CALIFORNIA CODE OF REGULATIONS, TITLE 10, CHAPTER 5

SUBCHAPTER 7.5 Unfair or Deceptive Acts or Practices in the Business of Insurance

Article 1. Fair Claims Settlement Practices

Section 2695.1. Preamble.
(a) Section 790.03(h) of the California Insurance Code enumerates sixteen claims settlement practices which, when either knowingly committed on a single occasion, or performed with such frequency as to indicate a general business practice, are considered to be unfair claims settlement practices and are, thus, prohibited by this section of the California Insurance Code. The Insurance Commissioner has promulgated these regulations in order to accomplish the following objectives:

(1) To delineate certain minimum standards for the settlement of claims which when violated knowingly on a single occasion or performed with such frequency as to indicate a general business practice shall constitute an unfair claims settlement practice within the meaning of Insurance Code Section 790.03(h);
(2) To promote the good faith, prompt, efficient and equitable settlement of claims on a cost effective basis;
(3) To discourage and monitor the presentation to insurers of false or fraudulent claims; and,
(4) To encourage the prompt and thorough investigation of suspected fraudulent claims and ensure the prompt and comprehensive reporting of suspected fraudulent claims as required by Insurance Code Section 1872.4.

(b) These regulations are not meant to provide the exclusive definition of all unfair claims settlement practices; other methods, act(s), or practices not specifically delineated in this set of regulations may also be a violation of California Insurance Code Section 790.03(h) pursuant to the provisions of California Insurance Code Section 790.06. These regulations are applicable to the handling or settlement of claims brought under all classes of insurance except as specifically provided below:

(1) Workers' compensation insurance;
(2) Liability insurance for the professional malpractice of health care providers as defined in California Code of Civil Procedure Section 364(f)(1);
(3) Self insured or self funded plans which are bona fide Employee Retirement Income Security Act ("ERISA") plans which are not also multiple employer welfare arrangements, to the extent that these ERISA plans are not covered by insurance;
(4) Any other self funded or self insured plan, to the extent it is not covered by insurance, which is lawfully conducting business in this state.

(c) These regulations recognize the unique relationship which exists under a surety bond between the insurer, the obligee or beneficiary, and the principal. In contrast to other classes of insurance, surety insurance involves a promise to answer for the debt, default or miscarriage of a principal who has the primary duty to pay the debt or discharge the obligation and who is bound to indemnify the insurer. Therefore, only sections 2695.1 through 2695.6, inclusive, section 2695.10, and sections 2695.12, 2695.13 and 2695.14, inclusive, shall apply to the handling or settlement of claims brought under surety bonds.
(d) These regulations shall not apply to the handling or settlement of claims brought under Workers' Compensation insurance policies.

(e) All licensees, as defined in this regulations, shall have thorough knowledge of the regulations contained in this subchapter.

§2695.2. Definitions. As used in these regulations:
(a) "Beneficiary" means:

(1) for the purpose of life and disability claims, the party or parties entitled to receive the proceeds or benefits occurring under the policy in lieu of the insured; or,
(2) for the purpose of surety claims, a person who is within the class of persons intended to be benefitted by the bond;

(b) "Calendar days" means each and every day including Saturdays, Sundays, Federal and California State Holidays, but if the last day for performance of any act required by these regulations falls on a Saturday, Sunday, Federal or State Holiday, then the period of time to perform the act is extended to and including the next calendar day which is not a Saturday, Sunday, or Federal or State holiday;

(c) "Claimant" means a first or third party claimant as defined in these regulations, any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant, or any of the following persons properly designated by the claimant in the manner specified in subsection 2695.5(c): an insurance adjuster, a public adjuster, or any member of the claimant's family.

(d) "Claims agent" means any person employed or authorized by an insurer, to conduct an investigation of a claim on behalf of an insurer or a person who is licensed by the Commissioner to conduct investigations of claims on behalf of an insurer. The term "claims agent", however, shall not include the following:

(1) an attorney retained by an insurer to defend a claim brought against an insured; or,
(2) persons hired by an insurer solely to provide valuation as to the subject matter of a claim.

(e) "Extraordinary circumstances" means circumstances outside of the control of the licensee which severely and materially affect the licensee's ability to conduct normal business operations;

(f) "First party claimant" means any person asserting a right under an insurance policy as a named insured, other insured or beneficiary under the terms of that insurance policy, and including any person seeking recovery of uninsured motorist benefits;

(g) "Gross settlement amount" means the amount of the draft tendered plus the amount deducted as provided in the policy in the settlement of an automobile total loss claim;

(h) "Insurance agent" means:

(1) the term "insurance agent" as used in section 31 of the California Insurance Code; or,
(2) the term "life agent" as used in section 32 of the California Insurance Code; or,
(3) any person who has authority or responsibility to notify an insurer of a claim upon receipt of a notice of claim by a claimant; or,
(4) an underwritten title company.

(i) "Insurer" means a person licensed to issue or that issues an insurance policy or surety bond in this state, or that otherwise transacts the business of insurance in the state, including reciprocal and interinsurance exchanges, fraternal benefit societies, stock and mutual insurance companies,

risk retention groups, California county mutual fire insurance companies, grants and annuities societies, entities holding certificates of exemption, non-profit hospital service plans, multiple employer welfare arrangements holding certificates of compliance pursuant to Article 4.7 of the Insurance Code, and motor clubs, to the extent that they transact the business of insurance in the State. The term insurer, for purposes of these regulations includes non-admitted insurers, the California FAIR Plan, and those persons licensed to issue or that issue an insurance policy pursuant to an assignment by the California Automobile Assigned Risk Plan, and shall not include insurance agents and brokers, surplus line brokers and special lines surplus line brokers;

(j) "Insurance policy" or "policy" means the written instrument in which any certificate of group insurance, contract of insurance, or non-profit hospital service plan is set forth. For the purposes of these regulations the terms insurance policy or policy do not include "surety bond" or "bond". For the purposes of these regulations the term insurance policy or policy includes any written instrument in which any certificate of insurance or contract of insurance is set forth that is issued pursuant to the California Automobile Assigned Risk or the California FAIR plan;

(k) "Investigation" means all activities of an insurer or its claims agent related to the determination of coverage, liabilities, or nature and extent of damages afforded by an insurance policy, obligations or duties under a bond, and other obligations or duties arising from an insurance policy or bond.

(l) "Knowingly committed" means performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law.

(m) "Licensee" means any person that holds a license or Certificate of Authority from the Insurance Commissioner, or any other entity for whom the Insurance Commissioner's consent is required before transacting business in the State of California or with California residents. The term "licensee" for purpose of these regulations does not include an underwritten title company if the underwriting agreement between the underwritten title company and the title insurer affirmatively states that the underwritten title company is not authorized to handle policy claims on behalf of the title insurer.

(n) "Notice of claim" means any written or oral notification to an insurer or its agent that reasonably apprises the insurer that the claimant wishes to make a claim against a policy or bond issued by the insurer and that a condition giving rise to the insurer's obligations under that policy or bond may have arisen. For purposes of these regulations the term "notice of claim" shall not include any written or oral communication provided by an insured or principal solely for informational or incident reporting purposes.

(o) "Notice of legal action" means notice of an action commenced against the insurer with respect to a claim, or notice of action against the insured received by the insurer, or notice of action against the principal under a bond, and includes any arbitration proceeding;

(p) "Obligee" means the person named as obligee in a bond;

(q) "Person" means any individual, association, organization, partnership, business, trust, corporation or other entity;

(r) "Principal" means the person whose debt or other obligation is secured or guaranteed by a bond and who has the primary duty to pay the debt or discharge the obligation;

(s) "Proof of claim" means any documentation in the claimant's possession submitted to the insurer which provides any evidence of the claim and that supports the magnitude or the amount of the claimed loss.

(t) "Remedial measures" means those actions taken by an insurer to correct or cure any error or

omission in the handling of claims on the part of its insurance agent as defined in subsection 2695.2(h), including, but not limited to:

(1) written notice to the insurance agent that he/she is in violation of the regulations contained in this subchapter;
(2) transmission of a copy of the regulations contained in this subchapter and instructions for their implementation;
(3) reporting the error or omission in the handling of claims by the insurance agent to the Department of Insurance;

(u) "Replacement crash part" means a replacement for any of the nonmechanical sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels;

(v) "Single act" for the purpose of determining any penalty pursuant to California Insurance Code Section 790.035 is any commission or omission which in and of itself constitutes a violation of California Insurance Code Section 790.03 or this subchapter;

(w) "Surety bond" or "bond" means the written instrument in which a contract of surety insurance, as defined in California Insurance Code Section 105, is set forth;

(x) "Third party claimant" means any person asserting a claim against any person or the interests insured under an insurance policy;

(y) "Willful" or "Willfully" when applied to the intent with which an act is done or omitted means simply a purpose or willingness to commit the act, or make the omission referred to in the California Insurance Code or this subchapter. It does not require any intent to violate law, or to injure another, or to acquire any advantage.

§2695.3. File and Record Documentation.

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

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

(1) maintain claim data that are accessible, legible and retrievable for examination so that an insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of acceptance, denial or date closed without payment; this data must be available for all open and closed files for the current year and the four preceding years;
(2) record in the file the date the licensee received, date(s) the licensee processed and date the licensee transmitted or mailed every material and relevant document in the file; and
(3) maintain hard copy files or maintain claim files that are accessible, legible and capable of duplication to hard copy; files shall be maintained for the current year and the preceding four years.

(c) The requirements of this section shall be satisfied where the licensee provides documentation evidencing inability to obtain data, nonexistence of data, or difficulty in obtaining clear documentary support for actions due to catastrophic losses, or other unusual circumstances providing the licensee establishes to the satisfaction of the Commissioner that the circumstances

alleged by the licensee do exist and have materially affected the licensee's ability to comply with this regulation. Any licensee that alleges an inability to comply with this section shall establish and submit to the Commissioner a plan for file and record documentation to be used by such licensee while the circumstances alleged to preclude compliance with this subsection continue to exist.

§2695.4. Representation of Policy Provisions and Benefits.
(a) Every insurer shall disclose to a first party claimant or beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant. When additional benefits might reasonably be payable under an insured's policy upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer's additional liability.

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

(c) No insurer shall deny a claim on the basis of the claimant's failure to exhibit property, unless there is documentation in the file

> (1) of demand by the insurer, and unfounded refusal by the claimant, to exhibit property, or
> (2) of the breach of any policy provision providing for the exhibition of property.

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

(e) No insurer shall:

> (1) request that a claimant sign a release that extends beyond the subject matter which gave rise to the claim payment unless, prior to execution of the release the legal effect of the release is disclosed and fully explained by the insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature;
> (2) be precluded from including in any release a provision requiring the claimant to waive the provisions of California Civil Code Section 1542, provided that prior to execution of the release the legal effect of the release is disclosed and fully explained by insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature.

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

§2695.5. Duties upon Receipt of Communications.
(a) Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim, every licensee shall immediately, but in no event more than twenty-one (21) calendar days of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any

documentation and claim files requested. This section is not intended to permit delay in responding to inquiries by Department personnel conducting a scheduled examination on the insurer's premises.

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

(c) The designation specified in subsection 2695.2(c) shall be in writing, signed and dated by the claimant, and shall indicate that the designated person is authorized to handle the claim. All designations shall be transmitted to the insurer and shall be valid from the date of execution until the claim is settled or the designation is revoked. A designation may be revoked by a writing transmitted to the insurer, signed and dated by the claimant, indicating that the designation is to be revoked and the effective date of the revocation.
(d) Upon receiving notice of claim, every licensee or claims agent shall immediately transmit notice of claim to the insurer. Failure of the licensee or claims agent to immediately transmit notice of claim to the insurer shall constitute a separate and distinct violation of California Insurance Code Section 790.03(h)(3) and this subsection, where the insurer has provided the appointed licensee or claims agent with written instructions as to the proper handling of a notice of claim. Transmission of the notice of claim by the licensee or claims agent to the insurer in conformity with the written instructions received from the insurer shall satisfy the licensee's or claims agent's duty under this section to promptly transmit the notice to the insurer.

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

> (1) acknowledge receipt of such notice to the claimant unless payment is made within that period of time. If the acknowledgement is not in writing, a notation of acknowledgement shall be made in the insurer's claim file and dated. Failure of an insurance agent or claims agent to promptly transmit notice of claim to the insurer shall be imputed to the insurer except where the subject policy was issued pursuant to the California Automobile Assigned Risk Program.
> (2) provide to the claimant necessary forms, instructions, and reasonable assistance, including but not limited to, specifying the information the claimant must provide for proof of claim;
> (3) begin any necessary investigation of the claim.
> (4) Subsection 2695.5(e) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the Insurance Code or life insurance subject to Section 10172.5 of the Insurance Code.

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

§2695.6. Training and Certification.

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

(b) All licensees shall provide thorough and adequate training regarding the regulations to all their claims agents. Licensees shall certify that their claims agents have been trained regarding these

regulations and any revisions thereto. However, licensees need not provide such training or certification to duly licensed attorneys.

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

(1) where the licensee is an individual, the licensee shall annually certify in writing under penalty of perjury that he or she has read and understands the regulations and any and all amendments thereto;
(2) where the licensee is an entity, the annual written certification shall be executed, under penalty of perjury, by a principal of the entity as follows:

(A) that the licensee's claims adjusting manual contains a copy of these regulations and all amendments thereto; and,
(B) that clear written instructions regarding the procedures to be followed to effect proper compliance with this subchapter were provided to all its claims agents;

(3) where the licensee retains independent adjusters, the licensee must provide training to the independent adjusters regarding these regulations and annually certify, in a declaration executed under penalty of perjury, that such training is provided. Alternately, the independent adjuster may annually certify in writing, under penalty of perjury, on an annual basis, that he or she has read and understands these regulations and all amendments thereto or has successfully completed a training seminar which explains these regulations;
(4) a copy of the certification required by subsections 2695.6(b)(1), (2) or (3) shall be maintained at all times at the principal place of business of the licensee, to be provided to the Commissioner only upon request.
(5) the annual certification required by this subsection shall be completed on or before September 1 of each calendar year.

§2695.7. Standards for Prompt, Fair and Equitable Settlements.
(a) No insurer shall discriminate in its claims settlement practices based upon the claimant's race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

(b) Upon receiving proof of claim, every insurer, except as specified in subsection 2695.7(b)(4) below, shall immediately, but in no event more than forty (40) calendar days later, accept or deny the claim, in whole or in part.

(1) Where an insurer denies or rejects a first party claim in whole or in part, it shall do so in writing and shall provide to the claimant a statement listing all bases for such rejection or denial and the factual and legal bases for each reason given for such rejection or denial which is then within the insurer's knowledge. Where an insurer's denial of a first party claim, in whole or in part, is based on a specific policy provision, condition or exclusion, the written denial shall include reference thereto and provide an explanation of the application of the provision, condition or exclusion to the claim. Every insurer that denies or rejects a third party claim in whole or in part, or disputes liability or damages shall do so in writing.
(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(b)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim.
(3) Written notification pursuant to this subsection shall include a statement that, if the claimant believes the claim has been wrongfully denied or rejected, he or

she may have the matter reviewed by the California Department of Insurance, and shall include the address and telephone number of the unit of the Department which reviews claims practices.
(4) The time frame in subsection 2695.7(b) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the Insurance Code, life insurance subject to Section 10172.5 of the Insurance Code, or mortgage guaranty insurance subject to Section 12640.09(a) of the Insurance Code, and shall not apply to automobile repair bills arising from policies of automobile collision and comprehensive insurance subject to Section 560 of the Insurance Code.

(c)

(1) If more time is required than is allotted in subsection 2695.7(b) to determine whether a claim should be accepted and/or denied in whole or in part, then, every insurer shall provide the claimant, within the time frame specified in subsection 2695.7(b), with written notice of the need for additional time. This written notice shall specify any additional information the insurer requires in order to make a determination and state any continuing reasons for the insurer's inability to make a determination. Thereafter, the written notice shall be provided every thirty (30) calendar days until a determination is made or notice of legal action is served. If the determination cannot be made until some future event occurs, then the insurer shall comply with this continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made.
(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(c)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the claim is being investigated as a possible suspected fraudulent claim.

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

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

(f) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a timely claim. Such notice shall be given to the claimant not less than sixty (60) days prior to the expiration date; except, if notice of claim is first received by the insurer within that sixty days, then notice of the expiration date must be given to the claimant immediately. With respect to a first party claimant in a matter involving an uninsured motorist, this notice shall be given at least thirty (30) days prior to the expiration date; except, if notice of claim is first received by the insurer within that thirty days, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter.

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

(1) the extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;
(2) the extent to which the insurer considered evidence made known to it or

reasonably available;
(3) the extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;
(4) the extent to which the insurer considered the advice of its counsel that there was a substantial likelihood of recovery in excess of policy limits;
(5) the procedures used by the insurer in determining the dollar amount of property damage;
(6) the extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter;
(7) any other credible evidence presented to the Commissioner that demonstrates that the final amount offered in settlement of the claim by the insurer is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

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

(1) Subsection 2695.7(h) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the Insurance Code, of life insurance subject to Section 10172.5 of the Insurance Code, of mortgage guaranty insurance subject to Section 12640.09(a) of the Insurance Code, or of fire insurance subject to Section 2057 of the Insurance Code, and shall not apply to automobile repair bills arising from policies of automobile collision and comprehensive insurance subject to Section 560 of the Insurance Code.
(2) Any insurer issuing a title insurance policy shall either tender payment pursuant to subsection 2695.7(h) or take action to resolve the problem which gave rise to the claim immediately upon, but in no event more than thirty (30) calendar days after, acceptance of the claim.

(i) No insurer shall inform a claimant that his or her rights may be impaired if a form or release is not completed within a specified time period unless the information is given for the purpose of notifying the claimant of any applicable statute of limitations or policy provision or the time limitation within which claims are required to be brought against state or local entities.

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

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

(1) increased to eighty (80) calendar days; or,
(2) suspended until otherwise ordered by the Commissioner, provided the insurer has complied with California Insurance Code Section 1872.4 and the insurer can demonstrate to the Commissioner that it has made a diligent attempt to

determine whether the subject claim is false or fraudulent within the eighty day period specified by subsection 2695.7(k)(1).

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

(m) No insurer shall make a payment to a provider, pursuant to a policy provision to pay medical benefits, and thereafter seek recovery or set-off from the insured on the basis that the amount was excessive and/or the services were unnecessary, except in the event of a proven false or fraudulent claim, subject to the provisions of Section 10123.145 of the California Insurance Code.

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

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

§2695.8. Additional Standards Applicable to Automobile Insurance.
(a) This section enumerates standards which apply to adjustment and settlement of automobile insurance claims. For purposes of this section:

(1) the words "automobile" and "vehicle" are used synonymously; and
(2) a comparable automobile is one of like kind and quality, made by the same manufacturer, of the same or newer model year, of a similar body type, with similar options and mileage as the insured vehicle. Any differences between the comparable automobile and the insured vehicle shall be permitted only if the insurer fairly adjusts for such differences. A comparable automobile must be available for retail purchase by the general public in the local market area within ninety (90) calendar days of the final settlement offer.

(b) When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with a comparable automobile, one of the following methods must apply:

(1) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost shall be determined as follows and, once determined, shall be fully itemized and explained in writing for the claimant:

(A) when comparable automobiles are available or were available in the local market area in the last 90 days, the average cost of two or more such comparable automobiles; or,
(B) when comparable automobiles are not available in the local market area, the average of two or more quotations from two or more licensed dealers in the local market area; or,
(C) when an automobile total loss is adjusted or settled on a basis which varies from the methods described in subsections (b)(1)(A) and (b)(1)(B) of this section, the determination of value must be supported by documentation. Any deductions from

value, including deduction for salvage, must be discernible, measurable, itemized, and specified as well as appropriate in dollar amount and so documented in the claims file. The insurer must take reasonable steps to verify that the value so determined is accurate and representative of the market value of a comparable automobile in the local market area.

(2) The insurer may elect to offer a replacement automobile which is a specified comparable automobile available to the insured, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid by the insurer at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the insurer's claim file. A replacement automobile must be in as good or better over all condition than the insured vehicle and available for inspection within a reasonable distance of the insured's residence.

(c) Every insurer shall, if notified within thirty-five (35) calendar days after receiving the claim draft or final settlement offer that the insured cannot purchase a comparable automobile for the gross settlement amount, reopen its claim file and utilize the following procedures:

(1) The insurer shall locate a comparable automobile for the gross settlement amount determined by the company at the time of settlement and shall provide the insured with the information required in (c)(4), below, or offer a replacement vehicle in accordance with section 2695.8(b)(2). Any such vehicle must be available in the local market area; or,
(2) The insurer shall either pay the insured the difference between the amount of the gross settlement and the cost of the comparable automobile which the insured has located, or negotiate and purchase this vehicle for the insured; or,
(3) The insurer shall invoke the appraisal provision of the insurance policy.
(4) No insurer is required to take action under this subsection if its documentation to the insured at the time of final settlement offer included written notification of the identity of a specified comparable automobile which was available for purchase at the time of final settlement offer for the gross settlement amount determined by the insurer. The documentation shall include the telephone number (including area code) or street address of the seller of the comparable automobile and:

(A) the vehicle identification number (VIN) or,
(B) the stock or order number of the vehicle from a licensed dealer, or
(C) the license plate number of such comparable vehicle.

(d) No insurer shall, where liability and damages are reasonably clear, recommend that the third party claimant make a claim under his or her own policy to avoid paying the claim under the policy issued by that insurer.

(e) No insurer shall:

(1) require that an automobile be repaired at a specific repair shop; or,
(2) direct, suggest or recommend that an automobile be repaired at a specific repair shop, unless,

(A) such referral is expressly requested by the claimant; or,
(B) the claimant has been informed in writing of the right to select

the repair facility; and,
(C) the insurer that elects to repair a vehicle directs, suggests or recommends that a specific repair shop be used, shall cause the damaged vehicle to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations.

(3) require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to conduct an inspection of the vehicle, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

(f) if partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the claimant with a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be in accordance with applicable policy provisions, and of an amount which will allow for repairs to be made in a workmanlike manner. If the claimant subsequently claims, based upon a written estimate which he or she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall:

(1) pay the difference between the written estimate and a higher estimate obtained by the claimant; or,
(2) promptly provide the claimant with the name of at least one repair shop, if requested by the claimant pursuant to subsection 2695.8(e)(2), that will make the repairs for the amount of the written estimate. If the insurer designates fewer than three repair shops, the insurer shall assure that the repairs are performed in a workmanlike manner. The insurer shall maintain documentation of all such communications; or,
(3) reasonably adjust any written estimates prepared by the repair shop of the insured's choice.

(g) No insurer shall require the use of non-original equipment manufacture replacement crash parts in the repair of an automobile unless:

(1) the parts are at least equal to the original equipment manufacturer parts in terms of kind, quality, safety, fit, and performance;
(2) insurers specifying the use of non-original equipment manufacturer replacement crash parts shall pay the cost of any modifications to the parts which may become necessary to effect the repair; and,
(3) insurers specifying the use of non-original equipment manufacture replacement crash parts warrant that such parts are of like kind, quality, safety, fit, and performance as original equipment manufacturer replacement crash parts; and,
(4) all original and non-original manufacture replacement crash parts, manufactured after the effective date of this subchapter, when supplied by repair shops shall carry sufficient permanent, non-removable identification so as to identify the manufacturer. Such identification shall be accessible to the greatest extent possible after installation.

(h) No insurer shall require an insured or claimant to supply parts for replacement.

(i) Every insurer shall provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation of the claim. Where an insurer elects not to pursue subrogation or discontinues pursuit of subrogation it shall include in its notification a statement that any recovery to be pursued is the responsibility of the first party claimant. This subsection does not require notification if the deductible is waived, the coverage under which the claim is paid requires no deductible to be paid, the total loss sustained does not exceed the applicable deductible, or there

is no legal basis for subrogation.
(j) Every insurer that makes a subrogation demand shall include in every demand the first party claimant's deductible. Every insurer shall share subrogation recoveries on a proportionate basis with the first party claimant, unless the first party claimant has otherwise recovered the whole deductible amount. No insurer shall deduct legal or other expenses from the recovery of the deductible unless the insurer has retained an outside attorney or collection agency to collect that recovery. The deduction may only be for a pro rata share of the allocated loss adjustment expense.

(k) When the amount claimed is adjusted because of betterment, depreciation, or salvage, all justification shall be contained in the claim file. Any adjustments shall be discernable, measurable, itemized, and specified as to dollar amount, and shall accurately reflect the value of the betterment, depreciation, or salvage. The basis for any adjustment shall be fully explained to the claimant in writing and shall:

> (1) reflect a measurable difference in market value attributable to the condition and age of the vehicle, or
> (2) apply only to parts normally subject to repair and replacement during the useful life of the vehicle such as, but not limited to, tires, batteries, et cetera.

(l) Every insurer shall provide reasonable notice to a claimant before terminating payment for storage charges, so that the claimant has time to remove the vehicle from storage.

(m) Unless the insurer has provided an insured with the name of a specific towing company prior to the insured's use of another towing company, the insurer shall pay the reasonable towing charges of the towing company used by the insured.

§2695.9. Additional Standards Applicable to Fire and Extended Coverage Type Policies with Replacement Cost Coverage.
(a) When a fire and extended coverage insurance policy provides for the adjustment and settlement of first party losses based on replacement cost, the following standards apply:

> (1) When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making the repair or replacement not otherwise excluded by the policy shall be included in the loss. The insured shall not have to pay for depreciation nor any other cost except for the applicable deductible.
> (2) When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace all items in the damaged area so as to conform to a reasonably uniform appearance.

§2695.10 Standards Applicable to Surety Claims.
[TEXT OMITTED]

§2695.11. Additional Standards Applicable to Life and Disability Insurance Claims.
[TEXT OMITTED]

§2695.12. Noncompliance and Penalties.
(a) A licensee has knowingly committed an act or acts in noncompliance with this subchapter under the following circumstances including, but not limited to:

> (1) where the licensee has promulgated express policies or procedures that are in noncompliance with this subchapter; or
> (2) where the act(s) in noncompliance with this subchapter are committed by an

employee or claims agent of a licensee and the licensee through its management, either:

(A) gives prior approval of the act(s); or,
(B) subsequently ratifies the propriety of the act(s); or,

(3) where the act(s) are committed by an employee or claims agent of a licensee, and it is established that:

(A) the licensee has failed to adopt, communicate and implement standards for the prompt, fair and reasonable investigation and settlement of claims in accordance with this subchapter or assure that such standards are consistently being met; or,
(B) the licensee's management was aware of facts which did apprise or should have apprised the licensee of the act(s) and the licensee failed to take any remedial measures.

(b) In determining noncompliance with this subchapter and appropriate penalties, if any, the Commissioner shall consider admissible evidence on the following:

(1) the existence of extraordinary circumstances;
(2) whether the licensee has a good faith and reasonable basis to believe that the claim or claims are fraudulent or otherwise in violation of applicable law and the licensee has complied with the provisions of Section 1872.4 of the Insurance Code;
(3) the complexity of the claims involved;
(4) gross exaggeration of the value of the property or severity of the injury, or amount of damages incurred;
(5) substantial mischaracterization of the circumstances surrounding the loss or the alleged default of the principal;
(6) secreting of property which has been claimed as lost or destroyed.
(7) the relative number of claims where the noncomplying act(s) are found to exist, as contrasted to the total number of claims handled by the licensee during the relevant time period;
(8) whether the licensee has taken remedial measures with respect to the noncomplying act(s);
(9) the existence or nonexistence of previous violations by the licensee;
(10) the degree of harm occasioned by the noncompliance; and
(11) whether, under the totality of circumstances, the licensee made a good faith attempt to comply with the provisions of this subchapter.
(12) Frequency of occurrence and/or severity of the detriment to the public caused by the violation of a particular subsection of this subchapter.

(c) The Commissioner shall not consider reasonable mistakes or opinions as to valuation of property, losses or damages when determining the licensee's non-compliance with this subchapter or penalties to be assessed