Claims made under employment contracts by directors, principal officers, or persons in fact performing similar functions or having similar powers are limited to payment for services rendered prior to the issuance of an order of rehabilitation or liquidation under section 8113 or 8118.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8138 Third party claim; claim by insured; insured as unexcused late filer; recommendations of liquidator; withholding dividends; hearing; payment of insured; reversions to undistributed assets; delay in final payment; filing of several claims founded on 1 policy; prohibited claims.

Sec. 8138. (1) If a third party asserts a cause of action against an insured of an insurer in liquidation, the third party may file a claim with the liquidator.

(2) Whether or not the third party files a claim, the insured may file a claim on his or her own behalf in the liquidation. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation or within 60 days after mailing of the notice required by section 8122, whichever is later, he or she is an unexcused late filer.

(3) The liquidator shall make his or her recommendations to the court under section 8142 for the allowance of an insured's claim under subsection (1) after consideration of the probable outcome of a pending action against the insured on which the claim is based, the probable damages recoverable in the action, and the probable costs and expenses of defense. After allowance by the court, the liquidator shall withhold dividends payable on the claim pending the outcome of litigation and negotiation with the insured. If appropriate, the liquidator shall reconsider the claim on the basis of additional information and amend his or her recommendations to the court. The insured shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in the initial determination. The court may amend the allowance as the court considers appropriate. As claims against the insured are settled or barred, the insured shall be paid from the amount withheld the same percentage dividend as was paid on other claims of like property, based on the lesser of the amount actually recovered from the insured by action or paid by agreement plus the reasonable costs and expense of defense, or the amount allowed on the claims by the court. After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection shall not be a reason for unreasonable delay of final distribution and discharge of the liquidator.

(4) If several claims founded upon 1 policy are filed, whether by third parties or as claims by the insured under this section, and the aggregate allowed amount of the claims to which the same limit of liability in the

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policy is applicable exceeds that limit, each claim as allowed shall be reduced in the same proportion so that the total equals the policy limit. Claims by the insured shall be evaluated as in subsection (3). If any insured's claim is subsequently reduced under subsection (3), the amount thus freed shall be apportioned ratably among the claims which have been reduced under this subsection.

(5) A claim may not be presented under this section if it is or may be covered by a guaranty association or foreign guaranty association.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8139 Denial of claim; filing of objections; hearing; notice.

Sec. 8139. (1) If a claim is denied in whole or in part by the liquidator, written notice of the determination shall be given to the claimant or his or her attorney by first-class mail at the address shown in the proof of claim. Within 60 days from the mailing of the notice, the claimant may file his or her objections with the liquidator. If a filing of objection is not made, the claimant shall not further object to the determination.

(2) If objections are filed with the liquidator and the liquidator does not alter his or her denial of the claim as a result of the objections, the liquidator shall ask the court for a hearing as soon as practicable and shall give notice of the hearing by first-class mail to the claimant or his or her attorney and to any other persons directly affected, not less than 10 nor more than 30 days before the date of the hearing. The matter may be heard by the court or by a court appointed referee who shall submit findings of fact along with his or her recommendation.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8140 Subrogation to rights of creditor; distribution; excess received by creditor.

Sec. 8140. If a creditor, whose claim against an insurer is secured in whole or in part by the undertaking of another person, fails to prove and file that claim, the other person may do so in the creditor's name and shall be subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that he or she discharges the undertaking. In the absence of an agreement with the creditor to the contrary, the other person shall not be entitled to any distribution until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor shall be held by him or her in trust for the other person. The term "other person", as used in this section, is not intended to apply to a guaranty association or foreign guaranty association.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8141 Value of security; determination; supervision and control; crediting amount determined; deficiency treated as unsecured claim; surrender of security to liquidator.

Sec. 8141. (1) The value of security held by a secured creditor shall be determined in 1 of the following ways, as the court may direct:

(a) By converting the same into money according to the terms of the agreement pursuant to which the security was delivered to the creditors.

(b) By agreement, arbitration, compromise, or litigation between the creditor and the liquidator.

(2) The determination shall be under the court's supervision and control with due regard for the liquidator's recommendation. The amount determined shall be credited upon the secured claim and any deficiency shall be treated as an unsecured claim. If the claimant surrenders his or her security to the liquidator, the entire claim shall be allowed as if unsecured.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8141a Payment of special deposit claims; priority; transfer of special deposits.

Sec. 8141a. (1) Special deposit claims shall be paid pursuant to the following order of priority:

(a) To the receiver for the costs and expenses of the receivership.

(b) To the guaranty association for the costs and expenses of administration with respect to the payment of claims.

(c) To claims of Michigan policyholders of the insurer and to claimants of those Michigan policyholders.

(d) To Michigan beneficiaries of insurance contracts owned by non-Michigan residents.

(e) To other Michigan claimants of the insurer.

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(f) To claims of non-Michigan policyholders of the insurer and to claimants of those non-Michigan policyholders.

(g) To non-Michigan beneficiaries of insurance contracts owned by non-Michigan residents.

(h) To the stockholders or owners of the insurer.

(2) Upon request of a guaranty association of this state to which the insurer is a member, special deposits made by the insurer shall be transferred to that guaranty association for the payment of claims pursuant to this section.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1994, Act 443, Imd. Eff. Jan. 10, 1995.

Compiler's note: Section 2 of Act 443 of 1994 provides:

"Section 8141a of Act No. 218 of the Public Acts of 1956, being section 500.8141a of the Michigan Compiled Laws, as amended by this amendatory act is curative, reflects the original intent of the legislature, is retroactive, and is effective beginning January 3, 1990."

Popular name: Act 218

500.8142 Priority of distribution of claims from insurer's estate; class of claims; subclasses prohibited; order of distribution; assets in separate account; definitions.

Sec. 8142. (1) Except as provided in subsection (2), the priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full or adequate funds retained for their payment before the members of the next class receive payment. Subclasses shall not be established within a class. The order of distribution of claims is as follows:

(a) Class 1. The costs and expenses of administration, including, but not limited to, the following:

(*i*) The actual and necessary costs of preserving or recovering the insurer's assets.

(*ii*) Compensation for all services rendered in the liquidation.

(*iii*) Any necessary filing fees.

(*iv*) The fees and mileage payable to witnesses.

(*v*) Reasonable attorney's fees.

(*vi*) The reasonable expenses of a guaranty association or foreign guaranty association in handling claims.

(*vii*) Debts due to employees for services performed to the extent that they do not exceed $1,000.00 and represent payment for services performed within 1 year before the filing of the petition for liquidation, if the court determines that the payments are reasonably necessary to an orderly and effective administration for the protection of class 2 claimants. Officers and directors are not entitled to the benefit of this priority. This priority is in lieu of any other similar priority authorized by law as to wages or compensation of employees.

(*viii*) Beginning January 3, 1990, the actual and necessary fees of a supervisor appointed pursuant to section 8109 if the liquidation was preceded by supervision pursuant to section 8109 and the fees were not paid at the date of liquidation.

(b) Class 2. Except as otherwise provided in this section, all claims under policies for losses incurred, including third party claims, and all claims of a guaranty association or foreign guaranty association. However, obligations of an insolvent insurer arising out of reinsurance contracts shall not be included in this class. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values, shall be treated as loss claims. For purposes of this section, life insurance and annuity policies include, but are not limited to, individual annuities, group annuities, guaranteed investment contracts, and funding agreement contracts, issued by an insurer. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance, or as gratuities. A payment by an employer to his or her employee shall not be treated as a gratuity.

(c) Class 3. Claims of the federal government.

(d) Class 4. All claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property that are not under policies and, to the extent not included in class 1, debts due to employees for services performed to the extent that they do not exceed $1,000.00 and represent payment for services performed within 1 year before the filing of the petition for liquidation. Officers and directors are not entitled to the benefit of the priority for debts due to employees for services performed. The priority for debts due to employees for services performed is in lieu of any other similar priority authorized by law as to wages or compensation of employees.

(e) Class 5. Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors.

(f) Class 6. Claims of any state or local government. Claims, including those of any governmental body for a penalty or forfeiture, are allowed in this class only to the extent of the pecuniary loss sustained from the act,

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transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs incurred. The remainder of the claims shall be postponed to the class of claims under subdivision (i).

(g) Class 7. Claims filed late or any other claims other than claims under subdivisions (h) and (i).

(h) Class 8. Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies are limited in accordance with law.

(i) Class 9. The claims of shareholders or other owners. In paying claims pursuant to this class, disinterested shareholders have priority over interested shareholders who are directors or officers who fail to exercise their duties in accordance with section 5240.

(2) If it is provided by written agreement, statute, or rule that the assets in a separate account are not chargeable with liabilities arising out of any other business of the insurer, that part of a claim that includes a separate account shall be satisfied out of the assets in the separate account equal to the reserves maintained in the separate account under the separate account agreement. The remainder of the claim shall be treated as a Class 2 claim against the insurer's estate to the extent that reserves have been established in the insurer's general account pursuant to statute, rule, or the separate account agreement.

(3) As used in this section:

(a) "Separate account" means a separate account authorized under section 925 and established in accordance with the terms of a written agreement or a contract on a variable basis.

(b) "Insurer's estate" means all of the assets of the insurer less any assets held in separate accounts. The following assets shall not be considered separate account assets:

(*i*) Assets that represent money provided by the insurer initially to fund the separate account.

(*ii*) Assets that represent policy reserves that are properly allocable to the general account.

(*iii*) General account investments held in the separate account.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1991, Act 79, Imd. Eff. July 18, 1991;—Am. 1996, Act 429, Imd. Eff. Nov. 26, 1996;—Am. 1998, Act 279, Imd. Eff. July 27, 1998;—Am. 2002, Act 359, Imd. Eff. May 23, 2002.

Compiler's note: Section 2 of 429 of 1996 provides:

"Section 2. (1) Sections 8142 and 8159 of Act No. 218 of the Public Acts of 1956, being sections 500.8142 and 500.8159 of the Michigan Compiled Laws, as amended by this amendatory act, apply to all pending and future cases brought under chapter 81 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being sections 500.8101 to 500.8159 of the Michigan Compiled Laws, on and after the effective date of this amendatory act. These sections, as amended by this amendatory act, are intended to correct existing law in light of the United States Supreme Court decision in US Dept of Treasury v Fabe, 508 US 491; 113 S Ct 2202; 124 L Ed 2d 449 (1993), and to introduce regulations conducive to the public good.

"(2) If any portion of this amendatory act or the application of this amendatory act to any person or circumstance is found to be invalid by a court, the invalidity shall not affect the remaining portions or applications of the amendatory act that can be given effect without the invalid portion or application provided the remaining portion is not determined by the court to be inoperable. The court may alter the composition and order of classes listed in section 8142 of Act No. 218 of the Public Acts of 1956, being section 500.8142 of the Michigan Compiled Laws, as amended by this amendatory act, to the minimum extent necessary to render that section valid."

Popular name: Act 218

500.8143 Review of claims by liquidator; investigation; negotiation; unresolved disputes; report on claims by liquidator; approval, disapproval, or modification; limitation.

Sec. 8143. (1) The liquidator shall review all claims duly filed in the liquidation and shall further investigate as he or she considers necessary. The liquidator may compound, compromise, or in any other manner negotiate the amount for which claims will be recommended to the court unless the liquidator is required by law to accept claims as settled by a person or organization, including a guaranty association or foreign guaranty association. Unresolved disputes shall be determined under section 8139. As soon as practicable, the liquidator shall present to the court a report of the claims against the insurer with his or her recommendations. The report shall include the name and address of each claimant and the amount of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the liquidator shall report the persons, according to the records of the insurer, to whom amounts are owed as cash surrender values or other investment value and the amounts owed.

(2) The court may approve, disapprove, or modify the report on claims by the liquidator. Reports not modified by the court within a period of 60 days following submission by the liquidator shall be treated by the liquidator as allowed claims, subject to later modification or to rulings made by the court pursuant to section 8139. A claim under a policy of insurance shall not be allowed for an amount in excess of the applicable policy limits.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8144 Distributions; manner of payment; distribution of assets in kind.

Sec. 8144. Under the court's direction, the liquidator shall pay distributions in a manner that will assure the

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proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third party claims. Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8145 Disposition of unclaimed or withheld funds.

Sec. 8145. (1) All unclaimed funds subject to distribution remaining in the liquidator's hands when he or she is ready to apply to the court for discharge, including the amount distributable to a creditor, shareholder, member, or other person who is unknown or cannot be found, shall be deposited with the state treasurer, and shall be paid without interest except in accordance with section 8142 to the person entitled or his or her legal representative upon proof of right to it satisfactory to the state treasurer. An amount on deposit not claimed within 6 years from the discharge of the liquidator shall be considered to have been abandoned, shall escheat to the state without formal escheat proceedings, and shall be deposited in the general fund.

(2) All funds withheld under section 8137 and not distributed shall be deposited, upon discharge of the liquidator, with the state treasurer and paid by him or her in accordance with section 8142. Sums remaining which under section 8142 would revert to the undistributed assets of the insurer shall be transferred to the state treasurer and become the property of the state under subsection (1), unless the commissioner in his or her discretion petitions the court to reopen the liquidation under section 8147.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8146 Application for discharge.

Sec. 8146. (1) If all assets justifying the expense of collection and distribution have been collected and distributed under this chapter, the liquidator shall apply to the court for discharge. The court may grant the discharge and make any other orders, including an order to transfer any remaining funds that are uneconomic to distribute, as may be considered appropriate.

(2) Any other person may apply to the court at any time for an order under subsection (1). If the application is denied, the applicant shall pay the costs and expenses of the liquidator in resisting the application, including a reasonable attorney's fee.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8147 Petition to reopen proceedings.

Sec. 8147. After the liquidation proceeding has been terminated and the liquidator discharged, the commissioner or other interested party may petition the circuit court at any time to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall order a reopening.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8148 Retention or destruction of records.

Sec. 8148. If it appears to the commissioner that the records of an insurer in process of liquidation or completely liquidated are no longer useful, the commissioner may recommend to the court and the court shall direct what records should be retained for future reference and what should be destroyed.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8149 Audits.

Sec. 8149. The circuit court may cause audits, as it considers desirable, to be made of the books of the commissioner relating to any receivership established under this chapter and a report of each audit shall be filed with the commissioner and with the court. The books, records, and other documents of the receivership shall be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of administration of the receivership.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

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500.8150 Conservator.

Sec. 8150. (1) If a domiciliary liquidator has not been appointed, the commissioner may apply to the circuit court by verified petition for an order directing him or her to act as conservator to conserve the property of an alien insurer not domiciled in this state or a foreign insurer on any 1 or more of the following grounds:

(a) Any of the grounds in section 8112.

(b) That any of its property has been sequestered by official action in its domiciliary state, or in any other state.

(c) That enough of its property has been sequestered in a foreign country to give reasonable cause to fear that the insurer is or may become insolvent.

(d) That its certificate of authority to do business in this state has been revoked or that none was ever issued, and that there are residents of this state with outstanding claims or outstanding policies.

(2) If an order is sought under subsection (1), the court shall cause the insurer to be given notice and time to respond as is reasonable under the circumstances.

(3) The court may issue the order in whatever terms it considers appropriate. The filing or recording of the order with the clerk of the circuit court or the recorder of deeds of the county in which the principal business of the company is located shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(4) The conservator may at any time petition for and the court may grant an order under section 8151 to liquidate assets of a foreign or alien insurer under conservation, or if appropriate for an order under section 8153 to be appointed ancillary receiver.

(5) The conservator may at any time petition the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, the court shall order that the insurer be restored to possession of its property and the control of its business. The court may also make such finding and issue such order at any time upon motion of any interested party, but if the motion is denied, all costs shall be assessed against that party.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

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500.8151 Petition for order directing commissioner to liquidate assets; grounds; notice; order; liquidator as ancillary receiver; commissioner as receiver; paying claims of residents.

Sec. 8151. (1) If a domiciliary receiver has not been appointed, the commissioner may apply to the circuit court by verified petition for an order directing him or her to liquidate the assets found in this state of a foreign insurer or an alien insurer not domiciled in this state, on any of the following grounds:

(a) Any of the grounds in section 8112 or 8117.

(b) Any of the grounds specified in section 8150(1)(b) to (d).

(2) If an order is sought under subsection (1), the court shall cause the insurer to be given notice and time to respond as is reasonable under the circumstances.

(3) If it appears to the court that the best interests of creditors, policyholders, and the public require, the court may issue an order to liquidate in terms the court considers appropriate. The filing or recording of the order with the clerk of the circuit court or the register of deeds of the county in which the principal business of the company is located or the county in which its principal office or place of business is located shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that register of deeds would have imparted.

(4) If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under this section, the liquidator under this section shall thereafter act as ancillary receiver under section 8153. If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under this section, the liquidator under this section may petition the court for permission to act as ancillary receiver under section 8153.

(5) On the same grounds as are specified in subsection (1), the commissioner may petition any appropriate federal district court to be appointed receiver to liquidate that portion of the insurer's assets and business over which the court will exercise jurisdiction or any lesser part thereof that the commissioner considers desirable for the protection of the policyholders and creditors in this state.

(6) The court may order the commissioner, when he or she has liquidated the assets of a foreign or alien insurer under this section, to pay claims of residents of this state against the insurer under rules as to the liquidation of insurers under this chapter as are otherwise compatible with the provisions of this section.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

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Popular name: Act 218

500.8152 Vesting of title in domiciliary liquidator or commissioner; filing claims.

Sec. 8152. (1) The domiciliary liquidator of an insurer domiciled in a reciprocal state shall be vested by operation of law, except as to special deposits and security on secured claims under section 8153(3), with the title to all of the assets, property, contracts and rights of action, agents' balances, and all of the books, accounts, and other records of the insurer located in this state. The date of vesting shall be the date of the filing of the petition, if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from agents and to obtain possession of the books, accounts, and other records of the insurer located in this state. The domiciliary liquidator shall also have the right to recover all other assets of the insurer located in this state, subject to section 8153.

(2) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the commissioner of this state shall be vested by operation of law with the title to all of the property, contracts and right of action, and all of the books, accounts, and other records of the insurer located in this state, at the same time that the domiciliary liquidator is vested with title in the domicile. The commissioner of this state may petition for a conservation or liquidation order under section 8150 or 8151, or for an ancillary receivership under section 8153, or after approval by the circuit court may transfer title to the domiciliary liquidator, as the interests of justice and the equitable distribution of the assets require.

(3) Claimants residing in this state may file claims with the liquidator or ancillary receiver, if any, in this state or with the domiciliary liquidator if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8153 Petition requesting appointment of ancillary receiver; order; notice; powers and duties of ancillary receiver.

Sec. 8153. (1) If a domiciliary liquidator has been appointed for an insurer not domiciled in this state, the commissioner may file a petition with the circuit court requesting appointment as ancillary receiver in this state in either of the following cases:

(a) If he or she finds that there are sufficient assets of the insurer located in this state to justify the appointment of an ancillary receiver.

(b) If the protection of creditors or policyholders in this state requires.

(2) The court may issue an order appointing an ancillary receiver in terms as the court considers appropriate. The filing or recording of the order with the register of deeds in this state imparts the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that register of deeds.

(3) If a domiciliary liquidator has been appointed in a reciprocal state the ancillary receiver appointed in this state may aid and assist the domiciliary liquidator in recovering assets of the insurer located in this state if necessary. The ancillary receiver shall liquidate from their respective securities, as soon as practicable, those special deposit claims and secured claims that are proved and allowed in the ancillary proceedings in this state and shall pay the necessary expenses of the proceedings. The ancillary receiver shall promptly transfer all remaining assets, books, accounts, and records to the domiciliary liquidator. Subject to this section, the ancillary receiver and his or her deputies shall have the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this state.

(4) If a domiciliary liquidator has been appointed in this state, ancillary receivers appointed in reciprocal states shall have, as to assets and books, accounts, and other records in their respective states, corresponding rights, duties, and powers to those provided in subsection (3) for ancillary receivers appointed in this state.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8154 Institution of proceedings under MCL 500.8109 to 500.8111.

Sec. 8154. The commissioner in his or her sole discretion may institute proceedings under sections 8109 to 8111 at the request of the commissioner or other appropriate insurance official of the domiciliary state of any foreign or alien insurer having property located in this state.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

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500.8155 Filing of claims; proof; conclusiveness of final allowance of claims.

Sec. 8155. (1) In a liquidation proceeding begun in this state against an insurer domiciled in this state, claimants residing in foreign countries or in states not reciprocal states shall file claims in this state, and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states or with the domiciliary liquidator. Claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

(2) Claims belonging to claimants residing in reciprocal states may be proved either in the liquidation proceeding in this state as provided in this chapter or in ancillary proceedings, if any, in the reciprocal states. If notice of the claims and opportunity to appear and be heard is afforded the domiciliary liquidator of this state as provided in section 8156(2) with respect to ancillary proceedings, the final allowance of claims by the courts in ancillary proceedings in reciprocal states shall be conclusive as to amount and as to priority against special deposits or other security located in such ancillary states, but shall not be conclusive with respect to priorities against general assets under section 8142.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8156 Filing of claims; proof; recommendation; hearing; notice; appearance or representation; conclusiveness of final allowance of claim.

Sec. 8156. (1) In a liquidation proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within this state may file claims either with the ancillary receiver, if any, in this state or with the domiciliary liquidator. Claims must be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

(2) Claims belonging to claimants residing in this state may be proved either in the domiciliary state under the law of that state, or in ancillary proceedings, if any, in this state. If a claimant elects to prove his or her claim in this state, he or she shall file his or her claim with the liquidator in the manner provided in sections 8135 and 8136. The ancillary receiver shall make his or her recommendation to the court as under section 8143. The ancillary receiver shall also arrange a date for hearing, if necessary under section 8139, and shall give notice to the liquidator in the domiciliary state by certified mail or by personal service at least 40 days prior to the date set for hearing. If the domiciliary liquidator, within 30 days after the giving of such notice, gives notice in writing to the ancillary receiver and to the claimant by certified mail or by personal service of his or her intention to contest the claim, he or she shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim.

(3) The final allowance of the claim by the courts of this state shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in this state.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Popular name: Act 218

500.8157 Prohibited action or proceeding.

Sec. 8157. during the pendency in this or any other state of a liquidation proceeding, whether called by that name or not, an action or proceeding in the nature of an attachment, garnishment, or levy of execution shall not be commenced or maintained in this state against the delinquent insurer or its assets.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990.

Compiler's note: At the beginning of this section, the word “during” evidently should read “During.”

Popular name: Act 218

500.8158 Controlling order of distribution; equal priority of payment; priority against special deposits; deficiency; deferred sharing; surrender of security and filing claim as general creditor; discharge of claim.

Sec. 8158. (1) In a liquidation proceeding in this state involving 1 or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and reciprocal states. All claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where the assets are located.

(2) The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit so that the claims secured by it are not fully discharged from it, the claimants may claim against a security fund or share in the general assets, but the sharing shall be deferred until general creditors having the same priority, and also claimants against other special deposits having the same priority who have received smaller percentages from their

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respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(3) The owner of a secured claim against an insurer for which a liquidator has been appointed in this or any other state may surrender his or her security for the claim and file his or her claim as a general creditor, or the claim may be discharged by resort to the security in accordance with section 8141, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer or the appropriate security fund on the same basis as claims of unsecured creditors having the same priority.

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1994, Act 226, Imd. Eff. June 27, 1994.

Popular name: Act 218

500.8159 Failure to transfer assets.

Sec. 8159. If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in this state any assets within his or her control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under section 8142(1)(h).

History: Add. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1996, Act 429, Imd. Eff. Nov. 26, 1996;—Am. 1998, Act 279, Imd. Eff. July 27, 1998.

Compiler's note: Section 2 of Act 429 of 1996 provides:

"Section 2. (1) Sections 8142 and 8159 of Act No. 218 of the Public Acts of 1956, being sections 500.8142 and 500.8159 of the Michigan Compiled Laws, as amended by this amendatory act, apply to all pending and future cases brought under chapter 81 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being sections 500.8101 to 500.8159 of the Michigan Compiled Laws, on and after the effective date of this amendatory act. These sections, as amended by this amendatory act, are intended to correct existing law in light of the United States Supreme Court decision in US Dept of Treasury v Fabe, 508 US 491; 113 S Ct 2202; 124 L Ed 2d 449 (1993), and to introduce regulations conducive to the public good.

"(2) If any portion of this amendatory act or the application of this amendatory act to any person or circumstance is found to be invalid by a court, the invalidity shall not affect the remaining portions or applications of the amendatory act that can be given effect without the invalid portion or application provided the remaining portion is not determined by the court to be inoperable. The court may alter the composition and order of classes listed in section 8142 of Act No. 218 of the Public Acts of 1956, being section 500.8142 of the Michigan Compiled Laws, as amended by this amendatory act, to the minimum extent necessary to render that section valid."

Popular name: Act 218

500.8160 Repealed. 2001, Act 143, Imd. Eff. Oct. 26, 2001.

Compiler's note: The repealed section pertained to reports to legislature.

Popular name: Act 218

CHAPTER 81a
FRATERNAL BENEFIT SOCIETIES

500.8161 Definitions.

Sec. 8161. As used in this chapter:

(a) "Benefit contract" means the agreement for provision of benefits authorized by section 8179, as that agreement is described in section 8182(1).

(b) "Benefit member" means an adult member designated by the laws or rules of the society to be a benefit member under a benefit contract.

(c) "Certificate" means the document issued as written evidence of a benefit contract.

(d) "Laws" means the society's articles of incorporation, constitution, and bylaws, however designated.

(e) "Lodge" means the subordinate member units of a society, including camps, courts, councils, branches, or other similar designation.

(f) "Premiums" means rates, dues, or other required contributions payable under a certificate.

(g) "Rules" means all rules, regulations, or resolutions adopted by a society's supreme governing body or board of directors that are intended to have general application to the members of the society.

(h) "Society", unless otherwise indicated, means a fraternal benefit society.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8162 Society governed by chapter; exemption.

Sec. 8162. Except as otherwise provided in this chapter, a society shall be governed by this chapter and shall be exempt from all other provisions of the insurance laws of this state unless the society is expressly designated in another law or is specifically made applicable by this chapter.

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History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8163 Society as charitable and benevolent institution; tax exemption.

Sec. 8163. Each society organized or licensed under this chapter is hereby declared to be a charitable and benevolent institution, and all of the society's funds shall be exempt from all state, county, district, municipal, and school taxes, other than taxes on real estate and office equipment.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8164 Definition of fraternal benefit society.

Sec. 8164. An incorporated society, order, or supreme lodge, without capital stock, including 1 exempted under the provisions of section 8199(1)(b) whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and that provides benefits in accordance with this chapter, is a fraternal benefit society.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8165 Society operating on lodge system; requirements; lodges for children.

Sec. 8165. (1) A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated, or admitted in accordance with its laws, rules, and ritual. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once in each month in furtherance of the purposes of the society.

(2) A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of the children, nor shall they have a voice or vote in the management of the society.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8166 Representative form of government; requirements; postponement of society meetings.

Sec. 8166. (1) A society has a representative form of government if:

(a) It has a supreme governing body constituted in 1 of the following ways:

(*i*) The supreme governing body is an assembly composed of delegates elected directly by the members or elected at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall have not less than 2/3 of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected, shall meet at least once every 4 years, and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws.

(*ii*) The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member may not exceed 4 years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society.

(b) The officers of the society are elected either by the supreme governing body or by the board of directors.

(c) Only benefit members are eligible for election to the supreme governing body and the board of directors.

(d) Each voting member has 1 vote and no vote may be cast by proxy.

(2) In time of war or other emergency, the commissioner may order the postponement of society meetings for the duration of the emergency or for any lesser period in his or her discretion. The officers of the society and the delegates and representatives constituting the supreme governing body shall continue to hold office

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and exercise and perform all powers and duties conferred on them during the postponement.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8167 Society operating for benefit of members and their beneficiaries; requirements; subsidiary corporations or affiliated organizations; laws and rules; additional powers.

Sec. 8167. (1) A society shall operate for the benefit of members and their beneficiaries by doing both of the following:

(a) Providing benefits as specified in section 8179.

(b) Operating for 1 or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic, or religious purposes for the benefit of its members, which may also be extended to others.

(2) Subsection (1) may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

(3) Each society may adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. Each society may change, alter, add to, or amend those laws and rules and shall have other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8168 Specification of eligibility standards, admission process, and rights and privileges; social members; rights personal and not assignable.

Sec. 8168. (1) A society shall specify all of the following in its laws or rules:

(a) Eligibility standards for each and every class of membership. However, if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age 15 and not greater than age 21.

(b) The process for admission to membership for each membership class.

(c) The rights and privileges of each membership class. Only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(2) A society may admit social members. A social member shall not have a voice or vote in the management of the insurance affairs of the society.

(3) Membership rights in a society are personal to the member and are not assignable.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8169 Principal office of domestic society; meetings of supreme governing body; validity of business transacted; minutes; official publication; report, notice, or statement; mailing or publication of synopsis of annual statement; grievance or complaint procedures.

Sec. 8169. (1) The principal office of a domestic society shall be located in this state. The meetings of its supreme governing body may be held in any state, district, province, or territory where the society has a subordinate lodge, or in another location as determined by the supreme governing body, and all business transacted at the meetings shall be as valid in all respects as if the meetings were held in this state. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

(2) A society may provide in its laws for an official publication in which a notice, report, or statement required by law to be given to members, including notice of election, may be published. A required report, notice, or statement shall be printed conspicuously in the publication. If the records of a society show that 2 or more members have the same mailing address, an official publication mailed to 1 member is considered to be mailed to all members at the same address unless a member requests a separate copy. Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or published in the society's official publication.

(3) A society may provide in its laws or rules for grievance or complaint procedures for members.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8170 Personal liability; indemnification and reimbursement; purchase of insurance.

Sec. 8170. (1) The officers and members of the supreme governing body or any subordinate body of a

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society shall not be personally liable for any benefits provided by a society.

(2) A person may be indemnified and reimbursed by a society for expenses reasonably incurred by, and liabilities imposed upon, that person in connection with or arising out of an action or proceeding, whether civil, criminal, administrative, or investigative, or the threat thereof, in which the person may be involved by reason of the fact that he or she is or was a director, officer, employee, or agent of the society or of any firm, corporation, or organization which he or she served in any capacity at the request of the society. A person shall not be indemnified or reimbursed in relation to any matter in an action or proceeding if he or she is finally adjudged to be or have been guilty of breach of a duty as a director, officer, employee, or agent of the society or for any matter in an action or proceeding, or the threat thereof, which has been made the subject of a compromise settlement, unless in either case, the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, for a criminal action or proceeding, had no reasonable cause to believe that his or her conduct was unlawful. The determination of whether a person acted in good faith or without reasonable cause may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to the action or proceeding or by a court of competent jurisdiction. The termination of an action or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest, as to the person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. This right of indemnification and reimbursement shall not be exclusive of other rights to which the person may be entitled as a matter of law and shall inure to the benefit of the person's heirs, executors, and administrators.

(3) A society may purchase and maintain insurance on behalf of a person who is or was a director, officer, employee, or agent of the society, or who is or was serving at the request of the society as a director, officer, employee, or agent of any other firm, corporation, or organization against any liability asserted against the person and incurred by him or her in his or her official capacity or arising out of his or her status as such, whether or not the society would have the power to indemnify the person against the liability under this section.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8171 Waiver of society's laws.

Sec. 8171. A society's laws may provide that a subordinate body and its subordinate officers or members shall not have the power or authority to waive any of the provisions of the society's laws and shall be binding on the society and every member and beneficiary of a member.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8172 Formation of domestic fraternal society; requirements; filing documents; bond; certifying, retaining, and filing articles of incorporation; preliminary certificate of authority; solicitation of members; collection of premium; receipt; liability; issuance of certificate; paying or allowing benefit; examination; information; evidence of compliance; issuance of certificate of authority; certificate as evidence; record.

Sec. 8172. (1) To form a domestic fraternal society on or after April 1, 1990, 7 or more citizens of the United States, a majority of whom are citizens of this state, shall make, sign, and acknowledge before an officer competent to take acknowledgment of deeds, articles of incorporation in which shall be stated:

(a) The society's proposed corporate name. The society's proposed corporate name shall not so closely resemble the name of another society or insurance company as to be misleading or confusing.

(b) The purposes for which the society is being formed and the mode in which its corporate powers are to be exercised. The purposes shall not include more liberal powers than are granted by this chapter.

(c) The names and residences of the incorporators and the names, residences, and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the society's affairs and funds for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body and which shall be held not later than 1 year from the date of issuance of the permanent certificate of authority.

(2) The articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, circulars to be issued by the society, and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within 1 year, shall be filed with the commissioner, who may require further information as the commissioner considers necessary. The bond with sureties approved by the commissioner shall be in an amount of not less

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than $300,000.00 or more than $1,500,000.00 as required by the commissioner. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this chapter and all provisions of the law have been complied with, the commissioner shall so certify, retain, and file the articles of incorporation and furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as provided in this chapter.

(3) A preliminary certificate of authority granted under the provisions of this section shall not be valid after 1 year from its date or after such further period, not exceeding 1 year, as may be authorized by the commissioner upon cause shown, unless the 500 applicants required in this section have been secured and the organization has been completed as provided in this section. The articles of incorporation and all other proceedings thereunder shall become null and void after 1 year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society has completed its organization and received a certificate of authority to do business as provided in this section.

(4) Upon receipt of a preliminary certificate of authority from the commissioner, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than 1 regular monthly premium in accordance with its table of rates, and shall issue to each applicant a receipt for the collected amount. A society shall not incur any liability other than for the return of the advance premium, issue any certificate, or pay, allow, or offer or promise to pay or allow, any benefit to any person until all of the following have been met:

(a) Actual bona fide applications for benefits have been secured on not less than 500 applicants, and any necessary evidence of insurability has been furnished to and approved by the society.

(b) At least 10 subordinate lodges have been established into which the 500 applicants have been admitted.

(c) There has been submitted to the commissioner, under oath of the president or secretary, or corresponding officer of the society, a list of the applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge that each applicant is a member of, amount of benefits to be granted, and premiums for those benefits.

(d) It has been shown to the commissioner, by sworn statement of the society's treasurer or the society's corresponding officer, that at least 500 applicants have each paid in cash at least 1 regular monthly premium as provided in this section and the premiums in the aggregate amount to at least $150,000.00. The advance premiums shall be held in trust during the period of organization, and if the society has not qualified for a certificate of authority under this section within 1 year, the premiums shall be returned to the applicants.

(5) The commissioner may make examination and require further information as the commissioner considers advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the commissioner shall issue to the society a certificate of authority to that effect authorizing the society to transact business pursuant to the provisions of this chapter. The certificate of authority shall be prima facie evidence of the existence of the society at the date of the certificate. The commissioner shall cause a record of the certificate of authority to be made. A certified copy of the record may be given in evidence with like effect as the original certificate of authority.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8173 Reincorporation not required.

Sec. 8173. An incorporated society authorized to transact business in this state on April 1, 1990 is not required to reincorporate under this chapter.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8174 Amendment to laws.

Sec. 8174. (1) A domestic society may amend its laws, as its laws provide, by action of its supreme governing body at any regular or special meeting or, if its laws so provide, by referendum. A referendum may be held in accordance with the provisions of the society's laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members, or by the vote of local lodges. A society may provide for voting by mail. An amendment submitted for adoption by referendum shall not be adopted unless, within 6 months from the date of submission of the amendment, a majority of the members voting shall have signified their consent to the amendment by 1 of the methods specified in this subsection.

(2) An amendment to the laws of any domestic society shall not take effect unless approved by the commissioner. The commissioner shall approve an amendment if the commissioner finds that the amendment has been duly adopted and is not inconsistent with any requirement of the laws of this state or with the character, objects, and purposes of the society. Unless the commissioner disapproves an amendment within 60

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days after the filing of the amendment, the amendment shall be considered approved. The approval or disapproval of the commissioner shall be in writing and mailed to the secretary or corresponding officer of the society at its principal office. If the commissioner disapproves an amendment, the reasons for the disapproval shall be stated in the written notice.

(3) Within 90 days from an amendment's approval by the commissioner, each amendment, or a synopsis of each amendment, shall be furnished to each society member either by mail or by publication in full in the society's official publication. The affidavit of a society officer or of anyone authorized by the society to mail an amendment or synopsis of an amendment stating facts that show the amendment or synopsis has been duly addressed and mailed, shall be prima facie evidence that the amendment or synopsis has been furnished the addressee.

(4) Each foreign or alien society authorized to do business in this state shall file with the commissioner a duly certified copy of all amendments of, or additions to, its laws within 90 days after its enactment.

(5) Printed copies of the amended laws, certified by the society's secretary or its corresponding officer, shall be prima facie evidence of their legal adoption.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8175 Not for profit institution; purposes; reporting real or personal property.

Sec. 8175. A society may create, maintain, and operate, or may establish organizations to operate, a not for profit institution to further the purposes permitted by section 8167(1)(b). A not for profit institution may furnish services free or at a reasonable charge. Any real or personal property owned, held, or leased by the society for the purposes permitted by section 8167(1)(b) shall be reported in each annual statement.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8176 Reinsurance agreement.

Sec. 8176. (1) A domestic society, by a reinsurance agreement, may cede any individual risk in whole or in part to an insurer, other than another fraternal benefit society, having the power to make reinsurance and authorized to do business in this state or approved by the commissioner. A society shall not reinsure substantially all of its insurance in force without the commissioner's written permission. A society may take credit for the reserves on such ceded risks to the extent reinsured, but credit shall not be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective on or after April 1, 1990, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract reinsured without diminution because of the insolvency of the ceding society.

(2) Notwithstanding the limitation in subsection (1), a society may reinsure the risks of another society in a consolidation or merger approved by the commissioner under section 8177.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8177 Consolidation or merger; compliance; filings; approval of contract; issuance of certificate; effective date; vesting of rights, franchises, and interest; affidavit as evidence of mailing notice or documents; payment of expenses and compensation; itemized statement of expenses; consolidation or merger subject to MCL 500.7604.

Sec. 8177. (1) A domestic society may consolidate or merge with another society by complying with the provisions of this section and filing with the commissioner all of the following:

(a) A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger.

(b) A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition of the society on a date fixed by the commissioner but not earlier than December 31 of the year preceding the date of the contract.

(c) A certificate of the officers listed in subdivision (b), duly verified by their respective oaths, that the consolidation or merger has been approved by a 2/3 vote of the supreme governing body of each society, the vote being conducted at a regular or special meeting of each society, or, if the society's laws permit, by mail.

(d) Evidence that at least 60 days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in each society's official publication.

(2) If the commissioner finds that the contract is in conformity with the provisions of this section, the

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financial statements are correct, and the consolidation or merger is just and equitable to the members of each society, the commissioner shall approve the contract and issue a certificate to that effect. Upon approval, the contract shall be in full force and effect unless any society that is a party to the contract is incorporated under the laws of any other state or territory. In such event, the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of each state or territory and a certificate of the approval is filed with the commissioner of this state or, if the laws of the state or territory do not contain such a provision, then the consolidation or merger shall not become effective unless and until it has been approved by the commissioner of insurance of each state or territory and a certificate of the approval is filed with the commissioner of this state.

(3) Upon the effective date of a consolidation or merger under this section, all the rights, franchises, and interests of the consolidated or merged societies in and to every species of property, real, personal, or mixed, and things in action belonging to the societies shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest in real estate, vested under the laws of this state in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after the consolidation or merger.

(4) The affidavit of any officer of the society or of anyone authorized by the society to mail any notice or document, stating that the notice or document has been duly addressed and mailed, is prima facie evidence that the notice or document has been furnished the addressees.

(5) All necessary and actual expenses and compensation incident to the proceedings for consolidation or merger shall be paid as provided by the contract of consolidation or merger except that a brokerage or commission shall not be included in the expenses and compensation, shall not be paid to any person by either of the parties to a contract in connection with the negotiation or execution of the contract, and compensation shall not be paid to any officer or employees of either of the parties to the contract for directly or indirectly aiding in effecting the contract of consolidation or merger. An itemized statement of all expenses shall be filed with each commissioner, is subject to each commissioner's approval, and upon approval is binding on the parties. Except as fully expressed in the contract of consolidation or merger or approved itemized statement of expenses, compensation shall not be paid to a person or officer or employee of the state, directly or indirectly, for in any manner aiding, promoting, or assisting any consolidation or merger.

(6) A consolidation or merger is also subject to the applicable provisions of section 7604.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8178 Domestic fraternal benefit society as mutual life insurance company.

Sec. 8178. A domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the requirements of chapter 82.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8179 Contractual benefits; specifying persons covered in rules.

Sec. 8179. (1) A society may provide in any form the following contractual benefits:

(a) Death benefits.

(b) Endowment benefits.

(c) Annuity benefits.

(d) Temporary or permanent disability benefits.

(e) Hospital, medical, or nursing benefits.

(f) Monument or tombstone benefits to the memory of deceased members.

(g) Other benefits authorized for life insurers and not inconsistent with this chapter.

(2) A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits listed in subsection (1), consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8180 Changing beneficiary; limiting scope of beneficiary designations; vested interest of revocable beneficiary; payment of funeral benefits; payment of benefit to personal

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representative or owner of certificate.

Sec. 8180. (1) The owner of a benefit contract may change the beneficiary in accordance with the society's laws or rules unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society, through its laws or rules, may limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of a certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(2) A society may make provision for the payment of funeral benefits to the extent of the portion of any payment under a certificate as might reasonably appear to be due to a person equitably entitled to the benefit by reason of having incurred expense occasioned by the burial of the member, if the portion paid does not exceed the sum of $1,000.00.

(3) If at the death of a person insured under a benefit contract there is no lawful beneficiary to whom the proceeds are payable, the amount of the benefit, except to the extent that funeral benefits are paid pursuant to subsection (2), shall be payable to the personal representative of the deceased insured, except that if the owner of the certificate is other than the insured, the proceeds shall be payable to that owner.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8181 Attachment, garnishment, or other process.

Sec. 8181. No money or other benefit, charity, relief, or aid to be paid, provided, or rendered by a society, shall be liable to attachment, garnishment, or other process, or seized, taken, appropriated, or applied by any legal or equitable process or operation of law to pay any debt or liability of a member, beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8182 Benefit contracts.

Sec. 8182. (1) Each society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided. The certificate, together with any attached riders or endorsements, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall state this. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

(2) Changes, additions, or amendments to the society's laws duly made or enacted subsequent to the issuance of the certificate shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though the changes, additions, or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition, or amendment shall destroy or diminish benefits that the society contracted to give the owner as of the date of issuance.

(3) A person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the society's laws and rules to the same extent as though the age of majority had been attained at the time of application.

(4) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired, its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of the deficiency as ascertained by its board, and that if the payment is not made either of the following applies:

(a) It shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates.

(b) In lieu of or in combination with subdivision (a), the owner may accept a proportionate reduction in benefits under the certificate.

(5) The society may specify the manner of the election under subsection (4) and which alternative is to be presumed if no election is made.

(6) Copies of any of the documents in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions of the document.

(7) A certificate shall not be delivered or issued for delivery in this state unless a copy of the form has been filed with the commissioner in the manner provided for like policies issued by life insurers in this state. Each life, accident, health, or disability insurance certificate and each annuity certificate issued on or after April 1,

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1991 shall meet the standard contract provision requirements not inconsistent with this chapter for like policies issued by life insurers in this state as provided in chapters 34 and 40, except that a society may provide for a grace period for payment of premiums of 1 full month in its certificates. The certificates shall also contain a provision stating the amount of premiums payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate that, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

(8) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control or ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government, and control of the certificate and all rights, obligations, and liabilities incident to and connected with the certificate. Ownership rights prior to the transfer shall be specified in the certificate.

(9) A society may specify the terms and conditions on which benefit contracts may be assigned.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8183 Value of paid-up nonforfeiture benefit; amount of cash surrender value, loan, or other option granted.

Sec. 8183. (1) For certificates issued before April 1, 1991, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall comply with the law applicable before April 1, 1990.

(2) For certificates issued on or after April 1, 1991, for which reserves are computed on the commissioner's 1980 standard mortality table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits based upon the tables.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8184 Investments generally.

Sec. 8184. A society shall invest its funds only in those investments authorized by the laws of this state for the investment of assets of life insurers and subject to the limitations of those laws. Any foreign or alien society permitted or seeking to do business in this state which invests its funds in accordance with the laws of the state, district, territory, country, or province in which it is incorporated, shall be held to meet the requirements of this section for the investment of funds.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8185 Assets; special fund; accounts; issuance of contracts on variable basis; special procedures; special voting and other rights.

Sec. 8185. (1) All assets shall be held, invested, and disbursed for the use and benefit of the society. A society member or beneficiary shall not have or acquire individual rights in a society's assets or become entitled to any apportionment on the surrender of any part of a society's assets, except as provided in the benefit contract.

(2) A society may create, maintain, invest, disburse, and apply any special fund necessary to carry out any purpose permitted by the laws of the society.

(3) A society, pursuant to resolution of its supreme governing body, may establish and operate 1 or more separate accounts and issue contracts on a variable basis, subject to all the provisions of law regulating life insurers establishing such accounts and issuing such contracts, including capital and surplus requirements. To the extent the society considers it necessary in order to comply with any applicable federal or state laws or rules, the society may adopt special procedures for the conduct of the business and affairs of a separate account, may provide, for persons having beneficial interest in such an account, special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the

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business and affairs of the account, and may issue contracts on a variable basis to which section 8182(2) and (4) shall not apply.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8186 Standards of valuation for certificates; excess reserves.

Sec. 8186. (1) Standards of valuation for certificates issued before April 1, 1991 shall be those provided by the laws applicable before April 1, 1990.

(2) The minimum standards of valuation for certificates issued on or after April 1, 1991 shall be under valuation methods and standards, including interest assumptions, in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits and shall be based on the following tables:

(a) For certificates of life insurance, the commissioner's 1980 standard ordinary mortality table or any more recent table made applicable to life insurers.

(b) For annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits, and for noncancelable accident and health benefits, the tables as are authorized for use by life insurers in this state.

(3) The commissioner, in his or her discretion, may accept other standards for valuation if the commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard prescribed in this section. The commissioner, in his or her discretion, may vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by any society authorized to do business in this state.

(4) A society, with the consent of the commissioner of insurance of the state of domicile of the society and under conditions, if any, that the commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, so long as the contractual rights of any benefit member are not affected.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8187 Reports; annual statement; valuation of certificates; penalty.

Sec. 8187. (1) Reports shall be filed in accordance with this section.

(2) On or before March 1, each society transacting business in this state shall annually file with the commissioner a true statement of its financial condition, transactions, and affairs for the preceding calendar year. The commissioner, in his or her discretion, for cause shown, may extend the time for filing. The statement shall be in a form as required by the commissioner which may be in the general form and context as approved by the national association of insurance commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner.

(3) As part of the annual statement required in subsection (2), each society shall file with the commissioner, on or before March 1, a valuation of its certificates in force on December 31 of the year preceding the filing. The commissioner, in his or her discretion for cause shown, may extend the time for filing the valuation for not more than 2 calendar months. The valuation shall be done in accordance with the standards specified in section 8186. The valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

(4) A society neglecting to file the annual statement in the form and within the time provided by this section shall be fined $100.00 for each day during which the neglect continues, and, upon notice by the commissioner to that effect, its authority to do business in this state shall cease while the default continues.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8188 Duration of license or authorization to transact business; copy of license as evidence.

Sec. 8188. A society that is licensed or authorized to transact business in this state may continue the business and the authority of the society until the society's license or authority is suspended or revoked by the commissioner or is terminated at the society's request. A duly certified copy or duplicate of the license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of this chapter.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

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500.8189 Examination of society.

Sec. 8189. (1) The commissioner, or any person he or she may appoint, may examine any domestic, foreign, or alien society transacting or applying for admission to transact business in this state in the same manner as authorized for examination of domestic, foreign, or alien insurers, shall have free access to all the books, papers, and documents that relate to the business of the society, and may summon and qualify as witness under oath and examine its officers, agents, and employees or other persons in relation to the affairs, transactions, and condition of the society. Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

(2) The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the commissioner.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8190 Foreign or alien society; license required; compliance; conditions.

Sec. 8190. A foreign or alien society shall not transact business in this state without a license issued by the commissioner. A society desiring admission to this state shall comply substantially with the requirements and limitations of this chapter applicable to a domestic society. A foreign or alien society may be licensed to transact business in this state if its assets are invested in accordance with the provisions of this chapter and upon filing with the commissioner all of the following:

(a) A duly certified copy of its articles of incorporation.

(b) A copy of its bylaws, certified by its secretary or corresponding officer.

(c) A power of attorney to the commissioner as provided in section 8196.

(d) A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the commissioner, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province, or country, satisfactory to the commissioner.

(e) Certification from the proper official of its home state, territory, province, or country that the society is legally incorporated and licensed to transact business there.

(f) Copies of its certificate forms.

(g) Such other information as the commissioner may consider necessary.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8191 Domestic society; deficiencies; notice; request for correction; noncompliance; action to enjoin or action in quo warranto; hearing; order; findings; liquidation; recognition of action; receiver; voluntary determination to discontinue business.

Sec. 8191. (1) If the commissioner upon investigation finds that a domestic society has exceeded its powers, has failed to comply with any provision of this chapter, is not fulfilling its contracts in good faith, has a membership of less than 400 after an existence of 1 year or more, or is conducting business fraudulently or in a manner hazardous to its members, creditors, the public, or the business, the commissioner shall notify the society of his or her findings and state in writing the reasons for his or her dissatisfaction. The commissioner shall issue immediately a written notice to the society requiring that each deficiency that exists be corrected. After notice, the society shall have a 30-day period in which to comply with the commissioner's request for correction, and if the society fails to comply, the commissioner shall notify the society of the findings of noncompliance and require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of is corrected, or why an action in quo warranto should not be commenced against the society.

(2) If the society pursuant to subsection (1) does not present good and sufficient reasons why it should not be enjoined or why an action in quo warranto should not be commenced, the commissioner may request the attorney general to commence an action to enjoin the society from transacting business or to commence an action in quo warranto.

(3) The court shall notify the society's officers of a hearing. If after a full hearing it appears that the society should be enjoined, liquidated, or a receiver appointed, the court shall enter the necessary order. An enjoined society shall not have the authority to do business until the commissioner finds all of the following:

(a) That the violation complained of has been corrected.

(b) The costs of the action have been paid by the society if the court finds that the society was in default as

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charged.

(c) The court has dissolved its injunction.

(d) The commissioner has reinstated the certificate of authority.

(4) If the court orders the society liquidated, the society shall be enjoined from carrying on any further business, and the receiver of the society shall proceed at once to take possession of the books, papers, money, and other assets of the society and, under the direction of the court, proceed immediately to close the affairs of the society and to distribute its funds to those entitled.

(5) An action under this section shall not be recognized in any court of this state unless brought by the attorney general upon request of the commissioner. If a receiver is to be appointed for a domestic society, the court shall appoint the commissioner as the receiver.

(6) The provisions of this section relating to hearing by the commissioner, action by the attorney general at the request of the commissioner, hearing by the court, injunction, and receivership shall be applicable to a society that voluntarily determines to discontinue business.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8192 Foreign or alien society; deficiencies; notice; request for correction; noncompliance; suspension, revocation, or refusal of license; contracts.

Sec. 8192. (1) If the commissioner upon investigation finds that a foreign or alien society transacting or applying to transact business in this state has exceeded its powers, has failed to comply with any of the provisions of this chapter, is not fulfilling its contracts in good faith, or is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public, the commissioner shall notify the society of his or her findings and state in writing the reasons for his or her dissatisfaction. The commissioner shall issue immediately a written notice to the society requiring that the deficiency or deficiencies that exist be corrected. After the notice the society shall have a 30-day period in which to comply with the commissioner's request for correction, and if the society fails to comply, the commissioner shall notify the society of the findings of noncompliance and require the society to show cause on a date named why its license should not be suspended, revoked, or refused. If on that date the society does not present good and sufficient reason why its authority to do business in this state should not be suspended, revoked, or refused, the commissioner may suspend or refuse the license of the society to do business in this state until satisfactory evidence is furnished to the commissioner that the suspension or refusal should be withdrawn or the commissioner may revoke the authority of the society to do business in this state.

(2) Nothing in this section shall be taken or construed as preventing a society from continuing in good faith all contracts made in this state during the time that the society was legally authorized to transact business in this state.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8193 Application or petition for injunction; recognition.

Sec. 8193. An application or petition for injunction against any domestic, foreign, or alien society, or lodge of such a society, shall not be recognized in any court of this state unless commenced by the attorney general upon request of the commissioner.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8194 Agent of society; license required; exceptions.

Sec. 8194. An agent of a society shall be licensed in accordance with the provisions of chapter 12 regulating the licensing, revocation, suspension, or termination of licenses of resident and nonresident agents except that an examination or license shall not be required of any regular salaried officer, employee, or member of a licensed society who devotes substantially all of his or her services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8195 Society subject to chapter 20.

Sec. 8195. Each society authorized to do business in this state shall be subject to the provisions of chapter 20 relating to unfair trade practices except that chapter 20 shall not be construed as applying to or affecting

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the right of a society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8196 Service of process.

Sec. 8196. (1) Each society authorized to do business in this state shall appoint in writing the commissioner and each successor in office to be its true and lawful attorney upon whom all lawful process in any action or proceeding against it shall be served, and shall agree in that writing that any lawful process against it that is served on the commissioner shall be of the same legal force and validity as if served upon the society, and that the authority shall continue in force so long as any liability remains outstanding in this state. Copies of the appointment, certified by the commissioner, shall be sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original might be admitted.

(2) Service shall only be made upon the commissioner, or the commissioner's deputy. Service shall be made in duplicate and shall constitute sufficient service upon the society. If legal process against a society is served upon the commissioner, the commissioner shall forward immediately 1 of the duplicate copies prepaid and directed to the secretary or corresponding officer of the society. Such service shall not require a society to file its answer, pleading, or defense in less than 30 days from the date of mailing the copy of the service to a society. Legal process shall not be served upon a society except in the manner provided in this section and upon payment of the fee specified in section 456.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8197 False or fraudulent statement or representation as misdemeanor or perjury; violation of MCL 500.8177 as felony; soliciting or procuring membership in unlicensed society as misdemeanor; violation of or noncompliance with chapter; penalties.

Sec. 8197. (1) A person, officer, member, or examining physician of any society authorized to do business under this chapter, who knowingly or willfully makes a false or fraudulent statement or representation in or with reference to an application for membership, or for the purpose of obtaining money from or benefit in any society transacting business under this chapter, is guilty of a misdemeanor, and upon conviction shall be punished by imprisonment for not less than 30 days or more than 1 year, or by a fine of not less than $100.00 or more than $500.00, or both.

(2) A person who willfully makes a false statement of a material fact or thing in a sworn statement as to the death or disability of a certificate holder in a society for the purpose of procuring payment of a benefit named in the certificate of the holder, and a person who willfully makes a false statement in a verified report or declaration under oath required or authorized by this chapter, is guilty of perjury.

(3) A person who violates section 8177 is guilty of a felony, and upon conviction shall be punished by imprisonment for not more than 5 years, or by a fine of not more than $5,000.00, or both.

(4) A person who solicits membership for or in any manner assists in procuring membership in a society not licensed to do business in this state is guilty of a misdemeanor punishable by a fine of not less than $50.00 or more than $200.00.

(5) A person guilty of a willful violation of or neglect or refusal to comply with the provisions of this chapter for which a penalty is not otherwise prescribed is subject to the penalty provided in section 150.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8198 Decisions and findings of commissioner; judicial review.

Sec. 8198. All decisions and findings of the commissioner made under the provisions of this chapter shall be subject to review by proper proceedings in a court of competent jurisdiction in this state.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8199 Exemptions.

Sec. 8199. (1) This chapter shall not be construed to affect or apply to any of the following described organizations which were in existence and issuing benefits on July 1, 1945:

(a) Grand or subordinate lodges of masons, odd fellows or knights of Pythias, exclusive of the insurance department of the supreme lodge knights of Pythias, the junior order of united American mechanics, exclusive

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of the beneficiary degree of insurance branch of the national council junior order of united American mechanics, the ladies' Lutheran benevolent federation of Michigan, labor organizations or societies that admit to membership only those persons who at the time of admission are engaged in any 1 occupation or who limit their membership to any 1 religious denomination, similar societies that do not issue insurance certificates, an association of local lodges of a society now doing business in this state that provides death benefits not exceeding $500.00 to any 1 person or disability benefits not exceeding $300.00 in any 1 year to any 1 person, or both, a contract of reinsurance business on such plan in this state, a domestic society that limits its membership to the employees of a particular city or town, similar societies that limit their membership to a designated firm, business house, or corporation granting death benefits not exceeding $1,000.00 or disability benefits not exceeding $300.00 in any 1 year to any 1 person, and domestic lodges orders or associations of a purely religious, charitable, and benevolent description that do not provide for a death benefit of more than $150.00 or for disability benefits of more than $150.00 to any 1 person in any 1 year.

(b) Orders, societies, or associations that admit to membership only persons engaged in 1 or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families, and the ladies' societies or ladies' auxiliaries to such orders, societies, or associations.

(2) The commissioner may require from a society such information as will enable him or her to determine whether the society is exempt from the provisions of this chapter.

(3) A fraternal benefit society, organized and incorporated and operating as set forth in sections 8164 to 8166, providing for benefits in case of death or disability resulting solely from accidents but which does not obligate itself to pay death or sick benefits, may be licensed under the provisions of this chapter and shall have all the privileges and be subject to all the provisions and regulations of this chapter, except that the provisions of this chapter requiring medical examinations and valuations of benefit certificates, and that the certificate shall specify the amount of benefits, shall not apply to such society.

(4) Societies exempted under the provisions of this section shall also be exempt from all other provisions of the insurance laws of this state.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8199a Additional chapters and provisions applicable to fraternal benefit society.

Sec. 8199a. A fraternal benefit society transacting business in this state and not exempt from the provisions of this chapter under section 8199 is also subject to the following additional chapters and provisions of this act, as applicable:

(a) Chapter 1.

(b) Chapter 2. However, as to section 240, only subsection (1)(c), (d), (h), and (j) apply, except as provided in section 5222.

(c) Sections 403, 405a, 436, 436a, 437, 476a, 839, 5222, and 5256.

(d) Chapter 9.

(e) Chapter 11.

(f) Chapter 34.

(g) Chapter 38.

(h) Chapter 39.

(i) Chapter 40 except as to section 4004.

(j) Chapter 81.

History: Add. 1990, Act 1, Eff. Apr. 1, 1990;—Am. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 1994, Act 226, Imd. Eff. June 27, 1994;—Am. 1998, Act 457, Imd. Eff. Jan. 4, 1999.

Popular name: Act 218

CHAPTER 82
TRANSFORMATION OF FRATERNAL BENEFIT SOCIETIES

500.8204 Fraternal benefit society; reorganization into legal reserve premium company; amendment of articles.

Sec. 8204. Any existing fraternal benefit society may amend its articles of incorporation and bylaws in such a way as to transform itself into a legal reserve level premium company doing business as a mutual company, but only after complying with the provisions of this chapter.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

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500.8206 Reorganization; proposed articles and bylaws; filing with insurance commissioner.

Sec. 8206. Whenever any such society shall propose to transform itself into a legal reserve level premium company as herein provided, it shall file with the commissioner, its proposed articles and bylaws, its plan of transformation, setting forth in detail the terms and conditions of such transformation and also the method by which it proposes to protect the interests of its membership.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.8208 Reorganization; hearing on petition.

Sec. 8208. The commissioner may proceed to hear and determine such petition without notice, or, if he deems it necessary that such notice should be given in order to conserve the interests of the membership, he shall require the society to first notify, by mail, all of the members of such society of the pendency of such petition, the contents of such notice to be determined by the commissioner.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.8210 Reorganization; member's right to appear.

Sec. 8210. When notice shall have been given, as above provided, any member of such society shall have the right to appear before the commissioner and be heard with reference to the petition.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.8212 Reorganization; examination; witnesses.

Sec. 8212. The commissioner may also make such examination into the affairs and conditions of the society as he deems proper, and shall have power to summon and compel the attendance and testimony of witnesses, and the production of books and papers, and may administer oaths.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.8214 Reorganization; authorization by insurance commissioner; modification.

Sec. 8214. If satisfied that the interests of the membership of said society are properly protected and that no reasonable objection to said petition exists, the commissioner may authorize in writing, such transformation, or may first require such modification thereof as may seem to him necessary for the best interests of such membership.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.8216 Reorganization; order; disposition of assets.

Sec. 8216. The commissioner shall make such order and disposition of the assets of any such society as in his judgment may be just and equitable.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.8218 Reorganization; submission of plan to governing body of society; meeting.

Sec. 8218. The commissioner shall require the plan of transformation to be submitted to the supreme governing body of such society, to be voted upon. When submitted, it shall be either at a regular meeting of the supreme governing body or at a special meeting of same called for that purpose.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.8220 Reorganization; special meeting; notice; approval; required vote; proxies.

Sec. 8220. A notice of said special meeting, in the form approved by the commissioner, shall be given in accordance with the requirement of the bylaws of such society. When so submitted, a majority vote of the supreme governing body present and voting, as authorized by its articles of incorporation and bylaws, shall be necessary to an approval of such plan of transformation; and no proxies shall in any case be voted.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

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500.8224 Reorganization; members; referendum.

Sec. 8224. If the supreme governing body approves the plan of transformation, the board of directors or other managing body of such society shall submit the plan to a referendum vote of the members of such society, and if the result of such vote shall show that the majority of the members of such society has voted to repeal the action of the supreme governing body, then the same shall be considered as repealed by such society and shall be null and of no effect.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.8228 Reorganization; plan; approval by insurance commissioner; vote; results.

Sec. 8228. Any such plan of transformation submitted to the supreme governing body as herein contemplated, must first have been approved by the commissioner; and the result of said vote must be filed with such commissioner and be by him determined before any transformation shall be so effective.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.8232 Reorganization; plan; adoption requirements.

Sec. 8232. No such transformation shall take place until after its plan has been approved by the commissioner, either with or without a hearing as herein provided, and until such approved plan has been adopted by a majority vote of the board of directors or board of trustees of such society; and, if submitted to the supreme governing body, until such approved plan has also been adopted by a majority vote of the said supreme governing body present and voting.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.8240 Applicability of MCL 500.8204 to 500.8232.

Sec. 8240. Nothing in sections 8204 through 8232 shall be construed to apply to any association exempt from the provisions of chapter 81a in accordance with the provisions of section 8199.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1990, Act 1, Eff. Apr. 1, 1990.

Popular name: Act 218

500.8242 Reorganization; effect; continuation of original corporation; powers; officers.

Sec. 8242. Any such society so transformed, shall incur the obligations and enjoy the benefits thereof the same as though originally thus incorporated, and such corporation, under its charter as thus amended, shall be a continuation of such original corporation, and the officers thereof shall serve through their respective terms as provided in the original charter, but their successors shall be elected and serve as in such amended articles provided. Any society so transformed shall have the power to acquire, own, hold, lease, mortgage, sell and convey personal and real property, and to provide the necessary funds, and to do all things necessary for the purpose of operating and maintaining such hospitals, asylums, sanitariums, schools, or homes as it was operating and maintaining when so transformed and it shall have the power to discontinue operating and maintaining the same and to lease, mortgage, sell and convey the personal and real property acquired for use in connection therewith.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.8246 Amendment or reincorporation; saving clause.

Sec. 8246. Such amendment or reincorporation shall not affect existing suits, claims, or contracts.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.8250 Liens upon certificates; notices to members; application of section.

Sec. 8250. If any fraternal benefit society, reorganizing under the provisions of this chapter shall have certificates in force, against the equity of which certificates a lien or other form of indebtedness has been placed, the society shall notify each member individually of the amount of his or her lien, and all accumulations thereto, at a date not more than 1 year prior to the effective date of such reorganization, and a similar individual notice shall be given every 5 years thereafter. The provisions of this section shall not apply to policy loans or premium loans, but only to liens or other forms of indebtedness created by the supreme

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governing body of the society, by a subordinate governing body, or by a vote of the membership during the time that the society was operating as a fraternal benefit society.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.8254 Certificates of membership; valuation; reserve; annual statement.

Sec. 8254. The existing certificates of membership of any fraternal benefit society which shall have transformed itself into a legal reserve level premium life insurance company, in conformity with the provisions of this chapter, shall be valued as follows:

(1) Certificates on which rates of contributions are not on the basis of any table of mortality, valued as yearly renewable term policies according to the standard of valuation of life insurance policies prescribed by the laws of this state.

(2) Certificates on which the rates of contribution are based upon a standard table of mortality and specified rate of interest, valued in accordance with such standard. The reserve so ascertained shall be held as a liability by the company in its annual statement rendered to the insurance department.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

CHAPTER 83

REPEALS, SAVING CLAUSE, EFFECTIVE DATE

500.8300 Repeals.

Sec. 8300. Act No. 256 of the Public Acts of 1917, as amended, being sections 501.1 to 548.107, inclusive, of the Compiled Laws of 1948, Act No. 151 of the Public Acts of 1893, being sections 550.151 and 550.152 of the Compiled Laws of 1948, and Act No. 158 of the Public Acts of 1943, being sections 550.201 to 550.213, inclusive, of the Compiled Laws of 1948, are hereby repealed.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.8301 Saving clause.

Sec. 8301. This act shall not impair or affect any act done, offense committed or right accruing, accrued, or acquired, or liability, penalty, forfeiture or punishment incurred prior to the time this act takes effect, but the same may be enjoyed, asserted, enforced, prosecuted or inflicted, as fully and to the same extent as if this act had not been passed.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.8302 Effective date of act.

Sec. 8302. This act shall become effective on January 1, 1957.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

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