AN ACT

Relating to insurance; establishing an insurance department; and amending, revising, and consolidating the law relating to the licensing, qualification, regulation, examination, suspension, and dissolution of insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and certain societies and orders, the examination and regulation of fire insurance rating bureaus, and the licensing and regulation of insurance agents and brokers; the service of legal process upon foreign insurance companies, associations or exchanges; providing penalties, and repealing existing laws. (Title amended Apr. 27, 1927, P.L.476, No.302)

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Section 1. Be it enacted, &c., That an insurance department is hereby established, and the laws relating to the licensing, qualification, regulation, examination, suspension, and dissolution of insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and certain societies and orders, the examination and regulation of fire insurance rating bureaus, and the licensing and regulation of insurance agents and brokers are hereby amended, consolidated, and revised, as follows:

ARTICLE I.
PRELIMINARY PROVISIONS.

Section 101. Certain Words Defined.--The word "company," as used in this act, shall be construed to include only incorporated insurance companies, and corporations possessing the power to insure owners of real property, mortgagees, and others interested in real property from loss by reason of defective titles, liens, and encumbrances, whether incorporated under the laws of this Commonwealth, or of any other State, territory or district, or under the laws of any foreign country.

Except where otherwise indicated, the word "association," as used in this act, shall be construed to include only individuals, partnerships, or associations of individuals, authorized to engage in the business of insurance in the Commonwealth as insurers on the Lloyds plan.

The word "exchange," as used in this act, shall be construed to include only individuals, partnerships, and corporations, authorized by the laws of the Commonwealth to exchange with each other inter-insurance or reciprocal insurance contracts.

(101 amended May 17, 1933, P.L.798, No.119)

Section 102. Short Title.--This act shall be known and may be cited as "The Insurance Department Act of 1921."

(102 amended Dec. 18, 1992, P.L.1496, No.177)

Section 103. Application of Act.--(a) The provisions of this act shall apply to all companies, associations, and exchanges transacting any class of insurance business, to rating organizations and to all insurance agents and insurance brokers. The provisions of this act, excepting sections two hundred and nineteen (219), three hundred and five (305), five hundred and one (501), five hundred and two (502), five hundred and four (504), five hundred and five (505), five hundred and six (506),

five hundred and seven (507), five hundred and eight (508), five hundred and nine (509), five hundred and ten (510) and six hundred and seven (607) hereof, shall not apply to fraternal benefit societies, orders, or associations conducted not for profit, and having a lodge system with ritualistic form of work and representative form of government, or to beneficial or relief associations conducted not for profit formed by churches, societies, classes, firms, or corporations, with or without ritualistic form of work, the privilege of membership in which are confined to the members of such churches, societies, or classes, and to members and employes of such firms or corporations. The provisions of this act, excepting sections two hundred and thirteen (213), two hundred and fourteen (214), two hundred and sixteen (216), two hundred and nineteen (219), five hundred and one (501), five hundred and two (502), five hundred and three (503), five hundred and four (504), five hundred and five (505), five hundred and six (506), five hundred and seven (507), five hundred and eight (508), five hundred and nine (509), and five hundred and ten (510) hereof, shall not apply to domestic mutual fire insurance companies of this Commonwealth, incorporated under special acts of Assembly or under the act of May first, one thousand eight hundred and seventy-six, with unlimited or limited liability to assessment for payment of expenses and of losses and loss adjustments, set forth in the policy contract or in the promissory notes attached to said policy.

(b) Nothing in this act shall apply to a religious publication, or its subscribers, that meet all of the following criteria:

(1) Is a nonprofit religious organization.

(2) Is limited to individuals who separately subscribe and who are members of the same denomination or religion, who have the approval of their pastor.

(3) Acts as an organizational clearinghouse for information between subscribers who have financial, physical or medical needs and subscribers who choose to assist with those needs, matching subscribers with a willingness to pay with subscribers with a present financial or medical need.

(4) Arranges for the payment of subscribers' financial or medical needs by payments directly from subscriber to subscriber.

(5) Suggests amounts to give that are voluntary among the subscribers, with no assumption of risk or promise to pay either among the subscribers or between the subscribers and the publication.

(6) Does not use any compensated agents, representatives or other persons to solicit or enroll subscribers.

(7) Does not make any direct or indirect representation that it is operating in a financially sound manner or that it has had a successful history of meeting subscribers' financial or medical needs.

(8) Provides a written monthly statement to all subscribers, listing the total dollar amount of qualified needs submitted for publication, as well as the amount actually published and assigned for payment.

(9) Does not use funds paid by subscribers for medical needs to cover administrative costs.

(10) Provides the following verbatim written disclaimer as a separate cover sheet for any and all documents distributed by or on behalf of the exempt entity, including applications, guidelines, promotional or informational materials and all periodic publications:

NOTICE

This publication is not an insurance company nor is it offered through an insurance company. This publication does not guarantee or promise that your medical bills will be published or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this publication should never be considered a substitute for insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always liable for any unpaid bills.

(103 amended Feb. 17, 1994. P.L.79, No.8)

Section 104. Constitutionality.--The provisions of this act shall be severable, and, if any of its provisions shall be held to be unconstitutional, the decision of the court shall not affect the validity of the remaining provisions of this act. It is hereby declared as a legislative intent that this act would have been adopted by the General Assembly had such unconstitutional provision not been included therein.

Section 105. Effect of Act.--The provisions of this act, so far as they are the same as those of existing laws, shall be construed as a continuation of such laws and not as new enactments. The repeal by this act of any provision of law shall not revive any law heretofore repealed or superseded, nor shall this act affect any act done, liability incurred, or any right accrued and established, or any suit or prosecution, civil or criminal, pending or to be instituted to enforce any right or penalty or punish any offense under the authority of the repealed laws. Any person who, at the time when said repeal takes effect, holds office under any of the laws repealed shall continue to hold such office according to the tenure thereof.

Section 106. Compliance with Act Required.--It shall be unlawful for any person, company, association, exchange, copartnership, or corporation to negotiate or solicit, within this Commonwealth, any contract of insurance, or to effect the same, or to receive and transmit any offer or offers of insurance, or receive or deliver a policy or policies of insurance, or in any manner to aid in the transaction of the business of insurance, without fully complying with the provisions of this act.

ARTICLE II.
INSURANCE DEPARTMENT.

Section 201. Insurance Department Established.--There is hereby established a department, to be known as the Insurance Department, which is charged with the execution of the laws of this Commonwealth in relation to insurance.

Section 202. Appointment of Insurance Commissioner.--The Governor, with the advice and consent of the Senate, shall appoint an Insurance Commissioner, who shall hold office for the term of four years and until his successor is appointed and qualified. The Insurance Commissioner in office at the date of the approval of this act shall, until the expiration of his present term of office or until his successor is appointed, hold the office of Insurance Commissioner created by this act, subject to removal by the Governor.

Section 203. Oath, Bond, and Salary of Insurance Commissioner.--(203 repealed June 7, 1923, P.L.498, No.274)

Section 204. Appointment of Deputy Insurance Commissioner; Powers and Duties; Salary.--(204 repealed June 7, 1923, P.L.498, No.274)

Section 205. Restrictions on Officers and Employes.--No officer or employe of the Insurance Department shall be employed by or be pecuniarily interested in any insurance company, association, or exchange, or in any insurance business, other than as a policyholder.

Section 206. Seal.--The Insurance Commissioner shall adopt and renew from time to time a seal of office, an impression of which shall be filed in the office of the Secretary of the Commonwealth.

Section 207. Certified Copies of Books, Papers, and Documents.--The Insurance Commissioner shall furnish, under seal of the department, when required for evidence in court, certificates relative to the authority of a company, association, exchange, agent, or broker to transact business in this Commonwealth upon any particular date, and such certificate shall be competent evidence thereof. He shall, at the request of any person and on payment of the fee, give certified copies of any charter, statement, or record in his office, whenever he deems it not prejudicial to the public interest.

Copies of all books, papers, accounts, annual statements, charters, and other papers or documents filed in the office of the Insurance Department, when certified under the hand and seal of the Insurance Commissioner, shall be admitted in evidence in all courts and elsewhere in this Commonwealth.

Section 208. Certificates of Authority To Do Business.--(a) No insurance company, association, or exchange of another state or foreign government shall do an insurance business within this Commonwealth without first having obtained a certificate of authority from the Insurance Commissioner authorizing such company, association or exchange to do such business. Before granting such a certificate of authority to an insurance company, association or exchange, the commissioner shall be satisfied, by such examination as he may make or by such evidence as he may require or demand, that such company, association, or exchange conforms to the requirements of this act and of the laws of this Commonwealth prerequisite to its issue. After such issue the holder shall continue to comply with the requirements as to its business set forth in this act and in the laws of this Commonwealth. The commissioner may renew the certificate of authority of any mutual assessment life or accident association, which is now lawfully doing business in this Commonwealth, beginning on the first day of April of each year, and continuing in force for one year unless sooner revoked by him or surrendered by the licensee. Any certificates issued after April first shall expire on the thirty-first day of March succeeding.

(b) Any of the following acts constitute the doing of an insurance business within this Commonwealth, whether effected by mail or otherwise:

(1) the issuance or delivery of contracts of insurance to persons resident in this Commonwealth, or

(2) the solicitation of applications for such contracts, or other negotiations preliminary to execution of such contracts, or

(3) the collection of premiums, membership fees, assessments or other consideration for such contracts, or

(4) the transaction of matters subsequent to execution of such contracts and arising out of them.

(c) (1) Whenever the commissioner believes, from evidence satisfactory to him, that any insurance company, association, or exchange is doing an insurance business within this

Commonwealth in violation of any provision of this act or any order or requirement of the commissioner issued or promulgated pursuant to authority expressly granted the commissioner by any provision of this act or by law, or is about to violate any such provision, order, or requirement, the commissioner may, in his discretion, take against the offending party or parties any one or more of the following courses of action:

(i) Revoke the certificate of authority of such offending company, association or exchange.

(ii) Refuse to renew the certificate of authority of such offending company, association or exchange.

This remedy is in addition to any other remedy provided by this act or by law.

(2) Before the Insurance Commissioner shall take any action as set forth in clause (1), he shall give written notice to the person, company, association or exchange accused of violating the laws, stating specifically the nature of such alleged violation and fixing a time and place, at least ten days thereafter, when a hearing before the Insurance Commissioner regarding the matter shall be held.

((c) amended Dec. 18, 1992, P.L.1496, No.177)

(d) (1) The performance by an insurance company, association, or exchange of another state or foreign government of any act which constitutes the doing of an insurance business within this Commonwealth is equivalent to and shall constitute an appointment by such company, association or exchange of the Secretary of the Commonwealth and his successor or successors in office as its true and lawful attorney upon whom may be served all lawful process in any action, suit or proceeding instituted by or on behalf of the Insurance Commissioner against it arising out of a violation of this section, and the performance of any such act shall be signification of its agreement that such service of process is of the same legal force and validity as personal service of process in this Commonwealth upon such company, association, or exchange.

(2) Such service of process shall be made by delivering to and leaving with the Secretary of the Commonwealth or his deputy two copies thereof. The Secretary of the Commonwealth shall forthwith mail, by registered or certified mail, one of the copies of such process to such company, association or exchange at its last known principal place of business and shall keep record of all process so served upon him. Such service of process is sufficient, provided that (i) notice of such service upon the Secretary of the Commonwealth and a copy of the process are sent within ten days thereafter, by registered or certified mail, by or on behalf of the Insurance Commissioner to such company, association or exchange at its last known principal place of business, and (ii) the receipt of such company, association or exchange or the receipt issued by the post office with which the letter is registered or certified, showing the name of the sender of the letter and the name and address of the company, association or exchange to whom the letter is addressed, and the affidavit of or on behalf of the commissioner showing a compliance herewith, are filed with the prothonotary or clerk of the court in which such action, suit or proceeding is pending on or before the date such company, association or exchange is required to appear or within such further time as the court may allow.

(3) Service of process in any such action, suit or proceeding shall, in addition to the manner provided in clause (2) of subsection (d) of this section, be valid if served upon

any person within this Commonwealth, who in this Commonwealth on behalf of such company, association or exchange is--

(i) soliciting insurance, or

(ii) making, issuing or delivering any contract of insurance, or

(iii) collecting or receiving any premium, membership fee, assessment, or other consideration for insurance:

Provided, That (i) notice of such service and a copy of such process is sent within ten days after such service, by registered or certified mail, by or on behalf of the Insurance Commissioner to such company, association or exchange at its last known principal place of business, and (ii) the receipt of such company, association or exchange or the receipt issued by the post office with which the letter is registered or certified, showing the name of the sender of the letter and the name and address of the company, association or exchange to whom the letter is addressed, and the affidavit of or on behalf of the commissioner showing a compliance herewith, are filed with the prothonotary or clerk of the court in which such action, suit or proceeding is pending on or before the date such company, association or exchange is required to appear or within such further time as the court may allow.

(4) Before any company, association or exchange of another state or foreign government shall file or cause to be filed any pleading in any action, suit or proceeding instituted against it under this section, such company, association or exchange shall, if the court in its discretion shall require, deposit with the prothonotary of the court in which such action, suit or proceeding is pending, cash or securities, or file with such prothonotary or clerk a bond with good and sufficient sureties to be approved by the court. Said deposit or bond shall be in such amount as the court in its sole discretion, after taking into account the financial condition of such company, association or exchange and such other factors as the court considers pertinent, may deem sufficient to secure the payment of any final judgment which may be rendered in such action, suit or proceeding.

(5) The court in any action, suit or proceeding in which service is made in the manner provided herein may, in its discretion, order such postponement as may be necessary to afford such company, association or exchange reasonable opportunity to comply with clause (4) of this subsection and to defend such action, suit or proceeding.

(6) No judgment by default or otherwise shall be entered in any action, suit or proceeding under this section until the expiration of thirty days from the date of the filing of the affidavit of compliance as set forth in clauses (2) or (3) of this subsection.

(7) Nothing contained in this section shall limit or abridge the right to serve any process, notice or demand upon any company, association or exchange of another state or foreign government in any manner now or hereafter permitted by law.

(e) The provisions of this section shall not apply to the following:

(1) Transactions regulated by the act of January 24, 1966 (1965 P.L.1509, No.531), entitled "An act relating to, regulating, taxing, supervising and controlling the placing of insurance on risks located in the Commonwealth of Pennsylvania with insurers not licensed to transact insurance business in Pennsylvania, permitting licensed insurers to afford coverage which may be placed with unlicensed insurers, providing fees and penalties, and repealing certain existing laws."

(2) Any life insurance or annuity company organized and operated, without profit to any shareholder or individual, exclusively for the purpose of aiding nonprofit educational or scientific institutions by issuing insurance and annuity contracts only to or for the benefit of such institutions and individuals engaged in the service of such institutions. Any insurance company as described in this clause is required to join the Life and Health Insurance Guaranty Association pursuant to the act of November 26, 1978 (P.L.1188, No.280), known as the "Life and Health Insurance Guaranty Association Act," and to join any successor association pursuant to any similar statute which replaces the "Life and Health Insurance Guaranty Association Act." The assessments for any company so required to join shall be the same as for member insurers, but these assessments shall not apply to annuity considerations. The "Life and Health Insurance Guaranty Association Act" shall not apply to annuity contracts issued by any insurance company as described in this clause.

(3) Contracts of reinsurance.

(4) Transactions in this Commonwealth which (i) involve a policy lawfully solicited, written and delivered outside of this Commonwealth covering only subjects of insurance not resident, located, or expressly to be performed in this Commonwealth at the time of issuance of such policy, and (ii) are subsequent to the issuance of such policy.

(5) (i) Transactions in this Commonwealth, except group credit life or group credit accident and health insurance transactions, involving group accident and health or life insurance policies or group annuity contracts where the group policy is issued to:

(A) An out-of-State trustee of a fund in another state, an organization in another state or a trust or trustee of a trust established or participated in by one or more organizations in another state, in which (state) the insurance supervisory official or agency of that state has determined that: the issuance of the group policy or certificate is not contrary to the best interests of the general public; the issuance of the group policy or certificate would result in economies of acquisition or administration; the benefits are reasonable in relation to the premium charged; and, for group accident and health insurance, the coverage is in compliance with any mandated benefit act specifically providing for coverage on residents of this Commonwealth regardless of whether the group policy is used within or outside this Commonwealth.

(B) An out-of-State single employer.

(C) A trustee of a fund established by any person acting directly as an employer having its principal office located in a state other than this Commonwealth.

(D) An association or a trust or trustee of a trust established or participated in by one or more associations to insure association members, spouses or dependents of members, provided, however, that the association must be organized or domiciled in a state other than this Commonwealth, have a constitution and bylaws, be organized by other than an insurer, be maintained in good faith for purposes other than that of obtaining insurance, have been in active existence for at least two years, operate from offices other than the insurer's and be controlled by principals other than the insurer's.

(E) A union-negotiated out-of-State trust.

(F) Other groups as may be determined by the Insurance Commissioner at his discretion.

(ii) As used in this clause (5):

An "organization" means any of the following:

(A) Any bank, retailer or other issuer which:

(I) issues a credit card, charge card or payment card for the purchase of goods or services; and

(II) is issued a policy insuring holders of the card.

(B) Any bank, savings and loan association, credit union, mutual fund, money market fund, stock broker or other similar financial institution which:

(I) is regulated by Federal or state law; and

(II) is issued a policy insuring its depositors, account holders or members.

An "out-of-State single employer" means any person acting directly as an employer and has its principal office located in a state other than this Commonwealth.

An "out-of-State trustee" of a fund means a trustee of a fund established by an insurer for two or more employers or established by two or more persons acting directly as employers and the trustee has its principal office located in a state other than this Commonwealth.

A "union-negotiated out-of-State trust" means a trust established under a collective bargaining agreement and which is located in a state other than this Commonwealth.

It shall be the responsibility of the insurer claiming exemption under this subsection to demonstrate compliance with each of the above conditions.

(6) (i) Any insurance company or underwriter issuing contracts of insurance to industrial insureds, (ii) industrial insureds, or (iii) contracts of insurance issued to an industrial insured: Provided, That nothing herein shall relieve such industrial insured from the requirement of compliance with the applicable provisions of the act of January 24, 1966 (1965 P.L.1509, No.531), referred to above. For purposes of this section, an "industrial insured" is an insured (i) who procures the insurance of any risk or risks by use of the services of a full-time employe acting as an insurance manager or buyer or the services of a regularly and continuously retained qualified insurance consultant, (ii) whose aggregate annual premiums for insurance on all risks total at least twenty-five thousand dollars ($25,000), and (iii) who has at least twenty-five full-time employes.

(7) Transactions in this Commonwealth involving a policy of insurance issued prior to the effective date of this act.

(8) Insurance on the property and operation of railroads or aircraft engaged in interstate or foreign commerce, insurance of vessels, crafts or hulls, cargoes, marine builder's risks, marine protection and indemnity, lessees and charterers' liability, or other risks including strikes and war risks commonly insured under ocean or wet marine forms of policies.

((e) amended Feb. 17, 1994, P.L.79, No.8)

(208 amended July 31, 1968, P.L.763, No.239)

Section 209. Penalty for Acting Without Certificate of Authority.--(a) Any insurance company, association, or exchange doing an insurance business within this Commonwealth without a certificate of authority as required by this act shall be required to pay a civil penalty of not less than one thousand dollars ($1,000) nor more than ten thousand dollars ($10,000) for each offense, to be recovered on behalf of the Commonwealth.

(b) Any person negotiating or soliciting any policy of insurance or suretyship in this Commonwealth, collecting or forwarding premiums or delivering policies for any company, association, or exchange to which a certificate of authority has not been granted, shall be deemed to be the agent of the

company, association, or exchange, in any legal proceedings brought against it. Such person shall be required to pay a civil penalty of not less than one thousand dollars ($1,000) nor more than ten thousand dollars ($10,000) for each offense to be recovered on behalf of the Commonwealth.

(c) Whenever the Insurance Commissioner has articulable evidence that any person, insurance company, association or exchange has or is doing an insurance business within this Commonwealth without a certificate of authority as required by this act, or has or is violating any order or requirement of the Insurance Commissioner issued or promulgated pursuant to authority expressly granted the Insurance Commissioner by this section and that the interests of policyholders, creditors or the public may be irreparably harmed by delay, the Insurance Commissioner may issue a cease and desist order. Notice of the cease and desist order and notice of hearing shall be served by first class mail.

(d) Unless mutually agreed upon by the Insurance Department and the insurance company, association, exchange or person, the hearing shall be held not more than fifteen days after issuance of the order. Any adjudication of the Insurance Commissioner under this subsection shall be in accordance with and subject to review and appeal in accordance with 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) and Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action).

(e) Upon satisfactory evidence that any person, insurance company, association or exchange has willfully violated a cease and desist order issued under subsection (c), the Insurance Commissioner may, in his discretion, impose a civil penalty of not more than five thousand dollars ($5,000) for each and every act in violation of the cease and desist order.

(209 amended Dec. 12, 1994, P.L.1035, No.141)

Section 209A. Penalty For Exceeding Powers Granted Under Certificate of Authority.--Any insurance company, association or exchange, doing an insurance business within this Commonwealth, that shall exceed the powers granted under a certificate of authority, shall forfeit and pay to the Commonwealth a sum of not more than five hundred dollars ($500) for each and every policy issued in violation of this section. Before the Insurance Commissioner shall take any action, as above set forth, he shall give written notice to the company, association or exchange accused of violating the law, and fixing a time and place, at least ten (10) days thereafter, when a hearing of the matter shall be held. After such hearing or failure of the accused to appear at such hearing, the Insurance Commissioner shall impose such penalty as he deems advisable.

Section 210. Service of Process.--(210 repealed Apr. 28, 1978, P.L.202, No.53)

Section 211. Fees.--The Insurance Commissioner shall charge and collect fees as follows: For valuation of life insurance policies, not exceeding one cent for each thousand dollars of insurance valued, but in no case shall the minimum fee be less than ten dollars ($10); for filing copy of charter of a domestic, foreign or alien company, association or exchange, in addition to any fee for filing such charter with the Department of State, twenty-five dollars; for the filing of an annual or other statement, forty dollars; for license to company, association, or exchange, or certified copy, or duplicate thereof, five dollars; for license to a rating organization the fee prescribed by the act of Assembly creating such rating organization; for each listing for written

examination of an applicant for license as an agent, broker, public adjuster or public adjuster's solicitor, ten dollars; for each applicant for such licenses who has qualified by previous examination, an application fee of five dollars; for license as insurance broker, twenty dollars for an individual, and for each license in the name of a copartnership or corporation, twenty-five dollars, and for each license in the name of qualified individual active members or officers of a copartnership or corporation, twenty-five dollars; for agents' license for each domestic or foreign company, association and exchange for either (i) life and/or accident and health lines, or (ii) fire and/or casualty lines, or (iii) title insurance lines, regardless of the number of powers, excepting variable annuities, for which licensed, five dollars. All of the said brokers' and agents' license fees shall be paid in full at time of issuance of license and shall not be apportioned pro ratably over the initial license period. For each copy of any paper filed in the department, twenty-five cents per page and two dollars for certifying the same; for any other certificate required, two dollars; for making examinations, the expense of the examination, for filing and reviewing agreements of merger of domestic, foreign and alien companies, fifty dollars for the first two companies involved and ten dollars for each additional company; for filing and review of a plan of conversion from a mutual company to a stock company, or for filing and review of a plan of conversion from a stock company to a mutual company, two hundred dollars; for filing and review of terms and conditions of proposed exchange of shares of stock, two hundred dollars; for filing and review of statements, information and material in connection with a proposed acquisition or offer to acquire the capital stock of a domestic insurance company or insurance holding company, two hundred dollars; for filing and review of registration statement by an insurer which is a member of an insurance holding company system, two hundred dollars; and for filing each amendment to registration statement, fifty dollars; for issuing a certificate of compliance, deposit or surety, or any other certificate required to be issued by the department, five dollars for each certificate; for filing and review of qualification of an insurer to issue variable annuities, one hundred dollars; for certification of an agent's or broker's license, or for duplicate or replacement licenses, five dollars; for any other certificate issued by the division of agents and brokers, five dollars; for each renewal of license as an individual agent, copartnership or corporation, five dollars; and for each additional variable annuity power in such license, five dollars. All fees collected shall be paid daily into the State Treasury.

(211 amended June 17, 1974, P.L.341, No.110)

Compiler's Note: Section 6(a) of Act 48 of 1981, which provided for the fixing of fees charged by administrative agencies, provided that section 211 is repealed insofar as it establishes a set fee for any activity inconsistent with the fees set forth in Act 48.

Section 211.1. Assessments to Defray Expenses of Committee on Valuation of Securities of the National Association of Insurance Commissioners.--(a) The purpose of this section is to provide a means of making funds available, not in excess of two hundred fifty thousand dollars in any one year, to the Committee on Valuation of Securities of the National Association of Insurance Commissioners, to defray the expenses of such committee in the investigation, analyses and valuation of securities and the determination of the amortizability of bonds

owned by insurance companies, for the purpose of furnishing to the several states on a uniform basis, information needed in the supervision of insurance companies licensed to transact business in the several states.

(b) The Insurance Commissioner shall have authority to contract with the committee on valuation of securities to make available to the insurance department the analyses, reports and information developed by the committee and, after taking into consideration similar payments which may be made by other states, to make payment to such committee to the extent authorized herein, on account of the expenses of the committee, from funds obtained through assessments for such purpose under this section.

(c) The Insurance Commissioner shall periodically obtain from the committee a verified budget estimate of the receipts and of the expenses to be incurred by the committee for a stated period not exceeding one year, with appropriate explanations of the estimates therein contained.

(d) If the Insurance Commissioner shall be satisfied as to the reasonableness of such budget estimate, he shall determine the portion of the funds required by such budget estimate, to be assessed as hereinafter provided, by deducting from such budget estimate or from the sum of two hundred fifty thousand dollars, whichever is less, any amounts received or receivable by the committee from other states whose laws do not substantially conform to the method of assessment herein provided, and applying to the remainder the proportion which the total investments in securities of domestic life insurers bear to the total investments in securities of life insurers domiciled in this and other states whose laws authorize and require assessments on substantially the same base as herein provided. The Insurance Commissioner shall thereafter, as soon as convenient, by notice stating the method of computation thereof, assess the amount to be paid on account of such expense pro rata upon all domestic life insurers in the proportion which the total investments in securities of each domestic life insurer shall bear to the total investments in securities of all such insurers: Provided, That the aggregate amount assessed upon all domestic life insurers pursuant to this section in any one year shall not exceed an amount determined by applying to the "remainder," referred to in the first sentence of this subsection, the proportion which the total investments in securities of domestic life insurers bear to seventy-five per cent of the total investments in securities of all life insurers domiciled in all the states of the United States and the District of Columbia. The total investments in securities of any life insurer, for purposes of this section, shall be the total admitted value of stock and bonds reported as such in its annual statement last filed prior to such assessment with the insurance department or with the supervisory official of its state of domicile. Upon receipt of such notice each such insurer shall, within thirty days, pay said assessment to the Insurance Commissioner. The Insurance Commissioner shall deposit all moneys collected by him pursuant to this section in an account entitled "Insurance Commissioner Security Valuation Expense Account," in a bank or trust company in the Commonwealth. Such moneys shall be paid by the Insurance Commissioner to the Committee on Valuation of Securities of the National Association of Insurance Commissioners, after audit by the Auditor General. ((d) amended May 25, 1951, P.L.406, No.94)

(e) The Insurance Commissioner shall require annually and at such other times as he may deem it necessary or advisable,

a duly certified audit of receipts and disbursements and statements of assets and liabilities, showing the details of the financial operations of the committee on valuation of securities.

(f) This section shall become effective the first day of June, one thousand nine hundred forty-nine. ((f) amended Apr. 11, 1974, P.L.256, No.65)

(211.1 added May 20, 1949, P.L.1529, No.461)

Section 212. Effect of Additional Restrictions of Other States.--As used in this section the term--

"Insurance Companies" includes insurance companies, insurance associations and insurance exchanges.

"Agents" includes insurance agents, insurance brokers, public adjusters and public adjusters' solicitors.

"Burdens or Prohibitions" includes taxes, fines, penalties, licenses, fees, rules, regulations, obligations, and prohibitions, including prohibitions against writing particular kinds of insurance by insurance companies, and restrictions on the payment or division of commissions to or with insurance agents or brokers licensed under the laws of this Commonwealth.

"Other States" includes other states of the United States and foreign governments.

If any other state imposes any burdens or prohibitions on insurance companies, or agents of this state doing business in such other state, which are in addition to, or in excess of, the burdens or prohibitions imposed by this Commonwealth on insurance companies and agents, like burdens and prohibitions shall be imposed on all insurance companies and agents of such other state doing business in this Commonwealth, so long as the burdens and prohibitions of such other state remain in force. In applying this section to an insurance company of another state, such company shall not be required to pay any taxes and fees which are greater in aggregate amount than those which would be imposed by the laws of such other state and any political subdivision thereof upon a like company of this Commonwealth transacting the same volume and kind of business in such other state.

If any other state requires additional or other insurance covering motorists, or motor vehicles that are insured in Pennsylvania insurance companies, or in insurance companies of other states that are licensed to do business in this Commonwealth in order to use the highways of such other state, like, additional or other insurance shall be required to cover all motorists and motor vehicles of such other state using the highways of this Commonwealth so long as the requirement of such other state shall remain in force.

The existence of a monopolistic State Fund for the writing of any class or classes of insurance in another state shall not be construed as a reason to deny to a company, association or exchange of that state a license to transact such classes of insurance in this Commonwealth.

(212 amended June 17, 1974, P.L.341, No.110)

Section 213. Examination of Companies, Et Cetera.--(213 repealed Feb. 17, 1994, P.L.79, No.8)

Section 214. Examination of Certain Corporations.--(214 repealed Feb. 17, 1994, P.L.79, No.8)

Section 215. Examinations of Fire Rating Bureaus.--(215 repealed June 11, 1947, P.L.551, No.247)

Section 216. Powers with Regard to Examinations.--(216 repealed Feb. 17, 1994, P.L.79, No.8)

Section 217. Information from Fire Rating Bureaus.--(217 repealed June 11, 1947, P.L.551, No.247)

Section 218. Collection of Unpaid Taxes, Fines and Penalties.--The taxes imposed by this act shall be collected by the Department of Revenue, and the fines and penalties provided in this act and in any other act prescribing fines and penalties, which may be imposed by the Insurance Commissioner, shall, in case of non-payment after notice from the Insurance Commissioner, be collected as taxes upon corporations or individuals are now collected by law, and, for this purpose, the Insurance Commissioner shall have all the powers now conferred by law upon the Department of Revenue in the settlement of accounts, subject however, to the approval of the Department of the Auditor General, and to the right of any party aggrieved to file a petition for resettlement, petition for review and appeal as in other cases.

(218 amended June 5, 1947, P.L.439, No.200)

Section 219. Records of Department; Annual Report.--The Insurance Commissioner shall preserve, in a permanent form, a full record of his proceedings and a concise statement of the condition of each company, association, exchange, society, and order or agency visited or examined. He shall make a report annually, to be submitted to the General Assembly at its biennial sessions, showing the receipts and expenses of his department, the condition of companies, associations, exchanges, societies, and orders doing business in this Commonwealth, and such other relevant information as will exhibit the affairs or activities of his department.

Section 220. Insurance Department Fund Created.--The sum of one hundred and seventy-five thousand dollars ($175,000) of the fees collected in each fiscal year in accordance with section two hundred and eleven of this act shall each year be kept separate and apart by the State Treasurer in a fund known as "Insurance Department Fund;" and shall be expended under direction of the Insurance Commissioner for the administration of the Insurance Department, which shall include payment of salary of the Insurance Commissioner and the Deputy Commissioner, salary and compensation of the regular clerical force, extra clerks, stenographers and extra stenographers, cashiers and assistant cashiers, accountants, auditors, messengers, janitors, investigators, inspectors, appraisers, examiners and assistant and special examiners, special deputies, actuaries, assistant and special actuaries, court expenses and counsel fees, notary public fees, hotel expenses, meals, baggage, transportation, and traveling expenses, including automobile hire, and for telegrams, postage, and telephones, and for rental and equipment and maintenance of branch offices of the department, and for contingent expenses, including in the discretion of the Insurance Commissioner any printing and the purchase of office supplies; and for such purposes such moneys are hereby specifically appropriated. The Auditor General shall from time to time upon requisition of the Insurance Commissioner draw his warrant for the amounts of said requisitions.

Any balance remaining in said fund at end of each fiscal year over and beyond obligations paid or contracted for in the fiscal year by the Insurance Commissioner or necessary for the purposes of the department, as hereinbefore provided, shall be paid over to the general fund of the State by warrant of the Auditor General upon requisition of the Insurance Commissioner.

(220 added May 6, 1925, P.L.513, No.277)

Section 221. Supervision of Title Insurance Companies by the Insurance Department.--The Insurance Department shall have the power and duty to supervise, examine, and regulate all

corporations possessing the power to insure owners of real property, mortgagees, and others interested in real property from loss by reason of defective titles, liens, and encumbrances, to the same extent and in the same manner as such power and duty has heretofore been conferred and imposed by law upon the Department of Banking and the Secretary of Banking of this Commonwealth, and all powers, rights, privileges, and duties, heretofore by any law of this Commonwealth conferred or imposed upon the Secretary of Banking or the Department of Banking in relation to such corporations, are hereby transferred to, and conferred and imposed upon, the Insurance Department, but if any such corporation has the additional power to receive money for deposit or safe-keeping or to act as fiduciary or to engage in any other business under the supervision of the Department of Banking, the Insurance Department shall not have the power to supervise, examine, or regulate any part of the business of such corporation where such part of its business is under the supervision of the Department of Banking.

(221 added May 17, 1933, P.L.798, No.119)

Section 222. Renewal of Licenses; Fees.--The Insurance Commissioner may issue licenses for a period of two years at two times the annual fees established by this act. One-half of any fee collected shall be refunded or be credited to the account of the payor entitled to the refund if such license is cancelled within twelve months of its inception date or within twelve months of effective date as certified to the Insurance Commissioner by insurance companies, associations and exchanges authorized by law to transact business within this Commonwealth.

(222 added June 17, 1974, P.L.341, No.110)

Section 223. Jurisdiction Over Providers of Health Care Benefits.--(a) Notwithstanding any other provision of law and except as provided in this section, any person or other entity which provides benefits in this Commonwealth for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital or optometric expenses, whether the benefits are provided by direct payment, reimbursement or otherwise, shall comply with the requirements of section 208, unless the person or other entity shows that while providing those services it is subject to the jurisdiction of another agency of the Commonwealth, any subdivisions thereof, or the Federal Government with respect to financial solvency.

(b) A person or entity may show that it is subject to the jurisdiction of another agency of the Commonwealth, or any subdivision thereof, or of the Federal Government by providing to the Insurance Commissioner the appropriate certificate, license or other document issued by the other governmental agency which permits or qualifies it to provide those services. Such certificate, license or other document may constitute evidence that a person or entity is subject to the jurisdiction of another agency of the Commonwealth, or any subdivision thereof, or of the Federal Government, but such evidence is subject to rebuttal. A Department of Labor letter concerning an entity's purported status under the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 29 U.S.C. § 1001 et seq.) is not a certificate, license or other document within the meaning of this section which permits or qualifies an entity to provide services.

(c) Any person or entity which is unable to show under subsection (b) that it is subject to the jurisdiction of another agency of the Commonwealth, or any subdivision thereof, or the Federal Government shall submit to an examination by the

Insurance Commissioner to determine the organization and solvency of the person or the entity and to determine whether or not such person or entity complies with the applicable provisions of law. The person or entity examined shall be responsible for the Insurance Department's examination expenses to the same extent as a licensed insurance company would be responsible if the person or entity is found to be subject to the requirements of section 208.

(d) Any person or entity unable to show that it is subject to the jurisdiction of another agency of the Commonwealth, or any subdivision thereof, or of the Federal Government shall be subject to all appropriate provisions of law regarding the conduct of its business.

(e) Any person, entity, agent or administrator which advertises, sells, transacts or administers in this Commonwealth the benefits described in subsection (a) and which is required to submit to an examination by the Insurance Commissioner under subsection (c) shall, if said benefits are not fully insured or otherwise fully covered by any insurer licensed to do the business of insurance in this Commonwealth, nonprofit hospital service plan or nonprofit health care plan, give notice to every purchaser, prospective purchaser and covered person of such lack of insurance or other coverage and lack of State insurance insolvency guaranty funds protection.

(f) Any administrator which advertises or administers in this Commonwealth the benefits described in subsection (a) and which is required to submit to an examination by the Insurance Commissioner under subsection (c) shall give notice to any person or agent, as described in subsection (e), of the elements of the coverage, including, but not limited to, the amount of "stop-loss" insurance in effect and lack of State insurance insolvency guaranty funds protection.

(g) The notice described in subsections (e) and (f) shall be in ten-point type on any solicitation, application, description of benefits, renewal form or any other form provided to any person covered by a person or entity described in subsection (a).

(h) Upon satisfactory evidence of the violation of any of the provisions of this section, the Insurance Commissioner may in his discretion pursue any one or more of the following courses of action, regardless of whether such person, entity, agent, solicitor, broker or company is licensed or not licensed by the Insurance Commissioner:

(1) Suspend or revoke or refuse to renew the license of such offending party or parties.

(2) Impose a civil penalty of not more than one thousand dollars ($1,000) for each and every act in violation of any of said sections by said party or parties.

(223 added Dec. 18, 1992, P.L.1496, No.177)

ARTICLE II-A.
AUTHORITY TO SHARE CONFIDENTIAL INFORMATION WITH OTHER JURISDICTIONS.
(Art. added June 18, 1997, P.L.221, No.20)

Section 201-A. Definitions.--The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Commissioner" means the Insurance Commissioner of the Commonwealth.

"Company" means any person engaging in or proposing or attempting to engage in any transaction or kind of insurance, surety or annuity business and any person or group of persons

who may otherwise be subject to the administrative or regulatory authority of the Insurance Department.

"Department" means the Insurance Department of the Commonwealth.

"Insurer" means any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's insurer and any other legal entity engaged in the business of insurance, including agents and brokers, and also means health plan corporations as defined in 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations) and 63 (relating to professional health services plan corporations), beneficial societies as defined in 40 Pa.C.S. Ch. 67 (relating to beneficial societies), fraternal benefit societies as defined in the act of December 14, 1992 (P.L.835, No.134), known as the "Fraternal Benefit Societies Code," health maintenance organizations as defined in the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act," and preferred provider organizations as defined in section 630 of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921," and 31 Pa. Code § 152.2 (relating to definitions).

"Person" means any individual, aggregation of individuals, trust, association, partnership or corporation, or any affiliate thereof.

(201-A added June 18, 1997 P.L.221, No.20)

Section 202-A. Authority to Share Confidential Information.--(a) The commissioner shall maintain as confidential any documents, materials or other information received from the National Association of Insurance Commissioners, or its successor organization, or from regulatory or law enforcement officials of this Commonwealth or other jurisdictions in which the documents, materials or other information are confidential by law in those jurisdictions. Documents, materials or other information obtained by the commissioner under this section shall be given confidential treatment, may not be subject to subpoena and may not be made public by the commissioner or any other person.

(b) The commissioner may share confidential documents, materials or other information relating to any company, insurer or person with regulatory or law enforcement officials of this Commonwealth or other jurisdictions as long as, prior to receiving the documents, materials or other information, those parties demonstrate by written statement the necessary authority and intent to provide to it the same confidential treatment as required by this article. Access may also be granted to the National Association of Insurance Commissioners, or its successor organization, if, prior to receiving the information, the organization demonstrates by written statement the intent to provide to it the same confidential treatment as required by this article.

(202-A added June 18, 1997, P.L.221, No.20)

ARTICLE III.
RESERVE LIABILITY.

(a) LIFE INSURANCE.

Section 301. Computation of Reserve Liability.--(301 repealed June 30, 2016, P.L.399, No.59)

Section 301.1. Computation of Reserve Liability; Health and Accident Insurance.--(301.1 repealed June 30, 2016, P.L.399, No.59)

Section 302. Notice of Impairment of Funds.--Whenever any life insurance company doing business in this Commonwealth has not on hand the net value, as above defined, of all policies in force, after all other debts and claims against it, including fifty per centum of capital, have been provided for, the Insurance Commissioner shall notify such company and its agents to issue no new policies until its funds become equal to its liabilities.

Section 303. Minimum Reserve Requirements of Companies Charging Less Than Net Premiums Computed on Mortality Tables.--(303 repealed June 30, 2016, P.L.399, No.59)

Section 304. Valuations by Other States.--In lieu of the valuation of the reserves required in sections 301 and 301.1 of this act of any foreign or alien company, the Insurance Commissioner may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when such valuation complies with the minimum standard provided in sections 301 and 301.1 of this act and if the official of such state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the Insurance Commissioner when such certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction. Each such company shall furnish to the Insurance Commissioner, on or before the first day of March in each year, a certificate from the proper officer of such State, or jurisdiction, setting forth the value of all the policies and contracts of the company in force on the previous thirty-first day of December. Any such company failing to furnish such certificate shall be required to make a full detailed list of policies to the Insurance Commissioner, and shall be liable for all charges and expenses resulting from the failure to furnish said certificate.

(304 amended May 20, 1949, P.L.1500, No.450)

Section 305. Valuation of Securities.--All bonds or other evidences of debt held by life insurance companies or fraternal beneficiary societies, authorized to do business in this Commonwealth, may, if amply secured, and if not in default as to principal or interest, be valued as follows: If purchased at par, at the par value; if purchased above or below par, on the basis of the purchase price adjusted so as to bring the value at maturity, and so as to yield meantime the effective rate of interest at which the purchase was made, but the purchase price shall in no case be taken at a higher figure than the actual market value at the time of purchase. The Insurance Commissioner shall have full discretion in determining the method of calculating values according to the foregoing rule, and the values found by him in accordance with such method shall be final and binding. Any such company or society may return such bonds or other evidences of debt at their market value or their book value, but in no case at an aggregate value exceeding the aggregate of the values calculated according to the foregoing rule.

This section shall not be construed to require any life insurance company or fraternal beneficiary society, authorized to do business in this Commonwealth, which shall not elect to value its bonds and other evidences of debt by amortization as herein provided, to do so, but any company or society, electing to adopt the amortized basis, shall continue to have its bonds valued upon that basis.

(b) INSURANCE OTHER THAN LIFE INSURANCE.

Section 310. Computation of Unearned Premium Liability.--In determining the liabilities upon its contracts of insurance of any insurance company, other than life insurance companies, and the amount such company should hold as an unearned premium liability, the Insurance Commissioner shall calculate such amount on a monthly pro-rata basis or its equivalent on the premiums in force at the end of any quarterly or annual period, except in the case of noncancellable health and accident insurance issued on and after January first, one thousand nine hundred fifty, such amount shall be calculated according to the methods set out in section 311.1 of this act; on perpetual insurance, he shall charge the cash deposit received, less a surrender charge of not exceeding ten per centum thereof. For marine and inland insurance, he shall charge fifty per centum of the premium written in the policy upon risks covering more than one passage not terminated, and the full amount of the premium written in the policy upon all other marine and inland risks not terminated: Provided, That the Insurance Commissioner may, in his discretion, charge a premium reserve equal to the unearned portions of the gross premiums charged, computed on each respective risk from the date of the issuance of the policy.

(310 amended Dec. 19, 1975, P.L.571, No.163)

Section 311. Computation of Reserve Against Unpaid Losses in Casualty Insurance Other Than Health and Accident Insurance.--The Insurance Commissioner shall, in calculating the reserve against unpaid losses of any insurance company, other than life insurance companies, for losses other than under health and accident insurance issued on and after January first, one thousand nine hundred fifty, set down, by careful estimate in each case, the loss likely to be incurred against every claim presented or that may be presented in pursuance of notice from the insured of the occurrence of an event that may result in a loss. The sum of the items so estimated shall be the total amount of the reserve.

(311 amended Feb. 17, 1994, P.L.79, No.8)

Section 311.1. Computation of Reserve Liability; Health and Accident Insurance.--(311.1 repealed June 30, 2016, P.L.399, No.59)

(c) COMPENSATION AND LIABILITY INSURANCE.

Section 312. Definitions.--The term "earned premiums," as used in sections 313 to 316 inclusive shall include gross premiums charged on all policies written, including all excess and additional premiums and reinsurance premiums accepted, less return premiums other than premiums returned to policyholders as dividends, and less all reinsurance premiums ceded and premiums on policies cancelled. Earned premiums attributable to any specific period shall be calculated by adding to the liability for unearned premiums at the beginning of the period, the premiums written during the period and subtracting the liability for unearned premiums at the end of the period.

The word "compensation" shall relate to all insurance effected by virtue of statutes providing compensation to employes for personal injuries irrespective of fault of the employer.

The word "liability" shall relate to all insurance except compensation insurance, against loss or damage from accident

to or injuries suffered by an employe or other person and for which the insured is liable.

The terms "loss payments" and "loss expense payments" shall include all payments to claimants, including payments for medical and surgical attendance, legal expenses, salaries, and expenses of investigators, adjusters, and field men, rents, stationery, telegraph and telephone charges, postage, salaries, and expenses of office employes, home office expenses, and all other payments made on account of claims, whether such payments shall be allocated to specific claims or unallocated.

The term "monthly pro-rata basis" shall mean that calculation by which written premium becomes earned in even monthly amounts for each entire calendar month or part thereof during which a policy is in force, except that for the calendar months in which a premium is written or expires, one-half the even monthly amount is earned.

The term "even monthly amount" shall mean the written premium divided by the number of months for which the premium is written.

(312 amended Dec. 19, 1975, P.L.571, No.163)

Section 313. Computation of Reserve.--In addition to the reserves required by section 311, any insurance company, other than life insurance companies, is required to establish statutory reserves for those lines of insurance reported in schedule "P" of the Annual Statement Blank, as adopted for use in Pennsylvania by the commissioner, in accordance with the instructions for calculation of such statutory reserves as published by the National Association of Insurance Commissioners.

(313 amended Dec. 18, 1992, P.L.1496, No.177)

Section 314. Distribution of Unallocated Liability Loss Expense Payments.--(314 repealed Dec. 18, 1992, P.L.1496, No.177)

Section 315. Distribution of Unallocated Compensation Loss Expense Payments.--(315 repealed Dec. 18, 1992, P.L.1496, No.177)

Section 316. Power of Insurance Commissioner To Fix Amount of Reserves.--Whenever, in the judgment of the Insurance Commissioner, the loss reserves of any insurer under his supervision, calculated in accordance with the foregoing provisions, are inadequate, he may, in his discretion, require such insurer to maintain additional reserves based upon estimated individual claims or otherwise; or whenever a satisfactory mathematical or actuarial table for valuing compensation loss reserves is promulgated and approved by the Insurance Commissioner, he may require any insurer under his supervision to maintain, upon such tabular basis, greater or lesser reserves than those hereinbefore provided for.

(316 amended Dec. 18, 1992, P.L.1496, No.177)

Section 317. Information To Be Furnished in Annual Report.--(317 repealed Dec. 19, 1975, P.L.571, No.163)

(d) IMPAIRMENT OF CAPITAL AND RESERVES.

Section 321. Notice of Impairment of Funds.--Having charged as a liability the reinsurance and loss reserves as above defined for insurance companies and exchanges of this Commonwealth other than life insurance companies, and adding thereto all other debts and claims against the company or exchange, the commissioner shall, in case he finds the capital or reserve of the company or exchange impaired to any degree,

give notice to the company or exchange to make good the capital or reserve within thirty days.
(321 amended Dec. 1, 1977, P.L.241, No.77)

(e) NONCANCELLABLE HEALTH AND ACCIDENT INSURANCE.
(Hdg. added May 20, 1949, P.L.1500, No.450)

Section 325. Definition.--For the purposes of this act, the term "noncancellable health and accident insurance" means insurance against disability resulting from sickness, ailment, or bodily injury, under a policy or contract under which the insurer does not have the option to cancel or otherwise terminate the contract at or after the expiration of one year from its effective date, but not including policies or contracts insuring solely against accidental injury, or total and permanent disability benefits, supplementary to life insurance or annuity policies or contracts.
(325 added May 20, 1949, P.L.1500, No.450)

ARTICLE IV.
DEPOSITS OF SECURITIES TO DO BUSINESS.

Section 401. Deposit of Securities with Insurance Commissioner.--Any insurance company, association, or exchange, incorporated or organized under the laws of this Commonwealth, desiring to transact business in other States, the laws whereof require that such company, association, or exchange shall first deposit securities of a designated value with the Insurance Commissioner or other proper officer of this Commonwealth in trust and for the benefit of all its policyholders, or any insurance company or association of a foreign government desiring to make the deposit required of foreign companies or associations in order to transact business in the United States, is hereby authorized to deposit with the Insurance Commissioner securities for such an amount as the laws of such other States designate, or as the laws of this State require for foreign companies or associations. If the Insurance Commissioner is satisfied that such securities are worth the required amount, it shall be his duty to receive the same, or those given in exchange therefor as hereinafter provided, for the purpose aforesaid. Upon the written request of said insurance company, association, or exchange, the Insurance Commissioner shall certify, under his hand and official seal, to the proper officer of such other State or States or of the United States Government, wherein said insurance company, association, or exchange may desire to transact business, that said company, association, or exchange has deposited with him securities, giving the items of kind thereof, and that he is satisfied they are worth the sum designated by the laws of such other State or States, or required by the United States Government.

Section 402. State Treasurer To Be Custodian of Securities.--The Insurance Commissioner shall, upon receipt of any deposit made under this act, immediately place the same with the State Treasurer, whose duty it shall be to receive and hold the same, in the name of the Commonwealth, in trust for the purposes for which such deposit is made. The State Treasurer shall at all times be responsible for their custody and safekeeping. The company, association, or exchange making the deposit shall be entitled, from time to time, to demand and receive from the State Treasurer, on the written order of the Insurance Commissioner, the whole or any portion of any

securities so deposited, upon depositing with him, in lieu thereof, other securities of at least equal value; and also to demand, receive, sue for, and recover the interest and income from said securities, from the payee or obligee thereof, as the same becomes due and payable.

Section 403. Return of Securities by State Treasurer.--Upon request of any company, association, or exchange, organized under the laws of this Commonwealth, making the deposit, the Insurance Commissioner may authorize the State Treasurer to return to such company, association, or exchange the whole, or any portion, of the securities held by him on deposit, if the Insurance Commissioner shall be satisfied that the securities so asked to be returned are subject to no liability, and are not required to be longer held by any provision of law, or for the purpose of the original deposit. He may, in like manner, return to the trustees, or other representatives authorized for that purpose, of an insurance company or association of a foreign government, any deposit made by such company, if it shall appear that such company or association has ceased to do business in this Commonwealth, and is under no obligation to policyholders or other persons in this Commonwealth or in the United States, for whose benefit such deposit was made. No deposit, when once made, shall be wholly withdrawn or diminished so long as any liability to policyholders remains unsatisfied, except in case of dissolution by a court or judge of any company, association, or exchange making the deposit, in which case the State Treasurer shall, upon the written order of said court or judge, assign and transfer to the receiver duly appointed all securities or funds in his possession belonging to the company, association, or exchange.

Section 404. Suits in Equity To Enforce, Administer, or Terminate Trusts Created by Deposit of Securities.--An insurance company, association, or exchange which has made such deposit, or its trustees or resident manager in the United States, or the Insurance Commissioner, may, at any time, bring, in any court having jurisdiction, a suit in equity, against the Commonwealth and other parties properly joined therein, to enforce, administer, or terminate the trust created by such deposit. The process in such suit shall be served on the State Treasurer, who shall appear and answer on behalf of the Commonwealth, and perform such orders and decrees as the court may make thereon.

ARTICLE V
SUSPENSION OF BUSINESS - INVOLUNTARY DISSOLUTIONS
SECTIONS 501-511

Compiler's Note: Article V was repealed Dec. 14, 1977, P.L.280, No.92, and a new Article V was added.

Section 501. Suspension of Business of Insurance Companies of Other States and Foreign Government, Et Cetera, by Insurance Commissioner. (501 repealed Dec. 14, 1977, P.L.280, No.92)

Section 502. Suspension of and Applications to Court to Take Over Business of Domestic Companies, Et Cetera, for Protection of Policyholders, Creditors, Et Cetera. (502 repealed Dec. 14, 1977, P.L.280, No.92)

Section 503. Nonpayment of Judgments by Mutual Companies; Assessment of Policyholders; Dissolution. (503 repealed Dec. 14, 1977, P.L.280, No.92)

Section 504. Service of Process. (504 repealed Dec. 14, 1977, P.L.280, No.92)

Section 505. Injunction; Return of Order to Show Cause and Decrees Thereon. (505 repealed Dec. 14, 1977, P.L.280, No.92)

Section 506. Orders for Liquidation of Affairs of Companies, Et Cetera; Insurance Commissioner To Act as Receiver. (506 repealed Dec. 14, 1977, P.L.280, No.92)

Section 507. Insurance Commissioner to Supersede Other Receivers. (507 repealed Dec. 14, 1977, P.L.280, No.92)

Section 508. Superseded Receivers, Et Cetera, To Deliver Over Property and File Accounts. (508 repealed Dec. 14, 1977, P.L.280, No.92)

Section 509. Appointment of Special Deputies to Conduct Business or Liquidate Affairs of Companies, Et Cetera; Special Counsel; Compensation; Power to Administer Oaths and Subpoena Witnesses. (509 repealed Dec. 14, 1977, P.L.280, No.92)

Section 509.1. Assessment of Members of a Mutual Insurance Company by Insurance Commissioner. (509.1 repealed Dec. 14, 1977, P.L.280, No.92)

Section 510. Report of Insurance Commissioner as Receiver; Procedure Thereon. (510 repealed Dec. 14, 1977, P.L.280, No.92)

Section 511. Liquidation of Title Insurance Companies Partially Under Supervision of Department of Banking. (511 repealed Dec. 14, 1977, P.L.280, No.92)

Section 501. Construction and Purpose.--(a) This article shall not be interpreted to limit the powers granted the commissioner by other provisions of the law.

(b) This article shall be liberally construed to effect the purpose stated in subsection (c).

(c) The purpose of this article is the protection of the interests of insureds, creditors, and the public generally, with minimum interference with the normal prerogatives of the owners and managers of insurers, through (i) early detection of any potentially dangerous condition in an insurer, and prompt application of appropriate corrective measures; (ii) improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry; (iii) enhanced efficiency and economy of liquidation, through clarification and specification of the law, to minimize legal uncertainty and litigation; (iv) equitable apportionment of any unavoidable loss; (v) lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this Commonwealth; and (vi) regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business.

(501 added Dec. 14, 1977, P.L.280, No.92)

Section 502. Persons Covered.--The proceedings authorized by this article may be applied to:

(1) All insurers who are doing, or have done, an insurance business in this Commonwealth, and against whom claims arising from that business may exist now or in the future.

(2) All insurers who purport to do an insurance business in this Commonwealth.

(3) All insurers who have insureds resident in this Commonwealth.

(4) All other persons organized or in the process of organizing with the intent to do an insurance business in this Commonwealth.

(5) All nonprofit service plans and all fraternal benefit societies and beneficial societies subject to Title 40 of the Pennsylvania Consolidated Statutes (relating to insurance).

(6) All title insurance companies, subject to Article VII of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

(502 added Dec. 14, 1977, P.L.280, No.92)

Compiler's Note: Section 2(a) of Act 53 of 1978 provided section 502 is repealed in part. However, the specific references in the repeal were to language contained in the prior version of section 502 which was repealed in 1977. Therefore, the specific repeals could not be applied against the language of the existing section.

Section 503. Definitions.--The following words and phrases when used in this act shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Ancillary state" means any state other than a domiciliary state.

"Commissioner" means the Insurance Commissioner of the Commonwealth of Pennsylvania.

"Creditor" is a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed or contingent.

"Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer, and any summary proceeding under sections 510 through 513.

"Doing business" shall include any of the following acts, whether effected by mail or otherwise:

(1) the issuance or delivery of contracts or certificates of insurance to persons resident in this Commonwealth;

(2) the solicitation of applications for such contracts, or other negotiations preliminary to the execution of such contracts;

(3) the collection of premiums, membership fees, assessments or other consideration for such contracts; or

(4) the transaction of matters subsequent to execution of such contracts and arising out of them.

"Domiciliary state" means the state in which an insurer is incorporated or organized, or, in the case of an alien insurer, its state of entry.

"Fair consideration" is given for property or obligation:

(1) when in exchange for such property or obligation, as a fair equivalent therefor, and in good faith, property is conveyed or services are rendered or an obligation is incurred or an antecedent debt is satisfied; or

(2) when such property or obligation is received in good faith to secure a present advance or antecedent debt in amount not disproportionately small as compared to the value of the property or obligation obtained.

"Federal Home Loan Bank Act" means the Federal Home Loan Bank Act (47 Stat. 725, 12 U.S.C. § 1421 et seq.). (Def. added Oct. 14, 2014, P.L.2502, No.144)

"FHLBank" means a bank as defined in section 2(1)(A) of the Federal Home Loan Bank Act (47 Stat. 725, 12 U.S.C. § 1422(1)(A)). (Def. added Oct. 14, 2014, P.L.2502, No.144)

"FHLBank security agreement" means any pledge, security, collateral or guarantee agreement or any similar arrangement or credit enhancement in favor of an FHLBank. (Def. added Oct. 14, 2014, P.L.2502, No.144)

"Foreign country" means any other jurisdiction not in any state.

"General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, "general assets" includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and on deposit for the security or benefit of all policyholders and creditors shall be treated as general assets.

"Guaranty association." The Pennsylvania Insurance Guaranty Association provided for by the act of November 25, 1970 (P.L.716, No.232), known as "The Pennsylvania Insurance Guaranty Association Act," and the Workmen's Compensation Security Fund provided for by the act of July 1, 1937 (P.L.2532, No.470), known as the "Workmen's Compensation Security Fund Act," as amended, and any other similar entity now or hereafter created by the Legislature of this or any other state for the payment of claims of insolvent insurers.

"Insolvency" means:

(1) For an insurer issuing only assessable fire insurance policies; (i) the inability to pay any obligation within thirty days after it becomes payable, or (ii) if an assessment be made within thirty days after such date, the inability to pay such obligation thirty days following the date specified in the first assessment notice issued after the date of loss pursuant to section 808 of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

(2) For any other insurer the inability to pay its obligations when they are due, or whose admitted assets do not exceed its liabilities plus the greater of (i) any capital and surplus required by law for its organization, or (ii) its authorized and issued capital stock. For any insurer licensed to do business in the Commonwealth as of the effective date of this act which does not meet this standard, the term "insolvency" shall mean for a period not to exceed three years from the effective date of this act that it is unable to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the commissioner under provisions of the insurance law. In determining the financial condition of an insurer, the Insurance Commissioner shall consider assets to be admitted or nonadmitted as provided in section 320.1 of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

For purposes of this article "liabilities" shall include but not be limited to reserves required by statute or by insurance department general regulations or specific requirements imposed by the commissioner upon a subject company at the time of admission or subsequent thereto, and any other capital and surplus requirements.

(Def. amended Feb. 17, 1994, P.L.79, No.8)

"Insurer" means any person who is doing, has done, purports to do, or is licensed to do an insurance business, and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization or conservation by any insurance commissioner. For purposes of this article, any other persons included under section 502 shall be deemed to be insurers.

"Insurer-member" means an insurer that is a member of an FHLBank. (Def. added Oct. 14, 2014, P.L.2502, No.144)

"Preferred claim" means any claim with respect to which the terms of this act accord priority of payment from the general assets of the insurer.

"Receiver" means receiver, liquidator, rehabilitator, or conservator as the context requires.

"Reciprocal state" means any state other than this Commonwealth in which in substance and effect sections 520(a), 555, 556 and 558 through 560 are in force, and in which provisions are in force requiring that the commissioner or equivalent official be the receiver of a delinquent insurer, and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers.

"Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow or otherwise, but not including special deposit claims or claims against general assets. The term also includes claims which have become liens upon specific assets by reason of judicial process.

"Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

"State" means any state, district or territory of the United States and the Panama Canal Zone.

"Transfer" shall include the sale and every other and different mode, direct or indirect, of disposing of or of parting with property or with an interest therein, or with the possession thereof or of fixing a lien upon property or upon an interest therein, absolutely or conditionally, voluntarily, by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be deemed a transfer suffered by the debtor.

Compiler's Note: Section 2(a) of Act 53 of 1978 provided section 503 is repealed in part. However, the specific references in the repeal were to language contained in the prior version of section 503 which was repealed in 1977. Therefore, the specific repeals could not be applied against the language of the existing section.

Section 504. Jurisdiction and Venue.--(a) No court of this Commonwealth shall have jurisdiction to entertain, hear or determine any delinquency proceeding other than as provided in this article.

(b) In addition to other grounds for jurisdiction provided by the law of this Commonwealth, a court of this Commonwealth having jurisdiction of the subject matter has jurisdiction over a person served pursuant to the Pennsylvania Rules of Civil Procedure or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this Commonwealth (i) if the person served is obligated to the insurer in any way as an incident to any agency or brokerage arrangement that may exist or has existed between the insurer and the agent or broker, in any action on or incident to the obligation; or (ii) if the person served is a reinsurer who has at any time written a policy of reinsurance for an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced, or is an agent or broker of or for the reinsurer, in any action on or incident to the reinsurance contract; or (iii) if the person served is or has been an officer, manager, trustee, organizer, promoter or person in a position of comparable authority or influence in an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced, in any action resulting from the relationship with the insurer.

(c) If the court on motion of any party finds that any action should as a matter of substantial justice be tried in a forum outside this Commonwealth, the court may enter an

appropriate order to stay further proceedings on the action in this Commonwealth.

(d) All action herein authorized shall be brought in the Commonwealth Court of the Commonwealth of Pennsylvania.

(504 added Dec. 14, 1977, P.L.280, No.92)

Section 505. Injunctions and Orders.--(a) Any receiver appointed in a proceeding under this article may at any time apply for and the Commonwealth Court may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to prevent: (i) the transaction of further business; (ii) the transfer of property; (iii) interference with the receiver or with the proceeding; (iv) waste of the insurer's assets; (v) dissipation and transfer of bank accounts; (vi) the institution or further prosecution of any actions or proceedings; (vii) the obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets or its policyholders; (viii) the levying of execution against the insurer, its assets or its policyholders; (ix) the making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of this insurer; (x) the withholding from the receiver of books, accounts, documents or other records relating to the business of the insurer; or (xi) any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors, or shareholders, or the administration of the proceeding.

(a.1) Notwithstanding subsection (a) or any other provision of this article to the contrary, no FHLBank shall be stayed, enjoined or prohibited from exercising any right or enforcing any obligation under an FHLBank security agreement relating to collateral pledged by an insurer-member to the FHLBank. ((a.1) amended Oct. 14, 2014, P.L.2502, No.144)

(b) The receiver may apply to any court outside of the Commonwealth for the relief described in subsection (a) or suspension of any insurance licenses issued by the commissioner.

Section 506. Cooperation of Officers and Employes.--(a) Any employe, officer, manager, trustee, or general agent of any insurer, and any other person with executive authority over or in charge of any segment of the insurer's affairs shall cooperate with the commissioner in any proceeding under this article or any investigation preliminary or incidental to the proceeding. The term "person" as used in this section, shall include any person who exercises control directly or indirectly over activities of an insurer through any holding company or other affiliate of the insurer. "To cooperate" shall include, but shall not be limited to the following:

(1) to reply promptly in writing to any inquiry from the commissioner requesting such a reply; and

(2) to make available and deliver to the commissioner any books, accounts, documents, or other records, or information or property of or pertaining to the insurer and in his possession, custody or control.

(b) No person shall obstruct or interfere with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

(c) This section shall not be construed to abridge otherwise legal rights to resist a petition for liquidation or other delinquency proceedings:

(i) An insurer shall have the right to engage legal counsel for defense of and appeal with respect to a delinquency proceeding. Reasonable costs and fees therefore may be paid

from the general assets of the insurer, subject to the approval of the administrative or judicial body to which appeal was made.

In the event that such proceedings result in a declaration of insolvency or are subsequent thereto, the approved costs thereof shall be administrative costs or expenses as provided under section 544(b).

(ii) If a stay of proceedings or order is specifically requested in a petition filed by an insurer, the administrative agency or court to which such petition is made may, in its discretion, grant such stay.

(d) Any person included within subsection (a) who fails to cooperate with the commissioner, or any person who obstructs or interferes with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto, or who violates any valid order the commissioner issued under this article may be sentenced to pay a fine not exceeding ten thousand dollars ($10,000) or to undergo imprisonment for a term of not more than one year, or both, or any person shall, after a hearing, be subject to the imposition by the commissioner, of a civil penalty not to exceed ten thousand dollars ($10,000) and shall be subject further to the revocation or suspension of any insurance license issued by the commissioner.

(506 added Dec. 14, 1977, P.L.280, No.92)

Section 507. Bonds.--In any proceeding under this article, the commissioner and his deputies shall be responsible on their official bonds for the faithful performance of their duties. If the court deems it desirable for the protection of the assets, it may at any time require an additional bond from the commissioner or his deputies. Such additional bond shall be paid for out of the assets of the insurer as a cost of administration.

(507 added Dec. 14, 1977, P.L.280, No.92)

Section 508. Commissioner's Reports.--The commissioner shall as receiver make such reports to the court at such times and in such manner as the court shall require.

(508 added Dec. 14, 1977, P.L.280, No.92)

Section 509. Continuation of Delinquency.--Every proceeding heretofore commenced under the laws in effect before the enactment of the amendment of this article effective ....., 1977, shall be deemed to have commenced under this article so amended for the purpose of conducting the proceeding henceforth, except that in the discretion of the commissioner the proceeding may be continued, in whole or in part, as it would have been continued had this article not been so amended.

(509 added Dec. 14, 1977, P.L.280, No.92)

(b) SUMMARY PROCEEDINGS

Section 510. Commissioner's Summary Orders.--(a) Whenever the commissioner has reasonable cause to believe, and determines, after a hearing held as prescribed in subsection (c), that any insurer has committed or engaged in any act, practice or transaction that would subject it to formal delinquency proceedings under this article, he may make and serve upon the insurer and any other persons involved, such orders, including an order suspending the business of an insurer, as are reasonably necessary to correct, eliminate or remedy such conduct, condition or ground.

(b) If the conditions of subsection (a), other than notice and hearing, are satisfied, and if the commissioner has reasonable grounds to believe that irreparable harm to the

property or business of the insurer or to the interests of its policy or certificate holders, creditors or the public may occur unless he issues with immediate effect the orders described in subsection (a), he may make and serve such orders without notice and before hearing, simultaneously serving upon the insurer notice of hearing under subsection (c).

(c) The notice of hearing under subsections (a) or (b) and the summary order issued under subsections (a) or (b) shall be served pursuant to the applicable rules of civil or administrative procedure. The notice of hearing under subsection (a) shall state the time and place of hearing, and the conduct, condition or ground upon which the commissioner would base his order; the notice of hearing under subsection (b) shall state the time and place of hearing. Unless mutually agreed between the commissioner and the insurer, the hearing shall occur not more than fifteen days after notice is served and shall be either in Dauphin County or in some other place convenient to the parties to be designated by the commissioner. The commissioner shall not publicize such hearings and shall hold all hearings in summary proceedings privately unless the insurer requests a public hearing, in which case the hearing shall be public.

(d) Any suspension order made by the commissioner under the provisions of subsection (a) shall prohibit issuance of policies, transfers of property, and payments of moneys, without prior written approval of the commissioner. Notice of such suspension shall be given, by first class mail within fifteen days thereof, by the suspended organization to those who were creditors, policyholders, members and certificate holders at the date of suspension. Notice of such suspension shall be given, within fifteen days thereof, by the commissioner to creditors, policyholders, members and certificate holders by advertising the same by one publication in a newspaper of general circulation in the county where the suspended organization has its principal office. From the date of such suspension on the ground that the insurer is insolvent, or is in such condition that its further transaction of business will be hazardous financially to its policyholders, creditors, or the public, no action at law or equity shall be commenced or prosecuted nor shall any judgment be entered against nor shall any execution or attachment be issued or prosecuted against the suspended insurer, or against its property, in any court of this Commonwealth: Provided, That if such suspension order be vacated by the Commonwealth Court for the reason that the suspended insurer is no longer insolvent, or in such condition that its further transaction of business will be hazardous to its policyholders or to its creditors or to the public, these restraints upon legal process regarding the insurer shall thereafter cease to be operative.

(e) If the commissioner issues a summary order before hearing under this section, the insurer may at any time waive the commissioner's hearing and apply for immediate judicial relief by means of any remedy afforded by law without first exhausting administrative remedies.

(f) If any person has violated any order issued under this section which as to him was then still in effect, he shall be liable to pay a civil penalty imposed by the Commonwealth Court not to exceed ten thousand dollars ($10,000).

(g) The commissioner may apply for and any court of general jurisdiction may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to enforce a summary order.

(510 added Dec. 14, 1977, P.L.280, No.92)

Compiler's Note: Section 2(a) of Act 53 of 1978 provided section 510 is repealed in part. However, the specific references in the repeal were to language contained in the prior version of section 510 which was repealed in 1977. Therefore, the specific repeals could not be applied against the language of the existing section.

Section 511. Commissioner's Supervision.--(a) If upon examination or at any other time the commissioner has reasonable cause to believe, and determines, that an insurer has committed, engaged, or is about to engage in any act, practice, or transaction that would subject it to formal delinquency proceedings under this article, or if such insurance company gives its consent, then the commissioner shall upon his determination notify the insurer of his determination and furnish to the insurer an order or orders containing a written list of the commissioner's requirements to abate his determination. If the commissioner after a hearing held as provided in subsection 510(c) makes a further determination to supervise he shall issue an order to the insurer notifying it that it is under the supervision of the commissioner and that the commissioner is applying and effecting the provisions of this section. The commissioner may issue an order under this section without a hearing under the conditions provided under section 510(b), and shall simultaneously serve upon the insurer notice of a hearing to be held in accordance with the provisions of section 510(c), and in such event, the insurer may file an appeal in accordance with the provisions of section 510(e). Such insurer shall comply with the lawful requirements of the commissioner and, if placed under an order of supervision shall have ninety days from the date of service of such order within which to comply with the requirements of the commissioner. In the event of such insurer's failure to comply within such time, the commissioner may institute proceedings in the Commonwealth Court to have a rehabilitator or liquidator appointed under the provisions of this article, or issue an order extending an existing order of supervision. Such order extending any existing order shall be issued prior to the end of each ninety-day period, unless otherwise agreed to by the insurer.

(b) The commissioner may appoint a supervisor to supervise such insurer and may provide that the insurer may not do any of the following acts, during the period of supervision, without the prior written approval of the commissioner or his supervisor: (i) dispose of, convey or encumber any of its assets or its business in force; (ii) withdraw any of its bank accounts; (iii) lend any of its funds; (iv) invest any of its funds; (v) transfer any of its property; (vi) incur any debit, obligation or liability; (vii) merge or consolidate with another company; or (viii) enter into any new reinsurance contract or treaty.

(c) In the event that any person, subject to the provisions of this article including those persons described in section 506(a), shall violate any valid order of the commissioner issued under the provisions of this section and, as a result, the net worth of the insurer shall be reduced or the insurer shall otherwise suffer loss said person shall become personally liable to the insurer for the amount of any such reduction or loss. The commissioner or supervisor is authorized to bring an action on behalf of the insurer in the Commonwealth Court to recover the amount of the reduction or loss together with any costs.

(511 added Dec. 14, 1977, P.L.280, No.92)

Section 512. Court's Seizure Order.--(a) Upon the filing by the commissioner in the Commonwealth Court of this Commonwealth of a petition alleging, (i) any ground that would justify a court order for a formal delinquency proceeding against an insurer under this article, and (ii) that the interests of policyholders, creditors or the public will be endangered by delay, and (iii) setting out the order deemed necessary by the commissioner, the court may issue forthwith, ex parte and without a hearing, the requested order which shall direct the commissioner to take possession and control of all or a part of the property, books, accounts, documents, and other records of an insurer, and of the premises occupied by it for the transaction of its business, and until further order of the court enjoin the insurer and its officers, managers, agents, and employes from disposition of its property and from transaction of its business except with the written consent of the commissioner.

(b) The court shall specify in the order what its duration shall be, which shall be such time as the court deems necessary for the commissioner to ascertain the condition of the insurer. Such initial duration or any extension thereof shall not exceed ninety days. On motion of either party or on its own motion, the court may from time to time hold such hearings as it deems desirable after such notice as it deems appropriate, and may extend, shorten, or modify the terms of the seizure order. The court shall vacate the seizure order if the commissioner fails to commence a formal proceeding under this article prior to the expiration of a seizure order or any extension thereof. An order of the court pursuant to a formal proceeding under this article shall ipso facto vacate the seizure order.

(c) Entry of a seizure order under this section shall not constitute an anticipatory breach of any contract of the insurer.

(d) An insurer subject to an ex parte order of the Commonwealth Court issued under the provisions of this section may petition the court at any time after the issuance of such order for a hearing and review of the order, and the court shall grant such a hearing and review within ten days of the filing of such petition.

(512 added Dec. 14, 1977, P.L.280, No.92)

Section 513. Conduct of Hearings in Summary Proceedings.--(a) The Commonwealth Court may hold all hearings in summary proceedings and judicial review thereof privately in chambers, and shall do so on request of the insurer proceeded against.

(b) In all summary proceedings and judicial reviews thereof, all records of the insurer, other documents, and all Insurance Department files and court records and papers, so far as they pertain to or are a part of the record of the summary proceedings, shall be and remain confidential except as is necessary to obtain compliance therewith, unless and until the Commonwealth Court, after hearing arguments from the parties in chambers, shall order otherwise, or unless the insurer requests that the matter be made public. Until such court order, all papers filed with the clerk of the Commonwealth Court shall be held by him in a confidential file.

(c) Any person having possession or custody of and refusing to deliver any of the property, books, accounts, documents or other records of or relating to an insurer against which a seizure order or a summary order has been issued by the commissioner or by the Commonwealth Court, may be fined not

more than ten thousand dollars ($10,000) or sentenced to undergo imprisonment for not more than one year, or both.

(513 added Dec. 14, 1977, P.L.280, No.92)

(c) FORMAL PROCEEDINGS
A. Rehabilitation

Section 514. Grounds for Rehabilitation.--An order of rehabilitation may be based on one or more of the following grounds:

(1) The insurer is insolvent, or is in such condition that the further transaction of business would be hazardous, financially, to its policyholders, creditors or the public.

(2) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

(3) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employe, or other person, if the person has been found after notice and hearing to be dishonest or untrustworthy in a way affecting the insurer's business.

(4) Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be dishonest or untrustworthy.

(5) Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employe, or other person, has refused to be examined under oath by the commissioner concerning its affairs, whether in this Commonwealth or elsewhere, and after reasonable notice of the fact the insurer has failed promptly and effectively to terminate the employment and status of the person and all his influence on management.

(6) After demand, the insurer has failed to submit promptly any of its own property, books, accounts, documents or other records, or those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer so far as they pertain to the insurer, to examination. If the insurer is unable to submit the property, books, accounts, documents or other records of a person having executive authority in the insurer, it shall be excused from doing so if it promptly and effectively terminates the relationship of the person to the insurer.

(7) Without first obtaining his written consent of the commissioner, the insurer has transferred, or attempted to transfer, substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person.

(8) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator or sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this Commonwealth, and such appointment has been made or is imminent, and such appointment might oust the courts of this Commonwealth of jurisdiction or prejudice orderly delinquency proceedings under this article.

(9) Within the previous four years the insurer has willfully violated its charter or articles of incorporation or its bylaws or any insurance law in a manner which may result or has resulted in substantial harm to the property or business of an insurer or to the interests of its policy or certificate holders, creditors, or the public, or any valid order of the commissioner under sections 510 and 511.

(10) The insurer has failed to pay within sixty days after due date any obligation to this Commonwealth or any subdivision thereof or any judgment entered in this Commonwealth, except that such nonpayment shall not be a ground until sixty days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the commissioner or in the courts, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full.

(11) The insurer has failed to file its annual report or other report within the time allowed by law and, after written demand by the commissioner, has failed to give a satisfactory explanation immediately.

(12) The board of directors or the holders of a majority of the shares entitled to vote, or a majority of those individuals entitled to the control of those entities specified in section 502, request or consent to rehabilitation under this article.

(514 added Dec. 14, 1977, P.L.280, No.92)

Section 515. Rehabilitation Orders.--(a) The commissioner may apply by petition to the Commonwealth Court, for an order authorizing him to rehabilitate a domestic insurer or an alien insurer domiciled in this Commonwealth, alleging that the insurer has committed one or more acts which may constitute grounds for rehabilitation as set forth in section 514 of this article.

(b) An order of the Commonwealth Court to rehabilitate the business of an insurer shall be issued only after a hearing before the court or pursuant to a written consent of the insurer.

(c) An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in this Commonwealth, shall appoint the commissioner and his successors in office the rehabilitator, and shall direct the rehabilitator forthwith to take possession of the assets of the insurer including any deposits held by the commissioner, and to administer them under the orders of the court. The filing or recording of the order with the clerk of the Commonwealth Court or recorder of deeds of the county in which the principal business of the company is conducted, or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(d) Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contracts of the insurer.

(515 added Dec. 14, 1977, P.L.280, No.92)

Section 516. Powers and Duties of the Rehabilitator.--(a) The commissioner as rehabilitator may appoint a special deputy who shall have all the powers of the rehabilitator granted under this section. The commissioner shall make such arrangements for compensation as are necessary to obtain a special deputy of proven ability. The special deputy shall serve at the pleasure of the commissioner.

(b) The rehabilitator may take such action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer. He shall have all the powers of the directors, officers and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. He shall have full power to direct and manage, to hire and discharge employes subject to any contract rights they may have, and to deal with the property and business of the insurer.

(c) If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employe, or other person, he may pursue all appropriate legal remedies on behalf of the insurer.

(d) The rehabilitator may prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer. Upon application of the rehabilitator for approval of the plan, and after such notice and hearing as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. If it is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the equities of policyholders of the company, provided that all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

(e) The rehabilitator shall have the power to avoid fraudulent transfers under sections 528 and 529.

(516 added Dec. 14, 1977, P.L.280, No.92)

Section 517. Actions By and Against Rehabilitator.--(a) On request of the rehabilitator, any court in this State before which any action or proceeding by or against an insurer is pending when a rehabilitation order against the insurer is entered shall stay the action or proceeding for such time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The Commonwealth Court shall order the rehabilitator to take such action respecting the pending litigation as the court deems necessary in the interests of justice and for the protection of creditors, policyholders, and the public. The rehabilitator shall immediately consider all litigation pending outside this Commonwealth and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

(b) The time between the filing of a petition for rehabilitation against an insurer and denial of the petition or an order of rehabilitation shall not be considered to be a part of the time within which any action may be commenced by or against the insurer. Any action by or against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty days after the order of rehabilitation is entered.

(517 added Dec. 14, 1977, P.L.280, No.92)

Section 518. Termination of Rehabilitation.--(a) Whenever he has reasonable cause to believe that further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policy and certificate holders, or the public, or would be futile, the rehabilitator may petition the Commonwealth Court for an order of liquidation. A petition under this subsection shall have the same effect as a petition under

section 520. The Commonwealth Court shall permit the directors to take such actions as are reasonably necessary to defend against the petition and may order payment from the estate of the insurer of such costs and other expenses of defense as justice may require.

(b) The rehabilitator may at any time petition the Commonwealth Court for an order terminating rehabilitation of an insurer. If the Commonwealth Court finds that rehabilitation has been accomplished and that grounds for rehabilitation under section 514 no longer exists, it shall order that the insurer be restored to possession of its property and the control of its business. The Commonwealth Court may also make that finding and issue that order at any time upon its own motion.

(518 added Dec. 14, 1977, P.L.280, No.92)

B. Liquidation

1. Initiation of Proceeding

Section 519. Grounds for Liquidation.--Any ground on which an order of rehabilitation may be based, as specified in section 514, whether or not there has been a prior order of rehabilitation of the insurer shall be grounds for liquidation.

(519 added Dec. 14, 1977, P.L.280, No.92)

Section 520. Liquidation Orders.--(a) The commissioner may apply by petition to the Commonwealth Court for an order directing him to liquidate a domestic insurer, domiciled in this Commonwealth, alleging that the insurer has committed one or more acts which may constitute grounds for liquidation as set forth in sections 514 and 519 of this article.

(b) An order of the Commonwealth Court to liquidate the business of an insurer shall be issued only after a hearing before the court or pursuant to a written consent of the insurer.

(c) An order to liquidate the business of a domestic insurer shall appoint the commissioner and his successors in office liquidator and shall direct the liquidator forthwith to take possession of the assets of the insurer and to administer them under the orders of the court. The liquidator shall be vested by operation of law with the title to all of the property, contracts and rights of action and all of the books and records of the insurer ordered liquidated, wherever located, as of the date of the filing of the petition for liquidation. He may recover and reduce the same to possession except that ancillary receivers in reciprocal states shall have, as to assets located in their respective states, the rights and powers which are prescribed in section 556(c) for ancillary receivers appointed in this Commonwealth as to assets located in this Commonwealth. The filing or recording of the order with the Clerk of the Commonwealth Court or with the recorder of deeds of the county in which the principal business of the company is conducted, or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(d) Upon issuance of the order, the rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members and all other persons interested in its estate shall become fixed as of the date of filing of the petition for liquidation, except as provided in sections 521 and 539.

(e) An order to liquidate the business of an alien insurer domiciled in this Commonwealth shall be in the same terms and

have the same legal effect as an order to liquidate a domestic insurer, except that the assets and the business in the United States shall be the only assets and business included therein.

(f) At the time of petitioning for an order of liquidation, or at any time thereafter, the commissioner, after making appropriate findings of an insurer's insolvency, following an administrative hearing, may petition the court for a judicial declaration of such insolvency. After providing such notice and hearing as are permitted for appeals from administrative agencies, the court may make the declaration.

(520 added Dec. 14, 1977, P.L.280, No.92)

Section 521. Continuance of Coverage.--All insurance in effect at the time of issuance an order of liquidation shall continue in force only with respect to the risks in effect, at that time (i) for a period of thirty days from the date of entry of the liquidation order; (ii) until the normal expiration of the policy coverage; (iii) until the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy; or (iv) until the liquidator has effected a transfer of the policy obligation pursuant to section 523(8), whichever time is less.

(521 added Dec. 14, 1977, P.L.280, No.92)

Section 522. Dissolution of Insurer.--The commissioner may petition for an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in this Commonwealth at the time he applied for a liquidation order. The court shall order dissolution of the corporation upon petition by the commissioner upon or after the granting of a liquidation order. If the dissolution has not previously been ordered, it shall be effected by operation of law upon the discharge of the liquidator.

(522 added Dec. 14, 1977, P.L.280, No.92)

2. Powers and Duties of Liquidators and Others

Section 523. Powers of Liquidator.--The liquidator shall have the power:

(1) To appoint a special deputy to act for him under this article, and to determine his compensation. The special deputy shall have all powers of the liquidator granted by this section. The special deputy shall serve at the pleasure of the commissioner.

(2) To employ employes and agents, legal counsel, actuaries, accountants, appraisers, consultants and such other personnel as he may deem necessary to assist in the liquidation.

(3) To fix the compensation of employes and agents, legal counsel, actuaries, accountants, appraisers and consultants without complying with civil service regulations.

(4) To pay compensation to persons appointed and to defray all expenses of taking possession of, conserving, conducting, liquidating, disposing of or otherwise dealing with the business and property of the insurer. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner shall advance the costs so incurred out of the appropriation for the maintenance of the Insurance Department. Any amounts so paid shall be deemed expense of administration and shall be repaid to the commissioner for the use of the Insurance Department out of the first available moneys of the insurer.

(5) To hold hearings, to subpoena witnesses, to compel their attendance, to administer oaths, to examine any person under oath, and to compel any person to subscribe to his testimony

after it has been correctly reduced to writing, and in connection therewith to require the production of any books, papers, records or other documents which he deems relevant to the inquiry.

(6) To collect all debts and moneys due and claims belonging to the insurer which it is economical to collect, wherever located, and for this purpose to institute timely action in other jurisdictions, in order to forestall garnishment and attachment proceedings against such debts; to do such other acts as are necessary or expedient to collect, conserve or protect its assets or property, including the power to sell, compound, compromise or assign for purposes of collection upon such terms and conditions as he deems best, any bad or doubtful debts; to pursue any creditor's remedies available to enforce his claims.

(7) To conduct public and private sales of the property of the insurer.

(8) To use assets of the estate to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under section 544.

(9) To acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon or otherwise dispose of or deal with, any property of the insurer at its market value or upon such terms and conditions as are fair and reasonable. He shall also have power to execute, acknowledge and deliver any and all deeds, assignments, releases and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation is pending, the liquidator shall cause to be filed with the recorder of deeds for the county in which the property is located a certified copy of the order appointing him liquidator.

(10) To borrow money on the security of the insurer's assets or without security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation.

(11) To enter into such contracts as are necessary to carry out the order to liquidate, and to affirm or disavow any contracts to which the insurer is a party.

(12) To continue to prosecute and to institute in the name of the insurer or in his own name any and all suits and other legal proceedings, in this Commonwealth or elsewhere, and to abandon the prosecution of claims he deems unprofitable to pursue further. If the insurer is dissolved under section 522, he shall have the power to apply to any court in this State or elsewhere for leave to substitute himself for the insurer as plaintiff.

(13) To prosecute any action which may exist in behalf of the creditors, members, policyholders or shareholders of the insurer against any officer of the insurer, or any other person.

(14) To remove any or all records and property of the insurer to the offices of the commissioner or to such other place as may be convenient for the purposes of efficient and orderly execution of the liquidation.

(15) To deposit in one or more banks in this Commonwealth such sums as are required for meeting current administration and operating costs.

(16) To invest, all sums not currently needed, unless the court orders otherwise.

(17) To file any necessary documents for record in the office of any recorder of deeds or record office in this

Commonwealth or elsewhere where property of the insurer is located.

(18) To assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds and the defense of usury; a waiver of any defense by the insurer after a petition in liquidation has been filed shall not bind the commissioner. When a guaranty association has an obligation to defend a suit, the liquidator shall give precedence to such obligations and shall defend only in the absence of a defense by the guaranty association.

(19) To exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder or member, including any power to avoid any transfer or lien that may be given by the general law and that is not included with sections 528 through 530.

(20) To intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee, and to act as the receiver or trustee whenever the appointment is offered.

(21) To enter into agreements with any receiver or commissioner of any other state relating to the rehabilitation, liquidation, conservation or dissolution of an insurer doing business in both states.

(22) To exercise all powers now held or hereafter conferred upon receivers by the laws of this Commonwealth not inconsistent with the provisions of this article.

(23) The enumeration, in this section, of the powers and authority of the liquidator shall not be construed as a limitation upon him, nor shall it exclude in any manner his right to do such other acts not herein specifically enumerated, or otherwise provided for, as may be necessary or expedient for the accomplishment of or in aid of the purpose of liquidation.

(523 added Dec. 14, 1977, P.L.280, No.92)

Section 523.1. Policyholder Collateral, Deductible Reimbursements and Other Policyholder Obligations.--(a) Collateral shall not be considered an asset of the estate and shall be maintained and administered by the receiver as provided in this section, notwithstanding any other provision of law or contract to the contrary.

(b) Subject to the provisions of this section, the collateral shall be used to secure the policyholder's obligation to fund or reimburse claims payment within the agreed deductible amount.

(c) If a claim that is subject to a deductible agreement and secured by collateral is not covered by any guaranty association and the policyholder is unwilling or unable to take over the handling and payment of the non-covered claims, the receiver shall adjust and pay the non-covered claims utilizing the collateral but only to the extent the available collateral, after allocation under subsection (d), is sufficient to pay all outstanding and anticipated claims. A claim against the collateral by a third-party claimant is not a claim against the insolvent insurer's estate for the purposes of releasing the policyholder to the extent of applicable policy coverage. If the collateral is exhausted and the insured is not able to provide funds to pay the remaining claims within the deductible after all collection means against the insured have been exhausted, the receiver's obligation to pay such claims from the collateral terminates, and the remaining claims shall be claims against the insurer's estate subject to complying with other provisions of this article for the filing and allowance of claims. When the liquidator determines the collateral

provided by the insured is insufficient to pay all additional and anticipated claims against the insured, the liquidator may file a plan for equitably allocating the collateral among claimants of the insured which provided the collateral, subject to court approval.

(d) To the extent that the receiver is holding collateral that secures other obligations of the policyholder to pay the insurer directly or indirectly amounts that will become assets of the estate, such as reinsurance obligations under a captive reinsurance program or premium obligations under a retrospectively rated insurance policy where the premium due is subject to adjustment based upon actual loss experience, the receiver shall equitably allocate the collateral among such obligations and administer the collateral allocated to the deductible agreement pursuant to this section. With respect to the collateral allocated to obligations under the deductible agreement, if the collateral-secured reimbursement obligations are under more than one line of insurance, then the collateral shall be equitably allocated among the various lines based upon the estimated ultimate exposure within the deductible amount for each line. The receiver shall inform the guaranty associations of the method and details of all the foregoing allocations.

(e) Regardless of whether there is collateral, if the insurer has contractually agreed to allow the policyholder to fund its own claims within the deductible amount pursuant to a deductible agreement either through the policyholder's own administration of its claims or through the policyholder providing funds directly to a third-party administrator who administers the claims, the receiver shall allow such funding arrangement to continue and, where applicable, will enforce such arrangements to the fullest extent possible. The funding of such claims by the policyholder within the deductible amount will act as a bar to a claim for such amount in the liquidation proceeding, including, but not limited to, a claim by the policyholder or the third-party claimant. The funding will extinguish both the obligation, if any, of any guaranty association to pay such claims within the deductible amount, as well as the obligation, if any, of the policyholder or the third-party administrator to reimburse the guaranty association. No charge of any kind shall be made against a guaranty association on the basis of the policyholder funding of claims payment made pursuant to the mechanism set forth in this subsection.

(f) (1) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount, to the extent a guaranty association is required by applicable State law to pay any claims for which the insurer would have been entitled to reimbursement from the policyholder under the terms of the deductible agreement and to the extent the claims have not been paid by the policyholder or by a third party, the receiver shall promptly bill the policyholder for such reimbursement, and the policyholder will be obligated to pay such amount to the receiver for the benefit of the guaranty associations who paid such claims. Neither the insolvency of the insurer nor its inability to perform any of its obligations under the deductible agreement shall be a defense to the policyholder's reimbursements obligation under the deductible agreement. When the policyholder reimbursements are collected, the receiver shall promptly reimburse such guaranty association for claims paid that were subject to the deductible. If the policyholder fails to pay the amounts due within sixty days

after such bill for such reimbursements is due, the receiver shall use the collateral to the extent necessary to reimburse the guaranty association and, at the same time, may pursue other collections efforts against the policyholder. If the policyholder reimbursements are not collected due to the reduction in such reimbursements as provided in paragraph (2), the receiver shall nonetheless reimburse such guaranty association as if such reimbursements had been collected. The receiver will obtain funds to reimburse a guaranty association claim affected by paragraph (2) by subtracting from funds collected by the receiver for other policyholder claim reimbursements under this paragraph amounts sufficient to reimburse the guaranty association affected by the application of paragraph (2). Subtraction of funds shall be made against all guaranty associations, including the guaranty association affected by paragraph (2) on the basis of the ratio stated in paragraph (3). If more than one guaranty association has a claim against the same collateral and the available collateral, after allocation under subsection (d), along with billing and collection efforts, are together insufficient to pay each guaranty association in full, then the receiver will prorate payments to each guaranty association based upon the proportion of the amount of claims each guaranty association has paid bears to the total of all claims paid by such guaranty associations.

(2) The obligation of a policyholder arising solely from a deductible agreement to reimburse the receiver for the benefit of one or more guaranty associations under paragraph (1) for losses paid by one or more guaranty associations shall be reduced by the amount of premium paid by or on behalf of the policyholder for one or more policies issued by a wholly owned affiliate or subsidiary of the insurer, which affiliate or subsidiary was either licensed to do business in this Commonwealth or was an eligible surplus lines insurer under Article XVI of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921," at the time of the issuance of such policies where such policies were purchased to fund the policyholder's obligation to reimburse the insurer for deductibles under the deductible agreement, but in no event shall the reduction in liability be less than ninety per centum of the total premiums paid to the insurer and such affiliate or subsidiary for such policies and coverage provided under the related deductible agreement, provided that the policyholder's reimbursement obligation shall be reduced only if: (i) the wholly owned affiliate or subsidiary was merged into the insurer that was a party to the deductible agreement before the entry of a liquidation order against the insurer; (ii) the merger was approved by the commissioner; and (iii) the merger took place before the enactment of this section.

(3) The reduction as a result of paragraph (2) in the amount of deductible reimbursements that one or more guaranty associations would have been entitled to claim from a policyholder of the insurer under paragraph (1) shall be allocated by the receiver pursuant to this paragraph pro rata among all guaranty associations receiving deductible reimbursements under paragraph (1). The pro rata allocation among guaranty associations shall be based upon the ratio of: (i) claims paid and to be paid as estimated by each guaranty association that are referred to in paragraph (1) to (ii) the total amount of claims paid and to be paid estimated by all the guaranty associations that are referred to in paragraph (1). Amounts used for the pro rata allocation shall be determined

after giving effect to the provisions referred to in subsection (k) relating to insured net worth.

(4) Any claim of the policyholder under one or more policies issued by the affiliate or subsidiary as described in paragraph (2) is hereby waived except for those claims under policies that are not paid by a guaranty association as a covered claim or amounts the policyholder has reimbursed a guaranty association under Article XVIII of "The Insurance Company Law of 1921" or similar laws in other states.

(g) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount and a deductible reimbursement policy is present, to the extent a guaranty association is required by applicable State law to pay any claims for which the insurer would have been entitled to reimbursement under the deductible reimbursement policy and to the extent the claims have not been paid by the policyholder or by a third party, the receiver shall first make a good faith attempt to recover reimbursements or collateral under the deductible reimbursement policy. Any resulting recoveries under the deductible reimbursement policy shall by payable to the guaranty associations to the extent of claims paid within the deductible. To the extent the receiver is unable in whole or in part to recover first under the deductible reimbursement policy for claims paid by the guaranty associations, the receiver shall promptly bill the policyholder for the reimbursement, and the policyholder will be obligated to pay the amount to the receiver for the benefit of the guaranty associations who paid the claims. The policyholder shall retain any and all defenses that may be asserted in connection with the receiver's efforts to collect reimbursements from the policyholder.

(h) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount and a deductible reimbursement policy is present and if a guaranty association is not paying claims for any reason for which the insurer would have been entitled to reimbursement under the deductible reimbursement policy, to the extent claims covered under a deductible reimbursement policy have been paid by the policyholder and sufficient information on the payments has been provided by the policyholder to the receiver for purposes of billing under the deductible reimbursement policy, the receiver shall make a good faith attempt to recover reimbursements or collateral under the deductible reimbursement policy from the insurer of the deductible reimbursement policy. Any resulting recoveries under the deductible reimbursement policy shall be payable to the policyholder.

(i) Receiver's duties and powers:

(1) The receiver is entitled to deduct from reimbursements owed to guaranty associations and/or policyholders under this section or collateral to be returned to a policyholder reasonable actual expenses incurred in fulfilling the responsibilities under this provision, not to exceed three per centum of the collateral or the total deductible reimbursements actually collected by the receiver.

(2) With respect to claim payments made by any guaranty associations, the receiver shall promptly provide the guaranty associations with a complete accounting of the receiver's deductible billing and collection activities, including, but not limited to, copies of the policyholder billings when rendered, the reimbursements collected, the available amounts and use of collateral for each account and any proration of payments when it occurs. The receiver's costs of accounting

shall be included with expenses referred to under this subsection and, together with other reasonable actual expenses, be subject to the overall limit called for by this subsection. If the receiver fails to make a good faith effort within one hundred twenty days of receipt of claims payment reports to collect reimbursements due from a policyholder under a deductible agreement based on claim payments made by one or more guaranty associations, then after such one-hundred-twenty-day-period such guaranty associations may pursue collection from the policyholders directly on the same basis as the receiver and with the same rights and remedies and will report any amounts so collected from each policyholder to the receiver. To the extent that guaranty associations pay claims within the deductible amount but are not reimbursed by either the receiver under this section or by policyholder payments from the guaranty association's own collection efforts, the guaranty association shall have a claim in the insolvent insurer's estate for such unreimbursed claims payments.

(3) The receiver shall periodically adjust the collateral being held while the claims subject to the deductible agreement are run off, provided that adequate collateral is maintained to secure the entire estimated ultimate obligation of the policyholder plus a reasonable safety factor, and the receiver shall not be required to adjust the collateral more than once a year. The guaranty associations and the policyholder shall be informed of all such collateral reviews, including, but not limited to, the basis for the adjustment. Once all claims covered by the collateral have been paid and the receiver is satisfied that no new claims can be presented, the receiver will release any remaining collateral to the policyholder.

(j) The Commonwealth Court shall have jurisdiction to resolve disputes arising under this section.

(k) Nothing in this section is intended to limit or adversely affect any right the guaranty associations may have under applicable State law to obtain reimbursement from certain classes of policyholders for claims payments made by such guaranty associations under policies of the insolvent insurer, or for related expenses the guaranty associations incur.

(l) This section will apply to all delinquency proceedings which are open and pending as of the effective date of this section.

(m) This section shall not apply to first party claims, or to claims funded by a guaranty association net of the deductible unless subsection (e) applies.

(n) For purposes of this section, the following terms shall have the meanings given to them in this subsection:

"Collateral" shall mean collateral held by, for the benefit of or assigned to the insurer or subsequently to the receiver in order to secure the obligations of a policyholder under a deductible agreement and also any collateral recovered or held by the receiver that secured the obligations of a policyholder under a deductible reimbursement policy.

"Deductible agreement" shall include any combination of one or more policies, endorsements, contracts or security agreements which provide for the policyholder to bear the risk of loss within a specified amount per each claim or occurrence covered under a policy of insurance and may be subject to aggregate limit of policyholder reimbursement obligations as set forth in an endorsement to a policy or in a program agreement.

"Deductible reimbursement policy" shall mean a policy other than one referred to in subsection (f)(2), purchased by the policyholder to secure the policyholder's obligation to

reimburse the insurer for deductibles under the deductible agreement.

"Non-covered claims" shall mean a claim that is subject to a deductible agreement, may be secured by collateral and is not covered by a guaranty association.

(523.1 added June 28, 2004, P.L.443, No.46)

Section 524. Notice to Creditors and Others.--(a) The liquidator shall give notice of the liquidation order as soon as possible by first class mail and either by telegram or telephone to the insurance commissioner of each jurisdiction in which the insurer is licensed to do business, by first class mail and by telephone to any responsible guaranty association of this Commonwealth, by first class mail to all insurance agents having a duty under section 525 and to all known policyholders, creditors and claimants.

(b) Notice to potential claimants under subsection (a) shall require claimants to file with the liquidator their claims together with proper proofs thereof under section 538, on or before a date the liquidator shall specify in the notice. All claimants shall have a duty to keep the liquidator informed of any change of address.

(524 added Dec. 14, 1977, P.L.280, No.92)

Section 525. Duties of Agents.--(a) Every person who receives notice in the form prescribed in section 524 that an insurer which he represents as an independent agent is the subject of a liquidation order, shall within fifteen days of such notice give notice of the liquidation order. The notice shall be sent by first class mail to the last address contained in the agent's records to each policyholder or other person named in any policy issued through the agent by the insurer, if he has a record of the address of the policyholder or other person. A policy shall be deemed issued through an agent if the agent has a property interest in the expiration of the policy; or if the agent has had in his possession a copy of the declarations of the policy at any time during the life of the policy, except where the ownership of the expiration of the policy has been transferred to another. The written notice shall include the name and address of the insurer, the name and address of the agent, identification of the policy impaired and the nature of the impairment including termination of coverage, as described in section 521. Notice by a general agent satisfies the notice requirement for any agents under contract to him.

(b) Any agent failing to give notice as required in subsection (a) may be subject to payment of a penalty of not more than one thousand dollars ($1,000) and may have his license suspended, said penalty to be imposed after a hearing held by the insurance commissioner.

(525 added Dec. 14, 1977, P.L.280, No.92)

Section 526. Actions By and Against Liquidator.--(a) Upon issuance of an order appointing the commissioner liquidator of a domestic insurer or of an alien insurer domiciled in this Commonwealth, no action at law or equity shall be brought by or against the insurer, whether in this Commonwealth or elsewhere, nor shall any such existing actions be continued after issuance of such order. Whenever in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside this Commonwealth, with approval of the court he may intervene in the action. The liquidator may defend any action in which he intervenes under this section at the expense of the estate of the insurer.

(b) The liquidator may, upon or after an order for liquidation, within two years or such additional time as applicable law may permit, institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered. Where, by any agreement, a period of limitation is fixed for instituting a suit or proceeding upon any claim, or for filing any claim, proof of claim, proof of loss, demand, notice, or the like, or where in any proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for taking any action, filing any claim or pleading, or doing any act, and where in any such case the period had not expired at the date of the filing of the petition, the liquidator may, for the benefit of the estate, take any such action or do any such act, required of or permitted to the insurer, within a period of one hundred and eighty days subsequent to the entry of an order for liquidation, or within such further period as is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

(c) The time between the filing of a petition for liquidation against an insurer and the denial of the petition shall not be considered to be a part of the time within which any action may be commenced against the insurer. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty days after the petition is denied.

(526 added Dec. 14, 1977, P.L.280, No.92)

3. Estate of Insurer

Section 527. Collection and List of Assets.--(a) As soon as practicable after the liquidation order, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended or supplemented from time to time as the court shall require. One copy shall be filed in the office of the clerk of the Commonwealth Court and one copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

(b) The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation as rapidly and economically as he can.

(527 added Dec. 14, 1977, P.L.280, No.92)

Section 528. Fraudulent Transfers Prior to Petition.--(a) Every transfer made or suffered and every obligation incurred by an insurer within one year prior to the filing of a successful petition for rehabilitation or liquidation under this article is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay, or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this article, which is fraudulent under this section, may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee for a present fair equivalent value, and except that any purchaser, lienor, or obligee, who in good faith has given a consideration less than fair for such transfer, lien, or obligation, may retain the property, lien or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver

shall succeed to and may enforce the rights of the purchaser, lienor, or obligee. Notwithstanding this subsection or any other provision of this article to the contrary, a receiver shall not avoid a transfer of money or other property arising under or in connection with an FHLBank security agreement that is made before the commencement of a formal delinquency proceeding under this article in the ordinary course of business and in compliance with the FHLBank security agreement unless such transfer was made with actual intent to hinder, delay or defraud the insurer-member, the receiver appointed for the insurer-member or existing or future creditors. ((a) amended Oct. 14, 2014, P.L.2502, No.144)

(b) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee, under section 530(c).

A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

Any transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

The provisions of this subsection apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

(c) Any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be avoided by the receiver under subsection (a) if (i) the transaction consists of the termination, adjustment or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transaction, unless the reinsurer gives a present fair equivalent value for the release; and (ii) any part of the transaction took place within one year prior to the date of filing of the petition through which the receivership was commenced.

(528 added Dec. 14, 1977, P.L.280, No.92)

Section 529. Fraudulent Transfers After Petition.--(a) After a petition for rehabilitation or liquidation a transfer of any of the real property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the recorder of deeds in the county where any real property in question is located. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

(b) After a petition for rehabilitation or liquidation and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(1) A transfer of any of the property of the insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred.

(2) A person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property, or any part thereof, to the insurer or upon his order, with the same effect as if the petition were not pending.

(3) A person having actual knowledge of the pending rehabilitation or liquidation shall be deemed not to act in good faith.

(4) A person asserting the validity of a transfer under this section shall have the burden of proof. Except as elsewhere provided in this section, no transfer by or in behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator shall be valid against the liquidator.

(c) Nothing in this article shall impair the negotiability of currency or negotiable instruments.

(529 added Dec. 14, 1977, P.L.280, No.92)

Section 530. Voidable Preferences and Liens.--(a) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for liquidation under this article the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then transfers otherwise qualifying shall be deemed preferences if made or suffered within one year before the filing of the successful petition for rehabilitation or within two years before the filing of the successful petition for liquidation, whichever time is shorter.

Any preference may be avoided by the liquidator, if (i) the insurer was insolvent at the time of the transfer; (ii) the transfer was made within four months before the filing of the petition; (iii) the creditor receiving it or to be benefited thereby or his agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or (iv) the creditor receiving it was an officer, any employe or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not he held such position, or any shareholder holding directly or indirectly more than five per centum of any class of any equity security issued by the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length. Where the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property, except where a bona fide purchaser or lienor has given less than fair equivalent value, he shall have a lien upon the property to the extent of the

consideration actually given by him. Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

(a.1) Notwithstanding subsection (a) or any other provision of this article to the contrary, (i) a receiver shall not avoid a transfer of money or other property arising under or in connection with an FHLBank security agreement that is made before the commencement of a formal proceeding under this article in the ordinary course of business and in compliance with the security agreement unless such transfer was made with actual intent to hinder, delay or defraud the insurer-member, a receiver appointed for the insurer-member or existing or future creditors; and (ii) a receiver shall not void a redemption or repurchase of any stock or equity securities which was made by the FHLBank within four months of a formal commencement of the delinquency proceedings or which received prior approval of the receiver. ((a.1) added Oct. 14, 2014, P.L.2502, No.144)

(a.2) Following the appointment of a receiver for an insurer-member and upon request of the receiver, the FHLBank shall, within ten days of such request, provide a process and establish timing for all of the following:

(1) The release of collateral that exceeds the lending value, as determined in accordance with the FHLBank security agreement, required to support secured obligations remaining after any repayment of advances.

(2) The release of any collateral remaining in the FHLBank's possession following repayment of all outstanding secured obligations in full.

(3) The payment of fees and the operation of deposits and other accounts with the FHLBank.

(4) The possible redemption or repurchase of FHLBank stock or excess stock of any class that an insurer-member is required to own.

((a.2) added Oct. 14, 2014, P.L.2502, No.144)

(a.3) Upon the request of the receiver for an insurer-member, the FHLBank shall provide any available options for such insurer-member to renew or restructure an advance to defer associated prepayment fees, to the extent that market conditions, the terms of the advance outstanding to the insurer-member, the applicable policies of the FHLBank and compliance with the Federal Home Loan Bank Act and corresponding regulations permit. ((a.3) added Oct. 14, 2014, P.L.2502, No.144)

(a.4) Nothing in this section shall affect the receiver's rights pursuant to section 12 CFR § 1266.4 (relating to limitations on access to advances) regarding advances to an insurer-member in delinquency proceedings. ((a.4) added Oct. 14, 2014, P.L.2502, No.144)

(b) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

A transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

The provisions of this subsection apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

(c) A lien obtainable by legal or equitable proceedings upon a simple contract is one arising in the ordinary course of such proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens which under applicable law are given a special priority over other liens which are prior in time.

A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee within the meaning of subsection (b), if such consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. Such a lien could not, however, become superior and such a purchase could not create superior rights for the purpose of subsection (b) through any acts subsequent to the obtaining of such a lien or subsequent to such a purchase which require the agreement or concurrence of any third party or which require any further judicial action, or ruling.

(d) A transfer of property for or on account of a new and contemporaneous consideration which is deemed under subsection (b) to be made or suffered after the transfer because of delay in perfecting it does not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within twenty-one days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer which becomes security for a future loan, shall have the same effect as a transfer for or on account of a new and contemporaneous consideration.

(e) If any lien deemed voidable under the second paragraph of subsection (a) has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition under this article which results in a liquidation order, the indemnifying transfer or lien shall also be deemed voidable.

(f) The property affected by any lien deemed voidable under subsections (a) and (e) shall be discharged from such lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator, except that the court may on due notice order any such lien to be preserved for the benefit of the estate and the court may direct that such conveyance be executed as may be proper or adequate to evidence the title of the liquidator.

(g) The Commonwealth Court shall have summary jurisdiction of any proceeding by the liquidator to hear and determine the

rights of any parties under this section. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. Where an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien, and if the value is less than the amount for which the property is indemnity or than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the court, to the liquidator, within such reasonable times as the court shall fix.

(h) The liability of a surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the liquidator, or where the property is retained under subsection (g) to the extent of the amount paid to the liquidator.

(i) If a creditor has been preferred, and afterward in good faith gives the insurer further credit without security of any kind, for property which becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition may be setoff against the preference which would otherwise be recoverable from him.

(j) If an insurer shall, directly or indirectly, within four months before the filing of a successful petition for liquidation under this article, or at any time in contemplation of a proceeding to liquidate it, pay money or transfer property to an attorney-at-law for services rendered or to be rendered, the transaction may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court, and the excess may be recovered by the liquidator for the benefit of the estate provided that where the attorney is in a position of influence in the insurer or an affiliate thereof payment of any money or the transfer of any property to the attorney-at-law for services rendered or to be rendered shall be governed by the provision of subsection (a)(iv).

(k) Every officer, manager, employe, shareholder, member, subscriber, attorney, or any other person acting on behalf of the insurer who knowingly participates in giving any preference when he has reasonable cause to believe the insurer is or is about to become insolvent at the time of the preference shall be personally liable to the liquidator for the amount of the preference. It is permissible to infer that there is reasonable cause to so believe if the transfer was made within four months before the date of filing of the successful petition for liquidation.

Every person receiving any property from the insurer or the benefit thereof as a preference voidable under subsection (a) shall be personally liable therefor and shall be bound to account to the liquidator.

Nothing in this subsection shall prejudice any other claim by the liquidator against any person.

(530 added Dec. 14, 1977, P.L.280, No.92)

Section 531. Claims of Holders of Void or Voidable Rights.--(a) No claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment or encumbrance, voidable under this article, shall be allowed unless he surrenders the preference, lien, conveyance, transfer

assignment or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within thirty days from the date of the entering of the final judgment, except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding.

(b) A claim allowable under subsection (a) by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment, or encumbrance, may be filed as an excused late filing under section 537 if filed within thirty days from the date of the avoidance, or within the further time allowed by the court under subsection (a).

(531 added Dec. 14, 1977, P.L.280, No.92)

Section 532. Setoffs and Counterclaims.--(a) Mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this article shall be setoff and the balance only shall be allowed or paid, except as provided in subsection (b).

(b) No setoff or counterclaim shall be allowed in favor of any person where:

(1) the obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer;

(2) the obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff;

(3) the obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, or is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution; or

(4) the obligation of the person is to pay premiums, whether earned or unearned, to the insurer.

(532 added Dec. 14, 1977, P.L.280, No.92)

Section 533. Assessments.--(a) As soon as practicable but not more than two years from the date of an order of liquidation under this article of an insurer issuing assessable policies, the liquidator shall make a report to the Commonwealth Court setting forth:

(1) the reasonable value of the assets of the insurer;

(2) the insurer's probable total liabilities;

(3) the probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment; and

(4) whether or not an assessment should be made and what amount.

(b) Upon the basis of the report provided in subsection (a), including any supplements and amendments thereto, the Commonwealth Court may levy one or more assessments against all members of the insurer who are subject to assessment. No member shall be assessed for any loss that occurred when his policy was not in effect. No assessment shall be made or collection procedures begun after two years from the expiration date of a policy. The maximum assessment against any member for each year or part thereof in which a policy or policies issued to such member were in effect shall not exceed one hundred per centum of the average total annual premium during the life of the policy as written in such policy or policies including any increase or reduction in premium as the result of any endorsement thereto.

Subject to any applicable legal limits on assessability, the aggregate assessment shall be for the amount that the sum of the probable liabilities, the expenses of administration and the estimated cost of collection of the assessment, exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

(c) After levy of assessment under subsection (b) the commissioner shall issue an order directing each member who has not paid the assessment pursuant to the order, to show cause why the liquidator should not pursue a judgment therefor.

(d) The liquidator shall give notice of the order to show cause by publication and by first class mail to each member liable thereunder mailed to his last known address as it appears on the insurer's records, at least twenty days before the return day of the order to show cause.

(e) If a member does not appear and serve duly verified objections upon the liquidator on or before the return day of the order to show cause under subsection (c), the court shall make an order adjudging the member liable for the amount of the assessment against him and other indebtedness, pursuant to subsection (c), together with costs, and the liquidator shall have a judgment against the member therefor. If on or before such return day, the member appears and serves duly verified objections upon the liquidator, the commissioner may hear and determine the matter or may appoint a referee to hear it and make such order as the facts warrant. In the event that the commissioner determines that such objections do not warrant relief from assessment, the member may request the court to review the matter and vacate the order to show cause.

(f) The liquidator may enforce any order or collect any judgment under subsection (e) by any lawful means.

(533 added Dec. 14, 1977, P.L.280, No.92)

Section 534. Reinsurer's Liability.--The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement. Payment made directly to an insured or other creditor shall not diminish the reinsurer's obligation to the insurer's estate except when the reinsurance contract provided for direct coverage of an individual named insured and the payment was made in discharge of that obligation.

(534 added Dec. 14, 1977, P.L.280, No.92)

Section 535. Recovery of Premiums Owed.--(a) An insured, agent, broker, premium finance company or any other person responsible for the payment of a premium shall be obligated to pay any unpaid premium for the full policy term due the insurer at the time of the declaration of insolvency whether earned or unearned as shown on the records of the insurer. The liquidator shall also have the right to recover from such person any part of an unearned premium that represents commission of such person. Credits and/or setoff shall not be allowed to an agent, broker or premium finance company on account of any credits volunteered by such person.

(b) Upon satisfactory evidence of a violation of this section, the Insurance Commissioner may, in his discretion, pursue any one or more of the following courses of action:

(1) Suspend or revoke or refuse to renew the licenses of such offending party or parties.

(2) Impose a penalty of not more than one thousand dollars ($1,000) for each and every act in violation of this section by said party or parties.

Before the Insurance Commissioner shall take any action as above set forth, he shall give written notice to the person, company, association, or exchange accused of violating the law, stating specifically the nature of the alleged violation, and fixing a time and place, at least ten days thereafter, when a hearing of the matter shall be held. After such hearing, or upon failure of the accused to appear at such hearing, the Insurance Commissioner shall impose such of the above penalties as he deems advisable.

When the Insurance Commissioner shall take action in any or all of the ways above recited, the party aggrieved may appeal from said action to the Commonwealth Court.

(535 added Dec. 14, 1977, P.L.280, No.92)

Section 536. Liquidator's Proposal to Distribute Assets.--(a) Within one hundred twenty days of a final determination that an insurer is insolvent or in such condition that its further transaction of business will be hazardous to its policyholders, or to its creditors, or to the public by a court of competent jurisdiction of this Commonwealth, the liquidator shall make application to the Commonwealth Court for approval of a proposal to disburse assets out of such company's marshalled assets, from time to time as such assets become available, to any guaranty association in the Commonwealth or in any other state having substantially the same provision of law. The liquidator need not make application, as required above, in instances where it is reasonable to conclude that the assets of the insolvent insurer will not exceed the amounts necessary to pay the costs of liquidation and the payment of claims of creditors either secured or with a priority higher than the claims of policyholders. A guaranty association shall have the right to petition the Commonwealth Court to review an order of the liquidator concluding the assets will not exceed such costs.

(b) The proposal shall at least include provisions for:

(1) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors to the extent of the value of the security held and claims having a priority higher than that of the claims of policyholders.

(2) Disbursement of assets marshalled to date and subsequent disbursement of assets as they become available.

(3) Equitable allocation of disbursements to each of the associations entitled thereto.

(4) The securing by the liquidator, from each of the associations entitled to disbursements pursuant to this section, of an agreement to return to the liquidator such assets previously disbursed as may be required to pay the claims of secured creditors, claims falling within the priorities referred to in subsection (b)(1) and the proportional share of the assets disbursed required by the liquidator to make equivalent distribution to creditors of the same class of priority as policyholders in the event that the association may have received a disbursement of assets in excess of that available to pay all creditors of the insolvent insurer in the same class of priority as policyholders. An association shall return such assets to the liquidator when needed upon its own initiative or upon demand of the liquidator together with any investment income earned on the assets reimbursed. No bond shall be required of any such association.

(5) The liquidator may require reports to be made by an association at such time and covering such matters as he may determine. A full report shall be made by the association to

the liquidator when assets received have been disbursed or the obligation of an association to pay covered claims of the insolvent insurer has been fulfilled accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets and any other matter as the court may direct.

(c) The liquidator's proposal shall provide for disbursements to the associations in amounts estimated to be at least equal to the claim payments made or to be made thereby for which such associations could assert a claim against the liquidator, and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such claim payments made or to be made by the associations then disbursements shall be in the amount of available assets.

(d) Notice of such application shall be given to the associations and to the commissioners of insurance of each of the states where the company is licensed. Any such notice shall be deemed to have been given when deposited in the United States certified mails, first class postage prepaid, at least thirty days prior to the submission of such application to the Commonwealth Court. Action on the application may be taken by the court provided the above required notice has been given and provided further that the liquidator's proposal complies with subsection (b)(1) and (4).

(536 added Dec. 14, 1977, P.L.280, No.92)

4. Claims

Section 537. Filing of Claims.--(a) Proof of all claims shall be filed with the liquidator in the form required by section 538 on or before the last day for filing specified in the notice required under section 524, except that proofs of claim for cash surrender values or other investment values in life insurance and annuities need not be filed unless the liquidator expressly so requires.

(b) For good cause shown, the liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if he were not late, to the extent that any such payment will not prejudice the orderly administration of the liquidation. Good cause shall include but shall not be limited to the following:

(1) that existence of claim was not known to the claimant and that he filed his claim as promptly thereafter as reasonably possible after learning of it;

(2) that a transfer to a creditor was avoided under sections 528 through 530, or was voluntarily surrendered under section 531, and that the filing satisfies the conditions of section 531;

(3) that valuation under section 543 of security held by a secured creditor shows a deficiency, which is filed within thirty days after the valuation;

(4) that a claim was contingent and became absolute, and was filed as soon as reasonably possible after it became absolute; and

(5) that the claim was the claim of a guaranty association for reimbursement of covered claims paid and/or expenses incurred, subsequent to the last day for filing where such payments were made and expenses incurred as a result of requirements of law.

(c) The liquidator may consider any claim filed late which is not covered by subsection (b), and permit it to receive

distributions which are subsequently declared on any claims of the same or lower priority if the payment does not prejudice the orderly administration of the liquidation. The late-filing claimant shall receive, at each distribution, the same percentage of the amount allowed on his claim as is then being paid to other claimants of the same priority plus the same percentage of the amount allowed on his claim as is then being paid to claimants of any lower priority. This shall continue until his claim has been paid in full.

(537 added Dec. 14, 1977, P.L.280, No.92)

Section 538. Proof of Claim.--(a) Proof of claim shall consist of a statement signed by the claimant that includes all of the following that are applicable:

(1) the particulars of the claim including the consideration given for it;

(2) the identity and amount of the security on the claim;

(3) the payments made on the debt, if any;

(4) that the sum claimed is justly owing and that there is no setoff, counterclaim or defense to the claim;

(5) any right of priority of payment or other specific right asserted by the claimants;

(6) a copy of written instrument which is the foundation of the claim;

(7) in the case of any third party claim based on a liability policy issued by the insurer, a conditional release of the insured pursuant to section 540(a); and

(8) the name and address of the claimant and the attorney who represents him, if any.

No claim need be considered or allowed if it does not contain all the foregoing information which may be applicable. The liquidator may require that a prescribed form be used, and may require that other information and documents be included.

(b) At any time the liquidator may request the claimant to present information or evidence supplementary to that required under subsection (a) and may take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

(c) No judgment or order against an insured or the insurer entered after the date of filing of a successful petition for liquidation, and no judgment or order against an insured or the insurer entered at any time by default or by collusion need be considered as evidence of liability or of quantum of damages.

(d) A claim of a guaranty association for reimbursement of payments made for the payments of covered claims and for expenses shall be in such form and contain such substantiation as may be agreed to by the guaranty association and the liquidator subject to review by the Commonwealth Court.

(538 added Dec. 14, 1977, P.L.280, No.92)

Section 539. Special Claims.--(a) The claim of a third party which is contingent only on his first obtaining a judgment against the insured shall be considered and allowed as if there were no such contingency.

(b) Any claim that would have become absolute if there had been no termination of coverage under section 521, and which was not covered by insurance acquired to replace the terminated coverage, shall be allowed as if the coverage had remained in effect, unless at least ten days before the insured event occurred either the claimant had actual notice of the termination or notice was mailed to him as prescribed by section 524(a) or 525(a). If allowed the claim shall share in distributions under section 544(f).

(c) A claim may be allowed even if contingent, if it is filed in accordance with section 537(b). It may be allowed and may participate in all distributions declared after it is filed to the extent that it does not prejudice the orderly administration of the liquidation.

(d) Claims that are due except for the passage of time shall be treated as absolute claims are treated, except that such claims may be discounted at the legal rate of interest.

(e) The treasurer of this State in his capacity as custodian of the workmen's compensation security funds may file a claim with the liquidator for all sums paid or to be paid from those funds.

(539 added Dec. 14, 1977, P.L.280, No.92)

Section 540. Special Provisions for Third Party Claims.--(a) Whenever any third party asserts a cause of action against an insured of an insurer in liquidation the third party may file a claim with the liquidator. The filing of the claim shall operate as a release of the insured's liability to the third party on that cause of action in the amount of the applicable policy limit, but the liquidator shall also insert in any form used for the filing of third party claims appropriate language to constitute such a release. The release shall be null and void if the insurance coverage is avoided by the liquidator.

(b) Whether or not the third party files a claim, the insured may file a claim on his own behalf in the liquidation. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation or within sixty days after mailing of the notice required by section 524(a), whichever is later, he shall be deemed to be an unexcused late filer.

(c) The liquidator shall make his recommendations to the court under section 545 for the allowance of an insured's claim under subsection (b) after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action, and the probable costs and expenses of defense. Such recommendations as are not modified by the court within a period of sixty days following submission by the liquidator shall be treated by the liquidator as allowed recommendations, subject thereafter to later modification or to rulings made by the court pursuant to section 541. After allowance by the court, the liquidator shall withhold any distributions payable on the claim, pending the outcome of litigation and negotiation with the insured. Whenever it seems appropriate, he shall reconsider the claim on the basis of additional information and amend his recommendations to the court. The court may amend its allowance as it thinks appropriate. As claims against the insured are settled, the claimant shall be paid from the amount withheld the same percentage distribution as was paid on other claims of like priority, based on the lesser of either: (i) the amount allowed on the claims by the court, or (ii) the amount actually recovered from the insured by action or paid by agreement plus the reasonable costs and expenses of defense. After all claims are settled, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection shall not be a reason for unreasonable delay of final distribution and discharge of the liquidator.

(d) In the event several claims founded upon one policy are filed, whether by third parties or as claims by the insured under this section, and the aggregate allowed amount of the

claims to which the same limit of liability in the policy is applicable exceeds that limit, then each claim as allowed shall be reduced a proportionate amount so that the total equals the policy limit. Claims by the insured shall be evaluated as in subsection (c). If any insured's claim is subsequently reduced under subsection (c), the amount thus freed shall be apportioned ratably among the claims which have been reduced under this subsection.

(540 added Dec. 14, 1977, P.L.280, No.92)

Section 541. Disputed Claims.--(a) When a claim is denied in whole or in part by the liquidator, written notice of the determination shall be given to the claimant and his attorney by first class mail at the address shown in the proof of claim. Within sixty days from the mailing of the notice, the claimant may file his objections with the court. If no such filing is made, the claimant may not further object to the determination.

(b) Whenever objections are filed with the liquidator, the liquidator shall ask the court for a hearing as soon as practicable and give notice of the hearing by first class mail to the claimant or his attorney and to any other persons directly affected, not less than ten nor more than thirty days before the date of the hearing. The matter may be heard by the court or by a court-appointed referee who shall submit findings of fact along with his recommendation.

(541 added Dec. 14, 1977, P.L.280, No.92)

Section 542. Claims of Surety.--Whenever a creditor whose claim against an insurer is secured, in whole or in part, by the undertaking of another person, fails to prove and file that claim, the other person may do so in the creditor's name, and shall be subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that he discharges the undertaking. In the absence of an agreement with the creditor to the contrary, the other person shall not be entitled to any distribution, however, until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor shall be held by him in trust for such other person. The term "other person," as used in this section is not intended to apply to a guaranty association.

(542 added Dec. 14, 1977, P.L.280, No.92)

Section 543. Secured Creditor's Claims.--The value of any security held by a secured creditor shall be determined in one of the following ways, as the court may direct:

(1) by converting the same into money according to the terms of the agreement pursuant to which the security was delivered to such creditor; or

(2) by agreement, arbitration, compromise or litigation between the creditor and the liquidator.

The determination shall be under the supervision and control of the court with due regard for the recommendation of the liquidator. The amount so determined shall be credited upon the secured claim, and any deficiency shall be treated as an unsecured claim. If the claimant shall surrender his security to the liquidator, the entire claim shall be allowed as if unsecured.

(543 added Dec. 14, 1977, P.L.280, No.92)

Section 544. Order of Distribution.--The order of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth. Every claim in each class shall be paid in

full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses shall be established within any class.

(a) The costs and expenses of administration, including but not limited to the following; the actual and necessary costs of preserving or recovering the assets of the insurer; compensation for all services rendered in the liquidation; any necessary filing fees; the fees and mileage payable to witnesses; reasonable attorney's fees; the expenses of a guaranty association in handling claims.

(b) All claims under policies for losses wherever incurred, including third party claims, and all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property which are not under policies, shall have the next priority. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment made by an employer to his employe shall be treated as a gratuity.

(c) Claims of the Federal government other than those claims included in subsection (b).

(d) Debts due to employes for services performed to the extent that they do not exceed one thousand dollars ($1,000) and represent payment for services performed within one year before the filing of the petition for liquidation. Officers and directors shall not be entitled to the benefit of this priority. This priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employes.

(e) Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors.

(f) Claims of state or local government. Claims, including those of any governmental body, for a penalty or forfeiture shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under subsection (h).

(g) The following claims:

(1) Claims under section 539(b), to the extent that such claims were disallowed under that section.

(2) Claims filed late.

(3) Claims or portions of claims, payment of which is provided by other benefits or advantages recovered by the claimant.

(h) Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.

(i) The claims of shareholders or other owners.

(544 amended July 2, 1996, P.L.463, No.72)

Compiler's Note: Section 6 of Act 72 of 1996, which amended section 544, provided that the amendment of section 544 shall apply to the distribution of claims in existing estates in receivership and future estates in receivership.

5. Settlement of the Estate

Section 545. Liquidator's Recommendations to the Court.--(a) The liquidator shall review all claims duly filed in the liquidation and shall make such further investigation as he shall deem necessary. He may comport, compromise or in any other manner negotiate the amount for which claims will be recommended to the court. Unresolved disputes shall be determined under section 541. As soon as practicable, he shall present to the court a report of the claims against the insurer with his recommendations. The report shall include the name and address of each claimant, the particulars of the claim, and the amount of the claim finally recommended, if any.

(b) The court may approve, disapprove, or modify, the report on claims by the liquidator, except that the liquidator's agreements with other parties shall be final and binding on the court to the extent permitted by law. Such recommendations as are not modified by the court within a period of sixty days following submission by the liquidator shall be treated by the liquidator as allowed recommendations, subject thereafter to later modification or to rulings made by the court pursuant to section 541. No claim under a policy of insurance shall be allowed for an amount in excess of the applicable policy limits.

(545 added Dec. 14, 1977, P.L.280, No.92)

Section 546. Distribution of Assets.--Under the direction of the court, the liquidator shall pay distributions in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third party claims. Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court.

(546 added Dec. 14, 1977, P.L.280, No.92)

Section 547. Unclaimed and Withheld Funds.--(a) All unclaimed funds subject to distribution remaining in the liquidator's hands when he is ready to apply to the court for discharge, including the amount distributable to any creditor, shareholder, member or other person who is unknown or cannot be found, shall be deposited with the State Treasurer. Any amount on deposit not claimed within six years from the discharge of the liquidator shall be deemed to have been abandoned and shall be escheated without formal escheat proceedings and be deposited with the General Fund. Any amounts barred shall become the property of the Commonwealth, and the State Treasurer shall at the end of each fiscal year transfer the amount so barred to the General Fund for the use and operation of liquidation proceedings.

(b) All funds withheld under section 540 and not distributed shall upon discharge of the liquidator be deposited with the State Treasurer and paid by him in accordance with section 540. Any sums remaining which under section 540 would revert to the undistributed assets of the insurer shall be transferred to the State Treasurer and become the property of the Commonwealth under subsection (a), unless the commissioner in his discretion petitions the court to reopen the liquidation under section 549.

(547 added Dec. 14, 1977, P.L.280, No.92)

Section 548. Termination of Proceedings.--(a) When all assets justifying the expense of collection and distribution have been collected and distributed under this article, the liquidator shall apply to the court for discharge. The court

may grant the discharge, and make any other orders deemed appropriate, including an order to transfer any remaining funds that are uneconomic to distribute as may be deemed appropriate.

(b) Any other person may apply to the court at any time for an order under subsection (a). If the application is denied, the applicant shall pay the costs and expenses of the liquidator in resisting the application, including a reasonable attorney's fee.

(548 added Dec. 14, 1977, P.L.280, No.92)

Section 549. Reopening Liquidation.--After the liquidation proceeding has been terminated and the liquidator discharged, the commissioner or other interested party may at any time petition the Commonwealth Court to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall so order.

(549 added Dec. 14, 1977, P.L.280, No.92)

Section 550. Disposition of Records During and After Termination of Liquidation.--Whenever it shall appear to the commissioner that the records of any insurer in process of liquidation or completely liquidated are no longer useful, he may recommend to the court what records should be retained for future reference and what should be destroyed.

(550 added Dec. 14, 1977, P.L.280, No.92)

Section 551. External Audit of the Receiver's Books.--The Commonwealth Court may, as it deems desirable, cause audits to be made of the books of the commissioner relating to any receivership established under this article, and a report of each audit shall be filed with the commissioner and with the court. The books, records, and other documents of the receivership shall be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of administration of the receivership.

(551 added Dec. 14, 1977, P.L.280, No.92)

Section 552. Federal Receivership.--(a) Whenever in the commissioner's opinion, liquidation of a domestic insurer or an alien insurer domiciled in this State would be facilitated by a Federal receivership, and when any ground exists upon which the commissioner might petition the court for an order of rehabilitation or liquidation under section 514 or section 519, or if an order of rehabilitation or liquidation has already been entered, the commissioner may request another commissioner of another state to petition any appropriate Federal District Court for the appointment of a Federal receiver. The commissioner shall have power to intervene in any such action to support or oppose the petition, and shall have power to accept appointment as the receiver if he is so designated. So much of this act shall apply to the receivership as can be made applicable and is appropriate. Upon motion of the commissioner, the Commonwealth Court shall relinquish all jurisdiction over the insurer for purposes of rehabilitation or liquidation.

(b) If the commissioner is appointed receiver under this section, he shall comply with any requirements necessary to give him title to and control over the assets and affairs of the insurer.

(552 added Dec. 14, 1977, P.L.280, No.92)

(d) INTERSTATE RELATIONS

Section 553. Conservation of Property of Foreign or Alien Insurers Found in This State.--(a) If a domiciliary liquidator has not been appointed, the commissioner may apply to the

Commonwealth Court by verified petition for an order directing him to conserve the property of an alien insurer not domiciled in this Commonwealth or a foreign insurer on any one or more of the following grounds:

(1) any of the grounds in section 514;

(2) that any of its property has been sequestered by official action in its domiciliary state, or in any other state;

(3) that enough of its property has been sequestered in a foreign country to give reasonable cause to fear that the insurer is or may become insolvent; or

(4) that (i) its certificate of authority to do business in this Commonwealth has been revoked or that none was ever issued, and (ii) there are residents of this Commonwealth with outstanding claims or outstanding policies.

(b) The court may issue the order in whatever terms it shall deem appropriate. The filing or recording of the order with the recorder of deeds of Dauphin County shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(c) The conservator may at any time petition for and the court may grant an order under section 554 to liquidate the assets of a foreign or alien insurer under conservation, or, if appropriate, for an order under section 556, to be appointed ancillary receiver.

(d) The conservator may at any time petition the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, it shall order that the insurer be restored to possession of its property and the control of its business. The court may also make such finding and issue such order at any time upon motion of any interested party.

(553 added Dec. 14, 1977, P.L.280, No.92)

Section 554. Liquidation of Property of Foreign or Alien Insurers Found in This State.--(a) If no domiciliary receiver has been appointed, the commissioner may apply to the Commonwealth Court by verified petition for an order directing him to liquidate the assets found in this Commonwealth of a foreign insurer or an alien insurer not domiciled in this Commonwealth, on any of the following grounds:

(1) any of the grounds in section 514; or

(2) any of the grounds in section 553.

(b) If it shall appear to the court that the best interests of creditors, policyholders and the public require, the court may issue an order to liquidate in whatever terms it shall deem appropriate. The filing or recording of the order with the clerk of the Commonwealth Court shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(c) If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under this section, the liquidator under this section shall thereafter act as ancillary receiver under section 556. If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under this section, the liquidator under this section may petition the court for permission to act as ancillary receiver under section 556.

(d) On the same grounds as are specified in subsection (a), the commissioner may petition any appropriate Federal district court to be appointed receiver to liquidate that portion of the insurer's assets and business over which the court will exercise jurisdiction, or any lesser part thereof that the commissioner deems desirable for the protection of the policyholders and

creditors in this Commonwealth. The commissioner may accept appointment as Federal receiver if another person files a petition.

(554 added Dec. 14, 1977, P.L.280, No.92)

Section 555. Foreign Domiciliary Receivers in Other States.--(a) The domiciliary liquidator of an insurer domiciled in a reciprocal state shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books, accounts and other records of the insurer located in this Commonwealth. The date of vesting shall be the date of the filing of the petition, if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from agents and to obtain possession of the books, accounts and other records of the insurer located in this Commonwealth. He also shall have the right to recover the other assets of the insurer located in this Commonwealth, subject to section 556.

(b) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the commissioner of this Commonwealth shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books, accounts and other records of the insurer located in this Commonwealth, at the same time and that the domiciliary liquidator is vested with title in the state of domicile. The commissioner of this Commonwealth may petition for a conservation or liquidation order under section 553 or 554, or for an ancillary receivership under section 556, or after approval by the Commonwealth Court, may transfer title to the domiciliary liquidator, as the interests of justice and the equitable distribution of the assets require.

(c) Claimants residing in the Commonwealth may file claims with the liquidator or ancillary receiver, if any, in this Commonwealth, or with the domiciliary liquidator, if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

(d) Subject to the provisions of this section, the ancillary receiver and his deputies shall have the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this Commonwealth.

(555 added Dec. 14, 1977, P.L.280, No.92)

Section 556. Ancillary Formal Proceedings.--(a) If a domiciliary liquidator has been appointed for an insurer not domiciled in this Commonwealth, the commissioner may file a petition with the Commonwealth Court requesting appointment as ancillary receiver in this Commonwealth:

(1) if he finds that there are sufficient assets of the insurer located in this Commonwealth to justify the appointment of an ancillary receiver; or

(2) if the protection of creditors or policyholders in this Commonwealth so requires.

(b) The court may issue an order appointing an ancillary receiver in whatever terms it shall deem appropriate. The filing or recording of the order with the recorder of deeds of Dauphin County shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(c) When a domiciliary liquidator has been appointed in a reciprocal state, then the ancillary receiver appointed in this Commonwealth under subsection (a) shall have the sole right to recover all the assets of the insurer in this Commonwealth not already recovered by the domiciliary liquidator. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this Commonwealth, and shall pay the necessary expenses of the proceedings. He shall promptly transfer all remaining assets, books, accounts and records to the domiciliary liquidator. Subject to this section, the ancillary receiver and his deputies shall have the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this Commonwealth.

(d) When a domiciliary liquidator has been appointed in this Commonwealth, ancillary receivers appointed in reciprocal states shall have, as to assets and books, accounts, and other records in their respective states, corresponding rights, duties and powers to those provided in subsection (c) for ancillary receivers appointed in this Commonwealth.

(556 added Dec. 14, 1977, P.L.280, No.92)

Section 557. Ancillary Summary Proceedings.--The commissioner in his sole discretion may institute proceedings under sections 510 through 513 at the request of the appropriate insurance official of the domiciliary state of any foreign or alien insurer having property located in this State.

(557 added Dec. 14, 1977, P.L.280, No.92)

Section 558. Claims of Nonresidents Against Insurers Domiciled in This State.--(a) In a liquidation proceeding begun in this Commonwealth against an insurer domiciled in this Commonwealth, claimants residing in foreign countries or in states not reciprocal states must file claims in this Commonwealth, and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary liquidator. In reciprocal states, where an ancillary receiver has been appointed, a guaranty association of that state must file its claims with the ancillary receiver. Claims must be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

(b) Claims belonging to claimants residing in reciprocal states may be proved either in the liquidation proceeding in this Commonwealth as provided in this article, or in ancillary proceedings, if any, in the reciprocal states. If notice of the claim and opportunity to appear and be heard is afforded the domiciliary liquidator of this Commonwealth as provided in section 559(b) with respect to ancillary proceedings in this Commonwealth, the final allowance of claims by the courts in ancillary proceedings in reciprocal states shall be conclusive as to amount and as to priority against special deposits or other security located in such ancillary states, but shall not be conclusive with respect to priorities against general assets under section 544.

(558 added Dec. 14, 1977, P.L.280, No.92)

Section 559. Claims of Residents Against Insurers Domiciled in Reciprocal States.--(a) In a liquidation proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within this Commonwealth may file claims either with the ancillary receiver, if any, in this Commonwealth, or with the domiciliary liquidator. Claims must be filed on or before the last dates

fixed for the filing of claims in the domiciliary liquidation proceeding.

(b) Claims belonging to claimants residing in this Commonwealth may be proved either in the domiciliary state under the law of that state, or in ancillary proceedings, if any, in this Commonwealth. If a claimant elects to prove his claim in this Commonwealth, he shall file his claim with the liquidator in the manner provided in sections 537 and 538. The ancillary receiver shall make his recommendation to the court as under section 545. He shall also arrange a date for hearing if necessary under section 541 and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service at least forty days prior to the date set for hearing. If the domiciliary liquidator, within thirty days after the giving of such notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or by personal service, of his intention to contest the claim, he shall be entitled to appear or to be represented in any proceeding in this Commonwealth involving the adjudication of the claims. The final allowance of the claim by the courts of this Commonwealth shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in this Commonwealth.

(559 added Dec. 14, 1977, P.L.280, No.92)

Section 560. Attachment, Garnishment and Levy of Execution.--During the pendency in this or any other state of a liquidation proceeding, whether called by that name or not, no action or proceeding in the nature of an attachment, garnishment or levy of execution shall be commenced or maintained in this Commonwealth against the delinquent insurer or its assets.

(560 added Dec. 14, 1977, P.L.280, No.92)

Section 561. Interstate Priorities.--(a) In a liquidation proceeding in this Commonwealth involving one or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and reciprocal states shall be given equal priority of payment from general assets regardless of where such assets are located.

(b) The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit, so that the claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(c) The owner of a secured claim against an insurer for which a liquidator has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security in accordance with section 543, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors.

(561 added Dec. 14, 1977, P.L.280, No.92)

Section 562. Subordination of Claims for Non-cooperation.--If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to

transfer to the domiciliary liquidator in this Commonwealth any assets within his control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under section 544(f).

(562 added Dec. 14, 1977, P.L.280, No.92)

Section 563. Constitutionality.--If any provision or clause of this article or the application thereof to any person or situation is held invalid, such invalidity shall not affect other provisions or applications of the article which can be given effect without the invalid provision or application, and to this end the provisions of this article are declared to be severable.

(563 added Dec. 14, 1977, P.L.280, No.92)

ARTICLE V-A.
RISK-BASED CAPITAL REQUIREMENTS.
(Art. added June 25, 1997, P.L.349, No.40)

Section 501-A. Definitions.

The following words and phrases when used in this article shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Adjusted RBC report" means an RBC report that has been recalculated by the Insurance Commissioner in accordance with section 502-A(c).

"Authorized control level event" means one or more of the following events:

(1) The filing of an RBC report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC.

(2) The notification by the Insurance Commissioner to the insurer of an adjusted RBC report that indicates the event in paragraph (1).

(3) The failure of the insurer to respond, in a manner satisfactory to the Insurance Commissioner, to a corrective order, provided the insurer has not challenged the corrective order under section 510-A.

(4) If the insurer has challenged a corrective order under section 510-A and the Insurance Commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the Insurance Commissioner, to the corrective order subsequent to rejection or modification by the Insurance Commissioner.

"Commissioner" means the Insurance Commissioner of the Commonwealth.

"Company action level event" means one or more of the following events:

(1) The filing of an RBC report by an insurer that indicates that:

(i) the insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(ii) if a life or health insurer, the insurer has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and has a negative trend; or

(iii) if a property or casualty insurer, the insurer has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its

authorized control level RBC and 3.0 and a trend test result that triggers regulatory attention, as determined in accordance with the Trend Test Calculation included in the RBC instructions.

(2) The notification by the Insurance Commissioner to the insurer of an adjusted RBC report that indicates an event in paragraph (1).

(Def. amended May 22, 2012, P.L.544, No.51)

"Corrective order" means an order issued by the Insurance Commissioner specifying corrective actions that the Insurance Commissioner has determined are required under section 507-A(b).

"Department" means the Insurance Department of the Commonwealth.

"Domestic insurer" means an insurer that is incorporated or organized under the laws of this Commonwealth.

"Foreign insurer" means an insurer that is licensed by the Insurance Department to do business in this Commonwealth and incorporated or organized under the laws of a jurisdiction other than this Commonwealth.

"Insurer" means life or health insurers and property or casualty insurers.

"Life or health insurer" means a stock or mutual insurance company, association, exchange or fraternal benefit society licensed by the Insurance Department to transact life or accident and health insurance coverages or both. (Def. amended May 22, 2012, P.L.544, No.51)

"Mandatory control level event" means one or more of the following events:

(1) The filing of an RBC report which indicates that the insurer's total adjusted capital is less than its mandatory control level RBC.

(2) Notification by the Insurance Commissioner to the insurer of an adjusted RBC report that indicates the event in paragraph (1).

"NAIC" means the National Association of Insurance Commissioners or successor organization.

"Negative trend" means, with respect to a life or health insurer, a decrease over a period of time, as determined in accordance with the Trend Test Calculation included in the RBC instructions.

"Property or casualty insurer" means a stock or mutual insurance company, association or exchange licensed by the Insurance Department to transact property or casualty insurance coverages or both.

"RBC" means risk-based capital.

"RBC instructions" means the RBC report, including RBC instructions and formula adopted by the NAIC as required by the Insurance Commissioner under section 320(a)(2) of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

"RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC or mandatory control level RBC where:

(1) "Company action level RBC" means the product of 2.0 and the authorized control level RBC.

(2) "Regulatory action level RBC" means the product of 1.5 and the authorized control level RBC.

(3) "Authorized control level RBC" means the amount of an insurer's authorized control level RBC calculated under the RBC formula in accordance with the RBC instructions.

(4) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC.

"RBC plan" means a comprehensive financial plan containing the elements specified in section 506-A(a).

"RBC report" means the report required under sections 502-A and 503-A.

"Regulatory action level event" means one or more of the following events:

(1) The filing of an RBC report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC.

(2) The notification by the Insurance Commissioner to an insurer of an adjusted RBC report that indicates the event in paragraph (1).

(3) The failure of the insurer to file an RBC report by the date required under this article unless the insurer has provided an explanation for the failure that is satisfactory to the Insurance Commissioner and has cured the failure within ten days after the date the report is required to be filed under this article.

(4) The failure of the insurer to submit an RBC plan or revised RBC plan to the Insurance Commissioner within the time period set forth in section 506-A(b) and (d).

(5) Notification by the Insurance Commissioner to the insurer that:

(i) the RBC plan or revised RBC plan submitted by the insurer is in the judgment of the Insurance Commissioner unsatisfactory; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer.

(6) Notification by the Insurance Commissioner to the insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the Insurance Commissioner has so stated in the notification.

"Revised RBC plan" means an RBC plan that has been rejected by the Insurance Commissioner and revised by the insurer, with or without the Insurance Commissioner's recommendation.

"Total adjusted capital" means the sum of:

(1) an insurer's statutory capital and surplus as determined in accordance with the statutory accounting applicable to its annual financial statements filed with the Insurance Department; and

(2) other items as the RBC instructions may provide.

(501-A added June 25, 1997, P.L.349, No.40)

Section 502-A. RBC Reports Required; Domestic Insurers.--(a) Every domestic insurer shall, on or prior to each March 1, prepare and submit to the commissioner and to the NAIC a report of its RBC levels as of the end of the calendar year just ended, in a form and containing the information required by the RBC instructions.

(b) In addition, every domestic insurer shall file its RBC report with the chief insurance regulatory official in any jurisdiction in which the insurer is authorized to do business if the chief insurance regulatory official of the jurisdiction has notified the insurer of its request in writing, in which case the insurer shall file its RBC report not later than the later of:

(1) the date instructed by the chief insurance regulatory official of the jurisdiction requesting the filing; or

(2) March 1 of the year following the end of the calendar year for which the report is requested.

(c) If a domestic insurer files an RBC report that, in the judgment of the commissioner, is inaccurate, the commissioner shall recalculate the RBC report to correct the inaccuracy and shall notify the insurer of the amount of the recalculation. The notice shall contain a statement of the reason for the recalculation. If, within thirty days after the notification from the commissioner, the insurer fails to prepare and submit to the commissioner and to the NAIC an adjusted RBC report to correct the inaccuracy in accordance with the commissioner's notification, the commissioner may enter an order calling for an investigatory hearing with no less than twenty days' notice to the insurer for purposes of obtaining additional documentation, data, information and testimony. Following the hearing, the commissioner shall issue a final order accepting the RBC report as filed or the adjusted RBC report as initially recalculated or with other corrections.

(502-A added June 25, 1997, P.L.349, No.40)

Section 503-A. RBC Requirements; Foreign Insurers.--(a) A foreign insurer shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the calendar year just ended no later than the later of:

(1) the date an RBC report would be required to be filed by a domestic insurer under this article; or

(2) fifteen days after the request is received by the foreign insurer.

(b) A foreign insurer shall, upon the written request of the commissioner, submit to the commissioner a copy of an RBC plan that is filed with the chief insurance regulatory official of any other jurisdiction, within fifteen days after receiving the request from the commissioner.

(c) In the event of a company action level event, regulatory action level event or authorized control level event with respect to a foreign insurer as determined under the RBC statute applicable in the jurisdiction of domicile of the insurer or, if no RBC statute is in force in that jurisdiction, under the provisions of this article, if the chief insurance regulatory official of the jurisdiction of domicile of the foreign insurer fails to require the foreign insurer to file an RBC plan in the manner specified under that state's RBC statute or, if no RBC statute is in force in that jurisdiction, under this article, the commissioner may require the foreign insurer to file an RBC plan with the commissioner. The failure of the foreign insurer to file an RBC plan with the commissioner under this section shall be grounds to order the insurer to cease and desist from writing new insurance business in this Commonwealth. The commissioner shall give written notice to the foreign insurer, stating specifically the nature of the grounds for the order and fixing a time and place, at least ten days thereafter, when a hearing before the commissioner regarding the matter shall be held.

(d) In the event of a mandatory control level event with respect to a foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the jurisdiction of domicile of the foreign insurer, the commissioner may make application to the Commonwealth Court under sections 553 and 554, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application under sections 553(a) and 554(a).

(503-A added June 25, 1997, P.L.349, No.40)

Section 504-A. Calculation of RBC Relating to Life or Health Insurers.--(a) A life or health insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions.

(b) The formula shall take into account and may adjust for the covariance between the following risks determined in each case by applying the factors in the manner set forth in the RBC instructions:

(1) The risk with respect to the insurer's assets.

(2) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations.

(3) The interest rate risk with respect to the insurer's business.

(4) All other business risks and other relevant risks as set forth in the RBC instructions.

(504-A added June 25, 1997, P.L.349, No.40)

Section 505-A. Calculation of RBC Relating to Property or Casualty Insurers.--(a) A property or casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions.

(b) The formula shall take into account and may adjust for the covariance between the following risks determined in each case by applying the factors in the manner set forth in the RBC instructions:

(1) Asset risk.

(2) Credit risk.

(3) Underwriting risk.

(4) All other business risks and other relevant risks as are set forth in the RBC instructions.

(505-A added June 25, 1997, P.L.349, No.40)

Section 506-A. Company Action Level Event.--(a) In the event of a company action level event, the insurer shall prepare and submit to the commissioner an RBC plan that shall include, at a minimum, all of the following:

(1) Identification of the conditions that contribute to the company action level event.

(2) Proposals of corrective actions that the insurer intends to take and that would be expected to result in the elimination of the company action level event.

(3) Projections of the insurer's financial results for the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus. Projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense and benefit component.

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

(5) Identification of the quality of and problems associated with the insurer's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(b) The RBC plan required under this section shall be submitted within forty-five days after the occurrence of the company action level event.

(c) Within sixty days after the submission by an insurer of an RBC plan to the commissioner, the commissioner shall

notify the insurer whether the RBC plan shall be implemented or whether the RBC plan is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination and may set forth proposed revisions that will render the RBC plan satisfactory in the judgment of the commissioner.

(d) Upon notification from the commissioner of a determination that the RBC plan is unsatisfactory, the insurer shall prepare a revised RBC plan which may incorporate by reference any revisions proposed by the commissioner and, unless the commissioner has taken action under subsection (e), shall submit the revised RBC plan to the commissioner within forty-five days after the notification from the commissioner.

(e) In the event of a notification by the commissioner to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner may specify in the notification that the notification constitutes a regulatory action level event or take action as necessary to place the insurer under regulatory control under Article V.

(f) Every domestic insurer that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the chief insurance regulatory official in any jurisdiction in which the insurer is authorized to do business if:

(1) The jurisdiction has an RBC provision substantially similar to section 512-A(a) and (b).

(2) The chief insurance regulatory official of that jurisdiction has notified the insurer of his request for the filing in writing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that jurisdiction no later than the later of:

(i) fifteen days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the jurisdiction; or

(ii) the date on which the RBC plan or revised RBC plan is filed under this section.

(506-A added June 25, 1997, P.L.349, No.40)

Section 507-A. Regulatory Action Level Event.--(a) In the event of a regulatory action level event, the commissioner:

(1) may require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(2) shall perform an examination under Article IX or analysis as the commissioner deems necessary of the assets, liabilities and operations of the insurer, including, if applicable, a review of its RBC plan or revised RBC plan; and

(3) subsequent to an examination or analysis performed under paragraph (2) shall issue an order specifying corrective actions as the commissioner shall determine are required.

(b) In determining corrective actions, the commissioner may take into account factors as the commissioner deems relevant with respect to the insurer based upon the commissioner's examination or analysis of the assets, liabilities and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions.

(c) The RBC plan or revised RBC plan required under this section shall be submitted within forty-five days after the occurrence of the regulatory action level event.

(d) The commissioner may retain actuaries, investment experts, attorneys, appraisers, certified public accountants and other professionals and specialists as may be necessary in the judgment of the commissioner to review the insurer's RBC

plan or revised RBC plan, examine or analyze the assets, liabilities and operations of the insurer and formulate the corrective order with respect to the insurer. The fees, costs and expenses relating to professionals and specialists retained under this section shall be charged to and paid by the affected insurer or other party as directed by the commissioner.

(507-A added June 25, 1997, P.L.349, No.40)

Section 508-A. Authorized Control Level Event.--In the event of an authorized control level event with respect to an insurer, the commissioner shall:

(1) Take such actions as are required under section 507-A regarding an insurer with respect to which a regulatory action level event has occurred.

(2) If the commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take actions necessary to cause the insurer to be placed under regulatory control under Article V. In the event the commissioner takes action under Article V, the authorized control level event shall be deemed sufficient grounds for the commissioner to take that action.

(508-A added June 25, 1997, P.L.349, No.40)

Section 509-A. Mandatory Control Level Event.--In the event of a mandatory control level event:

(1) With respect to a life or health insurer, the commissioner shall take actions necessary to place the insurer under regulatory control under sections 512 through 563. The mandatory control level event shall be deemed sufficient grounds for the commissioner to take action under section 514; however, the commissioner may forego action for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.

(2) With respect to a property or casualty insurer, the commissioner shall take actions necessary to place the insurer under regulatory control under sections 512 through 563 or, in the case of an insurer that is writing no business, may allow the insurer to run off its existing business under the supervision of the commissioner. In either event, the mandatory control level event shall be deemed sufficient grounds for the commissioner to take action under section 514; however, the commissioner may forego action for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.

(509-A added June 25, 1997, P.L.349, No.40)

Section 510-A. Hearings.--(a) The insurer shall have the right to a confidential departmental hearing at which the insurer may challenge a determination or action by the commissioner upon one or more of the following events:

(1) Issuance of a final order by the commissioner accepting an adjusted RBC report under section 502-A(c).

(2) Notification to an insurer by the commissioner of a corrective order with respect to the insurer.

(b) The insurer shall notify the commissioner of the insurer's request for a hearing under this section within five days after the action or notification by the commissioner under subsection (a). Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing, which date shall be no less than ten days nor more than thirty days after the date of the insurer's request.

(510-A added June 25, 1997, P.L.349, No.40)

Section 511-A. Notices.--(a) Notices by the commissioner to an insurer which may result in regulatory action under this article shall be effective upon dispatch if transmitted by certified mail or any other form of delivery that insures signature upon receipt.

(b) Notices by the commissioner to an insurer transmitted by a form of delivery other than that provided in subsection (a) shall be effective upon the insurer's receipt of the notice.

(511-A added June 25, 1997, P.L.349, No.40)

Section 512-A. Confidentiality; Prohibition on Announcements; Prohibition on Use in Ratemaking.--(a) RBC reports, to the extent the information therein is not required to be set forth in a publicly available annual statement schedule, and RBC plans, including the results or report of any examination or analysis of an insurer performed under this article, and any corrective order issued by the commissioner pursuant to examination or analysis with respect to a domestic insurer or foreign insurer that are filed with the commissioner constitute information that may be damaging to the insurer if made available to its competitors and therefore shall be kept confidential by the commissioner.

(b) Information described in subsection (a) shall be given confidential treatment, may not be subject to subpoena by any Federal, state or other jurisdiction and may not be made public by the commissioner or any other person, except to insurance or other regulatory officials of this or other jurisdictions, without the prior written consent of the insurer to which the information pertains unless the commissioner determines to make the information public for purposes of actions taken by the commissioner under Article V.

(c) The comparison of an insurer's total adjusted capital to any of its RBC levels is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer and is not intended as a means to rank insurers generally. Therefore, except as otherwise required under the provisions of this article, the making, publishing, disseminating, circulating or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication or in the form of a notice, circular, pamphlet, letter or poster or over a radio or television station or in any other way an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of an insurer or of a component derived in the calculation by an insurer, agent, broker or other person would be misleading and is prohibited, provided, however, that if a materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its RBC levels or an inappropriate comparison of any other amount to the insurer's RBC levels is published in a written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity or inappropriateness of the statement, the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false or inappropriate statement.

(d) The RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor

used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or any affiliate is authorized to write.

(512-A added June 25, 1997, P.L.349, No.40)

Section 513-A. Exemptions.--(a) The following insurers are exempt from this article:

(1) Monoline mortgage guaranty insurers.

(2) Financial guaranty insurers.

(3) Title insurers.

(4) Foreign or alien fraternal benefit societies.

(b) A domestic property or casualty insurer that meets all of the following conditions is exempt from this article unless the commissioner makes a specific finding that application of this article to the insurer is necessary for the commissioner to carry out statutory responsibilities:

(1) Writes direct business only in this Commonwealth.

(2) Writes direct annual premiums of ten million dollars ($10,000,000) or less or such higher amount as the commissioner may order in five-year intervals as necessary to reflect the impact of inflationary factors.

(3) Assumes no reinsurance in excess of five per centum of direct premium written except for assumed reinsurance of business directly written in this Commonwealth if the assuming insurer's total annual net written premium, direct plus assumed minus ceded, is ten million dollars ($10,000,000) or less.

(513-A amended May 22, 2012, P.L.544, No.51)

Section 514-A. Supplemental Provisions; Rules.--(a) The provisions of this article are supplemental to any other provisions of the laws of this Commonwealth and shall not preclude or limit any other powers or duties of the commissioner under those laws, including, but not limited to, Article V and 31 Pa. Code Ch. 160 (relating to standards to define insurers deemed to be in hazardous financial condition) and Article XXIV of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

(b) The commissioner may adopt regulations necessary for the implementation of this article.

(514-A amended May 22, 2012, P.L.544, No.51)

Section 515-A. Additional Penalties.--An insurer that fails to file an RBC report or adjusted RBC report within the time required under this article shall, in addition to any other penalties provided by law, forfeit a sum not to exceed two hundred dollars ($200) for each day during which the insurer fails to file.

(515-A added June 25, 1997, P.L.349, No.40)

ARTICLE V-B.
RISK-BASED CAPITAL REQUIREMENTS - HEALTH ORGANIZATIONS.
(Art. added June 22, 2000, P.L.457, No.62)

Section 501-B. Definitions.--The following words and phrases when used in this article shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Adjusted RBC report" means an RBC report that has been recalculated by the Insurance Department in accordance with section 502-B(c).

"Authorized control event" means any of the following events:

(1) Filing of an RBC report that indicates that the health organization's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC.

(2) Notification by the Insurance Department to a health organization of an adjusted RBC report that indicates an event under paragraph (1).

(3) Failure to respond, in a manner satisfactory to the Insurance Commissioner, to a corrective order, provided the health organization has not challenged the corrective order under section 509-B.

(4) If the health organization has challenged a corrective order under section 509-B and the Insurance Commissioner has, after a hearing, rejected the challenge or modified the corrective order, failure to respond, in a manner satisfactory to the Insurance Commissioner, to the corrective order subsequent to rejection or modification by the Insurance Commissioner.

"Commissioner" means the Insurance Commissioner of the Commonwealth.

"Company action level event" means any of the following events:

(1) Filing of an RBC report that indicates that the health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC.

(1.1) Filing of an RBC report that indicates the health organization's total adjusted capital is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and the health organization's trend test result triggers regulatory attention, as determined in accordance with the Trend Test Calculation included in the RBC instructions.

(2) Notification by the Insurance Department to a health organization of an adjusted RBC report that indicates an event under paragraph (1) or (1.1).

(Def. amended May 22, 2012, P.L.544, No.51)

"Corrective order" means an order issued by the Insurance Commissioner specifying corrective actions that the Insurance Commissioner has determined are required under section 506-B(b).

"Department" means the Insurance Department of the Commonwealth.

"Domestic health organization" means a health organization incorporated or organized under the laws of this Commonwealth.

"Foreign health organization" means a health organization that is licensed by the Insurance Department to do business in this Commonwealth and incorporated or organized under the laws of a jurisdiction other than this Commonwealth.

"Health organization" means a health maintenance organization as defined in the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act," a hospital plan corporation as defined in 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations), a professional health services plan corporation as defined in 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations), a preferred provider organization as defined in the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921," except that the term does not include a life or health insurer or a property or casualty insurer subject to Article V-A.

"Mandatory control level event" means any of the following events:

(1) Filing of an RBC report that indicates that the health organization's total adjusted capital is less than its mandatory control level RBC.

(2) Notification by the Insurance Department to a health organization of an adjusted RBC report that indicates an event under paragraph (1).

"NAIC" means the National Association of Insurance Commissioners or successor organization.

"RBC" means risk-based capital.

"RBC instructions" means the RBC report including RBC instructions adopted by the NAIC for health organizations as required by the Insurance Commissioner under section 11 of the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act," 40 Pa.C.S. §§ 6125 (relating to reports and examinations) and 6331 (relating to reports and examinations) and the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

"RBC level" means a health organization's company action level RBC, regulatory action level RBC, authorized control level RBC or mandatory control level RBC where:

(1) "Company action level RBC" means the product of 2.0 and the authorized control level RBC.

(2) "Regulatory action level RBC" means the product of 1.5 and the authorized control level RBC.

(3) "Authorized control level RBC" means the amount of a health organization's authorized control level RBC calculated under the RBC formula in accordance with the RBC instructions.

(4) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC.

"RBC plan" means a comprehensive financial plan filed in accordance with section 505-B(a).

"RBC report" means a report of RBC levels.

"Regulatory action level event" means any of the following events:

(1) Filing of an RBC report that indicates that the health organization's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC.

(2) Notification by the Insurance Department to a health organization of an adjusted RBC report that indicates an event under paragraph (1).

(3) Failure to file an RBC report by the required date unless the Insurance Department determines that the health organization has provided an adequate explanation for the failure to file and the health organization has filed the report within ten days of the filing date under this article.

(4) Failure to submit an RBC plan or revised RBC plan within the time set forth under this article.

(5) Notification by the Insurance Department to the health organization that:

(i) the RBC plan or revised RBC plan is unsatisfactory under section 506-B; and

(ii) the notification constitutes a regulatory action level event.

(6) Notification by the Insurance Department that the health organization has failed to comply with its RBC plan or revised RBC plan if the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan.

"Revised RBC plan" means an RBC plan that has been rejected by the Insurance Department and revised by the health organization.

"Total adjusted capital" means the sum of the total assets less total liabilities as calculated and reported in accordance

with required NAIC annual statement instructions and accounting practices and procedures manual for annual financial statements and any other items required by the RBC instructions.

(501-B added June 22, 2000, P.L.457, No.2)

Section 502-B. RBC Reports Required; Domestic Health Organizations.--(a) Every domestic health organization shall, on or before March 1 of every year, submit a report of its RBC levels as of the end of the preceding calendar year to the department and the NAIC as prescribed by the RBC instructions.

(b) Every domestic health organization shall, upon the written request of the chief insurance regulatory official of any jurisdiction in which the health organization is authorized to do business, file its RBC report with that jurisdiction by the date required by the requesting chief insurance regulatory official or March 1 of the year following the calendar year for which the report is requested, whichever is later.

(c) If the department determines that an RBC report is inaccurate, the department shall correct the inaccuracy and notify the health organization of the amount of the recalculation and the reason for the recalculation. If, within thirty days of the notification under this subsection, the health organization fails to submit an adjusted RBC report to the department and the NAIC that corrects the inaccuracy in accordance with the department's notification, the commissioner may order an investigatory hearing. The department shall provide notice to the health organization at least twenty days prior to the hearing. Following the hearing, the commissioner shall issue a final order accepting the original RBC report or an adjusted RBC report.

(502-B added June 22, 2000, P.L.457, No.62)

Section 503-B. RBC Reports Required; Foreign Health Organizations.--(a) A foreign health organization shall, upon the written request of the department, submit an RBC report for the immediate preceding calendar year within fifteen days of the receipt of the request or by the date an RBC report would be required to be filed by a domestic health organization under this article, whichever is later.

(b) A foreign health organization shall, upon the written request of the department, submit to the department a copy of an RBC plan that is filed with the chief insurance regulatory official of any other jurisdiction within fifteen days of receipt of the request.

(c) If a foreign health organization experiences a company action level event, regulatory action level event or authorized control level event under the RBC statute in effect in the jurisdiction of domicile or, if no RBC statute is in effect in the jurisdiction of domicile, under this article and the chief insurance regulatory official of the jurisdiction of domicile fails to require an RBC plan under the RBC statute in effect or this act, the department may require the foreign health organization to file an RBC plan with the department. The commissioner may order a foreign health organization to cease and desist from writing new insurance business in the Commonwealth if the foreign health organization fails to file the RBC plan with the department under this subsection. The commissioner shall provide written notice of the order, including the specific reasons for the order and the date and time of a hearing on the order, to the foreign health organization. The hearing shall be held at least ten days following the issuance of the notice.

(d) If a foreign health organization experiences a mandatory control level event and no receiver has been appointed under

the rehabilitation and liquidation statute of the jurisdiction of domicile of the foreign health organization, the commissioner may apply to the Commonwealth Court for a receiver under sections 553 and 554. The occurrence of the mandatory control level event shall be adequate grounds for the application under sections 553(a) and 554(a).

(503-B added June 22, 2000, P.L.457, No.62)

Section 504-B. Calculation of RBC.--(a) A health organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions.

(b) The formula shall use and may adjust for the covariance between the following risks determined in each case by applying the factors in the RBC instructions:

(1) Asset risk.

(2) Credit risk.

(3) Underwriting risk.

(4) All business and other risks set forth in the RBC instructions.

(504-B added June 22, 2000, P.L.457, No.62)

Section 505-B. Company Action Level Event.--(a) In the event of a company action level event, a health organization shall submit an RBC plan to the department to include, at a minimum, all of the following:

(1) Identification of the conditions that contributed to the company action level event.

(2) Proposed corrective actions to eliminate the company action level event.

(3) Projections of the health organization's financial results for the current year and at least the four succeeding years, with and without the proposed corrective actions, to include projections of statutory balance sheets, operating income, net income, capital, surplus and RBC levels. Projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense and benefit component.

(4) The key assumptions impacting the projections under paragraph (3) and the sensitivity of the projections to the assumptions.

(5) The quality of and problems associated with the health organization's business, including assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance.

(b) An RBC plan under subsection (a) shall be submitted within forty-five days after the occurrence of the company action level event.

(c) Within sixty days of the submission of an RBC plan under subsection (a), the department shall notify the health organization whether the RBC plan should be implemented or that the plan is unsatisfactory. The notification shall set forth the specific reasons for a determination that the plan is unsatisfactory and may include revisions that will make the RBC plan satisfactory to the department.

(d) Upon notification under subsection (c) that the RBC plan is unsatisfactory, the health organization shall prepare a revised RBC plan which may include revisions proposed by the department. Except as provided in subsection (e), the revised RBC plan shall be submitted within forty-five days after notification that the plan is unsatisfactory.

(e) The department may specify that the notification under subsection (c) constitutes a regulatory action level event. In the alternative, the department may take any other action

necessary to place the health organization under regulatory control pursuant to Article V.

(f) Every domestic health organization that files an RBC plan or revised RBC plan under this section shall file a copy with the chief insurance regulatory official of any jurisdiction in which the health organization is authorized to do business if:

(1) The jurisdiction has an RBC provision substantially similar to section 511-B(a) and (b).

(2) The chief insurance regulatory official of the jurisdiction has provided a written request to the health organization for a copy of the RBC plan or revised RBC plan. Upon receipt of the written request, the health organization shall file a copy of the RBC plan or revised RBC plan within fifteen days of the receipt of notice or by the date the RBC plan or revised RBC plan is filed under this section, whichever is later.

(505-B added June 22, 2000, P.L.457, No.62)

Section 506-B. Regulatory Action Level Event.--(a) In the event of a regulatory action level event, the department:

(1) may require the health organization to submit an RBC plan or, if applicable, a revised RBC plan; and

(2) shall perform an examination under Article IX or an analysis as necessary of assets, liabilities and operations of the health organization, including, if applicable, a review of the RBC plan or revised RBC plan, and issue an order specifying any corrective actions deemed appropriate.

(b) In order to determine appropriate corrective actions under subsection (a)(2), the department may consider the results of any sensitivity test undertaken pursuant to the RBC instructions.

(c) The RBC plan or revised RBC plan required under subsection (a) shall be submitted within forty-five days after the occurrence of the regulatory action level event.

(d) The department may retain actuaries, investment experts, attorneys, appraisers, certified public accountants and other individuals as the department deems necessary to:

(1) review the health organization's RBC plan or revised RBC plan;

(2) examine or analyze the assets, liabilities and operations of the health organization, including contractual relationships; and

(3) formulate corrective actions.

(e) Fees, costs and expenses related to individuals retained under subsection (d) shall be charged to and paid by the health organization or other party as directed by the commissioner.

(506-B added June 22, 2000, P.L.457, No.62)

Section 507-B. Authorized Control Level Event.--In the event of an authorized control level event, the department shall:

(1) Take all action required under section 506-B for a regulatory action level event.

(2) If the commissioner deems it to be in the best interest of the policyholders and creditors of the health organization and the public, take action necessary to place the health organization under regulatory control under Article V. The authorized control level event shall be sufficient grounds to place the health organization under regulatory control under Article V.

(507-B added June 22, 2000, P.L.457, No.62)

Section 508-B. Mandatory Control Level Event.--(a) In the event of a mandatory control level event, the department shall take action necessary to place the health organization under

regulatory control under sections 512 through 563. If the health organization is writing no business, the department may allow the health organization to run off its existing business under the supervision of the commissioner.

(b) The mandatory control level event shall be sufficient grounds for an order of rehabilitation under section 514.

(c) The commissioner may forego action to place the health organization under regulatory control under subsection (a) for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.

(508-B added June 22, 2000, P.L.457, No.62)

Section 509-B Hearings.--(a) A health organization shall have the right to a confidential departmental hearing to challenge a determination or action regarding any of the following events:

(1) A final order accepting an adjusted RBC report under section 502-B(c).

(2) Notification of a corrective order.

(b) A health organization shall notify the department of its request for a hearing within five days after the receipt of an order or notification under subsection (a). Upon receipt of the request, the department shall set a date for the hearing, which shall be no sooner than ten days nor later than thirty days after the date of the health organization's request.

(509-B added June 22, 2000, P.L.457, No.62)

Section 510-B. Notices.--(a) Notices under this article which may result in regulatory action shall be effective on the date of transmission by certified mail or other form of delivery that requires signature upon receipt.

(b) Notices under this article transmitted other than as provided in subsection (a) shall be effective upon the receipt of the notice.

(510-B added June 22, 2000, P.L.457, No.62)

Section 511-B. Confidentiality; Prohibition on Announcements, Prohibition on Use in Ratemaking.--(a) The following information filed with the department shall constitute information that may be damaging to a health organization if made available to its competitors and shall be confidential:

(1) RBC reports to the extent the information in the report is not required to be included in a publicly available annual statement schedule.

(2) RBC plans, including the results of reports of any examination or analysis of a health organization performed under this article.

(3) A corrective order issued pursuant to examination or analysis with respect to a domestic health organization or foreign health organization.

(b) Except for insurance or other regulatory officials of the Commonwealth or other jurisdictions, information under subsection (a) shall be confidential and may not be subject to subpoena by any Federal, State or other jurisdiction or made public by the department or any other person without the prior written consent of the health organization unless the commissioner makes the information public for purposes of Article V.

(c) The following shall apply to publication of RBC levels:

(1) Except as required by this article, the publication, dissemination, circulation or placement before the public, or directly or indirectly causing the publication, dissemination, circulation or placement before the public, of an assertion,

representation or statement with regard to the RBC levels or component derived in the calculation of RBC levels of a health organization, including assertions, representations or statements intended or used to rank health organizations, by an insurer, agent, broker or other person in a newspaper, magazine or other publication, notice, pamphlet, letter or other printed matter or by broadcast or electronic transmission, is prohibited.

(2) Notwithstanding the provisions of paragraph (1), if a health organization is able to demonstrate to the commissioner with substantial proof that a materially false statement regarding the comparison of a health organization's total adjusted capital to its RBC levels or an inappropriate comparison of any other amount to the health organization's RBC levels has been published in writing, the health organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false or inappropriate statement.

(d) The RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the department to monitor the solvency of health organizations and to determine the need for corrective action and shall not be used for ratemaking nor used as evidence in any rate proceeding nor to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which a health organization or any affiliate is authorized to write.

(511-B added June 22, 2000, P.L.457, No.62)

Section 512-B. Exemptions.--The department may exempt a domestic health organization that has been transacting business for less than three years from this article upon making a specific finding that application of this article is not necessary for the department to carry out statutory responsibilities.

(512-B added June 22, 2000, P.L.462, No.62)

Section 513-B. Supplemental Provisions; Rules.--(a) The provisions of this article are supplemental to any other provisions of the laws of this Commonwealth and shall not preclude or limit any other powers or duties of the commissioner under those laws, including, but not limited to, Article V and 31 Pa. Code Ch. 160 (relating to standards to define insurers deemed to be in hazardous financial condition).

(b) The department may adopt regulations necessary for the implementation of this article.

(513-B added June 22, 2000, P.L.452, No.62)

Section 514-B. Additional Penalties.--A health organization that fails to file an RBC report or adjusted RBC report within the time required under this article shall, in addition to any other penalties provided by law, forfeit a sum not to exceed two hundred dollars ($200) for each day during which the health organization fails to file.

(514-B added June 22, 2000, P.L.457, No.62)

Section 515-B. Phase-In Provisions.--(a) This article shall apply to RBC reports required for the year ending December 31, 1999, and each year thereafter.

(b) Notwithstanding the provisions of sections 505-B, 506-B, 507-B and 508-B, the following provisions shall apply to domestic health organizations with respect to RBC reports filed with the department for the year ending December 31, 1999:

(1) In the event of a company action level event, the commissioner shall take no regulatory action under this article.

(2) In the event of a regulatory action level event as defined in paragraphs (1) and (2) of the definition of "regulatory action level event" in section 501-B, the department and the health organization shall take the actions required under section 505-B.

(3) In the event of a regulatory action level event as defined in paragraph (3), (4), (5) or (6) of the definition of "regulatory action level event" in section 501-B, the department shall take the actions required under section 506-B.

(4) In the event of a mandatory control level event, the department shall take the actions required under section 507-B.

(515-B added June 22, 2000, P.L.457, No.62)

ARTICLE VI.
AGENTS AND BROKERS.
(Art. repealed Dec. 6, 2002, P.L.1183, No.147

(a) AGENTS.
(Subdiv. repealed Dec. 6, 2002, P.L.1183, No.147)

Section 601. Certain Words Defined.--(601 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 602. Requirements to Act as an Agent.--(602 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 603. Requirements to Obtain a Certificate of Qualification.--(603 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 604. Issuance of Certificate of Qualification.--(604 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 605. Appointment.--(605 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 606. Reports by Entities to the Insurance Department.--(606 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 607. Personal Liability of Agents for Unauthorized Entity.--(607 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 608. Penalty for Advertising as Agent of Unauthorized Entity.--(608 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 609. Penalty for Soliciting for Nonexistent Entity.--(609 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 610. Requirements for Nonresidents to Obtain Certificate of Qualification.--(610 repealed Dec. 6, 2002, P.L.1183, No.147)

(b) BROKERS.
(Subdiv. repealed Dec. 6, 2002, P.L.1183, No.147)

Section 621. Definitions and Applicability.--(621 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 622. Brokers' Licenses.--(622 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 623. Doing Business with Unlicensed Brokers.--(623 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 624. Excess Insurance Brokers.--(624 repealed Jan. 24, 1966, 1965 P.L.1509, No.531)

Section 625. Bond of Excess Insurance Brokers; Payment of Taxes.--(625 repealed Jan. 24, 1966, 1965 P.L.1509, No.531)

Section 626. Payment of Commissions to Brokers.--(626 repealed Dec. 6, 2002, P.L.1183, No.147)

(c) AGENTS AND BROKERS.
(Subdiv. repealed Dec. 6, 2002, P.L.1183, No.147)

Section 631. Fraudulent Unlicensed Activity.--(631 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 632. Penalty for Acting for Unauthorized Companies, Et Cetera.--(632 repealed Jan. 24, 1966, 1965 P.L.1509, No.531)

Section 633. Larceny by Agents and Brokers.--(633 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 633.1. Fiduciary Capacity of Agents and Brokers.--(633.1 repealed Dec.6, 2002, P.L.1183, No.147)

Section 634. Penalties for Paying or Receiving Commission or Compensation for Insuring Lives of Attorneys, Partners, Clerks, Servants, or Employes.--(634 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 635. Rebates and Inducements Prohibited.--(635 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 636. Insured Persons and Applicants for Insurance Prohibited from Accepting Rebates.--(636 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 637. Misrepresentation of Terms of Policy and Future Dividends by Agents, Brokers, or Solicitors.--(637 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 637.1. Disclosures and Acknowledgments.--(637.1 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 638. Misrepresentations, Et Cetera, for Purpose of Inducing Policyholders To Drop Present Policies and Insure with Other Companies, Et Cetera.--(638 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 639. Penalties Imposed by Insurance Department.--(639 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 640. Production of Evidence.--(640 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 641. Public Utilities Not to be Licensed.--(641 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 642. Temporary Certificate or License.--(642 repealed Dec. 6, 2002, P.L.1183, No.147)

(c.1) SALE OF INSURANCE BY FINANCIAL INSTITUTIONS.
(Subdiv. repealed Dec. 6, 2002, P.L.1183, No.147)

Section 646. The Sale of Insurance by Financial Institutions.--(646 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 647. Physical Premises.--(647 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 648. Customer Privacy.--(648 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 649. Credit, Life, Health and Accident Insurance and Credit Unemployment Insurance.--(649 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 649.1. Federal Preemption.--(649.1 repealed Dec. 6, 2002, P.L.1183, No.147)

(d) MANAGERS AND EXCLUSIVE GENERAL AGENTS.
(Subdiv. repealed Dec. 6, 2002, P.L.1183, No.147)

Section 650. Insurance Companies to Certify Names of Managers or Exclusive General Agents.--(650 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 651. License for Managers and Exclusive General Agents.--(651 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 652. Exclusion, Sale or Transfer.--(652 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 653. Revocation and Suspension of License; Penalty.--(653 repealed Dec. 6, 2002, P.L.1183, No.147)

Section 654. Penal Provision.--(654 repealed Dec. 6, 2002, P.L.1183, No.147)

(e) INJUNCTION OR OTHER PROCESS AGAINST UNLICENSED ACTIVITIES. (Subdiv. repealed Dec. 6, 2002, P.L.1183, No.147)

Section 660. Action for Injunction or Other Process Authorized.--(660 repealed Dec. 6, 2002, P.L.1183, No.147)
Section 661. Venue, Temporary Order; Prompt Determination.--(661 repealed Apr. 28, 1978, P.L.202, No.53)
Section 662. Bonds and Costs.--(662 repealed Dec. 6, 2002, P.L.1183, No.147)
Section 663. Act Supplementary.--(663 repealed Dec. 6, 2002, P.L.1183, No.147)

ARTICLE VI-A
INSURANCE PRODUCERS
(Art. added Dec. 6, 2002, P.L.1183, No.147)

Compiler's Note: Section 4 of Act 147 of 2002, which repealed Article VI and added Article VI-A, provided that existing references to persons licensed in accordance with Article VI are deemed to be references to persons licensed in accordance with Article VI-A and shall remain in effect until replaced, revised or amended.

SUBARTICLE A
LICENSING
(Subart. added Dec. 6, 2002, P.L.1183, No.147)

DIVISION 1
LICENSING OF INSURANCE PRODUCERS
(Div. added Dec. 6, 2002, P.L.1183, No.147)

Section 601-A. Definitions.
The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:
"Applicant." An individual who has passed or is exempt from taking the insurance producer licensing examination required by section 604-A.
"Application." A form approved by the Insurance Commissioner to be used to apply to the Insurance Department for an insurance producer license.
"Appointment." A written agreement between an insurance producer and an insurance entity under which the insurance producer may sell, solicit or negotiate contracts of insurance issued by the insurance entity for compensation.
"Business entity." A person which is not an individual.
"Business entity application." A form approved by the Insurance Commissioner to be used by a business entity to apply to the Insurance Department for an insurance producer license.
"Candidate." An individual who has satisfactorily completed or is exempt from the preexamination educational requirements of section 604-A.
"Commissioner." The Insurance Commissioner of the Commonwealth.
"Department." The Insurance Department of the Commonwealth.
"Designated licensee." An individual who is licensed by the Insurance Department as an insurance producer and who is designated by a business entity to be responsible for the

business entity's compliance with the insurance laws and regulations of this Commonwealth.

"Exclusive general agent." A licensee:

(1) which has been granted sole authority to act directly or indirectly as an insurance producer for a domestic insurer with respect to a specific portion of the insurer's business or within a specific territory;

(2) which has the authority to bind coverage on behalf of the insurer; and

(3) either separately or together with affiliates or subproducers directly or indirectly produces and underwrites in any one year an amount of gross direct written premium equal to or more than 25% of the surplus as regards policyholders as reported in the last annual statement of the insurer.

"Financial institution." A Federal or State-chartered bank, bank and trust company, savings bank, savings and loan association, trust company or credit union.

"Home state." The District of Columbia or a state or territory of the United States in which an insurance producer maintains the producer's principal place of residence or principal place of business and is licensed to act as a resident insurance producer.

"Insurance entity." A person doing business involving the insuring of risks. The term includes insurers.

"Insurance producer." A person that sells, solicits or negotiates contracts of insurance.

"Insurer." An insurance company, association, exchange, interinsurance exchange, health maintenance organization, preferred provider organization, professional health services plan corporation subject to 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations), a hospital plan corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations), fraternal benefits society, beneficial association, Lloyd's insurer or health plan corporation.

"Licensee." A person licensed by the Insurance Department as an insurance producer.

"Limited line credit insurance." Includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection (GAP) insurance and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation designated by the Insurance Commissioner as a form of limited line credit insurance.

"Limited line motor vehicle rental insurance." Insurance offered in connection with and incidental to the rental of a rental vehicle, including personal accident, accidental death and dismemberment, personal effects, roadside assistance that may include towing of the rental vehicle, emergency sickness and excess liability.

"Limited line self-service storage insurance." Insurance offered in connection with and incidental to the rental of space at a self-service storage facility. (Def. added Oct. 24, 2018, P.L.667, No.97)

"Line of authority." The licensed ability to sell, solicit or negotiate particular classes or types of insurance, including the following:

(1) Life. Insurance coverage on human lives, including benefits of endowment and annuities, and may include benefits

in the event of death or dismemberment by accident and benefits for disability income.

(2) Accident and health or sickness. Insurance coverage for sickness, bodily injury or accidental death and may include benefits for disability income.

(3) Property. Insurance coverage for the direct or consequential loss or damage to property of every kind.

(4) Casualty. Insurance coverage against legal liability, including that for death, injury or disability or damage to real or personal property.

(5) Variable life and variable annuity products. Insurance coverage provided under variable life insurance contracts and variable annuities.

(6) Personal lines. Property and casualty insurance coverage sold to individuals and families primarily for noncommercial purposes.

(7) Credit. Limited line credit insurance.

(8) Motor vehicle rental. Limited line motor vehicle rental insurance.

(8.1) Self-service storage. Limited line self-service storage insurance.

(9) Limited line. Any other line of insurance as determined by the Insurance Commissioner.

(Def. amended Oct. 24, 2018, P.L.667, No.97)

"Manager." A person that negotiates and binds ceding reinsurance contracts on behalf of a domestic insurer or manages all or part of the insurance business of an insurer and does not act as an agent for such insurer.

"NAIC." The National Association of Insurance Commissioners, its subsidiaries and affiliates.

"Negotiate." To confer directly with or to offer advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

"Nonresident insurance producer." An insurance producer whose home state is a state or territory other than this Commonwealth.

"Rental agreement." Any written agreement setting forth the terms and conditions governing the use of a vehicle provided by the rental company for rental or lease.

"Rental company." A person or entity in the business of providing primarily private passenger vehicles to the public under a rental agreement for a period not to exceed 90 days.

"Renter." Any person and other authorized drivers obtaining use of a vehicle from a rental company under the terms of a rental agreement for a period not to exceed 90 days.

"Sell." To exchange a contract of insurance by any means for money or its equivalent on behalf of an insurance entity.

"Solicit." To attempt to sell insurance or ask or urge a person to apply for a particular kind of insurance from a particular insurance entity.

"Vehicle" or "rental vehicle." A motor vehicle of the private passenger type, including passenger vans, minivans and sport utility vehicles, and of the cargo type, including cargo vans, pickup trucks and trucks with gross vehicle weight of less than 26,000 pounds and which do not require the operator to possess a commercial driver's license.

(601-A added Dec. 6, 2002, P.L.1183, No.147)

Section 602-A. Powers and duties of department.

(a) Responsibilities.--The commissioner shall do all of the following:

(1) License insurance producers in accordance with this act.

(2) Approve and administer or contract for the overall administration of the preexamination program, preexamination courses of study, insurance producer licensing examinations and continuing education programs. A preexamination education program approved by the department shall include no less than three credit hours on ethics.

(b) Authorizations.--The commissioner may do all of the following:

(1) Secure or require any documents or information, including fingerprints, reasonably necessary to verify the accuracy of information provided on an application. The information provided under this subsection shall not be limited by 18 Pa.C.S. § 9121(b)(2) (relating to general regulations). ((1) amended June 30, 2021, P.L.225, No.46)

(2) Participate with the NAIC in a centralized insurance producer license registry for purposes of submitting or obtaining information on insurance producers, including licensing history, lines of authority and regulatory action.

(3) Approve forms to be used by individuals and business entities to apply to the department for an insurance producer license.

(4) Approve additional limited lines of authority.

(602-A added Dec. 6, 2002, P.L.1183, No.147)

Section 603-A. License required.

(a) General rule.--Except as provided in subsection (b), a person shall not sell, solicit or negotiate a contract of insurance in this Commonwealth unless the person is licensed as an insurance producer for the line of authority under which the contract is issued.

(b) Exceptions.--The following persons shall not be insurance producers for purposes of this act:

(1) An insurer. For purposes of this exemption the term does not include an insurer's officers, directors or employees.

(2) An employee of an insurer or a rating organization employed by an insurer:

(i) who is not engaged in the sale, solicitation or negotiation of insurance contracts; and

(ii) who:

(A) inspects, rates or classifies risks; or

(B) supervises the training of insurance producers.

(3) An officer, director or employee of an insurer or of an insurance producer if the officer, director or employee does not receive a commission on policies written or sold to insure risks residing, located or to be performed in this Commonwealth and:

(i) the officer, director or employee's activities are executive, administrative, managerial, clerical or a combination of these and are only indirectly related to the sale, solicitation or negotiation of insurance. These activities may include discussing and informing on insurance inquiries and matters, so long as no recommendation is made with respect to specific coverages, products or rates; receiving requests for coverage for transmittal to a licensee or insurance entity; assisting with the completion of applications at the licensee's or insurance entity's place of

business; passing on to the licensee inquiries of a particular nature; receiving premium payments delivered to the licensee or insurance entity for coverage and issuing receipts on behalf of the licensee or insurance entity; and collecting expiration date information from clients or potential clients;

(ii) the officer, director or employee's function relates to underwriting, loss control, inspection or the processing, adjusting, investigating or settling of a claim on a contract of insurance; or

(iii) the officer, director or employee is acting in the capacity of assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance.

(4) A person that does any of the following, provided no commission is paid for the services:

(i) Secures and furnishes written information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance.

(ii) Performs administrative services related to the enrollment of individuals under plans.

(iii) Issues certificates under plans or otherwise assists in administering plans.

(iv) Performs administrative services related to mass marketed property and casualty insurance.

(v) Provides risk management services to a business entity.

(vi) Performs administrative functions, provides clerical support or enrolls renters on behalf of the rental company which offers insurance coverages in connection with and incidental to the rental of motor vehicles.

(5) An employer, including an association, or the trustees of an employee trust plan and their officers, directors and employees if:

(i) the employer, trustees, officers, directors or employees are engaged in the administration or operation of an employee benefits program;

(ii) the employee benefits program includes insurance issued by an insurer for the benefit of the employer's employees or the employees of its subsidiaries or affiliates; and

(iii) the employer, trustees, officers, directors or employees are not compensated, directly or indirectly, by the insurer issuing the policy of insurance.

(6) A person engaged in the advertising of insurance in this Commonwealth if:

(i) the person does not sell, solicit or negotiate insurance for risks residing, located or to be performed in this Commonwealth; and

(ii) the advertising is distributed to persons residing both within and outside this Commonwealth through the use of printed publications or other forms of electronic mass media.

(7) A person who:

(i) Is not a resident of this Commonwealth.

(ii) Sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to

an insured with risks located in more than one state under that contract.

(iii) Is licensed as an insurance producer to sell, solicit or negotiate that line of authority in the state where the insured maintains its principal place of business.

(iv) The contract of insurance insures risks located in the state where the insured maintains its principal place of business.

(8) A salaried full-time employee who:

(i) counsels or advises the employee's employer on the employer's insurance issues; and

(ii) does not sell or solicit insurance or receive a commission.

(603-A added Dec. 6, 2002, P.L.1183, No.147)

Section 604-A. License prerequisites.

(a) General rule.--Prior to applying to the department for an insurance producer license, an individual shall do the following:

(1) satisfactorily complete the preexamination education requirements of subsection (b); and

(2) pass an insurance producer licensing examination required for the lines of authority for which a candidate desires a license.

(b) Preexamination education requirements.--Prior to making an application for the insurance producer licensing examination, an individual who desires to be licensed as an insurance producer shall complete a minimum of 24 credit hours of approved preexamination courses. Upon satisfactory completion of an approved preexamination course of study, the individual shall be issued proof of completion by the provider.

(c) Insurance producer licensing examination.--Except as provided in subsection (d), upon satisfactory completion of an approved preexamination course of study a candidate may apply to take an insurance producer licensing examination. A candidate shall remit a completed application for examination indicating the lines of authority for which the candidate desires to be licensed, a copy of the candidate's approved preexamination study certificate and the nonrefundable examination fee established by the department prior to taking an insurance producer licensing examination.

(d) Exceptions.--The examination or preexamination education requirements of this act shall not be required if the person is:

(1) A business entity.

(2) A person who possesses the professional designation of Chartered Life Underwriter (CLU) and is applying for life or accident and health line of authority.

(3) A person who possesses the professional designation of Chartered Property and Casualty Underwriter (CPCU) and is applying for property, casualty or accident and health line of authority.

(4) A person who possesses the professional designation of Certified Insurance Counselor (CIC) and is applying for life, accident and health or property and casualty line of authority.

(5) A person who possesses any other professional designation for which the requirements are waived by the commissioner.

(6) A person who is licensed in another state as an insurance producer for the lines of authority for which the person desires to be licensed under section 606-A or 610-A.

(7) A person who has a line of authority limited to limited line credit insurance.

(8) A person who has a line of authority limited to a limited line.

(9) An individual whose line of authority will be restricted to domestic mutual fire insurance and will be with an insurer writing only coverage other than insurance upon automobiles as authorized by section 202(b)(1) through (3) of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(10) The individual whose line of authority will be restricted fraternal pursuant to section 609 of the act of December 14, 1992 (P.L.835, No.134), known as the Fraternal Benefit Societies Code.

(604-A added Dec. 6, 2002, P.L.1183, No.147)

Compiler's Note: Section 609 of Act 134 of 1992, referred to in subsec. (d)(10), was repealed by the act of July 10, 2002, (P.L.749, No.110)

Section 605-A. Application for insurance producer license.

(a) Individual application.--An applicant with a principal place of residence or business within this Commonwealth may apply to the department for a resident insurance producer license. An applicant with a principal place of residence or business outside this Commonwealth may apply for a nonresident insurance producer license. An applicant shall submit to the department:

(1) a completed application indicating the lines of authority for which the applicant desires to be licensed;

(2) the applicant's fingerprints, in order for the department to receive national criminal history records information from the Federal Bureau of Investigation Criminal Justice Information Services Division, and the information provided under this subsection shall not be limited by 18 Pa.C.S. § 9121(b)(2) (relating to general regulations); ((2) amended June 30, 2021, P.L.225, No.46)

(3) documentation verifying that the applicant passed or is exempt from the insurance producer licensing examination on the lines of authority for which the applicant desires a license; and

(4) the required license fee and fees for obtaining national criminal history records information.

(b) Business entity application.--Upon designating one or more individuals licensed under this act to be responsible for the business entity's compliance with the insurance laws and regulations of the Commonwealth, a business entity may apply to the department for an insurance producer license for the same lines of authority held by the designated licensees. A business entity with an office in this Commonwealth shall apply for a resident insurance producer license. A business entity that does not have an office in this Commonwealth shall apply for a nonresident insurance producer license. The designated licensees of the business entity shall submit to the department:

(1) a completed application indicating the lines of authority for which the business entity desires to be licensed;

(2) proof of the licenses held by the designated licensees; and

(3) the required license fee.

(c) License fee.--

(1) Residents. A nonrefundable $55 fee shall accompany an application for a resident insurance producer license until modified by the department by regulation.

(2) Nonresidents. A nonrefundable $110 fee shall accompany an application for a nonresident insurance producer license until modified by the department by regulation.

(605-A added Dec. 6, 2002, P.L.1183, No.147)

Section 606-A. Licensing.

(a) Applicants.--The department shall review each application and may conduct an investigation of each applicant who applies for a license in accordance with this act. The department shall issue a resident or nonresident insurance producer license, as appropriate, to the applicant when the department determines that all of the following criteria have been met:

(1) The applicant has reached 18 years of age.

(2) The applicant has not committed any act which is prohibited under this act.

(3) The applicant has satisfied the preexamination education requirements of this act.

(4) The applicant has passed or is exempt from the insurance producer licensing examination on the lines of authority for which the applicant has applied for licensing.

(5) The applicant has paid all applicable fees established pursuant to this act.

(6) The applicant possesses the general fitness, competence and reliability sufficient to satisfy the department that the applicant is worthy of licensure.

(b) Business entities.--The department shall review each application and may conduct an investigation of each business entity seeking licensure and its designated licensees. The department shall issue a resident or nonresident insurance producer license, as appropriate, to the business entity when the department determines that all of the following criteria have been met:

(1) The business entity has one or more designated licensees.

(2) The business entity's designated licensees are licensees in good standing with the department.

(3) The business entity is applying for licensure for the same lines of authority held by the designated licensees.

(4) The business entity or its designated licensees have not committed any act which is prohibited under this act.

(5) The business entity is owned, operated and managed by persons possessing the general fitness, competence and reliability sufficient to satisfy the department that the business entity is worthy of licensure.

(6) The business entity has paid all applicable fees.

(7) Such other criteria as the department may establish.

(606-A added Dec. 6, 2002, P.L.1183, No.147)

Section 606.1-A. Change of home state.

(a) General rule.--Upon establishing a principal place of residence or business within this Commonwealth, an individual who is licensed as a resident insurance producer in another state or territory may apply to the department to become licensed in this Commonwealth as a resident insurance producer for the equivalent lines of authority for which the individual is licensed in the individual's former home state. Within 90 days of establishing a principal place of residence or business in this Commonwealth, the individual shall submit to the department a completed application indicating the lines of

authority for which the individual desires to be licensed and for which the individual is licensed in the individual's former home state, proof of the individual's former home state license or a letter of clearance from the insurance commissioner of the individual's former home state and the required license fee. If the individual desires a resident insurance producer license for a line of authority for which the individual is not licensed in the individual's former home state, the individual shall comply with the requirements of this act prior to making applications to the department.

(b) Review of applications.--The department shall review each application and may conduct an investigation of each individual who applies for a license in accordance with this section. The department shall issue a resident insurance producer license to the individual when the department determines that all of the following criteria have been met:

(1) The individual holds a current insurance producer license in the individual's former home state or made application to the department within 90 days of the cancellation of the individual's license in the individual's former home state.

(2) The individual is applying for licensure in the equivalent lines of authority for which the individual was licensed in the individual's former home state.

(3) The individual has not committed any act which is prohibited under this act.

(4) The individual has paid all applicable fees.

(5) The individual:

(i) was issued a letter of clearance from the insurance commissioner of the individual's former home state;

(ii) was licensed in good standing in the individual's former home state at the time of cancellation; or

(iii) is recorded as being licensed for the lines of authority and is in good standing in the individual's former home state's insurance producer records or records maintained by the NAIC.

(6) Such other criteria as the department may establish.

(606.1-A added Dec. 6, 2002, P.L.1183, No.147)

Section 607-A. Issuance and term of license.

An insurance producer license issued by the department shall be:

(1) Issued only in the name of the applicant or business entity. If a licensee is doing business under a fictitious name other than the name appearing on the producer license, the licensee is required to notify the commissioner in writing prior to use of the fictitious name.

(2) Issued in paper or electronic form.

(3) Nontransferable.

(4) Issued in one or more lines of authority.

(5) Issued for a period not to exceed two years.

(607-A added Dec. 6, 2002, P.L.1183, No.147)

Section 608-A. License renewals.

(a) General rule.--A licensee may request renewal of the license. The licensee shall remit to the department a completed renewal form, the required fee and verification that the licensee has completed the continuing education required by this act. A resident licensee that has not previously submitted fingerprints to the department shall also submit the licensee's fingerprints and the fee in order to permit the department to receive national criminal history records information from the

Federal Bureau of Investigation Criminal Justice Information Services Division. Upon receipt and review, the department shall renew the license unless it determines that the licensee is not in compliance with this act. The information provided under this subsection shall not be limited by 18 Pa.C.S. § 9121(b)(2) (relating to general regulations). ((a) amended June 30, 2021, P.L.225, No.46)

(b) Continuing education.--A licensee shall successfully complete 24 credit hours of approved continuing education for each two-year license period as a condition for license renewal unless modified by the department by regulation. A licensee may carry forward excess continuing education credit hours up to a maximum of 24 credit hours from one licensing period to the next licensing period.

(c) Continuing education exemptions.--The following licensees shall be exempt from the requirements of continuing education:

(1) A licensee who was licensed as an agent or broker for a line of authority prior to January 1, 1971, and who has been continuously licensed as an agent, broker or producer for the line of authority since that time.

(2) A licensee which is a business entity.

(3) A licensee who has only a limited line of authority.

(4) A licensee who has a line of authority limited to restricted fraternal.

(5) A licensee who has a line of authority limited to limited line credit insurance if the insurer provided a course of instruction to each individual whose duties will include selling, soliciting or negotiating the insurance.

(6) A nonresident licensee who has satisfied the continuing education requirements of the licensee's home state if that state recognizes the satisfaction of its continuing education requirements by a resident licensee satisfying the requirements of this act. If the licensee's home state has continuing education requirements and the nonresident licensee fails to satisfy the home state's continuing education requirements, the licensee shall be subject to continuing education requirements of this act.

(7) A licensee's line of authority is restricted to domestic mutual fire insurance and the licensee's appointment is with an insurer writing only coverage other than insurance upon automobiles as authorized by section 202(b)(1) through (3) of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(d) Lapses.--A licensee who allows his or her license to lapse by failing to timely renew the license, pay the fee required by this act or complete the continuing education required by this act may within one year of the license renewal date request the department to reinstate the license. Persons requesting reinstatement of a lapsed license shall submit a completed renewal form, the fee required by this act and verification that the person has completed all continuing education required by subsection (b) for the previously licensed and lapsed periods. The department shall reinstate the license retroactively, with the reinstatement effective on the date the license lapsed, if the department receives a request for reinstatement together with a completed renewal application, payment of the lapsed license fee and proof of continuing education compliance within 60 days after the license lapsed. The department shall reinstate the license prospectively, with reinstatement effective on the date that the license is reinstated, if the department receives a request for

reinstatement of a lapsed license more than 60 days after the license lapsed. If a person applies for reinstatement more than one year after the lapse date, the person shall reapply for the license under this act.

(e) Extenuating circumstances.--A licensee who is unable to timely comply with the requirements of subsection (a) as a result of military service or other extenuating circumstance may request the department to waive the requirements of having to complete continuing education for the period in which the license had lapsed and payment of the lapsed license fee. The request shall include sufficient detail and supporting documentation to determine the necessity of the waiver. If the department determines that there is good cause for noncompliance, the department shall grant the waiver and permit the licensee to request renewal of the license in accordance with this act.

(f) Renewal fees.--The following nonrefundable fees shall accompany an application for renewal of an insurance producer license unless modified by the department by regulation:

(1) Resident renewal fee - $55.

(2) Nonresident renewal fee - $110.

(3) Lapsed license renewal fee - $165.

(608-A added Dec. 6, 2002, P.L.1183, No.147)

Section 609-A. Temporary licensing.

(a) General rule.--If the department determines that the issuance of a temporary insurance producer license is in the public interest and that the person requesting the license is worthy to receive a temporary license, the department may issue a temporary insurance producer license to the following persons:

(1) The surviving spouse or court-appointed personal representative of a resident individual licensee who dies or becomes mentally or physically disabled. The temporary license shall be used by the spouse or representative to operate the insurance business owned by the licensee until:

(i) the business is sold or transferred;

(ii) the licensee recovers and returns to the business; or

(iii) new personnel is trained and licensed to operate the licensee's business.

(2) An owner, partner or employee of a business entity licensee upon the death or disability of the designated licensee. The temporary license shall be used by the owner, partner or employee to operate the business entity until:

(i) the business is sold or transferred; or

(ii) new personnel is trained, licensed and designated as the designated licensee.

(3) The designee of an individual licensee who enters active service in the armed forces of the United States.

(4) Any other person in an extenuating circumstance where the commissioner deems that the public interest will best be served by the issuance of a temporary license.

(b) Period of license.--The temporary license shall be for a period not to exceed 180 days and is not transferable.

(c) Other requirements.--The department may impose requirements upon a temporary licensee, including requiring a sponsoring insurer and limiting the lines of authority of a temporary licensee, as deemed necessary to protect insureds and the public.

(d) Revocation.--The department may immediately and without notice revoke a temporary license if it is deemed in the public interest.

(609-A added Dec. 6, 2002, P.L.1183, No.147)

Section 610-A. Reciprocal licensing.

(a) Nonresident individuals.--

(1) An individual who is currently licensed as a resident insurance producer in another state or territory may apply to the department for a nonresident insurance producer license for the equivalent lines of authority as the individual is licensed in the individual's home state. The individual shall submit to the department a completed application or an updated copy of the individual's home state application indicating the lines of authority for which the individual desires to be licensed, proof of the individual's current home state license and the required license fee. If the individual desires a nonresident insurance producer license for a line of authority for which the individual is not licensed in the individual's home state, the individual shall comply with the requirements of this act prior to making application to the department.

(2) Upon receipt and review of the application, proof of the home state license and the fee, the department shall issue a nonresident insurance producer license to the individual for the equivalent lines of authority for which the individual is licensed in the individual's home state. The department may verify the individual's licensing status through the Producer Database maintained by the NAIC. The department may deny the application if the individual's home state does not award nonresident insurance producer licenses to resident licensees of this Commonwealth on the same basis.

(b) Nonresident business entities.--

(1) Upon designating one or more individuals licensed under this act to be responsible for the business entity's compliance with the insurance laws and regulations of this Commonwealth, a business entity which is currently licensed as a resident insurance producer in another state or territory may apply to the department for a nonresident insurance producer license for the equivalent lines of authority as the business entity is licensed in its home state. The designated licensees of the business entity shall remit to the department a completed business entity application or an updated copy of the business entity's home state application indicating the lines of authority for which the business entity desires to be licensed and for which the business entity is licensed in the other state, proof of the business entity's current home state license and the required license fee.

(2) Upon receipt and review of the application, proof of the home state license and the fee, the department shall issue a nonresident insurance producer license to the business entity for the equivalent lines of authority as the business entity is licensed in its home state if the department determines that the business entity and its designated licensees are licensees in good standing in the business entity's home state. The department may verify licensing status through the Producer Database maintained by the NAIC. The department may deny the application if the business entity's home state does not award nonresident insurance producer licenses to resident licensees of this Commonwealth on the same basis.

(610-A added Dec. 6, 2002, P.L.1183, No.147)

Section 611-A. Prohibited acts.

A licensee or applicant for an insurance producer license shall not:

(1) Provide incorrect, misleading, incomplete or false information to the department in a license application.

(2) Violate the insurance laws or regulations of this Commonwealth or a subpoena or order of the commissioner or of another state's insurance commissioner.

(3) Obtain or attempt to obtain a license through misrepresentation or fraud.

(4) Improperly withhold, misappropriate or convert money or property received in the course of doing business.

(5) Intentionally misrepresent the terms of an actual or proposed insurance contract or application for insurance.

(6) Admit to or been found to have committed any unfair insurance practice or fraud.

(7) Use fraudulent, coercive or dishonest practices or demonstrate incompetence, untrustworthiness or financial irresponsibility in the conduct of doing business in this Commonwealth or elsewhere.

(8) Have an insurance producer license or other financial services license, or its equivalent, denied, suspended or revoked by a governmental entity.

(9) Forge another person's name on an application for insurance or on any document related to an insurance or financial service transaction.

(10) Cheat on an examination for an insurance producer license.

(11) Knowingly accept insurance business which was sold, solicited or negotiated by a person who is not licensed as an insurance producer.

(12) Fail to comply with an administrative or court order imposing a child support obligation.

(13) Fail to pay State income tax or comply with any administrative or court order directing the payment of State income tax.

(14) Commit a felony or its equivalent.

(15) Commit a misdemeanor that involves the misuse or theft of money or property belonging to another person.

(16) Commit a violation of subarticle B.

(17) Commit fraud, forgery, dishonest acts or an act involving a breach of fiduciary duty.

(18) Transfer insurance coverage to an insurer other than the insurer expressly chosen by the insured without the consent of the insured.

(19) Fail to notify the department of a change of address, telephone number and email address within 30 days.

((19) amended June 30, 2021, P.L.225, No.46)

(20) Demonstrate a lack of general fitness, competence or reliability sufficient to satisfy the department that the licensee is worthy of licensure.

(611-A added Dec. 6, 2002, P.L.1183, No.147)

Section 612-A. Failure to respond or remit payment.

(a) Response.--A licensee who fails to provide a written response to the department within 30 days of receipt of a written inquiry from the department or who fails to remit valid payment for all fees due and owing to the department shall, after notice from the department specifying the violation and advising of corrective action to be taken, correct the violation within 15 days of receipt of the notice.

(b) Correction.--If a licensee fails to correct the violation within 15 days of receiving notice, the department may assess an administrative fine of no more than $100 per day per violation.

(612-A added Dec. 6, 2002, P.L.1183, No.147)

Section 613-A. Failure to appeal.

A decision of the department from which no timely appeal is taken to the administrative hearings office or an order of the commissioner from which no timely appeal is taken to a court of competent jurisdiction shall be a final order and shall be enforceable by a court of competent jurisdiction.

(613-A added Dec. 6, 2002, P.L.1183, No.147)

Section 614-A. Reciprocity.

(a) Waiver.--The department may waive the requirements for a person applying for a nonresident insurance producer license in this Commonwealth that possesses a valid insurance producer license from the person's home state if the person's home state awards nonresident insurance producer licenses to resident licensees of this Commonwealth on the same basis.

(b) Limited line.--Notwithstanding any other provision of this division, after application to the department in accordance with section 610-A, a person licensed as a limited line credit insurance or other type of limited lines producer in the person's home state shall receive a nonresident limited lines producer license in accordance with subsection (a), granting the same scope of authority as granted under the license issued by the producer's home state.

(614-A added Dec. 6, 2002, P.L.1183, No.147)

DIVISION 2
LICENSING OF MANAGERS AND EXCLUSIVE GENERAL AGENTS
(Div. added Dec. 6, 2002, P.L.1183, No.147)

Section 631-A. License required.

(a) General rule.--Except as provided in subsection (b), no person shall engage in any activities requiring a manager or exclusive general agent license without being licensed as a manager or exclusive general agent by the department.

(b) Exceptions.--The following persons shall not be required to be licensed as a manager or exclusive general agent:

(1) A licensee whose authority is limited primarily to the production of insurance business with limited underwriting authority.

(2) A manager or exclusive general agent operating under a management contract or exclusive general agency agreement entered into prior to December 22, 1965.

(3) A person subject to regulation as a managing general agent under Article VIII.

(c) Penalty.--A person that violates subsection (a) commits a misdemeanor of the third degree and, upon conviction, shall be sentenced to pay a fine not exceeding $1,000 for each day of operation without a license.

(631-A added Dec. 6, 2002, P.L.1183, No.147)

Section 632-A. Application and licensure.

(a) Application.--A person may apply to the department for a manager or exclusive general agent license. The person shall submit to the department a completed application, the fee required by subsection (c) and any other information required by the department.

(b) Licensure.--The department shall review the application and may conduct an investigation of the person. The department shall issue a license to the person when the department is satisfied that all of the following criteria have been met:

(1) The person possesses a good business reputation.

(2) The person possesses the fitness, competence and reliability sufficient to satisfy the department that the

individual is worthy of licensure as a manager or exclusive general agent.

(3) The person has paid all applicable fees established pursuant to this article.

(4) Such other criteria as the department may establish.

(c) License fee.--A nonrefundable $100 fee shall accompany an application for a manager or exclusive general agent license unless modified by the department by regulation.

(d) Term.--A license issued in accordance with this section shall be for a period of not more than one year.

(632-A added Dec. 6, 2002, P.L.1183, No.147)

Section 633-A. Insurers to certify names of managers or exclusive general agents.

(a) General rule.--Every domestic insurer operating under a management contract or an exclusive general agency agreement shall certify to the department the name of the manager or exclusive general agent within ten days from the effective date of the contract or agreement and within ten days after the renewal of the license of the manager or exclusive general agent.

(b) Penalty.--An insurer that fails to file the certification required by subsection (a) commits a misdemeanor of the third degree and, upon conviction, shall be sentenced to pay a fine not exceeding $1,000 for each day of noncompliance.

(633-A added Dec. 6, 2002, P.L.1183, No.147)

Section 634-A. Enforcement by department.

(a) Notice.--Upon evidence of conduct which would disqualify a licensed manager or exclusive general agent from initial issuance of a license, the department shall notify the manager or exclusive general agent, specifying the nature of the alleged conduct and fixing a time and place, at least ten days thereafter, when a hearing on the matter shall be held.

(b) Hearing.--The department shall conduct the hearing fixed in subsection (a) in accordance with 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies).

(c) Penalties.--After the hearing or upon failure of the manager or exclusive general agent to appear at the hearing, the commissioner may impose any combination of the following actions deemed appropriate:

(1) Suspension or revocation of the license, if any, of the person.

(2) An order to cease and desist.

(3) Any other conditions as the commissioner deems appropriate.

(634-A added Dec. 6, 2002, P.L.1183, No.147)

Section 635-A. Appeals.

The person aggrieved by a decision of the commissioner that has a direct interest in the decision may appeal the decision of the commissioner in accordance with 2 Pa.C.S. Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action).

(635-A added Dec. 6, 2002, P.L.1183, No.147)

SUBARTICLE B
REGULATION OF INSURANCE PRODUCERS
(Subart. added Dec. 6, 2002, P.L.1183, No.147)

Compiler's Note: Section 3 of Act 147 of 2002, which repealed Article VI and added Article VI-A, provided that persons currently licensed under Article VI remain licensed and are subject to the provisions of subarticle

B. Upon expiration of existing licenses, persons shall be licensed in accordance with Article VI-A.

DIVISION 1
PROHIBITED ACTIVITIES
(Div. added Dec. 6, 2002, P.L.1183, No.147)

Section 641-A. Unlicensed activity.

(a) Prohibition.--No person shall act as or perform the duties of an insurance producer in this Commonwealth without being licensed in accordance with this act. An insurer shall be responsible for a violation of this section by its employees; however, other than against directors and officers, the department may not seek to impose penalties against the individual employees in addition to the insurer for the same activity.

(b) Penalty.--A person that violates this section commits a felony of the third degree.

(641-A added Dec. 6, 2002, P.L.1183, No.147)

Section 641.1-A. Doing business with unlicensed persons.

(a) Violation.--Any insurance entity or licensee accepting applications or orders for insurance from any person or securing any insurance business that was sold, solicited or negotiated by any person acting without an insurance producer license shall be subject to civil penalty of no more than $5,000 per violation in accordance with this act. This section shall not prohibit an insurer from accepting an insurance application directly from a consumer or prohibit the payment or receipt of referral fees in accordance with this act.

(b) Penalty.--A person that violates this section commits a misdemeanor of the third degree.

(641.1-A added Dec. 6, 2002, P.L.1183, No.147)

Section 642-A. Theft by insurance producers.

(a) Prohibition.--No insurance producer shall sell, solicit or negotiate a contract of insurance and fraudulently appropriate or convert to his own use or, with intent to use or fraudulently appropriate, take, or otherwise dispose of, or withhold, appropriate, lend, invest or otherwise use or apply money or substitutes for money received by him as an insurance producer contrary to the instructions or without the consent of the insurer.

(b) Penalty.--A person that violates this section commits a theft punishable in accordance with 18 Pa.C.S. Ch. 39 (relating to theft and related offenses).

(642-A added Dec. 6, 2002, P.L.1183, No.147)

Section 643-A. Advertising as insurance producer of unauthorized entity.

(a) Prohibition.--No person shall represent or advertise himself to be an insurance producer or representative of an unauthorized insurance entity, including an insurer that is not approved or admitted under section 208 and an insurer that has not met the requirements of an eligible surplus lines insurer under section 1605 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(b) Penalty.--A person that violates subsection (a) commits a misdemeanor of the third degree.

(643-A added Dec. 6, 2002, P.L.1183, No.147)

Section 644-A. Soliciting for nonexistent entity.

(a) Prohibition.--No person shall, directly or indirectly, offer to sell, solicit or negotiate contracts, certificates, agreements, binders or applications for insurance, surety or indemnity in this Commonwealth for or on behalf of a fictitious,

nonexistent, dissolved, inactive, liquidated, liquidating or bankrupt insurance entity.

(b) Penalty.--A person that violates this section commits a misdemeanor of the third degree.

(644-A added Dec. 6, 2002, P.L.1183, No.147)

Section 645-A. Rebates prohibited.

(a) Prohibition.--Except as otherwise provided in this section, no insurance producer shall, directly or indirectly, offer, promise, allow, give, set off or pay a rebate of, or part of, a premium payable on the contract of insurance or on the insurance producer's commission, earnings, profits, dividends or other benefit founded, arising, accruing or to accrue thereon, or any special advantage in date of policy or age of issue, or any paid employment or contract for services of any kind, or any other valuable consideration or inducement, to or for insurance on a risk in this Commonwealth which is not specified in the contract of insurance.

(a.1) Exception.--An insurance producer may offer or give to an insured or a prospective insured, on an annual aggregate basis, any favor, advantage, object, valuable consideration or anything other than money that has a cost of or a redeemable value of less than or equal to $100, which is not specified in the contract of insurance. The commissioner may increase this amount upon publication of notice in the Pennsylvania Bulletin.

(a.2) Receipt contingent on purchase.--Notwithstanding any other provision of this section to the contrary, an insurance producer may not make receipt of anything of value contingent on the purchase of insurance.

(b) Penalty.--A person that violates subsection (a) commits a misdemeanor of the third degree.

(c) Construction.--Nothing in this section shall be construed as:

(1) permitting any unfair method of competition or an unfair or deceptive act or practice under the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act; or

(2) prohibiting an insurance producer from offering or giving to an insured, for free or at a discounted price, services or other offerings that relate to loss control of the risks covered under the policy.

(645-A amended May 4, 2018, P.L.114, No.22)

Section 646-A. Inducements prohibited.

(a) Prohibition.--Except as otherwise provided in this section, no insurance producer shall, directly or indirectly, offer, promise, give, option, sell or purchase any stocks, bonds, securities or property, or any dividends or profits accruing or to accrue thereon, or other thing of value whatsoever, as an inducement to purchase a contract of insurance. Nothing in this section shall be construed to prevent the taking of a bona fide obligation, with legal interest, in payment of any premium. This section shall not prohibit payment or receipt of referral fees in accordance with this act.

(a.1) Exception.--An insurance producer may offer or give to an insured or a prospective insured, on an annual aggregate basis, any favor, advantage, object, valuable consideration or anything other than money that has a cost of or a redeemable value of less than or equal to $100. The commissioner may increase this amount upon publication of notice in the Pennsylvania Bulletin.

(a.2) Receipt contingent on purchase.--Notwithstanding any other provision of this section to the contrary, an insurance

producer may not make receipt of anything of value contingent on the purchase of insurance.

(b) Penalty.--A person that violates subsection (a) commits a misdemeanor of the third degree.

(c) Construction.--Nothing in this section shall be construed as:

(1) permitting any unfair method of competition or an unfair or deceptive act or practice under the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act; or

(2) prohibiting an insurance producer from offering or giving to an insured, for free or at a discounted price, services or other offerings that relate to loss control of the risks covered under the policy.

(646-A amended May 4, 2018, P.L.114, No.22)

Section 647-A. Misrepresentation of terms of policy and future dividends by insurance producers.

(a) Prohibition.--No insurance producer shall, directly or indirectly:

(1) Issue, circulate or use, or cause or permit to be issued, circulated or used, a written or oral statement or circular misrepresenting the terms of a contract of insurance issued or to be issued by the insurer.

(2) Make an estimate with intent to deceive of the future dividends payable under the contract of insurance.

(b) Penalty.--A person that violates subsection (a) commits a misdemeanor of the third degree.

(647-A added Dec. 6, 2002, P.L.1183, No.147)

Section 648-A. Misrepresentations to an insured of another company.

(a) Prohibition.--No insurance producer shall, directly or indirectly, misrepresent or make an incomplete comparison of contracts of insurance for the purpose of inducing an insured of another insurer to lapse, forfeit or surrender his contract of insurance and to take out a contract of insurance insuring against similar risks with the licensee or solicitor's insurer.

(b) Penalty.--A person that violates subsection (a) commits a misdemeanor of the third degree.

(648-A added Dec. 6, 2002, P.L.1183, No.147)

Section 649-A. The licensing of financial institutions as insurers.

No financial institution shall apply to be licensed or to be admitted as an insurer except to underwrite title insurance.

(649-A added Dec. 6, 2002, P.L.1183, No.147)

Section 650-A. Requirements on insurance producers by financial institutions.

No financial institution may impose any unreasonable requirement on an insurance producer not associated with that financial institution.

(650-A added Dec. 6, 2002, P.L.1183, No.147)

Section 651-A. Conditional financial transactions.

No financial institution or its directors, officers, employees, agents or insurance producers may require the purchase of insurance from the financial institution or its affiliates or from a designated insurer or insurance producer as a condition of a loan or deposit transaction. A financial institution or its directors, officers, employees, agents or insurance producers may not reject a required contract of insurance solely because the contract was sold by a person that is not associated with the financial institution.

(651-A added Dec. 6, 2002, P.L.1183, No.147)

DIVISION 2
REGULATED ACTIVITIES
(Div. added Dec. 6, 2002, P.L.1183, No.147)

Section 671-A. Appointments.

(a) Representative of the insurer.--An insurance producer shall not act on behalf of or as a representative of the insurer unless the insurance producer is appointed by the insurer. An insurance producer not acting as a representative of an insurer is not required to be appointed.

(b) Representative of the consumer.--An insurance producer acting on behalf of or representing an insurance consumer shall execute a written agreement with the insurance consumer prior to representing or acting on their behalf that:

(1) delineates the services to be provided; and

(2) provides full and complete disclosure of the fee to be paid to the insurance producer by the insurance consumer.

(c) Notification to department.--An insurer that appoints an insurance producer shall file with the department a notice of appointment. The notice shall state for which companies within the insurer's holding company system or group the appointment is made. Upon receipt of the notice, the department shall verify if the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the department shall notify the insurer of the determination.

(d) Termination of appointment.--Once appointed, an insurance producer shall remain appointed by an insurer until such time as the insurer terminates the appointment in writing to the insurance producer or until the insurance producer's license is suspended, revoked or otherwise terminated.

(e) Appointment fee.--An appointment fee of $12.50 will be billed annually to the insurer for each producer appointed by the insurer during the preceding calendar year regardless of the length of time the producer held the appointment with the insurer. The appointment fee may be modified by regulation. The fee shall be paid in full within 30 days.

(f) Reporting.--An insurer shall, upon request, certify to the department the names of all licensees appointed by the insurer.

(671-A added Dec. 6, 2002, P.L.1183, No.147)

Section 671.1-A. Termination of appointments.

(a) Termination.--An insurer which terminates an appointment pursuant to section 671-A(d) shall notify the department in writing on a form approved by the department, or through an electronic process approved by the department, within 30 days following the effective date of the termination.

(b) Reason for termination.--If the reason for the termination was a violation of this act or if the insurer had knowledge that the licensee was found to have engaged in any activity prohibited by this act, the insurer shall inform the department in the notification. Upon the written request of the department, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the producer.

(c) Ongoing notification requirement.--The insurer shall promptly notify the department if upon further review or investigation the insurer discovers additional information that would have been reportable to the commissioner in accordance with subsection (b) had the insurer known of the existence of the information.

(d) Copy of notification to be provided to licensee.--

(1) Within 15 days of making a notification required by subsection (b) or (c), an insurer shall mail a copy of the notification to the licensee's last known home address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(2) Within 30 days of receiving notification pursuant to paragraph (1), a licensee may file written comments concerning the substance of the notification with the department. The licensee shall simultaneously mail a copy of the comments to the insurer by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(e) Reports.--An insurer or licensee that fails to report as required under the provisions of this section or that is found to have falsely reported with malice by a court of competent jurisdiction may, after notice and hearing, have its license or certificate of authority suspended or revoked and may have civil penalties imposed against the insurer or licensee in an amount not to exceed $5,000 for each violation.

(f) Immunities.--

(1) In the absence of actual malice, an insurer, the authorized representative of the insurer, a licensee, the Insurance Commissioner or an organization of which the Insurance Commissioner is a member and that compiles the information and makes it available to other insurance commissioners or regulatory or law enforcement agencies shall not be subject to civil liability, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees as a result of any statement or information required by or provided pursuant to this section or any information relating to any statement that may be requested in writing by the Insurance Commissioner, from an insurer or licensee; or a statement by a terminating insurer or licensee to an insurer or licensee limited solely and exclusively to whether a termination under subsection (a) was reported to the Insurance Commissioner, provided that the propriety of any termination under subsection (a) is certified in writing by an officer or authorized representative of the insurer or producer terminating the relationship.

(2) In any action brought against a person that may have immunity under paragraph (1) for making any statement required by this section or providing any information relating to any statement that may be requested by the Insurance Commissioner, the party bringing the action shall plead specifically in any allegation that paragraph (1) does not apply because the person making the statement or providing the information did so with actual malice.

(3) Paragraph (1) or (2) shall not abrogate or modify any existing statutory or common law privileges or immunities.

(g) Preemption.--Nothing in this section shall supersede any provision of the act of September 22, 1978 (P.L.763, No.143), entitled "An act establishing certain procedures relating to the termination of insurance agency contracts or accounts and providing penalties."

(671.1-A added Dec. 6, 2002, P.L.1183, No.147)

Section 672-A. Payment of commissions.

(a) Limitation.--An insurance entity may pay a commission, brokerage fee, service fee or other compensation to a licensee

for selling, soliciting or negotiating a contract of insurance. A licensee may pay a commission, brokerage fee, service fee or other compensation to a licensee for selling, soliciting or negotiating a contract of insurance. Except as provided in subsection (b), an insurance entity or licensee may not pay a commission, brokerage fee, service fee or other compensation to a person that is not a licensee for activities related to the sale, solicitation or negotiation of a contract of insurance.

(b) Exception.--An insurance entity or licensee may pay:

(1) a renewal or other deferred commission to a person that is not a licensee for selling, soliciting or negotiating a contract of insurance if the person was a licensee at the time of the sale, solicitation or negotiation; or

(2) a fee to a person that is not a licensee for referring to a licensee persons that are interested in purchasing insurance if the referring person does not discuss specific terms and conditions of a contract of insurance and, in the case of referrals for insurance that is primarily for personal, family or household use, the referring person receives no more than a one-time, nominal fee of a fixed dollar amount for each referral that does not depend on whether the referral results in a sale.

An insurance entity or licensee shall not pay a commission or fee to a person under this subsection if the person is a licensee under suspension or a former licensee whose insurance producer license was revoked.

(672-A added Dec. 6, 2002, P.L.1183, No.147)

Section 673-A. Receipt of commissions.

(a) Limitation.--A licensee may accept a commission, brokerage fee, service fee or other compensation from an insurance entity or licensee for selling, soliciting or negotiating a contract of insurance. Except as provided in subsection (b), a person may not accept a commission, brokerage fee, service fee or other compensation from an insurance entity or licensee if the person is not a licensee and the compensation is for activities related to the sale, solicitation or negotiation of a contract of insurance.

(b) Exception.--A person may accept:

(1) a renewal or other deferred commission for selling, soliciting or negotiating a contract of insurance if the person was a licensee at the time of the sale, solicitation or negotiation; or

(2) a fee for referring persons to a licensee that are interested in purchasing insurance provided they do not discuss specific terms and conditions of a contract of insurance and, in the case of referrals for insurance that is primarily for personal, family or household use, they receive no more than a one-time, nominal fee of a fixed dollar amount for each referral that does not depend on whether the referral results in a sale.

A person may not accept a commission or fee under this subsection if the person is a licensee under suspension or a former licensee whose insurance producer license was revoked.

(673-A added Dec. 6, 2002, P.L.1183, No.147)

Section 674-A. Imposition of additional fees.

(a) General rule.--A licensee may charge a fee in addition to a commission to a person for the sale, solicitation or negotiation of a contract of insurance for commercial business. The fee charged by the licensee shall be disclosed in advance in writing to the person and shall be reasonable in relationship to the services provided.

(b) Application fee.--Notwithstanding other provisions of this section, no insurance producer shall charge a fee for the completion of an application for a contract of insurance.

(674-A added Dec. 6, 2002, P.L.1183, No.147)

Section 675-A. Credit life, credit accident and health and credit unemployment insurance.

(a) Sales restrictions.--A person that sells, solicits or negotiates a contract of credit insurance shall do so in accordance with the act of September 2, 1961 (P.L.1232, No.540), known as the Model Act for the Regulation of Credit Life Insurance and Credit Accident and Health Insurance, for all of the following:

(1) Credit life insurance.

(2) Credit accident and health insurance.

(3) Credit unemployment insurance.

If the insurance is sold in connection with loans or other credit transactions, the provisions of the Model Act for the Regulation of Credit Life Insurance and Credit Accident and Health Insurance relating to credit life and credit accident and health insurance are applicable to credit unemployment insurance.

(b) Additional restrictions.--In addition to the requirements of subsection (a), the sale, solicitation or negotiation of credit unemployment insurance shall be subject to all of the following:

(1) The total amount of benefits payable by credit unemployment insurance in the event of unemployment shall not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness.

(2) The amount of each monthly payment shall not exceed the original indebtedness divided by the number of installments.

(3) The loss ratio for the insurance shall be set and regulated by the commissioner in the same manner as the loss ratio is set and regulated for credit life and credit accident and health insurance.

(4) Involuntary unemployment insurance sold in connection with open-end credit shall provide monthly benefits at least equal to the insured's minimum monthly payment calculated at the time of unemployment, subject to a maximum monthly indemnity contained in the certificate of insurance.

(5) Benefits are payable, at a minimum, upon the debtor meeting the eligibility requirements for unemployment compensation.

(6) The period during which benefits are payable in the event of the insured's involuntary unemployment shall continue at least until the earliest of the following:

(i) The insured's return to full-time work.

(ii) Satisfaction of the loan or other credit transaction.

(iii) In the case of open-end credit, payment of 12 consecutive monthly installments.

(7) The insurance shall not be required as a condition of the extension of credit.

(8) If a creditor offers the insurance to any of its debtors, it must offer it under the same terms and conditions to all of its like debtors and under the same terms and conditions as all of its offices or locations in this Commonwealth.

(675-A added Dec. 6, 2002, P.L.1183, No.147)

Section 676-A. Required purchases of insurance.

(a) Disclosures.--If a financial institution requires a person to obtain insurance in connection with a loan and the insurance is available through the financial institution, a licensee employed by or affiliated with the financial institution shall inform the person at or prior to the time of application that the purchase of the insurance from the financial institution is not a condition of the loan and will not affect current or future credit decisions. The licensee may inform the person that insurance is available from the financial institution.

(b) Acknowledgment.--If the person purchases the insurance through the financial institution, the licensee shall obtain a written statement or acknowledgment from the person prior to the purchase of the insurance stating that the person has been advised that the purchase of the insurance from the financial institution is not a condition of receiving the loan and will not affect current or future credit decisions.

(c) Regulations.--The commissioner may promulgate regulations providing for alternative methods of achieving the disclosures and acknowledgment required by this section for situations which do not involve direct contact with the customer at the time of solicitation or application.

(676-A added Dec. 6, 2002, P.L.1183, No.147)

Section 677-A. Sales on or from the premises of a financial institution.

(a) Disclosures.--A licensee employed by or affiliated with a financial institution that solicits the sale of annuities or life insurance, except credit life insurance, on or from the physical premises of the financial institution shall provide a person applying for a contract of insurance a written disclosure at or prior to the time of application for the insurance or annuity. The disclosure shall include a notice of all of the following:

(1) The insurance or annuity is not a deposit.

(2) The insurance or annuity is not insured by the Federal Deposit Insurance Corporation or any other agency or instrumentality of the Federal Government.

(3) The insurance or annuity is not guaranteed by the financial institution or an affiliated insured depository institution.

(4) The insurance or annuity is subject to investment risk, including potential loss of principal, when appropriate.

(b) Setting and circumstance.--Sales of annuities or insurance, except credit insurance, by a financial institution or by a licensee employed by or affiliated with the financial institution shall take place in a location which is distinct from the area where deposits are taken and loan applications are discussed and accepted. Signs or other means shall be used to distinguish the insurance or annuities sales area from the deposit taking and lending areas. The commissioner shall exempt a financial institution from the requirements of this section if the number of staff or size of the facility prevents compliance.

(c) Exceptions.--Compliance by a financial institution with the disclosure and the setting and circumstances requirements set forth in the Interagency Statement on Retail Sales of Nondeposit Investment Products issued February 15, 1994, by the Board of Governors of the Federal Reserve System, the Federal Deposit Insurance Corporation, the Office of the Comptroller of the Currency and the Office of Thrift Supervision shall satisfy the requirements of this section.

(677-A added Dec. 6, 2002, P.L.1183, No.147)

Section 677.1-A. Customer privacy.

(a) General rule.--No financial institution shall use or share with a third party any insurance coverage information obtained in making a loan to a current customer for the purpose of selling or soliciting the purchase of insurance or annuities unless the requirements of this section are met.

(b) Notice.--The following notice to a loan customer shall be set forth in standard or larger type:

USE OF INSURANCE INFORMATION RELATING TO YOUR LOAN

AS A CURRENT LOAN CUSTOMER, WE MAY HAVE INSURANCE COVERAGE INFORMATION THAT WAS OBTAINED AS PART OF YOUR LOAN PROCESS. UNDER PENNSYLVANIA LAW, YOU HAVE THE RIGHT TO DIRECT THAT WE NOT USE OR SHARE THIS INFORMATION IN THE MARKETING OF INSURANCE OR ANNUITIES. TO EXERCISE THIS RIGHT, YOU MUST SIGN AND RETURN THIS FORM WITHIN THIRTY (30) DAYS. IF YOU DO NOT SIGN AND RETURN THIS FORM TO US, WE MAY USE OR SHARE THIS INFORMATION IN THE MARKETING OF INSURANCE OR ANNUITIES.

.....

(Signature)

(c) Mailing.--The notice prescribed in subsection (b) shall be sent by first class mail and may be included in a solicitation for the purchase of insurance or annuities. This notice shall be addressed to the individual customer and shall include a postage prepaid response mechanism.

(d) Consent.--For the purpose of complying with subsection (a), a financial institution may directly obtain written consent for the use of customer information from a current or prospective loan customer. The following notice, set forth in standard or larger type, shall be used for this purpose:

USE OF INSURANCE INFORMATION RELATING TO YOUR LOAN

THE BORROWER HEREBY CONSENTS TO THE USE OR SHARING OF ANY INSURANCE COVERAGE INFORMATION OBTAINED AS PART OF THE LOAN PROCESS IN THE MARKETING OF INSURANCE OR ANNUITIES.

.....

(Signature)

(677.1-A added Dec. 6, 2002, P.L.1183, No.147)

Section 678-A. Licensee reporting of misconduct.

(a) Misconduct reporting.--A licensee shall report to the department any administrative action taken against the licensee in another jurisdiction or by another governmental agency in this Commonwealth within 30 days of the final disposition of the matter. This report shall include a copy of the order, consent order or other relevant legal documents.

(b) Criminal conduct reporting.--Within 30 days of being charged with criminal conduct, a licensee shall report the charges to the department. The licensee shall provide the department with all of the following within 30 days of their availability to the licensee:

(1) A copy of the criminal complaint, information or indictment.

(2) A copy of the order resulting from a pretrial hearing, if any.

(3) A report of the final disposition of the charges.

(678-A added Dec. 6, 2002, P.L.1183, No.147)

Section 679-A. Confidentiality.

(a) General rule.--Any documents, materials or other information in the control or possession of the department which

is furnished by an insurer or licensee under section 671.1-A or which is obtained by the department in an investigation pursuant to this act shall be confidential by law and privileged, shall not be subject to the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action. However, the department is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the department's duties.

(b) Testimony prohibited.--Neither the department nor any person who received documents, materials or other information while acting under the authority of the department shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (a).

(c) Information sharing.--In order to assist in the performance of the department's duties under this article, the department may share and receive confidential information in accordance with section 202-A.

(d) Effect of sharing.--No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the department under section 671.1-A or as a result of sharing as authorized in subsection (c).

(e) Exception.--Nothing in this article shall prohibit the department from releasing final, adjudicated actions that are open to public inspection pursuant to the Right-to-Know Law to a database or other clearinghouse service maintained by the NAIC, its affiliates or subsidiaries.

(679-A added Dec. 6, 2002, P.L.1183, No.147)

Compiler's Note: The June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, referred to in subsec. (a), was repealed by the act of Feb. 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.

DIVISION 2.1
SELF-SERVICE STORAGE INSURANCE
(Div. added Oct. 24, 2018, P.L.667, No.97)

Section 681-A. Self-service storage producer licenses.

(a) Authority to issue licenses.--The department may issue a self-service storage producer license to an owner that has complied with the requirements of this section authorizing the owner to offer or to sell the kinds of insurance prescribed in this section in connection with and incidental to the rental of space at a self-service storage facility. The self-service storage producer shall also be subject to the requirements of this article, Article XI and the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act.

(b) Application.--

(1) An applicant for a self-service storage producer license shall file a written application in a form prescribed by the department. The application shall specify all locations in this Commonwealth at which the self-service storage producer may conduct business under the license.

(2) A self-service storage producer is not required to have an individual licensee in each self-service storage facility or place where insurance is transacted.

(3) The self-service storage producer shall notify the department within 30 days after commencing business under

the self-service storage producer's license at any additional locations in this Commonwealth or of those locations in this Commonwealth that cease to do business under the license.

(c) Sale of insurance.--A self-service storage producer may offer or sell insurance only in connection with and incidental to the rental of space at a self-service storage facility on a master, corporate, commercial, group or individual policy basis and only with respect to personal property insurance that provides primary coverage to occupants at the self-service storage facility where the insurance is transacted for the loss of or damage to personal property that occurs at that facility or while the personal property is in transit during the rental agreement.

(d) Requirements.--A self-service storage producer shall not offer or sell insurance under this section unless:

(1) The self-service storage producer makes readily available to the prospective occupant brochures or other written materials that:

(i) Summarize the material terms of insurance coverage offered to occupants, including the identity of the insurer, price, benefits, deductibles, exclusions and conditions.

(ii) Disclose that the policies offered by the self-service storage producer may provide a duplication of coverage already provided by an occupant's homeowner's insurance policy, renter's insurance policy, vehicle insurance policy, watercraft insurance policy or other source of property insurance coverage. The disclosure shall be prominently displayed in the brochure or other written materials with at least 12-point bold type.

(iii) State that the insurance prescribed in this section is primary coverage over any other coverage covering the same loss.

(iv) State that if insurance is required as a condition of rental, the requirement may be satisfied by the occupant purchasing the insurance prescribed in this section or by presenting evidence of other applicable insurance coverage.

(v) State that the purchase of the insurance prescribed in this section is not required in order to rent storage space. The statement shall be prominently displayed in the brochure or other written materials with at least 12-point bold type.

(vi) Describe the process for filing a claim.

(vii) Include contact information for filing a complaint with the commissioner.

(2) All costs related to the insurance are stated in writing.

(3) Evidence of coverage in a form approved by the insurer is provided to every occupant who purchases the coverage.

(4) The insurance is provided by an insurer authorized to transact the applicable kinds of insurance in this Commonwealth or by a surplus lines insurer under Article V.

(e) Employee or authorized representative.--

(1) An employee or authorized representative of a self-service storage producer may act on behalf of and under the supervision of the self-service storage producer in matters relating to the conduct of business under the license that is issued under this section.

(2) The conduct of an employee or authorized representative of a self-service storage producer acting

within the scope of employment or agency is deemed the conduct of the self-service storage producer for purposes of this section.

(3) The self-service storage producer shall maintain a register, on a form which the commissioner requires, of each employee or authorized representative of the self-service storage producer who offers the insurance prescribed in this section on behalf of the self-service storage producer and shall, upon request of the commissioner, submit the register for inspection by the commissioner.

(f) Training.--Each self-service storage producer shall provide, or cause a licensed producer to provide, a training program approved by the commissioner that gives employees and authorized representatives of the self-service storage producer basic instruction about the provisions of this section, including the following:

(1) General information about homeowners, renters, business and similar insurance that an occupant may have that may provide coverage for property stored at a self-service storage facility.

(2) Information about the material terms of insurance coverage offered to occupants, including the price, benefits, deductibles, exclusions and conditions of the insurance.

(3) The disclosures required under subsection (d).

(g) Prohibitions.--A self-service storage producer may not:

(1) Offer or sell insurance except in connection with and incidental to the rental of space at a self-service storage facility.

(2) Advertise, represent or otherwise portray itself or any of its employees or authorized representatives as licensed insurers or insurance producers.

(h) Enforcement.--A violation of this section shall constitute a violation of this act and shall be subject to the provisions of sections 691-A and 692-A.

(i) Exclusions.--Nothing in this section shall be construed to prohibit:

(1) An insurer from paying, and a self-service storage producer from receiving, a commission, service fee or other valuable consideration dependent on the sale of insurance.

(2) A self-service storage producer from paying, and its employees or authorized representatives from receiving, production payments or incentive payments if the payments are not dependent on the sale of insurance.

(j) Promotional materials.--An owner is not required to be licensed under this section solely to display and make available to prospective occupants brochures and other promotional materials created by or on behalf of an authorized insurer or by a surplus lines insurer under this article, if the owner and its unlicensed employees and authorized representatives do not solicit prospective occupants to purchase the insurance.

(k) Continuing education.--A self-service storage producer is not subject to continuing education requirements.

(l) Definitions.--As used in this section, the following words and phrases shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Occupant." As defined in section 2 of the act of December 20, 1982 (P.L.1404, No.325), known as the Self-Service Storage Facility Act.

"Owner." As defined in section 2 of the Self-Service Storage Facility Act.

"Personal property." As defined in section 2 of the Self-Service Storage Facility Act.

"Self-service storage facility." As defined in section 2 of the Self-Service Storage Facility Act.

"Self-service storage producer." An owner or self-service storage facility operator licensed under this section.

(681-A added Oct. 24, 2018, P.L.667, No.97)

DIVISION 3
ENFORCEMENT
(Div. added Dec. 6, 2002, P.L.1183, No.147)

Section 691-A. Enforcement by department.

(a) Notice.--Upon evidence of a violation of this act, the department shall notify the person of the alleged violation. The notice shall specify the nature of the alleged violation and fix a time and place, at least ten days thereafter, when a hearing on the matter shall be held.

(b) Hearing.--The department shall conduct the hearing on the violation in accordance with 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies).

(c) Evidence.--No person shall be excused from testifying or from producing any books, papers, contracts, agreements or documents at any hearing held by the commissioner on the ground that the testimony or evidence may tend to incriminate that person.

(d) Penalties.--After the hearing or upon failure of the person to appear at the hearing, if a violation of this act is found, the commissioner may, in addition to any penalty which may be imposed by a court, impose any combination of the following deemed appropriate:

(1) Denial, suspension, refusal to renew or revocation of the license, if any, of the person.

(2) A civil penalty not to exceed $5,000 for each action in violation of this act.

(3) An order to cease and desist.

(4) Any other conditions as the commissioner deems appropriate.

(691-A added Dec. 6, 2002, P.L.1183, No.147)

Section 692-A. Injunctions.

The commissioner may maintain an action for an injunction or other process against any person to restrain and prevent the person from engaging in any activity violating this act or regulations promulgated under this act.

(692-A added Dec. 6, 2002, P.L.1183, No.147)

Section 693-A. Appeals.

The person aggrieved by a decision of the commissioner that has a direct interest in the decision may appeal the decision of the commissioner in accordance with 2 Pa.C.S. Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action).

(693-A added Dec. 6, 2002, P.L.1183, No.147)

DIVISION 4
MISCELLANEOUS
(Div. added Dec. 6, 2002, P.L.1183, No.147)

Section 695-A. Personal liability of an insurance producer for an unauthorized entity.

An insurance producer shall be personally liable on all contracts of insurance or suretyship unlawfully made by or through the producer, directly or indirectly, for or on behalf of any insurance entity which is not authorized to do business in this Commonwealth.

(695-A added Dec. 6, 2002, P.L.1183, No.147)

Section 696-A. Fiduciary capacity of an insurance producer.

An insurance producer shall be responsible in a fiduciary capacity for all funds received or collected as an insurance producer and shall not, without the express consent of the insurance entity on whose behalf the funds were received, mingle the funds with the producer's own funds or with funds held by the insurance producer in any other capacity. Nothing in this article shall be deemed to require an insurance producer to maintain a separate bank deposit for the funds of each insurance entity if and as long as the funds of each insurance entity are reasonably ascertainable from the books of account and records of the insurance producer.

(696-A added Dec. 6, 2002, P.L.1183, No.147)

Section 697-A. Federal preemption.

Notwithstanding any law or regulation of this Commonwealth to the contrary, in the event of Federal preemption of any of the provisions of this act or any other law of this Commonwealth regarding the sale of insurance or annuities by federally chartered financial institutions, State-chartered financial institutions shall not be subject to those provisions or laws which were the subject of the Federal preemption.

(697-A added Dec. 6, 2002, P.L.1183, No.147)

Section 698-A. Regulations.

The department may promulgate regulations necessary for the administration of this article. Regulations promulgated under Article VI which are not clearly inconsistent with the provisions of this article shall remain in effect until replaced, revised or amended.

(698-A added Dec. 6, 2002, P.L.1183, No.147)

SUBARTICLE C
CONFLICTING PROVISIONS
(Subart. added Dec. 6, 2002, P.L.1183, No.147)

Section 699.1-A. Scope.

(a) Provisions superseded.--The provisions of this article shall supersede conflicting provisions found elsewhere in this act.

(b) Provisions not superseded.--Nothing in this act shall supersede any provision of the act of December 21, 1995 (P.L.714, No.79), entitled "An act amending the act of May 17, 1921 (P.L.682, No.284), entitled 'An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws,' further providing for financial requirements, for agents, for prohibition of commissions and other considerations, for rate filing, for making of rates and for penalties; further providing for the operation of the Pennsylvania Property and Casualty Insurance Guaranty Association, for covered claims and for loans to companies; providing for conditions with respect to escrow, closing and settlement services and title indemnification accounts and for division of fees; providing for mutual to stock conversion and for contributions to surplus; further providing for investment; providing for additional investment authority for subsidiaries; and making repeals."

(699.1-A added Dec. 6, 2002, P.L.1183, No.147)

ARTICLE VII.
REINSURANCE INTERMEDIARIES.

(Art. repealed and added Dec. 18, 1992, P.L.1469, No.177)

Section 701. Definitions.--The following words and phrases when used in this article shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Actuary" means an individual who is a member in good standing of the American Academy of Actuaries.

"Commissioner" means the Insurance Commissioner of the Commonwealth.

"Controlling person" means any person, firm, association or corporation who directly or indirectly has the power to direct or cause to be directed the management, control or activities of the reinsurance intermediary.

"Department" means the Insurance Department of the Commonwealth.

"Insurer" means any person, firm, association or corporation duly licensed in this Commonwealth pursuant to the applicable provisions of the insurance law of the Commonwealth as an insurer.

"Licensed producer" means an agent, broker or reinsurance intermediary licensed pursuant to the applicable provisions of the insurance laws of the Commonwealth.

"Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager as these terms are defined in this section.

"Reinsurance intermediary-broker" or "RB" means any person, other than an officer or employe of the ceding insurer, firm, association or corporation who solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of such insurer.

"Reinsurance intermediary-manager" or "RM" means any person, firm, association or corporation who has authority to bind or to manage all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department or underwriting office, and acts as an agent for such reinsurer whether known as an RM, manager or other similar term. Notwithstanding the above, the following persons shall not be considered an RM with respect to such reinsurer for the purposes of this article:

(1) An employe of the reinsurer.

(2) A United States manager of the United States branch of an alien reinsurer.

(3) An underwriting manager which pursuant to contract manages all the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to Article XII of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921," and whose compensation is not based on the volume of premiums written.

(4) The manager of a group, association, pool or organization of insurers which engage in joint underwriting or joint reinsurance and who are subject to examination by the Insurance Commissioner of the state in which the manager's principal business office is located.

"Reinsurer" means any person, firm, association or corporation duly licensed in this Commonwealth pursuant to the applicable provisions of the insurance laws of the Commonwealth as an insurer with the authority to assume reinsurance.

"Qualified United States financial institution" means an institution that meets all of the following:

(1) Is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state thereof.

(2) Is regulated, supervised and examined by United States Federal or state authorities having regulatory authority over banks and trust companies.

(3) Has been determined by either the commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

"To be in violation" means that the reinsurance intermediary, insurer or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with the provisions of this article.

(701 repealed and added Dec. 18, 1992, P.L.1496, No.177)

Section 702. Licensure.--(a) No person, firm, association or corporation shall act as an RB in this Commonwealth if the RB maintains an office either directly or as a member or employe of a firm or association or an officer, director or employe of a corporation:

(1) in this Commonwealth unless the RB is a licensed producer in this Commonwealth; or

(2) in another state unless the RB is a licensed producer in this Commonwealth or another state having a law substantially similar to this article or the RB is licensed in this Commonwealth as a nonresident reinsurance intermediary.

(b) No person, firm, association or corporation shall act as an RM:

(1) For a reinsurer domiciled in this Commonwealth unless the RM is a licensed producer in this Commonwealth.

(2) In this Commonwealth if the RM maintains an office either directly or as a member or employe of a firm or association or an officer, director or employe of a corporation in this Commonwealth unless the RM is a licensed producer in this Commonwealth.

(3) In another state for a nondomestic insurer unless the RM is a licensed producer in this Commonwealth or another state having a law substantially similar to this article or the person is licensed in this Commonwealth as a nonresident reinsurance intermediary.

(c) The department may require an RM subject to subsection (b) to:

(1) file a bond in an amount from an insurer acceptable to the department for the protection of the reinsurer; and

(2) maintain an errors and omissions policy in an amount acceptable to the department.

(d) The department may issue a reinsurance intermediary license to any person, firm, association or corporation who has complied with the requirements of this article. Any such license issued to a firm or association will authorize all the members of such firm or association and any designated employes to act as reinsurance intermediaries under the license, and all such persons shall be named in the application and any supplements thereto. Any such license issued to a corporation shall authorize all of the officers and any designated employes and directors thereof to act as reinsurance intermediaries on behalf of that corporation, and all such persons shall be named in the application and any supplements thereto.

(e) The department may refuse to issue a reinsurance intermediary license if, in its judgment, the applicant, anyone named on the application or any member, principal, officer or director of the applicant is not trustworthy or that any controlling person of the applicant is not trustworthy to act as a reinsurance intermediary or that any of the foregoing has given cause for revocation or suspension of a license or has failed to comply with any prerequisite for the issuance of a license. Upon written request therefor, the department shall furnish a summary of the basis for refusal to issue a license which document shall be confidential and not subject to disclosure to any other party by the department.

(f) Licensed attorneys at law of this Commonwealth when acting in their professional capacity shall be exempt from this section.

(702 added Dec. 18, 1992, P.L.1496, No.177)

Section 703. Required Contract Provisions for Reinsurance Intermediary-Brokers.--Transactions between an RB and the insurer it represents in such capacity shall only be entered into pursuant to a written authorization specifying the responsibilities of each party. The authorization shall at a minimum contain provisions which provide as follows:

(1) The insurer may terminate the RB's authority at any time.

(2) The RB will render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by or owing to the RB and remit all funds due to the insurer within thirty days of receipt.

(3) All funds collected for the insurer's account will be held by the RB in a fiduciary capacity in a bank which is a qualified United States financial institution.

(4) The RB will comply with section 704.

(5) The RB will comply with the written standards established by the insurer for the cession or retrocession of all risks.

(6) The RB will disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

(703 added Dec. 18, 1992, P.L.1496, No.177)

Section 704. Books and Records of Reinsurance Intermediary-Brokers.--(a) For at least three years after expiration of each contract of reinsurance transacted by the RB with respect to first party coverages and for at least ten years after expiration of each contract of reinsurance transacted by the RB with respect to all other coverages, the RB will keep a complete record for each transaction showing all of the following:

(1) The type of contract, limits, underwriting restrictions, classes or risks and territory.

(2) Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation.

(3) Reporting and settlement requirements of balances.

(4) The rate used to compute the reinsurance premium.

(5) Names and addresses of assuming reinsurers.

(6) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the RB.

(7) Related correspondence and memoranda.

(8) Proof of placement.

(9) Details regarding retrocessions handled by the RB, including the identity of retrocessionaires and percentage of each contract assumed or ceded.

(10) Financial records, including, but not limited to, premium and loss accounts.

(11) When the RB procures a reinsurance contract on behalf of a licensed ceding insurer:

(i) directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(ii) if placed through a representative of the assuming reinsurer other than an employe, written evidence that such reinsurer has delegated binding authority to the representative.

(b) The insurer shall have access and the right to copy and audit all accounts and records maintained by the RB related to its business in a form usable by the insurer.

(704 added Dec. 18, 1992, P.L.1496, No.177)

Section 705. Duties of Insurers Utilizing the Services of a Reinsurance Intermediary-Broker.--(a) An insurer shall not engage the services of any person, firm, association or corporation to act as an RB on its behalf unless such person is licensed as required by section 702(a).

(b) An insurer may not employ an individual who is employed by an RB with which it transacts business unless the RB is under common control with the insurer and subject to Article XII of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

(c) The insurer shall annually obtain a copy of statements of the financial condition of each RB with which it transacts business.

(705 added Dec. 18, 1992, P.L.1496, No.177)

Section 706. Required Contract Provisions for Reinsurance Intermediary-Managers.--Transactions between an RM and the reinsurer it represents in such capacity shall only be entered into pursuant to a written contract specifying the responsibilities of each party which shall be approved by the reinsurer's board of directors. At least thirty days before such reinsurer assumes or cedes business through such licensed producer, a true copy of the approved contract shall be filed with the department for approval. The contract shall at a minimum contain the following provisions:

(1) The reinsurer may terminate the contract for cause upon written notice to the RM. The reinsurer may suspend the authority of the RM to assume or cede business during the pendency of any dispute regarding the cause for termination.

(2) The RM will render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by or owing to the RM, and remit all funds due under the contract to the reinsurer on not less than a monthly basis.

(3) All funds collected for the reinsurer's account will be held by the RM in a fiduciary capacity in a bank which is a qualified United States financial institution. The RM may retain no more than three months' estimated claims payments and allocated loss adjustment expenses. The RM shall maintain a separate bank account for each reinsurer that it represents.

(4) For at least three years after expiration of each contract of reinsurance transacted by the RM with respect to first party coverages and for at least ten years after expiration of each contract of reinsurance transacted by the RM with respect to all other coverages, the RM will keep a complete record for each transaction showing all of the following:

(i) The type of contract, limits, underwriting restrictions, classes or risks and territory.

(ii) Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation and disposition of outstanding reserves on covered risks.

(iii) Reporting and settlement requirements of balances.

(iv) Rate used to compute the reinsurance premium.

(v) Names and addresses of reinsurers.

(vi) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the RM.

(vii) Related correspondence and memoranda.

(viii) Proof of placement.

(ix) Details regarding retrocessions handled by the RM as permitted by section 708(d), including the identity of retrocessionaires and percentage of each contract assumed or ceded.

(x) Financial records, including, but not limited to, premium and loss accounts.

(xi) When the RM places a reinsurance contract on behalf of a ceding insurer:

(A) directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(B) if placed through a representative of the assuming reinsurer other than an employe, written evidence that such reinsurer has delegated binding authority to the representative.

(5) The reinsurer will have access and the right to copy all accounts and records maintained by the RM related to its business in a form usable by the reinsurer.

(6) The contract cannot be assigned in whole or in part by the RM.

(7) The RM will comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection or cession of all risks.

(8) Provisions setting forth the rates, terms and purposes of commissions, charges and other fees which the RM may levy against the reinsurer.

(9) If the contract permits the RM to settle claims on behalf of the reinsurer the following shall apply:

(i) All claims will be reported to the reinsurer in a timely manner.

(ii) A copy of the claim file will be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(A) has the potential to exceed the lesser of an amount determined by the commissioner or the limit set by the reinsurer;

(B) involves a coverage dispute;

(C) may exceed the RM's claims settlement authority;

(D) is open for more than six months; or

(E) is closed by payment of the lesser of an amount set by the department or an amount set by the reinsurer.

(iii) All claim files will be the joint property of the reinsurer and RM. However, upon an order of liquidation of the reinsurer such files shall become the sole property of the reinsurer or its estate; the RM shall have reasonable access to and the right to copy the files on a timely basis.

(iv) Any settlement authority granted to the RM may be terminated for cause upon the reinsurer's written notice to the RM or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

(10) If the contract provides for a sharing of interim profits by the RM, that such interim profits will not be paid until one year after the end of each underwriting period for property business and five years after the end of each underwriting period for casualty business, or a later period set by the department for specified lines of insurance, and not until the adequacy of reserves on remaining claims has been verified pursuant to section 708(c).

(11) The RM will annually provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant.

(12) The reinsurer shall periodically (at least semi-annually) conduct an onsite review of the underwriting and claims processing operations of the RM.

(13) The RM will disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with such insurer pursuant to this contract.

(14) The acts of the RM shall be deemed to be the acts of the reinsurer on whose behalf it is acting.

(706 added Dec. 18, 1992, P.L.1496, No.177)

Section 707. Prohibited Acts.--The RM shall not:

(1) Bind retrocessions on behalf of the reinsurer except that the RM may bind facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for such retrocessions. Such guidelines shall include a list of reinsurers with which such automatic agreements are in effect, and for each such reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(2) Commit the reinsurer to participate in reinsurance syndicates.

(3) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which he is appointed.

(4) Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one per centum of the reinsurer's policyholder's surplus as of December 31 of the last complete calendar year.

(5) Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer.

(6) Jointly employ an individual who is employed by the reinsurer.

(7) Appoint a sub-RM.

(707 added Dec. 18, 1992, P.L.1496, No.177)

Section 708. Duties of Reinsurers Utilizing the Services of a Reinsurance Intermediary-Manager.--(a) A reinsurer shall not engage the services of any person, firm, association or corporation to act as an RM on its behalf unless such person is licensed as required by section 702(b).

(b) The reinsurer shall annually obtain a copy of statements of the financial condition of each RM which such reinsurer has engaged, prepared by an independent certified accountant in a form acceptable to the department.

(c) If an RM establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the RM. This opinion shall be in addition to any other required loss reserve certification.

(d) Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the RM.

(e) Within thirty days of termination of a contract with an RM, the reinsurer shall provide written notification of such termination to the department.

(f) A reinsurer shall not appoint to its board of directors any officer, director, employe, controlling shareholder or subproducer of its RM. This subsection shall not apply to relationships governed by Articles XI or XII of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

(708 added Dec. 18, 1992, P.L.1496, No.177)

Section 709. Examination Authority.--(a) A reinsurance intermediary shall be subject to examination by the department. The department shall have access to all books, bank accounts and records of the reinsurance intermediary in a form usable by the department.

(b) An RM may be examined as if it were the reinsurer.

(709 added Dec. 18, 1992, P.L.1496, No.177)

Section 710. Penalties and Liability.--(a) A reinsurance intermediary, insurer or reinsurer found by the commissioner, after a hearing conducted in accordance with 2 Pa.C.S. (relating to administrative law and procedure), to be in violation of any provision of this article, shall:

(1) for each separate violation, pay a civil penalty in an amount not exceeding five thousand dollars ($5,000);

(2) be subject to revocation or suspension of its license; and

(3) if a violation was committed by the reinsurance intermediary such reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to such violation.

(b) The decision, determination or order of the commissioner pursuant to subsection (a) shall be subject to judicial review pursuant to 2 Pa.C.S.

(c) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided in the insurance laws of the Commonwealth.

(d) Nothing contained in this article is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors or other third parties or confer any rights to such persons.

(710 added Dec. 18, 1992, P.L.1496, No.177)

ARTICLE VIII.
MANAGING GENERAL AGENTS.
(Art. added Dec. 18, 1992, P.L.1469, No.177)

Section 801. Definitions.--The following words and phrases when used in this article shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Actuary" means an individual who is a member in good standing of the American Academy of Actuaries.

"Commissioner" means the Insurance Commissioner of the Commonwealth.

"Department" means the Insurance Department of the Commonwealth.

"Insurer" means any company, association or exchange authorized by the Insurance Commissioner to transact the

business of insurance in this Commonwealth except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia or a state or political subdivision of a state.

"Managing general agent" or "MGA" means:

(1) Any person, firm, association or corporation who negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer, including the management of a separate division, department or underwriting office, and acts as an agent for such insurer whether known as a managing general agent or other similar term who, with or without the authority either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five per centum of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with one or more of the following:

(i) adjusts or pays claims in excess of an amount determined by the Insurance Department; or

(ii) negotiates reinsurance on behalf of the insurer.

(2) Notwithstanding clause (1), the following persons shall not be considered as managing general agents for the purposes of this article:

(i) an employe of the insurer;

(ii) a United States manager of the United States branch of an alien insurer;

(iii) an underwriting manager which, pursuant to contract, manages all the insurance operations of the insurer, is under common control with the insurer, subject to Article XII of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921," and whose compensation is not based on the volume of premiums written;

(iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney;

(v) any manager or exclusive general agent operating under any management contract or exclusive general agency agreement entered into prior to December 22, 1965, and therefor not subject to licensing pursuant to section 651: Provided, however, That any such management contract or exclusive general agency agreement shall subject the manager or exclusive general agent and the insurer to Article XII of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921": And further provided, That any sale, assignment or transfer of any management contract or exclusive general agency agreement, whether said contract or agreement was entered into before or after December 22, 1965, shall make the purchaser, assignee or transferee subject to licensing under this article.

(Def. amended Feb. 17, 1994, P.L.79, No.8)

"Underwrite" means the authority to accept or reject risk on behalf of the insurer.

(801 added Dec. 18, 1992, P.L.1496, No.177)

Section 802. Licensure.--(a) No person, firm, association or corporation shall act in the capacity of an MGA with respect to risks located in this Commonwealth for an insurer licensed in this Commonwealth unless such person is a licensed agent in this Commonwealth.

(b) No person, firm, association or corporation shall act in the capacity of an MGA representing an insurer domiciled in this Commonwealth with respect to risks located outside this

Commonwealth unless that person is licensed as an agent in this Commonwealth. This license may be a nonresident license issued under this article.

(c) The department may require a bond in an amount acceptable to it for the protection of the insurer.

(d) The department may require the MGA to maintain an errors and omissions policy.

(802 added Dec. 18, 1992, P.L.1496, No.177)

Compiler's Note: Section 13 of Act 177 of 1992, which added Article VIII, provided that manager and exclusive general agents licensed in accordance with section 651 and subject to the provisions of Article VIII, as added by Act 177, shall be required to comply with Article VIII upon renewal of their existing license or upon the effective date of Act 177, whichever occurs later.

Section 803. Required Contract Provisions.--No person, firm, association or corporation acting in the capacity of an MGA shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party, and where both parties share responsibility for a particular function specifies the division of such responsibilities, and which contains the following minimum provisions:

(1) The insurer may terminate the contract for cause upon written notice to the MGA. The insurer may suspend the underwriting authority of the MGA during the pendency of any dispute regarding the cause for termination.

(2) The MGA will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

(3) All funds collected for the account of an insurer will be held by the MGA in a fiduciary capacity in a bank which is a member of the Federal Reserve System. This account shall be used for all payments on behalf of the insurer. The MGA may retain no more than three months' estimated claims payments and allocated loss adjustment expenses.

(4) Separate records of business written by the MGA will be maintained. The insurer shall have access and the right to copy all accounts and the records related to its business in a form usable by the insurer, and the department shall have access to all books, bank accounts and records of the MGA in a form usable to the department. These records shall be retained according to the laws pertaining to the conduct of examinations.

(5) The contract may not be assigned in whole or part by the MGA.

(6) Appropriate underwriting guidelines, including all of the following:

(i) The maximum annual premium volume.

(ii) The basis of the rates to be charged.

(iii) The types of risks which may be written.

(iv) Maximum limits of liability.

(v) Applicable exclusions.

(vi) Territorial limitations.

(vii) Policy cancellation provisions.

(viii) The maximum policy period.

(7) The insurer shall have the right to cancel or nonrenew any policy of insurance, subject to the applicable laws and regulations concerning the cancellation and nonrenewal of insurance policies.

(8) If the contract permits the MGA to settle claims on behalf of the insurer, the following shall apply:

(i) All claims must be reported to the company in a timely manner.

(ii) A copy of the claim file shall be sent to the insurer at its request or as soon as it becomes known that the claim:

(A) has the potential to exceed an amount determined by the commissioner or exceeds the limit set by the company, whichever is less;

(B) involves a coverage dispute;

(C) may exceed the MGA's claims settlement authority;

(D) is open for more than six months; or

(E) is closed by payment of an amount set by the department or an amount set by the company, whichever is less.

(iii) All claim files shall be the joint property of the insurer and the MGA. However, upon an order of liquidation of the insurer, such files shall become the sole property of the insurer or its estate. The MGA shall have reasonable access to and the right to copy the files on a timely basis.

(iv) Any settlement authority granted to the MGA may be terminated for cause upon the insurer's written notice to the MGA or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

(9) When electronic claims files are in existence, the contract must address the timely transmission of the data.

(10) If the contract provides for a sharing of interim profits by the MGA and the MGA has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments or in any other manner, interim profits will not be paid to the MGA until one year after they are earned for property insurance business and five years after they are earned on casualty business and not until the profits have been verified pursuant to section 805.

(803 added Dec. 18, 1992, P.L.1496, No.177)

Section 804. Prohibited Acts.--An MGA shall not:

(1) Bind reinsurance or retrocessions on behalf of the insurer except that the MGA may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines, including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and the commission schedules.

(2) Commit the insurer to participate in insurance or reinsurance syndicates.

(3) Appoint any agent without assuring that the agent is lawfully licensed to transact the type of insurance for which he is appointed.

(4) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one per centum of the insurer's policyholder's surplus as of December 31 of the last completed calendar year.

(5) Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer.

(6) Permit its subagent to serve on the insurer's board of directors.

(7) Jointly employ an individual who is employed with the insurer.

(8) Appoint a sub-MGA.

(804 added Dec. 18, 1992, P.L.1496, No.177)

Section 805. Duties of Insurers.--(a) The insurer shall have on file an independent financial examination, in a form acceptable to the department, of each MGA with which it has done business.

(b) If an MGA establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA. This is in addition to any other required loss reserve certification.

(c) The insurer shall periodically, at least semiannually, conduct an onsite review of the underwriting and claims processing operations of the MGA.

(d) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer who shall not be affiliated with the MGA.

(e) Within thirty days of entering into or termination of a contract with an MGA, the insurer shall provide written notification of such appointment or termination to the department. Notices of appointment of an MGA shall include a statement of duties which the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act and any other information the commissioner may request.

(f) An insurer shall review its books and records each quarter to determine if any agent has become, by operation of section 801, an MGA as defined in that section. If the insurer determines that an agent has become an MGA, the insurer shall promptly notify the agent and the department of such determination, and the insurer and agent must fully comply with the provisions of this article within thirty days.

(g) An insurer shall not appoint to its board of directors an officer, director, employe, subagent or controlling shareholder of its MGAs. This subsection shall not apply to relationships governed by Article XI or XII of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

(805 added Dec. 18, 1992, P.L.1496, No.177)

Section 806. Examination Authority.--The acts of the MGA are considered to be the acts of the insurer on whose behalf it is acting. An MGA may be examined as if it were the insurer in accordance with the law pertaining to the conduct of examinations.

(806 added Dec. 18, 1992, P.L.1496, No.177)

Section 807. Penalties and Liability.--(a) If the commissioner finds after a hearing conducted in accordance with 2 Pa.C.S. (relating to administrative law and procedure) that any person has violated any provision of this article, the commissioner may order:

(1) for each separate violation, a civil penalty not to exceed five thousand dollars ($5,000);

(2) revocation or suspension of the agent's license; and

(3) the MGA to reimburse the insurer, the rehabilitator or liquidator of the insurer for any losses incurred by the insurer caused by a violation of this article committed by the MGA.

(b) The decision, determination or order of the commissioner pursuant to subsection (a) shall be subject to judicial review pursuant to 2 Pa.C.S.

(c) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in the insurance laws of this Commonwealth.

(d) Nothing contained in this article is intended to or shall in any manner limit or restrict the rights of policyholders, claimants and auditors.

(807 added Dec. 18, 1992, P.L.1496, No.177)

ARTICLE IX.
EXAMINATIONS.

(Art. added Dec. 18, 1992, P.L.1469, No.177)

Section 901. Purpose.--The purpose of this article is to provide an effective and efficient system for examining the activities, operations, financial condition and affairs of all persons transacting the business of insurance in this Commonwealth and all persons otherwise subject to the jurisdiction of the department. The provisions of this article are intended to enable the department to adopt a flexible system of examinations which directs resources as may be deemed appropriate and necessary for the administration of the insurance and insurance related laws of this Commonwealth. This article recognizes the commitment of the department to work with the insurance industry to utilize the most efficient means to conduct examinations, minimize costs, facilitate cooperation and communication between insurers and the department, increase transparency and increase efficiencies to the greatest extent possible.

(901 amended June 22, 2018, P.L.273, No.41)

Compiler's Note: See section 5 of Act 34 of 2018 in the appendix to this act for special provisions relating to applicability.

Section 902. Definitions.--The following words and phrases when used in this article shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Commissioner" means the Insurance Commissioner of the Commonwealth.

"Company" means any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative or regulatory authority of the Insurance Department. The term includes the Pennsylvania Professional Liability Joint Underwriting Association established in section 731 of the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act.

"Department" means the Insurance Department of the Commonwealth.

"Examiner" means any individual or firm having been authorized by the Insurance Department to conduct an examination under this article.

"Insurer" means any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds insurer, fraternal benefit society, beneficial association and any other legal entity engaged in the business of insurance, including agents, brokers and adjusters and also means health care plans as defined in 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations), 63 (relating to professional health services plan corporations), 65 (relating to fraternal benefit societies) and 67 (relating to beneficial societies) and the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act." For purposes of this article, health care plans, fraternal benefit societies and beneficial societies shall be deemed to be engaged in the business of insurance.

"NAIC" means the National Association of Insurance Commissioners.

"Person" means any individual, aggregation of individuals, trust, association, partnership or corporation or any affiliate thereof. The term shall exclude agents.

(902 amended June 22, 2018, P.L.273, No.41)

Compiler's Note: See section 5 of Act 34 of 2018 in the appendix to this act for special provisions relating to applicability.

Section 903. Authority, Scope and Scheduling of Examinations.--(a) Every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person and ascertain whether the company or person has complied with the laws of this Commonwealth.

(b) The department or any of its examiners may conduct an examination under this article of any company as often as the commissioner in his sole discretion deems appropriate but shall at a minimum conduct an examination of every insurer licensed in this Commonwealth not less frequently than once every five years. In scheduling and determining the nature, scope and frequency of the examinations, the commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and other criteria as set forth in the Examiners' Handbook adopted by the NAIC and in effect when the commissioner exercises discretion under this subsection.

(c) For purposes of completing an examination of any company under this article, the department may examine or investigate any person or the business of any person insofar as such examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the company.

(d) In lieu of an examination under this article of any foreign or alien insurer licensed in this Commonwealth, the department may accept an examination report on such company as prepared by the insurance department for the company's state of domicile or port-of-entry state until January 1, 1994. Thereafter, such reports may only be accepted if:

(1) the insurance department of the other state was at the time of the examination accredited under the NAIC Financial Regulation Standards and Accreditation Program; or

(2) the examination is performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by that department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(903 added Dec. 18, 1992, P.L.1496, No.177)

Section 904. Conduct of Examinations.--(a) Upon determining that an examination should be conducted, the commissioner or his designee shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the

examination, the examiner shall observe those guidelines and procedures set forth in the Examiners' Handbook adopted by the NAIC. The department may also employ such other guidelines or procedures as it may deem appropriate.

(b) Every company or person from whom information is sought, its officers, directors and agents must provide to the examiners appointed under subsection (a) timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The officers, directors, employes and agents of the company or person must facilitate such examination and aid in such examination so far as it is in their power to do so. The refusal of any company by its officers, directors, employes or agents to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the department's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to 2 Pa.C.S. (relating to administrative law and procedure).

(c) The commissioner or any of his examiners shall have the power to issue subpoenas, to administer oaths and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of any person to obey a subpoena, the department may petition a court of competent jurisdiction, and, upon proper showing, the court may enter any order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court.

(d) When making an examination under this article, the department may retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners, the cost of which shall be borne by the company which is the subject of the examination.

(e) Nothing contained in this article shall be construed to limit the department's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this Commonwealth. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(f) Nothing contained in this article shall be construed to limit the department's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the commissioner may, in his sole discretion, deem appropriate.

(904 added Dec. 18, 1992, P.L.1496, No.177)

Section 904.1. Scheduling Conference.--Prior to commencing examination field work under this article, the department shall hold a scheduling conference with a company to discuss the following:

(1) The purpose and scope of the examination.

(2) The estimated costs for the examination.

(3) The types of information that the company will be asked to produce.

(4) The most efficient means of conducting the examination.

(5) Any alternative approaches in conducting the examination that would be more convenient, less burdensome or less expensive for the company while still providing for an effective examination by the department.

(904.1 added June 22, 2018, P.L.273, No.41)

Compiler's Note: See sections 5 and 6 of Act 34 of 2018 in the appendix to this act for special provisions relating to applicability.

Section 904.2. Budget Estimate and Revisions.--(a) No more than thirty days after the scheduling conference under section 904.1 has been conducted, the department shall provide the company with a detailed written budget estimate for the examination that must, for each forthcoming phase of the examination, as appropriate:

(1) Identify the individuals or firms performing the examination and their daily or hourly rates.

(2) Provide an estimate of travel, lodging, meal and other administrative or supply costs.

(3) Estimate the length of time to conduct on-site and off-site examination activities.

(b) Within fifteen days of receipt of a budget estimate under subsection (a), the company and the department shall have an additional discussion regarding the most efficient means of conducting the examination and producing information. If necessary, revisions of the budget estimate shall be made.

(c) The time periods under subsections (a) and (b) may be extended if the company and the department mutually agree to the extension.

(d) At any time during the examination, the department shall hold another scheduling conference with the company in accordance with section 904.1 and provide a revised budget estimate as set forth in subsection (a) if:

(1) the department determines that the cost of the examination will exceed the budget estimate by more than ten per centum; or

(2) there is a material change in staffing assignments.

(904.2 added June 22, 2018, P.L.273, No.41)

Compiler's Note: See sections 5 and 6 of Act 34 of 2018 in the appendix to this act for special provisions relating to applicability.

Section 904.3. Billing Invoices.--(a) The following shall apply for each billing invoice submitted to a company regarding examination work:

(1) An invoice which is submitted by a contractor of the department must contain an itemized and detailed description of charges on a quarterly hour basis by the examiner, including the applicable billing rates and a per charge description of related travel or other expenses.

(2) An invoice which is submitted by the department directly must contain instructions on how a company may obtain an itemized and detailed description of the charges.

(3) An invoice shall be submitted to a company on a monthly basis as soon as practicable but no later than sixty days after the date on which the billed activity was performed.

(4) An invoice must provide a due date of no fewer than thirty days after the bill is submitted to the company.

(5) An invoice must contain an explanation of the invoicing process and the procedure for resolving billing disputes.

(b) To the extent possible, the department shall follow the procedures under subsection (a) for billing invoices submitted

by third-party consultants retained as described under section 905.1(a)(2), (3), (4), (5) or (6).

(904.3 added June 22, 2018, P.L.273, No.41)

Compiler's Note: See sections 5 and 6 of Act 34 of 2018 in the appendix to this act for special provisions relating to applicability.

Section 905. Examination Reports.--(a) All examination reports shall be comprised of only facts appearing upon the books, records or other documents of the company, its agents or other persons examined or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs and such conclusions and recommendations as the examiners find reasonably warranted from such facts.

(b) No later than sixty days following completion of the examination, the examiner in charge shall file with the department a verified written report of examination under oath. Upon receipt of the verified report, the department shall transmit the report to the company examined, together with a notice which shall afford such company examined a reasonable opportunity of not more than thirty days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(c) Within thirty days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner or his designee shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers, and enter an order:

(1) adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the department, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure such violation;

(2) rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information and refiling pursuant to subsection (a); or

(3) calling for an investigatory hearing with no less than twenty days' notice to the company for purposes of obtaining additional documentation, data, information and testimony.

(d) (1) All orders entered pursuant to subsection (c)(1) shall be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner workpapers and any written submissions or rebuttals. Any such order shall be considered a final administrative decision and may be appealed to the commissioner pursuant to 2 Pa.C.S. (relating to administrative law and procedure), and shall be served upon the company by certified mail, together with a copy of the adopted examination report. Within thirty days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(2) Any hearing conducted under subsection (c)(3) by the department or its authorized representative shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the department's review of relevant workpapers or by the written

submission or rebuttal of the company. Within twenty days of the conclusion of any such hearing, the commissioner shall enter an order pursuant to subsection (c)(1).

(3) The commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously with discovery by the company limited to the examiner's workpapers which tend to substantiate any assertions set forth in any written submission or rebuttal. The commissioner or his representative may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation whether under the control of the department, the company or other persons. The documents produced shall be included in the record and testimony taken by the commissioner or his representative shall be under oath and preserved for the record.

(4) The hearing shall proceed with the commissioner or his designee posing questions to the persons subpoenaed. Thereafter the company and the department may present testimony relevant to the investigation. Cross examination shall be conducted only by the commissioner or his designee. The company and the department shall be permitted to make closing statements and may be represented by counsel of their choice.

(5) Nothing contained in this section shall require the department to disclose any information or records which would indicate or show the existence or content of any investigation or activity of a criminal justice agency.

(e) (1) Upon the adoption of the examination report under subsection (c)(1), the department shall continue to hold the content of the examination report as private and confidential information for a period of thirty days except to the extent provided in subsection (b). Thereafter, the department may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

(2) Nothing contained in this article shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results or any matter relating thereto to the Insurance Department of this or any other state or country or to law enforcement officials of this or any other state or agency of the Federal Government at any time so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this article.

(3) In the event the department determines that regulatory action is appropriate as a result of any examination, it may initiate any proceedings or actions as provided by law.

(f) All working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the department or any other person in the course of an examination made under this article shall be given confidential treatment and are not subject to subpoena and may not be made public by the department or any other person except to the extent provided in subsection (e). Access may also be granted to the NAIC. Such parties must agree in writing prior to receiving the information to provide to it the same confidential treatment as required by the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, unless the prior written consent of the company to which it pertains has been obtained.

(905 added Dec. 18, 1992, P.L.1496, No.177)

Compiler's Note: The act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, referred to in

subsec. (f), was repealed by the act of Feb. 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.

Section 905.1. Annual Examination and Analysis Report.--(a) Within thirty days of the end of each fiscal year, the department shall publish a report setting forth, for the immediately prior fiscal year, the total amount of money billed to companies by the department and its contractors retained in each of the following categories:

(1) Financial examinations conducted under section 904.

(2) Market conduct examinations conducted under section 904.

(3) Examinations conducted under section 1406 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(4) The review of transactions under any of the following sections of The Insurance Company Law of 1921:

(i) Section 803-A.

(ii) Section 807-A.

(iii) Section 1402.

(iv) Section 1405.

(5) The solvency monitoring of companies under any of the following:

(i) Section 507-A.

(ii) Section 506-B.

(iii) Section 2607 of The Insurance Company Law of 1921.

(6) Other subsequently enacted statutory provisions that provide for the retention of third-party consultants.

(b) The report under this section must:

(1) separately list the identity of each contractor retained by the department and the amount of money billed by the contractor to companies;

(2) disclose the total amount of deposits into the Insurance Regulation and Oversight Fund under section 4(a)(3) of the act of July 2, 2013 (P.L.255, No.46), known as the Insurance Regulation and Oversight Fund Act, as a result of financial and market regulation activities for which regulated entities are responsible to pay; and

(3) include an analysis of the effectiveness of the procedures under this article and recommendations to further improve the efficiency and transparency of the examination processes.

(905.1 added June 22, 2018, P.L.273, No.41)

Compiler's Note: See sections 5 and 6 of Act 34 of 2018 in the appendix to this act for special provisions relating to applicability.

Section 906. Conflict of Interest.--(a) No examiner may be appointed by the commissioner if such examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this article. This section shall not be construed to automatically preclude an examiner from being:

(1) a policyholder or claimant under an insurance policy;

(2) a grantor of a mortgage or similar instrument on such examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;

(3) an investment owner in shares of regulated diversified investment companies; or

(4) a settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed.

(b) Notwithstanding the requirements of this section, the department may retain from time to time, on an individual basis, qualified actuaries, certified public accountants or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under this article.

(906 added Dec. 18, 1992, P.L.1496, No.177)

Section 907. Cost of Examinations.--All the expenses incurred in and about the examination of any company, including compensation of department employes assisting in said examination and any other professionals or specialists retained in accordance with section 904(d), shall be charged to and paid by the company examined in such manner as the commissioner shall by regulation prescribe.

(907 added Dec. 18, 1992, P.L.1496, No.177)

Section 908. Immunity from Liability.--(a) No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this article.

(b) No cause of action shall arise nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner, his authorized representative or examiner or the department pursuant to an examination made under this article if such act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(c) This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subsection (a).

(d) A person identified in subsection (a) shall be entitled to an award of attorney fees and costs if he is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of his activities in carrying out the provisions of this article and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

(908 added Dec. 18, 1992, P.L.1496, No.177)

ARTICLE IX-A
PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION
(Art. added June 22, 2018, P.L.273, No.41)

SUBARTICLE A
PRELIMINARY PROVISIONS
(Subart. added June 22, 2018, P.L.273, No.41)

Compiler's Note: See section 5 of Act 34 of 2018 in the appendix to this act for special provisions relating to applicability.

Section 901-A. Declaration of policy.

The General Assembly finds and declares as follows:

(1) The commissioner's review of the association's plan of operation and rate filings has identified a decrease in the number of claim payments and the decline in the need in this Commonwealth for the types of medical professional

liability insurance policies offered by the association under Chapter 7 of the Mcare Act. The review has identified a need to modernize the association in order to produce needed economical and administrative efficiencies.

(2) Ensuring the future availability of and access to quality health care is a fundamental government goal, and it is essential to the public health, safety and welfare of all residents of this Commonwealth that access to a full spectrum of hospital services and to highly trained physicians in all specialties is available.

(3) In order to accomplish the goals under paragraph (2), medical professional liability insurance must continue to be obtainable at an affordable and reasonable cost in every geographic region of this Commonwealth. Placing the association within the department will give the commissioner more oversight of expenditures and ensure better efficiencies in the operation of the association.

(901-A added June 22, 2018, P.L.273, No.41)

Section 902-A. Definitions.

The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Association." The Pennsylvania Professional Liability Joint Underwriting Association established in section 731 of the Mcare Act.

"Board." The Joint Underwriting Association Board described in section 912-A(a).

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Insurance Department of the Commonwealth.

"Health care provider." As defined in section 702 of the Mcare Act.

"Mcare Act." The act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act.

"Plan." A plan of operation submitted to and approved by the commissioner under section 731(b)(1) of the Mcare Act or this article.

(902-A added June 22, 2018, P.L.273, No.41)

SUBARTICLE B
OVERSIGHT AND DUTIES
(Subart. added June 22, 2018, P.L.273, No.41)

Section 911-A. Association oversight and additional duties.

(a) Oversight.--The association shall continue as an instrumentality of the Commonwealth and shall operate under the control, direction and oversight of the department.

(b) Additional duties.--In addition to the duties described under Subchapter C of Chapter 7 of the Mcare Act, the association shall do all of the following:

(1) Submit monthly reports to the commissioner of premiums collected and claims paid during the immediately preceding month.

(2) Provide to the commissioner additional documents and information regarding the association's operations as the commissioner may request.

(3) Within 60 days following the effective date of this section, prepare and submit a new plan for approval by the commissioner under section 731(b)(1) of the Mcare Act. The new plan shall contain provisions not inconsistent with this

article. The plan may be amended at the direction of the board or the commissioner.

(4) Submit to examinations under Article IX.

(c) Claims.--The following shall apply:

(1) No member of the association or any health care provider insured by a policy provided by the association shall have a claim against the current or future funds, profits, investments or losses of the association, including upon dissolution.

(2) A claim against or a liability of the association under a policy provided by the association under the Mcare Act shall be considered a liability of the Commonwealth.

(911-A added June 22, 2018, P.L.273, No.41)

Section 912-A. Board.

(a) Membership and purpose.--The membership of the Joint Underwriting Association Board is statutorily established. The board shall govern the operations of the association and shall consist of the following members:

(1) Three members appointed by the Governor.

(2) One member appointed by each of the following:

(i) The President pro tempore of the Senate.

(ii) The Minority Leader of the Senate.

(iii) The Speaker of the House of Representatives.

(iv) The Minority Leader of the House of Representatives.

(b) Chair.--The Governor shall appoint the chair of the board from among the board members.

(c) Term and vacancy.--A member of the board shall serve at the will of the member's appointing authority for a term of four years or until the member's successor has been appointed and is qualified. A vacancy on the board shall be filled by the same appointing authority as the outgoing member.

(d) Quorum.--A majority of the members of the board shall constitute a quorum. The vote of a majority of the members attending a meeting of the board shall be required for all actions of the board.

(e) Compensation.--Members of the board shall not be compensated for service as board members but shall be entitled to reimbursement of expenses under rules governing the reimbursement of expenses to Commonwealth executive agency personnel.

(f) Executive director and administrative support.--The day-to-day operations of the board shall be managed by an executive director hired by the commissioner whose annual salary and other benefits of employment shall be determined by the commissioner. The department shall provide the board with other administrative support as the department, in consultation with the executive director, deems necessary and appropriate. The executive director and other staff hired to support the work of the board shall be considered Commonwealth employees.

(g) Powers and duties.--The board shall administer the plan, decide all matters of policy and have authority to exercise all reasonable and necessary powers relating to the operation of the association. In furtherance of the board's powers and duties, the board may do all of the following:

(1) Adopt bylaws and guidelines.

(2) Appoint committees and retain experts and advisors, consultants and agents to render services as the board deems necessary to carry out the operations of the board and the association.

(3) Enter into agreements and contracts as may be necessary for the administration of the plan and consistent

with this act and the applicable provisions of the Mcare Act.

(4) Develop rates, rating plans, rating and underwriting rules and standards, rate classifications, rate territories, policy forms and riders in accordance with applicable laws and subject to the commissioner's approval under sections 712(f) and 731(b)(2) and (4) of the Mcare Act.

(5) Invest, borrow and disburse funds, budget expenses, levy assessments, receive contributions, reinsure liabilities of the association and perform all other duties necessary or incidental to the proper administration of the plan.

(6) If the board deems it to be in the best interests of the policy holders and the Commonwealth, subject to the commissioner's approval, place a portion of the funds of the association in a restricted receipt account in the Treasury Department. The State Treasurer shall create a restricted receipt account at the request of the board. Money in the account is appropriated for the purposes required in the Mcare Act, this article and as may otherwise be directed by the board.

(7) Authorize the executive director to participate in the scheduling conferences and other provisions of Article IX on behalf of the board.

(912-A added June 22, 2018, P.L.273, No.41)

Section 913-A. Dissolution.

(a) General.--The association may be dissolved as follows:

(1) At the request of a majority of the members of the association and as approved by the commissioner.

(2) By act of the General Assembly.

(b) Distribution of assets.--Upon dissolution of the association under this section, all assets of the association, from whatever source, shall be distributed as the board may determine, subject to the approval of the commissioner.

(913-A added June 22, 2018, P.L.273, No.41)

SUBARTICLE C
MISCELLANEOUS PROVISIONS
(Subart. added June 22, 2018, P.L.273, No.41)

Section 921-A. Administration and construction.

The following shall apply:

(1) Within 30 days following the effective date of this section, all paper and electronic documents and files and other assets of the association in the possession of the association, its executive director and employees shall be transferred to the department.

(2) Within 30 days following the effective date of this section, authority to act on behalf of the board shall be transferred to the executive director hired by the commissioner under section 912-A(f). The commissioner may appoint an acting executive director to act until an executive director has been hired.

(921-A added June 22, 2018, P.L.273, No.41)

ARTICLE X.
INSURANCE ADMINISTRATOR LICENSURE.
(Art. added Dec. 12, 1994, P.L.1035, No.141)

Section 1001. Short Title.--This article shall be known and may be cited as the "Insurance Administrator Licensure Act."

(1001 added Dec. 12, 1994, P.L.1035, No.141)

Section 1002. Definitions.--The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Administrator" means any person who collects charges or premiums from or who adjusts or settles claims for residents of this Commonwealth in connection with life or health coverage or annuities. The term shall specifically include any person who collects charges or premiums from or who adjusts or settles claims for residents of this Commonwealth in connection with life or health coverages or annuities provided by or through an employe benefit plan, including, but not limited to, multiple employer welfare arrangements and self-insured municipalities or other political subdivisions. The term shall not include any of the following:

(1) An employer on behalf of its employes or the employes of one or more subsidiary or affiliated corporations of such employer.

(2) A union on behalf of its members.

(3) An insurance company which is either licensed in this Commonwealth or acting as an insurer with respect to a policy lawfully issued and delivered by it and pursuant to the laws of a state in which the insurer was authorized to do an insurance business.

(4) Professional health services plan corporations organized under 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations) or hospital plan corporations organized under 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations), subject to any limitations imposed by 40 Pa.C.S. Chs. 61 and 63.

(5) A life or health agent or broker licensed in this Commonwealth, whose activities are limited exclusively to the sale of insurance.

(6) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors.

(7) A trust, its trustees and employes acting thereunder established in conformity with section 302 of the Labor Management Relations Act, 1947 (61 Stat. 136, 29 U.S.C. § 186).

(8) A trust exempt from taxation under section 501(a) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 501(a)), its trustees, and employes acting thereunder, or a custodian, its agents and employes acting pursuant to a custodian account which meets the requirements of section 401(f) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 401(f)).

(9) A bank, credit union or other financial institution which is subject to supervision or examination by Federal or State banking authorities.

(10) A credit card issuing company which advances for its credit cardholders and collects premiums or charges from its credit cardholders who have authorized it to do so, provided such company does not adjust or settle claims.

(11) A person who adjusts or settles claims in the normal course of his practice or employment as an attorney-at-law and who does not collect charges or premiums in connection with life and health insurance coverage or annuities.

(12) A person licensed as an insurance agent and who has been appointed by an insurer to act as a managing general agent in this Commonwealth, whose activities are limited exclusively to the scope of activities conveyed under that license.

"Benefit plan" means an insured or wholly or partially self-funded coverage plan which, by means of direct payment, reimbursement or other arrangement, provides partial or complete

coverage for services, including, but not limited to, medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital or vision care or for drugs or other items reasonably related thereto.

"Commissioner" means the Insurance Commissioner of the Commonwealth.

"Department" means the Insurance Department of the Commonwealth.

(1002 added Dec. 12, 1994, P.L.1035, No.141)

Section 1003. License Required; Application; Unlicensed Activity.--On and after the effective date of this act, no person shall act as or hold himself out to be an administrator in this Commonwealth, other than an adjuster licensed in this Commonwealth for the kinds of business for which he is acting as an administrator, unless he shall hold a license as an administrator issued by the department. The license shall be renewable biennially. The license shall be issued by the department to an administrator unless the department determines that the administrator is not competent, trustworthy, financially responsible or of good personal and business reputation or has had a previous application for an insurance license denied for cause within five years. All applications shall be accompanied by a filing fee of one hundred dollars ($100). An applicant whose license is denied may request a hearing pursuant to 2 Pa.C.S. (relating to administrative law and procedure).

(1003 added Dec. 12, 1994, P.L.1035, No.141)

Section 1004. Financial Responsibility and Security Requirements.--All administrators shall be required to maintain an errors and omissions insurance policy and also to maintain financial responsibility in the form of a fidelity bond or a clean irrevocable and unconditional and ever-green letter of credit or, as established by regulation, other form of security acceptable to the department. Financial responsibility shall be established and maintained each year in an amount equal to fifty per centum of the average amount of funds entrusted to the administrator by benefit plans for the preceding twelve months, but not to exceed five hundred thousand dollars ($500,000) for any plans other than multiple employer welfare arrangements.

(1004 added Dec. 12, 1994, P.L.1035, No.141)

Section 1005. Written Agreement Necessary.--An administrator must have a written agreement between the administrator and the entity providing the benefit plan. The written agreement shall be retained as part of the official records of the administrator for the duration of the agreement and five years thereafter. The written agreement shall comply with the requirements of this act. Where an insurance policy is issued to a trustee or trustees, a copy of the trust agreement and any amendments thereto shall be furnished to the insurer by the administrator and shall be retained as part of the official records of both the benefit plan and the administrator for the duration of the contract and five years thereafter.

(1005 added Dec. 12, 1994, P.L.1035, No.141)

Section 1006. Payment to Administrator.--The payment to the administrator of any premiums or charges for benefit coverage by or on behalf of those persons covered by the benefit plan shall be deemed to have been received by the benefit plan, and the payment of return premiums, charges or claims by the benefit plan to the administrator shall not be deemed payment to the person or claimant until the payments are received by the person

or claimant. Nothing in this section shall limit any right of a benefit plan against the administrator resulting from its failure to make payments to the benefit plan, those persons covered by the benefit plan or claimants.

(1006 added Dec. 12, 1994, P.L.1035, No.141)

Section 1007. Maintenance of Information; Examination.--Every administrator shall maintain, at its principal administrative office for the duration of the written agreement referred to in section 1005 and five years thereafter, adequate books of all transactions and records of all transactions between it, the benefit plan and persons covered under the benefit plan. The commissioner shall have access to all books and records which are the property of administrators required to be maintained by this act for the purpose of examination, audit, inspection and investigation. Books and records, the property of bona fide employe benefit plans established by an employer or employe organization, or both, may be available to the department for audit, inspection, examination or investigation at the option of the employer or employe organization. Nothing in this subsection is intended to abridge or interfere with the department's authority to review all records necessary to determine jurisdiction over any entity that may be subject to this or other insurance laws generally. Expenses incurred by the department in examination of administrators shall be paid by the administrator in the same manner, and in the same amounts, pursuant to the examination provisions of this act and applicable regulations. Trade secrets, including the identity and addresses of policyholders and certificate holders, will be treated as confidential by the department, except the department may use that information in proceedings instituted against the administrator. The entity providing the benefit plan shall retain the right to continuing access to the books and records of the administrator sufficient to permit the benefit plan to fulfill all of its contractual obligations to the persons covered under the benefit plan, subject to any restrictions in the written agreement between the entity providing the benefit plan and the administrator on the proprietary rights of the parties in the books and records.

(1007 added Dec. 12, 1994, P.L.1035, No.141)

Section 1008. Approval of Advertising.--The administrator may use only advertising or solicitation materials of persons covered by a benefit plan as has been approved in advance by the entity providing the benefit plan.

(1008 added Dec. 12, 1994, P.L.1035, No.141)

Section 1009. Premium Collection.--All charges or premiums collected by an administrator on behalf of or for a benefit plan and return charges or premiums received from a benefit plan shall be held by the administrator in a fiduciary capacity. The funds shall be immediately remitted to the person or persons entitled thereto or shall be deposited promptly in one or more appropriately identified bank accounts in banks or other financial institutions which are subject to supervision or examination by Federal or State banking regulatory authorities. If charges or premiums so deposited have been collected on behalf of or for more than one benefit plan, the administrator shall maintain the accounts to clearly record the deposits in and withdrawals from the account on behalf of each benefit plan. The administrator shall promptly obtain and keep copies of all such records and, upon request of an entity providing a benefit plan, shall furnish the entity providing a benefit plan with copies of records pertaining to deposits and withdrawals on

behalf of or for the benefit plan. The administrator shall not pay any claim by withdrawals from the fiduciary account. Withdrawals from the fiduciary account shall be made, as provided in the written agreement between the administrator and the entity providing a benefit plan, for:

(1) Remittance to a benefit plan entitled thereto.

(2) Deposit in an account maintained in the name of the benefit plan.

(3) Transfer to and deposit in a claims-paying account.

(4) Payment to a benefit plan for remittance to an insurer entitled thereto.

(5) Payment to the administrator of its commission, fees or charges.

(6) Remittance of return premiums or charges to the person or persons entitled thereto.

(1009 added Dec. 12, 1994, P.L.1035, No.141)

Section 1010. Claim Adjustment and Settlement.--With respect to any contracts where an administrator adjusts or settles claims, the compensation to the administrator with regard to the contracts shall in no way be contingent upon claim experience. This section shall not prevent the compensation of an administrator from being based upon premiums or charges collected or number of claims paid or processed.

(1010 added Dec. 12, 1994, P.L.1035, No.141)

Section 1011. Notification Required.--Where services of an administrator are utilized, the administrator shall provide a written notice approved by the entity providing the benefit plan to persons covered by the benefit plan advising them of the identity of and relationship among the administrator, the entity providing the benefit plan and the insurer, if any. Where an administrator collects funds, it must identify and state separately in writing to the person paying any charge or premium to the administrator for coverage the amount of any such charge or premium specified by the benefit plan for the coverage.

(1011 added Dec. 12, 1994, P.L.1035, No.141)

Section 1012. Regulations; Applicability of Laws.--The commissioner may promulgate rules and regulations to implement and enforce the provisions of this article. The provisions of the act of July 22, 1974 (P.L.589, No.205), known as the "Unfair Insurance Practices Act," shall apply to administrators subject to this article.

(1012 added Dec. 12, 1994, P.L.1035, No.141)

Section 1013. Penalties; Suspension and Revocation.--(a) Failure to hold a license shall subject the administrator to a civil penalty of not less than one thousand dollars ($1,000) nor more than five thousand dollars ($5,000) for each instance of unlicensed activity.

(b) After notice and hearing, the commissioner may do any one or more of the following:

(1) Suspend, revoke or refuse to renew the license of an administrator.

(2) Impose a civil penalty on an administrator of not more than five thousand dollars ($5,000) for each violation.

(3) Order restitution upon finding that the administrator violated any of the requirements of this act or regulations or the administrator is not competent, trustworthy, financially responsible or of good personal and business reputation. All proceedings shall be pursuant to 2 Pa.C.S. (relating to administrative law and procedure).

(1013 added Dec. 12, 1994, P.L.1035, No.141)

INSURANCE FRAUD PREVENTION AUTHORITY
(Art. added Dec. 6, 2002, P.L.1183, No.147)

SUBARTICLE A
PRELIMINARY PROVISIONS
(Subart. added Dec. 6, 2002, P.L.1183, No.147)

Section 1101. Scope.

This article deals with insurance fraud prevention.

(1101 added Dec. 6, 2002, P.L.1183, No.147)

Section 1102. Purpose.

The purpose of this article is to establish, coordinate and fund activities in this Commonwealth to prevent, combat and reduce insurance fraud, to improve and support insurance fraud law enforcement and administration and to improve and support insurance fraud prosecution.

(1102 added Dec. 6, 2002, P.L.1183, No.147)

Section 1103. Definitions.

The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Authority." The Insurance Fraud Prevention Authority established in section 1121.

"Board." The board of directors of the Insurance Fraud Prevention Authority.

"Fund." The Insurance Fraud Prevention Trust Fund established in section 1123.

"Insurance fraud." Any activity defined as an offense under 18 Pa.C.S. § 4117 (relating to insurance fraud).

"Section of Insurance Fraud" or "section." The Section of Insurance Fraud in the Office of Attorney General.

(1103 added Dec. 6, 2002, P.L.1183, No.147)

SUBARTICLE B
INSURANCE FRAUD PREVENTION AUTHORITY
(Subart. added Dec. 6, 2002, P.L.1183, No.147)

Section 1121. Establishment of authority.

(a) Establishment.--There is hereby established a body corporate and politic to be known as the Insurance Fraud Prevention Authority. The purposes, powers and duties of the authority shall be vested in and exercised by a board of directors.

(b) Composition.--The board of the authority shall consist of seven members composed and appointed in accordance with the following:

(1) The Attorney General or his designee.

(2) A representative of the Philadelphia Federal Insurance Fraud Task Force.

(3) Four representatives of insurers, one of whom shall be appointed by the President pro tempore of the Senate, one of whom shall be appointed by the Minority Leader of the Senate, one of whom shall be appointed by the Speaker of the House of Representatives and one of whom shall be appointed by the Minority Leader of the House of Representatives. Each of the four members shall be, respectively, a representative of an insurer writing workers' compensation, accident and health, automobile or general commercial liability insurance in this Commonwealth.

(4) One representative of purchasers of insurance in this Commonwealth who is not employed by or connected with the business of insurance and is appointed by the Governor.

(c) Terms.--With the exception of the Attorney General and the representative of the Philadelphia Federal Insurance Fraud Task Force, members of the board shall serve for terms of four years.

(d) Compensation.--Members of the board shall serve without compensation but shall receive reimbursement for all reasonable and necessary expenses incurred in connection with their duties in accordance with the rules of the Executive Board.

(e) Quorum.--A majority of the members of the board shall constitute a quorum for the transaction of business at a meeting or the exercise of a power or function of the authority. Notwithstanding any other provision of law, action may be taken by the board at a meeting upon a vote of the majority of its members present in person or through the use of amplified telephonic equipment if authorized by the bylaws of the board. The board shall meet at the call of the chairperson or as may be provided in the bylaws of the board. The board shall meet at least quarterly. Meetings of the board may be held anywhere within this Commonwealth. The board shall elect its own chairperson.

(1121 added Dec. 6, 2002, P.L.1183, No.147)

Section 1122. Powers and duties.

The authority shall have the powers necessary and convenient to carry out and effectuate the purposes and provisions of this article and the purposes of the authority and the powers delegated by other laws, including, but not limited to:

(1) Employ administrative, professional, clerical and other personnel as may be required and organize the staff as may be appropriate to effectuate the purposes of this article.

(2) Have a seal and alter the same at pleasure, have perpetual succession, make, execute and deliver contracts, conveyances and other instruments necessary or convenient to the exercise of its powers and make and amend bylaws.

(3) Procure insurance against any loss in connection with its property, assets or activities.

(4) Apply for, solicit, receive, establish priorities for, allocate, disburse, contract for, administer and spend funds in the fund and other funds that are made available to the authority from any source consistent with the purposes of this article.

(5) Make grants to and provide financial support for the Section of Insurance Fraud, the unit of insurance fraud in the Philadelphia District Attorney's Office, other county district attorneys' offices, other government agencies, community, consumer and business organizations consistent with the purposes of this article and considering the extent of the insurance fraud problem in each county of this Commonwealth.

(6) Advise the State Treasurer in relation to the investment of any money held in the fund and any funds held in reserve or sinking funds and any money not required for immediate use or disbursement and to advise the State Treasurer in relation to the use of depositories for moneys of the fund.

(7) Assess the scope of the problem of insurance fraud, including areas of this Commonwealth where the problem is greatest, and review State and local criminal justice policies, programs and plans dealing with insurance fraud.

(8) Develop and sponsor the implementation of Statewide plans, programs and strategies to combat insurance fraud, improve the administration of the insurance fraud laws and

provide a forum for identification of critical problems for those persons dealing with insurance fraud.

(9) Coordinate the development, adoption and implementation of plans, programs and strategies relating to interagency and intergovernmental cooperation with respect to insurance fraud law enforcement.

(10) Promulgate rules or regulations related to the expenditure of moneys held in the fund in order to assist and support those agencies, units of government, county district attorneys' offices and other organizations charged with the responsibility of reducing insurance fraud or interested and involved in achieving this goal.

(11) Audit at its discretion the plans and programs that it has funded in whole or in part in order to evaluate the effectiveness of the plans and programs and withdraw funding should the authority determine that a plan or program is ineffective or is no longer in need of further financial support from the fund.

(12) Report annually on or before the first day of April to the Governor and the General Assembly on the authority's activities in the preceding period of operation.

(13) Meet with the Section of Insurance Fraud on at least a quarterly basis in order to advise and assist it in implementing its statutory mandate.

(14) Advise the General Assembly on matters relating to insurance fraud and recommend to the General Assembly on an annual basis any changes to the operation of the Section of Insurance Fraud. The report shall be available for public inspection.

(15) Establish either alone or in cooperation with authorized insurance companies and licensed agents and producers a fund to reward persons not connected with the insurance industry who provide information or furnish evidence leading to the arrest and conviction of persons responsible for insurance fraud.

(16) Require as a condition of every application and request for financial support, including every application for ongoing renewal of a multiyear grant under section 1123(f), that the applicant describe both the nature of and the amount of funding for the activities, if any, devoted to the investigation and prosecution of insurance fraud at the time of the application or request.

(17) Require as a condition of every application and request for financial support that every recipient of funding report annually within four months of the close of each funding cycle to the authority on the use of the funds obtained from the authority during the previous year, including a description of programs implemented and results obtained. The authority will include this information on the use of funds by grantees in its annual report under paragraph (12) and send a copy specifically to the chairman and the minority chairman of the standing committees of the Senate and the chairman and the minority chairman of the standing committees of the House of Representatives with jurisdiction over insurance matters.

(1122 added Dec. 6, 2002, P.L.1183, No.147)

Section 1123. Insurance Fraud Prevention Trust Fund.

(a) Establishment.--There is hereby established a separate account in the State Treasury to be known as the Insurance Fraud Prevention Trust Fund. This fund shall be administered by the State Treasurer with the advice of the authority. All interest

earned from the investment or deposit of moneys accumulated in the fund shall be deposited in the fund for the same use.

(b) Funds.--All moneys deposited into the fund shall be held in trust and shall not be considered general revenue of the Commonwealth but shall be used only to effectuate the purposes of this article as determined by the authority and shall be subject to audit by the Auditor General.

(c) Assessment.--

(1) Annually on or before the first day of April, each insurer engaged in the writing of the insurance coverages listed below, as a condition of its authorization to transact business in this Commonwealth, shall pay into the fund in trust an amount equal to the product obtained by multiplying $8,000,000 by a fraction, the numerator of which is the direct premium collected for those coverages listed below by that insurer in this Commonwealth during the preceding calendar year and the denominator of which is the direct premium written on such coverages in this Commonwealth by all insurers in the same period.

(2) The following coverages, as listed in the Annual Statistical Report of the Insurance Department, shall be considered in determining assessments: all fire and casualty direct business written and accident and health and credit accident and health written under life/annuity/accident and health direct business written. Assessments made under this section shall not be considered burdens and prohibitions under section 212.

(3) Assessments for health plan corporations and professional health services plan corporations when added together shall not be more than 10% of the total assessment authorized by this subsection. If the total assessment for these organizations is more than 10%, such organizations will share the assessment up to the 10% limit among themselves in the same proportion as they would otherwise have shared their calculated assessment absent this limit. Any deficiency in the total assessment caused by the application of this limit will be shared by all other entities being assessed in the same proportions as they are sharing the rest of the assessment.

(d) Base amount.--In succeeding years the authority may vary the base amount of $8,000,000, provided, however, that any increase which on an annual basis exceeds the increase in the Consumer Price Index for this Commonwealth must be approved by three of the four insurance representatives on the board.

(e) Expenditures.--Moneys in the fund may be expended by the authority for the following purposes:

(1) Effectuate the powers, duties and responsibilities of the authority as set forth in this article.

(2) Pay the costs of administration and operation of the Section of Insurance Fraud and the unit for insurance fraud in the Philadelphia District Attorney's Office.

(3) Provide financial support to law enforcement, correctional agencies and county district attorneys' offices for programs designed to reduce insurance fraud and to improve the administration of insurance fraud laws.

(4) Provide financial support for other governmental agencies, community, consumer and business organizations for programs designed to reduce insurance fraud and to improve the administration of insurance fraud laws.

(5) Provide financial support to programs designed to inform insurance consumers about the costs of insurance fraud

to individuals and to society and to suggest methods for preventing insurance fraud.

(6) Provide financial support for reward programs leading to the arrest and conviction of persons and organizations engaged in insurance fraud.

(7) Provide financial support for other plans, programs and strategies consistent with the purposes of this article.

(f) Multiyear grants.--In funding the Section of Insurance Fraud, the Unit for Insurance Fraud in the Philadelphia District Attorney's Office and in funding grant requests, the authority may consider and approve requests for multiyear grants of not more than four years in length, although extensions of such multiyear commitments may be renewed from year to year. No funding reduction under subsection (d) can be imposed by the authority in any given year which would operate to reduce funding for any multiyear approved program for which persons have been hired for full-time positions to a funding level where such positions must be terminated unless the organization employing such persons certifies either that other equivalent positions are available or that such positions with the antifraud program can be funded from other sources.

(g) Dissolution.--In the event that the trust fund is discontinued or the authority is dissolved by operation of law, any balance remaining in the fund, after deducting administrative costs for liquidation, shall be returned to insurers in proportion to their financial contributions to the fund in the preceding calendar year.

(1123 added Dec. 6, 2002, P.L.1183, No.147)

Section 1124. Immunity.

In the absence of malice, no board member and no employee of the authority shall be subject to any civil or criminal liability for receiving or disclosing information related to insurance fraud or the activities of the authority. In the absence of malice, persons or organizations shall not be subject to civil or criminal liability for providing information relating to insurance fraud to the authority, its employees, agents or designees. This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person.

(1124 added Dec. 6, 2002, P.L.1183, No.147)

SUBARTICLE C
SECTION OF INSURANCE FRAUD
(Subart. added Dec. 6, 2002, P.L.1183, No.147)

Section 1141. Establishment.

(a) Establishment.--There is hereby established within the Office of Attorney General a Section of Insurance Fraud to investigate and prosecute insurance fraud in accordance with jurisdictional mandates as specified by the act of October 15, 1980 (P.L.950, No.164), known as the Commonwealth Attorneys Act, and 18 Pa.C.S. § 4117 (relating to insurance fraud).

(b) Funding.--All costs of administration and operation of the section shall be borne by the fund. Any moneys or other property awarded to the section as costs of investigation or as a fine shall be credited to the fund.

(1141 added Dec. 6, 2002, P.L.1183, No.147)

Section 1142. Powers and duties.

The section shall have the powers necessary and convenient to carry out and effectuate the purposes and provisions of this article and the powers delegated by other laws, including, but not limited to, the power:

(1) To employ administrative, professional, clerical and other personnel as may be required and organize the staff as may be appropriate to effectuate the purposes of this article.

(2) To initiate inquiries and conduct investigations when the section has reason to believe that insurance fraud may have been or is being committed.

(3) To respond to notifications or complaints of suspected insurance fraud generated by State and local police, other law enforcement authorities, governmental units, including the Federal Government, and the general public.

(4) To review notices and reports of insurance fraud submitted by authorized insurers, their employees and licensed insurance agents or producers and to select those incidents of suspected fraud as, in its judgment, require further investigation and undertake such investigation.

(5) To conduct independent examination of insurance fraud, conduct studies to determine the extent of insurance fraud, deceit or intentional misrepresentation of any kind in the insurance process and publish information and reports on such examinations or studies.

(6) To prosecute both on its own and in conjunction with other sections and divisions within the Office of Attorney General any incidents of insurance fraud involving more than one county of this Commonwealth or involving any county of this Commonwealth and another state disclosed by its investigations and to assemble evidence, prepare charges, bring charges or, upon request of any other prosecutorial authority, otherwise assist that prosecutory authority having jurisdiction over such incidents.

(7) To report incidents of insurance fraud disclosed by its investigations to any other appropriate law enforcement, administrative, regulatory or licensing agency.

(8) To pay over all civil and criminal fines and penalties collected for violations and acts subject to investigation and prosecution into the fund.

(9) To undertake programs to investigate insurance fraud and to meet, at least on a quarterly basis, with the Insurance Fraud Prevention Authority.

(10) To employ investigators trained in accordance with the act of June 18, 1974 (P.L.359, No.120), referred to as the Municipal Police Education and Training Law. The laws applicable to law enforcement officers of this Commonwealth shall be applicable to the investigators. Investigators of the section shall have the following additional powers:

(i) To make arrests in accordance with existing jurisdictional rules for criminal violations established as a result of their investigations.

(ii) To execute arrest and search warrants in accordance with existing jurisdictional rules for the same criminal violations.

(11) To designate, if evidence, documentation and related materials sought are located outside of this Commonwealth, representatives, including officials of the state where the matter is located, to secure the matter or inspect the matter on its behalf. The person so requested shall either make the matter available to the section or shall make the matter available for inspection or examination by a designated representative of the section.

(1142 added Dec. 6, 2002, P.L.1183, No.147)

Compiler's Note: The act of June 18, 1974 (P.L.359, No.120), referred to as the Municipal Police Education and Training Law, referred to in par. (10), was repealed by the act of December 19, 1996 (P.L.1158, No.177). The subject matter is now contained in 53 Pa.C.S. Ch. 21 Subch. D (relating to municipal police education and training).

Section 1143. Document confidentiality and immunity from subpoena.

(a) General rule.--Papers, records, documents, reports, materials or other evidence relative to the subject of an insurance fraud investigation shall remain confidential and shall not be subject to public inspection for so long as the section deems it reasonably necessary to complete its investigation or for so long as the section deems it reasonably necessary to protect the privacy of the person investigated, to protect the person furnishing the matter or to be in the public interest.

(b) Subpoena.--

(1) Papers, records, documents, reports, materials or other evidence relative to the subject of an insurance fraud investigation shall not be subject to subpoena until opened for public inspection by the section unless the Office of Attorney General consents or until, after notice to the section and a hearing, a court of record determines that the section will not be unnecessarily hindered by compliance with a subpoena.

(2) Investigators employed by the section shall not be subject to subpoena in civil actions by any court in this Commonwealth to testify concerning any matter of which they have knowledge pursuant to a pending or continuing insurance fraud investigation being conducted by the section unless the Office of Attorney General consents or until, after notice to the Office of Attorney General and a hearing, a court of record determines that the investigation will not be hindered by the appearance.

(1143 added Dec. 6, 2002, P.L.1183, No.147)

Section 1144. Duties of insurers, employees, agents and brokers.

Every insurer, every employee of an insurer and every licensed agent or broker shall cooperate fully with the section. Where an insurer, agent or broker who believes that an insurance fraud has been or is being committed notifies the section, the notification shall toll any applicable time period in the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act, or any other law or regulation.

(1144 added Dec. 6, 2002, P.L.1183, No.147)

Section 1145. Persons not connected with insurance industry.

Any person having knowledge of or who believes that an insurance fraud is being or has been committed may send to the section a report or information pertinent to the knowledge and belief.

(1145 added Dec. 6, 2002, P.L.1183, No.147)

Section 1146. Refusal to cooperate with investigation.

It is unlawful for any person to resist an arrest authorized by this article or in any manner to interfere either by abetting or assisting such resistance or otherwise interfere with section investigators in the duties imposed upon them by this article or by any other applicable law.

(1146 added Dec. 6, 2002, P.L.1183, No.147)

Section 1147. Immunity.

(a) General rule.--In the absence of malice, persons or organizations providing information to or otherwise cooperating with the section, its employees, agents or designees shall not be subject to civil or criminal liability for supplying the information.

(b) Civil and criminal liability.--

(1) In the absence of malice, persons or organizations shall not be subject to civil or criminal liability for complying with an order issued by a court of competent jurisdiction acting in response to a request by the section.

(2) In the absence of malice, the Attorney General and any employee, agent or designee of the Office of Attorney General and the section shall not be subject to civil or criminal liability for the execution of official activities or duties of the section by virtue of the publication of any report or bulletin related to the official activities or duties of the section.

(c) Construction of section.--This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person.

(1147 added Dec. 6, 2002, P.L.1183, No.147)

SUBARTICLE D
MISCELLANEOUS PROVISIONS
(Subart. added Dec. 6, 2002, P.L.1183, No.147)

Section 1161. Other law enforcement authority.

This article shall not:

(1) Preempt the authority of or relieve the duty of any other law enforcement agencies to investigate and prosecute suspected violations of law.

(2) Prevent or prohibit a person from voluntarily disclosing any information concerning insurance fraud to any law enforcement agency other than the section.

(3) Limit any of the powers granted to the Insurance Commissioner to investigate possible violations of law and to take appropriate action against wrongdoers.

(1161 added Dec. 6, 2002, P.L.1183, No.147)

Section 1162. Severability.

If any provision of this article or its application thereof to any person or circumstances is held invalid, the invalidity does not affect other provisions or applications of this article which can be given effect without the invalid provision or application, and to this end the provisions of this article are severable.

(1162 added Dec. 6, 2002, P.L.1183, No.147)

ARTICLE XII
AUTOMOBILE THEFT PREVENTION AUTHORITY
(Art. added Dec. 6, 2002, P.L.1183, No.147)

Section 1201. Scope.

This article deals with automobile theft prevention.

(1201 added Dec. 6, 2002, P.L.1183, No.147)

Section 1202. Purpose.

The purpose of this article is to establish, coordinate and fund activities in this Commonwealth to prevent, combat and reduce automobile theft, to improve and support automobile theft law enforcement and administration and to improve and support automobile theft prosecution.

(1202 added Dec. 6, 2002, P.L.1183, No.147)

Section 1203. Definitions.

The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Authority." The Automobile Theft Prevention Authority established under this article.

"Automobile." A private passenger four-wheel motor vehicle, except recreational vehicles not intended for highway use, which is insured.

"Board." The board of directors of the Automobile Theft Prevention Authority.

"Fund." The Automobile Theft Prevention Trust Fund created under section 1206.

(1203 added Dec. 6, 2002, P.L.1183, No.147)

Section 1204. Automobile Theft Prevention Authority.

(a) Establishment.--There is hereby established a body corporate and politic to be known as the Automobile Theft Prevention Authority. The purposes, powers and duties of the authority shall be vested in and exercised by the board of directors thereof as provided for in this article.

(b) Composition.--The board of the authority shall consist of seven members composed and appointed in accordance with the following:

(1) The Attorney General or his designee.

(2) Three representatives of insurers authorized to write automobile insurance doing business in this Commonwealth.

(3) Three at-large members who are not employed by the insurance industry.

(c) Appointment.--With the exception of the Attorney General, all board members shall be appointed by the Governor from names submitted to the Governor by the Pennsylvania Anti-Car Theft Committee.

(d) Terms.--With the exception of the Attorney General, members of the board shall serve for terms of four years.

(e) Compensation.--Members of the board shall serve without compensation, except that members of the board shall receive reimbursement for all reasonable expenses incurred in connection with their duties, in accordance with the rules of the board.

(f) Quorum and meetings.--A majority of the members of the board shall constitute a quorum for the transaction of business at a meeting or the exercise of a power or function of the authority. Notwithstanding any other provision of law, action may be taken by the board at a meeting upon a vote of the majority of its members present in person or through the use of amplified telephonic equipment if authorized by the bylaws of the board and provided a quorum is present by such means. The board shall meet at the call of the chairperson or as may be provided in the bylaws of the board. The board shall meet at least quarterly. Meetings of the board may be held anywhere within this Commonwealth. The board shall elect its own chairperson.

(1204 added Dec. 6, 2002, P.L.1183, No.147)

Section 1205. Powers and duties.

The authority shall have the powers necessary and convenient to carry out and effectuate the purposes and provisions of this article and the purposes of the authority and the powers delegated by other laws, including, but not limited to, the power to:

(1) Employ administrative, professional, clerical and other personnel as may be required and organize the staff as may be appropriate to effectuate the purposes of this article.

(2) Have a seal and alter the same at pleasure, have perpetual succession, make, execute and deliver contracts, conveyances and other instruments necessary or convenient to the exercise of its powers and make and amend bylaws.

(3) Procure insurance against any loss in connection with its property, assets or activities.

(4) Apply for, solicit, receive, establish priorities for, allocate, disburse, contract for, administer and spend funds in the fund and other funds that are made available to the authority from any source consistent with the purposes of this article.

(5) Make grants to and provide financial support for government agencies, community, consumer and business organizations consistent with the purposes of this article.

(6) Invest any money held in the fund and any funds held in reserve or sinking funds and any money not required for immediate use or disbursement at its discretion and to name and use depositories for its money.

(7) Assess the scope of the problem of automobile theft, including identification of those areas of this Commonwealth where the problem is greatest, and review State and local criminal justice policies, programs and plans dealing with automobile theft.

(8) Develop and sponsor the implementation of Statewide plans, programs and strategies to combat automobile theft, improve the administration of the automobile theft laws and provide a forum for identification of critical problems for those persons dealing with automobile theft.

(9) Coordinate the development, adoption and implementation of plans, programs and strategies relating to interagency and intergovernmental cooperation with respect to automobile theft law enforcement.

(10) Promulgate rules or regulations related to the expenditure of moneys held in the fund in order to assist and support those agencies, units of government and other organizations charged with the responsibility of reducing automobile theft or interested and involved in achieving this goal.

(11) Audit at its discretion the plans and programs that it has funded in whole or in part in order to evaluate the effectiveness of the plans and programs and withdraw funding should the authority determine that a plan or program is ineffective or is no longer in need of further financial support from the fund.

(12) Report annually on or before the first day of April to the Governor and the General Assembly on the authority's activities in the preceding period. The report shall be available for public inspection.

(1205 added Dec. 6, 2002, P.L.1183, No.147)

Section 1206. Automobile Theft Prevention Trust Fund.

(a) Creation.--A separate account in the State Treasury is hereby established to be known as the Automobile Theft Prevention Trust Fund. The fund shall be administered by the authority. All interest earned from the investment or deposit of moneys accumulated in the fund shall be deposited in trust in the fund.

(b) Funds.--All moneys deposited into the fund shall not be considered general revenue of this Commonwealth but shall be used only to effectuate the purposes of this article as determined by the authority and shall be subject to audit by the Auditor General.

(c) Assessment.--Annually on or before the first day of April, each insurer engaged in the writing of automobile insurance coverages, as a condition of its authorization to transact automobile insurance business in this Commonwealth, shall pay into the fund in trust an amount equal to the product obtained by multiplying $4,000,000 by a fraction, the numerator of which is the total private passenger and commercial automobile physical damage insurance premiums written in this Commonwealth by that insurer during the preceding calendar year and the denominator of which is the total private passenger and commercial automobile physical damage insurance premiums written in this Commonwealth by all insurers in the same period. Assessments made under this section shall not be considered burdens and prohibitions under section 212.

(d) Base amount.--In succeeding years the authority may vary the base amount of $4,000,000, provided, however, that any increase which on an annual basis exceeds the increase in the Consumer Price Index for this Commonwealth must be approved by five of seven members of the board.

(e) Expenditures.--Moneys in the fund shall be expended by the authority for the following purposes:

(1) To effectuate the powers, duties and responsibilities of the authority as set forth in section 1205.

(2) To provide financial support to law enforcement, correctional agencies and prosecutors for programs designed to reduce automobile theft and to improve the administration of automobile theft laws.

(3) To provide financial support for other governmental agencies, community, consumer and business organizations for programs designed to reduce automobile theft and to improve the administration of automobile theft laws.

(4) To provide financial support to programs designed to inform owners of automobiles about the costs of automobile theft to individuals and to society and to suggest methods for preventing automobile theft.

(5) To provide financial support for reward programs leading to the arrest and conviction of persons and organizations engaged in automobile theft.

(6) To provide financial support for other plans, programs and strategies consistent with the purposes of this article.

(f) Dissolution.--In the event that the trust fund is discontinued or the authority is dissolved by operation of law, any balance remaining in the fund, after deducting administrative costs for liquidation, shall be returned to insurers in proportion to their financial contributions to the fund in the preceding calendar year.

(1206 added Dec. 6, 2002, P.L.1183, No.147)

Section 1207. Immunity.

In the absence of malice, no board member and no employee, agent or designee of the authority shall be subject to civil or criminal liability for receiving or disclosing information related to automobile theft or the activities of the authority. In the absence of malice, persons or organizations shall not be subject to civil or criminal liability for providing information to the authority or its employees relating to automobile theft. This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person.

(1207 added Dec. 6, 2002, P.L.1183, No.147)

APPENDIX

Supplementary Provisions of Amendatory Statutes

2018, June 22, P.L.273, NO.41

Section 5. The following shall apply:

(1) Orders, regulations, rules and decisions which were issued, promulgated or made by the Pennsylvania Professional Liability Joint Underwriting Association under the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, in connection with Subchapter C of Chapter 7 of the Mcare Act, and which are in effect on the effective date of this section, shall remain applicable and in full force and effect until modified or terminated.

(2) The following shall apply to administration and construction:

(i) Activities initiated under Subchapter C of Chapter 7 of the Mcare Act shall continue and remain in full force and effect.

(ii) Insurance policies issued and contracts entered into by the Pennsylvania Professional Liability Joint Underwriting Association prior to the effective date of this section are not affected nor impaired by this article.

Compiler's Note. Act 34 amended or added sections 901, 902, 904.1, 904.2, 904.3, 905.1 and Article IX-A of Act 285.

Section 6. The provisions of sections 904.1, 904.2, 904.3 and 905.1 of the act shall apply to examinations commencing at least 30 days after the effective date of this section.