

AMENDED IN ASSEMBLY APRIL 20, 2015

AMENDED IN ASSEMBLY APRIL 6, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 1515

Introduced by Committee on Insurance (Daly (Chair), Calderon, Cooley, Cooper, Dababneh, Frazier, Gatto, Gonzalez, Mayes, and Rodriguez)

March 5, 2015

An act to amend Sections 510, 739.3, 742.34, 790.034, 1725.5, 1729.2, 1764.1, 1861.02, 1861.025, 10111.2, 10127.13, 10169, 10192.18, 10232.3, 10233.5, 10235.35, 12418.4, 12820, and 12921 of, and to repeal Section 10233.9 of, the Insurance Code, and to amend Section 1299.04 of the Penal Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 1515, as amended, Committee on Insurance. Insurance.

(1) Existing law requires certain insurance disclosures in various circumstances, including, but not limited to, when a life or disability insurance policy or certificate of coverage is first issued or delivered to a new insured or policyholder, when an employer obtains coverage from a multiple employer welfare arrangement, ~~and~~ when a claim is up for ~~settlement~~. *settlement, and when a vehicle service contract form is offered.*

This bill would *generally* require those disclosures to also include the Department of Insurance's Internet Web site.

(2) Existing law defines the term "Adjusted RBC Report" as a Risk-Based Capital (RBC) report that has been adjusted by the Insurance Commissioner in accordance with specified provisions governing the

determination of a property and casualty insurer's RBC. Existing law requires the filing of an RBC report by a life or health insurer if the insurer has a Total Adjusted Capital that is greater than or equal to its Company Action Level RBC but the Total Adjusted Capital is less than the product of its Authorized Control Level RBC and 2.5.

This bill would require the RBC report if the Total Adjusted Capital is less than the product of its Authorized Control Level RBC and 3.0.

(3) Existing law provides requirements for various written insurance-related documents, including, among other things, the requirement on a licensee to include certain information on a business card, the requirement on all individual life insurance policies and individual annuity contracts to be in certain font, and an outline of coverage for long-term care insurance policies.

This bill would modify the requirements with respect to those written documents, as specified.

(4) Existing law requires an applicant or licensee to update his or her application if background information that was provided in the application for a license changes.

This bill would expand the definition of a license to include, among others, title insurance.

(5) This bill would make technical, nonsubstantive changes to correct obsolete cross-references and would delete obsolete provisions.

(6) Existing law, governing life and disability insurance, provides, among other things, that the only measure of insurer liability and damage is the sum payable to the insured in the manner and at the times as provided in the policy. Existing law requires, in addition, if any insurer fails to pay any benefits under a policy of disability income insurance, as defined, within 30 calendar days after the insurer has received all information needed to determine liability and has determined that liability exists, any delayed payment to bear interest, as specified.

This bill would specify that the above requirement to pay interest does not apply to health insurance, as defined.

(7) Existing law requires an outline of coverage to be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation. Existing law specifies the form for the outline of coverage and requires the form to state that the policy provides coverage for insureds diagnosed with Alzheimer's disease, organic disorders, or related degenerative and dementing illnesses.

This bill would require the form to state that the policy provides coverage for insureds for all mental illnesses.

(8) Existing law provides that any insurer offering long-term care insurance shall provide to the Department of Insurance a copy of the specimen individual policy form or group master policy and certificate forms, corresponding outline of coverage, and representative advertising materials to be used in the state.

This bill would eliminate that requirement.

(9) Existing law provides various procedural rights for, and requirements of, a title insurance representative applicant.

This bill would add the requirement to immediately notify the commissioner, using an approved method, of any change in email, other personal information, or other background information.

(10) Existing law requires the Insurance Commissioner to perform all duties imposed upon him or her by the Insurance Code and other laws regulating the business of insurance in this state and to enforce the execution of those provisions and laws. In an administrative action to enforce the Insurance Code and other laws regulating the business of insurance in this state, any settlement is subject to various requirements, including that the commissioner may delegate the power to negotiate the terms and conditions of a settlement, but shall not delegate the power to approve the settlement.

This bill would authorize the commissioner to delegate the power to approve settlements that do not involve an insurer, a managing general agent or production agent that manages the business of an insurer, a title company, a home protection company, an insurance adjuster whose claims practices are at issue, and an insurance agent or broker, or an insurance agent or broker applicant, who has allegedly engaged in theft, fraud, or the misappropriation of premium or other funds in an amount that exceeds \$50,000.

(11) Existing law requires a licensed bail agent, bail permittee, or bail solicitor who engages, in the arrest of a defendant to satisfy specified requirements, including, among other things, the completion of 20 hours of classroom education pertinent to the duties and responsibilities of a bail licensee.

This bill would require a bail fugitive recovery person licensed after December 31, 2012, to have at least 20 hours of classroom preclicensing education, and a bail fugitive recovery person licensed between January 1, 1994, and December 31, 2012, to have at least 12 hours of classroom preclicensing education. The bill would provide that a person licensed prior to January 1, 1994, has no preclicensing education requirement.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 510 of the Insurance Code is amended
2 to read:

3 510. Whenever a policy of insurance specified in Section 660
4 or 675, a policy of life insurance as defined in Section 101, a policy
5 of disability insurance as defined in Section 106, or a certificate
6 of coverage as defined in Section 10270.6, is first issued to or
7 delivered to a new insured or a new policyholder in this state, the
8 insurer shall include a written disclosure containing the name,
9 address, toll-free telephone number, and Internet Web site of the
10 unit within the Department of Insurance that deals with consumer
11 affairs. The telephone number shall be the same as that provided
12 to consumers under Section 12921.1. The disclosure shall be
13 printed in large, boldface type.

14 The disclosure shall also contain the address and customer
15 service telephone number of the insurer, or the address and
16 customer service telephone number of the agent or broker of record,
17 or all of those addresses and telephone numbers. All addresses and
18 telephone numbers for the insurer or the agent or broker of record
19 shall be prominently displayed, in boldfaced type. The disclosure
20 shall also contain a statement that the Department of Insurance
21 should be contacted only after discussions with the insurer, or its
22 agent or other representative, or both, have failed to produce a
23 satisfactory resolution to the problem. If the policy or certificate
24 was issued or delivered by an agent or broker, the disclosure shall
25 specifically advise the insured to contact his or her agent or broker
26 for assistance.

27 SEC. 2. Section 739.3 of the Insurance Code is amended to
28 read:

29 739.3. (a) “Company Action Level Event” means any of the
30 following events:

31 (1) The filing of an RBC Report by an insurer that indicates any
32 of the following:

33 (A) The insurer’s Total Adjusted Capital is greater than or equal
34 to its Regulatory Action Level RBC but less than its Company
35 Action Level RBC.

1 (B) If a life or health insurer, the insurer has Total Adjusted
2 Capital that is greater than or equal to its Company Action Level
3 RBC but less than the product of its Authorized Control Level
4 RBC and 3.0, and has a negative trend.

5 (C) If a property and casualty insurer, the insurer has Total
6 Adjusted Capital that is greater than or equal to its Company Action
7 Level RBC but less than the product of its Authorized Control
8 Level RBC and 3.0, and triggers the trend test determined in
9 accordance with the trend test calculation included in the Property
10 and Casualty RBC instructions.

11 (2) The notification by the commissioner to the insurer of an
12 Adjusted RBC Report that indicates the event in paragraph (1),
13 provided that the insurer does not challenge the Adjusted RBC
14 Report under Section 739.7.

15 (3) If the insurer challenges, under Section 739.7, an Adjusted
16 RBC Report that indicates the event in paragraph (1), the
17 notification by the commissioner to the insurer that the
18 commissioner has, after a hearing, rejected the insurer's challenge.

19 (b) In the event of a Company Action Level Event, the insurer
20 shall prepare and submit to the commissioner a comprehensive
21 financial plan that shall do all of the following:

22 (1) Identify the conditions in the insurer that contribute to the
23 Company Action Level Event.

24 (2) Contain proposals of corrective actions that the insurer
25 intends to take and would be expected to result in the elimination
26 of the Company Action Level Event.

27 (3) Provide projections of the insurer's financial results in the
28 current year and at least the four succeeding years, both in the
29 absence of proposed corrective actions and giving effect to the
30 proposed corrective actions, including projections of statutory
31 operating income, net income, capital, or surplus, or a combination.
32 The projections for both new and renewal business may include
33 separate projections for each major line of business and separately
34 identify each significant income, expense, and benefit component.

35 (4) Identify the key assumptions impacting the insurer's
36 projections and the sensitivity of the projections to the assumptions.

37 (5) Identify the quality of, and problems associated with, the
38 insurer's business, including, but not limited to, its assets,
39 anticipated business growth and associated surplus strain,

1 extraordinary exposure to risk, mix of business, and use of
2 reinsurance in each case, if any.

3 (c) The RBC Plan shall be submitted as follows:

4 (1) Within 45 days of the Company Action Level Event.

5 (2) If the insurer challenges an Adjusted RBC Report pursuant
6 to Section 739.7, within 45 days after notification to the insurer
7 that the commissioner has, after a hearing, rejected the insurer's
8 challenge.

9 (d) Within 60 days after the submission by an insurer of an RBC
10 Plan to the commissioner, the commissioner shall notify the insurer
11 whether the RBC Plan shall be implemented or is, in the judgment
12 of the commissioner, unsatisfactory. If the commissioner
13 determines that the RBC Plan is unsatisfactory, the notification to
14 the insurer shall set forth the reasons for the determination, and
15 may set forth proposed revisions that will render the RBC Plan
16 satisfactory, in the judgment of the commissioner. Upon
17 notification from the commissioner, the insurer shall prepare a
18 Revised RBC Plan, which may incorporate by reference revisions
19 proposed by the commissioner, and shall submit the Revised RBC
20 Plan to the commissioner as follows:

21 (1) Within 45 days after the notification from the commissioner.

22 (2) If the insurer challenges the notification from the
23 commissioner under Section 739.7, within 45 days after a
24 notification to the insurer that the commissioner has, after a
25 hearing, rejected the insurer's challenge.

26 (e) In the event of a notification by the commissioner to an
27 insurer that the insurer's RBC Plan or Revised RBC Plan is
28 unsatisfactory, the commissioner may, at his or her discretion,
29 subject to the insurer's right to a hearing under Section 739.7,
30 specify in the notification that the notification constitutes a
31 Regulatory Action Level Event.

32 (f) Every domestic insurer that files an RBC Plan or Revised
33 RBC Plan with the commissioner shall file a copy of the RBC Plan
34 or Revised RBC Plan with the insurance commissioner in any state
35 in which the insurer is authorized to do business if both of the
36 following apply:

37 (1) That state has an RBC provision substantially similar to
38 subdivision (a) of Section 739.8.

39 (2) The insurance commissioner of that state has notified the
40 insurer of its request for the filing in writing, in which case the

1 insurer shall file a copy of the RBC Plan or Revised RBC Plan in
2 that state no later than the later of:

3 (A) Fifteen days after the receipt of notice to file a copy of its
4 RBC Plan or Revised RBC Plan with the state.

5 (B) The date on which the RBC Plan or Revised RBC Plan is
6 filed under subdivision (c) of Section 739.7.

7 SEC. 3. Section 742.34 of the Insurance Code is amended to
8 read:

9 742.34. (a) The following notice shall be provided to
10 employers and employees who obtain coverage from a multiple
11 employer welfare arrangement:

12
13 NOTICE "NOTICE
14

15 (A) THE MULTIPLE EMPLOYER WELFARE
16 ARRANGEMENT IS NOT AN INSURANCE COMPANY AND
17 DOES NOT PARTICIPATE IN ANY OF THE GUARANTEE
18 FUNDS CREATED BY CALIFORNIA LAW. THEREFORE,
19 THESE FUNDS WILL NOT PAY YOUR CLAIMS OR
20 PROTECT YOUR ASSETS IF A MULTIPLE EMPLOYER
21 WELFARE ARRANGEMENT BECOMES INSOLVENT AND
22 IS UNABLE TO MAKE PAYMENTS AS PROMISED.

23 (B) THE HEALTH CARE BENEFITS THAT YOU HAVE
24 PURCHASED OR ARE APPLYING TO PURCHASE ARE
25 BEING ISSUED BY A MULTIPLE EMPLOYER WELFARE
26 ARRANGEMENT THAT IS LICENSED BY THE STATE OF
27 CALIFORNIA.

28 (C) FOR ADDITIONAL INFORMATION ABOUT THE
29 MULTIPLE EMPLOYER WELFARE ARRANGEMENT YOU
30 SHOULD ASK QUESTIONS OF YOUR TRUST
31 ADMINISTRATOR OR YOU MAY CONTACT THE
32 CALIFORNIA DEPARTMENT OF INSURANCE AT _____.
33 _____."

34 (b) Each multiple employer welfare arrangement should include
35 the department's current "800" consumer service telephone number
36 and Internet Web site address in the blank provided in paragraph
37 (C) of this notice.

38 SEC. 4. Section 790.034 of the Insurance Code is amended to
39 read:

1 790.034. (a) Regulations adopted by the commissioner
 2 pursuant to this article that relate to the settlement of claims shall
 3 take into consideration settlement practices by classes of insurers.

4 (b) (1) Upon receiving notice of a claim, every insurer shall
 5 immediately, but no more than 15 calendar days after receipt of
 6 the claim, provide the insured with a legible reproduction of
 7 subdivisions (h) and (i) of Section 790.03 along with a written
 8 notice containing the following language in at least 10-point type:
 9

10 “In addition to Section 790.03 of the Insurance Code, Fair Claims
 11 Settlement Practices Regulations govern how insurance claims
 12 must be processed in this state. These regulations are available at
 13 the Department of Insurance Internet Web site,
 14 www.insurance.ca.gov, or by calling the department’s consumer
 15 information line at 1-800-927-HELP(4357). You may also obtain
 16 a copy of this law and these regulations free of charge from this
 17 insurer.”
 18

19 (2) Every insurer shall provide, when requested orally or in
 20 writing by an insured, a legible reproduction of Section 790.03 of
 21 the Insurance Code and copies of Sections 2695.5, 2695.7, 2695.8,
 22 and 2695.9 of Subchapter 7.5 of Chapter 5 of Title 10 of the
 23 California Code of Regulations, unless the regulations are
 24 inapplicable to that class of insurer. This law and these regulations
 25 shall be provided to the insured within 15 calendar days of request.

26 (3) The provisions of this subdivision shall apply to all insurers
 27 except for those that are licensed pursuant to Chapter 1
 28 (commencing with Section 12340) of Part 6 of Division 2, with
 29 respect to policies and endorsements described in Section 790.031.

30 SEC. 5. Section 1725.5 of the Insurance Code is amended to
 31 read:

32 1725.5. (a) For purposes of Sections 32.5, 1625, 1626, 1724.5,
 33 1758.1, 1765, 1800, 14020, 14021, and 15006, every licensee shall
 34 prominently affix, type, or cause to be printed on business cards,
 35 written price quotations for insurance products, and print
 36 advertisements distributed exclusively in this state for insurance
 37 products its license number in type the same size as any indicated
 38 telephone number, address, or fax number. If the licensee maintains
 39 more than one organization license, one of the organization license
 40 numbers is sufficient for compliance with this section.

1 (b) Effective January 1, 2005, for purposes of Sections 32.5,
2 1625, 1626, 1724.5, 1758.1, 1765, 14020, 14021, and 15006, every
3 licensee shall prominently affix, type, or cause to be printed on
4 business cards, written price quotations for insurance products,
5 and print advertisements, distributed in this state for insurance
6 products, the word “Insurance” in type size that is at least as large
7 as the smallest telephone number or 12-point ~~font~~, *type*, whichever
8 is larger.

9 (c) In the case of transactors, or agent and broker licensees, who
10 are classified for licensing purposes as solicitors, working as
11 exclusive employees of motor clubs, organizational licensee
12 numbers shall be used.

13 (d) Any person in violation of this section shall be subject to a
14 fine levied by the commissioner in the amount of two hundred
15 dollars (\$200) for the first offense, five hundred dollars (\$500) for
16 the second offense, and one thousand dollars (\$1,000) for the third
17 and subsequent offenses. The penalty shall not exceed one thousand
18 dollars (\$1,000) for any one offense. These fines shall be deposited
19 into the Insurance Fund.

20 (e) A separate penalty shall not be imposed upon each piece of
21 printed material that fails to conform to the requirements of this
22 section.

23 (f) If the commissioner finds that the failure of a licensee to
24 comply with the provisions of subdivision (a) or (b) is due to
25 reasonable cause or circumstance beyond the licensee’s control,
26 and occurred notwithstanding the exercise of ordinary care and in
27 the absence of willful neglect, the licensee may be relieved of the
28 penalty in subdivision (d).

29 (g) A licensee seeking to be relieved of the penalty in
30 subdivision (d) shall file with the department a statement with
31 supporting documents setting forth the facts upon which the
32 licensee bases its claims for relief.

33 (h) This section does not apply to any person or entity that is
34 not currently required to be licensed by the department or that is
35 exempted from licensure.

36 (i) This section does not apply to general advertisements of
37 motor clubs that merely list insurance products as one of several
38 services offered by the motor club, and do not provide any details
39 of the insurance products.

1 (j) This section does not apply to life insurance policy
2 illustrations required by Chapter 5.5 (commencing with Section
3 10509.950) of Part 2 of Division 2 or to life insurance cost indexes
4 required by Chapter 5.6 (commencing with Section 10509.970)
5 of Part 2 of Division 2.

6 (k) This section shall become operative January 1, 1997.

7 SEC. 6. Section 1729.2 of the Insurance Code is amended to
8 read:

9 1729.2. (a) An applicant or licensee shall notify the
10 commissioner when any of the background information set forth
11 in this section changes after the application has been submitted or
12 the license has been issued. If the licensee is listed as an endorsee
13 on any business entity license, the licensee shall also provide this
14 notice to any officer, director, or partner listed on that business
15 entity license.

16 (b) A business entity licensee, upon learning of a change in
17 background information pertaining to any unlicensed person listed
18 on its business entity license or application therefor, shall notify
19 the commissioner of that change. The changes subject to this
20 requirement include changes pertaining to any unlicensed officer,
21 director, partner, member, or controlling person, or any other
22 natural person named under the business entity license or in an
23 application therefor.

24 (c) The following definitions apply for the purposes of this
25 section:

26 (1) "License" includes all types of licenses issued by the
27 commissioner pursuant to Chapter 5 (commencing with Section
28 1621), Chapter 5A (commencing with Section 1759), Chapter 6
29 (commencing with Section 1760), Chapter 6.5 (commencing with
30 Section 1781.1), Chapter 7 (commencing with Section 1800), and
31 Chapter 8 (commencing with Section 1831) of Part 2 of Division
32 1, Chapter 1 (commencing with Section 10110) of Part 2 of
33 Division 2, Chapter 4 (commencing with Section 12280) of Part
34 5 of Division 2, Article 8 (commencing with Section 12418) of
35 Chapter 1 of Part 6 of Division 2, and Chapter 1 (commencing
36 with Section 14000) and Chapter 2 (commencing with Section
37 15000) of Division 5.

38 (2) "Background information" means any of the following: a
39 misdemeanor or felony conviction; a filing of felony criminal
40 charges in state or federal court; an administrative action regarding

1 a professional or occupational license; any licensee’s discharge or
2 attempt to discharge, in a personal or organizational bankruptcy
3 proceeding, an obligation regarding any insurance premiums or
4 fiduciary funds owed to any company, including a premium finance
5 company, or managing general agent; and any admission, or
6 judicial finding or determination, of fraud, misappropriation or
7 conversion of funds, misrepresentation, or breach of fiduciary
8 duty.

9 (3) “Applicant” and “licensee” include individual and
10 organization applicants and licensees, and officers, directors,
11 partners, members, and controlling persons (as defined in
12 subdivision (b) of Section 1668.5) of an organization.

13 (d) Notification to the commissioner shall be in writing and
14 shall be sent within 30 days of the date the applicant or licensee
15 learns of the change in background information.

16 (e) The commissioner may adopt regulations necessary or
17 desirable to implement this section.

18 SEC. 7. Section 1764.1 of the Insurance Code is amended to
19 read:

20 1764.1. (a) (1) Every nonadmitted insurer, in the case of
21 insurance to be purchased by a home state insured pursuant to
22 Section 1760, and surplus line broker, in the case of any insurance
23 with a nonadmitted carrier for a home state insured to be transacted
24 by the surplus line broker, shall be responsible to ensure that, at
25 the time of accepting an application for an insurance policy, other
26 than a renewal of that policy, issued by a nonadmitted insurer, the
27 signature of the applicant on the disclosure statement set forth in
28 subdivision (b) is obtained. In fulfillment of this responsibility,
29 the nonadmitted insurer and the surplus line broker may rely, if it
30 is reasonable under all the circumstances to do so, on the disclosure
31 statement received from a licensee involved in the transaction as
32 prima facie evidence that the disclosure statement and appropriate
33 signature from the applicant have been obtained. The surplus line
34 broker shall maintain a copy of the signed disclosure statement in
35 his or her records for a period of at least five years. These records
36 shall be made available to the commissioner and the insured upon
37 request. This disclosure shall be signed by the applicant, and is
38 not subject to a limited power of attorney agreement between the
39 applicant and an agent or broker or a surplus line broker. The
40 disclosure statement shall be in boldface 16-point type on a

1 freestanding document. In addition, every policy issued by a
2 nonadmitted insurer and every certificate evidencing the placement
3 of insurance shall contain, or have affixed to it by the insurer or
4 surplus line broker, the disclosure statement set forth in subdivision
5 (b) in boldface 16-point type on the front page of the policy.

6 (2) In a case in which the applicant has not received and
7 completed the signed disclosure form required by this section, he
8 or she may cancel the insurance so placed. The cancellation shall
9 be on a pro rata basis as to premium, and the applicant shall be
10 entitled to the return of any broker’s fees charged for the placement.

11 (b) The following notice shall be provided to home state insureds
12 and home state insured applicants for insurance as provided by
13 subdivision (a), and shall be printed in English and in the language
14 principally used by the surplus line broker and nonadmitted insurer
15 to advertise, solicit, or negotiate the sale and purchase of surplus
16 line insurance. The surplus line broker and nonadmitted insurer
17 shall use the appropriate bracketed language for application and
18 issued policy disclosures:

19
20
21

“NOTICE:

22 1. THE INSURANCE POLICY THAT YOU [HAVE
23 PURCHASED] [ARE APPLYING TO PURCHASE] IS BEING
24 ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE
25 STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED
26 “NONADMITTED” OR “SURPLUS LINE” INSURERS.

27 2. THE INSURER IS NOT SUBJECT TO THE FINANCIAL
28 SOLVENCY REGULATION AND ENFORCEMENT THAT
29 APPLY TO CALIFORNIA LICENSED INSURERS.

30 3. THE INSURER DOES NOT PARTICIPATE IN ANY OF
31 THE INSURANCE GUARANTEE FUNDS CREATED BY
32 CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL
33 NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF
34 THE INSURER BECOMES INSOLVENT AND IS UNABLE
35 TO MAKE PAYMENTS AS PROMISED.

36 4. THE INSURER SHOULD BE LICENSED EITHER AS A
37 FOREIGN INSURER IN ANOTHER STATE IN THE UNITED
38 STATES OR AS A NON-UNITED STATES (ALIEN) INSURER.
39 YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE
40 AGENT, BROKER, OR “SURPLUS LINE” BROKER OR

1 CONTACT THE CALIFORNIA DEPARTMENT OF
2 INSURANCE AT THE FOLLOWING TOLL-FREE
3 TELEPHONE NUMBER ____ OR INTERNET WEB SITE
4 WWW.INSURANCE.CA.GOV. ASK WHETHER OR NOT THE
5 INSURER IS LICENSED AS A FOREIGN OR NON-UNITED
6 STATES (ALIEN) INSURER AND FOR ADDITIONAL
7 INFORMATION ABOUT THE INSURER. YOU MAY ALSO
8 CONTACT THE NAIC'S INTERNET WEB SITE AT
9 WWW.NAIC.ORG.

10 5. FOREIGN INSURERS SHOULD BE LICENSED BY A
11 STATE IN THE UNITED STATES AND YOU MAY CONTACT
12 THAT STATE'S DEPARTMENT OF INSURANCE TO OBTAIN
13 MORE INFORMATION ABOUT THAT INSURER.

14 6. FOR NON-UNITED STATES (ALIEN) INSURERS, THE
15 INSURER SHOULD BE LICENSED BY A COUNTRY
16 OUTSIDE OF THE UNITED STATES AND SHOULD BE ON
17 THE NAIC'S INTERNATIONAL INSURERS DEPARTMENT
18 (IID) LISTING OF APPROVED NONADMITTED
19 NON-UNITED STATES INSURERS. ASK YOUR AGENT,
20 BROKER, OR "SURPLUS LINE" BROKER TO OBTAIN MORE
21 INFORMATION ABOUT THAT INSURER.

22 7. CALIFORNIA MAINTAINS A LIST OF APPROVED
23 SURPLUS LINE INSURERS. ASK YOUR AGENT OR BROKER
24 IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST
25 AT THE INTERNET WEB SITE OF THE CALIFORNIA
26 DEPARTMENT OF INSURANCE:
27 WWW.INSURANCE.CA.GOV.

28 8. IF YOU, AS THE APPLICANT, REQUIRED THAT THE
29 INSURANCE POLICY YOU HAVE PURCHASED BE BOUND
30 IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE
31 WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR
32 BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE
33 WITHIN TWO BUSINESS DAYS, AND YOU DID NOT
34 RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR
35 YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME
36 EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS
37 POLICY WITHIN FIVE DAYS OF RECEIVING THIS
38 DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM
39 WILL BE PRORATED AND ANY BROKER'S FEE CHARGED
40 FOR THIS INSURANCE WILL BE RETURNED TO YOU."

1
2 (c) When a contract is issued to an industrial insured, neither
3 the nonadmitted insurer nor the surplus line broker is required to
4 provide the notice required in this section except on the
5 confirmation of insurance, the certificate of placement, or the
6 policy, whichever is first provided to the insured, nor is the insurer
7 or surplus line broker required to obtain the insured’s signature.
8 The producer shall ensure that the notice affixed to the confirmation
9 of insurance, certificate of placement, or the policy is provided to
10 the insured. The producer shall insert the current toll-free telephone
11 number of the Department of Insurance as provided in paragraph
12 4 of the notice.

13 (1) An industrial insured is an insured that does both of the
14 following:

15 (A) Employs at least 25 employees on average during the prior
16 12 months.

17 (B) Has aggregate annual premiums for insurance for all risks
18 other than workers’ compensation and health coverage totaling no
19 less than twenty-five thousand dollars (\$25,000) or obtains
20 insurance through the services of a full-time employee acting as
21 an insurance manager or a continuously retained insurance
22 consultant. A “continuously retained insurance consultant” does
23 not include: (i) an agent or broker through whom the insurance is
24 being placed, (ii) a subagent or subproducer involved in the
25 transaction, or (iii) an agent or broker that is a business organization
26 employing or contracting with a person mentioned in clauses (i)
27 and (ii).

28 (2) The surplus line broker shall be responsible for ensuring
29 that the applicant is an industrial insured. A surplus line broker
30 who reasonably relies on information provided in good faith by
31 the applicant, whether directly or through the producer, shall be
32 deemed to be in compliance with this requirement.

33 (d) For purposes of compliance with the requirement of
34 subdivision (a) that the signature of the applicant be obtained, the
35 following shall apply:

36 (1) If the insurance transaction is not conducted at an in-person,
37 face-to-face meeting, the applicant’s signature on the disclosure
38 form may be transmitted by the applicant to the agent or broker
39 via facsimile or comparable electronic transmittal.

1 (2) In the case of commercial lines coverage, or personal
2 insurance coverage subject to Section 675 and any umbrella
3 coverage associated therewith, where an applicant requires that
4 insurance coverage be bound immediately, either because existing
5 coverage will lapse within two business days of the time the
6 insurance is bound or because the applicant is required to have
7 coverage in place within two business days, and the applicant
8 cannot meet in person with the agent or broker to sign the
9 disclosure form, the agent or broker may obtain the signature of
10 the applicant within five days of binding coverage, provided that
11 the applicant may cancel the insurance so placed within five days
12 of receiving the disclosure form from the agent or broker. The
13 cancellation shall be on a pro rata basis, and the applicant shall be
14 entitled to the rescission or return of any broker's fees charged for
15 the placement. When a policy is canceled, the broker shall inform
16 the applicant that the broker's fee must be returned and that the
17 premium must be prorated.

18 (e) Notwithstanding subdivision (a), this section shall not apply
19 to insurance issued or delivered in this state by a nonadmitted
20 Mexican insurer by and through a surplus line broker affording
21 coverage exclusively in the Republic of Mexico on property located
22 temporarily or permanently in, or operations conducted temporarily
23 or permanently within, the Republic of Mexico.

24 SEC. 8. Section 1861.02 of the Insurance Code is amended to
25 read:

26 1861.02. (a) Rates and premiums for an automobile insurance
27 policy, as described in subdivision (a) of Section 660, shall be
28 determined by application of the following factors in decreasing
29 order of importance:

- 30 (1) The insured's driving safety record.
- 31 (2) The number of miles he or she drives annually.
- 32 (3) The number of years of driving experience the insured has
33 had.
- 34 (4) Those other factors that the commissioner may adopt by
35 regulation and that have a substantial relationship to the risk of
36 loss. The regulations shall set forth the respective weight to be
37 given each factor in determining automobile rates and premiums.
38 Notwithstanding any other provision of law, the use of any criterion
39 without approval shall constitute unfair discrimination.

1 (b) (1) Every person who meets the criteria of Section 1861.025
2 shall be qualified to purchase a Good Driver Discount policy from
3 the insurer of his or her choice. An insurer shall not refuse to offer
4 and sell a Good Driver Discount policy to any person who meets
5 the standards of this subdivision.

6 (2) The rate charged for a Good Driver Discount policy shall
7 comply with subdivision (a) and shall be at least 20 percent below
8 the rate the insured would otherwise have been charged for the
9 same coverage. Rates for Good Driver Discount policies shall be
10 approved pursuant to this article.

11 (3) (A) This subdivision shall not prevent a reciprocal insurer,
12 organized prior to November 8, 1988, by a motor club holding a
13 certificate of authority under Chapter 2 (commencing with Section
14 12160) of Part 5 of Division 2, and that requires membership in
15 the motor club as a condition precedent to applying for insurance
16 from requiring membership in the motor club as a condition
17 precedent to obtaining insurance described in this subdivision.

18 (B) This subdivision shall not prevent an insurer that requires
19 membership in a specified voluntary, nonprofit organization, which
20 was in existence prior to November 8, 1988, as a condition
21 precedent to applying for insurance issued to or through those
22 membership groups, including franchise groups, from requiring
23 that membership as a condition to applying for the coverage offered
24 to members of the group, provided that it or an affiliate also offers
25 and sells coverage to those who are not members of those
26 membership groups.

27 (C) However, all of the following conditions shall be applicable
28 to the insurance authorized by subparagraphs (A) and (B):

29 (i) Membership, if conditioned, is conditioned only on timely
30 payment of membership dues and other bona fide criteria not based
31 upon driving record or insurance, provided that membership in a
32 motor club may not be based on residence in any area within the
33 state.

34 (ii) Membership dues are paid solely for and in consideration
35 of the membership and membership benefits and bear a reasonable
36 relationship to the benefits provided. The amount of the dues shall
37 not depend on whether the member purchases insurance offered
38 by the membership organization. None of those membership dues
39 or any portion thereof shall be transferred by the membership
40 organization to the insurer, or any affiliate of the insurer,

1 attorney-in-fact, subsidiary, or holding company thereof, provided
2 that this provision shall not prevent any bona fide transaction
3 between the membership organization and those entities.

4 (iii) Membership provides bona fide services or benefits in
5 addition to the right to apply for insurance. Those services shall
6 be reasonably available to all members within each class of
7 membership.

8 Any insurer that violates clause (i), (ii), or (iii) shall be subject
9 to the penalties set forth in Section 1861.14.

10 (c) The absence of prior automobile insurance coverage, in and
11 of itself, shall not be a criterion for determining eligibility for a
12 Good Driver Discount policy, or generally for automobile rates,
13 premiums, or insurability.

14 (d) An insurer may refuse to sell a Good Driver Discount policy
15 insuring a motorcycle unless all named insureds have been licensed
16 to drive a motorcycle for the previous three years.

17 (e) This section shall become operative on November 8, 1989.
18 The commissioner shall adopt regulations implementing this
19 section and insurers may submit applications pursuant to this article
20 which comply with those regulations prior to that date, provided
21 that no such application shall be approved prior to that date.

22 SEC. 9. Section 1861.025 of the Insurance Code is amended
23 to read:

24 1861.025. A person is qualified to purchase a Good Driver
25 Discount policy if he or she meets all of the following criteria:

26 (a) He or she has been licensed to drive a motor vehicle for the
27 previous three years.

28 (b) During the previous three years, he or she has not done any
29 of the following:

30 (1) Had more than one violation point count determined as
31 provided by subdivision (a), (b), (c), (d), (f), or (j) of, or paragraph
32 (1) of subdivision (i) of, ~~of~~ Section 12810 of the Vehicle Code,
33 but subject to the following modifications:

34 (A) For the purposes of this section, the driver of a motor vehicle
35 involved in an accident for which he or she was principally at fault
36 that resulted only in damage to property shall receive one violation
37 point count, in addition to any other violation points that may be
38 imposed for this accident.

39 (B) If, under Section 488 or 488.5, an insurer is prohibited from
40 increasing the premium on a policy on account of a violation, that

1 violation shall not be included in determining the point count of
2 the person.

3 (C) If a violation is required to be reported under Section 1816
4 of the Vehicle Code, or under Section 784 of the Welfare and
5 Institutions Code, or any other provision requiring the reporting
6 of a violation by a minor, the violation shall be included for the
7 purposes of this section in determining the point count in the same
8 manner as is applicable to adult violations.

9 (2) Had more than one dismissal pursuant to Section 1803.5 of
10 the Vehicle Code that was not made confidential pursuant to
11 Section 1808.7 of the Vehicle Code, in the 36-month period for
12 violations that would have resulted in the imposition of more than
13 one violation point count under paragraph (1) if the complaint had
14 not been dismissed.

15 (3) Was the driver of a motor vehicle involved in an accident
16 that resulted in bodily injury or in the death of any person and was
17 principally at fault. The commissioner shall adopt regulations
18 setting guidelines to be used by insurers for the determination of
19 fault for the purposes of this paragraph and paragraph (1).

20 (c) During the period commencing on January 1, 1999, or the
21 date 10 years prior to the date of application for the issuance or
22 renewal of the Good Driver Discount policy, whichever is later,
23 and ending on the date of the application for the issuance or
24 renewal of the Good Driver Discount policy, he or she has not
25 been convicted of a violation of Section 23140, 23152, or 23153
26 of the Vehicle Code, a felony violation of Section 23550 or 23566,
27 or former Section 23175 or, as those sections read on January 1,
28 1999, of the Vehicle Code, or a violation of Section 191.5 or
29 subdivision (a) of Section 192.5 of the Penal Code.

30 (d) Any person who claims that he or she meets the criteria of
31 subdivisions (a), (b), and (c) based entirely or partially on a driver's
32 license and driving experience acquired anywhere other than in
33 the United States or Canada is rebuttably presumed to be qualified
34 to purchase a Good Driver Discount policy if he or she has been
35 licensed to drive in the United States or Canada for at least the
36 previous 18 months and meets the criteria of subdivisions (a), (b),
37 and (c) for that period.

38 SEC. 10. Section 10111.2 of the Insurance Code is amended
39 to read:

1 10111.2. (a) Under a policy of disability insurance other than
2 health insurance, as defined in Section 106, including a policy of
3 disability income insurance, as defined in subdivision (i) of Section
4 799.01, payment of benefits to the insured shall be made within
5 30 calendar days after the insurer has received all information
6 needed to determine liability for a claim. However, the
7 30-calendar-day period shall not include any time during which
8 the insurer is doing any of the following:

9 (1) Awaiting a response for relevant medical information from
10 a health care provider.

11 (2) Awaiting a response from the claimant to a request for
12 additional relevant information.

13 (3) Investigating possible fraud that has been reported to the
14 department's Fraud Division in compliance with subdivision (a)
15 of Section 1872.4.

16 (b) If the insurer has not received all information needed to
17 determine liability for a claim within 30 calendar days after receipt
18 of the claim, the insurer shall notify the insured in writing and
19 include a written list of all information it reasonably needs to
20 determine liability for the claim. In that event, the 30-calendar-day
21 period set out in subdivision (a) shall commence when the insured
22 has provided to the insurer all information in that notification. If
23 no notice is sent by the insurer within 30 calendar days after the
24 claim is filed by the insured, interest shall begin to accrue on the
25 payment of benefits on the 31st calendar day after receipt of the
26 claim, at the rate of 10 percent per year.

27 (c) When the insurer has received all information needed to
28 determine liability for a claim, and the insurer determines that
29 liability exists and fails to make payment of benefits to the insured
30 within 30 calendar days after the insurer has received that
31 information, any delayed payment shall bear interest, beginning
32 the 31st calendar day, at the rate of 10 percent per year. Liability
33 shall, in all cases, be determined by the insurer within 30 calendar
34 days of receiving all information set out in the insurer's written
35 notification to the insured.

36 (d) Nothing in this section is intended to restrict any other
37 remedies available to an insured by statute or any other law.

38 SEC. 11. Section 10127.13 of the Insurance Code, as added
39 by Section 8 of Chapter 166 of the Statutes of 2014, is amended
40 to read:

1 10127.13. (a) All individual life insurance policies and
2 individual annuity contracts for senior citizens that contain a charge
3 upon surrender, partial surrender, excess withdrawal, or penalties
4 upon surrender shall contain a notice disclosing the location of all
5 of the following: the charge, the charge time period, the charge
6 information, and any associated penalty information. The notice
7 shall be in bold 12-point ~~print~~ *type* on the front of the policy jacket
8 or on the cover page of the policy.

9 (b) A policy shall have just one cover page. If the notice required
10 by this section and the statutorily required right to examine notice
11 are both on the cover page, as opposed to the front cover of the
12 policy jacket, they shall appear on the same page.

13 (c) General references to “policy” in this section refer to both
14 life insurance policies and annuity contracts.

15 (d) This section shall become operative on July 1, 2015.

16 SEC. 12. Section 10169 of the Insurance Code, as added by
17 Section 8 of Chapter 872 of the Statutes of 2012, is amended to
18 read:

19 10169. (a) Commencing January 1, 2001, there is hereby
20 established in the department the Independent Medical Review
21 System.

22 (b) For the purposes of this chapter, “disputed health care
23 service” means any health care service eligible for coverage and
24 payment under a disability insurance contract that has been denied,
25 modified, or delayed by a decision of the insurer, or by one of its
26 contracting providers, in whole or in part due to a finding that the
27 service is not medically necessary. A decision regarding a disputed
28 health care service relates to the practice of medicine and is not a
29 coverage decision. A disputed health care service does not include
30 services provided by a group or individual policy of vision-only
31 or dental-only coverage, except to the extent that (1) the service
32 involves the practice of medicine, or (2) is provided pursuant to a
33 contract with a disability insurer that covers hospital, medical, or
34 surgical benefits. If an insurer, or one of its contracting providers,
35 issues a decision denying, modifying, or delaying health care
36 services, based in whole or in part on a finding that the proposed
37 health care services are not a covered benefit under the contract
38 that applies to the insured, the statement of decision shall clearly
39 specify the provision in the contract that excludes that coverage.

1 (c) For the purposes of this chapter, “coverage decision” means
2 the approval or denial of health care services by a disability insurer,
3 or by one of its contracting entities, substantially based on a finding
4 that the provision of a particular service is included or excluded
5 as a covered benefit under the terms and conditions of the disability
6 insurance contract. A coverage decision does not encompass a
7 disability insurer or contracting provider decision regarding a
8 disputed health care service.

9 (d) (1) All insured grievances involving a disputed health care
10 service are eligible for review under the Independent Medical
11 Review System if the requirements of this article are met. If the
12 department finds that an insured grievance involving a disputed
13 health care service does not meet the requirements of this article
14 for review under the Independent Medical Review System, the
15 insured request for review shall be treated as a request for the
16 department to review the grievance. All other insured grievances,
17 including grievances involving coverage decisions, remain eligible
18 for review by the department.

19 (2) In any case in which an insured or provider asserts that a
20 decision to deny, modify, or delay health care services was based,
21 in whole or in part, on consideration of medical necessity, the
22 department shall have the final authority to determine whether the
23 grievance is more properly resolved pursuant to an independent
24 medical review as provided under this article.

25 (3) The department shall be the final arbiter when there is a
26 question as to whether an insured grievance is a disputed health
27 care service or a coverage decision. The department shall establish
28 a process to complete an initial screening of an insured grievance.
29 If there appears to be any medical necessity issue, the grievance
30 shall be resolved pursuant to an independent medical review as
31 provided under this article.

32 (e) Every disability insurance contract that is issued, amended,
33 renewed, or delivered in this state on or after January 1, 2000, shall
34 provide an insured with the opportunity to seek an independent
35 medical review whenever health care services have been denied,
36 modified, or delayed by the insurer, or by one of its contracting
37 providers, if the decision was based in whole or in part on a finding
38 that the proposed health care services are not medically necessary.
39 For purposes of this article, an insured may designate an agent to
40 act on his or her behalf. The provider may join with or otherwise

1 assist the insured in seeking an independent medical review, and
2 may advocate on behalf of the insured.

3 (f) Medicare beneficiaries enrolled in Medicare + Choice
4 products shall not be excluded unless expressly preempted by
5 federal law.

6 (g) The department may seek to integrate the quality of care
7 and consumer protection provisions, including remedies, of the
8 Independent Medical Review System with related dispute
9 resolution procedures of other health care agency programs,
10 including the Medicare program, in a way that minimizes the
11 potential for duplication, conflict, and added costs. Nothing in this
12 subdivision shall be construed to limit any rights conferred upon
13 insureds under this chapter.

14 (h) The independent medical review process authorized by this
15 article is in addition to any other procedures or remedies that may
16 be available.

17 (i) Every disability insurer shall prominently display in every
18 insurer member handbook or relevant informational brochure, in
19 every insurance contract, on insured evidence of coverage forms,
20 on copies of insurer procedures for resolving grievances, on letters
21 of denials issued by either the insurer or its contracting
22 organization, and on all written responses to grievances,
23 information concerning the right of an insured to request an
24 independent medical review when the insured believes that health
25 care services have been improperly denied, modified, or delayed
26 by the insurer, or by one of its contracting providers. The
27 department's telephone number, 1-800-927-4357, and Internet
28 Web site, www.insurance.ca.gov, shall also be displayed.

29 (j) An insured may apply to the department for an independent
30 medical review when all of the following conditions are met:

31 (1) (A) The insured's provider has recommended a health care
32 service as medically necessary, or

33 (B) The insured has received urgent care or emergency services
34 that a provider determined was medically necessary, or

35 (C) The insured, in the absence of a provider recommendation
36 under subparagraph (A) or the receipt of urgent care or emergency
37 services by a provider under subparagraph (B), has been seen by
38 a contracting provider for the diagnosis or treatment of the medical
39 condition for which the insured seeks independent review. The
40 insurer shall expedite access to a contracting provider upon request

1 of an insured. The contracting provider need not recommend the
2 disputed health care service as a condition for the insured to be
3 eligible for an independent review.

4 For purposes of this article, the insured's provider may be a
5 noncontracting provider. However, the insurer shall have no
6 liability for payment of services provided by a noncontracting
7 provider, except as provided pursuant to Section 10169.3.

8 (2) The disputed health care service has been denied, modified,
9 or delayed by the insurer, or by one of its contracting providers,
10 based in whole or in part on a decision that the health care service
11 is not medically necessary.

12 (3) The insured has filed a grievance with the insurer or its
13 contracting provider, and the disputed decision is upheld or the
14 grievance remains unresolved after 30 days. The insured shall not
15 be required to participate in the insurer's grievance process for
16 more than 30 days. In the case of a grievance that requires
17 expedited review, the insured shall not be required to participate
18 in the insurer's grievance process for more than three days.

19 (k) An insured may apply to the department for an independent
20 medical review of a decision to deny, modify, or delay health care
21 services, based in whole or in part on a finding that the disputed
22 health care services are not medically necessary, within six months
23 of any of the qualifying periods or events under subdivision (j).
24 The commissioner may extend the application deadline beyond
25 six months if the circumstances of a case warrant the extension.

26 (l) The insured shall pay no application or processing fees of
27 any kind.

28 (m) As part of its notification to the insured regarding a
29 disposition of the insured's grievance that denies, modifies, or
30 delays health care services, the insurer shall provide the insured
31 with a one- or two-page application form approved by the
32 department, and an addressed envelope, which the insured may
33 return to initiate an independent medical review. The insurer shall
34 include on the form any information required by the department
35 to facilitate the completion of the independent medical review,
36 such as the insured's diagnosis or condition, the nature of the
37 disputed health care service sought by the insured, a means to
38 identify the insured's case, and any other material information.
39 The form shall also include the following:

1 (1) Notice that a decision not to participate in the independent
2 review process may cause the insured to forfeit any statutory right
3 to pursue legal action against the insurer regarding the disputed
4 health care service.

5 (2) A statement indicating the insured's consent to obtain any
6 necessary medical records from the insurer, any of its contracting
7 providers, and any noncontracting provider the insured may have
8 consulted on the matter, to be signed by the insured.

9 (3) Notice of the insured's right to provide information or
10 documentation, either directly or through the insured's provider,
11 regarding any of the following:

12 (A) A provider recommendation indicating that the disputed
13 health care service is medically necessary for the insured's medical
14 condition.

15 (B) Medical information or justification that a disputed health
16 care service, on an urgent care or emergency basis, was medically
17 necessary for the insured's medical condition.

18 (C) Reasonable information supporting the insured's position
19 that the disputed health care service is or was medically necessary
20 for the insured's medical condition, including all information
21 provided to the insured by the insurer or any of its contracting
22 providers, still in the possession of the insured, concerning an
23 insurer or provider decision regarding disputed health care services,
24 and a copy of any materials the insured submitted to the insurer,
25 still in the possession of the insured, in support of the grievance,
26 as well as any additional material that the insured believes is
27 relevant.

28 (4) A section designed to collect information on the insured's
29 ethnicity, race, and primary language spoken that includes both of
30 the following:

31 (A) A statement of intent indicating that the information is used
32 for statistics only, in order to ensure that all insureds get the best
33 care possible.

34 (B) A statement indicating that providing this information is
35 optional and will not affect the independent medical review process
36 in any way.

37 (n) Upon notice from the department that the insured has applied
38 for an independent medical review, the insurer or its contracting
39 providers, shall provide to the independent medical review
40 organization designated by the department a copy of all of the

1 following documents within three business days of the insurer's
2 receipt of the department's notice of a request by an insured for
3 an independent review:

4 (1) (A) A copy of all of the insured's medical records in the
5 possession of the insurer or its contracting providers relevant to
6 each of the following:

7 (i) The insured's medical condition.

8 (ii) The health care services being provided by the insurer and
9 its contracting providers for the condition.

10 (iii) The disputed health care services requested by the insured
11 for the condition.

12 (B) Any newly developed or discovered relevant medical records
13 in the possession of the insurer or its contracting providers after
14 the initial documents are provided to the independent medical
15 review organization shall be forwarded immediately to the
16 independent medical review organization. The insurer shall
17 concurrently provide a copy of medical records required by this
18 subparagraph to the insured or the insured's provider, if authorized
19 by the insured, unless the offer of medical records is declined or
20 otherwise prohibited by law. The confidentiality of all medical
21 record information shall be maintained pursuant to applicable state
22 and federal laws.

23 (2) A copy of all information provided to the insured by the
24 insurer and any of its contracting providers concerning insurer and
25 provider decisions regarding the insured's condition and care, and
26 a copy of any materials the insured or the insured's provider
27 submitted to the insurer and to the insurer's contracting providers
28 in support of the insured's request for disputed health care services.
29 This documentation shall include the written response to the
30 insured's grievance. The confidentiality of any insured medical
31 information shall be maintained pursuant to applicable state and
32 federal laws.

33 (3) A copy of any other relevant documents or information used
34 by the insurer or its contracting providers in determining whether
35 disputed health care services should have been provided, and any
36 statements by the insurer and its contracting providers explaining
37 the reasons for the decision to deny, modify, or delay disputed
38 health care services on the basis of medical necessity. The insurer
39 shall concurrently provide a copy of documents required by this
40 paragraph, except for any information found by the commissioner

1 to be legally privileged information, to the insured and the insured’s
2 provider. The department and the independent medical review
3 organization shall maintain the confidentiality of any information
4 found by the commissioner to be the proprietary information of
5 the insurer.

6 (o) This section shall become operative on July 1, 2015.

7 SEC. 13. Section 10192.18 of the Insurance Code is amended
8 to read:

9 10192.18. (a) Application forms shall include the following
10 questions designed to elicit information as to whether, as of the
11 date of the application, the applicant currently has Medicare
12 supplement, Medicare Advantage, Medi-Cal coverage, or another
13 health insurance policy or certificate in force or whether a Medicare
14 supplement policy or certificate is intended to replace any other
15 disability policy or certificate presently in force. A supplementary
16 application or other form to be signed by the applicant and agent
17 containing those questions and statements may be used.

18
19 (Statements)

20
21 (1) You do not need more than one Medicare supplement policy.

22 (2) If you purchase this policy, you may want to evaluate your
23 existing health coverage and decide if you need multiple coverages.

24 (3) You may be eligible for benefits under Medi-Cal and may
25 not need a Medicare supplement policy.

26 (4) If after purchasing this policy you become eligible for
27 Medi-Cal, the benefits and premiums under your Medicare
28 supplement policy can be suspended, if requested, during your
29 entitlement to benefits under Medi-Cal for 24 months. You must
30 request this suspension within 90 days of becoming eligible for
31 Medi-Cal. If you are no longer entitled to Medi-Cal, your
32 suspended Medicare supplement policy or if that is no longer
33 available, a substantially equivalent policy, will be reinstated if
34 requested within 90 days of losing Medi-Cal eligibility. If the
35 Medicare supplement policy provided coverage for outpatient
36 prescription drugs and you enrolled in Medicare Part D while your
37 policy was suspended, the reinstated policy will not have
38 outpatient prescription drug coverage, but will otherwise be
39 substantially equivalent to your coverage before the date of the
40 suspension.

1 (5) If you are eligible for, and have enrolled in, a Medicare
2 supplement policy by reason of disability and you later become
3 covered by an employer or union-based group health plan, the
4 benefits and premiums under your Medicare supplement policy
5 can be suspended, if requested, while you are covered under the
6 employer or union-based group health plan. If you suspend your
7 Medicare supplement policy under these circumstances and later
8 lose your employer or union-based group health plan, your
9 suspended Medicare supplement policy or if that is no longer
10 available, a substantially equivalent policy, will be reinstated if
11 requested within 90 days of losing your employer or union-based
12 group health plan. If the Medicare supplement policy provided
13 coverage for outpatient prescription drugs and you enrolled in
14 Medicare Part D while your policy was suspended, the reinstated
15 policy will not have outpatient prescription drug coverage, but will
16 otherwise be substantially equivalent to your coverage before the
17 date of the suspension.

18 (6) Counseling services are available in this state to provide
19 advice concerning your purchase of Medicare supplement insurance
20 and concerning medical assistance through the Medi-Cal program,
21 including benefits as a qualified Medicare beneficiary (QMB) and
22 a specified low-income Medicare beneficiary (SLMB). If you want
23 to discuss buying Medicare supplement insurance with a trained
24 insurance counselor, call the California Department of Insurance's
25 toll-free telephone number 1-800-927-HELP, or access the
26 department's Internet Web site, www.insurance.ca.gov, and ask
27 how to contact your local Health Insurance Counseling and
28 Advocacy Program (HICAP) office. HICAP is a service provided
29 free of charge by the State of California.

30

31

(Questions)

32

33 If you lost or are losing other health insurance coverage and
34 received a notice from your prior insurer saying you were eligible
35 for guaranteed issue of a Medicare supplement insurance policy
36 or that you had certain rights to buy such a policy, you may be
37 guaranteed acceptance in one or more of our Medicare supplement
38 plans. Please include a copy of the notice from your prior insurer
39 with your application. PLEASE ANSWER ALL QUESTIONS.

40

[Please mark Yes or No below with an "X."]

- 1 To the best of your knowledge,
- 2 (1) (a) Did you turn 65 years of age in the last 6 months
- 3 Yes___ No___
- 4 (b) Did you enroll in Medicare Part B in the last 6 months
- 5 Yes___ No___
- 6 (c) If yes, what is the effective date _____
- 7 (2) Are you covered for medical assistance through California’s
- 8 Medi-Cal program
- 9 NOTE TO APPLICANT: If you have a share of cost under the
- 10 Medi-Cal program, please answer NO to this question.
- 11 Yes___ No___
- 12 If yes,
- 13 (a) Will Medi-Cal pay your premiums for this Medicare
- 14 supplement policy
- 15 Yes___ No___
- 16 (b) Do you receive benefits from Medi-Cal OTHER THAN
- 17 payments toward your Medicare Part B premium
- 18 Yes___ No___
- 19 (3) (a) If you had coverage from any Medicare plan other than
- 20 original Medicare within the past 63 days (for example, a Medicare
- 21 Advantage plan or a Medicare HMO or PPO), fill in your start and
- 22 end dates below. If you are still covered under this plan, leave
- 23 “END” blank.
- 24 START __/__/__ END __/__/__
- 25 (b) If you are still covered under the Medicare plan, do you
- 26 intend to replace your current coverage with this new Medicare
- 27 supplement policy
- 28 Yes___ No___
- 29 (c) Was this your first time in this type of Medicare plan
- 30 Yes___ No___
- 31 (d) Did you drop a Medicare supplement policy to enroll in the
- 32 Medicare plan
- 33 Yes___ No___
- 34 (4) (a) Do you have another Medicare supplement policy in
- 35 force
- 36 Yes___ No___
- 37 (b) If so, with what company, and what plan do you have
- 38 [optional for direct mailers]
- 39 Yes___ No___

1 (c) If so, do you intend to replace your current Medicare
2 supplement policy with this policy

3 Yes ___ No ___

4 (5) Have you had coverage under any other health insurance
5 within the past 63 days (For example, an employer, union, or
6 individual plan)

7 Yes ___ No ___

8 (a) If so, with what companies and what kind of policy

9 _____

10 _____

11 _____

12 _____

13 (b) What are your dates of coverage under the other policy

14 START ___/___/___ END ___/___/___

15 (If you are still covered under the other policy, leave “END”
16 blank.)

17
18 (b) Agents shall list any other health insurance policies they
19 have sold to the applicant as follows:

20 (1) List policies sold that are still in force.

21 (2) List policies sold in the past five years that are no longer in
22 force.

23 (c) In the case of a direct response issuer, a copy of the
24 application or supplemental form, signed by the applicant, and
25 acknowledged by the issuer, shall be returned to the applicant by
26 the issuer upon delivery of the policy.

27 (d) Upon determining that a sale will involve replacement of
28 Medicare supplement coverage, any issuer, other than a direct
29 response issuer, or its agent, shall furnish the applicant, prior to
30 issuance for delivery of the Medicare supplement policy or
31 certificate, a notice regarding replacement of Medicare supplement
32 coverage. One copy of the notice signed by the applicant and the
33 agent, except where the coverage is sold without an agent, shall
34 be provided to the applicant and an additional signed copy shall
35 be retained by the issuer as provided in Section 10508. A direct
36 response issuer shall deliver to the applicant at the time of the
37 issuance of the policy the notice regarding replacement of Medicare
38 supplement coverage.

39 (e) The notice required by subdivision (d) for an issuer shall be
40 in the form specified by the commissioner, using, to the extent

1 practicable, a model notice prepared by the National Association
2 of Insurance Commissioners for this purpose. The replacement
3 notice shall be printed in no less than 12-point type in substantially
4 the following form:

5
6 [Insurer’s name and address]

7
8 NOTICE TO APPLICANT REGARDING REPLACEMENT
9 OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE
10 ADVANTAGE

11
12 SAVE THIS NOTICE! IT MAY BE IMPORTANT IN THE
13 FUTURE.

14 If you intend to cancel or terminate existing Medicare supplement
15 or Medicare Advantage insurance and replace it with coverage
16 issued by [company name], please review the new coverage
17 carefully and replace the existing coverage ONLY if the new
18 coverage materially improves your position. DO NOT CANCEL
19 YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED
20 YOUR NEW POLICY AND ARE SURE THAT YOU WANT
21 TO KEEP IT.

22 If you decide to purchase the new coverage, you will have 30
23 days after you receive the policy to return it to the insurer, for any
24 reason, and receive a refund of your money.

25 If you want to discuss buying Medicare supplement or Medicare
26 Advantage coverage with a trained insurance counselor, call the
27 California Department of Insurance’s toll-free telephone number
28 1-800-927-HELP, and ask how to contact your local Health
29 Insurance Counseling and Advocacy Program (HICAP) office.
30 HICAP is a service provided free of charge by the State of
31 California.

32 STATEMENT TO APPLICANT FROM THE INSURER AND
33 AGENT: I have reviewed your current health insurance coverage.
34 To the best of my knowledge, the replacement of insurance
35 involved in this transaction does not duplicate coverage or, if
36 applicable, Medicare Advantage coverage because you intend to
37 terminate your existing Medicare supplement coverage or leave
38 your Medicare Advantage plan. In addition, the replacement
39 coverage contains benefits that are clearly and substantially greater
40 than your current benefits for the following reasons:

- 1 ___ Additional benefits that are: _____
- 2 ___ No change in benefits, but lower premiums.
- 3 ___ Fewer benefits and lower premiums.
- 4 ___ Plan has outpatient prescription drug coverage and applicant
- 5 is enrolled in Medicare Part D.
- 6 ___ Disenrollment from a Medicare Advantage plan. Reasons for
- 7 disenrollment:
- 8 ___ Other reasons specified here: _____

9 1. Note: If the issuer of the Medicare supplement policy being
 10 applied for does not impose, or is otherwise prohibited from
 11 imposing, preexisting condition limitations, please skip to statement
 12 3 below. Health conditions that you may presently have
 13 (preexisting conditions) may not be immediately or fully covered
 14 under the new policy. This could result in denial or delay of a claim
 15 for benefits under the new policy, whereas a similar claim might
 16 have been payable under your present policy.

17 2. State law provides that your replacement Medicare supplement
 18 policy may not contain new preexisting conditions, waiting periods,
 19 elimination periods, or probationary periods. The insurer will waive
 20 any time periods applicable to preexisting conditions, waiting
 21 periods, elimination periods, or probationary periods in the new
 22 coverage for similar benefits to the extent that time was spent
 23 (depleted) under the original policy.

24 3. If you still wish to terminate your present policy and replace
 25 it with new coverage, be certain to truthfully and completely
 26 answer any and all questions on the application concerning your
 27 medical and health history. Failure to include all material medical
 28 information on an application requesting that information may
 29 provide a basis for the insurer to deny any future claims and to
 30 refund your premium as though your policy had never been in
 31 force. After the application has been completed and before you
 32 sign it, review it carefully to be certain that all information has
 33 been properly recorded. [If the policy or certificate is guaranteed
 34 issue, this paragraph need not appear.]

35 **DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU**
 36 **HAVE RECEIVED YOUR NEW POLICY AND ARE SURE**
 37 **THAT YOU WANT TO KEEP IT.**

38
 39 _____
 40 (Signature of Agent, Broker, or Other Representative)

1 _____
2 (Signature of Applicant)

3 _____
4 (Date)

5
6 (f) No issuer, broker, agent, or other person shall cause an
7 insured to replace a Medicare supplement insurance policy
8 unnecessarily. In recommending replacement of any Medicare
9 supplement insurance, an agent shall make reasonable efforts to
10 determine the appropriateness to the potential insured.

11 (g) An issuer shall not require, request, or obtain health
12 information as part of the application process for an applicant who
13 is eligible for guaranteed issuance of, or open enrollment for, any
14 Medicare supplement coverage pursuant to Section 10192.11 or
15 10192.12, except for purposes of paragraph (1) or (2) of subdivision
16 (a) of Section 10192.11 when the applicant is first enrolled in
17 Medicare Part B. The application form shall include a clear and
18 conspicuous statement that the applicant is not required to provide
19 health information during a period where guaranteed issue or open
20 enrollment applies, as specified in Section 10192.11 or 10192.12,
21 except for purposes of paragraph (1) or (2) of subdivision (a) of
22 Section 10192.11 when the applicant is first enrolled in Medicare
23 Part B, and shall inform the applicant of those periods of
24 guaranteed issuance of Medicare supplement coverage. This
25 subdivision shall not prohibit an issuer from requiring proof of
26 eligibility for a guaranteed issuance of Medicare supplement
27 coverage.

28 SEC. 14. Section 10232.3 of the Insurance Code is amended
29 to read:

30 10232.3. (a) All applications for long-term care insurance
31 except that which is guaranteed issue, shall contain clear,
32 unambiguous, short, simple questions designed to ascertain the
33 health condition of the applicant. Each question shall contain only
34 one health status inquiry and shall require only a “yes” or “no”
35 answer, except that the application may include a request for the
36 name of any prescribed medication and the name of a prescribing
37 physician. If the application requests the name of any prescribed
38 medication or prescribing physician, then any mistake or omission
39 shall not be used as a basis for the denial of a claim or the
40 rescission of a policy or certificate.

1 (b) The following warning shall be printed conspicuously and
2 in close conjunction with the applicant’s signature block:

3 “Caution: If your answers on this application are misstated or
4 untrue, the insurer may have the right to deny benefits or rescind
5 your coverage.”

6 (c) Every application for long-term care insurance shall include
7 a checklist that enumerates each of the specific documents that
8 this chapter requires be given to the applicant at the time of
9 solicitation. The documents and notices to be listed in the checklist
10 include, but are not limited to, the following:

11 (1) The outline of coverage pursuant to Section 10233.5.

12 (2) The HICAP notice pursuant to paragraph (8) of subdivision
13 (a) of Section 10234.93.

14 (3) The long-term care insurance shoppers guide pursuant to
15 paragraph (9) of subdivision (a) of Section 10234.93.

16 (4) The “Long-Term Care Insurance Personal Worksheet”
17 pursuant to subdivision (c) of Section 10234.95.

18 (5) The “Notice to Applicant Regarding Replacement of
19 Accident and Sickness or Long-Term Care Insurance” pursuant
20 to Section 10235.16 if replacement is not made by direct response
21 solicitation or Section 10235.18 if replacement is made by direct
22 response solicitation. Unless the solicitation was made by a direct
23 response method, the agent and applicant shall both sign at the
24 bottom of the checklist to indicate the required documents were
25 delivered and received.

26 (d) If an insurer does not complete medical underwriting and
27 resolve all reasonable questions arising from information submitted
28 on or with an application before issuing the policy or certificate,
29 then the insurer may only rescind the policy or certificate or deny
30 an otherwise valid claim, upon clear and convincing evidence of
31 fraud or material misrepresentation of the risk by the applicant.
32 The evidence shall:

33 (1) Pertain to the condition for which benefits are sought.

34 (2) Involve a chronic condition or involve dates of treatment
35 before the date of application.

36 (3) Be material to the acceptance for coverage.

37 (e) No long-term care policy or certificate may be field issued.

38 (f) The contestability period as defined in Section 10350.2 for
39 long-term care insurance shall be two years.

1 (g) A copy of the completed application shall be delivered to
2 the insured at the time of delivery of the policy or certificate.

3 (h) Every insurer shall maintain a record, in accordance with
4 Section 10508, of all policy or certificate rescissions, both state
5 and countrywide, and shall annually furnish this information to
6 the commissioner, which shall include the reason for rescission,
7 the length of time the policy or certificate was in force, and the
8 age and gender of the insured person, in a format prescribed by
9 the commissioner.

10 (i) The commissioner may, in his or her discretion, make public
11 the aggregate data collected under subdivision (h), upon request.

12 SEC. 15. Section 10233.5 of the Insurance Code is amended
13 to read:

14 10233.5. (a) An outline of coverage shall be delivered to a
15 prospective applicant for long-term care insurance at the time of
16 initial solicitation through means which prominently direct the
17 attention of the recipient to the document and its purpose.

18 (b) In the case of agent solicitations, an agent shall deliver the
19 outline of coverage prior to the presentation of an application or
20 enrollment form.

21 (c) In the case of direct response solicitations, the outline of
22 coverage shall be presented in conjunction with any application
23 or enrollment form.

24 (d) The outline of coverage shall be a freestanding document,
25 using no smaller than 10-point type.

26 (e) The outline of coverage shall contain no material of an
27 advertising nature.

28 (f) Use of the text and sequence of the text of the outline of
29 coverage set forth in this section is mandatory, unless otherwise
30 specifically indicated.

31 (g) Text that is capitalized or underscored in the outline of
32 coverage may be emphasized by other means that provide
33 prominence equivalent to capitalization or underscoring.

34 (h) The outline of coverage shall be in the following form:

35
36 (COMPANY—(COMPANY NAME)
37 (ADDRESS—CITY AND STATE)
38 (TELEPHONE NUMBER)
39 LONG-TERM CARE INSURANCE
40 OUTLINE OF COVERAGE

1 (Policy Number or Group Master Policy and Certificate Number)

2

3 1. This policy is (an individual policy of insurance) ((a group
4 policy) which was issued in the (indicate jurisdiction in which
5 group policy was issued)).

6 2. PURPOSE OF OUTLINE OF COVERAGE. This outline
7 of coverage provides a very brief description of the important
8 features of the policy. You should compare this outline of coverage
9 to outlines of coverage for other policies available to you. This is
10 not an insurance contract, but only a summary of coverage. Only
11 the individual or group policy contains governing contractual
12 provisions. This means that the policy or group policy sets forth
13 in detail the rights and obligations of both you and the insurance
14 company. Therefore, if you purchase this coverage, or any other
15 coverage, it is important that you READ YOUR POLICY (OR
16 CERTIFICATE) CAREFULLY!

17 3. TERMS UNDER WHICH THE POLICY OR
18 CERTIFICATE MAY BE RETURNED AND PREMIUM
19 REFUNDED.

20 (a) Provide a brief description of the right to return—“free look”
21 provision of the policy.

22 (b) Include a statement that the policy either does or does not
23 contain provisions providing for a refund or partial refund of
24 premium upon the death of an insured or surrender of the policy
25 or certificate. If the policy contains those provisions, include a
26 description of them.

27 4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.
28 If you are eligible for Medicare, review the Medicare Supplement
29 Buyer’s Guide available from the insurance company.

30 (a) (For agents) Neither (insert company name) nor its agents
31 represent Medicare, the federal government or any state
32 government.

33 (b) (For direct response) (insert company name) is not
34 representing Medicare, the federal government or any state
35 government.

36 5. LONG-TERM CARE COVERAGE. Policies of this category
37 are designed to provide coverage for one or more necessary or
38 medically necessary diagnostic, preventive, therapeutic,
39 rehabilitative, maintenance, or personal care services, provided in

1 a setting other than an acute care unit of a hospital, such as in a
2 nursing home, in the community, or in the home.

3 This policy provides coverage in the form of a fixed dollar
4 indemnity benefit for covered long-term care expenses, subject to
5 policy (limitations) (waiting periods) and (coinsurance)
6 requirements. (Modify this paragraph if the policy is not an
7 indemnity policy.)

8 **6. BENEFITS PROVIDED BY THIS POLICY.**

9 (a) (Covered services, related deductible(s), waiting periods,
10 elimination periods, and benefit maximums.)

11 (b) (Institutional benefits, by skill level.)

12 (c) (Noninstitutional benefits, by skill level.)

13 (Any benefit screens must be explained in this section. If these
14 screens differ for different benefits, explanation of the screen
15 should accompany each benefit description. If an attending
16 physician or other specified person must certify a certain level of
17 functional dependency in order to be eligible for benefits, this too
18 must be specified. If activities of daily living (ADLs) are used to
19 measure an insured's need for long-term care, then these qualifying
20 criteria or screens must be explained.)

21 **7. LIMITATIONS AND EXCLUSIONS.**

22 (Describe:

23 (a) Preexisting conditions.

24 (b) Noneligible facilities/provider.

25 (c) Noneligible levels of care (e.g., unlicensed providers, care
26 or treatments provided by a family member, etc.).

27 (d) Exclusions/exceptions.

28 (e) Limitations.)

29 (This section should provide a brief specific description of any
30 policy provisions which limit, exclude, restrict, reduce, delay, or
31 in any other manner operate to qualify payment of the benefits
32 described in (6) above.)

33 **THIS POLICY MAY NOT COVER ALL THE EXPENSES
34 ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.**

35 **8. RELATIONSHIP OF COST OF CARE AND BENEFITS.**

36 Because the costs of long-term care services will likely increase
37 over time, you should consider whether and how the benefits of
38 this plan may be adjusted. (As applicable, indicate the following:

39 (a) That the benefit level will NOT increase over time.

40 (b) Any automatic benefit adjustment provisions.

1 (c) Whether the insured will be guaranteed the option to buy
2 additional benefits and the basis upon which benefits will be
3 increased over time if not by a specified amount or percentage.

4 (d) If there is a guarantee, include whether additional
5 underwriting or health screening will be required, the frequency
6 and amounts of the upgrade options, and any significant restrictions
7 or limitations.

8 (e) And finally, describe whether there will be any additional
9 premium charge imposed, and how that is to be calculated.)

10 9. TERMS UNDER WHICH THE POLICY (OR
11 CERTIFICATE) MAY BE CONTINUED IN FORCE OR
12 DISCONTINUED.

13 (a) Describe the policy renewability provisions.

14 (b) For group coverage, specifically describe
15 continuation/conversion provisions applicable to the certificate
16 and group policy.

17 (c) Describe waiver of premium provisions or state that there
18 are no waiver of premium provisions.

19 (d) State whether or not the company has a right to change
20 premium, and if that right exists, describe clearly and concisely
21 each circumstance under which the premium may change.

22 10. ALL MENTAL ILLNESSES COVERED.

23 (State that the policy provides coverage for insureds for all
24 mental illnesses. Specifically describe each benefit screen or other
25 policy provision that provides preconditions to the availability of
26 policy benefits for that insured.)

27 11. PREMIUM.

28 (a) State the total annual premium for the policy.

29 (b) If the premium varies with an applicant's choice among
30 benefit options, indicate the portion of annual premium which
31 corresponds to each benefit option.

32 12. ADDITIONAL FEATURES.

33 (a) Indicate if medical underwriting is used.

34 (b) Describe other important features.

35 13. INFORMATION AND COUNSELING. The California
36 Department of Insurance has prepared a Consumer Guide to
37 Long-Term Care Insurance. This guide can be obtained by calling
38 the Department of Insurance toll-free telephone number or by
39 accessing the department's Internet Web site at
40 www.insurance.ca.gov. The department's number is

1 1-800-927-HELP. Additionally, the Health Insurance Counseling
2 and Advocacy Program (HICAP) administered by the California
3 Department of Aging, provides long-term care insurance counseling
4 to California senior citizens. Call the HICAP toll-free telephone
5 number 1-800-434-0222 for a referral to your local HICAP office.”

6 SEC. 16. Section 10233.9 of the Insurance Code is repealed.

7 SEC. 17. Section 10235.35 of the Insurance Code is amended
8 to read:

9 10235.35. (a) Notwithstanding any other provision of law, the
10 commissioner may require the administration by an insurer of the
11 contingent benefit upon lapse, as described in Section 28 (A), (D)
12 (3), (E), (F), (G), and (J) of the Long-Term Care Insurance Model
13 Regulation promulgated by the National Association of Insurance
14 Commissioners, as adopted in September 2014, as a condition of
15 approval or acknowledgment of a rate adjustment for a block of
16 business for which the contingent benefit upon lapse is not
17 otherwise available.

18 (b) The insurer shall notify policyholders and certificate holders
19 of the contingent benefit upon lapse when required by the
20 commissioner in conjunction with the implementation of a rate
21 adjustment. The commissioner may require an insurer who files
22 for such a rate adjustment to allow policyholders and certificate
23 holders to reduce coverage pursuant to Section 10235.50 to avoid
24 an increase in the policy’s premium amount.

25 (c) The commissioner may also approve any other alternative
26 mechanism filed by the insurer in lieu of the contingent benefit
27 upon lapse.

28 SEC. 18. Section 12418.4 of the Insurance Code is amended
29 to read:

30 12418.4. (a) Sections 1667, 1668, 1669, 1670, 1729, 1729.2,
31 1738, 1738.5, 1743, and Article 6 (commencing with Section
32 12404), shall apply to all applicants or holders of a certificate of
33 registration issued pursuant to this article.

34 (b) The department may revoke, suspend, restrict, or decline to
35 issue a certificate of registration if it determines that the title
36 marketing representative or applicant has violated provisions of
37 Article 6 (commencing with Section 12404) pursuant to the due
38 process and hearing requirements set forth in subdivision (c).

39 (c) Except as provided in Section 1669, a certificate of
40 registration shall not be denied, restricted, suspended, or revoked

1 without a hearing conducted in accordance with Chapter 5
2 (commencing with Section 11500) of Part 1 of Division 3 of Title
3 2 of the Government Code.

4 (d) In addition to, or in lieu of, any other penalty that may be
5 imposed under this article against a title marketing representative,
6 the commissioner may bring an administrative action against a
7 title marketing representative for any violation of the provisions
8 of Article 6 (commencing with Section 12404). If a title marketing
9 representative charged with a violation of Article 6 (commencing
10 with Section 12404) is determined by the commissioner to have
11 committed the violation, the commissioner may require the
12 surrender of, temporarily suspend or revoke either permanently or
13 temporarily the title marketing representative's certificate of
14 registration, and, in addition, may impose a monetary penalty. Any
15 payment of a monetary penalty pursuant to a settlement or final
16 adjudication shall be made from the title marketing representative's
17 personal funds and not by his or her employer either directly or
18 through the title marketing representative. This article shall not
19 preclude an action against a company that had actual knowledge
20 of the violation by the title marketing representative. A title
21 marketing representative who is issued a certificate of registration
22 under this article may not engage in any activity that is otherwise
23 prohibited through a separate entity controlled by the title
24 marketing representative or by the company or entity that employs
25 him or her.

26 (e) A title marketing representative who has his or her certificate
27 of registration revoked by the department shall not be permitted
28 to reapply for another certificate of registration with the department
29 for five years from the date of revocation.

30 SEC. 19. Section 12820 of the Insurance Code is amended to
31 read:

32 12820. (a) Prior to offering a vehicle service contract form to
33 a purchaser or providing a vehicle service contract form to a seller,
34 an obligor shall file with the commissioner a specimen of that
35 vehicle service contract form.

36 (b) A vehicle service contract form may include any or all of
37 the benefits described in subdivision (c) of Section 12800 and shall
38 comply with all of the following requirements:

39 (1) (A) If an obligor has complied with Section 12830, the
40 vehicle service contract shall include a disclosure in substantially

1 the following form: “Performance to you under this contract is
2 guaranteed by a California approved insurance company. You may
3 file a claim with this insurance company if any promise made in
4 the contract has been denied or has not been honored within 60
5 days after your request. The name and address of the insurance
6 company is: (insert name and address). If you are not satisfied with
7 the insurance company’s response, you may contact the California
8 Department of Insurance at 1-800-927-4357 or access the
9 department’s Internet Web site (www.insurance.ca.gov).”

10 (B) If an obligor has complied with Section 12836, the vehicle
11 service contract shall include a disclosure in substantially the
12 following form: “If any promise made in the contract has been
13 denied or has not been honored within 60 days after your request,
14 you may contact the California Department of Insurance at
15 1-800-927-4357 or access the department’s Internet Web site
16 (www.insurance.ca.gov).”

17 (C) *The requirement that a vehicle service contract form include*
18 *the department’s Internet Web site shall not apply to a form for*
19 *which the department has issued a “no objection letter” as of*
20 *December 31, 2016.*

21 (2) All vehicle service contract language that excludes coverage,
22 or imposes duties upon the purchaser, shall be conspicuously
23 printed in boldface type no smaller than the surrounding type.

24 (3) The vehicle service contract shall do each of the following:

25 (A) State the obligor’s full corporate name or a fictitious name
26 approved by the commissioner, the obligor’s mailing address, the
27 obligor’s telephone number, and the obligor’s vehicle service
28 contract provider license number.

29 (B) State the name of the purchaser and the name of the seller.

30 (C) Conspicuously state the vehicle service contract’s purchase
31 price.

32 (D) Comply with Sections 1794.4 and 1794.41 of the Civil
33 Code.

34 (E) Name the administrator, if any, and provide the
35 administrator’s license number.

36 (4) If the vehicle service contract excludes coverage for
37 preexisting conditions, the contract must disclose this exclusion
38 in 12-point type.

39 (c) The following benefits constitute insurance, whether offered
40 as part of a vehicle service contract or in a separate agreement:

1 (1) Indemnification for a loss caused by misplacement, theft,
2 collision, fire, or other peril typically covered in the comprehensive
3 coverage section of an automobile insurance policy, a homeowner's
4 policy, or a marine or inland marine policy.

5 (2) Locksmith services, unless offered as part of an emergency
6 road service benefit.

7 SEC. 20. Section 12921 of the Insurance Code is amended to
8 read:

9 12921. (a) The commissioner shall perform all duties imposed
10 upon him or her by the provisions of this code and other laws
11 regulating the business of insurance in this state, and shall enforce
12 the execution of those provisions and laws.

13 (b) In an administrative action to enforce the provisions of this
14 code and other laws regulating the business of insurance in this
15 state, any settlement is subject to all of the following:

16 (1) The commissioner may delegate the power to negotiate the
17 terms and conditions of a settlement. The commissioner may
18 delegate the power to approve a settlement, unless the settlement
19 involves any of the following:

20 (A) An insurer.

21 (B) A managing general agent or production agent that manages
22 the business of an insurer.

23 (C) A title company.

24 (D) A home protection company.

25 (E) An insurance adjuster whose claims practices are at issue.

26 (F) An insurance agent or broker, or an applicant for an
27 insurance agent or broker license, who has allegedly engaged in
28 theft, fraud, or the misappropriation of premium or other funds in
29 an amount that exceeds fifty thousand dollars (\$50,000).

30 (2) Unless specifically provided for in a provision of this code,
31 the commissioner may not agree to any of the following:

32 (A) That the respondent contribute, deposit, or transfer any
33 moneys or other resources to a nonprofit entity.

34 (B) That a respondent contribute, deposit, or transfer any fine,
35 penalty, assessment, cost, or fee except to the commissioner for
36 deposit in the appropriate state fund pursuant to Section 12975.7.

37 (C) That the commissioner may or shall direct the transfer,
38 distribution, or payment to another person or entity of any fine,
39 penalty, assessment, cost, or fee.

1 (D) The use of the commissioner's name, likeness, or voice in
2 any printed material or audio or visual medium, either for general
3 distribution or for distribution to specific recipients.

4 (3) The commissioner may only agree to payment to those
5 persons or entities to whom payment may be due because of the
6 respondent's violation of a provision of this code or other law
7 regulating the business of insurance in this state.

8 (4) A settlement may only include the sanctions provided by
9 this code or other laws regulating the business of insurance in this
10 state, except that the settlement may include attorney's fees, costs
11 of the department in bringing the enforcement action, and future
12 costs of the department to ensure compliance with the settlement
13 agreement.

14 (c) Notwithstanding any other provision of law, the
15 commissioner may accept documents submitted for filing or
16 approval, process transactions, and maintain records in electronic
17 form or as paper documents, and may adopt regulations to further
18 this subdivision.

19 SEC. 21. Section 1299.04 of the Penal Code is amended to
20 read:

21 1299.04. (a) A bail fugitive recovery person, a bail agent, bail
22 permittee, or bail solicitor who contracts his or her services to
23 another bail agent or surety as a bail fugitive recovery person for
24 the purposes specified in subdivision (d) of Section 1299.01, and
25 any bail agent, bail permittee, or bail solicitor who obtains licensing
26 after January 1, 2000, and who engages in the arrest of a defendant
27 pursuant to Section 1301 shall comply with the following
28 requirements:

29 (1) The person shall be at least 18 years of age.

30 (2) The person shall have completed a 40-hour power of arrest
31 course certified by the Commission on Peace Officer Standards
32 and Training pursuant to Section 832. Completion of the course
33 shall be for educational purposes only and not intended to confer
34 the power of arrest of a peace officer or public officer, or agent of
35 any federal, state, or local government, unless the person is so
36 employed by a governmental agency.

37 (3) The person shall have completed a minimum of 20 hours of
38 classroom prelicensing education certified pursuant to Section
39 1810.7 of the Insurance Code. For those persons licensed by the
40 department as a bail licensee prior to January 1, 1994, there is no

1 prelicensing education requirement. For those persons licensed by
2 the department as a bail licensee between January 1, 1994, and
3 December 31, 2012, a minimum of 12 hours of classroom
4 prelicensing education is required.

5 (4) The person shall not have been convicted of a felony, unless
6 the person is licensed by the Department of Insurance pursuant to
7 Section 1800 of the Insurance Code.

8 (b) Upon completion of any course or training program required
9 by this section, an individual authorized by Section 1299.02 to
10 apprehend a bail fugitive shall carry certificates of completion
11 with him or her at all times in the course of performing his or her
12 duties under this article.

O