Life and Health Insurance

State Law Supplement

North Dakota

KAPLAN FINANCIAL EDUCATION

Life and Health Insurance

State Law Supplement

Important: Check for Updates

States sometimes revise their exam content outlines unexpectedly or on short notice. To see whether there is an update for this product because of an exam change, go to **www.kfeducation.com** and check the Insurance Licensing Blog. If there is an update, it will be clearly noted in the blog entries for this state.

North Dakota

Effective January 1, 2013

KAPLAN FINANCIAL EDUCATION

At press time, this edition contains the most complete and accurate information currently available. Owing to the nature of license examinations, however, information may have been added recently to the actual test that does not appear in this edition. Please contact the publisher to verify that you have the most current edition.

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional services. If legal advice or other expert assistance is required, the services of a competent professional should be sought.

NORTH DAKOTA LIFE AND HEALTH INSURANCE LAW
SUPPLEMENT, EFFECTIVE JANUARY 1, 2013

If you find imperfections or incorrect information in this product, please visit www.kfeducation.com and submit an errata report.

Published in April 2013 by Kaplan Financial Education.

Printed in the United States of America.

ISBN: 978-1-4277-4682-5 / 1-4277-4682-6

PPN: 3200-3583

INTRODUCTION

This supplement focuses on statutes regarding North Dakota insurance law. Key aspects of each statute are discussed to help the student pass the state law portion of the licensing examination. In order to understand the content of this supplement, the student should first study the national insurance License Exam Manual. Thorough preparation for the exam requires the complete study of both the national License Exam Manual and the supplement.

I. STATE LAWS AND REGULATIONS PERTAINING TO ALL INSURANCE PRODUCERS

A. RESPONSIBILITIES OF THE INSURANCE COMMISSIONER

1. General powers and duties [26.1-01-03; 26.1-04-09]

a. The North Dakota Insurance Commissioner:

- sees that all the laws of North Dakota affecting insurance companies and benevolent societies are executed faithfully;
- reports any violation of law relative to insurance companies and their officers or agents to the attorney general;
- files articles of incorporation of all insurance companies organized or doing business in North Dakota (a filing fee is charged);
- furnishes necessary blank forms for submitting required statements and reports;
- preserves a permanent record of his proceedings and a concise statement of each company or agency visited or examined;
- furnishes certified copies of any record or paper in his office upon request and payment of the required fee (information that is prejudicial to the public interests will not be released);
- submits a biennial report to the governor and the Office of Management and Budget that contains an abstract of the condition of the various insurance companies doing business in North Dakota;
- sends a copy of the Commissioner's annual report to the Insurance Commissioner of every other state and every company doing business in this state;
- communicates to other state Insurance Commissioners any facts that it is the Commissioner's duty by law to ascertain respecting companies of North Dakota doing business within that state;
- manages, controls, and supervises the state bonding fund;
- manages, controls, and supervises the state fire and tornado fund and the insurance of public buildings in that fund; and
- may make rules and conduct administrative proceedings.

b. The Commissioner may examine and investigate the affairs of every person engaged in the insurance business in the state to determine whether the person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by law.

2. Examination of books and records [26.1-01-07, 26.1-03-19.2, 19.6; 26.1-26-48]

a. The Commissioner or any of the Commissioner's examiners may conduct an examination of any company whenever it is deemed appropriate but will, at a minimum, conduct an examination of every insurer licensed in this state at least once every five years. In scheduling and determining the nature, scope, and frequency of the examination, the Commissioner will consider the 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 set forth in the examiner's handbook.

b. Instead of an examination of any foreign insurer licensed in North Dakota, the Commissioner may accept an examination report on the company as prepared by the Insurance Department for the company's state of domicile if the Insurance Department was at the time of the examination accredited under the National Association of Insurance Commissioners' financial regulation standards and accreditation program or 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 an accredited state Insurance Department.

c. Whenever the Commissioner believes there has been a violation of the Insurance Code, the Commissioner, at the expense of the insurer involved, may examine at the offices of the insurer or the insurance producer all books, records, and papers of the insurer or insurance producer and any books, records, and papers of any insured within North Dakota and may examine under oath the officers, managers, and producers of the insurer, or the insured, about the violation.

d. The company being examined will pay all reasonable costs related to the exam, including travel expenses and the examiner's fee.

3. Filing of policy forms required [26.1-30-19]

No insurance policy, contract, agreement, or rate schedule may be issued or delivered until it has been filed with and approved by the Commissioner. Similarly, all applications, riders, or endorsements, risk classifications, and their premium rates must be filed and approved by the Commissioner prior to use with the public.

B. LICENSING REQUIREMENTS

1. License required; penalties [26.1-26-02, 03, 05-07; 26.1-33.4-08; 26.2-26-11 and 19]

a. No person may act as or hold oneself out to be an insurance producer, insurance consultant, or surplus lines insurance producer unless that person is licensed under North Dakota law. Any person who violates this requirement is guilty of a Class C felony.

b. An **insurance consultant** is a person who, for a fee, offers advice, counsel, opinion, or service about the benefits, advantages, or disadvantages of any insurance policy that could be issued in North Dakota.

c. An **insurance producer** is a person required to be licensed under North Dakota law to sell, solicit, or negotiate insurance.

d. A **surplus lines insurance producer** is a person that sells, solicits, negotiates, or procures an insurance policy from an insurer not licensed in North Dakota that cannot be procured from an insurer licensed to do business in North Dakota.

e. Agents or representatives of funeral homes or other businesses engaged in selling **pre-need contracts** for funeral services are deemed to be insurance producers and required to meet the provisions of this statute.

f. Agents or representatives, **life settlement brokers**, or other businesses engaged in the buying or selling of existing life insurance contracts in the secondary market are deemed to be insurance producers and required to meet the provisions of this statute. Additionally, such producers shall be required to satisfactorily complete a 15-hour training program, as established by the Department of Insurance, prior to being licensed.

2. Personal qualifications for license [26.1-26-15; Reg. 45-02-02-03] Applicants must pass their insurance exam prior to applying. An applicant for any license must be deemed by the Commissioner to be competent, trustworthy, financially responsible, and of good personal and business reputation.

3. Lines of authority [26.1-26-11; Reg. 45-02-02-02]

a. An insurance producer or surplus lines insurance producer may receive a license to market products under one or more of the following lines:

- Life and annuity—insurance coverage on human lives including benefits of endowment, annuities, and credit life
- Accident and health—insurance coverage for sickness, disease, injury, accidental death, and disability
- Property—insurance coverage for direct and consequential loss of or damage to property of every kind
- Casualty—insurance coverage against legal liability including that for death, injury, or disability or damage to real or personal property
- Variable life and annuity—insurance coverage provided under variable life insurance contracts and variable annuities

b. An application form is required to add an additional line of insurance.

4. Unlicensed person as agent of insurer [26.1-26-05] A person not licensed as an insurance producer or surplus lines insurance producer who sells, solicits, or negotiates an insurance policy on behalf of an insurer is treated as an insurance producer under North Dakota law and is liable for all the duties, requirements, liabilities, and penalties to which an insurance producer of the insurer is subject. An insurer accepting business from an unlicensed person through any of its officers, insurance producers, or employees thereby acknowledges that person as an insurance producer acting on its behalf in the transaction.

5. **Producer as agent of insurer [26.1-26-06]** An insurance producer who sells, solicits, or negotiates an application for insurance of any kind is, in any controversy between the insured or the insured's beneficiary and the insurer, regarded as representing the insurer and not the insured or the beneficiary. However, an insurance producer may not act as an agent of an insurer unless the insurance producer becomes an appointed insurance producer of that insurer. This section does not affect the apparent authority of an agent.

6. **Producer as agent of insured [26.1-26-07]** An insurance producer or surplus lines producer who is not an appointed insurance producer of the insurer with which an insurance policy is placed and who acts or aids in negotiating insurance contracts or placing insurance for a party other than oneself is regarded as representing the insured or the insured's beneficiary and not the insurer.

7. **Consultants [26.1-26-10, 35, 41; Reg. 45-02-02-09, 10]**

   a. Consultants must serve with objectivity and complete loyalty the interests of the client alone and render the information, counsel, and service that best serve the client to the extent that the licensee's knowledge, understanding, and opinion in good faith permit. Before rendering any service, a consultant must prepare a written agreement on a form approved by the Commissioner.

   b. The form must substantially comply with the model form available on request from the Insurance Department. The consultant's form must be submitted to the Commissioner for approval. The agreement must outline the nature of the work to be performed and state the fee. The consultant and the client must sign the agreement. The consultant must retain a copy of the agreement for at least two years after services are completed. This copy must be available to the Commissioner.

   c. No licensed consultant may employ, be employed by, or be in a partnership or limited liability company, nor receive any remuneration from any insurance producer, surplus lines insurance producer, or insurer arising out of activities as a consultant. No person may concurrently hold a consultant's license and a license as an insurance producer or surplus lines producer in any line. If the applicant holds such licenses at the time of application, the licenses must be terminated before obtaining a consultant's license.

   d. Although licensed insurance producers or surplus lines insurance producers are exempt from licensing as consultants and are specifically prohibited from concurrently holding a consultant's license and a license as an insurance producer or surplus lines insurance producer, they may perform consulting services in the ordinary course of their businesses. However, if licensed insurance producers or surplus lines insurance producers charge a fee or receive any type of remuneration for such consulting service, they must comply with the provisions concerning consultant's agreements.

   e. A license as an insurance consultant is not required of:

   - An attorney licensed to practice law in North Dakota acting in his professional capacity

- A licensed insurance producer or surplus lines insurance producer
- A trust officer of a bank acting in the normal course of employment
- An actuary or certified public accountant who provides information, recommendations, advice, or services in her professional capacity

8. Experience requirements for surplus lines producer's license [26.1-26-17] An applicant for a surplus lines producer license must be licensed in North Dakota as a producer for the line or lines to be written.

9. Requirements for resident license [26.1-26-19] An applicant may qualify as a resident if he resides or maintains his principal place of business in North Dakota. A license issued to an applicant claiming residency constitutes an election of residency in North Dakota. A license is void if the licensee, while holding a resident license in North Dakota, also holds or applies for a resident license from, or claims to be a resident of, any other state or jurisdiction or ceases to be a resident of North Dakota.

10. Application for license—resident producers [26.1-26-13.3; Reg. 45-02-02-02]

a. An individual applying for a resident insurance producer license must apply to the Commissioner on the uniform application and declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the Commissioner must find that the individual:

- is at least 18 years old;
- has not committed any act that is a ground for denial, suspension, or revocation of a license;
- has paid the required fees; and
- has successfully passed the examinations for the line(s) of authority for which the individual has applied.

b. An applicant licensed in another state within the preceding 12 months who moves to North Dakota must provide, with the application, proof of clearance from the state in which the producer is currently or was most recently licensed as a resident insurance producer.

c. The Commissioner may require any documents reasonably necessary to verify the information contained in an application.

11. Application for license—business entities [26.1-26-13.3]

a. A business entity acting as an insurance producer must obtain an insurance producer license. Application must be made using the uniform business entity application. Before approving the application, the Commissioner must find that:

- the business entity has paid the required fee;

- the business entity has designated a licensed individual principal insurance producer responsible for the business entity's compliance with the insurance laws, rules, and regulations of North Dakota; and
- the individual designated as the licensed principal insurance producer of the business entity has taken the required examination.

b. An applicant for an insurance producer's license by a business entity must have an active certificate of authority with the North Dakota Secretary of State's office.

c. A business entity may only be licensed for those lines of insurance for which one or more of its principal insurance producers is licensed and must inform the Commissioner within 10 working days of any change in the status of its principal insurance producer or producers.

d. The Commissioner may require any documents reasonably necessary to verify the information contained in an application.

12. Examination requirements [26.1-26-13.2; Regs. 45-02-02-02 and 45-02-02-03]

a. A resident individual applying for an insurance producer license or an insurance consultant license must pass a written examination, unless the individual is exempt from the examination requirements. The examination must test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer or consultant, and the insurance laws and regulations of North Dakota. An individual applying for an examination must remit a nonrefundable fee as prescribed by the Commissioner.

b. The individual must pass the examination with a grade determined by the Commissioner to indicate satisfactory knowledge and understanding of the area of insurance for which the individual seeks qualification. An individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for an examination provided the individual remits all required fees and forms before being rescheduled for another examination.

c. The examination must pertain to the line(s) of authority for which the producer will be licensed.

d. The examination will be administered for the Department under a contract with a testing service.

e. An applicant must present a photo identification card at the test center prior to being admitted for testing.

f. An examination score is valid for one year after the date of the examination for a license applicant who has not completed the application process and who has not obtained licensure. After one year from the date of the examination, an applicant must retake the required examination.

g. An examination is valid for as long as a person continuously holds a valid insurance producer's license and for 12 months following cancellation of a license, with the exception that an examination ceases to be valid immediately upon the suspension or revocation of the license unless the order of suspension or revocation specifies otherwise.

13. Requirements for nonresident license [26.1-26-20, 33, 47.1; Reg. 45-02-02-02]

a. Unless the Commissioner denies licensure, the Commissioner must issue a nonresident person a nonresident insurance producer license if the applicant:

- is currently licensed as a resident and is in good standing in the person's home state;
- has submitted the proper request for licensure and has paid the required fees;
- has submitted to the Commissioner either the person's home state application for licensure or a completed uniform application; and
- lives in a state that awards nonresident insurance producer licenses to residents of North Dakota on the same basis.

b. An application for a nonresident insurance producer's license must contain a written designation of the Commissioner as that producer's attorney for purposes of service of process.

c. The Commissioner must waive any requirements for a nonresident license applicant with a valid license from the insurance producer's home state, except the requirements listed above, if the applicant's home state awards nonresident licenses to residents of North Dakota on the same basis.

d. An applicant for a nonresident producer's license must have the state that issued the producer's resident license supply to the Department of Insurance a certificate showing the lines to which the producer is licensed and eligible to write in that state. The Commissioner may verify the insurance producer's licensing status through the insurance producer database maintained by the National Association of Insurance Commissioners.

e. A nonresident insurance producer who moves from one state to another or a resident insurance producer who moves from North Dakota to another state must file a change of address and provide certification from the new resident state within 30 days of the change of legal residence. A fee or license application for a change of address is not required.

f. A person licensed as a surplus lines insurance producer in the person's home state is entitled to receive a nonresident surplus lines insurance producer license. A person licensed as a limited line credit insurance or other type of limited lines insurance producer in the person's home state is entitled to receive a nonresident insurance producer license, granting the same scope of authority as granted under the license issued by the insurance producer's home state.

g. For the purpose of this subsection, **limited line insurance** is any authority granted by the home state that restricts the authority of the license to less than the total authority prescribed in the associated major lines under North Dakota law.

h. Similar to residents, a nonresident insurance producer must pay a biennial continuation fee of $25.

14. Effective date of license [Reg. 45-02-02-05] An applicant who has filed a completed application for an insurance producer's license may begin transacting business under that license on the date the application is approved by the Insurance Department. An insurance producer who is adding a new line of insurance may first transact business in that new line on the date the Insurance Department approves the application.

15. Temporary license [26.1-26-26; Reg. 45-02-02-02]

a. The Commissioner may issue a temporary license as an insurance producer for up to 180 days without requiring an examination if the Commissioner determines that the temporary license is necessary for the servicing of an insurance business in the following cases:

- To the surviving spouse, next of kin, administrator, executor, or employee of a licensed insurance producer who died, or to the spouse, next of kin, employee, or legal guardian of a licensed insurance producer who became disabled
- To a member or employee of a business entity, licensed as an insurance producer, upon the death or disability of an individual designated as the principal insurance producer in the business entity application or the license
- To the designee of a licensed insurance producer entering upon active service in the armed forces of the United States
- In any other circumstance where the Commissioner determines that the public interest will best be served by the issuance of the license

b. An application for a temporary producer's license must be accompanied by a written statement of the reasons for requesting the issuance of a temporary license. A temporary license will not be issued solely for the reason that the applicant has failed to pass the insurance producer's examination and desires to be licensed until a passing score is obtained.

C. MAINTENANCE AND DURATION OF LICENSE

1. Renewal fee [26.1-26-32] An appointment of an insurance producer, surplus lines producer, or insurance consultant terminates if the required annual renewal fees are not paid by insurers before May 1.

2. Termination of license [26.1-26-31, 34] An insurance producer license continues in force indefinitely unless:

- the license is suspended, revoked, or refused by the Commissioner;

- the licensee voluntarily consents to the suspension, revocation, or refusal of the license;
- the licensee dies or, in the case of a business entity, the licensee is dissolved, consolidated, merged, or otherwise ceases to exist;
- the licensee no longer meets the applicable residence requirements;
- in the case of a surplus lines producer, the producer has failed to maintain a resident or nonresident producer's license or has failed to pay the annual renewal fee;
- in the case of an insurance consultant, the consultant has failed to pay the annual renewal fee; or
- insurer appointment is terminated with or without cause (the insurer must notify the Commissioner of terminations within 30 days of those terminations and mail notices of termination to the producers with 15 days' notice to the last known address).

3. **Biennial continuation (renewal) [26.1-26-13.4]** A licensed individual insurance producer must file for biennial license continuation and pay a fee of $25. The Commissioner will give a licensee at least 60 days' notice of the biennial license continuation filing deadline.

4. **Change of address or legal name [26.1-26-33; Reg. 45-02-02-13]**

   a. Every licensee must notify the Commissioner of any change in the licensee's residential or business address or legal name within 30 days of the change. There is no fee to file a change of address.

   b. A licensee who ceases to maintain residency in North Dakota must deliver the insurance license to the Commissioner by personal delivery or mail within 30 days after terminating residency. The change of address must be provided to the Commissioner electronically or on a letter or form separate from the application or appointment forms and submitted solely for that purpose.

5. **Reporting of actions [26.1-26-45.1]**

   a. An insurance producer must report to the Commissioner any administrative action taken against the insurance producer's license in another jurisdiction or by another governmental agency in North Dakota within 30 days of the final disposition of the matter. This report must include a copy of the order, consent to order, or other relevant legal documents.

   b. An insurance producer must report to the Commissioner any criminal conviction of the insurance producer taken in any jurisdiction within 30 days of the conviction. The report must include a copy of the initial complaint, the order issued by the court, and any other relevant legal documents.

6. **Assumed names [26.1-26-25.1]** An insurance producer doing business under any name other than the producer's legal name must notify the Commissioner before using the assumed name.

D. CONTINUING EDUCATION REQUIREMENTS [26.1-26-31-31.8]

1. Required hours [26.1-26-31.1]

a. Producers and consultants must complete 24 hours of continuing education every two years. Three of the hours must be in ethics.

b. Credit for courses attended in any one year over the minimum number of hours of coursework required, not to exceed 12 hours, may be carried backward to the preceding year or carried forward to the next year.

c. No continuing education is required for producers who are at least 62 years old and who have a combined total years of continuous licensure and years of age that equals 85.

2. General rules [Reg. 45-02-04-03]

a. The insurance continuing education course requirements include an educational presentation involving insurance fundamentals, policies, laws, risk management, or other courses that are offered in a process of instruction approved by the commissioner as expanding skills and developing knowledge to better serve the insurance buying public. The following course content will not qualify for insurance continuing education credit:

- Prelicense training
- Prospecting
- Recruiting
- Sales skills and promotions
- Motivation
- Psychology
- Communication skills
- Supportive office and machine skills
- Personnel management

b. Licensees must maintain original records of continuing education certificates of attendance for one year from the last reporting deadline. These records must be made available to the Commissioner upon request.

c. Credit received by an insurance producer for a correspondence course must be based on successful completion of the course as prescribed by the provider and approved by the Commissioner.

d. Neither students nor instructors may earn credit for attending or instructing at any subsequent offering of an insurance continuing education course more than once during a reporting period.

e. No certificate of attendance will be issued to a participant who is absent for more than 10% of classroom hours.

f. Textbooks and course examinations are not required. All course materials must contain accurate and current information relating to the subject matter being taught.

3. **Teaching credit [26.1-26-31.6]** Any person teaching or lecturing at an approved continuing education course qualifies for the same number of hours granted to a person enrolled in the course.

4. **Extension of time [26.2-26-31.5]** The Commissioner may grant an extension of time of up to one year to complete the requirements for continuing education. Requests for extensions must be in writing and received by the Commissioner 30 days prior to the ending date of the period for which the extension is requested. An extension may be granted for health, disability, or other extenuating circumstances.

5. **Report of compliance [Reg. 45-02-04-09.1, 9.3]**

a. On or before the last day of the month of the licensee's birthday following the two-year anniversary of the issue date of a license, and every two years thereafter, proof of compliance for continuing education credit must be submitted with a fee of $25.

b. Continuing education providers are required to report completion of continuing education courses to the Commissioner. However, it is the responsibility of the individual resident producer to be sure the records are correct and timely.

c. Producers licensed exclusively to sell title insurance, travel or baggage insurance, surety, bail bonds, legal expense insurance, and credit insurance are exempt from continuing education requirements.

d. Failure to comply with the continuing education requirement is punishable by license suspension. The license will remain suspended until proof of compliance is submitted.

6. **Reciprocity [Reg. 45-02-04-11]** A nonresident insurance producer who has satisfied her home state's insurance continuing education requirements and is in good standing in her home state must electronically submit the Uniform Application for Individual Producer License Renewal/Continuation through the NAIC and pay a biennial $25 continuation fee.

7. **Task force [26.1-26-31.2]** The Commissioner is advised on continuing education matters by an industry task force containing nine members. The task force may advise the Commissioner in regard to whether courses submitted for approval meet the necessary requirements, but the Commissioner will make the final decision. Courses must be submitted with a $50 fee.

E. DISCIPLINARY ACTIONS

1. Denial of license [26.1-26-39, 40, 42]

a. If the Commissioner finds that the applicant has not met the requirements for licensing, the Commissioner will refuse to issue the license. The Commissioner must promptly notify the applicant and the appointing insurer in writing of the refusal, stating the grounds for the refusal. All fees accompanying the application for license are not refundable.

b. If the Commissioner refuses to issue a license to an applicant, the notice to the applicant must state that the applicant may request a hearing within 30 days from the date the notice was issued. If a hearing is requested by the applicant, the Commissioner must hold it within 30 days of receiving the request and upon 10 days' written notice to the applicant.

2. Cease and desist order [26.1-01-03.1; 26.104-13]

a. The Commissioner may issue a cease and desist order and notice of hearing when it appears that any person is engaged in an act or practice that violates or may lead to a violation of the Insurance Code. Any party aggrieved by the Commissioner's order may make written application for a hearing within 30 days of the date of the order. The application for a hearing must briefly state how the applicant is aggrieved by the order and the grounds for relief. A hearing must be held no later than 10 days after an application for hearing is received unless a delay is requested by all persons named in the order. The Commissioner, within 30 days after the hearing, must issue an order vacating the cease and desist order or making the cease and desist order permanent, as the facts require.

b. If the named person fails to appear at a hearing after receiving notice, he will be considered in default, and the allegations contained in the cease and desist order may be deemed to be true and may be used against the person at the hearing. If no hearing is requested by written application, the Commissioner's order becomes permanent.

3. Suspension, revocation, or refusal of license [26.1-26-42]

The Commissioner may suspend, revoke, refuse to issue, or place on probation any license issued under this chapter if, after notice to the licensee and hearing, the Commissioner finds the licensee or applicant:

- made a materially untrue statement in the license application;
- attempted to acquire a license through misrepresentation or fraud;
- has been found to have been cheating on an examination for an insurance license;
- performed acts or practices which, had they been known at the time of application, would have resulted in the Commissioner refusing the license;
- was convicted of an offense determined by the Commissioner to have a direct bearing upon the person's ability to serve the public as an insurance producer, consultant, or surplus lines producer;

- used fraudulent, coercive, or dishonest practices, or has shown himself to be incompetent, untrustworthy, or financially irresponsible;
- misrepresented the terms of any actual or proposed insurance contract;
- has been found to have knowingly solicited, procured, or sold unnecessary or excessive insurance coverage to any person;
- has forged another's name to an application for insurance;
- improperly withheld, misappropriated, or converted to his own use any money belonging to policyholders, insurers, beneficiaries, or others;
- has been found guilty of any unfair trade practice or fraud;
- violated any insurance laws, rules, or orders of the Commissioner;
- has had his license suspended or revoked in any other state, province, district, or territory;
- has refused to respond within 20 days to a written request by the Commissioner for information regarding any potential violation;
- communicates with a person who has contacted the Department regarding an alleged violation committed by the licensee in an attempt to force the complainant to dismiss the complaint;
- knowingly accepts insurance business from an individual who is not licensed;
- knowingly fails to comply with a court order imposing a child support obligation; or
- knowingly fails to pay state income tax or to comply with a court order directing payment of state income tax.

4. Suspension, revocation, or refusal of business entity license [26.1-26-43] The license of a business entity may be suspended, revoked, or refused if the Commissioner finds, after a hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers, or managers acting on behalf of the business entity, or if the violation was not reported to the Commissioner, and no corrective action taken in relation to the violation.

5. Suspension or revocation of nonresident license [26.1-26-45]

a. Any nonresident license may be suspended or revoked without notice and hearing to the licensee and without a formal proceeding if the Commissioner receives a certified copy of the form revoking or suspending the producer's resident license.

b. If the Commissioner suspends or revokes any nonresident's license through a formal proceeding, the Commissioner must promptly notify the appropriate Commissioner of the licensee's residence of the action and of the particulars of the action.

6. Return of license [26.1-26-44, 46]

a. The Commissioner must promptly notify all appointing insurers, where applicable, and the licensee regarding any suspension, revocation, or refusal of a license.

Upon suspension, revocation, or refusal of the license of a North Dakota resident, the Commissioner will notify the central office of the National Association of Insurance Commissioners.

b. Upon suspension or revocation of a license, the licensee must immediately deliver it to the Commissioner by personal delivery or mail.

7. Penalties for violations [26.1-04-13, 14-17; 26.1-26-50; 26.1-01-03.3]

a. If, after a hearing, the Commissioner determines that the person charged has engaged in an unfair method of competition or an unfair or deceptive act or practice, the Commissioner will order the person to cease and desist from engaging in the activity. If the person charged is found to have willfully engaged in the violation, the Commissioner may order any one or more of the following:

- Payment of a monetary penalty of up to $1,000 for each violation but not to exceed a total penalty of $10,000, unless the person knew or reasonably should have known he was violating the Code, in which case the penalty must be no more than $5,000 for each violation but not to exceed $50,000 in any six-month period
- Suspension or revocation of the person's license if the person knew or reasonably should have known he was in violation of the Code

b. If no appeal is filed, the Commissioner may modify or set aside in whole or in part any cease and desist order until the time allowed for filing an appeal expires. If an appeal is filed, the Commissioner may modify or set aside an order until the transcript of the proceeding has been filed in district court. If the time for filing an appeal expires with no appeal being filed, the Commissioner may, after notice and opportunity for hearing, reopen and alter or set aside in whole or in part any order if in the Commissioner's opinion the conditions of fact or law have so changed as to require the action or if the public interest requires it.

c. Any person who violates a cease and desist order of the Commissioner after it has become final and while it is in effect will be fined up to $10,000 for each violation.

8. Judicial review [26.1-04-15] If the Commissioner does not charge a violation of this chapter, then any intervenor in the proceedings may, within 10 days after the service of the report, cause a notice of appeal to be filed in the district court of Burleigh County for a review of the report. The court may issue appropriate orders and decrees in connection therewith, including orders enjoining and restraining the continuance of any method of competition, act, or practice that it finds violates this chapter.

9. Penalties for rebating, misrepresentation, and discrimination [26.1-04-05-07; 16, 17] Any person who engages in rebating, illegal inducement, misrepresentation, or discrimination is guilty of a Class A misdemeanor. The Commissioner may, after a hearing upon 15 days' notice, revoke the license to of any insurance organization engaged in discrimination or rebating.

10. **Additional penalties [26.1-26-50]** In addition to or instead of any applicable denial, suspension, or revocation of a license, any person violating this chapter may, after hearing, be subject to a civil fine not to exceed $10,000 per violation.

F. UNFAIR CLAIMS SETTLEMENT PRACTICES [26.1-04-03(9)] Committing any of the following acts, if done without just cause, and if performed with a frequency indicating a general business practice, is an unfair claims settlement practice:

- Knowingly misrepresenting, to claimants, pertinent facts or policy provisions relating to the coverage at issue
- Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under insurance policies
- Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies
- Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear
- Compelling insureds to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered
- Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration
- Attempting settlement or compromise of claims on the basis of applications which were altered without notice to, or knowledge or consent of, insureds
- Attempting to settle a claim for less than the amount for which a reasonable person would have believed one was entitled based on written or printed advertising material accompanying or made part of an application
- Attempting to delay the investigation or payment of claims by requiring an insured and the insured's physician to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which contain substantially the same information
- Failing to affirm or deny coverage of claims within a reasonable time after proof of loss has been completed
- Refusing payment of claims solely on the basis of the insured's request without making an independent evaluation of the insured's liability based on all available information
- Providing coverage under a policy for confinement to a nursing home and refusing to pay a claim when a person is covered by such a policy and the person's confinement was ordered by his physician for care other than custodial care (custodial care means care that is primarily for the purpose of meeting personal needs without supervision by a registered nurse or a licensed practical nurse)
- Failing to use standard health insurance proof of loss and claim forms or failing to pay a health insurance claim as required by law

G. PROHIBITED PRACTICES

1. Sharing of commissions [26.1-26-04]

a. An insurance company or insurance producer may not pay (and a person cannot accept) a commission, service fee, brokerage, or other valuable consideration to a person for selling, soliciting, or negotiating insurance in North Dakota if that person is required to be licensed but isn't.

b. Renewal or other deferred compensation may be paid to a person for selling, soliciting, or negotiating insurance in North Dakota if the person was required to be, and was, licensed at the time of the sale, solicitation, or negotiation. An insurer or insurance producer may pay or assign commissions, service fees, brokerages, or other valuable consideration to an insurance agency or to persons that do not sell, solicit, or negotiate insurance in North Dakota, unless the payment would be an illegal rebate.

2. Misrepresentations in insurance applications [26.1-04-03(1 through 12); 26.1-04-07] It is illegal to make a false or fraudulent statement on or concerning an application for an insurance policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer or individual.

3. Misrepresentations of policy contracts [26.1-04-03(1)] No person may make, issue, circulate, or cause to be made, issued, or circulated any estimate, illustration, circular, statement, sales presentation, omission, or comparison that has any of the following effects:

- Misrepresenting the terms of any policy issued or its benefits or advantages
- Misrepresenting the dividends or share of the surplus
- Making any false or misleading statements as to dividends or shares previously paid on any insurance policy
- Making any misleading representation as to the financial condition of any person or to the legal reserve system upon which the insurer operates
- Using any name or title of any policy that misrepresents its true nature

4. False information and advertising [26.1-04-03(2)] It is unlawful for any person to place before the public in any form an advertisement, announcement, or statement that is untrue, deceptive, or misleading about any person in the conduct of his insurance business.

5. Defamation [26.1-04-03(3)] Making, publishing, disseminating, or circulating any oral or written statement, pamphlet, circular, article, or literature that is false or maliciously critical of or derogatory to the financial condition of any person and that is calculated to injure any person engaged in the insurance business is an illegal practice.

6. Boycott, coercion, and intimidation [26.1-04-03(4)] It is illegal to enter into an agreement to commit, or to actually commit, any act of boycott, coercion, or intimidation resulting in unreasonable restraint of, or monopoly in, the business of insurance.

7. **False financial statements [26.1-04-03(5)]** Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person any false statement of financial condition of any person with intent to deceive is illegal.

8. **Unfair discrimination [26.1-04-03(7), 03(11); 26.1-04-05]** It is an illegal practice to:
   - make any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for life insurance or an annuity, the dividends or benefits payable, or in any other terms and conditions of the contract;
   - make any unfair discrimination, including consideration of an individual's history or status as a subject of domestic abuse, between individuals of the same class and essentially the same hazard in the amount of premium, policy fees, rates charged, benefits, or terms and conditions of an accident and health insurance contract;
   - refuse to insure or to continue to insure, or limit the amount of life insurance, accident and sickness insurance, health services or health care protection insurance, or charge an individual a different rate for the same coverage, solely because of the individual is blind or partially blind;
   - make or permit any unfair discrimination between individuals or risks of the same class and of essentially the same hazard by refusing to insure, refusing to renew, canceling, or limiting the amount of insurance coverage on a property or casualty risk solely because of the geographic location of the risk, unless the action is the result of the application of sound underwriting and actuarial principles related to actual or reasonably anticipated loss experience; or
   - refuse to insure risks solely because of race, color, creed, sex, or national origin or refuse to continue to insure risks solely because an employer chooses to offer a health maintenance organization option to employees in its health benefit plan.

9. **Rebates and illegal inducements [26.1-04-03(8)a, 05; 26.1-04-06]**

   a. This section does not prevent the taking of a bona fide obligation, with legal interest, in payment of any premium. For life insurance, no producer may offer, promise, allow, give, set off, or pay any rebate of some or all of a client's premium. Neither should the producer promise nor give any special favor or advantage in the dividends, earnings, profits, or other benefit, including any advantage in the date of the policy or the age of issue. There can be no inducement in connection with any stocks, bonds, securities, or property, or any dividends or profits accruing, or other thing of value whatsoever not specified in the policy.

   b. Exceptions to discrimination and rebate provisions [26.1-04-03(8)b] The following practices are not considered to be illegal discrimination or rebates and are permitted:
      - Paying bonuses to life insurance or annuity policyholders or abating their premiums out of surplus accumulated from nonparticipating insurance, provided the bonuses are fair and equitable to policyholders

- For industrial debit life insurance policyholders who have continuously paid premiums directly to an insurer's office, making allowance for an amount representing the savings in collection expenses
- Readjusting the rate of premium for a group insurance policy based on the loss or expense experience, made retroactive only for that policy year

10. Twisting/churning [26.1-04-03(1)] It is illegal to make any misrepresentation tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy or for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance.

11. Coercion, boycott, and intimidation of purchaser or borrower prohibited [26.1-04-04; 03(4)]

a. There is to be no unreasonable restraint of trade in the insurance business.

b. No person engaged in selling, financing, or lending money on the purchase of real or personal property may require as a condition that the person making the purchase or loan carry insurance through a particular insurance company or insurance producer. This section also applies to the renewal or extension of such a loan.

c. This section does not prevent any person from designating reasonable financial requirements as to the insurance company, the terms and provisions of the policy, and the adequacy of the coverage with respect to insurance on property pledged or mortgaged to the person. Nor does this section prohibit the right of any person from voluntarily negotiating or soliciting the placement of insurance. Further, it does not prohibit the seller or creditor from securing or renewing insurance at the request of the purchaser or borrower when he fails to furnish the necessary insurance or renewal. Violation of this section is an unfair insurance practice.

12. Controlled business [26.1-26-53] **Controlled business** means:

- insurance written on the interests of the licensee, the licensee's immediate family, or the licensee's employer; and
- insurance covering a business entity or the officers, directors, substantial stockholders, partners, or employees of a business entity of which the licensee or a member of her immediate family is an officer, director, substantial stockholder, partner, an associate, or employee.

The Commissioner will not grant, renew, or continue any license used for the purpose of writing controlled business. A license is deemed to have been used to write controlled business if, during any 12-month period, the aggregate commissions earned from controlled business exceed 35% percent of the aggregate commissions earned on all business written by the licensee during the same period.

13. Unearned premium returns [26.1-24-03]

a. An insured is entitled to a full premium refund, including all policy fees in excess of $2 and all other sums of money paid in consideration of the insurance policy, under the following circumstances.

- The contract is voidable due to the insurer's fraud or misrepresentation.
- The contract is voidable due to facts that the insured was unaware of without the insured's fault.
- The insurer never incurred any liability under the policy due to the insured's default (other than actual fraud).
- No part of the insured's interest in the item insured is exposed to any of the perils insured against.

b. The insured is entitled to a proportional premium refund when she surrenders the policy prior to its expiration date.

H. APPOINTMENT AND TERMINATION OF PRODUCERS

1. Producer appointment [26.1-26-13.1; Reg. 45-02-02-06]

a. An insurance producer may not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

b. To appoint an insurance producer as its agent, the appointing insurer must file a notice of appointment, either on a form prescribed by the Commissioner or electronically through the National Association of Insurance Commissioner's subsidiary, within 30 days from the later of the date the agency contract is executed or the first insurance application is submitted. The notice must include the month, day, and year of the appointment and be in a format approved by the Insurance Commissioner. An insurer may appoint an insurance producer to all or some insurers within the insurer's holding company system or group by filing a single appointment request.

c. An insurer must pay a prescribed appointment fee for each insurance producer appointed by the insurer.

2. Renewal of appointment [26.1-26-32; Reg. 45-02-02-07]

a. On or before December 1 of each year, the insurance department will furnish each insurer with a preliminary renewal list of the producers appointed by that company.

b. On or before March 15 of each year, an electronic renewal invoice will be made available through the NAIC's subsidiary to all companies with active appointments. The renewal fee for the appointments on this list must be paid before May 1.

3. Termination of appointment [26.1-26-34; Reg. 45-02-02-06]

a. Termination for cause

1.) An insurer or authorized representative of an insurer that terminates the appointment, employment, contract, or other insurance business relationship with an insurance producer must notify the Commissioner within 30 days following the effective date of the termination, if the termination is for cause.

2.) A termination is for cause if it is based on an activity that would justify the suspension, revocation, or refusal of the producer's license or if the insurer has knowledge the producer was found by a court, government body, or self-regulatory organization to have engaged in any of those activities.

3.) Upon the written request of the Commissioner, the insurer must provide additional information, documents, records, or other data pertaining to the termination or the producer's activity. The insurer or the authorized representative of the insurer must promptly notify the Commissioner if the insurer discovers additional information that would have been reportable to the Commissioner under this provision had the insurer then known of the information's existence.

b. Termination without cause

1.) An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with an insurance producer for any other reason must also notify the Commissioner within 30 days following the effective date of the termination and, upon the Commissioner's written request, provide additional information, documents, records, or other data pertaining to the termination.

2.) Within 15 days after making the required notification to the Commissioner, the insurer must mail a copy of the notification to the insurance producer at the insurance producer's last known address. If the insurance producer is terminated for cause, the insurer must provide a copy of the notification to the insurance producer at the insurance producer's last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

3.) Within 30 days after receiving the original or additional notification, the insurance producer may file written comments concerning the substance of the notification with the Commissioner. The insurance producer must by the same means simultaneously send a copy of the comments to the reporting insurer. The comments become a part of the Commissioner's file and must accompany every copy of a report distributed or disclosed for any reason about the insurance producer as permitted by law.

4.) In the absence of actual malice, neither an insurer, authorized representative of an insurer, producer, or the Commissioner may be held liable for providing any statements or information required under this section.

An insurer, authorized representative of the insurer, or insurance producer that fails to report as required under this section or that is found to have reported with actual malice may, after notice and hearing, have its license or certificate of authority suspended or revoked and may be fined as provided by law.

I. INSURANCE FRAUD REGULATION

1. Definitions [26.1-02.1-01]

a. **Business of insurance** means the writing of insurance or the reinsuring of risks by an insurer, including acts necessary or incidental to writing insurance or reinsuring risks and the activities of persons who act as or who are officers, directors, agents, or employees of insurers, or who are other persons authorized to act on their behalf. The term does not include the activities of the North Dakota Life and Health Insurance Guaranty Association or the North Dakota Insurance Guaranty Association.

b. **Fraudulent insurance act** includes the following acts or omissions committed by a person knowingly and with intent to defraud:

- Presenting, causing to be presented, or preparing with knowledge that it will be presented to or by an insurer, reinsurer, insurance producer, or any agent false or misleading information as part of a fact material to one or more of the following:
  - An application for the issuance or renewal of an insurance policy or reinsurance contract
  - The rating of an insurance policy or reinsurance contract
  - A claim for payment or benefit
  - Premiums paid on an insurance policy or reinsurance contract
  - Payments made in accordance with the terms of an insurance policy or reinsurance contract
  - A document filed with the Commissioner or the chief insurance regulatory official of another jurisdiction
  - The financial condition of an insurer or reinsurer
  - The formation, acquisition, merger, reconsolidation, dissolution, or withdrawal from one or more lines of insurance or reinsurance in all or part of North Dakota by an insurer or reinsurer
  - The issuance of written evidence of insurance
  - The reinstatement of an insurance policy
  - The formation of an agency, brokerage, or insurance producer contract
- Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer, reinsurer, or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction

- Removal, concealment, alteration, or destruction of the assets or records of an insurer, reinsurer, or other person engaged in the business of insurance
- Theft by deception or embezzlement, abstracting, purloining, or conversion of moneys, funds, premiums, credits, or other property of an insurer, reinsurer, or person engaged in the business of insurance
- Attempting to commit, aiding or abetting in the commission of, or conspiring to commit the acts or omissions specified in this section

c. A **practitioner** is a licensee of North Dakota authorized to practice medicine and surgery, psychology, chiropractic, or law or any other licensee whose services are compensated by insurance proceeds; or a licensee similarly licensed in other states and nations; or the practitioner of any nonmedical treatment rendered in accordance with a recognized religious method of healing.

2. Prohibitions [26.1-02.1-02.1] The law regulating insurance fraud contains all of the following prohibitions.

a. A person may not commit a fraudulent insurance act.

b. A person may not knowingly or intentionally interfere with the enforcement of the law regulating insurance fraud or investigations of suspected or actual violations.

c. A person convicted of a felony involving dishonesty or breach of trust may not participate in the business of insurance.

d. A person in the business of insurance may not knowingly or intentionally permit a person convicted of a felony involving dishonesty or breach of trust to participate in the business of insurance.

3. Immunity [26.1-02.1-04] A person who provides information concerning a fraudulent insurance act to an authorized agency without malice cannot be held liable as long as he provides the information in good faith. If a person provides evidence or testimony after being requested to by an authorized agency or court of law, he cannot be subject to a criminal proceeding or civil penalty unless he is being prosecuted for perjury or insurance fraud.

4. Penalties [26.1-02.1-05]

a. A person who commits a fraudulent insurance act from which he gained more than $5,000 will be charged with a Class C felony. In all other fraud cases, the offender will be charged with a Class A misdemeanor.

b. When a practitioner is found guilty of committing a fraudulent insurance act, the court will notify the appropriate licensing authority of the finding. Upon notification, the licensing authority must hold an administrative hearing to consider imposing sanctions against the guilty practitioner.

c. In addition to any other punishment, a person found guilty of committing fraudulent insurance acts must be ordered to make financial restitution to the insurer or to any other person for any financial loss sustained as a result of the violation. The court will determine the extent and method of restitution.

5. Reporting suspected fraud [26.1-02.1-06; Reg. 45-15-01-01] A person engaged in the business of insurance who knows or reasonably believes that a fraudulent insurance act has been or will be committed must report the matter to the Commissioner. The report must be made in writing within 60 days after the individual first becomes aware of the matter. Any other person who has that knowledge or reasonable belief may also make a report to the Commissioner. A person who provides nonpublic personal information to the Commissioner under this section does not violate the insurance privacy law.

6. Confidentiality [26.1-02.1-07] Any documents or other materials in the Commissioner's control relating to insurance fraud are confidential and privileged, are not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action. However, the Commissioner may use the materials in any regulatory or legal action brought as a part of the Commissioner's official duties. Neither the Commissioner nor any person who received documents or other information while acting under the authority of the Commissioner may testify in a private civil action concerning any confidential documents, materials, or information.

7. Insurance fraud unit [26.1-02.1-08] The North Dakota insurance fraud unit, which is part of the Insurance Department, was established to:

- initiate independent inquiries and conduct independent investigations when it believes that a fraudulent insurance act may be, is being, or has been committed;
- review reports or complaints of alleged fraudulent insurance activities from federal, state, and local law enforcement and regulatory agencies, persons engaged in the business of insurance, and the public to determine whether the reports require further investigation and to conduct these investigations; and
- conduct independent examinations of alleged fraudulent insurance acts and undertake independent studies to determine the extent of fraudulent insurance acts.

8. The insurance fraud unit is authorized to:

- inspect, copy, or collect records and evidence;
- serve subpoenas;
- administer oaths and affirmations;
- share records and evidence with federal, state, or local law enforcement or regulatory agencies;
- execute search warrants and arrest warrants for criminal violations of this chapter;
- arrest upon probable cause without warrant a person found in the act of violating or attempting to violate a provision of this chapter;
- make criminal referrals to prosecuting authorities; and
- conduct investigations outside of North Dakota.

J. BINDERS [26.1-39-23] A binder or contract for temporary farm and personal lines of insurance may be made orally or in writing and is deemed to include all the terms of a standard fire insurance policy and all applicable endorsements as may be designated in the binder. However, the cancellation clause of the standard fire insurance policy and the clause specifying the hour of the day at which the insurance commences may be superseded by the express terms of the binder. A duly authorized binder must be accepted as evidence of insurance coverage required as a condition of financing the purchase of property, except that a mortgagee or lender is not required to accept a renewal or extension of the binder. Any insurance producer who has express authority to bind farm and personal lines of insurance coverage, and who orally agrees on behalf of an insurer to provide insurance coverage, if requested, shall execute and deliver a written memorandum or binder containing the terms of the oral agreement to the insured within three business days from the time of the oral agreement.

K. LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION [26.1-38.1-01 THROUGH 02, 06 THROUGH 07, 14]

1. The North Dakota Life and Health Insurance Guaranty Association protects policyowners, insureds, and beneficiaries from the financial dangers caused by insurers who become impaired and unable to perform their contractual obligations. The Association must have a current plan of operation approved by the Commissioner as to how it assesses its members for the funds to pay benefits and continue coverage for impaired insurers. Class A assessments are for legal and administrative expenses of the Association. Class B assessments provide money to carry out the powers and duties of the fund. The Association also helps the Commissioner detect and prevent insurer impairments. The Association, its agents, and its directors are immune from liability arising from the performance of their Association duties.

a. Membership All insurers must be members of the Association as a condition of their authority to transact insurance in North Dakota. The Association exercises its powers through a board of directors.

b. Scope of coverage The Association protects policyowners who are North Dakota residents. It also covers nonresidents of North Dakota who meet the following conditions.

1.) Their policies were issued by insurers that are domiciled in North Dakota.

2.) The insurer did not hold a license or certificate of authority in the state in which the insured resides at the time specified in the state's guaranty association law.

3.) The other state has a guaranty association similar to North Dakota's, although the insured is not eligible for coverage by the other state's association.

c. In addition to coverage for such policyholders, coverage is also provided to their beneficiaries, payees, and assignees regardless of residence.

d. The Association covers all direct group and individual life, health, and annuity policies and contracts issued by member insurers, except for:

- portions of policies or contracts not guaranteed by the insurer or under which the risk is borne by the policyholder;
- reinsurance policies issued without assumption certificates;
- portions of policies based on an excessive interest rate;
- self-funded or uninsured employer or association plans that provide life, health, or annuity benefits to employees or members;
- portions of policies that provide the policyholder with dividends, experience rating credits, or administrative charges;
- policies issued in North Dakota by member insurers that, at the time of issue, were not licensed to issue policies in North Dakota;
- unallocated annuity contracts issued to employee benefit plans protected under the Federal Pension Guaranty Corporation;
- unallocated annuities not issued to specific persons or organizations;
- policies for which guaranty association assessments cannot be collected under federal or state law;
- obligations based on marketing materials, misrepresentations, unapproved policy or rider forms, legal damages, or any basis other than the express terms of an approved policy;
- book value accounting guaranties made to defined contribution plans;
- indexed-based earnings not yet credited to a policy; and
- Medicare Part C or D.

2. Powers and duties If a member insurer becomes impaired or insolvent, the Association may:

- guarantee, assume, or reinsure the insurer's policies and contracts;
- provide necessary money, pledges, and guarantees to assume payment of the insurer's obligations; and
- loan money to the insurer.

3. Benefits

a. The Association is liable, at most, for the lesser of:

- the contractual obligation the insurer would have been liable for had it not become impaired or insolvent;
- $300,000 in life insurance death benefits for any one life (with no more than $100,000 in total net cash surrender and net cash withdrawal values);
- $100,000 in health insurance benefits other than for disability, medical expense, or long-term care policies (including any net cash surrender and net cash withdrawal values) for any one life;
- $300,000 for disability or long-term care policies;
- $500,000 for medical, hospital, or surgical expense policies;
- $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values) for any one life;

- $250,000 for participants in 401(k), 403(b), 457 plans, or structured annuities; or
- $5 million dollars for one owner of multiple nongroup life insurance policies (such as a business that owns policies on all of its owners under a buy-sell agreement).

b. The limits on aggregate benefits are:

- $300,000 on any one life for multiple policies of all types except a medical expense policy; and
- $500,000 on any one life for multiple policies if the combination includes a medical expense policy, the limit is $500,000.

c. Advertising prohibited [26.1-38.1-16] It is illegal to make any advertisements, announcements, or statements that mention the Association to induce people to purchase insurance covered by the Association. However, agents, brokers, and others may answer prospective purchasers' questions about the Association.

L. CREDIT INSURANCE [26.1-37-02, 05 THROUGH 08, 13, 14]

1. Definitions

a. **Creditor-placed insurance** means insurance that is purchased unilaterally by the creditor, after the date of the credit transaction, providing coverage against physical damage to the collateralized personal property. It is purchased under the terms of the credit agreement as a result of the debtor's failure to provide required physical damage insurance, with the cost of the coverage being charged to the debtor. It is either single interest insurance or limited dual interest insurance.

b. **Dual interest insurance** means credit property insurance covering the creditor's interest and at least partially the borrower's interest in the goods purchased through the credit transaction.

c. **Finance charge** means any charge payable as a condition of the extension of credit, including interest, time price differentials, amount payable under a discount system of additional charges, service charges, loan fees, points, appraisal fees, or charges incurred for investigating the credit worthiness of the consumer. The term does not include charges as a result of default, taxes, license fees, delinquency charges, or filing fees.

2. License requirement Credit insurance may be delivered or issued for delivery in this state only by an insurer authorized to do insurance business in North Dakota, and may be issued only through holders of licenses or authorizations issued by the Commissioner.

3. Amount of insurance

a. Except as otherwise provided, the initial amount of credit life insurance may not exceed the total amount repayable under the contract of indebtedness and, when

an indebtedness is repayable in substantially equal installments, the amount of insurance may not exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater.

b. In the absence of any preexisting condition exclusions, the amount of insurance payable in the event of death due to natural causes may be limited to the balance that existed six months before the date of death if:

- there has been one increase or more in the outstanding balance during the six-month period, other than those due to the accrual of interest or late charges; and
- evidence of individual insurability has not been required during the six-month period.

c. Other patterns of insurance may be used which are not inconsistent with this subsection including those providing coverage for lease payments or lump-sum purchase at the end of the lease.

4. Effective date of coverage

a. For consumer credit insurance elected by the debtor before or at the time of a credit transaction, the term of the insurance begins on the date when the debtor becomes obligated to the creditor, except that when evidence of individual insurability is required and the evidence is furnished more than 30 days later, the term of the credit insurance may begin on the date the insurer determines the evidence to be satisfactory.

b. For insurance coverage elected by the debtor after the consumer credit transaction, the insurance begins not earlier than the date the election is made by the debtor nor later than 30 days following the date the insurance company accepts the risk.

5. Termination date of coverage

a. The term of consumer credit insurance may not extend beyond the termination date specified in the policy. The termination date of insurance may precede, coincide with, or follow the scheduled maturity date of the debt to which it relates.

b. The term of any consumer credit insurance may not extend more than 15 days beyond the scheduled maturity date of the debt except when extended without additional cost to the debtor or when extended under a written agreement, signed by the debtor, in connection with a variable interest rate credit transaction or a deferral, renewal, refinancing, or consolidation of debt.

c. In all cases of termination of insurance prior to the scheduled termination of the insurance, an appropriate refund or credit to the debtor must be made of any unearned insurance charge paid by the debtor, except that a refund is not required if the insurance is terminated by payment of the insurance proceeds by the insurer.

d. An insured debtor may terminate consumer credit insurance at any time by providing advance request to the insurer. The individual policy or group certificate may require that the request be in writing or that the debtor surrender the individual policy or group certificate or both. The debtor's right to terminate coverage may also be subject to the terms of the credit transaction contract.

6. Disclosure requirements

a. Before a debtor elects to purchase consumer credit insurance, the following must be disclosed to the debtor in writing.

1.) The purchase of consumer credit insurance is optional and not a condition of obtaining credit approval.

2.) If more than one kind of consumer credit insurance is being made available to the debtor, whether the debtor can purchase each kind of insurance separately or the multiple coverages only as a package.

3.) The conditions of eligibility, if any.

4.) If the consumer has other insurance that covers the risk, the consumer may not want or need credit insurance.

5.) Within the first 30 days after receiving the individual policy or group certificate, the debtor may cancel the coverage and have all premiums refunded or credited. Thereafter, the debtor may cancel the policy at any time during the term of the loan and receive a refund of any of the unearned premium. However, when insurance is a requirement for the extension of credit, the debtor may be required to offer evidence of alternative insurance acceptable to the creditor at the time of cancellation.

6.) Provide a brief description of the coverage, including a description of the amount, the term, any exceptions, limitations, and exclusions, the insured event, any waiting or elimination period, any deductible, any applicable waiver of premium provision, to whom the benefits would be paid, and the premium rate for each coverage or for all coverages in a package.

7). If the premium or insurance charge is financed, it will be subject to finance charges at the rate applicable to the credit transaction.

b. The disclosures must be provided in the following manner.

1.) In connection with consumer credit insurance offered along with the extension of credit or offered through direct mail advertisements, disclosure must be made in writing and presented to the consumer in a clear and conspicuous manner.

2.) In conjunction with the offer of credit insurance after the extension of credit by other than direct mail advertisements, disclosure may be provided orally so long as written disclosures are provided to the debtor no later than the earlier of 10 days after the election of coverage or the date any other written material is provided to the debtor.

c. All consumer credit insurance must be evidenced by an individual policy or a group certificate of insurance which must be delivered to the debtor.

d. The individual policy or group certificate must, in addition to other requirements of law, set forth:

- the name and home office address of the insurer;
- the name or names of the debtor or debtors, or in the case of a group certificate, the identity by name or otherwise of the debtor or debtors;
- the premium or amount of payment by the debtor separately for each kind of coverage or for all coverages in a package, except that for open-end loans, the premium rate and the balance to which the premium rate applies;
- a full description of the coverage or coverages, including the amount and term thereof, and any exceptions, limitations, and exclusions;
- a statement that the benefits will be paid to the creditor to reduce or extinguish the unpaid debt or to repair or replace the property and, whenever the amount of insurance benefit exceeds the unpaid debt that any excess is payable to a beneficiary, other than the creditor, named by the debtor or to the debtor's estate; and
- if the scheduled term of insurance is less than the scheduled term of the credit transaction, a statement to that effect on the face of the individual policy or group certificate in not less than 10-point bold-faced type.

e. The debtor has 30 days from the date the debtor receives either the individual policy or the group certificate to review the coverage purchased. At any time within the 30-day period, the debtor may contact the creditor or insurer issuing the policy or certificate and request that the coverage be canceled. The individual policy or group certificate may require the request to be in writing or that the policy or certificate be returned to the insurer, or both. The debtor must, within 30 days of the request, receive a full refund or credit of all premiums or insurance charges paid by the debtor.

7. Premium rates and refunds

a. An insurer may revise its schedules of premium rates from time to time and shall file the revised schedules with the Commissioner. No insurer may issue any consumer credit insurance policy or group certificate for which the premium rate exceeds that determined by the schedules of the insurer as on file with the Commissioner. The Commissioner may adopt rules to assure that the premium rates are reasonable in relation to the benefits provided.

b. The Commissioner shall prescribe a minimum refund, and no refund which would be less than the minimum need be made. Refund formulas must be at least

as favorable to the debtor as refunds equal to the premium cost of scheduled benefits after the date of cancellation or termination, computed at the schedule of premium rates in effect on the date of issue. The formula to be used in computing the refund must be filed with and approved by the Commissioner.

8. **Debtor's selection rights** When consumer credit insurance is required as additional security for any debt, the debtor shall have the option of furnishing the required insurance through existing insurance policies owned or controlled by the debtor or of procuring and furnishing the required coverage through any authorized insurer.

II. STATE LAWS AND REGULATIONS PERTAINING TO LIFE AND HEALTH INSURANCE ADVERTISING

A. PURPOSE

1. Minimum standards and guidelines for insurance solicitation, sales presentations, and advertising have been established to:
   - assure truthful disclosure of benefits, limitations, and exclusions of insurance policies that are advertised to the public; and
   - prevent unfair, deceptive, and misleading advertisements.

B. ADVERTISING DEFINED [REGS. 45-04-10-01-08]

1. An **advertisement** is any material designed to promote a reader's or viewer's interest in insurance, an insurer, or an agent. Advertisements can assume any of the following forms:
   - An insurer's printed and published material, audiovisual material, and descriptive literature used in direct mail, newspapers, magazines, television scripts, billboards, and similar displays
   - Prepared sales talks and presentations for use by sales personnel, agents, solicitors, and brokers
   - Descriptive literature, identification cards, and sales aids issued by insurers or agents
   - Material for recruitment, training, and education of the insurer's sales personnel, agents, solicitors, and brokers that is designed to induce the public to purchase or modify policies

2. The following are not subject to the advertising rules:
   - Communications or materials used within the insurer's, agent's, or broker's own organization and not intended for public dissemination
   - Communications with policyholders (other than material urging them to purchase or modify policies)
   - General announcements from group or blanket policyholders informing eligible individuals on an employment or membership list that the policy or program has been arranged (a booklet explaining the proposed coverage must follow)

3. Insurers are responsible for assuring that the form and dissemination of their advertisements adhere to these rules, regardless of who creates them.

4. Ads cannot be ambiguous, confusing, or misleading.

- Ads cannot omit material words, phrases, or references despite the consumer being allowed a free-look period.
- Ads must indicate that the product is life insurance and the type of policy, premium design, dividends (if any), and that dividends are not guaranteed.
- Ads must use genuine testimonials from third parties that are accurately reproduced. Any compensation to or financial interest of the third party must be revealed.
- An advertisement may not state or imply that policies are an introductory, initial, or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. The company may not state or imply that only a specific number of policies will be sold.
  - When an insurer charges an initial premium that differs in amount from the amount of the renewal premium, all references to the reduced initial premium must be followed by an asterisk calling attention to where the ad shows the full rate schedule.
- An enrollment period may not be offered in North Dakota unless there has been not less than 12 months between the close of the immediately preceding enrollment period for the same policy and the opening of the new enrollment period. The mailing deadline is defined and must be included in the ad.

5. The name of the insurer must be clearly identified in all advertisements. There may be no misrepresentations concerning the company's assets, liabilities, and ratings. Policies must be referred to by form number. No advertisement may hint it is connected with or endorsed by a governmental program or agency unless that is factual.

6. Each insurer must maintain at its home or principal office a complete file containing a specimen copy of every printed, published, or prepared advertisement of its individual policies and specimen copies of typical printed, published, or prepared advertisements of its blanket, franchise, and group policies disseminated in North Dakota, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. The file is subject to inspection by the Department of Insurance. All such advertisements must be maintained in the file for a period of either four years or until the filing of the next regular report on the examination of the insurer, whichever is the longer period of time.

C. ILLUSTRATIONS IN SALES PRESENTATIONS [REGS. 45-04-01.1-10]

1. The use of benefit comparisons in sales presentations is a common practice in North Dakota. While such comparisons provide useful factual information to potential consumers, the Insurance Department often receives complaints about misleading or inaccurate benefit comparisons. The Department expects that the use of these comparisons and any illustration used in a sales presentation follow the regulations governing competition and sales practices.

2. All benefit comparisons must carry this statement in bold print close to the illustration on the advertisement:

> This comparison of benefits may not be completely accurate and should not be the sole source of information you rely upon in deciding which insurance coverage to purchase. For completely reliable benefit comparisons, the North Dakota Insurance Department advises that you obtain the benefit schedules directly from each applicable insurance company.

3. Life insurance illustrations [Regs. 45-04-01.1-01 to 10] Each insurer must notify the Commissioner whether a policy form is to be marketed with or without an illustration. If a policy form is to be marketed without an illustration, any use of an illustration for any policy using that form prior to the first policy anniversary is prohibited. Illustrations used in the sale of a life insurance policy must be clearly labeled as such. An illustration is a presentation or depiction that includes guaranteed and nonguaranteed elements of a life insurance policy over a period of years. This chapter is intended to ensure that illustrations do not mislead buyers. As much as possible, insurers will eliminate the use of footnotes and define terminology in language that would be understood by a typical person within the segment of the public to which the illustration is directed. This chapter applies to all group and individual life insurance policies and certificates except:

- variable life insurance;
- individual and group annuity contracts;
- credit life insurance; and
- life insurance policies with no illustrated death benefits exceeding $10,000.

a. Illustrations must contain the:

- insurer's name;
- name and business address of the producer or the insurer's representative, if any;
- name, age, and sex of the proposed insured;
- underwriting or rating classification upon which the illustration is based;
- generic name of the policy, the insurer's product name (if different), and the form number;
- initial death benefit;
- pagination and date of creation; and
- dividend option election or application of nonguaranteed elements, if any.

b. When using an illustration to sell a life insurance policy, an insurer and its producers cannot:

- provide an incomplete illustration;
- represent the policy as anything other than a life insurance policy;
- describe or use nonguaranteed elements in a way that is misleading or could mislead;
- state or imply that the payment or amount of nonguaranteed elements is guaranteed;

- state or imply that premium payments will not be required for each year of the policy to maintain the illustrated death benefits, unless that is true; or
- use the terms *vanish* or *vanishing premium* or similar term that implies the policy becomes paid up, when describing a plan for using nonguaranteed elements to pay part of future premiums.

4. If a basic illustration was used in the sale and the policy is applied for as illustrated, a copy of that illustration, signed by the applicant and producer, must be submitted with the application. A copy must be provided to the applicant.

- If the policy is issued other than as applied for, a revised basic illustration, labeled as "revised," must be sent with the policy. It too must be signed and dated by the applicant or policyowner and producer or other authorized representative of the insurer no later than the time the policy is delivered. Copies must be provided to the insurer and the policyowner.
- If no illustration is used in the sale, the representative must certify that in writing. On the same form, the applicant shall acknowledge that no illustration was provided. The applicant should also acknowledge that the applicant understands an illustration conforming to the policy issued will be provided no later than at the time of policy delivery. This form must be submitted to the insurer at the time of policy application.
- If the policy is issued, a basic illustration conforming to the policy as issued must be sent with the policy and signed no later than at delivery. Copies must be provided to the insurer and the policyowner.
- Copies shall be retained by the insurer until three years after the policy is no longer in force. A copy need not be retained if no policy is issued.

5. If an interest rate used to determine the illustrated nonguaranteed elements is shown, it may not be greater than the earned interest rate underlying the current scale.

6. Annual statement reports must be given to policyholders if the insurance was sold with policy illustrations. Specific information and format required is defined in the chapter.

7. The Insurance Department will investigate any complaints of inaccurate illustrations or benefit comparisons. Anyone found guilty of deliberately using inaccurate illustrations will be subject to the fines applied to those committing unfair trade practices.

D. DISCLOSURE REQUIREMENTS [26.1-33-02; REG. 45-04-10-03]

Advertisements, which include insurance illustrations, should provide information to improve the purchaser's ability to select the most appropriate plan of life insurance for the purchaser's needs and which will improve the purchaser's understanding of the basic features of the policy under consideration. Information should improve the buyer's ability to evaluate the relative costs of similar plans of life insurance. Advertisements must not omit information or use words, references, or illustrations that may mislead or deceive prospective purchasers about the nature of any benefit or premium payable, loss covered, or state and federal tax consequences regarding the policy. The fact that the policy is made available to the prospective insured for inspection, with an offer to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

E. HEALTH INSURANCE REQUIREMENTS [REG. 45-06-04]

1. Health insurance advertisements must follow the following requirements.

a. They cannot use words or phrases such as *all*, *full*, or *unlimited* in a manner that exaggerates any benefit beyond the terms of the policy.

b. They cannot use word descriptions of policy limitations or exceptions in a positive manner to imply that they are benefits.

c. Advertisement of benefits that require confinement in a hospital or similar facility cannot use phrases such as *tax free*, *extra cash*, or any phrase that will lead purchasers to believe that they will profit from being hospitalized.

d. Specified disease policies cannot imply that coverage extends beyond the terms of the policy.

e. Policies that provide benefits for only specified illnesses or accidents must clearly state their limited nature.

f. Advertisements that are invitations to contract for insurance must disclose the exceptions, reductions, or limitations affecting the policy provisions.

g. They must disclose any waiting or elimination period between the effective date of the policy and the effective date of coverage (or the period between when the loss occurs and when the benefits begin).

h. They cannot use words such as *only* or *minimum* when referring to exceptions and reductions.

2. Preexisting conditions [Reg. 45-06-04-07]

a. Health insurance advertisements must disclose in negative terms the extent to which any loss is not covered if it is traceable to a condition that existed prior to the effective date of the policy. The term *preexisting condition* must be defined.

b. If a policy does not cover losses resulting from preexisting conditions, the advertisement cannot imply that the applicant's physical condition or medical history will not affect issuance of a policy or payment of claims.

F. LIFE INSURANCE REQUIREMENTS [REG. 45-04-10-03]

1. Life insurance advertisements must follow the following requirements.

a. Advertisements that do not guarantee policy issue but use the terms *nonmedical*, *no medical examination required*, or similar terms must also state that policy issuance may depend on answers to health questions.

b. They must include language that clearly indicates that the advertisement refers to life insurance or an annuity.

c. They must prominently describe the type of policy advertised.

d. Advertisements for policies marketed by the direct-response method must not state or imply that there will be a cost savings to prospective purchasers because there is no agent or commission involved, unless that is true.

e. Advertisements for graded or modified policies must prominently display any limitation of benefits and disclose whether the premium is level and whether coverage decreases or increases with age or duration.

f. Advertisements for policies with nonlevel premiums must prominently describe the premium changes.

g. They must not state or imply that payment of dividends is guaranteed or that the purchaser of the policy will share in or receive a stated percentage or portion of the earnings in the insurance company's general assets.

III. STATE LAWS AND REGULATIONS PERTAINING TO LIFE INSURANCE

A. REQUIRED LIFE INSURANCE PROVISIONS [26.1-33-05, 18] All individual life insurance policies delivered or issued for delivery in North Dakota must include a(n):

- payment of premium provision stating that all premiums are payable in advance to an agent of the company or to the company directly;
- 31-day grace period for payment of any premium except the first, during which the death benefit coverage continues in force (but the late premium may be subject to an interest charge and/or the late premium be subtracted from a death claim);
- incontestability provision stating that the validity of the policy cannot be contested except for nonpayment of premiums after it has been in force for two years;
- entire contract provision stating that the policy constitutes the entire contract between both parties;
- misstatement of age provision stating that if the insured's age was understated, any amount payable under the policy will be determined according to how much coverage the premium paid would have purchased for the correct age;
- provision stating that all statements made by the insured (in the absence of fraud) are representations, not warranties, and that no such statement can void the policy unless it was made on the written application, which must be attached to the policy when issued;
- policy loan provision, except for term policies, stating that after the policy has been in effect for three years, the insurer may loan, with the policy pledged as security, an amount equal to the surrender value at the end of the current policy year (loans may be delayed by the insurer up to six months. Failure to repay any advance or to pay loan interest does not void the policy unless the total indebtedness equals or exceeds the loan value. Notice of such lapse must be mailed to the owner at their last known address);

- nonforfeiture provision that grants:
  - — paid-up nonforfeiture benefit on a plan stated in the policy, in the event of default, and upon the policyowner's request within 60 days of the default, and
  - — cash surrender value of a specified amount instead of any paid-up nonforfeiture benefit if a policy is surrendered within 60 days after a default and premiums have been paid for the last three years;
- death claims provision stating that settlement must be made within two months of receiving the legal proof of death and must include reasonable interest accrued from the date of death provided that the proof is filed within 180 days of the death;
- premium refund provision stating that, within 30 days of receiving notice of an insured's death, the insurer will refund the portion of premiums or fees paid beyond the month of death except for term insurance; and
- reinstatement provision stating that unless a policy has been surrendered, it can be reinstated at any time within three years from the date of premium default if the policyholder pays all premiums due with interest.

B. SUICIDE OF THE INSURED [26.1-33-37] An insurer cannot use a policyowner's suicide, if committed after the first policy year, as a defense against the payment of the policy. Furthermore, the policyowner's sanity or insanity is not a factor in determining whether the person committed suicide within the terms of the policy.

C. TRANSFER RIGHTS [26.1-33-33] A policy may be assigned to someone else, whether or not the assignee has an insurable interest in the insured, unless the policy provides otherwise. An insured under a group life insurance policy may make an assignment of all or any part of the incidents of ownership held by the insured under the policy, including any right to designate a beneficiary and any right to have an individual policy issued in case of termination of employment.

D. DIVIDENDS [26.1-33-05] All policies that participate in the company surplus must include a dividends provision, stating that beginning no later than the end of the third policy year the insurer will annually determine the portion of divisible surplus on the policy, which the policyholder can receive in cash. The policy can also offer the following options for dividend payment and must state which is the default option if the owner does not state a preference:

- Applied toward premiums
- Applied toward purchase of paid-up additions to the policy
- Payable with interest on policy maturity or anniversary

E. FREE LOOK [26.1-33-02.1] A person who purchases a life insurance policy can return the policy within 20 days of delivery and receive a refund of the premium. Every life insurance policy must have a notice printed on or attached to the first page of the policy stating that if within 20 days of policy delivery the applicant is dissatisfied for any reason, he may return the policy and have the premium refunded.

F. EXCLUSIONS [26.1-33-05(12)] Policies issued in North Dakota may contain provisions that exclude or restrict coverage in the event that death occurs from:

- a result of any action in the military service;

- aviation or any air travel or flight (restrictions effective for no more than two years after issue);
- hazardous occupation or avocation (restrictions effective for no more than two years after issue);
- residing outside the continental United States and Canada (restrictions effective for no more than two years after issue); and
- suicide within one year from the date of issue of the policy.

G. PROHIBITED PROVISIONS [26.1-33-06] Life insurance policies cannot be issued or delivered in North Dakota if they contain a provision:

- for forfeiture of the policy if any loan or interest on a loan is not paid (unless the provision stipulates that no forfeiture will occur until at least one month after notice has been mailed by the company);
- limiting the time for beginning any action to within five years after the basis for the claim arises;
- by which the policy is intended to be issued or take effect more than six months before the original application for the insurance was made (this does not prohibit the exchange, alteration, or conversion of any life insurance policy); and
- for any mode of settlement at maturity that is worth less than the amount insured on the face of the policy, plus dividend additions (if any), minus any indebtedness to the company on the policy and minus any premium that by the terms of the policy can be deducted.

H. INSURABLE INTERESTS [26.1-29-09.1]

1. According to North Dakota law, the sole object of insurance is to indemnify (i.e., restore) financial parties to the contract. In other words, insurance must be payable to the individual insured or that individual's personal representatives, or to a person having, at the time the contract was made, an insurable interest in the individual insured. Insurable interest must exist for life insurance at the time of application. For other insurances, the interest must exist when the loss occurs.

2. An individual of competent legal capacity may purchase an insurance contract upon his own life for the benefit of any person. However, no person can purchase insurance upon the life of another person unless the benefits under the insurance contract are payable to the individual insured (or personal representative) or to a person who had an insurable interest in the insured when the contract was made. The insured (or representative) may take legal action to recover benefits received by anyone who did not have an insurable interest at the time the contract was made.

3. The following people have insurable interests:

- Individuals related closely by blood or by law who are deemed to have a substantial interest engendered by love and affection
- Persons with a lawful and substantial economic interest in having the life, health, or bodily safety of the insured individual continue

- Individual parties to a contract for the purchase or sale of an interest in a business partnership or firm, in addition to any insurable interest that may otherwise exist on the life of the individual
- Religious, educational, or charitable organizations with lawful interest in the life of the individual (if the individual signs written consent to the insurance contract)

I. GROUP LIFE INSURANCE [26.1-33-11]

1. All group life insurance policies delivered in North Dakota (except policies issued to a creditor to insure debtors) must include a(n):

- grace period provision, stating that the policyholder is entitled to at least a 31-day grace period for payment of any premium except the first, during which the death benefit coverage continues in force;
- statement that the validity of the policy cannot be contested except for nonpayment of premiums after it has been in force for two years;
- statement that a copy of the application, if any, must be attached to the policy when issued and that all statements made by the policyholder or insured are representations and not warranties;
- statement of the conditions, if any, under which a person eligible for insurance is required to furnish evidence of individual insurability;
- description of the method of adjusting premiums and benefits if the insured's age was originally misstated;
- statement that any sum that comes due because of the insured's death is payable to the beneficiary designated (procedures are also stipulated should no beneficiary have been designated);
- statement that the insurer must issue a certificate to the policyholder for delivery to the insured stating the amount of insurance protection to which the insured is entitled;
- statement regarding the coverage of dependents; and
- equitable nonforfeiture provision to insureds and policyholders, except for term insurance (not necessarily the same as offered under individual policies).

2. Conversion [26.1-33-11; 12]

a. All group policies must contain a conversion provision stating that if the insured's coverage ceases because employment or membership in a class eligible for insurance is terminated, the former insured is entitled to have issued by the insurer, without evidence of insurability, an individual life insurance policy (without disability or other supplementary benefits), provided that an individual policy application is completed and the first premium is paid to the insurer no later than 31 days after the termination.

b. The individual policy must:

- at the option of the insured, be any one of the forms customarily issued by the insurer for that age and the amount (term insurance may be excluded);

- not exceed the amount of the previous life insurance minus the amount of any life insurance for which the person becomes eligible within 31 days after termination (not including the amount of insurance that matured as of the termination date as an endowment payable to the insured); and
- include the customary premium rate for other individual policies issued for the insured's class of risk and age.

c. The conversion privilege must be available to any:

- surviving dependents at the death of an employee or group member (if also covered under the group policy); or
- dependent of an employee or member who no longer qualifies as a family member under the group policy.

d. Group policies must contain a provision stating that if the group policy terminates the insurance of any class of insureds, anyone affected (including dependents who have been insured for at least five years by the date of termination) is entitled to have an individual policy issued by the insurer without evidence of insurability. This individual policy must not exceed the smaller of:

- the amount of life insurance protection ceasing because of the termination, minus the amount of any life insurance for which the insured becomes eligible under any group policy issued within 31 days after termination; or
- $10,000 for any individual policy.

e. If a person insured under the group life insurance policy dies during the period of eligibility for conversion and before the individual policy becomes effective, the amount of life insurance to which he would have been entitled is payable as a claim under the group policy, whether or not the person had submitted the individual application or paid the first premium.

f. If active employment is a condition for insurance, the policy must include a provision stating that the insured may continue coverage during total disability if the individual continues to pay the portion of the premium that would have been required in the absence of a total disability.

g. The continuation must be on a premium paying basis until the earlier of:

- six months from the date on which the total disability begins;
- approval by the insurer of continuation of the coverage under any disability provision contained in the group insurance policy; or
- discontinuance of the group insurance policy.

h. The settlement of a death claim must be made upon proof of death, or not later than two months after receipt of proof of death. Settlement must include reasonable interest from the date of death as long as a proof of death is filed within 180 days after the date of the death.

i. Individuals insured under group policies must be given notice of their right to a converted policy at least 15 days before the period for conversion is over. If not notified by this time, they must be granted an additional continuation period that expires 15 days after the individual is given notice.

J. MARKETING, SOLICITATION, AND DISCLOSURE OF LIFE INSURANCE [REGS. 45-04-01-01 TO 04]

1. Insurers and agents must provide all prospective life insurance buyers with information that will help them:

- select the most appropriate plan for their needs;
- evaluate relative costs of similar plans; and
- understand the basic policy under consideration.

2. The disclosure requirements apply to all sales of life insurance in North Dakota (including fraternal benefit societies) except:

- annuities;
- credit life insurance;
- group life insurance (except preneed funeral contracts);
- insurance policies issued in connection with pension welfare plans subject to the Federal Employee Retirement Income Securities Act of 1974 (ERISA); and
- variable life insurance under which the death benefits and cash values vary according to the investment experience of a separate account.

3. Insurers must provide all prospective buyers with a *Buyer's Guide* and *Policy Summary* before accepting the applicant's initial premium or deposit. Insureds who are given an unconditional refund provision of at least 10 days must receive the information no later than at policy delivery.

4. A *Buyer's Guide* must include information, in writing, that will help prospective life insurance purchasers:

- decide how much life insurance they should purchase;
- decide what kind of life insurance policy they need; and
- compare the cost of similar life insurance policies.

5. The *Buyer's Guide* must include sections regarding:

- buying life insurance;
- choosing the amount;
- choosing the right kind; and
- finding a low-cost policy.

6. A *Policy Summary* is a written statement describing various elements of the life insurance policy, including:

- the name and address of the agent;
- the name and home office address of the insurer;
- the generic name of the basic policy and each rider;
- the effective policy loan annual percentage interest rate (if included in the policy);

- cost comparison indexes and the equivalent level annual dividend (if a participating policy) for 10 and 20 years or the end of the premium paying period, if earlier; and
- the date on which the policy summary is prepared.

7. Policy summaries that include dividends must state that the dividends are based on the company's current dividend scale and are not guaranteed. Policy summaries must also list the:

- annual premium for the basic policy and each optional rider;
- guaranteed amount payable upon death at the beginning of the policy year;
- total guaranteed cash surrender values at the end of the year;
- cash dividends payable at the end of the year (not beyond the 20th policy year); and
- guaranteed endowment amounts payable under the policy (which are not included under guaranteed cash surrender values).

8. These values must be listed, when applicable, for:

- the first five policy years;
- representative policy years thereafter to illustrate the premium and benefit patterns; and
- at least one year in which the policyholder is between ages 60 and 65 (or policy maturity, whichever is earlier).

9. General solicitation rules [26.1-33-02; Regs. 45-04-01-05, 45-04-10-01 to 08]

a. Before beginning a life insurance sales presentation, agents must inform prospective purchasers that they are acting as agents for a particular insurance company. Terms such as *financial planner* and *investment advisor* cannot be used to imply that the agent is engaged in an advisory business in which compensation is unrelated to sales, unless that is true.

b. All references to policy dividends and cost indexes that reflect dividends must include a statement explaining that they are based on the company's current dividend or rate schedule and are not guaranteed.

c. Presentations that do not recognize the time value of money through the use of appropriate interest adjustments cannot be used for comparing the cost of two or more life insurance policies.

d. A presentation of benefits cannot display guaranteed and nonguaranteed benefits as a single sum, unless they are also shown separately.

e. Statements regarding the use of cost comparison indexes must explain that the indexes are only useful to compare the relative costs of two or more similar policies.

f. Insurers must maintain files of all documents used for solicitation for three years after the last authorized date of use.

g. Insurers are responsible for controlling the content, form, and method of disseminating advertisements for their policies.

h. Insurers must provide information to life insurance consumers that will help them choose the most appropriate life insurance policy for their needs, explain the terms of the policy they are considering, and help them evaluate the relative costs of similar policies.

K. ANNUITIES

1. Free look provision [26.1-34-01.1]

a. Any person purchasing an annuity policy or certificate may return the policy within 20 days of delivery. If the policy or certificate is returned, the purchaser is entitled to a refund of the premium, except in the sale of variable annuities in which the purchaser is entitled to the value of the annuity plus all expense charges.

b. Every annuity, policy, or certificate must have a notice prominently printed on or attached to its first page stating that the purchaser may return the policy or certificate within 20 days and have the premium (or such other amount in the case of a variable annuity) refunded if the applicant is unsatisfied for any reason.

2. Death claim settlement and interest [26.1-34-01(5)] When an annuity contract becomes a claim by reason of death, settlement:

- if payable in one sum, must be made upon due proof of death or not later than two months after receipt of the proof and must include reasonable interest accrued from the date of death; or
- if made under a settlement option other than that described above it, must include reasonable interest accrued from date of death until such option is made according to the provisions of the contract.

IV. STATE LAWS AND REGULATIONS PERTAINING TO ACCIDENT AND HEALTH INSURANCE

A. FORM OF POLICY [26.1-36-03] All accident and health insurance policies delivered in North Dakota must include:

- the entire money and other considerations for the policy;
- the time at which the insurance takes effect and terminates;
- a statement that the policy will only insure one person (and eligible family members, such as spouse and dependent children, upon application);
- exceptions and reductions of indemnity; and
- identification of each form (including riders and endorsements) by form number.

B. INDIVIDUAL HEALTH INSURANCE POLICIES [26.1-36-04(1)]

1. The following provisions must be included in all individual health insurance policies issued in North Dakota:

- Entire contract provision stating that the policy, including the endorsements and attached papers, constitutes the entire insurance contract
- Provision that no agent has the authority to change the policy or waive any of its provisions
- Incontestability provision stating that two years after the date of issue, no misstatements on the application can be used to void the policy or deny a claim (except fraudulent misstatements)
- Grace period provision granting the policyholder 31 days for payment of any premium due (except the first) during which the policy continues in force
- Reinstatement provision stating the conditions under which any lapsed policy may be put back in force
  - For example, an application may or may not be required, and accidents may be covered after a reinstatement 45 days from conditional receipt, but sickness or illness claims following reinstatement require an additional 10 days
- Provision stating that written notice of claim must be given to the insurer within 20 days after the beginning of any loss covered by the policy
- Provision stating that the insurer must provide the person making the claim with proof of loss forms no later than 15 days after the insurer receives notice of any claim under the policy
- Provision stating that written proof of loss forms for disability claims must be furnished to the insurer within 90 days after commencement of the period for which the insurer is liable
- Time payment of claims provision stating that all benefits payable for any loss (other than benefits for loss of time) in an individual policy must be paid monthly and "timely" after the insurer receives proof of loss
- Provision stating that benefits for the insured's loss of life will be payable according to the beneficiary designation
- Physical examination or autopsy provision stating that the insurer has a right to a physical examination or autopsy of the insured while a claim is pending (if the autopsy is not forbidden by law)
- Provision listing the conditions under which benefits cannot be denied for health care services performed by a registered nurse
- Legal actions provision stating that any legal actions to recover on a policy must begin between 60 days and three years after written proof of loss is provided
- Refund of premiums provision stating that, within 30 days after receiving notice of the insured's death, the insurer must refund the portion of the premium, fees, or other sum paid beyond the month of death (after deducting any claim for losses during the current term of the policy)

2. **Preexisting condition exclusion [26.1-36-04(1)(d)]** An insurer may impose a preexisting condition exclusion on individuals only if:
   - the exclusion relates to a condition, regardless of the cause of the condition, for which medical diagnosis, care, or treatment was recommended or received within the two-year period ending on the effective date of the person's coverage; and
   - the exclusion extends for a period of not more than two years after the effective date of coverage.

3. **Free look [26.1-36-02.1]** Accident and health policies and certificates must have a notice prominently printed on or attached to the first page of the policy or certificate stating in substance that the applicant may return the policy or certificate within 10 days of its delivery and have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

4. **Optional provisions [26.1-36-04(2)]** An insurer may include any of the following provisions provided that they are at least as favorable to the insured and beneficiary as stated below:
   - **Change of occupation** provision stating that if the insured changes to a more hazardous occupation than the one listed in the policy, the insurer will only pay benefits that the premium would have purchased for the more hazardous job; if the insured changes to a less hazardous job, the insurer must reduce the premium accordingly and return any excess premium paid
   - **Misstatement of age** provision stating that if the insured's age has been misstated, he will receive the benefits that the premium paid would have purchased at the correct age
   - **Overinsurance** provision stating that if more than one accident and health policy is issued to the insured by the same insurer and the total indemnity for the two policies exceeds the maximum limit of indemnity allowable, then the excess insurance is void and all premiums paid for the excess will be returned to the insured (or insurers may include a provision stating that an individual may only have one effective policy with that insurer at one time)
   - **Unpaid premium** provision stating that when a claim is paid, any premium due and unpaid may be deducted from the claim payment
   - **Cancellation** provision allowing the insurer to cancel the policy at any time by giving the insured five days' written notice (any unearned premium must be returned to the insured)
   - Provision that the policy must be in conformity with state laws and, if it is not, the policy will be amended to conform to the minimum requirements of the laws of the insured's state of residence
   - Provision stating that the company is not liable for losses resulting from the insured's committing a felony or engaging in an illegal occupation
   - Provision that the insurer is not liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician

C. GROUP HEALTH INSURANCE POLICIES [26.1-36.4-03 AND 04, 26.1-36-05]

1. The following provisions must be included in all group accident and sickness insurance policies in North Dakota:

- 31-day **grace period** for the payment of any premium due except the first
- **Incontestability** provision that the insurer may not contest the validity of a policy after two years from its issue date, except for nonpayment of premiums
- **Entire contract** provision that a copy of the application must be attached to the policy when issued
- Provision that statements made by the policyholder are representations, not warranties, and no statement by any person will be used to contest coverage unless that person or his beneficiary receives a copy of the statement
- **Evidence of individual insurability** provision that outlines the conditions under which the insurer may require evidence of individual insurability as a condition of an eligible person's coverage
- **Misstatement of age** provision that the insurer must make an equitable adjustment of the premium or benefits payable if the insured's age is misstated
- **Certificate of coverage** provision that each person insured must receive a certificate from the policyholder or contract holder setting forth the conditions and benefits of insurance and a statement about coverage for family members or dependents
- **Notice of claim** provision that written notice of claim must be given to the insurer within 20 days after the beginning of any loss covered by the policy, or as soon thereafter as possible
- **Exclusion** provision (unless a late enrollee to the group) that any exclusion or limitation of coverage may only apply to a condition for which medical advice or treatment was received during the 6 months prior to the effective date of coverage (the exclusion or limitation may not apply 12 months after the effective date of coverage)
- **Claim form** provision that the insurer must provide claim forms to the insured within 15 days of receiving notice of claim. Failure to do so means the insured may meet the time requirement for submitting proof of loss by submitting a written statement to the insurer verifying the loss
- **Proof of loss** provision that written proof of loss must be given to the insurer within 90 days of the loss or as soon as reasonably possible (in no event, other than for lack of legal capacity, can proof of loss be submitted after one year)
- **Time limit of benefit payments** provision that claims must be paid within 60 days of receipt of written proof of loss, unless the claim is for a periodic payment, in which case it must be paid no less frequently than monthly
- **Facility of payment** provision that allows an insurer to pay a specified amount of benefits or proceeds to any relative appearing entitled to it if there is no beneficiary or if the insured or beneficiary is a minor or legally incompetent
- Provision that the insurer, at its own expense, may examine an insured as often as reasonably necessary while a claim is pending and may have an autopsy performed on a deceased insured, unless prohibited by law

- Provision that no legal action may be brought to recover on a policy before 60 days and no more than three years after proof of loss is submitted
- Provision stating that the company is not liable for losses resulting from the insured committing a felony or engaging in an illegal occupation

2. Prescription drugs and chiropractic care [26.1-36-06] No insurance company may issue a group health insurance policy unless it makes available, at the option of the policyholder, the following coverages (for which an additional premium may be charged):

- All drugs and medicines prescribed by the provider of health services
- Services rendered and care administered by licensed chiropractors

3. Coverage for substance abuse and mental disorders [26.1-36-08, 09]

a. All individual and group health insurance policies must offer benefits for the diagnosis, evaluation, and treatment of alcoholism, drug addiction, or other related illnesses on the same basis as benefits for any other illnesses (to a specified maximum).

b. All group health insurance policies delivered in North Dakota must provide benefits of the same type offered under the policy or contract for other illnesses for health services to any person covered under the policy for the diagnosis, evaluation, and treatment of mental disorders and other related illnesses.

c. Coverage must be provided for inpatient treatment, partial hospitalization treatment, and outpatient treatment for the following amounts of time in any one calendar year:

- At least 60 days of benefits for covered inpatient treatment
- At least 120 days of covered services for partial hospitalization (continuous treatment for between 3 and 12 hours in any 24-hour period)
- At least 20 outpatient visits for covered services (a minimum of 30 hours of treatment services for mental disorders)

d. The insurer may offer an approved combination of inpatient treatment and partial hospitalization. These totals apply separately for substance abuse and partial hospitalization. Each day of inpatient treatment is equivalent to two days of treatment by partial hospitalization, provided that no more than 46 days of the inpatient treatment benefits required by this section may be traded for treatment by partial hospitalization.

e. The insurer cannot establish a deductible or co-payment for the first five visits in a calendar year and cannot establish a co-payment greater than 20% for the remaining visits.

4. Coverage of newborn and adopted children [26.1-36-07]

a. All individual and group health insurance policies that provide coverage for children of the insured must provide newborn children, from the moment of birth

(and adopted children from the moment of placement), with the same health insurance benefits that apply to any other children. Injury and sickness benefits must include the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

b. If a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that the insurer be notified of the child's birth and paid any required fee within 31 days of the date of birth for coverage to continue beyond that 31-day period.

5. Dependent coverage [26.1-36-22]

a. A group health insurance policy may be extended to the family members or dependents of employees or members, subject to the following.

1.) The premium must be paid either from funds contributed by the employer or other person to whom the policy has been issued, funds contributed by the covered persons, or both. If no part of the premium for family members or dependents is from funds contributed by the covered persons, then the eligible family members or dependents of all employees, or class of employees, must be covered.

2.) An insurer may exclude or limit the coverage on any family member or dependent who does not provide satisfactory evidence of individual insurability.

b. Policies that provide coverage for a dependent child of the insured must provide that coverage until the child reaches a limiting age of 22 years, provided the dependent child physically resides with the employee and is chiefly dependent upon the employee for support.

c. However, coverage will not be terminated for a dependent child at the limiting age in the following circumstances.

1.) The child is a full-time student (in which case, coverage may continue until age 26).

2.) The child is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and is chiefly dependent upon the employee for support and maintenance (proof of incapacity must be furnished to the insurer by the employee within 31 days after the child reaches the limiting age and thereafter whenever required by the insurer, but not more frequently than annually after the two-year period following the child's attaining the limiting age).

6. Portability of coverage [26.1-36.4-04 and 05] Coverage for a particular service is to be provided by a policy that follows another policy with all of the following conditions.

a. The previous policy must satisfy the definition of qualifying previous coverage.

b. Any waiting period enforced by the employer is subtracted from the total period between coverages in determination of the 90-day limit.

c. A new preexisting condition provision may be applied to any service in the new policy that was not covered in the previous policy.

d. The preexisting condition provision in the new policy is cancelled for a period of time that equals the period of coverage from the previous coverage.

7. Health Insurance Portability and Accountability Act (HIPAA) [26.1-36.3-05 and 06; 26.1-36.4-04 and 05]

a. An insurer offering group health insurance coverage in connection with a group health benefit plan may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan based on a health status-related factor.

b. An insurer offering group health insurance coverage in connection with a group health benefit plan is required to permit employees and dependents described in this section to enroll for coverage under the terms of the plan if:

- when the employee declined enrollment for the employee or the dependent, the employee stated in writing that coverage under another group health benefit plan or other health insurance coverage was the reason for declining enrollment (or an exception applies); and
- the enrollment is requested not later than 30 days after the exhaustion of the other coverage or termination of other coverage has resulted in the loss of eligibility for the other coverage.

c. Preexisting condition exclusions An insurer may exclude a preexisting condition if medical diagnosis, care, or treatment was recommended or received within six months before the effective date of coverage, and the exclusion extends for no more than 12 months after the effective date of coverage. A group policy may impose an 18-month preexisting condition exclusion for a late enrollee.

- A group policy may not exclude a preexisting condition that relates to pregnancy or treats genetic information as a preexisting condition without diagnosis of a condition related to that information.

d. Portability of coverage; creditable coverage [26.1-36.4-04] An insurer must reduce any time period that applies to a preexisting condition for a policy by the total time during which the person was covered by qualifying previous coverage, if the previous coverage was continuous until at least 63 days before the effective date of the new coverage.

e. Renewability or cancellation [26.1-36.4-04-05] An insurer must allow for the renewability or continuation of coverage unless:

- the insured or group fails to pay premiums or contributions or pays them late;

- the insured or group committed a fraudulent act or misrepresented a material fact relating to the coverage;
- the group fails to comply with the insurer's minimum group participation or contribution requirements; or
- the insurer discontinues a particular type of health insurance coverage in the group or individual market or discontinues all health insurance coverage issued to employers or individuals in North Dakota.

f. Notice of these rights must be provided.

g. Renewability of small employer health plan coverage [26.1-36.3-05] A small employer health benefit plan must be renewable for all eligible employees and dependents, except when:

- the plan sponsor failed to pay premiums or the insurer did not receive timely premium payments;
- the plan sponsor or small employer performed a fraudulent act or made an intentional misrepresentation of a material fact under the terms of the coverage;
- noncompliance occurred with the insurer's minimum participation requirements;
- noncompliance occurred with the insurer's employer contribution requirements;
- the insurer decided to discontinue a type of group health benefit plan in the small employer market, in which case the insurer must notify the Commissioner, the plan participants, and their beneficiaries and dependents at least 90 days prior to the nonrenewal and offer to the plan sponsor the option to purchase other health benefit plans; and
- the Commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders or would impair the insurer's ability to meet its contractual obligations, in which case the Commissioner will help affected employers find replacement coverage.

8. Coordination of benefits [26.1-36-10; Reg. 45-08-01.2]

a. A coordination of benefits provision helps avoid delays in claims payment and duplication of benefits when a person is covered by two or more insurance plans providing benefits or services for medical, dental, or other care or treatment.

b. A coordination of benefits provision establishes the order in which plans pay their claims and provides the authority for the orderly transfer of information needed to pay claims promptly. Duplication of benefits is avoided by permitting a reduction of the benefits of a plan when it does not have to pay its benefits first.

c. Primary plans must provide benefits as if a second plan did not exist. Secondary plan benefits are determined after the primary plans'. Nothing provided in the secondary plan affects the liability of the primary plan.

9. Continuation privilege for the employee [26.1-36-23] Group health plans in North Dakota must provide that employees or members whose insurance under the group policy would otherwise terminate because of termination of employment or membership are entitled to continue their hospital, surgical, and major medical insurance under that group policy, for themselves and their eligible dependents, subject to the following conditions.

- Continuation is only available to an employee or member who has been continuously insured under the group policy during the entire three-month period ending with the termination.
- Continuation is not available for those covered by Medicare.
- Continuation need not include dental, vision care, or prescription drug benefits.
- To continue coverage, the insured must request it in writing between 10 and 31 days following the later of the date of termination or the day the employee is given notice of the right.
- An employee or member electing continuation shall pay the employer, on a monthly basis in advance, but not more than the group rate for the insurance being continued.
- Continuation of insurance under the group policy for any person terminates when the person fails to pay or 39 weeks after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or membership.
- Coverage under continuation rules could also cease if the group policy is terminated or, in the case of an employee, the date the employer terminates participation under the group policy.

10. Continuation privilege for spouses and children [26.1-36-23.1]

a. Group health insurance policies delivered in North Dakota that extend coverage to the insured's spouse cannot contain a provision for termination of the spouse's coverage, except by decree of divorce or annulment.

b. Every group health insurance policy must contain a provision that permits continuation of coverage of the insured's former spouse and dependent children upon entry of a decree of annulment of marriage or divorce, if the decree requires the insured to provide continued coverage for those persons. The coverage may be continued until the date of remarriage of the insured's former spouse or the date coverage would otherwise terminate, whichever occurs first, but not to exceed 36 months. The insured must pay any required premium contributions for the coverage, not to exceed 102% of the premium for the group coverage.

c. Every group health insurance policy must contain a provision allowing a former spouse and dependent children, without providing evidence of insurability, to obtain from the insurer at the expiration of any continuation of coverage or upon termination of coverage by reason of annulment or divorce that does not require the insured to provide continued coverage for the former spouse and dependent children conversion coverage providing comparable benefits of the group policy or contract. An application must be made to the insurer within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate premium.

d. A policy providing reduced benefits at a reduced premium rate may be accepted by the former spouse and dependent children in lieu of the existing coverage. The policy, contract, or evidence of coverage must be renewable at the option of the former spouse provided that the former spouse is not covered under another accident and health insurance plan, policy, or contract, up to age 65 or to the day before the date of eligibility for coverage under Medicare.

D. LONG-TERM CARE POLICIES AND REGULATIONS [26.1-45-01, 05, 05.2; REG. 45-06-05.1]

1. **Long-term care insurance** is any policy or rider designed to provide coverage for at least one year for each covered person on an expense-incurred, indemnity, prepaid, or other basis. Coverage must include one or more diagnostic, preventive, therapeutic, rehabilitative, or personal care service provided in a setting other than the acute care unit of a hospital.

2. Long-term care insurance does not include policies offered primarily to provide basic Medicare supplement, basic hospital expense, basic medical-surgical, hospital confinement indemnity, major medical expense, disability income protection, accident only, specified accident, or limited benefit health coverages.

3. Long-term care insurance policies cannot:

- be cancelled, nonrenewed, or terminated on the grounds of the insured's age or the deterioration of his mental or physical health;
- contain a provision establishing a new waiting period in the event that existing coverage is converted to or replaced by a new policy within the same company, unless the insured individual or group policyholder voluntarily selects to increase benefits; or
- provide coverage only for skilled nursing care or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

4. Long-term care policies cannot contain renewal provisions that are less favorable than guaranteed renewable for life. For guaranteed renewable policies, the insured has the right to continue the policy by timely payment of premiums. The insurer has no unilateral right to change the policy provisions while the policy is in force and cannot refuse to renew a policy. Rates can be revised by the insurer on a class basis.

5. **Limitations and exclusions** Long-term care insurance policies may not limit or exclude coverage by type of illness, treatment, medical condition, or accident, except for:

- preexisting conditions or diseases;
- mental or nervous disorders (however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease);
- alcoholism and drug addiction;
- illness, treatment, or medical condition arising out of
  - war or act of war (whether declared or undeclared),
  - participation in a felony, riot, or insurrection,

  - — service in the armed forces or units auxiliary thereto,
  - — suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury, or
  - — aviation (this exclusion applies only to non-fare-paying passengers);
- treatment provided in a government facility unless otherwise required by law;
- treatment provided under any state or federal law pertaining to
  - — workers' compensation,
  - — employer's liability or occupational disease, or
  - — no-fault motor vehicle benefits,
- services for which benefits are available under Medicare or other governmental program except Medicaid;
- services provided by a member of the covered person's immediate family;
- services for which no charge is normally made in the absence of insurance;
- expenses for services or items available or paid under another long-term care insurance or health insurance policy;
- in the case of a qualified long-term care insurance contract, expenses that are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount; and
- exclusions and limitations by type of provider or territorial limitations.

6. Incontestability and rescission [26.1-45-05.1]

a. If a long-term care insurance policy has been in effect for less than six months, it may not be rescinded nor may a valid claim be denied unless the insurer can show misrepresentation that is material to the acceptance of coverage.

b. If a policy has been in effect for at least six months but less than two years, the insurer must show misrepresentation that is both material to the acceptance of coverage and pertinent to the condition for which benefits are sought.

c. If a policy has been in force for at least two years, the policy may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts about the insured's health. Misrepresentation alone is not sufficient to contest the policy.

7. Inflation protection [Reg. 45-06-05-05.1-11]

a. Insurers must offer each policyholder the option to purchase inflation protection no less favorable than one of the following:

- Benefit levels increase annually at a compounded rate of not less than 5%
- The insured is guaranteed the right to increase benefit levels periodically without providing evidence of insurability or health status provided that the option for the previous period has not been declined
- A specified percentage of actual or reasonable charges is allowed and does not include a maximum indemnity amount

b. If the policy is issued to a group, the inflation protection must be made to the group policyholder.

c. Insurers must include the following about inflation protection with the outline of coverage:

- A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not (the graphic comparison must show benefit levels for at least 20 years)
- Any expected premium increases or additional premiums to pay for automatic or optional benefit increases

d. Inflation protection will be included unless an insurer obtains a rejection signed by the policyholder either in the application or on a separate form. The rejection is considered part of the application and will state:

> I have reviewed the outline of coverage and graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____ , and I reject inflation protection.

8. Contingent nonforfeiture provision [26.1-45-14; Reg. 45-06-05.1-24] Any policy or certificate offered with nonforfeiture benefits must have eligibility provisions, benefit triggers, and benefit periods that are the same as coverage issued without nonforfeiture benefits.

a. Nonforfeiture benefits, available by at least the third policy year, constitute at least:

- reduced paid-up insurance;
- extended term insurance;
- shortened benefit period; or
- any other similar offerings approved by the Commissioner.

b. If the insured rejects the offer of nonforfeiture benefits, the insurer will provide a contingent benefit upon lapse.

9. Preexisting conditions [26.1-45-05.2, 06] Long-term care insurance policies cannot use a definition of preexisting condition that is more restrictive than "a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six months before the effective date of an insured's coverage."

10. Right to return (free look) [26.1-45-09] All individual long-term care insurance policyholders must have the right to return their policies within 30 days of delivery and have the premiums refunded if, after examination of the policy, they are not satisfied for any reason.

11. Outline of coverage [26.1-45-09; Reg. 45-06-05.1-27] All applicants for long-term care insurance must receive an outline of coverage at the time the policy is initially solicited. The outline of coverage must follow a specific format and include a:

- description of the policy's principal benefits and coverage;
- statement of the policy's principal exclusions, reductions, and limitations;
- statement of the terms under which the policy can be continued in force or discontinued (including any reservation in the policy of a right to change premiums);
- description of continuation or conversion provisions for group coverage (if applicable);
- statement that the outline of coverage is a summary only, not an insurance contract, and that the policy itself should be consulted to determine the governing contractual provisions;
- description of the terms under which the policy or certificate can be returned and the premium refunded;
- brief description of the relationship between the cost of care and benefits; and
- statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract.

12. Advertising [Reg. 45-06-04-01]

a. False, deceptive, or misleading advertising is prohibited.

b. An insurer, health care service plan, or other entity providing long-term care insurance or benefits must provide a copy of any advertisement whether print, radio, or television to the Commissioner for review and approval. All advertisements must be retained by the insurer for at least three years from the date the advertisement was first used.

13. Standards for marketing [Reg. 45-06-05.1-21]

a. Every insurer, health care service plan, or other entity marketing long-term care insurance must:

- establish marketing procedures to assure that any comparison of policies by its agents or producers will be fair and accurate;
- establish marketing procedures to assure that excessive insurance is not sold;
- display prominently on the first page of the outline of coverage and policy the following: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.";
- make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and, if so, the types and amounts; and
- establish auditable procedures for verifying compliance with this regulation.

b. In addition, the following acts and practices are prohibited.

1.) **Twisting** is knowingly making any misleading representation or fraudulent comparison of insurance policies for the purpose of inducing a person to

lapse, forfeit, surrender, or convert an insurance policy or to take out an insurance policy with another insurer.

2.) **High-pressure tactics** include inducing the purchase of insurance through force, fright, threat, or undue pressure.

3.) **Cold lead advertising** is using any method of marketing that fails to disclose in a conspicuous manner that its purpose is the solicitation of insurance and that contact will be made by an insurance agent or insurance company.

14. Required disclosures [Reg. 45-06-05.1-06] An individual long-term care insurance policy must provide the following.

a. The policy is guaranteed renewable or noncancelable. The provision must also note that premium rates may change upon renewal.

b. The insured is required to give written consent to any rider or endorsement that the insurer adds to a policy after it is issued when the rider or endorsement reduces or eliminates benefits or coverage.

c. If a policy pays benefits based on standards described as "usual and customary," "reasonable and customary," or similar terms, it must explain the terms in the outline of coverage.

d. If a policy contains limitations for preexisting conditions, the limitations must be specified in a separate section of the policy and be labeled as such.

e. If a policy contains limitations or conditions for eligibility, they must be specified in a separate section of the policy and be labeled as such.

f. If a life insurance policy provides an accelerated benefit for long-term care, the policy is required to state that receipt of these accelerated benefits may be taxable, and that the insured should seek assistance from a personal tax advisor. (This does not apply to qualified long-term care insurance policies.)

g. Activities of daily living (ADLs) and cognitive impairment are to be used to measure an insured's need for long-term care. They are to be described in the policy and clearly labeled.

h. A qualified long-term care policy must disclose that it is intended to be a qualified LTC insurance policy. Similarly, a nonqualified long-term care policy must disclose that it is not intended to be a qualified LTC insurance policy.

15. Replacement [Reg. 45-06-05.1-12, 23]

a. Long-term care insurance application forms must include questions designed to find out whether the applicant has another long-term care insurance policy or certificate in force or whether the insurance being applied for is intended to replace a long-term care policy presently in force.

b. If an insurance sale will involve replacement, an insurer or its agent will give the applicant a Notice Regarding Replacement of long-term care coverage. The notice must be signed by the applicant and the agent, and both the applicant and the insurer must keep copies of it.

c. If a long-term care insurance policy replaces another, the replacing insurer must waive any time periods in the new long-term care policy, providing similar benefits to the extent that similar exclusions have been satisfied under the original policy.

16. Shopper's guide [Reg. 45-06-05.1-28]

a. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners or a guide developed or approved by the Commissioner must be provided to all prospective applicants of long-term care insurance.

b. In the case of agent solicitations, an agent must deliver the shopper's guide before presenting an application or enrollment form.

c. If part of a direct mail solicitation, the shopper's guide must be presented along with any application or enrollment form.

d. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the guide but instead will furnish the *Policy Summary*.

17. Suitability—appropriateness of recommended purchase [Reg. 45-06-05.1-22]

In recommending the purchase or replacement of any long-term care insurance policy or certificate, an agent must make reasonable efforts to determine the appropriateness of a recommended purchase or replacement. This includes completion of the Long-term Care Insurance Personal Worksheet at or before taking the application.

In addition to producer training and supervision systems, the insurer must track and report the number of applicants, applicants who decline to provide personal details, and the number of applicants found to be unsuitable for a long-term care purchase.

18. Policy Summary [26.1-45-09] A *Policy Summary* must be delivered with all individual life insurance policies and riders that provide long-term care benefits. The policy summary must include:

- an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);
- an illustration for each covered person of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits, if any;
- a statement as to whether a long-term care inflation protection option is available under the policy;

- any exclusions, reductions, and limitations on long-term care benefits; and
- a disclosure of the effects of exercising other rights under the policy, the guarantees related to long-term care costs of insurance charges, and the current and projected maximum lifetime benefits (if applicable to the policy type).

19. Antilapse protection [Reg. 45-06-05.1-05]

a. Long-term care insurers must offer policyholders the opportunity to designate an individual who can be contacted in the event the policy is about to lapse. If the policyholder does not wish to take advantage of this provision, the insurer must obtain a written waiver. If the policy lapses due to nonpayment of premium by a policyholder with a cognitive impairment, the insured has five months to request reinstatement.

b. The insurer must notify the insured of the right to change the designated person at least once every two years.

c. The insurer, at least 30 days before the effective date of the lapse or termination, must mail notice to the insured and the persons designated. Notice of lapse may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

20. Home health care benefits [Reg. 45-06-05.1-10]

a. If a long-term care insurance policy provides benefits for home health care or community care services, it may not limit or exclude benefits by:

- requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided by the policy;
- requiring that the insured or claimant first or simultaneously receive nursing services, therapeutic services, or both in a home, community, or institutional setting before home health care services are covered;
- limiting eligible services to services provided by registered nurses or licensed practical nurses;
- requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of his licensure or certification;
- requiring that the insured or claimant have an acute condition before home health care services are covered;
- limiting benefits to services provided by Medicare-certified agencies or providers;
- excluding coverage for personal care services provided by a home health aide;
- requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service; or
- excluding coverage for adult day care services.

b. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

c. A long-term care insurance policy, if it provides for home health or community care services, must provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement does not apply to policies issued to residents of continuing care retirement communities.

21. Qualified long-term care policies [26.1.45-01-06]

a. A **qualified long-term care insurance contract**, or federally tax-qualified long-term care insurance contract, is an individual or group insurance contract that:

- provides coverage only for long-term services;
- does not duplicate the coverage offered by Medicare or Medicaid;
- is guaranteed renewable;
- does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed, with certain exceptions; and
- applies premium refunds and policyowner dividends to reductions in future premiums or to increase future benefits.

b. [Reg. 45-06-05.1-26] Additional standards for qualified long-term care policies are as follows.

1.) A "chronically ill" individual is defined as being unable to perform, without substantial assistance, at least two activities of daily living for at least 90 days due to a loss of functional capacity or needing substantial supervision to protect the individual from harm due to severe cognitive impairment.

2.) To be considered chronically ill, a person's condition must be certified as such by a health care professional within the preceding 12-month period.

3.) Qualified long-term care services include necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation, and rehabilitative services, as well as personal care services required by a chronically ill person, provided under a plan of care prescribed by a health care professional.

4.) Benefits are paid when a person is expected to be unable to perform activities of daily living for at least 90 days due to a loss of functional capacity. Benefits can also be paid for protection from threats to health and safety due to severe cognitive impairment.

E. MEDICARE SUPPLEMENT INSURANCE

1. Medicare supplement insurance is regulated to:

- provide for reasonable standardization of coverage and simplification of terms and benefits;
- help the public understand and compare policies;
- eliminate misleading or confusing provisions; and
- provide full disclosure in the sale of such coverages.

2. These rules apply to all Medicare supplement policies delivered in North Dakota. They do not apply to policies or contracts of one or more employers, labor organizations, or trustees of a fund established by one or more employers or labor organizations, or a combination, for employees or former members.

3. Medicare Advantage [Regs. 45-06-01.1-02, (13)] A Medicare Advantage plan is a health plan offered under Part C of Medicare. Such plans may be:

- coordinated care plans, including health maintenance organizations, with or without a point-of-service option, provider-sponsored organizations, and preferred provider organizations;
- Medical Savings Accounts coupled with a contribution into a Medicare Advantage Medical Savings Account; and
- Medicare Advantage private fee-for-service plans.

4. Preexisting conditions [Reg. 45-06-01.1-06] Medicare supplement policies or certificates cannot exclude or limit benefits for losses that occur more than six months from the effective date of coverage because the losses involved a preexisting condition. The policy cannot define preexisting condition more restrictively than "a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage."

5. Policy requirements All Medicare supplement insurance policies delivered in North Dakota must adhere to the following requirements.

a. Policies cannot contain limitations or exclusions on coverage that are more restrictive than those required by Medicare (except for permitted preexisting condition clauses).

b. Policies cannot use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

c. Policies cannot duplicate benefits provided by Medicare, including outpatient prescription drug benefits under Part D of Medicare.

6. Outline of coverage [26.1-36.1-05; Reg. 45-06-01.1-14(4)]

a. All Medicare supplement policies or certificates delivered in North Dakota must provide an outline of coverage to the applicant at the time the application is presented to the applicant. The outline of coverage must include:

- a description of the principal benefits and coverage provided in the policy;
- charts displaying features of each benefit plan offered by the insurer;
- information regarding replacement of policies;
- a statement that the applicant has the right to return the policy within 30 days of delivery and have all premiums refunded if not satisfied for any reason (free look);
- a statement of the policy's exceptions, reductions, and limitations;
- a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and
- a statement that the outline of coverage is a summary only and that the policy should be consulted to determine the governing contractual provisions.

b. If the issued policy is different from the one for which an outline of coverage was presented at time of application, a notice in 12-point type must warn the individual of that fact and urge him to read the new outline of coverage.

7. General minimum standards [Regs. 45-06-01.1-06.1] To be advertised or issued for delivery in North Dakota as a Medicare supplement policy, a policy:

- cannot indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;
- must provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and co-payment percentage factors (premiums can also be modified to correspond with the changes);
- cannot terminate coverage of a spouse solely due to the occurrence of an event specified for termination of coverage for an insured (other than for nonpayment of premium);
- cannot be cancelled or refused renewal by the insurer solely on the grounds of the insured's health status; and
- must be guaranteed renewable (the issuer cannot cancel or nonrenew the policy except for nonpayment of premiums or misrepresentation).

8. Conversion and replacement [Regs. 45-06-01.1-06; 15]

a. If a Medicare supplement insurance policy is terminated by the group policyholder and not replaced, the insurer must offer each certificate holder an individual Medicare supplement policy. The issuer must offer the certificate holder at least the following choices of policies:

- One that continues the benefits contained in the group policy
- One that provides the minimum benefits required by law

b. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the insurer that provides the new policy must offer coverage to all persons who were covered under the former group policy when it was terminated. Coverage under the new group policy cannot result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

9. Minimum benefit standards (core benefits) [Regs. 45-06-01.1-06.1]
Medicare supplement policies must offer the following minimum benefits:

- Coverage of Part A Medicare-eligible expenses for hospitalization not covered by Medicare from the 61st through the 90th day in any Medicare benefit period
- Coverage of Part A Medicare-eligible expenses for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used
- Upon exhaustion of the Medicare hospital inpatient coverage (including the lifetime reserve days), coverage of the Part A Medicare-eligible expenses for hospitalization, subject to a lifetime maximum benefit of an additional 365 days
- Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells), unless replaced in accordance with federal regulations
- Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Medicare Part B regardless of hospital confinement, subject to the Medicare Part B deductible
- Coverage of cost-sharing for all Part A Medicare eligible hospice care and respite care expenses

10. Standardized Medicare supplement plans [Regs. 45-06-01.1-07.1] In June 2010, standard plans were revamped. Some plans were eliminated. Outpatient drug benefits are no longer part of Medicare supplement insurance plans unless the senior has continually renewed a previous plan. Plan differences are summarized in the federal guide "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

a. Each Medicare supplement plan must include the core benefits, plus other benefits specified by the Commissioner, such as:

- additional Medicare deductibles;
- at-home recovery benefits;
- skilled nursing home care; and
- preventive care.

b. All insurers must offer at least a Medicare supplement policy that provides the core benefits (called Plan A).

11. Open enrollment, guaranteed issue [Regs. 45-06-01.1-09, 09.1]

a. Insurers cannot deny or discriminate in pricing or condition issuance of any Medicare supplement policy because of the health status, claims experience, or

medical condition of the applicant if the application is submitted during a six-month period beginning with the first months in which all individuals (age 65 and older) first enrolled for benefits under Medicare Plan B. All Medicare supplement policies currently available from an insurer must be made available to all applicants who qualify.

b. These provisions do not prevent the exclusion of benefits under a policy during the first six months based on a preexisting condition for which treatment or diagnosis was provided or recommended during six months before the policy became effective.

c. Persons who lose their other health coverage are eligible for guaranteed issue for 63 days following their loss of coverage. Persons must be notified of their guaranteed issue rights at the time they receive notice that their coverage is terminating, or within 10 days after the plan learns of the individual's disenrollment.

12. Permitted compensation arrangements [Regs. 45-06-01.1-13]

a. An insurer may provide level commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy for the year of issue and at least five renewal years.

b. In the case where an existing policy is replaced, the insurer cannot give agents compensation that is greater than the compensation that would be paid by the insurer on policies or certificates that are being replaced. In other words, the commission is equivalent to a renewal commission so there is not incentive to replace unnecessarily.

13. Required disclosure provisions [Regs. 45-06-01.1-14]

a. All Medicare supplement policies must include a renewal or continuation provision.

b. Except for riders or endorsements requested by the insured or those required to avoid duplication of Medicare benefits, all riders and endorsements added to a Medicare supplement policy after the policy is issued that reduce or eliminate benefits must require a signed acceptance by the insured.

c. Medicare supplement policies may not condition the payment of benefits based on standards described as usual and customary or similar words.

d. Any limitations regarding preexisting conditions must appear as a separate paragraph of the policy, labeled as preexisting condition limitations.

e. Medicare supplement policies must include a notice stating that policyholders have a right to return the policy within 30 days of its delivery and have the premiums refunded if, after examining the policy, they are not satisfied for any reason.

f. Issuers of accident and sickness policies that provide hospital or medical expense coverage to people eligible for Medicare by reason of age must provide those applicants with an approved Medicare supplement *Buyer's Guide* in a minimum 12-point font. Except for direct response insurers, the *Buyer's Guide* must be delivered to the applicant at the time of application.

g. As soon as possible, but no later than 30 days before the annual effective date of any Medicare benefit changes, issuers must notify policyholders of modifications made to Medicare supplement insurance policies.

14. Advertising requirements [26.1-36.1-07; Regs. 45-06-01.1-16]

Every insurer, health services plan, or other entity providing Medicare supplement benefits in North Dakota must provide a copy of any advertisement intended for use in North Dakota, whether print, radio, or television, to the Commissioner for review. Due date is 10 days after its first use. The advertisement must comply with all applicable North Dakota laws.

15. Standards for marketing [26.1-36.1-06; Regs. 45-02-02-14, 45-06-01.1-17, 18]

a. An issuer must:

- establish marketing procedures to make sure that any comparison of policies by their producers will be fair and accurate;
- establish marketing procedures to make sure excessive insurance is not sold or issued;
- prominently display the following statement: "Notice to buyer: This policy may not cover all of your medical expenses"; and
- make a reasonable attempt to identify whether a prospective applicant for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of that insurance.

b. The following practices are prohibited.

1.) **Twisting** is knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing any person to lapse, forfeit, surrender, or convert any insurance policy or take out a policy with another insurer.

2.) **High-pressure tactics** include employing any method of marketing that tends to induce the purchase of insurance through force, fright, threat, or undue pressure to purchase insurance.

3.) **Cold lead advertising** is using any marketing method that fails to disclose conspicuously that the purpose of the marketing method is solicitation of insurance and that contact will be made by an insurance agent or company.

c. When recommending the purchase or replacement of any Medicare supplement policy, an agent must make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

d. Any sale of a Medicare supplement policy or certificate that will provide an individual with more than one Medicare supplement policy or certificate is prohibited.

e. An issuer must not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C (Medicare Advantage) unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

f. Medicare supplement policies or certificates must have a notice prominently printed on or attached to the first page stating that it may be returned within 30 days of its delivery for a full refund if the applicant is not satisfied for any reason.

16. Medicare select [Regs. 45-06-01.1-08]

a. Medicare Select is a special program that functions on a restricted network provision or select, preferred provider basis. Insurers wishing to offer a Select plan must agree to meet minimum standards and must first be approved by the Commissioner to offer these plans.

b. To qualify as a Select plan issuer, the insurer must arrange for a sufficient number and variety of medical care providers in its network area. The plan must cover emergency care 24 hours a day, seven days a week, even if such care is outside the approved service area.

17. Replacement [Regs. 45-06-01.1-15, 20]

a. Application forms must include the questions designed to elicit information as to whether the applicant currently has Medicare supplement insurance, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether the policy is intended to replace any other accident and sickness coverage presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

b. If a Medicare supplement policy replaces another Medicare supplement policy, the replacing issuer must waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods applicable to similar benefits in the new Medicare supplement policy to the extent such time was spent under the original policy. If the replaced policy has been in effect for at least six months, the replacing policy may not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods for benefits similar to those contained in the original policy.

F. COMPREHENSIVE HEALTH ASSOCIATION OF NORTH DAKOTA (CHAND) [26.1-08-11, 12, 06, 06.1]

1. The Comprehensive Health Association of North Dakota (CHAND) provides health benefits on an indemnity or prepaid basis, which pays the costs of medical, surgical, hospital, or chiropractic care for North Dakota residents who have difficulty obtaining coverage.

a. Sales of association benefit plans [26.1-08-11] All licensed producers may sell or market qualified association benefit plans. They are entitled to referral fees for referring applicants to the association plan if the applicants are accepted.

b. An insurer that rejects or applies underwriting restrictions to an applicant for accident and health insurance must inform the applicant of the association's existence, the requirements for acceptance in it, and the application procedure.

2. An individual may qualify to enroll in the association for benefit plan coverage as a standard applicant, a HIPAA applicant, or on the basis of age or disability.

a. A standard applicant is:

- an individual who has been a resident of the state for 183 days and continues to be a resident of the state and who has received from at least one insurance carrier within 180 days of the date of application one of the following
  - written evidence of rejection or refusal to issue substantially similar insurance for health reasons by one insurer,
  - written evidence that a restrictive rider or a preexisting condition limitation, the effect of which is to substantially reduce coverage from that received by an individual considered a standard risk, has been placed on the individual's policy, or
  - refusal by an insurer to issue insurance except at the rate exceeding the Association benefit rate; and
- not eligible for the state's medical assistance program.

b. A HIPAA applicant is an individual who meets the following federally defined eligibility guidelines:

- Has had 18 months of qualifying previous coverage, the most recent of which is covered under a group health plan, governmental plan, or church plan
- Has applied for coverage under this chapter within 63 days of the termination of the qualifying previous coverage
- Is not eligible for coverage under a group health benefit plan, Medicare, or Medicaid
- Does not have any other health insurance coverage
- Has not had the most recent qualifying previous coverage terminated for nonpayment of premiums or fraud
- If offered under the option, has elected continuation coverage under COBRA or under a similar state program and that coverage has exhausted

c. An applicant age 65 and older or disabled may also qualify.

3. All insurance companies that have at least $100,000 of annual premiums for accident and health insurance written on North Dakota residents must be members of the association.

4. The association must provide a qualified comprehensive health insurance plan, a basic Medicare supplement plan, and a standard Medicare supplement plan.

5. Minimum benefits [26.1-08-06 and 6.1]

a. The minimum benefits for covered individuals must equal at least 80% of the cost of covered services, with a deductible of not less than $500 per person per benefit period. The coverage must include an annual out-of-pocket limit of not less than $3,000 per person and a maximum lifetime benefit of not more than $1 million.

b. The benefit plan must offer comprehensive health care coverage to every eligible individual. The coverage to be issued by the association and its schedule of benefits, exclusions, and other limitations are established by the lead carrier and subject to the approval of the board.

c. In establishing the benefit plan coverage, the board takes into consideration the levels of health insurance coverage provided in the state and medical economic factors it deems appropriate. Benefit levels, deductibles, coinsurance factors, copayments, exclusions, and limitations may be applied that generally reflect the health insurance coverage provided in the state.

NORTH DAKOTA LAW SUPPLEMENT PRACTICE FINAL

Student instructions: Following your thorough study of this supplement, take this 50-question sample examination. Grade your performance using the answer key provided. Carefully review the topics pertaining to those questions answered incorrectly.

I. General Insurance

1. What type of insurer is formed by the authority of a state other than North Dakota?
   A. Foreign
   B. Domestic
   C. Alien
   D. Interstate

2. Whom does an insurance producer represent in an insurance transaction?
   A. Policyowner
   B. Insurer
   C. State of North Dakota
   D. Broker

3. Who administers all laws that relate to insurance in North Dakota?
   A. Insurance Department and Commissioner of Insurance
   B. Insurance producers
   C. Federal Insurance Association
   D. North Dakota legislature

4. Which of the following is NOT a duty of the Commissioner of Insurance?
   A. Making regulations to help carry out the provisions of the North Dakota insurance title
   B. Issuing certificates of authority to transact insurance business in North Dakota
   C. Writing the North Dakota insurance laws
   D. Conducting hearings

5. The Commissioner must examine all domestic insurance companies at least
   A. every year
   B. once every 3 years
   C. once every 5 years
   D. once every 10 years

6. Which of the following is covered by the North Dakota Life and Health Insurance Guaranty Association?
   A. Reinsurance policies issued without assumption certificates
   B. Life insurance policies held by North Dakota residents
   C. Portions of life insurance policies not guaranteed by the insurer
   D. Uninsured employer plans that provide life, health, or annuity benefits to employees

7. What is meant by the term *authorized insurer*?
   A. A producer who is authorized by the Commissioner to transact business in North Dakota
   B. A company that is authorized by the Commissioner to transact insurance business in North Dakota
   C. A producer who has the authority to represent an insurance company
   D. A policyholder who has a legal contract with an insurance company

8. Applicants for resident insurance producer licenses must
   A. be at least 18 years old
   B. reside in North Dakota for at least 5 years
   C. serve for 5 years as an insurance consultant
   D. earn more than $10,000 per year in commissions

9. Which of the following is NOT an unfair trade practice?
   A. An act of boycott that results in an unreasonable restraint of the insurance business
   B. Making derogatory statements regarding an insurer's financial condition
   C. Rebating premiums
   D. Refunding premiums to policyholders who cancel their policies

10. Which of the following must comply with the continuing education requirements of North Dakota?
    A. Surplus lines insurance brokers
    B. Insurance producers who only sell group credit accident and health insurance
    C. Insurance producers over age 62 whose combined years of age and years as licensed producers equal at least 85 and whose commissions from new business do not exceed $10,000 per year
    D. Insurance producers who only sell group credit life insurance

11. How many hours of continuing education must all resident insurance producers complete each year?
    A. 5
    B. 10
    C. 12
    D. 40

12. How many years of experience must an individual have as a producer or employee with an insurance company, agency, or brokerage before becoming a consultant?
    A. 2
    B. 5
    C. 10
    D. 12

13. Which of the following must be appointed by at least one insurer to transact insurance business in North Dakota?
    A. Producers
    B. Service representatives
    C. Consultants
    D. Surplus lines insurance brokers and consultants

14. Which of the following involves misrepresenting a policy to induce a person to lapse or exchange a policy?
    A. Rebating
    B. Boycotting
    C. Twisting
    D. Unfair discrimination

15. If more than 25% of a producer's premiums in one year come from insurance written on the producer's family, the producer is primarily participating in
    A. rebating
    B. group insurance
    C. controlled business
    D. coercion

16. All of the following are unfair claim settlement practices EXCEPT
    A. failure to adopt reasonable standards for prompt investigation of claims
    B. attempting to refuse a claim based on a policy application that was altered by the insurer without the insured's knowledge
    C. not making prompt and fair settlements when liability has become reasonably clear
    D. requiring the submission of a proof-of-loss form before paying a claim

17. Within how many days of becoming aware of suspected fraudulent activity must a person involved in the insurance business report the matter to the Commissioner?
    A. 10
    B. 30
    C. 60
    D. 90

18. A person who knowingly makes a false statement in an insurance application has committed
    A. an unfair claim settlement practice
    B. insurance fraud
    C. rebating
    D. twisting

19. Which of the following statements about insurance consultants is NOT correct?
    A. They cannot simultaneously hold a license as an agent and a broker.
    B. They must prepare a written agreement explaining the work to be performed and fee to be charged before providing any services.
    C. They can receive compensation from licensed agents for work performed as a consultant.
    D. Consultant licenses are not required for attorneys or actuaries who provide insurance advice in their normal course of employment.

20. The Commissioner may issue a temporary producer license for up to how many days?
    A. 60
    B. 90
    C. 120
    D. 180

21. Which of the following statements about appointing insurance producers is CORRECT?
    A. An insurer must give an insurance producer at least 15 days' written notice before terminating the appointment.
    B. To appoint an insurance producer as its agent, an insurer must file a notice of appointment within 15 days from the date the agency contract is executed.
    C. An insurer must notify the Commissioner within 30 days after terminating a producer's appointment.
    D. An insurer who fails to notify the Commissioner of any termination of appointment is guilty of a felony.

22. The Commissioner may suspend an insurance producer's license for committing all of the following acts EXCEPT
    A. misrepresenting the terms of an insurance contract
    B. making a false statement in the licensing application
    C. using coercive practices while transacting insurance
    D. failing to meet the appointing insurer's sales goals for the year

23. All of the following statements about temporary producer licenses are correct EXCEPT
    A. they are granted by the Commissioner
    B. they are issued for a limited time period
    C. they require a special examination
    D. they can be granted to the surviving spouse of a deceased licensed producer

24. Circulating a maliciously critical statement about an insurer's financial condition to injure the insurer is called
    A. conservation
    B. unfair discrimination
    C. defamation
    D. coercion

25. Which of the following would NOT be subject to North Dakota's advertising rules?
    A. Printed brochures distributed to shareholders that explain the insurer's new confidentiality policies
    B. Materials used in training an insurer's sales personnel that are designed to induce the public to purchase policies
    C. Prepared sales talks by agents
    D. Sales aids used by agents

II. Life Insurance

26. What association protects owners of life insurance policies issued by insurers that become impaired?
    A. North Dakota Life and Health Insurance Guaranty Association
    B. Consumer Protection Department
    C. North Dakota Life Insurance Pool
    D. Insurance Insolvency Board

27. Producers must do all of the following when conducting a life insurance presentation EXCEPT
    A. inform the prospective purchasers that they are acting as producers for a particular life insurance company
    B. provide prospective purchasers with a list of guaranteed benefits
    C. explain that any cost comparison indexes used are only useful to compare the relative costs of two or more similar policies
    D. show guaranteed and nonguaranteed benefits separately

28. If the insured's age was understated on the application, how much will the insured receive?
    A. Half of the amount of coverage
    B. The amount of coverage that the premium paid would have purchased for the correct age
    C. A fine of $1,000 for misrepresentation
    D. No benefits

29. Group life insurance policies must include a provision entitling policyholders to a grace period of
    A. 10 days
    B. 31 days
    C. 90 days
    D. 1 year

30. What happens to the surrender value of a life insurance policy upon the death of the insured?
    A. It must be used to pay the insured's creditors.
    B. It may be rolled over into a variable life policy.
    C. It is divided between the creditors and the beneficiaries.
    D. It is exempt from the insured's creditors.

31. An individual life insurance policy will become incontestable no later than how long after its effective date?
    A. 18 months
    B. 1 year
    C. 2 years
    D. 3 years

32. An individual life insurance policy may exclude or restrict coverage if death occurs under any of the following circumstances EXCEPT
    A. war
    B. hazardous occupation
    C. suicide within 2 years from the policy's issue date
    D. residing outside the continental United States

33. Bill is insured under an individual life insurance policy. His next premium is due April 1, but he forgets to pay it and then dies on April 15. Which one of the following statements is CORRECT?
    A. Bill's heirs will not receive any insurance proceeds.
    B. Bill's heirs will receive only half of the insurance proceeds.
    C. Bill's heirs must pay a reinstatement penalty before receiving the insurance proceeds.
    D. Bill's heirs will receive the insurance proceeds.

34. Which of the following statements about the conversion provision in group life insurance policies is CORRECT?
    A. The conversion privilege must be available to any surviving dependents if the employee dies.
    B. The employee must provide evidence of insurability to convert to an individual life insurance policy.
    C. The employee must complete an individual policy application and pay the first premium within 6 months after the termination date.
    D. Conversion provisions are optional in group life insurance policies.

35. Life insurance advertisements must comply with all of the following requirements EXCEPT
    A. they must prominently describe the type of policy advertised
    B. they must describe the premium changes for policies with nonlevel premiums
    C. they must state that the payment of dividends is guaranteed
    D. they must disclose whether coverage decreases or increases with age and if the policy is a graded or modified policy

III. Accident and Health Insurance

36. Which of the following statements about a long-term care insurance policy is CORRECT?
    A. It can be cancelled on the grounds of the insured's age.
    B. It contains a provision establishing a new waiting period if existing coverage is replaced by a new policy within the same company.
    C. It contains renewal provisions that are at least as favorable as guaranteed renewable.
    D. It provides significantly more coverage for skilled nursing care in a facility than coverage for lower levels of care.

37. Medicare supplement policies must do all of the following EXCEPT
    A. indemnify against losses resulting from sickness on a different basis than losses resulting from accidents
    B. provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount
    C. be guaranteed renewable
    D. cover Part A Medicare-eligible expenses for hospitalization not covered by Medicare from the 61st through 90th day in any Medicare benefit period

38. All health insurance policies must include a provision stating that all benefits for any loss (other than loss of time) must be paid within how many days after the insurer receives proof of the loss?
    A. 10
    B. 30
    C. 60
    D. 90

39. Long-term care insurance policies cannot contain renewal provisions that grant less than which of the following?
    A. Guaranteed renewability
    B. Renewability after proof of insurability
    C. Renewability based on the age of the insured
    D. Renewability based on fulfilling a new waiting period

40. Which of the following statements about children on family health insurance policies is CORRECT?
    A. Coverage begins when the child is born.
    B. Coverage begins 24 hours after birth.
    C. Coverage begins when the family notifies the insurer of the birth.
    D. Coverage begins when the child is 1 year old.

41. Long-term care insurance policies can limit coverage for all of the following EXCEPT
    A. mental disorder
    B. suicide
    C. treatment provided in a government facility
    D. Alzheimer's disease

42. Which of the following provides low-cost access to health insurance coverage for North Dakota residents who have difficulty obtaining coverage?
    A. North Dakota Health Insurance Guaranty Association
    B. Comprehensive Health Association of North Dakota
    C. North Dakota Associated Physician's Society
    D. North Dakota Health Insurance Emergency Fund

43. Which of the following statements about long-term care insurance policies is CORRECT?
    A. They generally provide less than 12 months of coverage.
    B. They must contain a provision establishing a new waiting period if the existing coverage is converted.
    C. They must have a 30-day free look period.
    D. They are generally not guaranteed renewable.

44. The most that the Life and Health Insurance Guaranty Association will pay in death benefits on any one life is
    A. $100,000
    B. $300,000
    C. $500,000
    D. $750,000

45. Which of the following must be included in all Medicare supplement policies?
    A. Coverage for the reasonable cost of the first 3 pints of blood
    B. Coverage for preventive care
    C. Coverage for skilled nursing home care
    D. Coverage for at-home recovery services

46. Group health insurance policies that cover an insured's children must provide coverage until the child reaches age
    A. 18
    B. 19
    C. 22
    D. 26

47. An insurer may deny coverage under a group health insurance policy to which of the following dependents?
    A. Child born out of wedlock
    B. Child who is not claimed as a dependent on the parent's federal income tax return
    C. Child who does not live in the insurer's service area
    D. Child who is a part-time student and 25 years old

48. Which of the following statements about the coverage of mental disorders and substance abuse under group health insurance policies is CORRECT?
    A. Policies must offer benefits for treating alcoholism and drug addiction on the same basis as any other illness.
    B. Policies must provide at least 90 days of benefits for inpatient treatment.
    C. Insurers can provide coverage for outpatient coverage only.
    D. Insurers can establish co-payments for the first 10 visits that are no greater than 20% of the total amount due.

49. Long-term care insurance policies can
    A. be cancelled because the insured's health deteriorates
    B. provide coverage only for skilled nursing care
    C. only be sold to insureds who are over age 65
    D. establish a new waiting period if the insured decides to increase benefit

50. Which of the following acts is prohibited when selling long-term care insurance?
    A. Cold lead advertising
    B. Replacing long-term care policies
    C. Direct marketing of long-term care policies
    D. Using personal leads to contact prospects

ANSWERS TO NORTH DAKOTA LAW PRACTICE FINAL

1. **A**	11. **C**	21. **C**	31. **C**	41. **D**
2. **B**	12. **B**	22. **D**	32. **C**	42. **B**
3. **A**	13. **A**	23. **C**	33. **D**	43. **C**
4. **C**	14. **C**	24. **C**	34. **A**	44. **B**
5. **C**	15. **C**	25. **A**	35. **C**	45. **A**
6. **B**	16. **D**	26. **A**	36. **C**	46. **C**
7. **B**	17. **C**	27. **B**	37. **A**	47. **D**
8. **A**	18. **B**	28. **B**	38. **C**	48. **A**
9. **D**	19. **C**	29. **B**	39. **A**	49. **D**
10. **A**	20. **D**	30. **D**	40. **A**	50. **A**

Notes