INSURANCE COMPANIES AND RATES

CHAPTER 316

SENATE BILL NO. 2078
(Legislative Council)
(Insurance Code Revision Committee)

INSURANCE CODE REVISION

AN ACT to create and enact sections 26.1-01-03.1 and 26.1-01-03.2, and chapters 26.1-26, 26.1-27, 26.1-28, 26.1-29, 26.1-30, 26.1-31, 26.1-32, 26.1-33, 26.1-34, 26.1-35, 26.1-36, 26.1-37, 26.1-38, 26.1-39, 26.1-40, 26.1-41, 26.1-42, 26.1-43, and 26.1-44 of the North Dakota Century Code, relating to the authority of the commissioner of insurance; insurance agents, brokers, consultants, and representatives; insurance administrators; insurance vending machines; insurance contracts; insurance policies; reinsurance and double insurance; loss and notice of loss; life insurance; annuities; life insurance and annuity valuation; accident and health insurance; credit life and accident and health insurance; the North Dakota life and health insurance guaranty association; property and casualty insurance; automobile insurance and warranties; auto accident reparations; the North Dakota insurance guaranty association; legal expense insurance; and surplus line insurance; to repeal chapters 26-02, 26-03, 26-03.1, 26-03.2, 26-03.3, 26-03.4, 26-03.5, 26-03.6, 26-05, 26-06, 26-09.2, 26-10, 26-10.1, 26-11.1, 26-17.1, 26-17.2, 26-18, 26-31, 26-33, 26-34, 26-35, 26-36, 26-36.1, 26-39, and 26-41, and sections 26.1-17-13, 26.1-17-14, 26.1-17-15, 26.1-17-17, 26.1-18-15, and 26.1-18-16 of the North Dakota Century Code, sections 1 and 10 of chapter 247, sections 1 and 12 of chapter 248, and section 1 of chapter 249 of the 1977 Session Laws, section 1 of chapter 303 of the 1981 Session Laws, and section 27 of chapter 332 of the 1983 Session Laws, relating to the insurance laws remaining in title 26, uncodified provisions pertaining to those laws, contract requirements covered by title 26.1, and temporary transition from title 26 to title 26.1; to provide penalties; and to provide for transition.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. Section 26.1-01-03.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-01-03.1. Cease and desist authority - Hearing - Failure to appear. The commissioner may issue an order to cease and desist when it appears that any person is engaged in an act or practice which violates or may lead to a violation of this title. The commissioner shall provide written notice to the person named in the order stating the time and place of the hearing on the matter and setting forth the alleged violation. A hearing must be held not later than ten days after the issuance of the order unless a delay is requested by all persons named in the order. The commissioner shall, within thirty days after the issuance of the cease and desist order, issue an order vacating the cease and desist order or making the cease and desist order permanent, as the facts require. The failure of any named person to appear at any proper hearing under this section after receiving notice of the hearing will cause that person to be 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.

SECTION 2. Section 26.1-01-03.2 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-01-03.2. Injunctive authority. The commissioner may bring an action in the district court of Burleigh County to enjoin any acts or practices which are prohibited under this title, upon not less than eight days' notice to the defendants named in the action.

SECTION 3. Chapter 26.1-26 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-26-01. Scope. This chapter governs the qualifications and procedures for the licensing of insurance agents, insurance brokers, insurance consultants, limited insurance representatives, and surplus lines insurance brokers. This chapter applies to all lines of insurance and types of insurers including life, health, property, liability, credit, title, fire, or marine operating on a stock, mutual, reciprocal, benevolent, fraternal, or health service plan, as set forth in this title.

26.1-26-02. Definitions. As used in this chapter, unless the context requires otherwise:

1. "Insurance" includes annuities.

2. "Insurance agent" means an individual, partnership, or corporation appointed by an insurer to solicit applications for an insurance policy or to negotiate a policy on its behalf.

3. "Insurance broker" means any individual, partnership, or corporation which, for compensation, not being a licensed agent for the insurer in which an insurance policy is placed, acts or aids in any manner in negotiating insurance contracts or placing risks of effecting insurance for a party other than oneself or itself.

4. "Insurance consultant" means an individual, partnership, or corporation that, for a fee, holds oneself or itself out to the public as engaged in the business of offering any advice, counsel, opinion, or service with respect to the benefits, advantages, or disadvantages promised under any insurance policy that could be issued in this state.

5. "Limited insurance representative" means an individual, partnership, or corporation authorized by the commissioner to solicit or negotiate contracts for a particular line of insurance which the commissioner may by rule deem essential for the transaction of business in this state and which does not require the professional competency demanded for a license as an insurance agent or insurance broker.

6. "Surplus lines insurance broker" means an individual, partnership, or corporation which solicits, negotiates, or procures an insurance policy from an insurer not licensed to transact business in this state which cannot be procured from an insurer licensed to do business in this state.

26.1-26-03. Acting as agent, broker, consultant, or limited representative without license prohibited - Penalty. No person may act as or hold oneself out to be an insurance agent, insurance broker, insurance consultant, limited insurance representative, or surplus lines insurance broker unless licensed under this chapter. No insurance agent, insurance broker, limited insurance representative, or surplus lines insurance broker may apply for, procure, negotiate for, or place for others, any policy for any line of insurance as to which that person is not then qualified and licensed under this chapter. No insurance agent or limited insurance representative may place an insurance policy with any insurer as to which that person does not then hold a license as an insurance agent or limited insurance representative under this chapter. Any person violating this section is guilty of a class B misdemeanor.

26.1-26-04. Payment to or acceptance by unlicensed person of commission prohibited - When payment or assignment of commissions permitted. No insurer, insurance agent, insurance broker, limited insurance representative, or surplus lines insurance broker may pay, directly or indirectly, any commission, brokerage, or other valuable consideration to any person for services as an insurance agent, insurance broker, limited insurance representative, or surplus lines insurance broker within this state, unless that person held at the time the services were performed a valid license for that line of insurance as required by the laws of this state; nor may any person, other than a person licensed by this state as an insurance agent, insurance broker, limited insurance representative, or surplus lines insurance broker at the time the services were performed, accept any such commission, brokerage, or other valuable consideration. However, any person licensed under this chapter may pay or assign that person's commissions, or direct that the commissions be paid,

to a partnership of which that person is a member, employee, or agent, or to a corporation of which that person is an officer, employee, or agent. This section does not prevent payment or receipt of renewal or other deferred commissions to or by any person entitled thereto under this section.

26.1-26-05. Unlicensed person - Effect - Agent for insurer. A person not licensed as an insurance agent, insurance broker, limited insurance representative, or surplus lines insurance broker who solicits an insurance policy on behalf of an insurer is an insurance agent within the intent of this chapter, and is liable for all the duties, requirements, liabilities, and penalties to which an insurance agent of the insurer is subject, and the insurer by compensating that person through any of its officers, agents, or employees for soliciting insurance policies thereby accepts and acknowledges that person as its agent in the transaction. A person not licensed as an insurance broker, but who solicits an insurance policy on behalf of others or transmits for others an application for an insurance policy to or from an insurer, or offers or assumes to act in the negotiations of such insurance, is an insurance broker within the intent of this chapter, and is liable for all the duties, requirements, liabilities, and penalties to which licensed brokers are subject.

26.1-26-06. Agent or limited representative - Agent of insurer. Every insurance agent or limited insurance representative who 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 insured's beneficiary. This section does not affect the apparent authority of an agent.

26.1-26-07. Broker - Agent of insured. Every insurance broker or surplus lines insurance broker who solicits an application for insurance of any kind is, in any controversy between the insured or the insured's beneficiary and the insurer issuing any policy upon the application, regarded as representing the insured or the insured's beneficiary and not the insurer. However, any insurer that directly or through its agents delivers in this state to any insurance broker a policy of insurance pursuant to the application or request of the broker, acting for an insured other than oneself, is deemed to have authorized the broker to receive on its behalf payment of any premium which is due on the insurance policy at the time of its issuance or delivery.

26.1-26-08. Licensing of partnership or corporation - Notice of change of individuals. A partnership or corporation may be licensed as an insurance agent, insurance broker, limited insurance representative, or surplus lines insurance broker. Every member of the partnership and every officer, director, stockholder, and employee of the corporation personally engaged in this state in soliciting or negotiating policies of insurance must be registered with the commissioner, and each member, officer, director, stockholder, or employee must also be licensed. The required license fee must be

paid for the partnership or corporation and for each individual registered. The partnership or corporate licensee shall within ten business days notify the commissioner of every change relative to the individuals registered under the partnership or corporation. This section does not apply to a management association, partnership, or corporation whose operations do not entail the solicitation of insurance from the public.

26.1-26-09. Exceptions to licensing requirements. No license as an insurance agent, insurance broker, limited insurance representative, or surplus lines insurance broker is required of:

1. Any regular salaried officer or employee of an insurance company, licensed insurance agent, insurance broker, limited insurance representative, or surplus lines insurance broker if the officer's or employee's duties and responsibilities do not include the negotiation or solicitation of insurance.

2. Any person who secures and furnishes information for the purpose of group or wholesale life insurance, annuities, or group, blanket, or franchise health insurance, or for enrolling individuals under such plans or issuing certificates under such plans or otherwise assisting in administering such plans, where no commission is paid for the service.

3. Employers or their officers or employees or the trustees of any employee trust plan, to the extent that the employers, officers, employees, or trustees are engaged in the administration or operation of any program of employee benefits for their own employees or the employees of their subsidiaries or affiliates involving the use of insurance issued by a licensed insurance company; provided, that the employers, officers, employees, or trustees are not in any manner compensated, directly or indirectly, by the insurance company issuing the insurance.

4. Employees of a creditor who enrolls debtors under a group policy; provided, that the employees receive no commission or other compensation directly related to the enrollment.

26.1-26-10. Consultant - Exceptions to licensing requirement. No license as an insurance consultant is required of:

1. An attorney licensed to practice law in this state acting in the attorney's professional capacity.

2. A licensed insurance agent, insurance broker, or surplus lines insurance broker.

3. A trust officer of a bank acting in the normal course of the trust officer's employment.

4. An actuary or a certified public accountant who provides information, recommendations, advice, or services in the actuary's or the certified public accountant's professional capacity.

26.1-26-11. License of agent or broker - Lines of insurance. An insurance agent, insurance broker, or surplus lines insurance broker may receive qualification for a license in one or more of the following lines:

1. Life insurance and annuity contracts.
2. Sickness, accident, and health insurance.
3. Credit life insurance and credit accident and health insurance.
4. Fire and allied lines.
5. Vehicle liability and vehicle physical damage insurance.
6. Comprehensive personal and general liability coverage.
7. Marine and transportation insurance.
8. Credit and mortgage guarantee insurance.
9. Burglary and theft insurance.
10. Crop insurance.
11. Bail bonds.
12. Fidelity and surety insurance.
13. Homeowners' and farmowners' multiple peril insurance.
14. Commercial multiple peril insurance.
15. Property and casualty insurance sold in connection with a credit transaction.
16. Industrial fire insurance.
17. Legal expense insurance.
18. Variable annuities and variable life insurance.
19. Title insurance.

26.1-26-12. License application - Accompanied by fees. Application for a license must be made to the commissioner by the applicant on a form prescribed by the commissioner. All applications must be

accompanied by the applicable fees as provided in section 26.1-01-07.

26.1-26-13. Agent or limited representative - Application - Age - Appointment by insurer. Every applicant for a license as an insurance agent or limited insurance representative, except a partnership or corporation, must be eighteen years or more of age. The application for a license as an insurance agent or limited insurance representative must be accompanied by a written appointment. The appointment must be made by an officer of the insurer designating the applicant as an insurance agent or limited insurance representative for the lines of insurance the applicant will be authorized to write for the insurer. An insurance agent or limited insurance representative may represent as many insurers as may appoint the agent or representative. All appointments for any licensee must be submitted on behalf of the appointing insurer, on a form prescribed by the commissioner, and unless terminated remain in force until 12:01 a.m. on the annual renewal date.

26.1-26-14. Consultant - Investigation by commissioner. Within a reasonable time after receipt of a properly completed application for a license as an insurance consultant, the commissioner may conduct investigations and propound interrogatories concerning the applicant's qualifications, residence, business affiliations, and any other matter which the commissioner believes necessary or advisable to determine compliance with this chapter or for the protection of the public.

26.1-26-15. License requirement - Character. An applicant for any license under this chapter must be deemed by the commissioner to be competent, trustworthy, financially responsible, and of good personal and business reputation.

26.1-26-16. License requirement - Insurance broker - Experience. Each applicant for a license as an insurance broker must have had not less than two years' experience as an insurance agent or in comparable employment for an insurance company, agency, or brokerage firm during the three years immediately next preceding the date of application and must hold and maintain a resident or nonresident license as an insurance agent in this state. The application for a license must be accompanied by an affidavit from the employer or insurer to the effect that the applicant was engaged in the required responsible insurance duties.

26.1-26-17. License requirement - Surplus lines insurance broker - Resident insurance agent's or insurance broker's license. An applicant for a license as a surplus lines insurance broker must be licensed in this state as a resident insurance agent or insurance broker qualified as to the line or lines to be written.

26.1-26-18. License requirement - Brokers - Bond - Waiver for nonresident insurance broker. Prior to issuance of a license as an insurance broker, the applicant shall file with the commissioner, and thereafter, for as long as the license remains in effect, shall

keep in force a bond in the penal sum of not less than two thousand dollars with authorized corporate surety approved by the commissioner. Prior to issuance of a license as a surplus lines insurance broker, the applicant shall file with the commissioner, and thereafter, for as long as the license remains in effect, shall keep in force a bond in the penal sum of not less than an amount equal to the taxes paid to the commissioner the previous year as required by section 26.1-44-06, with a minimum bond of five hundred dollars and a maximum bond of twenty thousand dollars required. The commissioner shall set the bond for a surplus lines insurance broker not previously licensed or whose license has lapsed, but the bond may not be less than five hundred dollars nor greater than twenty thousand dollars. The aggregate liability of the surety for claims on any bond may not exceed the penal sum of the bond. No bond may be terminated unless at least thirty days' prior written notice is given by the surety to the licensee and the commissioner. Upon termination of the license for which the bond was in effect, the commissioner shall notify the surety within ten working days. Any licensee who is the holder of a license as an insurance broker and a license as a surplus lines insurance broker may satisfy the bonding requirements by a single bond in the penal sum of not less than twenty thousand dollars.

Notwithstanding other provisions of this chapter, no new bond may be required for a nonresident insurance broker if the commissioner is satisfied that the existing bond covers the broker's insurance business in this state.

26.1-26-19. Determination of residency for license issuance - Election of residency - When void. An applicant may qualify as a resident if the applicant resides in this state or maintains the applicant's principal place of business in this state. A license issued pursuant to an application claiming residency for licensing purposes constitutes an election of residency in this state. A license is void if the licensee, while holding a resident license in this state, also holds or applies for a resident license from, or thereafter claims to be a resident of, any other state or other jurisdiction or ceases to be a resident of this state.

26.1-26-20. Nonresident license - Must hold like license elsewhere. An applicant may qualify for a nonresident license if the applicant holds a like resident license from a state, province of Canada, or other foreign country. A license issued to a nonresident of this state grants the same rights and privileges afforded a resident licensee, except as provided in section 26.1-26-47.

26.1-26-21. Nonresident to designate commissioner as attorney for service of process - Fee. The commissioner may not issue a license to any nonresident applicant until the applicant files with the commissioner a designation of the commissioner and the commissioner's successors in office, as the applicant's true and lawful attorney, upon whom may be served all lawful process in any action or proceeding instituted by or on behalf of any interested person arising out of the applicant's insurance business in this

state. The designation constitutes an agreement that the service of process is of the same legal force and validity as personal service of process in this state upon the person.

26.1-26-22. Nonresident proceeding by commissioner - Service of process - Procedure. The commissioner shall serve process upon any nonresident licensee in any action or proceeding instituted by the commissioner under this chapter by mailing the process by registered mail return receipt requested to the licensee at the licensee's last known address of record or principal place of business.

26.1-26-23. Examination of individuals. Except as provided in section 26.1-26-25, the commissioner shall subject each applicant for a license as an insurance agent, insurance broker, insurance consultant, limited insurance representative, or surplus lines insurance broker to a written examination as to competence to act as a licensee.

26.1-26-24. Examination when partnership or corporation is applicant. If an applicant is a partnership or corporation, each individual who is to be registered with the corporate or partnership license shall take the examination.

26.1-26-25. Exceptions from examination. The requirement for a written examination is subject to the following exceptions:

1. An applicant for a license covering the same line or lines of insurance for which the applicant was licensed under a like resident license in this state, other than a temporary license, within the twelve months next preceding the date of application, unless the previous license was suspended or revoked by the commissioner.

2. A nonresident applicant may be licensed without examination if the commissioner of the state of the applicant's residence certifies, by facsimile signature and seal, that the applicant has passed a similar written examination, or has been a continuous holder prior to the time the written examination was required, of a license like the license being applied for in this state.

3. An applicant who has been licensed under a like license in another state within twelve months prior to the application for a license in this state, and who files with the commissioner the certificate of the public official having supervision of insurance in the other state, by facsimile signature and seal, as to the applicant's license and good standing in such state; provided, however, that the applicant shall take that portion of the examination pertaining to state laws and rules.

4. An applicant who has attained the designation of chartered life underwriter is only required to take that portion of

the examination for lines 1 and 18 pertaining to state laws and rules.

5. An applicant who has attained the designation of chartered property and casualty underwriter is only required to take that portion of the examination for lines 2 through 17 pertaining to state laws and rules.

6. An applicant for a license to act as a limited insurance representative may be licensed without examination in one or more of the following lines:

   a. Any ticket-selling agent of a common carrier who acts thereunder only with reference to the issuance of insurance on personal effects carried as baggage, in connection with the transportation provided by the common carrier, or an applicant selling limited travel accident insurance in transportation terminals.

   b. Any other lines that the commissioner finds by rule do not require the professional competency demanded for a license as an agent or broker.

26.1-26-26. Temporary license as an agent or broker. The commissioner may issue a temporary license as an insurance agent or insurance broker for a period not to exceed ninety 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:

1. To the surviving spouse, next of kin, administrator, executor, or employee of a licensed insurance agent who died, or to the spouse, next of kin, employee, or legal guardian of a licensed insurance agent or insurance broker who became disabled.

2. To a member or employee of a partnership or officer or employee of a corporation, licensed as an insurance agent, upon the death or disability of an individual registered with the license.

3. To the designee of a licensed insurance agent entering upon active service in the armed forces of the United States.

4. In any other circumstance where the commissioner determines that the public interest will best be served by the issuance of the license.

26.1-26-27. Approval of examination by commissioner - Contents. Each examination must be approved for use by the commissioner and must reasonably test the applicant's knowledge as to the lines of insurance, policies, and transactions to be handled under the

license applied for, the duties and responsibilities of the licensee, and the pertinent insurance laws of this state.

26.1-26-28. Time and place of examination - Grading of examination - Notice of results. The commissioner shall designate reasonable times and places for conducting the examination for licensing. An applicant must personally take the examination. The commissioner shall give, conduct, and grade all examinations in a fair and impartial manner and without discrimination as between individuals examined. The applicant 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 applicant seeks qualification. Within ten days or as soon as is reasonable after the examination, the commissioner shall inform the applicant and the appointing insurer, where applicable, as to whether the applicant has passed. The commissioner shall issue within a reasonable time formal evidence of licensing.

26.1-26-29. Failure to pass examination - Reexamination. An applicant who fails to pass the first examination for the license applied for may retake the examination. Examination fees for subsequent examinations may not be waived.

26.1-26-30. Contents of license. The license must state the name, resident address, social security or internal revenue service identification number of the licensee, date of issue, and the line or lines of insurance covered by the license, and any other information the commissioner determines to be proper for inclusion in the license.

26.1-26-31. Term of license. A license issued under this chapter continues in force in perpetuity unless:

1. The license is suspended, revoked, or refused by the commissioner;

2. The licensee voluntarily consents to the suspension, revocation, or refusal of the license;

3. The licensee dies or in the case of a corporation or partnership, the licensee is dissolved, consolidated, merged, or otherwise has ceased to exist;

4. The licensee no longer meets the residence requirements of section 26.1-26-19;

5. The insurance agent or limited insurance representative is terminated or nonrenewed by all appointing insurers;

6. The insurance broker or surplus lines insurance broker has failed to maintain a bond as required by section 26.1-26-18, has failed to maintain a resident or nonresident license as an insurance agent as required by

section 26.1-26-16, or has failed to pay the annual renewal fee to the commissioner; or

7. The insurance consultant has failed to pay the annual renewal fee to the commissioner.

26.1-26-32. Renewal of appointments and licenses - Annual fee. An appointment of an insurance agent or limited insurance representative and the license of an insurance broker, surplus lines insurance broker, or insurance consultant terminates upon failure to pay the prescribed annual renewal fee before May first.

26.1-26-33. Notification of address change - Duty of licensee. Every licensee shall notify the commissioner of any change in the licensee's residential or business address within thirty days of the change. Any licensee who ceases to maintain residency in this state shall deliver the insurance license to the commissioner by personal delivery or by mail within thirty days after terminating residency.

26.1-26-34. Termination reports by insurer - Duty of insurer - Information furnished privileged in civil action. If an appointment is terminated, the insurer shall promptly give written notice of the termination and the effective date of the termination to the commissioner and to the licensee where reasonably possible. The commissioner may require the insurer to demonstrate that the insurer has made a reasonable effort to notify the licensee.

All notices of termination must be filed in due course on forms prescribed by the commissioner stating the grounds and circumstances of termination.

If the termination is for any of the grounds listed in this chapter, the insurer shall so notify the commissioner. Any information, document, record, or statement provided pursuant to this section may be used by the commissioner in any action taken pursuant to sections 26.1-26-42, 26.1-26-43, and 26.1-26-50; however, the information is privileged in any civil action between the reporting insurer and the terminated licensee.

26.1-26-35. Duties of consultant - Agreements. An insurance consultant shall serve with objectivity and complete loyalty the interests of the consultant's client alone and to render the client such information, counsel, and service as within the knowledge, understanding, and opinion, in good faith of the licensee, best serves the client's insurance needs and interests. Before rendering any service set forth in subsection 4 of section 26.1-26-02, an insurance consultant shall prepare a written agreement on a form approved by the commissioner. The agreement must outline the nature of the work to be performed by the consultant and must state the fee for the work. The consultant and the client shall sign the agreement. The consultant shall retain a copy of the agreement for not less than two years after completion of the services. This copy must be available to the commissioner.

26.1-26-36. Surplus lines insurance broker's authority. A surplus lines insurance broker may act as a surplus lines insurance broker in this state for any foreign company or insurer not authorized to transact business in this state in securing, issuing, or placing insurance policies, indemnity contracts, or surety bonds on property located in, or undertakings to be carried out in, this state for the company or insurer. A surplus lines insurance broker may accept business from any licensed agent for an admitted company and may compensate the agent for the business, provided the insurance is written in conformity with this title.

26.1-26-37. Lost, stolen, or destroyed license - Issuance of duplicate. The commissioner may issue a duplicate license for any lost, stolen, or destroyed license issued pursuant to this chapter upon an affidavit of the licensee, as prescribed by the commissioner, concerning the facts of the loss, theft, or destruction.

26.1-26-38. Controlled business prohibited - Definition - Formula for determination. The commissioner may not grant, renew, continue, or permit to continue any license if the commissioner finds that the license is being or will be used by the applicant or licensee for the purpose of writing controlled business. Controlled business means insurance written on the interests of the licensee, or those of the licensee's immediate family or of the licensee's employer; or insurance covering the licensee or members of the licensee's immediate family or a corporation, association, or partnership, or the officers, directors, substantial stockholders, partners, or employees of such a corporation, association, or partnership of which the licensee or a member of the licensee's immediate family is an officer, director, substantial stockholder, partner, associate, or employee. A license is deemed to have been, or intended to be, used for the purpose of writing controlled business if the commissioner finds that during any twelve-month period the aggregate commissions earned from such controlled business has exceeded twenty-five percent of the aggregate commissions earned on all business written by the licensee during the same period. This section does not apply to insurance written in connection with credit transactions.

26.1-26-39. Refusal of license - Notification of applicant - No refund of fees. If the commissioner finds that the applicant has not met the requirements for licensing, the commissioner shall refuse to issue the license. The commissioner shall, in writing, promptly notify the applicant and the appointing insurer, where applicable, of the refusal, stating the grounds for the refusal. All fees accompanying the application for license are not refundable.

26.1-26-40. Refusal of initial license - Notice - Hearing. If the commissioner refuses to issue a license to an applicant not previously licensed in this state, the notice to the applicant as provided in section 26.1-26-39 must state that the applicant may request a hearing within thirty days from the date of issuance of the notice. The commissioner shall hold a hearing, if requested by

the applicant, within thirty days of the receipt of the request for a hearing and upon ten days written notice to the applicant.

26.1-26-41. Prohibited activities by consultants. No licensed consultant may employ, be employed by, or be in partnership with nor receive any remuneration whatsoever from any licensed insurance agent, insurance broker, limited insurance representative, surplus lines insurance broker, or insurer arising out of activities as a consultant. No person may concurrently hold a consultant's license and a license as an insurance agent, insurance broker, limited insurance representative, or surplus lines insurance broker in any line.

26.1-26-42. License suspension, revocation, or refusal - Grounds. The commissioner may suspend, revoke, or refuse to continue or refuse to issue any license issued under this chapter if, after notice to the licensee and hearing, the commissioner finds as to the licensee any of the following conditions:

1. A materially untrue statement in the license application.

2. An acquisition or attempt to acquire a license through misrepresentation or fraud.

3. The applicant has been found to have been cheating on an examination for an insurance license.

4. Any cause for which issuance of the license could have been refused had it then existed and been known to the commissioner at the time of issuance.

5. A conviction of an offense, as defined by section 12.1-01-04, determined by the commissioner to have a direct bearing upon a person's ability to serve the public as an insurance agent, insurance broker, insurance consultant, limited insurance representative, or surplus lines insurance broker, or the commissioner finds, after conviction of an offense, that the person is not sufficiently rehabilitated under section 12.1-33-02.1.

6. In the conduct of affairs under the license, the licensee has used fraudulent, coercive, or dishonest practices, or has shown oneself to be incompetent, untrustworthy, or financially irresponsible.

7. A misrepresentation of the terms of any actual or proposed insurance contract.

8. The licensee has been found to have knowingly solicited, procured, or sold unnecessary, or excessive insurance coverage to any person.

9. The licensee has forged another's name to an application for insurance.

10. An improper withholding of, misappropriating of, or converting to one's own use any moneys belonging to policyholders, insurers, beneficiaries, or others received in the course of one's insurance business.

11. The licensee has been found guilty of any unfair trade practice or fraud defined in this title.

12. A violation of, or noncompliance with, any insurance laws, or violation of any lawful rules or orders of the commissioner or of a commissioner of another state.

13. The licensee's license has been suspended or revoked in any other state, province, district, or territory.

14. The applicant or licensee has refused to respond within twenty days to a written request by the commissioner for information regarding any potential violation of this section.

26.1-26-43. License suspension, revocation, or refusal - Partnership or corporation - Additional ground. The license of a partnership or corporation may be suspended, revoked, or refused if the commissioner finds, after 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 partnership or corporation and the violation was not reported to the commissioner nor corrective action taken in relation to the violation.

26.1-26-44. Notification of suspension, revocation, or refusal - Duty of commissioner. The commissioner shall promptly notify all appointing insurers, where applicable, and the licensee regarding any suspension, revocation, or refusal of a license by the commissioner.

Upon suspension, revocation, or refusal of the license of a resident of this state, the commissioner shall notify the central office of the national association of insurance commissioners and the insurance commissioner of each state for whom the commissioner has executed a certificate as provided for in accordance with subsection 2 of section 26.1-26-25.

26.1-26-45. Notification of suspension or revocation of nonresident license. If the commissioner suspends or revokes any nonresident's license through a formal proceeding under this chapter, the commissioner shall promptly notify the appropriate commissioner of the licensee's residence of the action and of the particulars of the action.

26.1-26-46. License suspension, revocation, or refusal - Duty of licensee. Upon suspension, revocation, or refusal of a license, the licensee shall forthwith deliver it to the commissioner by personal delivery or by mail.

26.1-26-47. Reciprocal provision - Retaliatory action. Whenever, by the laws or rules of any other state or jurisdiction, any limitation of rights and privileges, conditions precedent, or any other requirements are imposed upon residents of this state who are nonresident applicants or licensees of that state or jurisdiction in addition to, or in excess of, those imposed on nonresidents under this chapter, the same requirements are imposed upon residents of that other state or jurisdiction.

26.1-26-48. Commissioner may make examinations and investigations. Whenever the commissioner believes that this chapter has been violated, the commissioner, at the expense of the insurer involved, may examine, at the offices of the insurer, whether located within or without this state, all books, records, and papers of the insurer and any books, records, and papers of any insured within this state, and may examine under oath, the officers, managers, and agents of the insurer, or the insured, as to the violation.

26.1-26-49. Rulemaking authority. The commissioner may adopt reasonable rules for the implementation and administration of this chapter.

26.1-26-50. Civil penalty for violation of chapter. In addition to or in lieu of any applicable denial, suspension, or revocation of a license, any person violating this chapter may, after hearing, be subject to a civil fine of not less than one hundred dollars nor more than one thousand dollars. The fine may be collected and recovered in an action brought in the name of the state.

SECTION 4. Chapter 26.1-27 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-27-01. "Administrator" defined. In this chapter, "administrator" means any person who collects charges or premiums from, or who adjusts or settles claims on, residents of this state in connection with life or health insurance coverage or annuities other than:

1. An employer on behalf of its employees or the employees of one or more subsidiary or affiliated corporations of the employer.

2. A union on behalf of its members.

3. An insurance company, health maintenance organization, or nonprofit health service corporation either licensed in this state or acting as an insurer with respect to a policy lawfully issued and delivered by it in and pursuant to the laws of a state in which the insurer was authorized to do an insurance business or prepaid health care plan including its sales representatives licensed in this state when engaged in the performance of their duties as such.

4. A life or health agent or broker licensed in this state, whose activities are limited exclusively to the sale of insurance.

5. A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors.

6. A trust, its trustees, agents, and employees acting thereunder, established in conformity with 29 U.S.C. 186.

7. A trust exempt from taxation under section 501(a) of the federal Internal Revenue Code of 1954 as amended, its trustees, and employees acting thereunder, or a custodian, its agents and employees acting pursuant to a custodian account which meets the requirements of section 401(f) of the federal Internal Revenue Code of 1954 as amended.

8. A financial institution subject to supervision or examination by federal or state banking authorities.

9. A credit card issuing company that advances for and collects premiums or charges from its credit card holders who have authorized it to do so, provided the company does not adjust or settle claims.

10. A person who adjusts or settles claims in the normal course of practice or employment as an attorney at law, and who does not collect charges or premiums in connection with life or health insurance coverage or annuities.

26.1-27-02. "Insurer" defined. In this chapter, "insurer" means any person, including a self-insurer, engaged as a principal in the business of annuities or life or health insurance.

26.1-27-03. Certificate of registration required - Penalty.

1. No person may act as or hold oneself out to be an administrator in this state, for the kinds of business for which the person is acting as an administrator, without a certificate of registration issued by the commissioner. Any person violating this subsection is guilty of a class B misdemeanor.

2. All applications must be accompanied by a filing fee of twenty-five dollars.

3. The commissioner shall issue a certificate unless the commissioner after due notice and hearing determines that the administrator is not competent, trustworthy, financially responsible, or of good personal and business reputation, or has had a previous application for an insurance license denied for cause within five years.

4. The administrator shall pay an annual renewal fee of twenty-five dollars to maintain the certificate.

5. After notice and hearing, the commissioner may revoke a certificate or fine the administrator not more than ten thousand dollars, or both, or the commissioner may suspend a certificate, or fine the administrator not more than five thousand dollars, or both, upon finding that either the administrator violated section 26.1-27-05 and subsection 4 of section 26.1-27-06 and also violated subsection 1, 2, or 3 of section 26.1-27-06 or section 26.1-27-07, 26.1-27-08, 26.1-27-10, 26.1-27-11, or 26.1-27-12, or the administrator is not competent, trustworthy, financially responsible, or of good personal and business reputation.

26.1-27-04. Waiving of registration requirements. The commissioner may waive the requirements of section 26.1-27-03 for any person or class of persons. The factors taken into account in granting waiver include:

1. Whether the person acting as an administrator is primarily in a business other than that of administrator.

2. Whether the financial strength and history of the organization indicates stability in its continuity of doing business.

3. Whether the regular duties being performed as an administrator are such that the covered persons are not likely to be injured by a waiver of the requirements.

26.1-27-05. Written agreement required - Trust agreement - Retention. No person may act as an administrator without a written agreement between the administrator and the insurer. The administrator and the insurer shall retain the written agreement as part of their official records for the duration of the agreement and five years thereafter. Where a policy is issued to a trustee or trustees, the administrator shall furnish a copy of the trust agreement and any amendments thereto to the insurer. The administrator and the insurer shall retain a copy of the trust agreement, with amendments, as part of their official records for the duration of the policy and five years thereafter.

26.1-27-06. Contents of agreement - Requirements. The agreement between the administrator and the insurer must contain:

1. A provision with respect to underwriting or other standards pertaining to the business underwritten by the insurer.

2. A provision that the administrator may use only such advertising pertaining to the business underwritten by an

insurer as has been approved by the insurer in advance of its use.

3. A provision that withdrawals from the fiduciary account may be made only for:

   a. Remittance to an insurer entitled thereto.

   b. Deposit in an account maintained in the name of the insurer.

   c. Transfer to and deposit in a claims paying account, with claims to be paid as provided in section 26-17.2-08.

   d. Payment to a group policyholder for remittance to the insurer entitled thereto.

   e. Payment to the administrator of its commission, fees, or charges.

   f. Remittance of return premiums to the person or persons entitled thereto.

4. Provisions which include the requirements of sections 26.1-27-08, 26.1-27-10, 26.1-27-11, and 26.1-27-12 except insofar as those requirements do not apply to the functions performed by the administrator.

26.1-27-07. Notification required. Where the services of an administrator are used, the administrator shall provide a written notice approved by the insurer, to insureds, advising them of the identity of and relationship among the administrator, the policyholder, and the insurer. Where an administrator collects funds, it shall identify and state separately in writing to the person paying to the administrator any charge or premium for insurance coverage the amount of any such charge or premium specified by the insurer for the insurance coverage.

26.1-27-08. Premium collection - Fiduciary account required. All insurance charges or premiums collected by an administrator on behalf of or for an insurer or insurers, and return premiums received from such insurer or insurers, must be held by the administrator in a fiduciary capacity. The funds must be immediately remitted to the person or persons entitled thereto, or must be deposited promptly in a fiduciary bank account established and maintained by the administrator. If charges or premiums so deposited have been collected on behalf of or for more than one insurer, the administrator shall cause the bank in which the fiduciary account is maintained to keep records clearly recording the deposits in and withdrawals from the account on behalf of or for each insurer. The administrator shall promptly obtain and keep copies of all such records and, upon request of an insurer, shall furnish the insurer with copies of such records pertaining to

deposits and withdrawals on behalf of or for the insurer. The administrator may not pay any claim by withdrawals from the fiduciary account.

26.1-27-09. Payment to administrator. Whenever an insurer uses the services of an administrator, the payment to the administrator of any premiums or charges for insurance by or on behalf of the insured is deemed to have been received by the insurer, and the payment of return premiums or claims by the insurer to the administrator is not deemed payment to the insured or claimant until the payment is received by the insured or claimant. This section does not limit any right of the insurer against the administrator resulting from its failure to make payments to the insurer, insureds, or claimants.

26.1-27-10. Payment of claims. All claims paid by the administrator from funds collected on behalf of the insurer may be paid only on drafts of and as authorized by the insurer.

26.1-27-11. Claim adjustment or settlement. With respect to any policies where an administrator adjusts or settles claims, the compensation to the administrator with regard to the policies may not be contingent on claim experience. This section does not prevent the compensation of an administrator from being based on premiums or charges collected or number of claims paid or processed.

26.1-27-12. Maintenance of information. Every administrator shall maintain at its principal administrative office for the duration of the written agreement and five years thereafter adequate books and records of all transactions between it, insurers, and insureds. The books and records must be maintained in accordance with prudent standards of insurance recordkeeping. The commissioner shall have access to such books and records for the purpose of examination, audit, and inspection. Any trade secrets contained therein, including the identity and addresses of policyholders and certificate holders, are confidential, except the commissioner may use such information in any proceedings instituted against the administrator. The insurer shall retain the right to continuing access to the books and records of the administrator sufficient to permit the insurer to fulfill all of its contractual obligations to insured persons, subject to any restrictions in the written agreement between the insurer and administrator on the proprietary rights of the parties in the books and records.

SECTION 5. Chapter 26.1-28 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-28-01. Sale of insurance from vending machines restricted. No insurance may be offered for sale, issued, or sold by or from any vending machine or appliance or any other medium, device, or object designed or used for vending purposes, in this chapter referred to as a vending machine, except as provided in this chapter.

26.1-28-02. Sale of insurance through vending machines under certain conditions. Resident insurance agents licensed by the commissioner

under this title to solicit applications for and to sell policies of personal travel accident insurance providing benefits for accidental bodily injury or accidental death may also solicit applications for and issue or sell such insurance by means of vending machines supervised by them and placed in locations for the convenience of the traveling public, upon the following conditions:

1. That each policy is reasonably suited for sale and issuance through a vending machine, and that use of a vending machine in a proposed location would be of material convenience to the traveling public.

2. That the type of vending machine proposed to be used is reasonably suitable and practical for the purpose.

3. That reasonable means, as determined by the commissioner, are provided for informing the prospective purchaser of the benefits, limitations, and exclusions of the policy, the premium rates, the name and address of the agent, and the name and home office address of the insurer.

4. That the vending machine is constructed and operated to retain, or is provided with a suitable place for deposit and safekeeping of, a copy of the application, which shows the date of the application, name and address of the applicant and the beneficiary, and the amount of insurance.

5. That no policy of insurance sold through a vending machine may be for a period of time longer than the duration of a specified one-way or round trip not exceeding one hundred eighty days.

6. That the vending machine has provided on it or immediately adjacent thereto, in a prominent location, adequate envelopes for use of purchasers in mailing policies vended through the machine, or that the policy itself, if designed to permit the procedure, may be mailed without an envelope; provided, however, that the commissioner may modify or waive this requirement, by a writing delivered to the agent.

7. That each vending machine is supervised, inspected, and tested by the agent with such frequency as may reasonably be required by the commissioner, and if any machine is not in good working condition the agent shall promptly cause a notice to be displayed on the machine that the machine is out of order, and cause the machine to be promptly removed from service until it is in proper working order.

8. That prompt refund by the agent is provided to each applicant or prospective applicant of money deposited in any defective vending machine and for which no insurance, or a less amount than paid for, is actually received.

The commissioner may adopt by rule additional conditions for types and locations of vending machines, their maintenance and operation, and the methods to be used by the agent in the solicitation and sale of insurance by means of vending machines as are reasonable and necessary.

26.1-28-03. Licensing of vending machine devices - Expiration date. The insurance agent shall apply for a license for each vending machine to be used. The commissioner shall prescribe the form of the application. A fee of two dollars for each vending machine must be paid at the time of making the application. Upon approval of the application the commissioner shall issue to the agent a special vending machine license. The license applies to a specific vending machine or to any machine of identical type which, after written notice by the agent to the commissioner, is substituted for it. The license must specify the name and address of the agent, the name and home office address of the insurer, the name or other identifying information of the policy or policies to be sold, the serial number or other identification of the vending machine, and the address, including the location on the premises, where the machine is to be in operation. A vending machine for which a license has been issued for operation at a specific address may be transferred to a different address during the license year upon written notice to the commissioner at the time of the transfer. The license for each vending machine expires April thirtieth of each year, but may be renewed from year to year by the commissioner upon approval of the application of the agent, the furnishing of information requested by the commissioner, and the payment of two dollars for each license year or part thereof for each machine. Proof of the existence of a subsisting license must be displayed on or about each vending machine in use in the manner the commissioner may reasonably require.

26.1-28-04. Suspension, revocation, or refusal of license - Notice and opportunity to be heard. The license for each vending machine is subject to expiration, suspension, or revocation coincidentally with that of the agent or the insurer. The commissioner also may suspend, revoke, or refuse to renew the license as to any vending machine concerning which the commissioner finds any conditions upon which the machine was licensed or referred to in section 26.1-28-02 have been violated, or no longer exist, or that the machine is being used or operated by the agent in violation of the laws of this state. Before suspending, revoking, or refusing to renew a license for a vending machine, the commissioner shall conduct a hearing and shall make a determination upon the basis of the standards, conditions, and requirements of this section.

26.1-28-05. Penalty. Any person who violates this chapter is guilty of a class B misdemeanor.

SECTION 6. Chapter 26.1-29 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-29-01. "Insurance contract" defined. An insurance contract is a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from an unknown or contingent event.

26.1-29-02. "Insurer" and "insured" defined. An insurer is a person who undertakes to indemnify another by an insurance contract, and the insured is the person indemnified.

26.1-29-03. Who may be parties to insurance contract. Anyone who is capable of making a contract, except as restricted by law, may be an insurer, and anyone except a public enemy may be an insured.

26.1-29-04. "Insurable interest" defined and classified. An insurable interest is an interest in property, or any relation thereto, or liability in respect thereof, of such a nature that a contemplated peril might damnify directly the insured, and may consist in:

1. An existing interest;

2. An inchoate interest founded on an existing interest; or

3. An expectancy coupled with an existing interest in that out of which the expectancy arises.

26.1-29-05. Insurable interest essential to insurance contract. The sole object of insurance is the indemnity of the insured, and if the insured has no insurable interest, the contract is void.

26.1-29-06. When insurable interest must exist. An insurable interest must exist when the insurance takes effect and when the loss occurs but need not exist in the meantime.

26.1-29-07. Measure of insurable interest. The measure of an insurable interest in property is the extent to which the insured might be damnified by loss or injury of the property.

26.1-29-08. Carrier or depositary has insurable interest. A carrier or depositary of any kind has an insurable interest in a thing held by the carrier or depositary as such to the extent of its value.

26.1-29-09. Insurable interest in life or health insurance. Every person has an insurable interest in the life and health of:

1. Oneself.

2. Any person on whom the person depends wholly or in part for education or support.

3. Any person under a legal obligation to the person for the payment of money, or respecting property or services, of which death or illness might delay or prevent the performance.

4. Any person upon whose life any estate or interest vested in the person depends.

26.1-29-10. Contingent or expectant interest not insurable. A mere contingent or expectant interest in anything, not founded on an actual right to the thing nor upon any valid contract for it, is not insurable.

26.1-29-11. What may be insured against. Any contingent or unknown event, whether past or future, which may damnify a person having an insurable interest or create a liability against the person may be insured against, subject to this title, with the exception of an insurance for or against the drawing of any lottery or for or against any chance or ticket in a lottery drawing a prize.

26.1-29-12. Effect of change in insurable interest. A change of interest in any part of a thing insured, unaccompanied by a corresponding change of interest in the insurance, suspends the insurance to an equivalent extent until the interest in the thing insured and the interest in the insurance are vested in the same person, except as follows:

1. In the cases of life, accident, and health insurance.

2. A change of interest in a thing insured after the occurrence of an injury which results in a loss does not affect the right of the insured to indemnity for the loss.

3. A change of interest in one or more of several distinct things insured by one policy does not avoid the insurance as to the others.

4. A change of interest by will or succession on the death of the insured does not avoid an insurance, and the decedent's interest in the insurance passes to the person taking the decedent's interest in the thing insured.

5. A transfer of interest by one of several partners, joint owners, or owners in common who are insured jointly to the others does not avoid an insurance even though it has been agreed that the insurance shall cease upon an alienation of the thing insured.

6. The encumbering of one or more of several distinct things insured by one policy does not render void any insurance upon the things not covered by the encumbrance, but in case of loss or damage, such an amount must be deducted from the insurance as the value of the property so encumbered bears to the value of all the property covered by the policy.

Any agreement to waive subsection 3 or 6 is void.

26.1-29-13. Mutual disclosures required in insurance contract. Each party to an insurance contract must communicate to the other in good faith all facts within the party's knowledge which are or which the party believes to be material to the contract and which the other party has not the means of ascertaining and as to which the party makes no warranty.

26.1-29-14. "Concealment" defined. Concealment is a neglect to communicate that which a party knows and ought to communicate.

26.1-29-15. Rescission for concealment. A concealment, whether intentional or unintentional, entitles the injured party to rescind an insurance contract. An intentional and fraudulent omission on the part of one insured to communicate information of matters proving or tending to prove the falsity of a warranty entitles the insurer to rescind.

26.1-29-16. Matters as to which disclosure is not required. Neither party to an insurance contract is bound to communicate information of the matters following, except in answer to the inquiries of the other:

1. Those that the other knows.
2. Those that in the exercise of ordinary care the other ought to know and the former has no reason to suppose the other ignorant.
3. Those that the other waives communication.
4. Those that prove or tend to prove the existence of a risk excluded by a warranty and which are not otherwise material.
5. Those that relate to a risk excepted from the policy and are not otherwise material.

26.1-29-17. Materiality of matters - How determined. Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due in forming the party's estimate of the disadvantages of the proposed contract or in making the party's inquiries.

26.1-29-18. Presumption of knowledge. Each party to an insurance contract is bound to know all the general causes which are open to the party's inquiry equally with that of the other and which may affect either the political or material perils contemplated and all general usages of trade.

26.1-29-19. Communication of material facts may be waived. The right to information of material facts may be waived, either by the terms of insurance or by neglect to make inquiries as to such facts, when

they distinctly are implied in other facts of which information is communicated.

26.1-29-20. Information as to interest need not be communicated. Information of the nature or amount of the interest of one insured need not be communicated unless in answer to inquiry, except as required to prepare the policy as prescribed by section 26.1-30-01.

26.1-29-21. Matters of opinion need not be disclosed. Neither party to an insurance contract is bound to communicate, even upon inquiry, information of the party's own judgment upon the matters in question.

26.1-29-22. Representation - Form - When made. A representation, either oral or written, may be made before or at the time of issuing the policy.

26.1-29-23. Interpretation of representations regarding insurance. A representation is to be interpreted by the general rules of contract interpretation. A representation as to the future is a promise unless the representation appears that it was merely a statement of belief or expectation. A representation cannot qualify an express provision in an insurance contract, but it may qualify an implied warranty.

26.1-29-24. False representation - Materiality and effect. A representation is false when the facts fail to correspond with its assertions or stipulations. If a representation is false in a material point, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time when the representation becomes false. The materiality of a representation is determined by the same rule which determines the materiality of a concealment.

26.1-29-25. Misrepresentations - Determination of materiality - Effect. An oral or written misrepresentation made in the negotiation of an insurance contract or policy by the insured or in the insured's behalf is material or defeats or avoids the policy or prevents its attaching only if the misrepresentation has been made with actual intent to deceive or unless the matter misrepresented increased the risk of loss.

26.1-29-26. Representations on information and belief. When a person insured has no personal knowledge of a fact, the person may repeat information which that person has upon the subject and which that person believes to be true with the explanation that that person does so on the information of others, or that person may submit the information in its whole extent to the insurer. In neither case is the person responsible for the truth of the representation unless it proceeds from an agent of the insured who has a duty to give the information.

26.1-29-27. Time to which representation refers. A representation must be presumed to refer to the time of the completion of the insurance contract.

26.1-29-28. Alteration or withdrawal of representation. A representation may be altered or withdrawn before the effective date of the insurance but not afterwards.

26.1-29-29. Insurance of mortgaged property - Act of mortgagor may avoid insurance. When a mortgagor of property effects insurance in the mortgagor's own name providing that the loss is payable to the mortgagee, or when the mortgagor assigns an insurance policy to the mortgagee, the insurance is considered to be upon the interest of the mortgagor. The mortgagor does not cease to be a party to the original contract, and any act of the mortgagor which otherwise would avoid the insurance will have the same effect although the property is in the hands of the mortgagee.

26.1-29-30. New contract on transfer of insurance on mortgaged property - Effect of mortgagor's acts. If an insurer assents to the transfer of an insurance contract from a mortgagor to a mortgagee and at the time of the insurer's assent imposes further obligations on the assignee, making a new contract with the assignee, the acts of the mortgagor cannot affect the mortgagee's right under the insurance.

26.1-29-31. Modification of insurance contract - Exercise of right of rescission. This chapter applies to a modification of an insurance contract as well as to its original formation. The right to rescind an insurance contract given to the insurer under the provisions of this title may be exercised at any time prior to the commencement of an action on the contract.

SECTION 7. Chapter 26.1-30 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-30-01. "Insurance policy" defined - Requirements. An insurance policy is the written insurance contract. It must specify:

1. The parties between whom the contract is made.
2. The rate of premium.
3. The property or life insured.
4. The interest of the insured in the property insured if the insured is not the absolute owner of the property.
5. The risks insured against.
6. The period during which the insurance is to continue.

26.1-30-02. Policy executed by gambling void. Every insurance policy executed by way of gaming or wagering is void.

26.1-30-03. Policies classified - "Open", "running", and "valued" policies defined. An insurance policy is open, running, or valued, and these terms are defined as follows:

1. An open policy is one in which the value of the thing insured is not agreed upon but is left to be ascertained in case of loss.

2. A running policy is one which contemplates successive insurances and which provides that the object of the policy may be defined from time to time, especially as to the subjects of insurance, by additional statements or endorsements.

3. A valued policy is one which expresses on its face an agreement that the thing insured must be valued at a specified sum.

26.1-30-04. Insurance only on interest of insured - Stipulation of interest void. When the name of the person intended to be insured is specified in an insurance policy, it can be applied only to that person's own proper interest. Every stipulation in an insurance policy for the payment of loss regardless of whether the person insured has or has not any interest in the property insured or that the policy is proof of such interest is void.

26.1-30-05. Policy may provide for benefit to any owner. An insurance policy may be written so it will inure to the benefit of whomever, during the continuance of the risk, may become the owner of the interest insured.

26.1-30-06. Insurance by agent or trustee may be designated in policy. When an insurance is made by an agent or trustee, the fact that the principal or beneficiary is the person actually insured may be indicated by designation of the agent or trustee or by other general words in the insurance policy.

26.1-30-07. Joint or common interest must be shown in policy. When an insurance policy is entered into by a part owner of an interest, the terms of the insurance policy must be applicable to joint or common interest for the policy to be effective as to the interests of other part owners.

26.1-30-08. Person intended may claim benefit of policy. When the description of the insured in an insurance policy is so general that it may comprehend any person or any class of persons, the benefit of the policy may be claimed only by a person who can show that it was intended to include that person.

26.1-30-09. Agreement not to transfer claim on policy is void. An agreement made before a loss occurs that the insured will not transfer any claim that might arise on the insurance policy is void.

26.1-30-10. Warranties - Form and scope. A warranty is either express or implied. No particular form of words is necessary to create a warranty. It may relate to the past, present, or future, or to all of them.

26.1-30-11. Express warranty must be written as part of policy. Every express warranty made at or before the execution of an insurance policy must be contained in the policy or in another instrument signed by the insured and referred to in the policy as a part of the policy.

26.1-30-12. Statement of fact in policy is a warranty. A statement in an insurance policy of a matter relating to the person or thing insured or to the risk as a fact is an express warranty thereof.

26.1-30-13. Statement of intention in policy is a warranty. A statement in an insurance policy which imports that it is intended to do or not to do a thing which materially affects the risk is a warranty that the act or omission will take place.

26.1-30-14. Breach of warranty - When excused. When, before the time arrives for the performance of a warranty relating to the future, a loss insured against happens, or performance becomes impossible or unlawful at the place of the contract, the omission to fulfill the warranty does not avoid the insurance policy.

26.1-30-15. Policy may be rescinded for violation of material warranty. The violation of a material warranty or other material provision of an insurance policy on the part of either party to the policy entitles the other to rescind.

26.1-30-16. Effect of nonfraudulent breach of warranty in policy. A breach of warranty without fraud exonerates an insurer from the time the breach occurs, or when a warranty is broken in its inception, prevents the insurance policy from attaching to the risk.

26.1-30-17. Breach of immaterial provision does not avoid policy unless otherwise provided. An insurance policy may declare that a violation of specified provisions of the policy avoids it. In the absence of such declaration, the breach of an immaterial provision does not avoid the insurance policy.

26.1-30-18. Inception and expiration of policies - Inception of hail insurance policies. An insurance policy covers the insured at 12:01 a.m. on the day on which coverage begins and expires at 12:01 a.m. on the day of expiration of the policy. However, a policy of insurance on growing crops against loss by hail takes effect at the time and on the day stated on the application for the insurance. The provision allowing a policy of insurance on growing crops against loss by hail to take effect as provided on the application may not be limited or restricted by rule or bulletin of the commissioner.

26.1-30-19. Policy forms to be filed with and approved by commissioner.

1. No insurance policy, contract, agreement, or rate schedule may be issued or delivered in this state until the form of that policy, contract, agreement, or rate schedule has been filed with and approved by the commissioner.

2. No life insurance policy, certificate, contract, or agreement or annuity contract may be issued for delivery or delivered to any person in this state nor may any application, rider, or endorsement be used in connection therewith until the form thereof has been filed with and approved by the commissioner and is in compliance with chapters 26.1-33, 26.1-34, 26.1-35, and 26.1-37.

3. No insurance policy, certificate, contract, or agreement or notice of proposed insurance against loss or expense from the sickness, bodily injury, or death by accident of the insured may be issued for delivery or delivered to any person in this state nor may any application, rider, or endorsement be used in connection therewith until the form thereof and the classification of risks and the premium rates, or in the case of cooperatives or assessment companies the estimated costs pertaining thereto, have been filed with and approved by the commissioner. A form must be disapproved if the benefits provided are unreasonable in relation to the premium charge or if the benefits do not comply with chapters 26.1-36 and 26.1-37.

4. No casualty or fire and property insurance policy, certificate, contract, or agreement may be issued for delivery or delivered to any person in this state nor may any application, rider, or endorsement be used in connection therewith until the form thereof has been filed and approved by the commissioner to the extent rates are filed and approved pursuant to chapter 26.1-25.

26.1-30-20. Procedure for approval, disapproval, and withdrawal of approval by commissioner. No insurance policy, certificate, contract, agreement, or rate schedule, except as is otherwise provided, may be issued, nor may any application, rider, or endorsement be used in connection therewith until the expiration of thirty days after it has been filed unless the commissioner gives written approval. The commissioner may extend the thirty-day period for an additional period not to exceed fifteen days if the commissioner gives written notice within the thirty-day period to the insurer which made the filing that the commissioner needs the additional time for the consideration of the filing.

26.1-30-21. Disapproval of form by commissioner - Notice and hearing.

1. If the commissioner disapproves any form, the commissioner shall notify the company or organization which filed the form within thirty days after filing or within the additional period provided for in section 26.1-30-20 and provide written notice of disapproval of the form,

specifying the reasons for disapproval and stating that a hearing may be requested in writing within forty-five days. No company or organization may issue any insurance policy in the form which has been disapproved. If a hearing is requested, the commissioner may suspend or postpone the effective date of disapproval.

2. The commissioner may, at any time after a hearing of which not less than twenty days written notice has been given to the insurer, withdraw approval of any form if it contains a provision which is unjust, unfair, inequitable, misleading, or deceptive, or on any of the grounds stated in this title. It is unlawful for the insurer to issue the form or use it in connection with any policy after the effective date of withdrawal of approval. The notice of any hearing called under this subsection must specify the matters to be considered at the hearing and any decision affirming disapproval or directing withdrawal of approval under this section must be in writing and must specify the reasons for the decision.

SECTION 8. Chapter 26.1-31 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-31-01. "Reinsurance contract" defined. A reinsurance contract is one by which an insurer contracts with a third person to insure the insurer against loss or liability by reason of an original insurance contract made by the insurer.

26.1-31-02. Scope of reinsurance contract. A reinsurance contract is presumed to be a contract of indemnity against liability and not merely against damage.

26.1-31-03. Interest of insured in reinsurance contract. The original insured has no interest in a reinsurance contract.

26.1-31-04. Disclosures required on reinsurance. When an insurer obtains reinsurance, the insurer must communicate all the representations of the original insured and all the knowledge and information the insurer possesses, regardless of when acquired, which is material to the risk.

26.1-31-05. "Double insurance" defined. A double insurance exists when the same person is insured by several insurers separately in respect to the same interest.

26.1-31-06. Double insurance of one of several things. The procurement of any other insurance contract upon one or more of several distinct interests insured by one insurance policy does not render void any insurance upon the interests not covered by such other insurance contract. In case of loss or damage, the value of property doubly insured shall be deducted from the value of all the property covered by the insurance policy. Any agreement made to waive the provisions of this section is void.

26.1-31-07. Contribution of insurers on fire loss doubly insured. In case of double fire insurance, each insurer must contribute proportionally towards the loss without regard to the dates of the insurance policies.

SECTION 9. Chapter 26.1-32 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-32-01. Liability of insurer for loss - Proximate and remote cause. An insurer is liable for a loss proximately caused by a peril insured against even though a peril not contemplated by the insurance contract may have been a remote cause of the loss. An insurer is not liable for a loss of which the peril insured against was only a remote cause.

26.1-32-02. Liability of insurer for loss in rescuing thing insured. An insurer is liable when the thing insured is rescued from a peril insured against that otherwise would have caused a loss, if in the course of rescue the thing is exposed to peril not insured against which permanently deprives the insured of its possession in whole or in part. The insurer is liable, also, when a loss is caused by efforts to rescue the thing insured from a peril insured against.

26.1-32-03. Insurer not liable for excepted peril. When a peril is excepted specially in an insurance contract, a loss which would not have occurred but for that peril is excepted although the immediate cause of the loss was a peril which was not excepted.

26.1-32-04. Willful act exonerates insurer, negligence does not. An insurer is not liable for a loss caused by the willful act of the insured, but the insurer is not exonerated by the negligence of the insured or of the insured's agents or others.

26.1-32-05. Notice of loss must be given promptly. In case of loss upon an insurance against fire, an insurer is exonerated if notice of the loss is not given to the insurer by some person insured or entitled to the benefit of the insurance without unnecessary delay.

26.1-32-06. Proof or notice of loss - Requirements. When preliminary proof of loss is required by an insurance policy, the insured is not bound to give such proof as would be necessary in a court, but it is sufficient for the insured to give the best evidence which the insured has at the time.

26.1-32-07. Waiver of defects in notice of loss. All defects in a notice of loss or in preliminary proof of loss which the insured might remedy and which the insurer omits to specify to the insured without unnecessary delay as grounds of objection are waived.

26.1-32-08. Proof of loss - Insurer to furnish blanks - Waiver. When notice of loss is given to the insurer on behalf of the insured or the beneficiary of a life insurance policy, the insurer, within twenty days after receipt of notice, shall furnish to the insured or beneficiary, as the case may be, a blank form of proof of loss. In

the case of life insurance, the beneficiary shall have ninety days after receipt of the blank form in which to make proof of loss. In the case of insurance other than life insurance, the insured shall have sixty days after the blank form is furnished in which to make proof of loss. If the insurer fails to furnish a blank form of proof of loss within the required time, the insurer has waived the requirement of proof of loss. Any agreement made to waive the provisions of this section is void.

26.1-32-09. Waiver of delay in presenting notice or proof of loss. Delay in the presentation to an insurer of notice or proof of loss is waived if the delay is caused by any act of the insurer, or if the insurer fails to make a prompt and specific objection.

26.1-32-10. Policy requiring corroboration - Proof of loss - How made. If an insurance policy requires the certificate or testimony of a person other than the insured for a preliminary proof of loss, it is sufficient for the insured to use reasonable diligence to procure the evidence and in case of the refusal of the person to provide evidence, to furnish reasonable evidence to the insurer that refusal was not induced by any just grounds of disbelief of the facts necessary to be certified.

SECTION 10. Chapter 26.1-33 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-33-01. Life insurance policy contains entire contract. Every life insurance policy issued or delivered in this state by any life insurance corporation doing business in the state must contain the entire contract between the parties.

26.1-33-02. Solicitation of life insurance regulated by rule of the commissioner. Insurers must deliver to purchasers of life insurance information which will improve the purchaser's ability to select the most appropriate plan of life insurance for the purchaser's needs, which will improve the purchaser's understanding of the basic features of the policy which has been purchased or which is under consideration, and which will improve the ability of the purchaser to evaluate the relative costs of similar plans of life insurance. The commissioner shall adopt by rule the national association of insurance commissioners life insurance disclosure model regulation of December 9, 1983.

26.1-33-03. Form of life insurance policy restricted. No life insurance policy may be issued or delivered in this state unless the form of the policy is authorized by this chapter.

26.1-33-04. Single premium and nonparticipating life policies. A single premium life insurance policy may be issued in any form prescribed in this chapter omitting therefrom provisions or portions thereof applicable only to other than single premium policies. A nonparticipating life insurance policy may be issued in any form prescribed in this chapter if the policy contains a provision that

the policy is nonparticipating, and the policy omits clauses for participation in the surplus of the company.

26.1-33-05. Provisions required in life policy. No life insurance policy may be issued or delivered in this state, unless the policy contains:

1. A provision that all premiums are payable in advance either at the home office of the company, or to an agent of the company, upon delivery of a receipt signed by one or more of the officers who are named in the policy.

2. A provision that the policyholder is entitled to a thirty-one day grace period for the payment of every premium after the first, which may be subject to an interest charge, during which grace period the insurance continues in force. The provision may contain a stipulation that if the insured dies during the grace period, the overdue premium will be deducted in any settlement under the policy.

3. A provision that the policy constitutes the entire contract between the parties and is incontestable after it has been in force during the lifetime of the insured for two years from its date, except for nonpayment of premiums and except for violations of the policy relating to naval or military service in time of war, and, at the option of the company, provisions relative to benefits in the event of total and permanent disability and provisions that grant additional insurance specifically against death by accident also may be excepted.

4. A provision that all statements made by the insured, in the absence of fraud, are representations and not warranties, and that no such statement avoids the policy unless it is contained in a written application and a copy of the application is endorsed upon or attached to the policy when issued.

5. A provision that if the age of the insured has been understated, the amount payable under the policy is such as the premium would have purchased at the correct age.

6. A provision that the policy participates in the surplus of the company and that, beginning not later than the end of the third policy year, the company annually will determine and account for the portion of the divisible surplus accruing on the policy, and that the owner of the policy has the right each year to have the current dividend arising from such participation paid in cash; and if the policy provides other dividend options, it must provide further which one of the four standard options is effective if the owner of the policy does not elect any of the other options. The four standard options are:

payment in cash; application toward payment of any premiums; application to the purchase of paid-up additions to the policy; or accumulation to the credit of the policy with interest at the rate provided for in the policy and payable at the maturity of the policy or at the anniversary of the policy. This provision, however, is not required in nonparticipating policies.

7. A provision that after the policy has been in force three years, the company at any time while the policy is in force, will advance on proper assignment of the policy and on the sole security thereof, at a specified rate of interest, a sum equal to, or at the option of the owner of the policy, less than, the reserve at the end of the current policy year on the policy and on any dividend additions thereto, computed according to a mortality table, interest rate, and method of valuation permitted by chapter 26-10.1, less a sum not more than two and one-half percent of the amount insured by the policy and of any dividend additions thereto; and that the company will deduct from the loan value any existing indebtedness on the policy and any unpaid balance of the premium for the current policy year, and may collect interest in advance on the loan to the end of the current policy year. The provision may provide further that the loan may be deferred for not exceeding six months after the application for the loan is made. It must be stipulated further in the policy that failure to repay any advance or to pay interest thereon does not void the policy unless the total indebtedness thereon to the company equals or exceeds the loan value at the time of the failure nor until one month after notice has been mailed by the company to the last known address of the insured and of the assignee, if any. No other condition may be exacted as a prerequisite to any such advance. This provision is not required in a policy of term insurance.

8. A provision that if, in event of default in premium payments, the value of the policy is applied to the purchase of other insurance, and if the insurance is in force and the original policy has not been surrendered to the company and canceled, the policy may be reinstated within three years from the default upon evidence of insurability satisfactory to the company and payment of arrears of premiums with interest.

9. A provision that when a policy becomes a claim by the death of the insured, settlement must be made upon receipt of due proof of death, or not later than two months after receipt of the proof.

10. A table showing the amounts of installments in which the policy may provide its proceeds may be payable.

11. A title on the face and on the back of the policy correctly describing the policy.

12. A statement whether any conditions or restrictions of liability by reason of travel, occupation, change of residence, or suicide are provided. These restrictions, except in the case of armed forces or military service in time of war, may only be effective during the first year after the issuance of the policy for suicide and for two years after the issuance of the policy in all other instances.

Any of the foregoing provisions or portions thereof, relating to premiums not applicable to single premium policies, may not be incorporated to the extent to which they are inapplicable in a single premium policy.

26.1-33-06. Provisions prohibited in life policy. No life insurance policy may be issued or delivered in this state if it contains any of the following:

1. A provision for forfeiture of the policy for failure to repay any loan on the policy, or to pay interest on such loan, while the total indebtedness on the policy is less than the loan value thereof; or any provision for forfeiture for failure to repay any such loan or to pay interest on the loan unless the provision contains a stipulation that no forfeiture occurs until at least one month after notice has been mailed by the company to the last known address of the insured and of the assignee, if any.

2. A provision limiting the time within which any action may be commenced to less than five years after the claim for relief accrues.

3. A provision by which the policy purports to be issued or take effect more than six months before the original application for the insurance was made. This subsection does not prohibit the exchange, alteration, or conversion of any policy of life insurance.

4. A provision for any mode of settlement at maturity of less value than the amount insured on the face of the policy plus dividend additions, if any, less any indebtedness to the company on the policy and less any premium that by the terms of the policy may be deducted.

26.1-33-07. Life policy issued by domestic companies in foreign state may conform to laws thereof. The life insurance policies of a domestic life insurance company, when issued or delivered in any other state, country, province, or territory, may contain any provision required by the laws of the state, country, province, or territory in which issued, anything in this chapter to the contrary notwithstanding.

26.1-33-08. Exempted companies. Sections 26.1-33-03 through 26.1-33-07 do not apply to annuity or industrial policies nor to corporations or associations operating on the assessment or fraternal plan.

26.1-33-09. Cooperative or assessment life association must identify policies. Every cooperative or assessment life association transacting business in this state shall print in bold type and in red ink, near the top of the front page of each policy or certificate issued upon the life of any resident of this state, the words "issued upon the assessment plan".

26.1-33-10. Agreement depriving insured in life policy of right to apportionment of surplus and automatic insurance void. No agreement between a life insurance company and a holder of a participating policy or an applicant for insurance under a participating policy relating to the apportionment annually of the surplus of the company, the rights of the policyholder in the surplus, automatic insurance, or to the limitation on contingency reserves, waives any of the provisions of this chapter relating thereto.

26.1-33-11. Group life policy - Required provisions. No group life insurance policy may be delivered in this state unless it contains in substance the following provisions, or provisions which in the opinion of the commissioner are more favorable to the insureds, or at least as favorable to the insureds and more favorable to the policyholder; provided, however, that the standard provisions required for an individual life insurance policy may not apply to a group life insurance policy:

1. A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the death benefit coverage continues in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such a grace period.

2. A provision that the validity of the policy may not be contested except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that no statement made by any person insured under the policy relating to insurability may be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two years during the insured's lifetime nor unless it is contained in a written instrument signed by the insured; provided, however, that no such provision may preclude the assertion of any time of defenses based upon provisions in the policy which relate to eligibility for coverage.

3. A provision that a copy of the application, if any, of the policyholder will be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are representations and not warranties, and that no statement made by any insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured or, in the event of death or incapacity of the insured, to the insured's beneficiary or personal representative.

4. A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage.

5. A provision specifying an equitable adjustment of premiums or of benefits or of both to be made if the age of an insured has been misstated. The provision must contain a clear statement of the method of adjustment to be made.

6. A provision that any sum becoming due by reason of the death of an insured is payable to the beneficiary designated by the insured, except that where the policy contains conditions pertaining to family status the beneficiary may be the family member specified by the policy terms, subject to the provisions of the policy in the event there is no designated beneficiary, as to all or any part of such sum, living at the death of the insured and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding five thousand dollars to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured.

7. If the group life insurance policy is on a plan of insurance other than the term plan, a nonforfeiture provision which in the opinion of the commissioner is equitable to the insureds and to the policyholder, but this does not require the policy to contain the same nonforfeiture provision required for an individual life insurance policy.

8. A provision that the insurer will issue to the policyholder for delivery to each insured a certificate setting forth a statement as to the insurance protection to which that person is entitled, a statement as to any dependent's coverage included in the certificate, and the rights and conditions set forth in subsections 9, 10, 11, and 12.

9. A provision that if the insurance, or any portion of it, on an insured or on the dependent of an insured, ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, the insured is entitled to have issued to the insured by the insurer, without evidence of insurability, an individual life insurance policy without disability or other supplementary benefits, provided application for the individual policy is made, and the first premium paid to the insurer, within thirty-one days after such termination, and provided further that:

   a. The individual policy must, at the option of such person, be on any one of the forms then customarily issued by the insurer at the age and for the amount applied for, except that the group policy may exclude the option to elect term insurance.

   b. The individual policy must be in an amount not in excess of life insurance which ceases because of such termination, less the amount of life insurance for which the person becomes eligible under the same or any other group policy within thirty-one days after termination, provided that any amount of insurance which has matured on or before the date of termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, may not, for purposes of this provision, be included in the amount which is considered to cease because of the termination; and

   c. The premium on the individual life insurance policy is at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to the individual age attained on the effective date of the individual policy.

   Subject to the same conditions set forth above, the conversion privilege must be available to a surviving dependent, if any, at the death of the employee or member, with respect to the coverage under the group policy which terminates by reason of such death and to the dependent of the employee or member upon termination of coverage of the dependent, while the employee or member remains under the group policy, by reason of the dependent ceasing to be a qualified family member under the group policy.

10. A provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every insured at the date of termination whose insurance terminates, including the insured dependent of a covered person, and who has been so insured for at least five years prior to the termination date is

entitled to have issued by the insurer an individual life insurance policy, subject to the same conditions and limitations as are provided by subsection 9, except that the group policy may provide that the amount of such individual policy may not exceed the smaller of (a) the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which the person is or becomes eligible under a group policy issued or reinstated by the same or another insurer within thirty-one days after such termination, or (b) ten thousand dollars.

11. A provision that if an insured, or the insured dependent of a covered person, dies during the period within which the individual would have been entitled to have an individual life insurance policy issued in accordance with subsection 9 or 10 and before such an individual policy has become effective, the amount of life insurance that the insured would have been entitled to have issued under the individual policy is payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made.

12. Where active employment is a condition of insurance, a provision that an insured may continue coverage during the insured's total disability by timely payment to the policyholder of that portion, if any, of the premium that would have been required from the insured had total disability not occurred. The continuation shall be on a premium paying basis for a period of six months from the date on which the total disability started, but not beyond the earlier of (a) approval by the insurer of continuation of the coverage under any disability provision which the group policy may contain, or (b) the discontinuance of the group policy.

26.1-33-12. Group life policy conversion privileges. If any individual insured under a group life insurance policy delivered in this state after July 1, 1983, becomes entitled under the terms of the policy to have an individual life insurance policy issued without evidence of insurability, subject to making of application and payment of the first premium within the period specified in the policy, and if the individual is not given notice of the existence of the right at least fifteen days prior to the expiration date of the period, then the individual has an additional period within which to exercise that right. This additional period expires fifteen days after the individual is given notice. Written notice presented to the individual or mailed to the policyholder to the last known address of the individual or mailed by the insurer to the last known address of the individual as furnished by the policyholder or notice of the right of conversion included in a certificate provided to each employee or notice provided by the

attachment of a separate notice to the certificate constitutes notice for the purpose of this section.

26.1-33-13. Variable life contracts - Separate accounts. Any domestic life insurance company, including any domestic fraternal benefit society that operates on a legal reserve basis, may establish one or more separate accounts and may allocate thereto amounts, including proceeds applied under optional modes of settlement or under dividend options, to provide for life insurance, and benefits incidental thereto, payable in fixed or variable amounts or both, subject to the following:

1. The income, gains, and losses, realized or unrealized from assets allocated to a separate account, must be credited to or charged against the account, without regard to other income, gains, or losses of the company.

2. Except as may be provided with respect to reserves for guaranteed benefits and funds referred to in subsection 3:

   a. Amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by laws of this state governing the investments of life insurance companies.

   b. Investments in a separate account or accounts may not be taken into account in applying the investment limitations otherwise applicable to the investments of the company.

3. Except with the approval of the commissioner and under any conditions as to investments and other matters the commissioner may prescribe, which must recognize the guaranteed nature of the benefits provided, reserves for benefits guaranteed as to dollar amount and duration and funds guaranteed as to principal amount or stated rate of interest may not be maintained in a separate account.

4. Unless otherwise approved by the commissioner, assets allocated to a separate account must be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to the separate account. Unless otherwise approved by the commissioner, the portion of the assets of the separate account equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in subsection 3 must be valued in accordance with the rules otherwise applicable to the company's assets.

5. Amounts allocated to a separate account are owned by the company, and the company may not be, nor hold itself out

to be, a trustee with respect to such amounts. To the extent provided under the applicable contracts, that portion of the assets of any separate account equal to the reserves and other contract liabilities with respect to the account is not chargeable with liabilities arising out of any other business the company may conduct.

6. No sale, exchange, or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and its separate accounts unless, in case of a transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless the transfer, whether into or from a separate account, is made by a transfer of cash or by a transfer of securities having a readily determinable market value, provided that a transfer of securities is approved by the commissioner. The commissioner may approve other transfers among such accounts if, in the commissioner's opinion, the transfers would not be inequitable.

7. To the extent the company determines it is necessary to comply with any applicable federal or state laws, the company, with respect to any separate account, including any separate account which is a management investment company or a unit investment trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct of the business of the account, including special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and selection of a committee, the members of which need not be otherwise affiliated with the company, to manage the business of the account.

26.1-33-14. License required for variable life contracts. No company may deliver or issue for delivery in this state variable life insurance contracts unless it is licensed or organized to do a life insurance business in this state, and the commissioner is satisfied that the company's condition or method of operation in connection with the issuance of variable contracts will not render its operation hazardous to the public or its policyholders in this state. In this connection, the commissioner shall consider, among other things, the history and financial condition of the company; the character, responsibility, and fitness of the officers and directors of the company; and the laws and rules under which the company is authorized in the state of domicile to issue variable life insurance contracts. If the company is a subsidiary of an admitted life insurance company, or affiliated with such company through common management or ownership, it may be deemed by the commissioner to have met the provisions of this section if it or the parent or the affiliated company meets these requirements.

26.1-33-15. Content of variable life contracts. Any variable life insurance contract delivered or issued for delivery in this state must contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of the variable benefits. Any contract under which the benefits vary to reflect investment experience, including a group contract and any certificate in evidence of variable benefits issued thereunder, must state that the dollar amount will so vary and must contain on its first page a statement to the effect that the benefits under the contract are on a variable basis.

26.1-33-16. Policy provisions exceptions for variable life contracts. Except for subsections 2, 6, 7, 8, and 10 of section 26.1-33-05, and except as otherwise provided in sections 26.1-33-13 through 26.1-33-15, all pertinent provisions of this title apply to separate accounts and variable life insurance contracts. Any individual variable life insurance contract, delivered or issued for delivery in this state, must contain grace, reinstatement, and nonforfeiture provisions appropriate to the contract. The reserve liability for variable contracts must be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

26.1-33-17. Rulemaking authority relating to variable life contracts. The commissioner may adopt reasonable rules to implement sections 26.1-33-13 through 26.1-33-16.

26.1-33-18. Required provisions relating to lapsing policyholder. In the case of policies issued after December 31, 1978, no life insurance policy, except as stated in section 26.1-33-28, may be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements hereinafter specified and are essentially in compliance with section 26.1-33-27:

1. In the event of default in any premium payment, the company will grant, upon proper request not later than sixty days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of the due date, of the amount as may be hereinafter specified. In lieu of the stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than sixty days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit that provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

2. Upon surrender of the policy within sixty days after the due date of any premium payment in default after premiums have been paid for at least three full years in the case of ordinary insurance or five full years in the case of

industrial insurance, the company will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of the amount as may be hereinafter specified.

3. A specified paid-up nonforfeiture benefit becomes effective as specified in the policy unless the person entitled to make the election elects another available option not later than sixty days after the due date of the premium in default.

4. If the policy has become paid-up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, then the company will pay, upon surrender of the policy within thirty days after any policy anniversary, a cash surrender value of the amount as may be hereinafter specified.

5. In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate or rates used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first twenty policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy.

6. A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of this state. An explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy. If a detailed statement of the method of computation of the values and benefits shown in the policy is not stated in the policy, a statement that the method of computation has been filed with the commissioner. A statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the

policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

The company shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy.

26.1-33-19. Minimum cash surrender value.

1. Any cash surrender value available under a life insurance policy in the event of default in a premium payment due on any policy anniversary, whether or not required by section 26.1-33-18, must be an amount not less than the excess, if any, of the present value, on the anniversary, of the future guaranteed benefits which would have been provided by the policy, including any existing paid-up additions, if there had been no default, over the sum of (a) the then present value of the adjusted premiums as defined in sections 26.1-33-21 through 26.1-33-24 corresponding to premiums which would have fallen due on and after such anniversary, and (b) the amount of any indebtedness to the company on the policy.

2. Any life insurance policy issued on or after the operative date of section 26.1-33-24, which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in subsection 1 must be an amount not less than the sum of the cash surrender value as defined in that subsection for an otherwise similar policy issued at the same age without the rider or supplemental policy provision and the cash surrender value as defined in that subsection for a policy which provides only the benefits otherwise provided by the rider or supplemental policy provision.

3. For any family life insurance policy issued on or after the operative date of section 26.1-33-24, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age seventy-one, the cash surrender value referred to in subsection 1 must be an amount not less than the sum of the cash surrender value as defined in that subsection for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in that subsection for a policy which provides only the benefits

otherwise provided by such term insurance on the life of the spouse.

4. Any cash surrender value available within thirty days after any policy anniversary under any policy paid-up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by section 26.1-33-18, must be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the company on the policy.

26.1-33-20. Minimum paid-up nonforfeiture benefit. Any paid-up nonforfeiture benefit available under a life insurance policy in the event of default in a premium payment due on any policy anniversary must be such that its present value as of the anniversary must be at least equal to the cash surrender value then provided by the policy or, if none is provided, that cash surrender value which would have been required by sections 26.1-33-18 through 26.1-33-28 in the absence of the condition that premiums must have been paid for at least a specified period.

26.1-33-21. Definition of adjusted premiums used in obtaining minimum cash surrender value.

1. Except as provided in subsection 3, the adjusted premiums for any policy must be calculated on an annual basis and must be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts stated in the policy as extra premiums to cover impairments or special hazards, that the present value, at the date of issue of the policy, of all the adjusted premiums equals the sum of:

   a. The then present value of the future guaranteed benefits provided by the policy.

   b. Two percent of the amount of insurance, if the insurance is uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy.

   c. Forty percent of the adjusted premium for the first policy year.

   d. Twenty-five percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life insurance policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less.

In applying the percentages specified in subdivisions c and d, no adjusted premium may be deemed to exceed four percent of the amount of insurance or equivalent uniform amount. The date of issue of a policy for the purpose of this section is the date as of which the rated age of the insured is determined.

2. In the case of a life insurance policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount of insurance for the purpose of this section is the level amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue of the policy as do the benefits under the policy.

3. The adjusted premiums for any life insurance policy providing term insurance benefits by rider or supplemental policy provision must be equal to (a) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for the term insurance benefits are payable, by (b) the adjusted premiums for such term insurance, the foregoing items (a) and (b) must be calculated separately and as specified in subsections 1 and 2 except that, for the purposes of subdivisions b, c, and d of subsection 1, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (b) must be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (a).

4. This section does not apply to life insurance policies issued on or after the operative date of section 26.1-33-24.

26.1-33-22. Mortality and interest bases for adjusted premiums and present values - Ordinary insurance. In the case of ordinary policies, all adjusted premiums and present values referred to in sections 26.1-33-18 through 26.1-33-28 must be calculated on the basis of the commissioners' 1958 standard ordinary mortality table and the rate or rates of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. No such rate of interest may exceed five and one-half percent per year, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent per year may be used. For any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured. In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as

a nonforfeiture benefit, the rates of mortality assumed may be not greater than those shown in the commissioners' 1958 extended term insurance table. For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner. This section does not apply to ordinary life insurance policies issued on or after the operative date of section 26.1-33-24.

26.1-33-23. Mortality and interest bases for adjusted premiums and present values - Industrial insurance. In the case of industrial policies, all adjusted premiums and present values referred to in sections 26.1-33-18 through 26.1-33-28 must be calculated on the basis of the commissioners' 1961 standard industrial mortality table and the rate or rates of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. No such rate of interest may exceed five and one-half percent per year, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent per year may be used. In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not greater than those shown in the commissioners' 1961 industrial extended term insurance table. For insurance issued on a substandard basis, the calculations of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner. This section does not apply to industrial policies issued on or after the operative date of section 26.1-33-24.

26.1-33-24. Determination of minimum values.

1. Except as provided in subsection 7, the adjusted premiums for any policy must be calculated on an annual basis and must be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums equals the sum of:

   a. The then present value of the future guaranteed benefits provided for by the policy.

   b. One percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years.

c. One hundred twenty-five percent of the nonforfeiture net level premium as hereinafter defined.

In applying the percentage specified in subdivision c, no nonforfeiture net level premium may exceed four percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this section is the date as of which the rated age of the insured is determined.

2. The nonforfeiture net level premium is equal to the present value, at the date of issue of the life insurance policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

3. In the case of life insurance policies that cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or that provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values must initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values must be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

4. Except as otherwise provided in subsection 7, the recalculated future adjusted premiums for any life insurance policy must be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums equals the excess of (a) the sum of the then present value of the then future guaranteed benefits provided for by the policy, and the additional expense allowance, if any, over (b) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

5. The additional expense allowance, at the time of the change to the newly defined benefits or premiums, is the sum of (a) one percent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and (b) one hundred twenty-five percent of the increase, if positive, in the nonforfeiture net level premium.

6. The recalculated nonforfeiture net level premium is equal to the result obtained by dividing the sum of:

   a. The nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred; and

   b. The present value of the increase in future guaranteed benefits provided for by the policy; by

   c. The present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

7. Notwithstanding any other provision of this section to the contrary, in the case of a life insurance policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, the policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for the substandard policy may be calculated as if it were issued to provide the higher uniform amounts of insurance on the standard basis.

8. All adjusted premiums and present values referred to in sections 26.1-33-18, 26.1-33-19, 26.1-33-21 through 26.1-33-26, and 26.1-33-28 must for all ordinary life insurance policies be calculated on the basis of (a) the commissioners' 1980 standard ordinary mortality table, or (b) at the election of the company for any one or more specified plans of life insurance, the commissioners' 1980 standard ordinary mortality table with ten-year select mortality factors; must for all policies of industrial insurance be calculated on the basis of the commissioners' 1961 standard industrial mortality table; and must for all policies issued in a particular calendar year be

calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this section for policies issued in that calendar year. However:

a. At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this section, for policies issued in the immediately preceding calendar year.

b. Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by section 26.1-33-18, must be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.

c. A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

d. In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners' 1980 extended term insurance table for ordinary life insurance policies and not more than the commissioners' 1961 industrial extended term insurance table for industrial insurance policies.

e. For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the tables.

f. Any ordinary mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by rule adopted by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the commissioners' 1980 standard ordinary mortality table with or without ten-year select mortality factors or for the commissioners' 1980 extended term insurance table.

g. Any industrial mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by rule adopted by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the commissioners'

1961 standard industrial mortality table or the commissioners' 1961 industrial extended term insurance table.

9. The nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred twenty-five percent of the calendar year statutory valuation interest rate for such policy as defined in sections 26.1-35-01 through 26.1-35-10, rounded to the nearer one quarter of one percent.

10. Notwithstanding any other provision in this title to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values does not require refiling of any other provisions of that policy form.

11. This section applies to all life insurance policies issued after December 31, 1988, unless the insurance company, by written notice filed with the commissioner, opts for an earlier operative date.

26.1-33-25. Determination of minimum value of policies with future premium determination - Indeterminable value. In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in sections 26.1-33-18 through 26.1-33-24, then:

1. The commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by sections 26.1-33-18 through 26.1-33-24;

2. The commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds; and

3. The cash surrender values and paid-up nonforfeiture benefits provided by the plan may not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of sections 26.1-33-18 through 26.1-33-28, as determined by rules adopted by the commissioner.

26.1-33-26. Benefits on default off the anniversary - Exempted benefits. Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, must

be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in sections 26.1-33-19 through 26.1-33-24 may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, may be not less than the amounts used to provide the additions. Notwithstanding section 26.1-33-19, additional benefits payable (1) in the event of death or dismemberment by accident or accidental means; (2) in the event of total and permanent disability; (3) as reversionary annuity or deferred reversionary annuity benefits; (4) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, sections 26.1-33-18 through 26.1-33-28 would not apply; (5) as term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six years, is uniform in amount after the child's age is one year, and has not become paid-up by reason of the death of a parent of the child; and (6) as other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits, must be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by sections 26.1-33-18 through 26.1-33-28, and no such additional benefits may be required to be included in any paid-up nonforfeiture benefits.

26.1-33-27. Determination of minimum values after January 1, 1987.

1. Any cash surrender value available under a life insurance policy in the event of default in a premium payment due on any policy anniversary must be in an amount which does not differ by more than two-tenths of one percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years, from the sum of (a) the greater of zero and the basic cash value hereinafter specified and (b) the present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

2. The basic cash value is equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors corresponding to premiums that would have fallen due on and after such anniversary. However, the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in section 26.1-33-19 or 26.1-33-21, whichever is applicable, shall be the same as are the effects specified in section 26.1-33-19 or 26.1-33-21, whichever is applicable, on the cash surrender values defined in that section.

3. The nonforfeiture factor for each policy year is an amount equal to a percentage of the adjusted premium for the policy year, as defined in section 26.1-33-21 or 26.1-33-24, whichever is applicable. Except as is required by subsection 4, the percentage:

   a. Must be the same percentage for each policy year between the second policy anniversary and the later of the fifth policy anniversary and the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and

   b. Must be such that no percentage after the later of the two policy anniversaries specified in subdivision a may apply to fewer than five consecutive policy years.

4. No basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in section 26.1-33-21 or 26.1-33-24, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

5. All adjusted premiums and present values referred to in this section must for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with sections 26.1-33-18, 26.1-33-19, 26.1-33-21 through 26.1-33-26, and 26.1-33-28. The cash surrender values referred to in this section include any endowment benefits provided for by the policy.

6. Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment must be determined in manners consistent with the manners specified for determining the analogous minimum amounts in sections 26.1-33-18 through 26.1-33-20, 26.1-33-24, and 26.1-33-26. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as items (1) through (6) in section 26.1-33-26 must conform with the principles of this section.

7. This section, in addition to all other applicable provisions of sections 26.1-33-18, 26.1-33-19, 26.1-33-21

through 26.1-33-26, and 26.1-33-28, applies to all policies issued on or after January 1, 1987.

26.1-33-28. Exemptions from nonforfeiture provisions. Sections 26.1-33-18 through 26.1-33-27 do not apply to:

1. Reinsurance.
2. Group insurance.
3. Pure endowment.
4. An annuity or reversionary annuity contract.
5. A term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy.
6. A policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in sections 26.1-33-21 through 26.1-33-24 is less than the adjusted premium so calculated on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy.
7. A policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in sections 26.1-33-19 through 26.1-33-24, exceeds two and one-half percent of the amount of insurance at the beginning of the same policy year.
8. A policy delivered outside this state through an agent or other representative of the company issuing the policy.

For purposes of determining the applicability of sections 26.1-33-18 through 26.1-33-28, the age of expiry for a joint term life insurance policy is the age of expiry of the oldest life.

26.1-33-29. Applicability of life policy simplification standards.

1. Except as provided in subsection 3, sections 26.1-33-29 through 26.1-33-32 apply to all individual and group life insurance policies, insurance certificates under group life insurance policies, and death benefit certificates issued by fraternal benefit societies filed after June 30,

1982. No policy may be delivered or issued for delivery in this state after June 30, 1986, unless the policy form has been approved by the commissioner or is permitted to be issued under sections 26.1-33-29 through 26.1-33-32. Any policy form that has been approved or permitted to be issued prior to July 1, 1986, and that meets the standards set by sections 26.1-33-29 through 26.1-33-32 need not be refiled for approval, but may continue to be delivered or issued for delivery in this state upon the filing with the commissioner of a list of the forms identified by form number and accompanied by a certificate as to each form in the manner provided in subsection 6 of section 26.1-33-30.

2. The commissioner may extend the dates in subsection 1.

3. Sections 26.1-33-29 through 26.1-33-32 do not apply to:

   a. A policy that is a security subject to federal jurisdiction.

   b. A group life insurance policy covering a group of one thousand or more lives at date of issue. However, this does not except any certificate issued pursuant to a group policy delivered or issued for delivery in this state.

   c. A group annuity contract that serves as a funding vehicle for pension, profit sharing, or deferred compensation plans.

   d. A form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates the form must be approved under sections 26.1-33-29 through 26.1-33-32.

   e. The renewal of a policy delivered or issued for delivery prior to the dates the form must be approved under sections 26.1-33-29 through 26.1-33-32.

4. No other state law setting language simplification standards applies to a policy form.

26.1-33-30. Minimum life policy language simplification standards.

1. No policy form may be delivered or issued for delivery in this state, unless:

   a. The text achieves a minimum score of forty on the Flesch reading ease test or an equivalent score on any other comparable test as provided in subsection 3.

b. It is printed, except for specification pages, schedules, and tables, in not less than ten-point type, one point leaded.

c. The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsement or rider.

d. It contains a table of contents or an index of the principal sections of the policy, if the policy has more than three thousand words printed or three or fewer pages of text, or if the policy has more than three pages regardless of the number of words.

2. The commissioner may authorize a lower score than the Flesch reading ease score required in subdivision a of subsection 1 whenever the commissioner finds that a lower score:

a. Will provide a more accurate reflection of the readability of a policy form.

b. Is warranted by the nature of a particular policy form or type or class of policy forms.

c. Is caused by certain policy language which is drafted to conform to the requirements of any state law or rule, or agency interpretation.

3. A Flesch reading ease test score is measured by the following method:

a. For policy forms containing ten thousand words or less of text, the entire form must be analyzed. For policy forms containing more than ten thousand words, the readability of two 2-hundred word samples per page may be analyzed instead of the entire form. The samples must be separated by at least twenty printed lines.

b. The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of one and fifteen thousandths.

c. The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of eighty-four and six-tenths.

d. The sum of the figures computed under subdivisions b and c subtracted from two hundred six and eight hundred thirty-five thousandths equals the Flesch reading ease score for the policy form.

e. For purposes of subdivisions b, c, and d, the following procedures must be used:

(1) A contraction, hyphenated word, or numbers and letters, when separated by spaces, are counted as one word.

(2) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, is counted as a sentence.

(3) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

4. As used in this section, "text" includes all printed matter except:

a. The name and address of the insurer, the name, number, or title of the policy, the table of contents or index, captions and subcaptions, specification pages, schedules, and tables.

b. Any policy language drafted to conform to the requirements of any federal law, regulation, or agency interpretation, any policy language required by any collectively bargained agreement, any medical terminology, any words defined in the policy, and any policy language required by law or rule; provided, however, the insurer identifies the language or terminology excepted by this subdivision and certifies, in writing, that the language or terminology is entitled to be excepted by this subdivision.

5. The commissioner may approve any other reading test for use as an alternative to the Flesch reading ease test if the other test is comparable in result to the Flesch reading ease test.

6. Filings subject to this section must be accompanied by a certificate signed by an officer of the life insurance company or fraternal benefit society stating that it meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved in accordance with subsection 2. To confirm the accuracy of any certification, the commissioner may require the submission of further information to verify the certification in question.

7. At the option of the life insurance company or fraternal benefit society, riders, endorsements, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

26.1-33-31. Approval of life policy forms. A policy form meeting the requirements of subsection 1 of section 26.1-33-30 must be approved notwithstanding any other law which specifies the contents of a policy, if the policy form provides the policyholders and claimants protection not less favorable than they would be entitled to under such laws.

26.1-33-32. Effect of life policy simplification standards on filed policies. Sections 26.1-33-29 through 26.1-33-31 do not negate any law of this state permitting the issuance of a policy form after it has been on file for the required time period and has not been disapproved by the commissioner.

26.1-33-33. Life policy transferable. A life insurance policy may pass by transfer, will, or succession to any person, whether that person has an insurable interest or not, and that person may recover upon the policy in accordance with the terms of the policy. An insured under a group life insurance policy, pursuant to agreement among the insured, the group policyholder, and the insurer, 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. An assignment, whether made prior to or subsequent to July 1, 1971, is valid for the purpose of vesting in the assignee all the incidents of ownership assigned, and entitles the insurer to deal with the assignee as the owner in accordance with the policy, but without prejudice to the insurer on account of any payment made or individual policy issued prior to receipt by the insurer of such notice as may be required by the policy.

26.1-33-34. Notice of transfer of life policy unnecessary - Exception. Notice to an insurer of a transfer or bequest of a life insurance policy is not necessary to preserve the validity of the policy unless notice is required by the policy.

26.1-33-35. Insurance in favor of corporation on life of corporate officer or employee - Powers of corporation. Whenever a domestic corporation causes to be insured the life of any director, officer, agent, or employee of the corporation, or whenever a domestic corporation is named as a beneficiary in or assignee of any life insurance policy, due authority to effect, assign, release, relinquish, convert, or surrender, or to change the beneficiary in, the policy, or to take any other or different action with reference to, the insurance, is sufficiently evidenced to the insurance company by a written statement to that effect signed by the president and the secretary or other corresponding officers of the corporation. The statement is binding upon the corporation and protects the insurance company

in any act done or suffered by it upon the faith of the notice without further inquiry into the validity of the corporate authority or the regularity of the corporate proceedings. No person may be disqualified, by reason of interest in the subject matter, from acting as a director or as a member of the executive committee of the corporation on any corporate act touching the insurance.

26.1-33-36. Rights in life policies exempt from claims of creditors. The surrender value of any life insurance policy which, upon the death of the insured, would be payable to the spouse, children, or any relative of the insured dependent, or likely to be dependent, upon the insured for support, is exempt absolutely from the claims of creditors of the insured. No creditor of the insured, and no court or officer of a court acting for any such creditors, may elect for the insured to have the life insurance policy surrendered or in anywise converted into money, and no life insurance policy or property right in the policy belonging to the holder, and no value thereof, may be subject to seizure under any process of any court under any circumstance.

26.1-33-37. Suicide no defense to life policy after one year. In any suit on a life insurance policy, it is no defense after the policy has been in force one year that the insured committed suicide, and any provision or stipulation to the contrary in the policy is void.

26.1-33-38. Measure of indemnity in life policy. Unless the interest of a person insured is susceptible of exact pecuniary measurement, the measure of indemnity under a life insurance policy is the sum fixed in the policy.

26.1-33-39. Life policy - When payable. A life insurance policy may be made payable on the death of the insured or on the insured's surviving a specified period, or periodically so long as the insured lives, or otherwise contingently on the continuance or termination of life.

26.1-33-40. Avails of life policy payable to deceased or to the deceased's heirs, personal representatives, or estate - Exemption - Distribution. The avails of a life insurance policy or of a contract payable by any mutual aid or benevolent society, when made payable to the deceased, to the personal representatives of the deceased, to the deceased's heirs, or to the deceased's estate, is not subject to the debts of the decedent upon the death of the insured or member of the society except by special contract. The avails must be inventoried as a part of the estate of the decedent and must be considered as part of the general assets of the estate. The insured may transfer the avails of the life insurance policy or contract either by will or by contract. Nothing contained in this section affects, in any manner, any life insurance policy or beneficiary certificate which is made payable to a designated person, including the spouse of the insured, or to persons or to members of a family designated as a class, such as "all children" or "all brothers and sisters", even though the members of the class are not designated by name; or permits any insured to dispose of the avails of a contract by a mutual or

fraternal society by will to anyone who could not be a beneficiary in the contract under the charter or bylaws of the society.

26.1-33-41. Designation of beneficiary not affected by wills law. A designation in accordance with the terms of any insurance, annuity, or endowment contract where the designation in any agreement issued or entered into by the insurance company in connection therewith, supplemental thereto, or in settlement thereof, or the designation under a thrift, pension, retirement, death benefit, stock bonus, or profit-sharing contract, plan, system, or trust, created by an employer for the exclusive benefit of some or all of the employer's employees, or their beneficiary, of a person to be a beneficiary, payee, or owner of any right, title, or interest thereunder upon the death of another, is not subject to or defeated or impaired by any law relating to the signing and attestation of wills, even though the designation is revocable with the rights of the beneficiary, payee, or owner, or otherwise subject to defeasance.

26.1-33-42. Designation of trustee as beneficiary - Prior existence of will not required - Payments - Discharge.

1. Under section 26.1-33-41, it is permissible to designate as beneficiary, payee, or owner, a trustee named in any inter vivos or testamentary trust whether or not such will (or codicil) is in existence at the date of such designation. It is not necessary to the validity of the trust that there be in existence a trust corpus other than the right to receive the benefits or to exercise the rights resulting from such a designation.

2. It is also permissible to designate as a beneficiary, payee, or owner, a trustee named or to be named in, or ascertainable under, the will of the designator. Benefits or rights resulting from such a designation are payable or transferable to the trustee upon admission of the will (or codicil) to probate. Upon the payment of benefits to the trustee, the benefits must be held, administered, and disposed of in accordance with the terms of the testamentary trust created by the will (or codicil). Payment of the benefits does not cause the benefits or rights to be included in the property administered as part of the designator's estate as subject to the claims of creditors.

3. If a trustee is designated pursuant to this section and no qualified trustee makes claim to the benefits or rights resulting from the designation within one year of the death of the designator, or if it is satisfactory to the person obligated to make the payment or transfer as furnished within the one-year period that there is or will be no trustee to receive the proceeds, payment or transfer must be made to the person or representative of the designator, unless otherwise provided by the designation

or other controlling agreement made during the lifetime of the designator.

4. The payment of the benefits due or a transfer of the rights given under a designation pursuant to this section and the receipt of the payment or transfer executed by the trustee or other authorized payee constitutes a full discharge and acquittance of the person or institution obligated to make payment or transfer.

26.1-33-43. Commingling of death benefits with trust assets. Death benefits held in trust may be commingled with any other assets which may properly come into the trust. Sections 26.1-33-41 and 26.1-33-42 do not invalidate previous life insurance policy beneficiary designations naming trustees of trusts established by will.

SECTION 11. Chapter 26.1-34 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-34-01. Required annuity contract provisions relating to cessation of payment of considerations by contractholder. In the case of annuity contracts issued after June 30, 1979, unless the company, by written notice filed with the commissioner, opted for an earlier operative date, no annuity contract, except as stated in section 26.1-34-10, may be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contractholder upon cessation of payment of considerations under the contract:

1. Upon cessation of payment of considerations under an annuity contract, the company will grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in sections 26.1-34-03 through 26.1-34-06 and section 26.1-34-08.

2. If an annuity contract provides for a lump-sum settlement at maturity, or at any other time, then upon surrender of the contract at or prior to the commencement of any annuity payments, the company will pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in sections 26.1-34-03, 26.1-34-04, 26.1-34-06, and 26.1-34-08. The company shall reserve the right to defer the payment of the cash surrender benefit for a period of six months after demand for the benefit with surrender of the contract.

3. A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the annuity contract, together with sufficient information to determine the amounts of the benefits.

4. A statement that any paid-up annuity, cash surrender, or death benefits that may be available under the annuity contract are not less than the minimum benefits required by any law of this state and an explanation of the manner in which the benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract, or any prior withdrawals from or partial surrenders of the contract.

Notwithstanding the requirements of this section, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to such period would be less than twenty dollars monthly, the company may at its option terminate the contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment is relieved of any further obligation under the contract.

26.1-34-02. Minimum nonforfeiture amount defined. The minimum values as specified in sections 26.1-34-03 through 26.1-34-06 and section 26.1-34-08 of any paid-up annuity, cash surrender, or death benefits available under an annuity contract must be based upon minimum nonforfeiture amounts as defined in this section:

1. With respect to annuity contracts providing for flexible considerations, the minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments must be equal to an accumulation up to such time at a rate of interest of three percent per year of percentages of the net considerations (as hereinafter defined) paid prior to such time, decreased by the sum of any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of three percent per year and the amount of any indebtedness to the company on the contract, including interest due and accrued; and increased by any existing additional amounts credited by the company to the contract. The net considerations for a given contract year used to define the minimum nonforfeiture amount must be an amount not less than zero and must equal the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of thirty dollars and less a collection charge of one dollar and twenty-five cents for each consideration credited to the contract during that contract year. The percentages of net considerations must be sixty-five percent of the net consideration for the first contract year and eighty-seven and one-half percent of the net considerations for the second and later contract years. Notwithstanding the

preceding sentence, the percentage must be sixty-five percent of the portion of the total net consideration for any renewal contract year which exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was sixty-five percent.

2. With respect to contracts providing for fixed scheduled considerations, minimum nonforfeiture amounts must be calculated on the assumption that considerations are paid annually in advance and must be defined as for contracts with flexible considerations which are paid annually, with two exceptions:

   a. The portion of the net consideration for the first contract year to be accumulated is the sum of sixty-five percent of the net consideration for the first contract year plus twenty-two and one-half percent of the excess of the net consideration for the first contract year over the lesser of the net considerations for the second and third contract years.

   b. The annual contract charge is the lesser of (a) thirty dollars or (b) ten percent of the gross annual considerations.

3. With respect to contracts providing for a single consideration, minimum nonforfeiture amounts must be defined as for contracts with flexible considerations except that the percentage of net consideration used to determine the minimum nonforfeiture amount must equal ninety percent and the net consideration must be the gross consideration less a contract charge of seventy-five dollars.

26.1-34-03. Value of paid-up annuity benefit to be at least equal to minimum nonforfeiture amount. Any paid-up annuity benefit available under an annuity contract must be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. The present value must be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

26.1-34-04. Cash surrender benefit to be at least equal to value of paid-up annuity benefit. For annuity contracts that provide cash surrender benefits, the cash surrender benefits available prior to maturity may not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract. The present value must be

calculated on the basis of an interest rate not more than one percent higher than the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. A cash surrender benefit may not be less than the minimum nonforfeiture amount at that time. The death benefit under the contracts must at least equal the cash surrender benefit.

26.1-34-05. Minimum value of paid-up annuity on cessation of payment of considerations, where cash surrender benefits not provided. For annuity contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity may not be less than the present value of the portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity. The present value must be calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, and increased by any existing additional amounts credited by the company to the contract. For contracts that do not provide any death benefits prior to the commencement of any annuity payments, the present values must be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. The present value of a paid-up annuity benefit may not be less than the minimum nonforfeiture amount at that time.

26.1-34-06. Definition of maturity date. For the purpose of determining the benefits calculated under sections 26.1-34-04 and 26.1-34-05, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date is deemed to be the latest date for which election is permitted by the contract, but may not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

26.1-34-07. Disclosure where annuity contract does not provide cash surrender or death benefits. Any annuity contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amounts prior to the commencement of any annuity payments must include a statement in a prominent place in the contract that such benefits are not provided.

26.1-34-08. Benefits on cessation of payment of considerations off the anniversary. Any paid-up annuity, cash surrender, or death benefits available at any time, other than on the contract anniversary, under any annuity contract with fixed scheduled considerations, must be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract

year in which cessation of payment of considerations under the contract occurs.

26.1-34-09. Minimum nonforfeiture benefits for annuity contract providing both annuity and life insurance benefits - Excepted benefits. For any annuity contract that provides within the same contract, by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits must equal the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding sections 26.1-34-03 through 26.1-34-06 and section 26.1-34-08, additional benefits payable (a) in the event of total and permanent disability, (b) as reversionary annuity or deferred reversionary annuity benefits, or (c) as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, must be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits that may be required by sections 26.1-34-01 through 26.1-34-09. The inclusion of such additional benefits may not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender, or death benefits.

26.1-34-10. Exemptions from annuity nonforfeiture provisions. Sections 26.1-34-01 through 26.1-34-09 do not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the federal Internal Revenue Code, as amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract delivered outside this state.

26.1-34-11. Variable annuities authorized - Application of variable life policy sections - Rulemaking authority. Any domestic life insurance company, including any domestic fraternal benefit society which operates on a legal reserve basis, may establish one or more separate accounts and may allocate thereto amounts, including proceeds applied under optional modes of settlement or under dividend options, to provide for annuities, and benefits incidental thereto, payable in fixed or variable amounts or both, subject to the requirements of subsections 1 through 7 of section 26.1-33-13. No company may deliver or issue for delivery in this state variable contracts unless it is licensed or organized to do an annuity business in this state. Except for the requirement that an individual variable life insurance contract contain certain provisions, sections 26.1-33-14, 26.1-33-15, and 26.1-33-16 apply to

variable annuities authorized by this section. The commissioner may adopt reasonable rules to implement this section.

SECTION 12. Chapter 26.1-35 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-35-01. Commissioner to annually value liabilities for life policies and annuities. The commissioner shall annually value, or cause to be valued, the reserve liabilities, in this chapter referred to as reserves, for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in this state, and may certify the amount of the reserves, specifying the mortality table or tables, rate or rates of interest, and methods, net level premium method or other, used in the calculation of the reserves. In calculating the reserves, the commissioner may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves of any foreign or alien company, the commissioner may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction where the valuation complies with the minimum standards provided in this chapter, if the official of that state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the commissioner when the certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction.

26.1-35-02. Minimum standards of valuation for life or accident insurance. The minimum standards for the valuation of all life or accident insurance policies issued prior to July 1, 1977, are those provided by sections 26-03-33, 26-03-34, and 26-10-01 as they existed on June 30, 1977. Except as otherwise provided in sections 26.1-35-03 and 26.1-35-04, the minimum standard for the valuation of all life or accident insurance policies and contracts issued after June 30, 1977, is the commissioners' reserve valuation methods defined in sections 26.1-35-05, 26.1-35-06, and 26.1-35-09; five and one-half percent interest for single premium life insurance policies and four and one-half percent interest for all other such policies and contracts, other than annuity and pure endowment contracts, and the following tables:

1. For all policies of ordinary life insurance issued on the standard basis, excluding any disability and accidental death benefits in the policies, the commissioners' 1958 standard ordinary mortality table for policies issued on or after the operative date of section 26.1-33-22 and prior to the earlier of a specified date filed by a company with the commissioner in a written notice of the company's election to comply with this chapter or January 1, 1989, provided that for any category of policies issued on female risks, all modified net premiums and present values referred to in this chapter may be calculated

according to an age not more than six years younger than the actual age of the insured; and for policies issued on or after the earlier of a specified date filed by a company with the commissioner in a written notice of the company's election to comply with this chapter or January 1, 1989:

a. The commissioners' 1980 standard ordinary mortality table;

b. At the election of the company for any one or more specified plans of life insurance, the commissioners' 1980 standard ordinary mortality table with ten-year select mortality factors; or

c. Any ordinary mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by rule adopted by the commissioner for use in determining the minimum standard of valuation for the policies.

2. For all policies of industrial life insurance issued on the standard basis, excluding any disability and accidental death benefits in the policies, the commissioners' 1961 standard industrial mortality table or any industrial mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by rule adopted by the commissioner for use in determining the minimum standard of valuation for the policies.

3. For total and permanent disability benefits in or supplementary to policies or contracts, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the society of actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates, adopted after 1980 by the national association of insurance commissioners, that are approved by rule adopted by the commissioner for use in determining the minimum standard of valuation for the policies. The table must, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.

4. For accidental death benefits in or supplementary to policies or contracts, the 1959 accidental death benefits table or any accidental death benefits table, adopted after 1980 by the national association of insurance commissioners, that is approved by rule adopted by the commissioner for use in determining the minimum standard of valuation for the policies. The table must be combined with a mortality table permitted for calculating the reserves for life insurance policies.

5. For group life insurance, life insurance issued on the substandard basis and other special benefits, any tables that may be approved by the commissioner.

26.1-35-03. Minimum standards of valuation for annuities. Except as provided in section 26.1-35-04, the minimum standards for the valuation of all individual annuity and pure endowment contracts, and for all annuities and pure endowments purchased under group annuity and pure endowment contracts, must be the commissioners' reserve valuation methods defined in sections 26.1-35-05 and 26.1-35-06 and the following tables and interest rates:

1. For individual single premium immediate annuity contracts, excluding any disability and accidental death benefits in the contracts, the 1971 individual annuity mortality table or any individual annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by rule adopted by the commissioner for use in determining the minimum standard of valuation for the contracts, or any modification of these tables approved by the commissioner, and seven and one-half percent interest.

2. For individual annuity and pure endowment contracts, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in the contracts, the 1971 individual annuity mortality table or any individual annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by rule adopted by the commissioner for use in determining the minimum standard of valuation for the contracts, or any modification of these tables approved by the commissioner, and five and one-half percent interest for single premium deferred annuity and pure endowment contracts and four and one-half percent interest for all other individual annuity and pure endowment contracts.

3. For all annuities and pure endowments purchased under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under the contracts, the 1971 group annuity mortality table or any group annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by rule adopted by the commissioner for use in determining the minimum standard of valuation for the annuities and pure endowments, or any modification of these tables approved by the commissioner, and seven and one-half percent interest.

26.1-35-04. Determination of standard for valuation - Interest rates. The calendar year statutory valuation interest rates as defined in this section are:

1. The interest rates used in determining the minimum standard for the valuation of:

   a. All life insurance policies issued in a particular calendar year, on or after the earlier of a specified date filed by a company with the commissioner in a written notice of the company's election to comply with this chapter or January 1, 1989.

   b. All individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1984.

   c. All annuities and pure endowments purchased in a particular calendar year on or after January 1, 1984, under group annuity and pure endowment contracts.

   d. The net increase, if any, in a particular calendar year after January 1, 1984, in amounts held under guaranteed interest contracts.

2. The calendar year statutory valuation interest rates, I, must be determined as follows and the results rounded to the nearer one-quarter of one percent:

   a. For life insurance:

$$I = .03 + W (R_1 - .03) + \frac{W}{2} (R_2 - .09)$$

   b. For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

$$I = .03 + W (R - .03)$$

   where R_1 is the lesser of R and .09, R_2 is the greater of R and .09, R is the reference interest rate defined in this section, and W is the weighting factor defined in this section.

   c. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subdivision b, the formula for life insurance stated in subdivision a applies to annuities and guaranteed interest contracts with guarantee durations in excess of ten years and the formula for single premium immediate annuities stated in subdivision b applies to annuities and guaranteed interest contracts with guarantee duration of ten years or less.

d. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in subdivision b applies.

e. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in subdivision b applies.

However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent, the calendar year statutory valuation interest rate for the policies must equal the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year must be determined for 1980 by using the reference interest rate defined for 1979, and must be determined for each subsequent calendar year regardless of when section 26.1-33-26 becomes operative.

3. The weighting factors referred to in the formulas in subsection 2 are given in the following tables:

a. The weighting factors for life insurance are:

Guarantee Duration	Weighting Factors
10 years or less	.50
More than 10 years, but not more than 20 years	.45
More than 20 years	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy.

b. The weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options is eighty-hundredths.

c. The weighting factors for other annuities and for guaranteed interest contracts, except as stated in subdivision b, are as specified in paragraphs 1, 2, and 3, according to the requirements and definitions in paragraphs 4, 5, and 6:

(1) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration	Weighting Factor for Plan Type A	B	C
5 years or less	.80	.60	.50
More than 5 years, but not more than 10 years	.75	.60	.50
More than 10 years, but not more than 20 years	.65	.50	.45
More than 20 years	.45	.35	.35

(2) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in paragraph 1 increased by .15 .25 .05

(3) For annuities and guaranteed interest contracts valued on an issue year basis, other than those with no cash settlement options, which do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than twelve months beyond the valuation date, the factors shown in paragraph 1 or derived in paragraph 2 increased by .05 .05 .05

(4) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(5) The plan type as used in the tables in this subsection is defined as follows:

(a) Plan Type A: At any time the policyholder may withdraw funds only (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, (2) without such adjustment but in installments over five years or more, (3) as an immediate life annuity, or (4) no withdrawal permitted.

(b) Plan Type B: Before expiration of the interest rate guarantee, the policyholder may withdraw funds only (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, (2) without such adjustment but in installments over five years or more, or (3) no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years.

(c) Plan Type C: The policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either (1) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(6) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either

an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. An issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract. A change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

4. The reference interest rate referred to in subsection 2 is defined as follows:

   a. For all life insurance, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June thirtieth of the calendar year next preceding the year of issue, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, incorporated.

   b. For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or year of purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, incorporated.

   c. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in subdivision b with guarantee duration in excess of ten years, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, incorporated.

d. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in subdivision b with guaranteed duration of ten years or less, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, incorporated.

e. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, incorporated.

f. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in subdivision b the average over a period of twelve months, ending on June thirtieth of the calendar year of the change in the fund, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, incorporated.

5. If Moody's corporate bond yield average - monthly average corporates is no longer published by Moody's investors service, incorporated, or if the national association of insurance commissioners determines that Moody's corporate bond yield average - monthly average corporates as published by Moody's investors service, incorporated is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the national association of insurance commissioners and approved by rule adopted by the commissioner, may be substituted.

26.1-35-05. Reserves by commissioners' reserve valuation method.

1. Except as otherwise provided in sections 26.1-35-06 and 26.1-35-09, reserves according to the commissioners' reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, must be the excess, if any, of the present value, at the date of valuation, of the future guaranteed benefits provided by the policies, over the present value of any future modified net premiums for the policies. The modified net premiums must be the uniform percentage of

the respective contract premiums for the benefits that the present value, at the date of issue of the policy, of all the modified net premiums equals the sum of the present value of the benefits provided by the policy and the excess of subdivision a over subdivision b as follows:

a. A net level annual premium equal to the present value, at the date of issue, of the benefits provided after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium falls due; provided, however, that the net level annual premium may not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of the policy.

b. A net one-year term premium for the benefits provided in the first policy year.

2. For any life insurance policy issued after December 31, 1986, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than the excess premium, the reserve according to the commissioners' reserve valuation method as of any policy anniversary occurring on or before the assumed ending date, which is defined as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than the excess premium, must, except as otherwise provided in section 26.1-35-09, be the greater of the reserve as of such policy anniversary calculated as described in this section and the reserve as of such policy anniversary calculated as described in this section, but with (a) the value defined in subdivision a of subsection 1 being reduced by fifteen percent of the amount of such excess first year premium; (b) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date; (c) the policy being assumed to mature on such date as an endowment; and (d) the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in sections 26.1-35-02 and 26.1-35-04 must be used.

3. Reserves according to the commissioners' reserve valuation method for: (a) life insurance policies providing a varying amount of insurance or requiring the payment of varying premiums; (b) group annuity and pure endowment

contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the federal Internal Revenue Code, as amended; (c) disability and accidental death benefits in all policies and contracts; and (d) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, must be calculated by a method consistent with the principles of this section.

26.1-35-06. Reserves by commissioners' annuity reserve method. This section applies to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the federal Internal Revenue Code of 1954, as amended.

Reserves according to the commissioners' annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in the contracts, must be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by the contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of the contracts, that become payable prior to the end of such respective contract year. The future guaranteed benefits must be determined by using the mortality tables, if any, and the interest rate, or rates, specified in the contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of the contracts to determine nonforfeiture values.

26.1-35-07. Minimum aggregate reserves for life policies issued after June 30, 1977. A company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued after June 30, 1977, may not be less than the aggregate reserves calculated in accordance with the methods set forth in sections 26.1-35-05, 26.1-35-06, and 26.1-35-09 and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for the policies.

26.1-35-08. Calculation of minimum aggregate reserves by other standards. Reserves for all policies and contracts issued prior to July 1, 1977, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves

for the policies and contracts than the minimum reserves required by the laws in effect on June 30, 1977.

Reserves for any category of policies, contracts, or benefits, as established by the commissioner, issued on or after July 1, 1977, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for the category than those calculated according to the minimum standard provided in this chapter, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, may not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided in the policies and contracts. Any company that has adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided in this chapter may, with the approval of the commissioner, adopt any lower standard of valuation, but not lower than the minimum provided in this chapter.

26.1-35-09. Minimum reserve where net premium exceeds gross premium.

1. If in any contract year the gross premium charged by any life insurance company on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve on the policy or contract but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for the policy or contract is the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for the policy or contract, or the reserve calculated by the method actually used for the policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in sections 26.1-35-02 and 26.1-35-04.

2. For any life insurance policy issued after December 31, 1986, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than the excess premium, subsection 1 must be applied as if the method actually used in calculating the reserve for the policy was the method described in section 26.1-35-05, ignoring subsection 2 of that section. The minimum reserve at each policy anniversary must be the greater of the minimum reserve calculated in accordance with section 26.1-35-05, including subsection 2 of that section, and the minimum reserve calculated in accordance with this section.

26.1-35-10. Future premium determination. In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in sections 26.1-35-05, 26.1-35-06, and 26.1-35-09, the reserves which are held under the plan must be appropriate in relation to the benefits and the pattern of premiums for that plan, and must be computed by a method that is consistent with the principles of this chapter, as determined by rules adopted by the commissioner.

SECTION 13. Chapter 26.1-36 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-36-01. Scope. No section of this chapter applies to or affects (1) any policy of workmen's compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein; or (2) any policy or contract of reinsurance; or (3) any blanket or group insurance policy, except when the section refers to a blanket or group insurance policy; or (4) life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (b) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

26.1-36-02. "Accident and health insurance policy" defined. "Accident and health insurance policy" includes any contract policy insuring against loss resulting from sickness or bodily injury, or death by accident, or both.

26.1-36-03. Form of policy.

1. No accident and health insurance policy may be delivered or issued for delivery to any person in this state unless:

   a. The entire money and other considerations for the policy are expressed in the policy.

   b. The time at which the insurance takes effect and terminates is expressed in the policy.

   c. The policy purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who is deemed the policyholder, any two or more eligible members of that family, including spouse, dependent children or any children under a

specified age which may not exceed nineteen years, and any other person dependent upon the policyholder.

d. The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightfaced type of a style in general use, the size of which is uniform and not less than ten point with a lowercase unspaced alphabet length not less than one hundred twenty point. The "text" must include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions.

e. The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 26.1-36-04 are printed at the insurer's option, either included with the benefit provisions to which they apply, or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS". If an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

f. Each form, including riders and endorsements, must be identified by a form number in the lower left-hand corner of the first page thereof.

g. It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

2. If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the insurance department of that state has advised the commissioner that the policy is not subject to approval or disapproval by that official, the commissioner may by ruling require that the policy meet the standards set forth in subsection 1 and in section 26.1-36-04.

26.1-36-04. Accident and health policy provisions.

1. Except as provided in subsection 3, each accident and health insurance policy delivered or issued for delivery to any person in this state must contain provisions described in this section. The provisions contained in

any policy may not be less favorable in any respect to the insured or the beneficiary.

a. A provision that the policy, including the endorsements and the attached papers, if any, constitutes the entire insurance contract and that no change in the policy is valid until approved by an executive officer of the insurer and unless the approval is endorsed on or attached to the policy.

b. A provision that no agent has authority to change the policy or to waive any of its provisions.

c. A provision that the validity of the policy may not be contested except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that the validity of the policy may not be contested on the basis of a statement made relating to insurability by any person covered under the policy after the insurance has been in force for two years during the person's lifetime unless the statement is contained in a written instrument signed by the person making the statement; provided, however, that no such provision precludes the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy.

d. A provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. Any such exclusion or limitation may only apply to a preexisting disease or physical condition which first manifested itself in the five years immediately prior to the effective date of the person's coverage. The exclusion or limitation may not apply to loss incurred or disability commencing after the end of the two-year period commencing on the effective date of the person's coverage.

e. A provision that the policyholder is entitled to a grace period of fifteen days for monthly premiums and thirty-one days for all others for the payment of any premium due except the first, during which the policy continues in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.

f. A provision that if any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept the premium, without requiring in connection therewith an application for reinstatement, reinstates the policy; provided, however, that if the insurer or the agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of the application by the insurer or, lacking the approval, upon the forty-fifth day following the date of the conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application. The policy must provide that the reinstated policy covers only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to any sickness that begins more than ten days after the date. The policy must provide that in all other respects the insured and insurer have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed thereon or attached thereto in connection with the reinstatement. The provision may include a statement that any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement. This statement may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age fifty or (2) in the case of a policy issued after age forty-four, for at least five years from its date of issue.

g. A provision that written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within this time does not invalidate nor reduce any claim if it is shown not to have been reasonably possible to give the notice and that notice was given as soon as was reasonably possible.

h. A provision that the insurer will furnish to the person making claim, or to the policyholder for delivery to such person, the forms usually furnished for filing proof of loss. If the forms are not furnished before the expiration of fifteen days after the insurer receives notice of any claim under the policy, the person making the claim is deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in

the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claims are made.

i. A provision that in the case of claim for loss of time for disability, written proof of loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, and that subsequent written proof of continuance of the disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of loss must be furnished to the insurer within ninety days after the date of loss. Failure to furnish the proof within this time does not invalidate nor reduce any claim if it was not reasonably possible to furnish the proof within that time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

j. A provision that all benefits payable under the policy other than benefits for loss of time will be payable not more than sixty days after receipt of proof, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid as soon as possible after receipt of proof of loss.

k. A provision that benefits for loss of life of the person insured will be payable to the beneficiary designated by the insured person. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living at the death of the insured person. All other benefits of the policy are payable to the insured person. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount not exceeding five thousand dollars, to any relative by blood or connection by marriage of the person deemed by the insurer to be equitably entitled to the benefit.

l. A provision that the insurer may examine the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy and also may make an autopsy in case of death where the autopsy is not prohibited by law.

m. A provision that no action may be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action may be brought at all unless brought within three years from the expiration of the time which proof of loss is required by the policy.

2. Except as provided in subsection 3, no accident and health insurance policy delivered or issued for delivery to any person in this state may contain provisions respecting the matters described in this subsection unless the provisions in the policy are not less favorable in any respect to the insured or the beneficiary.

a. A provision that if the insured is injured or contracts sickness after having changed occupation to one classified by the insurer as more hazardous than that stated in the policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in the policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for the more hazardous occupation. If the insured changes occupation to one classified by the insurer as less hazardous than that stated in the policy, the insurer, upon receipt of proof of the change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of proof, whichever is the more recent. The provision must provide that the classification of occupational risk and the premium rates will be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time the policy was issued; but if the filing was not required, then the classification of occupational risk and the premium rates will be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

b. A provision that if the age of the insured has been misstated, all amounts payable under the policy will

be such as the premium paid would have purchased at the correct age.

c. A provision that if an accident or health or accident and health policy or policies previously issued by the insurer to the insured are in force concurrently therewith, making the aggregate indemnity for the type of coverage or coverages, in excess of the maximum limit of indemnity or indemnities, the excess insurance is void and all premiums paid for the excess will be returned to the insured or to the insured's estate. In lieu of this type of provision the policy may provide that insurance effective at any one time on the insured under the policy and a like policy or policies in the insurer is limited to the one such policy elected by the insured, the insured's beneficiary or the insured's estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

d. A provision that upon the payment of a claim under the policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

e. A provision that the insurer may cancel the policy at any time by written notice delivered to the insured, or mailed to the insured's last address as shown by the records of the insurer, stating when, not less than five days thereafter, the cancellation is effective; and after the policy has been continued beyond its original term the insured may cancel the policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in the notice. The provision must provide that in the event of cancellation, the insurer will return promptly the unearned portion of any premium paid, and, if the insured cancels, the earned premium will be computed by the use of the short-rate table last filed in the state where the insured resided when the policy was issued. The provision must provide that if the insurer cancels, the earned premium shall be computed pro rata. The provision must provide that cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

f. A provision that any provision of the policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is amended to conform to the minimum requirements of such statutes.

g. A provision that the insurer is not liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

h. A 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.

i. A provision that if, with respect to a person covered under the policy, benefits for allowable expense incurred during a claim determination period under the policy together with benefits for allowable expense during such period under all other valid coverage exceed the total of the person's allowable expense during such period, the insurer is liable only for such proportionate amount of the benefits for allowable expense under the policy during such period as (1) the total allowable expense during such period bears to (2) the total amount of benefits payable during such period for such expense under the policy and all other valid coverage (without giving effect to this provision or to any "overinsurance provision" applying to such other valid coverage) less in both (1) and (2) any amount of benefits for allowable expense payable under other valid coverage which does not contain an overinsurance provision. The provision must provide that in no event does the provision operate to increase the amount of benefits for allowable expense payable under the policy with respect to a person covered under the policy above the amount which would have been paid in the absence of the provision. The provision must provide that the insurer may pay benefits to any insurer providing other valid coverage in the event of overpayment by such insurer, and any such payment discharges the liability of this insurer as fully as if the payment had been made directly to the insured, the insured's assignee, or the insured's beneficiary. The provision must provide that in the event that the insurer pays benefits to the insured, the insured's assignee, or the insured's beneficiary, in excess of the amount which would have been payable if the existence of other valid coverage had been disclosed, the insurer has a claim for relief against the insured, the insured's assignee, or the insured's beneficiary, to recover the amount which would not have been paid had there been a disclosure of the existence of the other valid coverage. The provision must provide that the amount of other valid coverage which is on a provision of service basis will be computed as the amount the

services rendered would have cost in the absence of such coverage. The provision must provide that:

(1) "Allowable expense" means one hundred ten percent of any necessary, reasonable, and customary item of expense which is covered, in whole or in part, as a hospital, surgical, medical, or major medical expense under this policy or under any other valid coverage.

(2) "Claim determination period" with respect to any covered person means the initial period, as provided in the policy, but not less than thirty days and each successive period of a like number of days, during which allowable expense covered under the policy is incurred on account of such person. The first period begins on the date when the first expense is incurred, and successive periods begin when successive expense is incurred after expiration of a prior period.

Or, in lieu thereof:

"Claim determination period" with respect to any covered person means the number of days, as provided in the policy but not less than thirty days during which allowable expense covered under the policy is incurred on account of such person.

(3) "Overinsurance provision" means the provision which may reduce an insurer's liability because of the existence of benefits under other valid coverage.

This type of provision may be inserted in all policies providing hospital, surgical, medical, or major medical benefits. The insurer may make this provision applicable to either or both: other valid coverage with other insurers; and, except for individual policies individually underwritten, other valid coverage with the same insurer. The insurer must include in the provision a definition of "other valid coverage". The definition may include hospital, surgical, medical, or major medical benefits provided by group, blanket, or franchise coverage, individual and family-type coverage, blue cross-blue shield coverage, and other prepayment plans, group practice, and individual practice plans, uninsured benefits provided by labor-management trusteed plans, or union welfare plans, or by employer or employee benefit organizations, benefits provided under governmental programs, workmen's compensation insurance, or any coverage required or provided by any other statute, and medical payments under automobile liability and

personal liability policies. Other valid coverage may not include payments made under third party liability coverage as a result of a determination of negligence. The insurer may require, as part of the proof of claim, the information necessary to administer the provision.

j. A provision that after the loss-of-time benefit of the policy has been payable for ninety days, such benefit will be adjusted, as provided below, if the total amount of unadjusted loss-of-time benefits provided in all valid loss-of-time coverage upon the insured should exceed a percent of the insured's earned income as providing in the policy; provided, however, that if the information contained in the application discloses that the total amount of loss-of-time benefits under the policy and under all other valid loss-of-time coverage expected to be effective upon the insured in accordance with the application for this policy exceeded an alternative percent of the insured's earned income as provided in the policy, at the time of the application, such higher percentage will be used in place of the original percent provided. The provision must provide that the adjusted loss-of-time benefit under the policy for any month will be only such proportion of the loss-of-time benefit otherwise payable under the policy as (1) the product of the insured's earned income and the original percent (or, if higher, the alternative percentage) bears to (2) the total amount of loss-of-time benefits payable for such month under the policy and all other valid loss-of-time coverage on the insured (without giving effect to the "overinsurance provision" in this or any other coverage) less in both (1) and (2) any amount of loss-of-time benefits payable under other valid loss-of-time coverage which does not contain an "overinsurance provision". The provision must provide that in making the computation, all benefits and earnings will be converted to a consistent basis weekly if the loss-of-time benefit of the policy is payable weekly, or monthly if the benefit is payable monthly, or otherwise, based upon the time period. If the numerator of the foregoing ratio is zero or is negative, no benefit is payable. The provision must provide that in no event does the provision operate to reduce the total combined amount of loss-of-time benefits for such month payable under the policy and all other valid loss-of-time coverage below the lesser of three hundred dollars and the total combined amount of loss-of-time benefits determined without giving effect to any "overinsurance provision", nor operate to increase the amount of benefits payable under the policy above the amount which would have been paid in the absence of the provision, nor take into account or

operate to reduce any benefit other than the loss-of-time benefit. The provision must provide that:

(1) "Earned income", except where otherwise specified, means the greater of the monthly earnings of the insured at the time disability commences and the insured's average monthly earnings for a period of two years immediately preceding the commencement of the disability, and does not include any investment income or any other income not derived from the insured's vocational activities.

(2) "Overinsurance provision" includes this type of provision and any other provision with respect to any loss-of-time coverage which may have the effect of reducing an insurer's liability if the total amount of loss-of-time benefits under all coverage exceeds a stated relationship to the insured's earnings.

This type of provision may be included only in a policy which provides a loss-of-time benefit which may be payable for at least fifty-two weeks, which is issued on the basis of selective underwriting of each individual application, and for which the application includes a question designed to elicit information necessary either to determine the ratio of the total loss-of-time benefits of the insured to the insured's earned income or to determine that such ratio does not exceed the percentage of earnings, not less than sixty percent, selected by the insurer and inserted in lieu of the blank factor above. The insurer may require, as part of the proof of claim, the information necessary to administer this provision. If the application indicates that other loss-of-time coverage is to be discontinued, the amount of such other coverage must be excluded in computing the alternative percentage in the first sentence of the overinsurance provision. The policy must include a definition of "valid loss-of-time coverage" which may include coverage provided by governmental agencies and by organizations subject to regulation by insurance law and by insurance departments of this or any other state or of any other country or subdivision thereof, coverage provided for the insured pursuant to any disability benefits statute or any workmen's compensation or employer's liability statute, benefits provided by labor-management trusteed plans or union welfare plans or by employer or employee benefit organizations, or by salary continuance or pension programs, and any other coverage the inclusion of which may be approved.

3. If any requirement of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from the policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

4. The provisions that are subject to subsections 1 and 2, must be printed in the consecutive order of the requirements in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy is not in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

5. A provision not subject to this section may not make a policy, or any portion of the policy, less favorable in any respect to the insured or to the beneficiary than any provision which is subject to this chapter.

6. Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision that is not less favorable to the insured or the beneficiary than the provisions of this chapter and that is prescribed or required by the law of the state under which the insurer is organized. Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

26.1-36-05. Group health policy or service contract standard provisions. Neither a group health insurance policy nor a group health service contract may be delivered in this state unless it contains in substance the following provisions, or provisions that in the opinion of the commissioner are more favorable to the persons insured and more favorable to the policyholder or contractholder; provided, however, that subsections 5, 7, and 12 do not apply to credit accident and health insurance policies, that the standard provisions required for individual health insurance policies do not apply to group health insurance policies, and that if any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy or contract, the insurer shall omit from the policy or contract any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy or contract consistent with the coverage provided by the policy or contract:

1. A provision that the policyholder or contractholder is entitled to a grace period of fifteen days for monthly premiums and thirty-one days for all others for the payment of any premium due except the first, during which the policy or contract continues in force, unless the policyholder or contractholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy or contract. The policy or contract may provide that the policyholder or contractholder is liable to the insurer for the payment of a pro rata premium for the time the policy or contract was in force during the grace period.

2. A provision that the validity of the policy or contract may not be contested except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that the validity of the policy or contract may not be contested on the basis of a statement made relating to insurability by any person covered under the policy or contract after the insurance has been in force for two years during the person's lifetime unless the statement is contained in a written instrument signed by the person making the statement; provided, however, that no such provision precludes the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or contract.

3. A provision that a copy of the application, if any, of the policyholder or contractholder will be attached to the policy or contract when issued, that all statements made by the policyholder or contractholder or by the persons insured are deemed representations and not warranties, and that no statement made by any insured person may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to that person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.

4. A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage.

5. A provision specifying the additional exclusions or limitations, if any, applicable under the policy or contract with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy or contract. Any such exclusion or limitation may only

apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve months prior to the effective date of the person's coverage. The exclusion or limitation may not apply to loss incurred or disability commencing after the earlier of the end of a continuance period of twelve months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition, or the end of the two-year period commencing on the effective date of the person's coverage.

6. If the premiums or benefits vary by age, a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of a covered person has been misstated. The provision must contain a clear statement of the method of adjustment to be used.

7. A provision that the insurer will issue to the policyholder or contractholder for delivery to each person insured a certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance benefits are payable, and a statement as to any family member's or dependent's coverage.

8. A provision that written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy or contract. Failure to give notice within this time does not invalidate nor reduce any claim if it is shown not to have been reasonably possible to give the notice and that notice was given as soon as was reasonably possible.

9. A provision that the insurer will furnish to the person making claim, or to the policyholder or contractholder for delivery to such person, the forms usually furnished for filing proof of loss. If the forms are not furnished before the expiration of fifteen days after the insurer receives notice of any claim under the policy or contract, the person making the claim is deemed to have complied with the requirements of the policy or contract as to proof of loss upon submitting within the time fixed in the policy or contract for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claims are made.

10. A provision that in the case of claim for loss of time for disability, written proof of loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, and that subsequent written proof of continuance of the disability must be furnished to the insurer at such intervals as the

insurer may reasonably require, and that in the case of claim for any other loss, written proof of loss must be furnished to the insurer within ninety days after the date of loss. Failure to furnish the proof within this time does not invalidate nor reduce any claim if it was not reasonably possible to furnish the proof within that time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

11. A provision that all benefits payable under the policy or contract other than benefits for loss of time will be payable not more than sixty days after receipt of proof, and that, subject to due proof of loss, all accrued benefits payable under the policy or contract for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid as soon as possible after receipt of proof of loss.

12. A provision that benefits for loss of life of the person insured will be payable to the beneficiary designated by the insured person. However, if the policy or contract contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy or contract terms. In either case, payment of these benefits is subject to the provisions of the policy or contract in the event no such designated or specified beneficiary is living at the death of the insured person. All other benefits of the policy or contract are payable to the insured person. The policy or contract may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount not exceeding five thousand dollars, to any relative by blood or connection by marriage of the person deemed by the insurer to be equitably entitled to the benefit.

13. A provision that the insurer may examine the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy or contract and also may make an autopsy in case of death where the autopsy is not prohibited by law.

14. A provision that no action may be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action may be brought at all unless brought within three years from the expiration of the time which proof of loss is required by the policy or contract.

26.1-36-06. Group health policy and medical service contract options for drugs and chiropractic care. No insurance company or health service corporation may deliver, issue, execute, or renew any health insurance policy or medical service contract that includes coverage of medical benefits on a group, blanket, franchise, or association basis unless the insurer makes available, at the option of the insured or subscriber, the following coverages for which an additional premium may be charged:

1. All drugs and medicines prescribed by the provider of health services.

2. Services rendered and care administered by chiropractors licensed under chapter 43-06.

26.1-36-07. Health insurance coverage per newborn children - Scope of coverage - Notification of birth.

1. All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provides coverage for a family member of the insured or subscriber must, as to the family members' coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the insured or subscriber from the moment of birth.

2. The coverage for newly born children consists of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

3. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one days after the date of birth in order to have the coverage continue beyond the thirty-one-day period.

26.1-36-08. Group health policy and health service contract substance abuse coverage.

1. An insurance company or nonprofit health service corporation may not deliver, issue, execute, or renew any health insurance policy or health service contract on a group or blanket or franchise or association basis where more than fifty persons are covered or are to be covered by the policy or contract and where the number of persons covered or to be covered represents more than seventy percent of all persons eligible for the coverage unless the policy or contract provides benefits, of the same type

offered under the policy or contract for other illnesses, for health services to any person covered under the policy or contract, for the diagnosis, evaluation, and treatment of alcoholism, drug addiction, or other related illness, in a hospital, as defined in subsection 25 of section 52-01-01 and the state department of health's rules pursuant thereto or as licensed under section 23-17.1-01, offering treatment for the prevention or cure of alcoholism, drug addiction, or other related illness.

2. The benefits may be provided for inpatient treatment and treatment by partial hospitalization:

   a. In the case of benefits provided for inpatient treatment, the benefits must be provided for a minimum of seventy days of services covered under this section and section 26.1-36-09 in any calendar year.

   b. In the case of benefits provided for partial hospitalization, the benefits must be provided for a minimum of one hundred forty days of services covered under this section and section 26.1-36-09 in any calendar year.

   c. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is equivalent to two days of treatment by partial hospitalization.

   "Partial hospitalization" means that level and intensity of treatment that is greater than outpatient treatment, but less than inpatient treatment.

3. This section does not prevent any insurance company or nonprofit health service corporation from issuing, delivering, or renewing, at its option, any policy or contract containing provisions similar to those required by this section, where the policy or contract is not subject to such provisions.

26.1-36-09. Group health policy and health service contract mental illness coverage.

1. An insurance company or nonprofit health service corporation may not deliver, issue, execute, or renew any health insurance policy or health service contract on a group or blanket or franchise or association basis where more than fifty persons are covered or are to be covered by the policy or contract and where the number of persons covered or to be covered represents more than seventy percent of all persons eligible for the coverage unless the policy or contract provides benefits, of the same type

offered under the policy or contract for other illnesses, for health services to any person covered under the policy or contract, for the diagnosis, evaluation, and treatment of mental illness and other related illness in a hospital, as defined in subsection 25 of section 52-01-01 and the state department of health's rules pursuant thereto or as licensed under section 23-17.1-01, offering treatment for the prevention or cure of mental illness and other related illness.

2. The benefits may be provided for inpatient treatment and treatment by partial hospitalization:

   a. In the case of benefits provided for inpatient treatment, the benefits must be provided for a minimum of seventy days of services covered under this section and section 26.1-36-08 in any calendar year.

   b. In the case of benefits provided for partial hospitalization, the benefits must be provided for a minimum of one hundred forty days of services covered under this section and section 26.1-36-08 in any calendar year.

   c. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is equivalent to two days of treatment by partial hospitalization.

   "Partial hospitalization" means that level and intensity of treatment that is greater than outpatient treatment, but less than inpatient treatment.

3. This section does not prevent any insurance company or nonprofit health service corporation from issuing, delivering, or renewing, at its option, any policy or contract containing provisions similar to those required by this section, where the policy or contract is not subject to such provisions.

26.1-36-10. Group health policy and health service contract coordination of benefit provisions. A group health insurance policy or a group health service contract may contain coordination of benefit provisions for the control of overinsurance. These provisions must be in accordance with appropriate guidelines set forth in rules adopted by the commissioner.

26.1-36-11. Accident and health policy provision denying insured right to employ doctor or enter hospital prohibited. Any provision in any accident or health insurance policy issued by any insurance company denying the insured, in case of accident or sickness, the right to consult or employ any doctor licensed to practice in this state the insured

may choose, or to enter any hospital or sanatarium organized and operating under the laws of this state the insured may select is void. The insurance company shall recognize any proof of claim duly certified by such doctor or hospital or sanatarium notwithstanding any provision contained in the policy.

26.1-36-12. Provisions prohibited in individual and group accident and health insurance policies and nonprofit health service contracts.

1. Any provision in any individual or group accident and health insurance policy or nonprofit health service contract issued by any insurance company or nonprofit health service corporation denying or prohibiting the insured or subscriber from assigning to the department of human services any rights to medical benefits coverage to which the insured or subscriber is entitled under the policy or contract is void. An individual or group insurance company or nonprofit health service corporation shall recognize the assignment of medical benefits coverage completed by the insured or subscriber, notwithstanding any provision contained in the policy or contract to the contrary.

2. Any individual or group provision in any accident and health insurance policy or nonprofit health service corporation contract issued by any insurance company or nonprofit health service corporation which limits or excludes payments of medical benefits coverage to or on behalf of the insured or subscriber if the insured or subscriber is eligible for medical assistance benefits under chapter 50-24.1 is void.

26.1-36-13. Applicability of accident and health policy simplification standards.

1. Except as provided in subsection 3, sections 26.1-36-13 through 26.1-36-16 apply to all individual and group accident and health insurance contracts, policies, plans, or agreements, insurance certificates under group accident and health insurance policies, and disability benefit certificates issued by fraternal benefit societies filed after June 30, 1982. No policy may be delivered or issued for delivery in this state after June 30, 1986, unless approved by the commissioner or permitted to be issued under sections 26.1-36-13 through 26.1-36-16. Any policy form that has been approved or permitted to be issued prior to July 1, 1986, and that meets the standards set by sections 26.1-36-13 through 26.1-36-16 need not be refiled for approval, but may continue to be delivered or issued for delivery in this state upon the filing with the commissioner of a list of the forms identified by form number and accompanied by a certificate as to each such form in the manner provided in subsection 6 of section 26.1-36-14.

2. The commissioner may extend the dates in subsection 1.

3. Sections 26.1-36-13 through 26.1-36-16 do not apply to:

   a. A policy that is a security subject to federal jurisdiction.

   b. Any group policy covering a group of one thousand or more lives at date of issue. However, this does not except any certificate issued pursuant to a group policy delivered or issued for delivery in this state.

   c. A form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates such forms must be approved under sections 26.1-36-13 through 26.1-36-16.

   d. The renewal of a policy delivered or issued for delivery prior to the dates the forms must be approved under sections 26.1-36-13 through 26.1-36-16.

4. No other state law setting language simplification standards applies to a policy form.

26.1-36-14. Minimum accident and health policy language simplification standards.

1. No policy form may be delivered or issued for delivery in this state unless:

   a. The text achieves a minimum score of forty on the Flesch reading ease test or an equivalent score on any other comparable test as provided in subsection 3.

   b. It is printed, except for specification pages, schedules, and tables, in not less than ten-point type, one point leaded.

   c. The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsement or rider.

   d. It contains a table of contents or an index of the principal sections of the policy, if the policy has more than three thousand words printed or three or fewer pages of text, or if the policy has more than three pages regardless of the number of words.

2. The commissioner may authorize a lower score than the Flesch reading ease score required in subdivision a of subsection 1 whenever the commissioner finds that a lower score:

a. Will provide a more accurate reflection of the readability of a policy form.

b. Is warranted by the nature of a particular policy form or type or class of policy forms.

c. Is caused by certain policy language which is drafted to conform to the requirements of any state law or rule, or agency interpretation.

3. A Flesch reading ease test score is measured by the following method:

a. For policy forms containing ten thousand words or less of text, the entire form must be analyzed. For policy forms containing more than ten thousand words, the readability of two 2-hundred word samples per page may be analyzed instead of the entire form. The samples must be separated by at least twenty printed lines.

b. The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of one and fifteen thousandths.

c. The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of eighty-four and six-tenths.

d. The sum of the figures computed under subdivisions b and c subtracted from two hundred six and eight hundred thirty-five thousandths equals the Flesch reading ease score for the policy form.

e. For purposes of subdivisions b, c, and d, the following procedures must be used:

(1) A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word.

(2) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence.

(3) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

4. As used in this section, "text" includes all printed matter except:

   a. The name and address of the insurer, the name, number, or title of the policy, the table of contents or index, captions and subcaptions, specification pages, schedules, and tables.

   b. Any policy language drafted to conform to the requirements of any federal law, regulation, or agency interpretation, any policy language required by any collectively bargained agreement, any medical terminology, any words defined in the policy, and any policy language required by law or rule, provided, however, the insurer identifies the language or terminology excepted by this subdivision and certifies, in writing, that the language or terminology is entitled to be excepted by this subdivision.

5. The commissioner may approve any other reading test for use as an alternative to the Flesch reading ease test if the other test is comparable in result to the Flesch reading ease test.

6. Filings subject to this section must be accompanied by a certificate signed by an officer of the insurance company, nonprofit health service corporation, fraternal benefit society, or health maintenance organization stating that it meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved in accordance with subsection 2. To confirm the accuracy of any certification, the commissioner may require the submission of further information to verify the certification in question.

7. At the option of the insurance company, nonprofit health service corporation, fraternal benefit society, or health maintenance organization, riders, endorsements, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

26.1-36-15. Approval of accident and health policy forms. A policy form meeting the requirements of subsection 1 of section 26.1-36-14 must be approved notwithstanding any other law which specifies the contents of a policy, if the policy form provides the policyholders and claimants protection not less favorable than they would be entitled to under such laws.

26.1-36-16. Effect of accident and health policy simplification standards on filed policies. Sections 26.1-36-13 through 26.1-36-15 do not negate any law of this state permitting the issuance of a policy form after

it has been on file for the required time period and has not been disapproved by the commissioner.

26.1-36-17. Application for accident and health policy.

1. The insured is not bound by any statement made in an application for an accident and health insurance policy unless a copy of the application is attached to or endorsed on the policy. If any policy delivered or issued for delivery to any person in this state is to be reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes written request to the insurer for a copy of the application, if any, for reinstatement or renewal, the insurer shall within fifteen days after the receipt of the request at its home office or any branch office of the insurer, deliver or mail to the person making the request, a copy of the application. If the copy is not delivered or mailed, the insurer is precluded from introducing the application as evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal.

2. No alteration of any written application for an accident and health insurance policy may be made by any person other than the applicant without the applicant's written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that the insertions are not to be ascribed to the applicant.

3. The falsity of any statement in the application for an accident and health insurance policy may not bar the right to recovery under the policy unless the false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

26.1-36-18. Notice under accident and health policy - Waiver. The acknowledgment by any insurer of the receipt of notice given under an accident or health insurance policy, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim does not operate as a waiver of any of the rights of the insurer in defense of any claim arising under the policy.

26.1-36-19. Age limit in accident and health policy. If an accident and health insurance policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if the date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after that date, the coverage provided by the policy continues in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided

by the policy would not have become effective, or would have ceased prior to the acceptance of the premium or premiums, then the liability of the insurer is limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

26.1-36-20. Juvenile's accident and health coverage to continue - Conditions. Insurance companies and nonprofit health service corporations licensed in this state shall continue coverage of a juvenile insured under an accident and health insurance policy or a health service contract while the legal custody of the juvenile has been given by a court, under chapter 27-20, to any state institution or agency, to the same extent as the general public is covered as long as the juvenile meets all the other usual qualifications for insurability and continues to pay the policy or contract premiums. A juvenile's incarceration may not be a basis for cancellation of the juvenile's accident and health insurance policy or health service contract.

26.1-36-21. Prisoner's accident and health coverage to continue - Conditions. Insurance companies and nonprofit health service corporations licensed in this state shall continue coverage of a prisoner insured under an accident and health insurance policy or a health service contract while the prisoner is incarcerated and under state supervision to the same extent as the general public is covered as long as the prisoner meets all the other usual qualifications for insurability and continues to pay the policy or contract premiums. A prisoner's incarceration may not be a basis for cancellation of the prisoner's accident and health insurance policy or health service contract.

26.1-36-22. Group health insurance for dependents. A group health insurance policy may be extended to insure the employees or members with respect to their family members or dependents, or any class or classes thereof, subject to the following:

1. The premium for the insurance must be paid either from funds contributed by the employer, union, association, or other person to whom the policy has been issued, or from funds contributed by the covered persons, or from both. A policy on which no part of the premium for the family members or dependents coverage is to be derived from funds contributed by the covered persons must insure all eligible employees or members with respect to their family members or dependents, or any class or classes thereof.

2. An insurer may exclude or limit the coverage on any family member or dependent as to whom evidence of individual insurability is not satisfactory to the insurer.

3. A policy that provides coverage for a dependent child of an employee or other member of the covered group must provide such coverage up to a limiting age of nineteen years of age, if the dependent child physically resides

with the employee or other member and is chiefly dependent upon the employee or member for support and maintenance.

4. A policy that provides that coverage for a dependent child of an employee or other member of the covered group terminates upon attainment of the limiting age for dependent children specified in the policy does not operate to terminate the coverage of a dependent child: (a) while the child is a full-time student and has not attained the age of twenty-three years of age; or (b) while the child is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the employee or member for support and maintenance, provided proof of incapacity and dependency is furnished to the insurer by the employee or member within thirty-one days of the child's attainment of limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

26.1-36-23. Continuation of group hospital, surgical, and major medical coverage after termination of employment or membership. A group policy delivered or issued for delivery in this state issued by any insurance company, nonprofit health service corporation, health maintenance organization, or any other insurer that provides hospital, surgical, or major medical expense insurance or any accommodation of these coverages on an expense incurred basis, but not a policy that provides benefits for specific diseases or for accidental injuries only, 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 all of the group policy's terms and conditions applicable to those forms of insurance and to the following conditions:

1. Continuation is only available to an employee or member who has been continuously insured under the group policy (and for similar benefits under any group policy which it replaced) during the entire three-month period ending with the termination.

2. Continuation is not available for any person who is covered by medicare. Neither is continuation available for any person who is covered by any other insured or uninsured arrangement which provides hospital, surgical, or medical coverages for individuals in a group and under which the person was not covered immediately prior to the termination.

3. Continuation need not include dental, vision care, or prescription drug benefits or any other benefits provided

under the group policy in addition to its hospital, surgical, or major medical benefits.

4. An employee or member who wishes continuation of coverage must request the continuation in writing within the ten-day period following the later of the date of termination, or the day the employee is given notice of the right of continuation by either the employer or the group policyholder. The employee or member may not elect continuation more than thirty-one days after the date of termination.

5. An employee or member electing continuation shall pay to the group policyholder or the employer, on a monthly basis in advance, the amount of contribution required by the policyholder or employer, but not more than the group rate for the insurance being continued under the group policy on the due date of each payment. The employee's or member's written election of continuation, together with the first contribution required to establish contributions on a monthly basis in advance, must be given to the policyholder or employer within thirty-one days of the date the employee's or member's insurance would otherwise terminate.

6. Continuation of insurance under the group policy for any person terminates when the person fails to satisfy subsection 2 or, if earlier, at the first to occur of the following:

   a. The date thirty-nine 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.

   b. If the employee or member fails to make timely payment of a required contribution, the end of the period for which contributions were made.

   c. The date on which the group policy is terminated or, in the case of an employee, the date the employer terminates participation under the group policy. However, if this subdivision applies and the coverage ceasing by reason of such termination is replaced by similar coverage under another group policy, the following apply:

      (1) The employee or member may become covered under that other group policy for the balance of the period that the employee or member would have remained covered under the prior group policy in accordance with this subsection had a termination described in this subdivision not occurred.

(2) The minimum level of benefits to be provided by the other group policy is the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior group policy.

(3) The prior group policy must continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

7. A notification of the continuation privilege must be included in each certificate of coverage.

8. Upon termination of the continuation period, the member, surviving spouse, or dependent is entitled to exercise any option which is provided in the group plan to elect a conversion policy. The member electing a conversion policy shall notify the carrier of the election and pay the required premium within thirty-one days of the termination of the continued coverage under the group contract.

26.1-36-24. Health policy transferable. A health insurance policy may pass by transfer, will, or succession to any person, whether that person has an insurable interest or not, and that person may recover any benefit payable under the policy in accordance with the terms of the policy, but in no event shall such transfer or succession operate to change the named insured or insureds covered under the policy. An insured under a group health insurance policy, pursuant to agreement among the insured, the group policyholder and the insurer, 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. An assignment, whether made prior to or subsequent to July 1, 1971, is valid for the purpose of vesting in the assignee all the incidents of ownership assigned, and entitles the insurer to deal with the assignee as the owner in accordance with the policy, but without prejudice to the insurer on account of any payment made or individual policy issued prior to receipt by the insurer of such notice as may be required by the policy.

26.1-36-25. Notice of transfer of health policy unnecessary - Exception. Notice to an insurer of a transfer or bequest of a health insurance policy is not necessary to preserve the validity of the policy unless notice is required by the policy.

26.1-36-26. Dual choice option on group health coverage - Minimum conditions - Transfer of coverage. If an existing or prospective employer group desires a dual choice option between a nonprofit health service corporation or an insurance company and a health maintenance organization, the dual choice option may be made available to the employees in the group only if all of the following conditions are met:

1. There are at least fifteen employees in the group.

2. The group must maintain the highest enrollment percentage as specified in the underwriting manual of the nonprofit health service corporation, the insurance company, or the health maintenance organization, and the health maintenance organization enrollees must be combined with subscribers of nonprofit health service corporations or insureds of insurance companies in meeting the percentage requirements.

3. An employee must be allowed to transfer between coverage offered by a health maintenance organization and coverage offered by a nonprofit health service organization or insurance company on the group's anniversary date as specified in the master contract with the group, except a special opening must be offered at the group's request for the following reasons:

   a. Upon a group's initial offering of a dual choice plan in addition to existing coverages offered by a nonprofit health service corporation or an insurance company.

   b. When a group discontinues offering a dual choice plan with a health maintenance organization to request open enrollment into the group offered by the nonprofit health service corporation or the insurance company.

   c. If the group offers both coverage by a nonprofit health service corporation or an insurance company and a health maintenance organization and an individual employee enrolled in the health maintenance organization transfers within the same company but leaves the service area of the health maintenance organization, the employee must be allowed to enroll in the plan offered by the nonprofit health service corporation or the insurance company at the time of transfer.

   d. Any group that offers health coverage to its retired employees by a nonprofit health service corporation or an insurance company and a health maintenance organization must advise the employees who are enrolled under their present coverage that they may change to other coverage offered at the time of retirement and if the employees who retire elect to retain or change their present coverage, the employees will no longer be eligible to change coverage after retirement.

26.1-36-27. Dual choice option on group health coverage - Continuous coverage - Payment of benefits. If an employee, or an eligible dependent of the employee, transfers from coverage provided by a

nonprofit health service corporation or an insurance company to coverage offered by a health maintenance organization or transfers from coverage offered by a health maintenance organization to coverage offered by a nonprofit health service corporation or an insurance company and is an inpatient of a hospital or alcoholism treatment center on the day the coverage becomes effective, then the benefits for confinement on an inpatient basis of a hospital or alcoholism treatment center must be provided by the nonprofit health service corporation, insurance company, or health maintenance organization providing coverage on the date the employee or the eligible dependent of the employee was confined as an inpatient of a hospital or alcoholism treatment center so long as coverage is uninterrupted, medically necessary, and directly related to the inpatient's stay.

26.1-36-28. Measure of indemnity in health policy. Unless the interest of a person insured is susceptible of exact pecuniary measurement, the measure of indemnity under a health insurance policy is the sum fixed in the policy.

26.1-36-29. Coordination of benefits in individual and group accident and health policies - Limitations. An insurer or health service corporation may not issue or renew any individual or group accident and health insurance policy that excludes or reduces the benefits payable or services to be rendered to or on behalf of any insured because benefits have been paid or are also payable under any individually underwritten and individually issued contract or plan of insurance which provides exclusively for accident and health benefits, irrespective of the mode or channel of premium payment, with or without payroll deduction, to the insurer and regardless of any reduction in the premium by virtue of the insured's membership in any organization or of the insured's status as an employee. This section does not affect the practice of coordination of benefits between group policies as provided in sections 26.1-17-17 and 26.1-36-10.

26.1-36-30. Individual or group accident and health insurer or nonprofit health service corporation responsibility - Release of information to department of human services.

1. Any individual or group accident and health insurer or nonprofit health service corporation, upon request of the department of human services, shall provide any information contained in its records pertaining to an individual who is an applicant for or recipient of medical assistance under chapter 50-24.1, and who is covered under an accident and health insurance policy or a health service contract issued by the insurer or nonprofit health service corporation or the medical benefits paid by or claims paid to the insured or subscriber under a policy or contract. The insurer or nonprofit health service corporation shall make the requested records or information available upon receipt of a certification by the department of human services that the individual is an

applicant for or recipient of medical assistance under chapter 50-24.1, or is a person who is legally responsible for the applicant or recipient.

2. The information required to be made available pursuant to this section is limited to information necessary to determine whether benefits under the policy or contract have been or should have been claimed and paid pursuant to an accident and health insurance policy or health service contract with respect to items of medical care and services received by a particular individual for which medical assistance coverage would otherwise be available.

3. The department of human services shall, in consultation with the commissioner, establish guidelines:

   a. For the method of requesting and furnishing appropriate information, the time in which the information is to be provided, and method of reimbursing insurance companies and nonprofit health service corporations for necessary costs incurred in furnishing the requested information.

   b. To assure that information relating to an individual certified to be an applicant for or recipient of medical assistance under chapter 50-24.1, furnished to an insurer or subscriber pursuant to this section, is used only for the purpose of identifying the records or information requested in such manner so as not to violate section 50-06-15.

26.1-36-31. Medicare supplement policies - Definitions. In sections 26.1-36-31 through 26.1-36-36, unless the context otherwise requires:

1. "Applicant" means:

   a. In the case of an individual medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits.

   b. In the case of a group medicare supplement policy or subscriber contract, the proposed certificate holder.

2. "Certificate" means any certificate issued under a group medicare supplement policy which has been delivered or issued for delivery in this state.

3. "Medicare" means the Health Insurance for the Aged and Disabled Act, title XVIII of the Social Security Act of 1935, as amended [Pub. L. 92-603; 86 Stat. 1370].

4. "Medicare supplement policy" means a group or individual accident and health insurance policy or a subscriber

contract of a health service corporation, which is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare. The term does not include:

a. A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations.

b. A policy or contract of any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if the association:

(1) Is composed of individuals all of whom are actively engaged in the same profession, trade, or occupation;

(2) Has been maintained in good faith for purposes other than obtaining insurance; and

(3) Has been in existence for at least two years prior to the date of its initial offering of the policy or plan to its members.

c. Individual policies or contracts issued pursuant to a conversion privilege under an individual or group insurance policy or contract when the individual or group policy or contract includes provisions which are inconsistent with the requirements of sections 26.1-36-32 through 26.1-36-36.

26.1-36-32. Standards for medicare supplement policies.

1. The commissioner shall adopt reasonable rules to establish specific standards for provisions of medicare supplement policies. The standards are in addition to and in accordance with applicable laws of this state, and may cover:

a. Terms of renewability.

b. Initial and subsequent conditions of eligibility.

c. Nonduplication of coverage.

d. Probationary periods.

e. Benefit limitations, exceptions, and reductions.

f. Elimination periods.

g. Requirements for replacement.

h. Recurrent conditions.

i. Definitions of terms.

2. The commissioner may adopt rules that specify prohibited medicare supplement policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed for coverage under a medicare supplement policy.

3. Notwithstanding any other law, a medicare supplement policy may not deny a claim for losses incurred for more than six months from the effective date of coverage for a preexisting condition. The policy may not define a 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.

26.1-36-33. Medicare supplement policy benefit standards. The commissioner shall adopt rules to establish minimum standards for benefits under medicare supplement policies.

26.1-36-34. Medicare supplement policy loss ratio standards. Medicare supplement policies must return benefits to individual policyholders in the aggregate of not less than sixty percent of premium received. The commissioner shall adopt rules to establish minimum standards for medicare supplement policy loss ratios on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed to provide coverage and in accordance with accepted actuarial principles and practices. For purposes of rules adopted pursuant to this section, medicare supplement policies issued as a result of individual solicitations through the mail or mass media advertising, including both print and broadcast advertising, are treated as individual policies.

26.1-36-35. Medicare supplement policy disclosure standards.

1. To provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy may be delivered or issued for delivery in this state and no certificate may be delivered pursuant to a group medicare supplement policy delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time application is made.

2. The commissioner shall prescribe the format and content of the outline of coverage required by subsection 1. For

purposes of this section, "format" means style, arrangement, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. The outline of coverage must include:

a. A description of the principal benefits and coverage provided in the policy.

b. A statement of the exceptions, reductions, and limitations contained in the policy.

c. A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums.

d. A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

3. The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for medicare which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the information brochure be provided to any prospective insureds eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for medicare by reason of age, but in no event later than the time of policy delivery.

4. The commissioner may adopt rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and health insurance policies sold to persons eligible for medicare, other than:

a. Medicare supplement policies.

b. Disability income policies.

c. Basic, catastrophic, or major medical expense policies.

d. Single premium, nonrenewable policies.

e. Policies excepted from the definition of medicare supplement policies in section 26.1-36-31.

5. The commissioner may also adopt rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts, or certificates by persons eligible for medicare.

26.1-36-36. Medicare supplement policies - Notice of free examination. Medicare supplement policies or certificates, other than those issued pursuant to direct response solicitation, must have a notice prominently printed on or attached to the first page of the policy stating in substance that the applicant may return the policy or certificate within ten 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. Medicare supplement policies or certificates issued pursuant to a direct response solicitation to persons eligible for medicare must have a notice prominently printed on or attached to the first page stating in substance that the applicant has the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination, the applicant is not satisfied for any reason.

26.1-36-37. Nursing home policy - Guaranteed renewable for life - Limitation on preexisting conditions. Any policy providing benefits for confinement to a nursing home must be guaranteed renewable for life. For the purposes of this section, "guaranteed renewable" means a policy which the insured has the right to continue in force for life subject to its terms by the timely payment of premiums during which the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force. The insurer may, however, in accordance with the provisions of the policy, make changes in premium rates as to all insureds who are placed in the same class for purposes of rate determination in the process of issuance of the policy or making it guaranteed renewable.

A policy providing nursing home coverage may not contain any provision limiting payment of benefits due to preexisting conditions of the insured after the policy has been in force for a period of six months.

26.1-36-38. Rulemaking authority. The commissioner may adopt reasonable rules necessary, proper, or advisable to administer this chapter.

26.1-36-39. Effect of policy not conforming to chapter. A policy delivered or issued for delivery to any person in this state in violation of this chapter is valid but must be construed as provided in this chapter. When any provision in a policy subject to this chapter is in conflict with this chapter, the rights, duties, and obligations of the insurer, the insured, and the beneficiary are governed by this chapter.

26.1-36-40. General penalty - License suspension or revocation. Any person willfully violating any provision of this chapter or order of the commissioner made in accordance with this chapter, is guilty of a class A misdemeanor. The commissioner may also suspend or revoke the license of an insurer or agent for any such willful violation.

SECTION 14. Chapter 26.1-37 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-37-01. Scope and construction. All life insurance and all accident and health insurance in connection with loans or other credit transactions are subject to this chapter, except such insurance in connection with a loan or other credit transaction of more than twenty years' duration, and except where the issuance of such insurance is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor. This chapter must be liberally construed.

26.1-37-02. Definitions. For the purpose of this chapter:

1. "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy.

2. "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.

3. "Creditor" means the lender of money or vendor or lessor of goods, services, or property, rights, or privileges, for which payment is arranged through a credit transaction, or any successor to the right, title, or interest of the lender, vendor, or lessor, and an affiliate, associate, or subsidiary of any of them or any director, officer, or employee of any of them, or any other person in any way associated with any of them.

4. "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights, or privileges for which payment is arranged through a credit transaction.

5. "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

26.1-37-03. Issuance of policies. All credit life insurance and credit accident and health insurance policies may be delivered or issued for delivery in this state only by an insurer authorized to do an insurance business therein, and may be issued only through holders of licenses or authorizations issued by the commissioner.

26.1-37-04. Forms of credit life insurance and credit accident and health insurance. Credit life insurance and credit accident and health insurance may be issued only in the following forms:

1. Individual life insurance policies issued to debtors on the term plan.

2. Individual accident and health insurance policies issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance.

3. Group life insurance policies issued to creditors providing insurance upon the lives of debtors on the term plan.

4. Group accident and health insurance policies issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies.

26.1-37-05. Amount of credit life insurance and credit accident and health insurance.

1. Except as otherwise provided in this subsection, the initial amount of credit life insurance may not exceed the total amount repayable under the contract of indebtedness and, where 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. Insurance on agricultural credit transaction commitments, not exceeding one year in duration, may be written up to the amount of the loan commitment, on a nondecreasing or level term plan. Insurance on educational credit transaction commitments may be written for the amount of the portion of such commitment that has not been advanced by the creditor.

2. The total amount of periodic indemnity payable by credit accident and health insurance in the event of disability, as defined in the policy, may not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness; and the amount of each periodic indemnity payment may not exceed the original indebtedness divided by the number of periodic installments.

26.1-37-06. Term of credit life insurance and credit accident and health insurance. The term of any credit life insurance or credit accident and health insurance, subject to acceptance by the insurer, commences on the date when the debtor becomes obligated to the creditor, except that where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to the indebtedness commences on the effective date of the policy. Where evidence of insurability is required and the evidence is furnished more than thirty days after the date when the debtor

becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurer determines the evidence to be satisfactory, and in that event there must be an appropriate refund or adjustment of any charge to the debtor for insurance. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force must be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund must be paid or credited as provided in section 26.1-37-08.

26.1-37-07. Provisions of policies and certificates of insurance - Disclosure to debtors.

1. All credit life insurance and credit accident and health insurance must be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance.

2. Each individual policy or group certificate of credit life insurance or credit accident and health insurance 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 in the case of a certificate under a group policy, the identity by name or otherwise of the debtor, the premium or amount of payment, if any, by the debtor separately for credit life insurance and credit accident and health insurance, a description of the coverage including the amount and term thereof, and any exceptions, limitations, and restrictions, and must state that the benefits will be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance exceeds the unpaid indebtedness, that any excess is payable to a beneficiary, other than the creditor, named by the debtor or to the debtor's estate.

3. The individual policy or group certificate of insurance must be delivered to the insured at the time the indebtedness is incurred except as provided in subsection 4.

4. If the individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for the policy or a notice of proposed insurance, signed by the debtor and setting forth the name and home office address of the insurer, the name or names of the debtor, the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit accident and health insurance, the amount, term, and a brief description of the coverage provided, must be delivered to the debtor at the time the indebtedness is incurred. The copy of the application or notice of proposed insurance must also refer exclusively to insurance coverage, and must be separate and apart from the loan, sale, or other

credit statement of account, instrument, or agreement, unless the information required by this subsection is prominently set forth in that material. Upon acceptance of the insurance by the insurer and within thirty days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. The application or notice of proposed insurance must state that upon acceptance by the insurer, the insurance becomes effective as provided in section 26.1-37-06. If the named insurer does not accept the risk, the debtor must receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer and the amount of the premium to be charged, and if the amount of premium is less than that set forth in the notice of proposed insurance an appropriate refund must be made.

26.1-37-08. Premiums and refunds.

1. No insurer may issue any credit life insurance policy or credit accident and health insurance policy for which the premium rate exceeds that determined by the schedules of the insurer as on file with the commissioner.

2. Each individual policy or group certificate must provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance must be paid or credited promptly to the person entitled thereto; provided, however, that the commissioner shall prescribe a minimum refund and no refund which would be less than the minimum need be made.

3. If a creditor requires a debtor to make any payment for credit life insurance or credit accident and health insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to the debtor and shall promptly make an appropriate credit to the account.

4. The amount charged to a debtor for any credit life or credit health and accident insurance may not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

5. This chapter does not authorize any payments for insurance prohibited under any law or rule governing credit transactions.

26.1-37-09. Applicability of credit life and health policy simplification standards.

1. Except as provided in subsection 3, sections 26.1-37-09 through 26.1-37-12 apply to all individual and group credit life insurance and credit accident and health insurance policies and insurance certificates under group credit life and accident and health insurance policies filed after June 30, 1982. No policy may be delivered or issued for delivery in this state after June 30, 1986, unless the policy form has been approved by the commissioner or is permitted to be issued under sections 26.1-37-09 through 26.1-37-12. Any policy form that has been approved or permitted to be issued prior to July 1, 1986, and that meets the standards set by sections 26.1-37-09 through 26.1-37-12 need not be refiled for approval, but may continue to be delivered or issued for delivery in this state upon the filing with the commissioner of a list of the forms identified by form number and accompanied by a certificate as to each such form in the manner provided in subsection 6 of section 26.1-37-10.

2. The commissioner may extend the dates in subsection 1.

3. Sections 26.1-37-09 through 26.1-37-12 do not apply to:

   a. Any policy that is a security subject to federal jurisdiction.

   b. Any form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates the form must be approved under sections 26.1-37-09 through 26.1-37-12.

   c. The renewal of a policy delivered or issued for delivery prior to the dates such forms must be approved under sections 26.1-37-09 through 26.1-37-12.

4. No other state law setting language simplification standards applies to policy form.

26.1-37-10. Minimum credit life and health policy language simplification standards.

1. No policy form may be delivered or issued for delivery in this state, unless:

   a. The text achieves a minimum score of forty on the Flesch reading ease test or an equivalent score on any other comparable test as provided in subsection 3.

   b. It is printed, except for specification pages, schedules, and tables, in not less than ten-point type, one point leaded.

c. The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsement or rider.

d. It contains a table of contents or an index of the principal sections of the policy, if the policy has more than three thousand words printed or three or fewer pages of text, or if the policy has more than three pages regardless of the number of words.

2. The commissioner may authorize a lower score than the Flesch reading ease score required in subdivision a of subsection 1 whenever the commissioner finds that a lower score:

a. Will provide a more accurate reflection of the readability of a policy form.

b. Is warranted by the nature of a particular policy form or type or class of policy forms.

c. Is caused by certain policy language which is drafted to conform to the requirements of any state law or rule, or agency interpretation.

3. A Flesch reading ease test score is measured by the following method:

a. For policy forms containing ten thousand words or less of text, the entire form must be analyzed. For policy forms containing more than ten thousand words, the readability of two 2-hundred word samples per page may be analyzed instead of the entire form. The samples must be separated by at least twenty printed lines.

b. The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of one and fifteen thousandths.

c. The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of eighty-four and six-tenths.

d. The sum of the figures computed under subdivisions b and c subtracted from two hundred six and eight hundred thirty-five thousandths equals the Flesch reading ease score for the policy form.

e. For purposes of subdivisions b, c, and d, the following procedures must be used:

(1) A contraction, hyphenated word, or numbers and letters, when separated by spaces, are counted as one word.

(2) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, is counted as a sentence.

(3) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

4. As used in this section, "text" includes all printed matter except:

a. The name and address of the insurer, the name, number, or title of the policy, the table of contents or index, captions and subcaptions, specification pages, schedules, and tables.

b. Any policy language drafted to conform to the requirements of any federal law, regulation, or agency interpretation, any policy language required by any collectively bargained agreement, any medical terminology, any words defined in the policy, and any policy language required by law or rule, provided, however, the insurer identifies the language or terminology excepted by this paragraph and certifies, in writing, that the language or terminology is entitled to be excepted by this paragraph.

5. The commissioner may approve any other reading test for use as an alternative to the Flesch reading ease test if the other test is comparable in result to the Flesch reading ease test.

6. Filings subject to this section must be accompanied by a certificate signed by an officer of the insurer stating that it meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved in accordance with subsection 2. To confirm the accuracy of any certification, the commissioner may require the submission of further information to verify the certification in question.

7. At the option of the insurer, riders, endorsements, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

26.1-37-11. Approval of credit life and health forms. A policy form meeting the requirements of subsection 1 of section 26.1-37-10 must be approved notwithstanding any other law which specifies the contents of a policy, if the policy form provides the policyholders and claimants protection not less favorable than they would be entitled to under such laws.

26.1-37-12. Effect of credit life and health policy simplification standards on filed policies. Sections 26.1-37-09 through 26.1-37-11 do not negate any law of this state permitting the issuance of a policy form after it has been on file for the required time period and has not been disapproved by the commissioner.

26.1-37-13. Claims.

1. All claims must be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims must be settled as soon as possible and in accordance with the terms of the insurance contract.

2. All claims must be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of the claimant to one specified.

3. No plan or arrangement may be used whereby any person other than the insurer or its designated claim representative is authorized to settle or adjust claims. The creditor may not be designated as claim representative for the insurer in adjusting claims; provided, that a group policyholder may, by arrangement with the group insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

26.1-37-14. Existing insurance - Choice of insurer. When credit life insurance or credit accident and health insurance is required as additional security for any indebtedness, the debtor, upon request to the creditor, has the option of furnishing the required amount of insurance through existing insurance policies owned or controlled by the debtor or of procuring and furnishing the required coverage through any insurer authorized to transact insurance business in this state.

26.1-37-15. Enforcement. The commissioner may adopt rules to implement this chapter. Whenever the commissioner finds that there has been a violation of this chapter or any rules adopted pursuant to this chapter, and after written notice thereof and hearing given to the insurer or other person authorized or licensed by the commissioner, the commissioner shall set forth the details of the findings together with an order for compliance by a specified date. The order is binding on the insurer and other person authorized or

licensed by the commissioner on the date specified unless sooner withdrawn by the commissioner or a stay has been ordered by a court of competent jurisdiction.

26.1-37-16. Penalties. In addition to any other penalty provided by law, any person violating an order of the commissioner after it has become final, and while the order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to this state a sum not to exceed two hundred and fifty dollars which may be recovered in a civil action, except that if the violation is found to be willful, the amount of the penalty may be a sum not to exceed one thousand dollars. The commissioner may after notice and hearing revoke or suspend the license or certificate of authority of the person guilty of the violation.

SECTION 15. Chapter 26.1-38 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-38-01. Scope. This chapter applies to direct life insurance policies, accident and health insurance policies, health service contracts, annuity contracts, and contracts supplemental to life and accident and health insurance policies and annuity contracts issued by persons licensed to transact business in this state at any time. This chapter does not apply to:

1. That portion or part of a variable life insurance or variable annuity contract not guaranteed by an insurer.

2. That portion or part of any policy or contract under which the risk is borne by the policyholder.

3. Any policy or contract or part thereof assumed by the impaired or insolvent insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued.

4. Any policy or contract issued by a health maintenance organization, a fraternal benefit society, a benevolent society, or the comprehensive health association.

5. Any policy or contract within the application of section 26.1-42-01.

26.1-38-02. Definitions. As used in this chapter:

1. "Account" means either of the three accounts created under section 26.1-38-03.

2. "Association" means the North Dakota life and health insurance guaranty association.

3. "Board" means the board of directors of the association.

4. "Contractual obligation" means any obligation under covered policies.

5. "Covered policy" means any policy or contract within the scope of this chapter under section 26.1-38-01.

6. "Impaired insurer" means a member insurer deemed by the commissioner after July 1, 1983, to be potentially unable to fulfill its contractual obligations and not an insolvent insurer.

7. "Insolvent insurer" means a member insurer that after July 1, 1983, becomes insolvent and is placed under a final order of liquidation, rehabilitation, or conservation by a court of competent jurisdiction.

8. "Member insurer" means any person licensed to transact in this state any kind of insurance to which this chapter applies under section 26.1-38-01.

9. "Premiums" means direct gross insurance premiums, subscriber fees, and annuity considerations received on covered policies, less return premiums and considerations thereon and dividends paid or credited to policyholders on such direct business. "Premiums" does not include premiums and considerations on contracts between insurers and reinsurers.

10. "Resident" means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom contractual obligations are owed.

26.1-38-03. Creation of the North Dakota life and health insurance guaranty association - Accounts - Supervision by commissioner. There is created a nonprofit legal entity to be known as the North Dakota life and health insurance guaranty association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under its plan of operation and shall exercise its powers through a board of directors. For purposes of administration and assessment, the association shall maintain a health insurance account, a life insurance account, and an annuity account. The association is under the supervision of the commissioner and is subject to the applicable provisions of this title.

26.1-38-04. Board of directors. The board of directors of the association must consist of no fewer than five nor more than nine member insurers serving terms as established in the plan of operation. The member insurers shall select the members of the board, subject to the approval of the commissioner. Vacancies on the board must be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the

approval of the commissioner. To select the initial board, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer is entitled to one vote in person or by proxy. In approving selections to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented. Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board but members of the board may not otherwise be compensated by the association for their services.

26.1-38-05. Powers, duties, and authority of the association. In addition to the powers and duties enumerated in other sections of this chapter:

1. If a domestic insurer is an impaired insurer, the association may, subject to any conditions imposed by the association other than those which impair the contractual obligations of the impaired insurer, and approved by the impaired insurer and the commissioner:

   a. Guarantee or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the covered policies of the impaired insurers.

   b. Provide any moneys, pledges, notes, guarantees, or other means as are proper to effectuate subdivision a, and assure payment of the contractual obligations of the impaired insurer pending action under subdivision a.

   c. Loan money to the impaired insurer.

2. If a domestic insurer is an insolvent insurer, the association shall, subject to the approval of the commissioner:

   a. Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured the covered policies of the insolvent insurer.

   b. Assure payment of the contractual obligations of the insolvent insurer.

   c. Provide any moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge duties under subdivisions a and b.

3. If a foreign or alien insurer is an insolvent insurer, the association shall, subject to the approval of the commissioner:

a. Guarantee, assume, or reinsure or cause to be guaranteed, assumed, or reinsured the covered policies of residents.

b. Assure payment of the contractual obligations of the insolvent insurer to residents.

c. Provide any moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge duties under subdivisions a and b.

This subsection does not apply where the commissioner has determined that the foreign or alien insurer's domiciliary jurisdiction or state of entry provides, by statute, protection substantially similar to that provided by this chapter for residents of this state.

4. In carrying out its duties under subsections 2 and 3, permanent policy liens or contract liens may be imposed in connection with any guarantee, assumption, or reinsurance agreement, if the court:

a. Finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the insolvent insurer's contractual obligations, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of policy or contract liens, to be in the public interest; and

b. Approves the specific policy liens or contract liens to be used.

Before being obligated under subsections 2 and 3, the association may request that there be imposed temporary moratoriums or liens on payments of cash values and policy loans in addition to any contractual provisions for deferral of cash or policy loan values. Such temporary moratoriums and liens may be imposed if they are approved by the court.

5. If the association fails to act within a reasonable period of time as provided in subsections 2 and 3, the commissioner shall have the powers and duties of the association under this chapter with respect to insolvent insurers.

6. The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

7. The association may appear before any court in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter. This standing extends to all matters germane to the powers and duties of the association, including proposals for reinsuring or guaranteeing the covered policies of the impaired or insolvent insurer and the determination of the covered policies and contractual obligations.

8. Any person receiving benefits under this chapter is deemed to have assigned the rights under the covered policy to the association to the extent of the benefits received because of this whether the benefits are payments of contractual obligations or continuation of coverage. The association may require an assignment to it of such rights by any payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this chapter upon that person. The association is subrogated to these rights against the assets of any insolvent insurer. The subrogation rights of the association under this subsection have the same priority against the assets of the insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

9. The contractual obligations of the insolvent insurer for which the association becomes or may become liable are as great as but no greater than the contractual obligations of the insolvent insurer would have been in the absence of an insolvency unless the obligations are reduced as permitted by subsection 4 but the aggregate liability of the association may not exceed one hundred thousand dollars in cash values, or three hundred thousand dollars for all benefits, including cash values, with respect to any one life.

10. The association may:

    a. Enter into contracts necessary or proper to carry out this chapter.

    b. Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under section 26.1-38-06.

    c. Borrow money to effect the purposes of this chapter.

    d. Employ or retain such persons as are necessary to handle the financial transactions of the association, and to perform any other functions as become necessary or proper under this chapter.

e. Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association.

f. Take any necessary legal action to avoid payment of improper claims.

g. Exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life or accident and health insurer, but the association may not issue insurance policies or annuity contracts other than those issued to perform the contractual obligations of the impaired or insolvent insurer.

26.1-38-06. Assessments.

1. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board shall assess the member insurers, separately for each account, at the time and for the amounts the board finds necessary. Assessments are due not less than thirty days after prior written notice to the member insurers and accrue interest at eighteen percent per annum on and after the due date.

2. There are three classes of assessments:

   a. Class A assessments are made for the purpose of meeting administrative costs and other general expenses and examinations conducted under the authority of subsection 5 of section 26.1-38-11 not related to a particular impaired or insolvent insurer.

   b. Class B assessments are made to the extent necessary to carry out the powers and duties of the association under section 26.1-38-05 with regard to an impaired or insolvent domestic insurer.

   c. Class C assessments are made to the extent necessary to carry out the powers and duties of the association under section 26.1-38-05 with regard to an insolvent foreign or alien insurer.

3. a. The board shall determine the amount of any class A assessment. The assessment may be made on a non-pro rata basis. The assessment must be credited against future insolvency assessments and may not exceed fifty dollars per company in any calendar year. The amount of any class B or class C assessment must be allocated for assessment purposes among the accounts in the proportion that the premiums received by the impaired or insolvent insurer on the policies covered by each account for the last calendar year preceding the

assessment in which the impaired or insolvent insurer received premiums bears to the premiums received by such insurer for such calendar year on all covered policies.

b. Class C assessments against member insurers for each account must be in the proportion that the premiums received on business in this state by each assessed member insurer on policies covered by each account for the calendar year preceding the assessments bears to such premiums received on business in this state for the calendar year preceding the assessment by all assessed member insurers.

c. Class B assessments for each account must be made separately for each state in which the impaired or insolvent domestic insurer was authorized to transact insurance at any time, in the proportion that the premiums received on business in that state by the impaired or insolvent insurer on policies covered by the account for the last calendar year preceding the assessment in which the impaired or insolvent insurer received premiums bears to the premiums received in all such states for that calendar year by the impaired or insolvent insurer. The assessments against member insurers must be in the proportion that the premiums received on business in each such state by each assessed member insurer on policies covered by each account for the calendar year preceding the assessment bears to such premiums received on business in each state for the calendar year preceding assessment by all assessed member insurers.

d. Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be made until necessary to implement this chapter. Classification of assessments under subsection 2 and computation of assessments under this subsection must be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

4. The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. If an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

5. The total of all assessments upon a member insurer for each account may not in any one calendar year exceed two

percent of the insurer's premiums received in this state during the calendar year preceding the assessment on the policies covered by the account. If the maximum assessment, together with the other assets of the association in either account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon thereafter as permitted by this chapter.

6. The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses if refunds are impractical.

7. The association shall issue to each insurer paying an assessment under this chapter, other than a class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment paid. All outstanding certificates are of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

26.1-38-07. Tax exemption. The association is exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

26.1-38-08. Credits for assessments paid.

1. A member insurer may offset against its premium tax liability to this state an assessment described in subsection 7 of section 26.1-38-06 to the extent of twenty percent of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid. If a member insurer ceases doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

2. The association shall pay any sums acquired by refund, pursuant to subsection 6 of section 26.1-38-06, from the association which have theretofore been written off by contributing insurers and offset against premium taxes as

provided in subsection 1, and are not then needed for purposes of this chapter, to the commissioner. The commissioner shall deposit these sums with the state treasurer for credit to the general fund of this state.

26.1-38-09. Plan of operation.

1. The association shall submit to the commissioner a plan of operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments become effective upon approval in writing by the commissioner. If the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt any reasonable rules necessary or advisable to effectuate this chapter. The rules continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

2. All member insurers shall comply with the plan of operation.

3. The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:

   a. Establish procedures for handling the assets of the association.

   b. Establish the amount and method of reimbursing members of the board under section 26.1-38-04.

   c. Establish regular places and times for meetings of the board.

   d. Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board.

   e. Establish the procedures whereby selections for the board will be made and submitted to the commissioner.

   f. Establish any additional procedures for assessments under section 26.1-38-06.

   g. Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

4. The plan of operation may provide that any or all powers and duties of the association, except those under subdivision c of subsection 10 of section 26.1-38-05 and section 26.1-38-06, are delegated to a corporation, association, or other organization which performs or will

perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, association, or organization must be reimbursed for any payments made on behalf of the association and must be paid for its performance of any function of the association. A delegation under this subsection takes effect only with the approval of both the board and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

26.1-38-10. Powers and duties of the commissioner. In addition to the duties and powers enumerated elsewhere in this chapter:

1. The commissioner shall:

   a. Upon request of the board, provide the association with a statement of the premiums in the appropriate states for each member insurer.

   b. When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer constitutes notice to its shareholders, if any. The failure of the insurer to promptly comply with this demand does not excuse the association from the performance of its powers and duties under this chapter.

   c. In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the commissioner shall be appointed conservator.

2. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. The forfeiture may not exceed five percent of the unpaid assessment per month, but no forfeiture may be less than one hundred dollars per month.

3. Any action of the board may be appealed to the commissioner by any member insurer within thirty days of the action being appealed.

4. The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of this chapter.

26.1-38-11. Prevention of insolvencies. To aid in the detection and prevention of insurer insolvencies or impairments:

1. The commissioner shall:

   a. Notify the insurance departments of all the other states when the commissioner takes any of the following actions against a member insurer:

      (1) Revocation of license.

      (2) Suspension of license.

      (3) Issuance of any formal order that the company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors.

   The notice must be mailed within thirty days following the action taken or the date on which such action occurs.

   b. Report to the board when the commissioner has taken any of the actions set forth in subdivision a or has received a report from any other commissioner indicating that any such action has been taken in another state. The report to the board must contain all significant details of the action taken or the report received from another commissioner.

   c. Report to the board when the commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member company that the company may be an impaired or insolvent insurer.

   d. Furnish to the board the early warning tests developed by the national association of insurance commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The board shall keep the report and the information contained in the report confidential until made public by the commissioner or other lawful authority.

2. The commissioner may seek the advice and recommendations of the board concerning any matter affecting the

commissioner's duties and responsibilities regarding the financial condition of member companies and companies seeking admission to transact insurance business in this state.

3. The board may, upon majority vote, make reports and recommendations to the commissioner upon any manner germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. The reports and recommendations are not public documents.

4. The board shall, upon majority vote, notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

5. The board may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty days of the receipt of the request, the commissioner shall begin the examination. The examination may be conducted as a national association of insurance commissioners examination or may be conducted by any person the commissioner designates. The association shall pay the cost of the examination, and the examination report must be treated as are other examination reports. The examination report may not be released to the board prior to its release to the public, but this does not preclude the commissioner from complying with subsection 1. The commissioner shall notify the board when the examination is completed. The commissioner shall keep the request for an examination on file but the request is not open to public inspection prior to the release of the examination report to the public.

6. The board may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

7. The board shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the commissioner containing the information it may have in its possession bearing on the history and causes of the insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes for insolvency of a particular insurer, and may adopt by reference any report prepared by the other associations.

26.1-38-12. Assessment liability - Recordkeeping - Obligations - Distributions.

1. This chapter does not reduce the liability for unpaid assessments of the insureds on an impaired or insolvent insurer operating under a plan with assessment liability.

2. Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under section 26.1-38-05. Records of the negotiations or meetings may be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment of insolvency of the insurer, or upon the order of a court of competent jurisdiction. This subsection does not limit the duty of the association to render a report of its activities under section 26.1-38-15.

3. For the purpose of carrying out its obligations under this chapter, the association is deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to subsection 8 of section 26.1-38-05. Assets of the impaired or insolvent insurer attributable to covered policies must be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. Assets attributable to covered policies, as used in this subsection, is that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

4. a. Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders and policyowners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In the determination consideration must be given to the welfare of the policyholders of the continuing or successor insurer.

   b. No distribution to stockholders, if any, of an impaired or insolvent insurer may be made until and unless the total amount of valid claims of the association for funds expended in carrying out its powers and duties under section 26.1-38-05 with respect to the insurer have been fully recovered by the association.

5. a. If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under the order has the right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of subdivisions b through d. As used in this subsection, "affiliate" and "control" have the meanings contained in section 26.1-10-01.

b. No such dividend is recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

c. Any person who was an affiliate that controlled the insurer at the time the distributions were paid is liable up to the amount of distributions that person received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared, is liable up to the amount of distributions that person would have received if they had been paid immediately. If two persons are liable with respect to the same distributions, they are jointly and severally liable.

d. The maximum amount recoverable under this subsection is the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

e. If any person liable under subdivision c is insolvent, all its affiliates that controlled it at the time the dividend was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

26.1-38-13. Stay of proceedings - Reopening default judgments. All proceedings in which the insolvent insurer is a party in any court in this state must be stayed sixty days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default, the association may apply to have the judgment set aside by the same court that made the judgment and must be permitted to defend against such suit on the merits.

26.1-38-14. Prohibited advertisement of chapter in insurance sales. No person, including an insurer, agent, or affiliate of an insurer may

make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement which uses the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by this chapter. This section does not apply to the association or any other entity which does not sell or solicit insurance.

26.1-38-15. Examination of the association - Annual statement. The association is subject to examination and regulation by the commissioner. The board shall submit to the commissioner, not later than March first of each year, a financial report for the preceding calendar year in a form approved by the commissioner and a report of its activities during the preceding calendar year.

26.1-38-16. Immunity. There is no liability on the part of and no claim for relief of any nature may arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board, or the commissioner or the commissioner's representatives, for any action taken by them in the performance of their powers and duties under this chapter.

SECTION 16. Chapter 26.1-39 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-39-01. Rescission of fire insurance contract for alteration increasing risk. An alteration in the use or condition of a thing insured from that to which it is limited by the policy, if made without the consent of the insurer, by means within the control of the insured, and if it increases the risk, entitles an insurer to rescind a fire insurance contract.

26.1-39-02. Rescission of fire contract not permitted if risk not increased. An alteration in the use or condition of a thing insured from that to which it is limited by the policy, which does not increase the risk, does not affect a fire insurance contract.

26.1-39-03. When fire contract unaffected though risk increased. A fire insurance contract is not affected by any act of the insured subsequent to the execution of the policy, if the act does not violate its provisions, even though it increases the risk and is the cause of a loss.

26.1-39-04. Measure of indemnity on fire policy. If there is no valuation in the policy, the measure of indemnity in an insurance against fire is the full amount stated in the policy. If there is a valuation in the policy, the valuation is conclusive between the parties in the adjustment either of a partial or a total loss if the insured has some interest at risk and there is no fraud on the insured's part. In the event of a partial loss, the insurer is

liable only for the proportion of the amount insured as the loss bears to the value of the whole interest of the insured in the property insured. A valuation fraudulent in fact, however, entitles the insurer to rescind the contract.

26.1-39-05. Face of fire policy to be paid in case of loss by fire. Whenever any insurance policy is written to insure any real property in this state against loss by fire and the insured property is destroyed by fire without fraud on the part of the insured or the insured's assigns, the stated amount of the insurance written in the policy is the true value of the property insured.

26.1-39-06. Standard fire insurance policy. No fire insurance contract or policy, including a renewal, may be made, issued, used or delivered by any insurer or by any agent or representative of the insurer, on property in this state other than such as conform in all particulars as to blanks, size of type, context, provisions, agreements, and conditions with the 1943 standard fire insurance policy of the state of New York, a copy of which must be filed in the office of the commissioner as the standard policy for this state. The cancellation provisions contained in the standard policy are superseded to the extent sections 26.1-39-10 through 26.1-39-21 are inconsistent with the provisions. No other or different provision, agreement, condition, or clause may be made a part of the contract or policy or be endorsed on the contract or policy or delivered with the contract or policy, except as follows:

1. The name of the insurer, its location and place of business, the date of its incorporation or organization, and the state or county under which the insurer is organized, the amount of paid-up capital stock, whether it is a stock or mutual company, the names of its officers, the number and the date of the policy, and appropriate company emblems may be printed on policies issued on property in this state; provided, however, that any insurer organized under special charter provisions may so indicate upon its policy, and may add a statement of the plan under which it operates in this state.

2. Printed or written forms of description and specifications or schedules of the property covered by any particular policy and any other matter necessary to express clearly all the facts and conditions of insurance on any particular risk, which facts or conditions may not be inconsistent with or a waiver of any of the provisions or conditions of the standard policy, may be written upon or attached or appended to any policy issued on property in this state. Appropriate forms of contracts, supplemental contracts, or endorsements, whereby the interest in the property described is insured against one or more of the perils which the insurer is empowered to assume, may be used in connection with the standard policy. The forms of contracts, supplemental contracts, or endorsements attached or printed on the policy may contain provisions

and stipulations inconsistent with the standard policy if applicable only to the other perils. The first page of the standard policy may be rearranged to provide space for the listing of rates and premiums for coverages insured under the policy or under endorsements attached or printed on the policy, and such other data as may be included for duplication on daily reports for office records.

3. An insurer, if entitled to do business in this state, may with the approval of the commissioner, if not already included in the standard form as filed with the commissioner, print on its policies, any provision which it is required by law to insert in the policies, if the provision is not in conflict with the laws of this state or the United States, or of the provisions of the standard policy, but the provision must be printed apart from the other provisions, agreements, or conditions of the policy and in type not smaller than the body of the policy and a separate title, as follows: "Provisions required by law to be stated in this policy", and must be a part of the policy.

4. There may be endorsed in writing on the outside of any policy the name, with the word "Agent or Agents" and place of business, of any insurance agent or agents. There may also be added, with the approval of the commissioner, a statement of the group of companies with which the insurer is financially affiliated.

5. When two or more insurers, each having previously complied with the laws of this state, unite to issue a joint policy, there may be expressed in head line of each policy the fact of the severalty of the contract; also the proportion of premiums to be paid to each insurer and the proportion of liability which each insurer agrees to assume. And in the printed conditions of the policy the necessary change may be made from the singular to plural number, when reference is had to the insurers issuing such policy.

6. With the approval of the commissioner, a combined farm policy may be used, the fire portion of which must be substantially in accord with the standard policy.

7. The standard policy is an interest policy and must be so construed as to at all times protect the interest, whatever it may be, of any named insured. Provided, however, that a five-day grace period is allowed after the execution of any written instrument transferring interest in insured property during which full protection must be granted under the terms of the policy.

8. In case of other coverage on the same peril, the liability of each insurer may not be for any greater amount or

proportion of the loss than the ratio such insurance bears to the valid and collectible whole insurance covering the property against the peril involved.

9. No contract or policy issued under this section may contain a limitation of less than three years for the bringing of any suit or action under the contract or policy.

10. This section does not apply to inland marine, ocean marine, or automobile insurance.

26.1-39-07. Standard fire policy - Loss or damage caused by nuclear reaction. An insurer issuing the standard policy pursuant to section 26.1-39-06 may affix to the policy or include in the policy a written statement that the policy does not cover loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination, all whether directly or indirectly resulting from an insured peril under the policy. An insurer may attach to the standard policy an endorsement or endorsements specifically assuming coverage for loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination.

26.1-39-08. Construction of standard fire policy. The standard policy is a valued policy as defined under section 26.1-30-03. An insurance policy in the form prescribed by section 26.1-39-06 is subject to the rules of construction as to its effect or the waiver of any of its provisions which would apply if the form had not been prescribed.

26.1-39-09. Nonstandard fire policy. The commissioner may approve for use in this state a form of policy which does not correspond to the standard policy as provided by section 26.1-39-06; provided, that the coverage of the approved policy form with respect to the peril of fire may not be less than that contained in the standard policy.

26.1-39-10. Property and casualty policies - Declination, cancellation, and nonrenewal - Scope. Sections 26.1-39-10 through 26.1-39-21 apply to insurance policies or risks located or resident in this state which are issued and take effect or which are renewed after July 1, 1983, and insure against any of the following:

1. Loss of or damage to real property which consists of not more than four residential units, one of which is the principal place of residence of the named insured.

2. Loss of or damage to personal property owned by the named insured or used for personal, family, or household purposes within a residential dwelling.

3. Legal liability of the named insured arising out of bodily injury to or death of any persons or damage to property, except bodily injury, death, or property damage arising

out of business pursuits or the rendering or failure to render professional services.

Sections 26.1-39-10 through 26.1-39-21 do not apply to workmen's compensation policies, automobile policies, inland marine policies, insurance policies issued through a residual market mechanism, or policies primarily insuring risks arising from the conduct of a commercial or industrial enterprise.

For purposes of sections 26.1-39-10 through 26.1-39-21, any policy period or term of less than six months is considered a policy period or term of six months and any policy period or term of more than one year or any policy with no fixed expiration date is considered a policy period or term of one year.

26.1-39-11. Definitions.

1. "Declination" means the refusal of an insurer to issue a property insurance policy upon receipt of a written nonbinding application or written request for coverage from its agent or an applicant. For the purposes of sections 26.1-39-10 through 26.1-39-21, the offering of insurance coverage with a company within an insurance group which is different from the company requested on the nonbinding application or written request for coverage or the offering of insurance upon different terms than requested in the nonbinding application or written request for coverage is considered a declination.

2. "Nonpayment of premium" means the failure of the named insured to discharge any obligation in connection with the payment of premiums on property insurance policies subject to sections 26.1-39-10 through 26.1-39-21, whether the payments are directly payable to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit. "Nonpayment of premium" includes the failure to pay dues or fees where payment of dues or fees is a prerequisite to obtaining or continuing property insurance coverage.

3. "Renewal" or "to renew" means the issuance and delivery by an insurer at the end of a policy period of a policy superseding a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of an existing policy beyond its policy period or term.

4. "Termination" means either a cancellation or nonrenewal of property insurance coverage in whole or in part. A cancellation occurs during the policy term. A nonrenewal occurs at the end of the policy term as set forth in subsection 3. For purposes of sections 26.1-39-10 through 26.1-39-21, the transfer of a policyholder between companies within the same insurance group is considered a

termination. Requiring a reasonable deductible, reasonable changes in the amount of insurance, or reasonable reductions in policy limits or coverage is not considered a termination if the requirements are directly related to the hazard involved and are made on the renewal date for the policy.

26.1-39-12. Notification and reasons for declination of property and casualty policies.

1. Upon declining to insure any property subject to sections 26.1-39-10 through 26.1-39-21, the insurer making the declination shall either provide the insurance applicant with a written explanation of the specific reasons for the declination at the time of the declination or advise the applicant that a written explanation of the specific reasons for the declination will be provided within twenty-one days of the time of the receipt of the applicant's written request for such an explanation. An applicant's written request is timely under this section if received within ninety days of the date of that notice to the applicant.

2. No insurer not represented by an agent or broker, may refuse to provide an insurance application form or other means of making a written request for insurance to a prospective applicant who requires insurance coverage from the insurer.

3. No agent or broker, for any reason set out in section 26.1-39-17, may refuse to provide an insurance application form or other means of making a written request for insurance to a prospective applicant who requests insurance coverage from the agent, broker, or insurer.

26.1-39-13. Notification and reasons for cancellation of property and casualty policies.

1. After coverage has been in effect for more than sixty days or after the effective date of a renewal policy, a notice of cancellation may not be issued unless it is based upon at least one of the following reasons:

   a. Nonpayment of premium.

   b. Discovery of fraud or material misrepresentation and the procurement of the insurance or with respect to any claims submitted thereunder.

   c. Discovery of willful or reckless acts or omissions on the part of the named insured which increase any hazard insured against.

d. The occurrence of a change in the risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed.

e. A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof which substantially increases any hazard insured against.

f. A determination by the commissioner that the continuation of the policy would place the insurer in violation of the insurance laws of this state.

g. Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured against.

2. A written notice of cancellation must be mailed or delivered to the named insured, at the last known address of the named insured, at least thirty days prior to the effective date of cancellation or when the cancellation is for nonpayment of premium at least ten days prior to the effective date of cancellation. A postal service certificate of mailing to the named insured at the insured's last known address is conclusive proof of mailing and receipt on the third calendar day after the mailing.

26.1-39-14. Five-day notice exception for cancellation of property and casualty policies. Policies subject to sections 26.1-39-10 through 26.1-39-21 may be canceled upon five days' written notice to the named insureds if one or more of the following conditions exist:

1. Buildings with at least sixty-five percent of the rental units in the building unoccupied.

2. Buildings that have been damaged by a peril insured against and the insured has stated or such time has elapsed as clearly indicates that the damage will not be repaired.

3. Buildings to which, following a fire, permanent repairs have not commenced within sixty days following satisfactory adjustment of loss.

4. Buildings that have been unoccupied sixty consecutive days, except buildings that have a seasonal occupancy, and buildings actually in the course of construction or repair and reconstruction which are properly secured against unauthorized entry.

5. Buildings that are in danger of collapse because of serious structural conditions or those buildings subject

to extremely hazardous conditions not contemplated in filed rating plans such as those buildings that are in a state of disrepair as to be dilapidated.

6. Buildings on which, because of their physical condition, there is an outstanding order to vacate or an outstanding demolition order, or which have been declared unsafe in accordance with applicable law.

7. Buildings from which fixed and salvageable items have been or are being removed and the insured can give no reasonable explanation for the removal.

8. Buildings on which there is reasonable knowledge and belief that the property is endangered and is not reasonably protected from possible arson for the purpose of defrauding an insurer.

9. Buildings with any of the following conditions:

   a. Failure to furnish heat, water, sewer service, or public lighting for thirty consecutive days or more.

   b. Failure to correct conditions dangerous to life, health, or safety.

   c. Failure to maintain the building in accordance with applicable law.

   d. Failure to pay property taxes for more than one year.

10. Buildings that have characteristics of ownership condition, occupancy, or maintenance which are violative of law or public policy.

26.1-39-15. Statement of reasons for cancellation of property and casualty policies. The notice of cancellation must state or be accompanied by either a statement of the reason for cancellation, or a statement that upon written request of the named insured, the insurer will specify in writing the reason for cancellation. The written request must be mailed or delivered to the insurer at least ten days prior to the effective date of cancellation or if cancellation occurs pursuant to section 26.1-39-14, within ten days from the effective date of cancellation. The insurer shall mail or deliver the reason to the named insured within ten days after receipt of the written request.

26.1-39-16. Notification and statement of reasons for nonrenewal of property and casualty policies.

1. No insurer may fail to renew a property insurance policy unless a written notice of nonrenewal is mailed or delivered to the named insured, at the last known address of the named insured, at least thirty days prior to the

expiration date of the policy. A postal service certificate of mailing to the named insured at the insured's last known address is conclusive proof of mailing and receipt on the third calendar day after the mailing.

2. The insurer shall include a statement of the reasons for a nonrenewal with the notice, or shall furnish it upon the written request of the insured. The written request must be mailed or delivered to the insurer at least ten days prior to the expiration date of the policy. The insurer shall comply with such a request within ten days after receipt thereof.

3. No notice of intention not to renew is required where the named insured is given notice of the insurer's willingness to renew the policy by the mailing or delivering of a renewal notice, bill, certificate, or policy. If notice as required by this subsection is not provided, coverage is deemed to be renewed for the ensuing policy period upon payment of the appropriate premium under the same terms and conditions, and subject to subsection 1 of section 26.1-39-13, until the named insured has accepted the replacement coverage with another insurer or until the named insured has agreed to the nonrenewal.

4. Proof of mailing a notice of intention not to renew or business records of the notice of the insurer's willingness to renew must be retained for a period of not less than one year by the insurer or agent or broker giving the notice.

26.1-39-17. Prohibited reasons for declination or termination of property and casualty policies. The declination or termination of a property insurance policy subject to sections 26.1-39-10 through 26.1-39-21 by an insurer, agent, or broker is prohibited if the declination or termination is based upon any of the following reasons:

1. The race, religion, nationality, ethnic group, age, sex, or marital status of the applicant or named insured.

2. The lawful occupation or profession of the applicant or named insured, except that this provision does not apply to an insurer that limits its market to one lawful occupation or profession or to several related lawful occupations or professions.

3. The age or location of the residence of the applicant or named insured unless the decision is for a business purpose that is not a mere pretext for unfair discrimination.

4. The fact that another insurer previously declined to insure the applicant or terminated an existing policy in which the applicant was the named insured.

5. The fact that the applicant or named insured previously obtained insurance coverage through a residual market insurance mechanism.

26.1-39-18. Declination or termination requirements for property and casualty policies - Enforcement - Penalties.

1. Whenever the commissioner, upon the filing of a complaint or through the commissioner's own investigation has reason to believe that an insurer, agent, or broker has engaged in practices which violate sections 26.1-39-10 through 26.1-39-21 and that a proceeding would be in the public interest, the commissioner shall conduct a hearing.

2. If after hearing, the commissioner determines that an insurer has violated subsection 1 of section 26.1-39-13, section 26.1-39-16, or section 26.1-39-17, the commissioner may require the insured to accept the application or written request for insurance coverage at a rate and on the same terms and conditions as are available to other risks similarly situated, or reinstate insurance coverage to the end of the policy period, or continue insurance coverage at a rate and on the same terms and conditions as are available to other risks similarly situated.

3. If the commissioner after hearing determines that any person has violated sections 26.1-39-10 through 26.1-39-21, the commissioner may issue a cease and desist order to restrain the person from engaging in practices that violate these sections or assess a penalty against the person of up to five hundred dollars for each violation of the sections or for each willful and knowing violation of these sections assess a penalty against such person of up to five thousand dollars or cancel, revoke, or refuse to renew a company's certificate of authority to do business in this state.

4. If the commissioner determines in a final order that an insurer has violated subsection 1 of section 26.1-39-13, section 26.1-39-16, or section 26.1-39-17, the applicant or named insured aggrieved by the violation may bring an action in a court of competent jurisdiction in this state to recover from the insurer any loss not otherwise recovered through insurance which would have been paid under the insurance coverage that was declined or terminated in violation of these sections.

5. Any amount recovered may not be duplicative of any recovery obtained through the exercise of any other

statutory, or common law claim for relief arising out of the same occurrence. No action under this section may be brought two years after the date of a final order of the commissioner finding a violation of subsection 1 of section 26.1-39-13 or section 26.1-39-16.

26.1-39-19. Immunity. There is no liability on the part of and no claim for relief arises against the commissioner, any insurer or its authorized representatives, agents, or employees, any licensed insurance agent or broker, or any person furnishing information to an insurer as to reasons for a termination or declination, for any communication giving notice of or specifying the reasons for a declination or termination or for any statement made in connection with an attempt to discover or verify the existence of conditions which would be a reason for a declination or termination under these sections. This section does not apply to statements made in bad faith with malice in fact.

26.1-39-20. Duplicate coverage. If an insured obtains a replacement policy that provides equal or more extensive coverage for any property covered in both policies, the first insurer's coverage of the property may be terminated either by cancellation or nonrenewal. The termination is effective on the effective date of the policy providing duplicate coverage.

26.1-39-21. Renewal of property and casualty policies - Waiver - Estoppel. Renewal of a property insurance policy does not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of the policy providing duplicate coverage.

26.1-39-22. Termination of property and casualty insurance agency contracts. Any insurer authorized to transact property or casualty business in this state shall, upon termination of an agent's appointment by the insurer, permit the renewal and endorsement of all insurance contracts written by the agent for a period of one year from the date of the termination, as determined by the individual underwriting requirements of the insurer. If any contract does not meet the underwriting requirements, the insurer shall give the agent sixty days' notice of its intention not to renew the contract. This section does not apply if the contract is terminated because of the agent's failure, after receiving a written demand, to pay over moneys due the insurer.

SECTION 17. Chapter 26.1-40 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-40-01. Definitions - Limitations. As used in sections 26.1-40-02 through 26.1-40-12:

1. "Declination" means the refusal of an insurer to issue a policy upon receipt of a written nonbinding application or written request for coverage from its agent or an applicant. The offering of insurance coverage with a

company within an insurance group which is different from the company requested on the nonbinding application or written request for coverage, or the offering of policy coverage or rates substantially less favorable than requested in the nonbinding application or written request for coverage, is a declination.

2. "Nonpayment of premium" means failure of the insured to discharge when due any of the insured's obligations in connection with the payment of premium on a policy, or any installment of the premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit.

3. "Policy" means any automobile policy which includes automobile liability coverage, uninsured motorist coverage, automobile medical payments coverage, basic or optional excess no-fault benefits, or automobile physical damage coverage, delivered or issued for delivery in this state, insuring as the named insured an individual residing in this state, and under which the insured vehicles designated in the policy are of the following types only:

   a. A motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance, nor rented to others.

   b. Any four-wheel motor vehicle with a load capacity of one thousand five hundred pounds [680.39 kilograms] or less which is not used in the occupation, profession, or business of the insured, nor used as a public or livery conveyance, nor rented to others.

   "Policy" does not include any policy that has been in effect less than sixty days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy; any policy issued under the North Dakota assigned risk plan; any policy insuring more than six motor vehicles; any policy covering the operation of a garage, automobile sales agency, repair shop, service station, or public parking place; any policy providing insurance only on an excess basis; or any other contract providing insurance to a named insured even though the contract may incidentally provide insurance with respect to such motor vehicles.

4. "Renewal" or "to renew" means:

   a. The issuance and delivery by an insurer of a policy replacing, at the end of the previous policy period, a policy previously issued and delivered by the same insurer;

b. The issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term; or

c. The extension of the term of a policy beyond its policy period or term pursuant to a provision for extending the policy by payment of a continuation premium.

Any policy with a policy period or term of less than six months must be considered as if written for a policy period or term of six months except in case of termination under any of the circumstances specified in subsection 2 of section 26.1-40-05. Any policy written for a term longer than one year or any policy with no fixed expiration date must be considered as if written for successive policy periods or terms of one year and any termination by an insurer effective on an anniversary date of the policy is deemed a failure to renew.

5. "Termination" means either a cancellation or nonrenewal of automobile insurance coverage in whole or in part. A cancellation occurs during the policy term. A nonrenewal occurs at the end of the policy term. An insurer's substitution of insurance upon renewal which results in substantially equivalent coverage is not a termination.

26.1-40-02. Cancellation of policy - Exclusive reasons.

1. No insurer may cancel a policy except for the following reasons:

a. Nonpayment of premium.

b. Because the motor vehicle operator's license or motor vehicle registration of either the named insured or any other operator who resides in the same household as the named insured or who customarily operates a motor vehicle insured under the policy has been suspended, rescinded, canceled, or revoked during the policy period, or, if the policy is a renewal, during its policy period or for one hundred eighty days immediately preceding its effective date. This subdivision does not apply and the insurer may not cancel a policy where the operator whose license is suspended or revoked is excluded from coverage under the policy. The insurer shall notify the named insured of the possibility of excluding an operator whose license has been suspended or revoked prior to cancellation of the policy. When an operator whose license is suspended or revoked is excluded from coverage under the policy covering a secured motor vehicle, the owner of the motor vehicle who gives expressed or implied consent to the operator to use

the motor vehicle is not relieved of liability under subsection 5 of section 26.1-41-03.

c. Fraud or material misrepresentation made by or with the knowledge of any insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy.

d. The insured motor vehicle is:

(1) So mechanically defective that its operation might endanger public safety;

(2) Used in carrying passengers for hire or compensation; provided, however, that the use of an automobile for a car pool is not use of an automobile for hire or compensation;

(3) Used in the transportation of flammables or explosives or for an illegal purpose;

(4) An authorized emergency vehicle; or

(5) Altered by an insured during the policy period so as to substantially increase the risk.

e. The named insured moves to a state where the insurer is not licensed to do business.

f. Failure to pay dues or fees where payment of the dues or fees is a prerequisite to obtaining or continuing automobile insurance coverage.

g. A determination by the commissioner that the continuation of the policy would place the insurer in violation of the law or would be hazardous to the interests of policyholders, creditors, or the public.

2. During the policy period no modification of automobile physical damage coverage, except coverage for loss caused by collision, whereby provision is made for the application of a deductible amount not exceeding one hundred dollars is deemed a cancellation of the coverage or of the policy.

3. Renewal of a policy does not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of the renewal.

26.1-40-03. Notice of cancellation. No insurer may exercise its right to cancel a policy unless a written notice of cancellation is mailed or delivered to the named insured, at the address shown in the policy, at least twenty days prior to the effective date of cancellation. When cancellation is for nonpayment of premium the

notice must be mailed or delivered to the named insured at the address shown in the policy at least ten days prior to the effective date of cancellation.

26.1-40-04. Statement of reason for cancellation. A notice of cancellation for nonpayment of premium must include or be accompanied by a statement of the reason for cancellation. Any other notice of cancellation must state or be accompanied by either a statement of the reason for cancellation, or a statement that upon written request of the named insured, the insurer will specify in writing the reason for cancellation. The written request must be mailed or delivered to the insurer at least ten days prior to the effective date of cancellation. The insurer shall mail or deliver the reason to the named insured within ten days after receipt of the written request. Failure to comply with the notice of cancellation provisions of section 26.1-40-03, or failure to furnish reasons for cancellation when required or requested is sufficient cause for the commissioner to cancel, revoke, or refuse to renew that company's certificate of authority to do business in this state.

26.1-40-05. Nonrenewal - Notice - Statement of reasons - Nonrenewal not to be based on certain facts.

1. No insurer may fail to renew a policy unless a written notice of nonrenewal is mailed or delivered to the named insured, at the address shown in the policy, at least thirty days prior to the expiration date of the policy or anniversary date of a policy written for a term longer than one year or with no fixed expiration date. The insurer shall include a statement of the reasons for nonrenewal with the notice, or shall furnish it upon the written request of the insured mailed or delivered to the insurer at least ten days prior to the expiration date of the policy. The insurer shall comply with such a request within ten days after receipt thereof.

2. Subsection 1 does not apply:

   a. If the insurer has manifested in any way its willingness to renew;

   b. In case of nonpayment of premium for the expiring policy; or

   c. If the insured fails to pay the premium as required by the insurer for renewal.

26.1-40-06. Notification of possible eligibility for assigned risk policy. When a policy is canceled, other than for nonpayment of premium, or in the event of failure to renew a policy to which subsection 1 of section 26.1-40-05 applies, the insurer shall notify the named insured of the insured's possible eligibility for automobile insurance through the automobile assigned risk plan, or automobile insurance plan. The notification must accompany or be included in

the notice of cancellation or nonrenewal required by sections 26.1-40-03 and 26.1-40-05.

26.1-40-07. Proof of notice of termination. A postal service certificate of mailing to the named insured at the address shown in the policy is sufficient proof of notice. Proof of mailing a notice of cancellation or a notice of an intention not to renew, or business records of the notice of the insured's willingness to renew, must be retained for a period of one year by the insurer or agent or broker giving the notice.

26.1-40-08. Reason for cancellation or nonrenewal - Nonliability of parties. The specific reason for cancellation or nonrenewal which is furnished to the insured does not constitute grounds for any claim for relief against the insurer or the insured's authorized representative, or its agents or employees, or any person who in good faith furnishes to the insurer the information upon which the reasons for cancellation or nonrenewal are based.

26.1-40-09. Termination of coverage when another policy in force. Notwithstanding the failure of an insurer to comply with sections 26.1-40-01 through 26.1-40-12, termination of any coverage under the policy either by cancellation or nonrenewal is effective on the effective date of any other policy providing similar coverage on the same motor vehicle or any replacement of the motor vehicle.

26.1-40-10. Notification and reasons for a declination.

1. Upon declining an application or written request for a policy, the insurer making the declination shall either provide the insurance applicant with the specific reasons in writing for the declination at the time of the declination or advise the applicant in writing that specific written reasons for the declination will be provided within twenty-one days of the timely receipt by the insurer making the declination of the applicant's written request for the reasons. An applicant's written request is timely under this subsection if received within ninety days of the date of the notice to the applicant.

2. No insurer not represented by an agent or broker may refuse to provide an insurance application form or other means of making a written request for insurance to a prospective applicant who requests insurance coverage from the insurer.

3. No agent or broker, for any reason set out in section 26.1-40-11, may refuse to provide an insurance application form or other means of making a written request for insurance to a prospective applicant who requests insurance coverage from the agent, broker, or insurer.

26.1-40-11. Terminations - Declinations - Prohibited reasons. The declination of an application for, or the termination of, a policy

by an insurer, agent, or broker is prohibited if the declination or termination is:

1. Based upon the race, religion, nationality, or ethnic group, of the applicant or named insured.

2. Based solely upon the lawful occupation or profession of the applicant or named insured, except that this provision does not apply to any insurer, agent, or broker which limits its market to one lawful occupation or profession or to several related lawful occupations or professions.

3. Based upon the principal location of the insured motor vehicle unless such decision is for a business purpose which is not mere pretext for unfair discrimination.

4. Based solely upon the age, sex, or marital status of an applicant or an insured, except that this subsection does not prohibit rating differentials based upon age, sex, or marital status.

5. Based upon the fact that the applicant or named insured previously obtained insurance coverage through a residual market insurance mechanism.

6. Based upon the fact that another insurer previously declined to insure the applicant or terminated an existing policy in which the applicant was the named insured.

26.1-40-12. Sanctions. If the commissioner after hearing determines that an insurer has violated section 26.1-40-02, 26.1-40-10, or 26.1-40-11, the commissioner may require the insurer to: accept the application or written request for insurance coverage at a rate and on the same terms and conditions as are available to its other risks with similar characteristics, or reinstate insurance coverage to the end of the policy period; or continue insurance coverage at a rate and on the same terms and conditions as are available to its other risks with similar characteristics. If the commissioner has determined, after hearing, that any person has violated sections 26.1-40-02 through 26.1-40-12, the commissioner may: issue a cease and desist order to restrain the person from engaging in practices which violate these sections, or assess a penalty against the person of up to five hundred dollars for each violation, or assess a penalty against the person of up to five thousand dollars for each willful and knowing violation, or cancel, revoke, or refuse to renew a company's certificate of authority to do business in this state.

26.1-40-13. "Uninsured motor vehicle" defined - Includes insolvent insurer. For the purposes of sections 26.1-40-13 through 26.1-40-15, "uninsured motor vehicle" means any motor vehicle not subject to insurance providing at least the bodily injury and death limits set forth in section 39-16.1-11 and includes an insured motor vehicle where the liability insurer is unable to make payment with respect

to the legal liability of its insured within the specified limits because of insolvency.

26.1-40-14. Uninsured motorist coverage - Compulsory - Stacking not permitted.

1. No motor vehicle liability insurance policy against loss resulting from liability imposed by law for bodily injury or death suffered by any person arising out of ownership, maintenance, or use of any motor vehicle may be delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state unless coverage is provided therein or supplemental thereto in amounts not less than that set forth in section 39-16.1-11 for bodily injury or death for the protection of insureds who are legally entitled to recover damages from owners or operators of uninsured motor vehicles and hit-and-run motor vehicles because of bodily injury, sickness or disease, including death, resulting therefrom.

2. Any motor vehicle liability insurance policy which provides uninsured motorist coverage, as specified in subsection 1, must provide that an insured or named insured is only protected to the extent of the coverage provided on the vehicle covered by the policy and involved in the accident. If no such vehicle is involved, coverage is only available to the extent of the applicable uninsured motorist coverage provided on any of the insured or named insured's vehicles. In either instance, coverage on any other vehicle may not be added or stacked upon the applicable coverage.

26.1-40-15. Rights of insurer making payments under uninsured motorist coverage. In the event of payment by an insurer to any person under the uninsured motorist coverage, the insurer making the payments is, to the extent thereof, entitled to the proceeds of any settlement of judgment resulting from the exercise of any rights of recovery of such person against any person or organization legally responsible for the damage for which the payment is made, including the proceeds recoverable from the assets of the insolvent insurer. This section does not allow any insurer a claim for relief against or recovery from the unsatisfied judgment fund.

26.1-40-16. Exclusion of spouse of named insured. No insurer is responsible under a private passenger automobile insurance policy covering an automobile registered or principally garaged in this state from any liability for any claims resulting from the operation of the motor vehicle by a spouse of the named insured who resides in the same household if an endorsement on the policy excludes that spouse from coverage under the policy and the spouse excluded signs the endorsement. If the named insured expressly or impliedly consents to the operation of a secured motor vehicle by a spouse excluded under the policy, the named insured is not relieved of

personal liability as provided by subsection 5 of section 26.1-41-02.

26.1-40-17. Establishment of primary and excess automobile liability coverages in certain instances. When an automobile insurance policy which includes only automobile liability coverage, uninsured motorist coverage, automobile medical payments coverage, and basic or optional excess no-fault benefits, is in force for anyone engaged in the business of selling, repairing, servicing, storing, leasing, or parking motor vehicles and the owner of the vehicles loans, rents, or leases a vehicle to any other person or organization and the vehicle is involved in an accident out of which bodily injury or property damage arises, the following is applicable:

1. If no other automobile insurance policy is in force at the time of the accident for the person or organization to whom the vehicle was loaned, rented, or leased, the coverage provided by the motor vehicle owner's automobile policy extends to the borrower, rentee, or lessee in the event the owner's automobile insurance policy extends coverage to the borrower, rentee, or lessee.

2. If another automobile insurance policy is in force for the person or organization to whom the vehicle was loaned, rented, or leased, any coverage provided by the motor vehicle owner's automobile insurance policy is excess coverage only but limited, however, by the terms of the owner's applicable automobile insurance policy. The policy afforded the person or organization to whom the vehicle was loaned, rented, or leased is primary.

Any policy provisions at variance with this section must be interpreted so as to comply with this section.

26.1-40-18. Automobile warranties construed. An automobile warranty issued by anyone other than the automobile manufacturer or dealer is a contract of insurance and all warranties must be on a contract form prescribed or approved by the commissioner.

26.1-40-19. Certificate of authority to issue automobile warranty policy - Issuance - Qualifications - Renewal. No person may engage in the business of providing or writing automobile warranty insurance without a certificate of authority to issue automobile warranty insurance policies. The commissioner may not issue a certificate of authority unless the commissioner is satisfied that the person is qualified in accordance with the laws of this state governing insurance companies, to transact business in this state. A certificate of authority remains in force in perpetuity if the required renewal fee is paid and the commissioner is satisfied that the requirements of law are met.

26.1-40-20. Automobile warranties considered insurance - Surety bond. Any person engaged in the issuance of car warranty insurance policies is an insurance company and is subject to the fees

specified by law to be paid by insurance companies. Before an automobile warranty insurance company receives a certificate of authority to transact business in this state, the company shall file with the commissioner a cash surety bond in the sum of one hundred thousand dollars on the form prescribed by the commissioner.

26.1-40-21. Revocation of certificate of authority. The commissioner may revoke the certificate of authority of any person engaged in the sale of automobile warranty insurance when the commissioner determines that a breach of warranty contract has occurred.

26.1-40-22. Penalty. Any person violating sections 26.1-40-18 through 26.1-40-21 is guilty of a class A misdemeanor.

SECTION 18. Chapter 26.1-41 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-41-01. Definitions. As used in this chapter:

1. "Accidental bodily injury" means bodily injury, sickness, or disease, including death resulting therefrom, arising out of the operation of a motor vehicle, and which is accidental as to the person claiming basic or optional excess no-fault benefits.

2. "Basic no-fault benefits" means benefits for economic loss resulting from accidental bodily injury. The maximum amount of basic no-fault benefits payable for all economic loss incurred and resulting from accidental bodily injury to any one person as the result of any one accident may not exceed fifteen thousand dollars, regardless of the number of persons entitled to the benefits or the number of basic no-fault insurers obligated to pay the benefits. Basic no-fault benefits payable may not exceed one hundred fifty dollars per week per person prorated for any lesser period for work loss or survivors' income loss, or one thousand dollars for funeral, cremation, and burial expenses.

3. "Basic no-fault insurer" means an insurer or a qualified self-insurer.

4. "Bus" means:

   a. Any motor vehicle owned by a public or governmental agency and operated for the transportation of children to or from school or privately owned and operated for compensation for the transportation of children to or from school.

   b. Any motor vehicle owned by a charitable, religious, educational, or governmental corporation or organization designed for carrying more than ten

passengers and used for the transportation of persons not for compensation.

5. "Dependent survivors" means the surviving spouse of a deceased injured person if residing in the deceased's household at the time of the deceased's death, and other persons receiving support from the deceased injured person at the time of the deceased's death which would qualify them as dependents of the deceased for federal income tax purposes under the federal Internal Revenue Code. The dependency of a surviving spouse terminates upon remarriage.

6. "Disability" means the inability to engage in substantially all of the injured person's usual and customary daily activities.

7. "Economic loss" means medical expenses, rehabilitation expenses, work loss, replacement services loss, survivors' income loss, survivors' replacement services loss, and funeral, cremation, and burial expenses.

8. "Injured person" means a person who sustains accidental bodily injury.

9. "Medical expenses" means reasonable charges incurred for necessary medical, surgical, x-ray, dental, prosthetic, ambulance, hospital, or professional nursing services or services for remedial treatment and care rendered in accordance with a recognized religious healing method. Medical expenses do not include that portion of the charge for a room in any hospital, clinic, convalescent or nursing home, extended care facility, or any similar facility in excess of the reasonable and customary charge for semiprivate accommodations unless intensive care is medically needed.

10. "Motor vehicle" means a vehicle having more than three load-bearing wheels, of a kind required to be registered under the laws of this state relating to motor vehicles, designed primarily for operation upon the public streets, roads, and highways, and driven by power other than muscular power, and includes a trailer drawn by or attached to such a vehicle.

11. "Noneconomic loss" means pain, suffering, inconvenience, and other nonpecuniary damage recoverable under the tort law of this state.

12. "Occupying" means to be in or upon a motor vehicle or engaged in the immediate act of entering into or alighting from the motor vehicle.

13. "Operation of a motor vehicle" means operation, maintenance, or use of a motor vehicle as a vehicle. Operation of a motor vehicle does not include conduct within the course of a business of repairing, servicing, or otherwise maintaining motor vehicles unless the injury occurs off the business premises, or conduct in the course of loading and unloading the vehicle unless the injury occurs while occupying it.

14. "Owner" means the person in whose name the motor vehicle has been registered. If ownership has been transferred, but the registration record has not been changed, "owner" means the person, other than a lienholder, to whom ownership has been transferred. If no registration is in effect at the time of an accident involving the motor vehicle, "owner" means the person, other than a lienholder, who holds the legal title to the motor vehicle. If the motor vehicle is the subject of a security agreement with the debtor having the right to possession, a lease with an option to purchase with the lessee having the right to possession, or a lease with a term of six months or more with the lessee having the right to possession, "owner" means the debtor or lessee.

15. "Pedestrian" means any person not occupying any vehicle designed to be driven or drawn by power other than muscular power.

16. "Rehabilitation expense" means the cost of a procedure or treatment for rehabilitation or a course of rehabilitative occupational training if the procedure, treatment, or training is reasonable and appropriate for the particular case, its cost is reasonable in relation to its probable rehabilitative effects, and it is likely to contribute substantially to medical or occupational rehabilitation.

17. "Relative" means any of the following residing in the same household as the owner: a person related to the owner by blood, marriage, or adoption, or a foster child. A person resides in the same household if that person usually makes a home in the same family unit, even though temporarily living elsewhere.

18. "Replacement services loss" means expenses not exceeding fifteen dollars per day in obtaining ordinary and necessary services from others not members of the injured person's household in lieu of those that the injured person would have performed had the injured person not been injured, not for income but for the benefit of the injured person or the injured person's household. Replacement services loss does not include any loss after the death of an injured person.

19. "Secured motor vehicle" means a motor vehicle with respect to which the security required by this chapter was in effect at the time of its involvement in the accident resulting in accidental bodily injury.

20. "Secured person" means the owner, operator, or occupant of a secured motor vehicle, and any other person legally responsible for the acts or omissions of the owner, operator, or occupant.

21. "Serious injury" means an accidental bodily injury which results in death, dismemberment, serious and permanent disfigurement or disability beyond sixty days, or medical expenses in excess of one thousand dollars. An injured person who is furnished the services in subsection 9 without charge or at less than the average reasonable charge for the service in this state is deemed to have sustained a serious injury if a court determines that the fair and reasonable value of the services exceeds one thousand dollars.

22. "Survivors' income loss" means loss sustained after an injured person's death by dependent survivors during their dependency and consisting of the loss of the contributions they would have received for their support from the decedent out of income from work the decedent would normally have performed had the decedent not died.

23. "Survivors' replacement services loss" means expenses, not to exceed fifteen dollars per day after the injured person's death, by dependent survivors in obtaining ordinary and necessary services from others not members of the decedent's household in lieu of the services the decedent would have performed not for income but for the benefit of the decedent's household.

24. "Work loss" means eighty-five percent of loss of income from work an injured person who would normally be employed in gainful activity during the period of disability, would have performed had the person not been injured, reduced by any income from substitute work actually performed by the injured person or by income the injured person would have earned in available appropriate substitute work that the injured person was capable of performing but unreasonably failed to undertake. Work loss does not include any loss after death of an injured person.

26.1-41-02. Security requirements - Authority of registrar of motor vehicles.

1. The owner of a motor vehicle required to be registered in this state, or the owner of a motor vehicle operated in this state by the owner or with the owner's permission, shall continuously provide with respect to the motor

vehicle during the period in which operation is contemplated in this state security for payment of basic no-fault benefits and the liabilities covered under the motor vehicle liability insurance.

2. The security may be provided by an insurance policy complying with this chapter issued by an insurer authorized to transact business in this state, or, by self-insurance as approved by the commissioner.

3. If the motor vehicle is registered in another state, the security may be provided by an insurance policy issued by an insurer authorized to transact business in either this state or the state in which the motor vehicle is registered, or, by self-insurance as approved by the insurance department of the state in which the motor vehicle is registered.

4. The owner of any motor vehicle who operates it or permits it to be operated in this state when the owner knows or should know that the owner has failed to comply with the requirement that the owner provide security under this chapter shall have the motor vehicle registration revoked or suspended in accordance with procedures established by the registrar of motor vehicles under the motor vehicle law of this state until the owner provides the security required by this chapter.

5. An owner of a motor vehicle with respect to which security is required who fails to have the security in effect at the time of an accident is absolutely liable at law for payment of basic no-fault benefits, and has all the rights and obligations of a basic no-fault insurer under this chapter. This remedy is in addition to any other remedy that an injured person may have against the owner.

6. An insurance policy which purports to provide coverage for basic no-fault benefits or is sold with the representation that it fulfills the requirements of security as required by this chapter is deemed to include all coverage required by this chapter.

7. The registrar of motor vehicles may supervise the enforcement of the compulsory security requirements of this chapter and may adopt the rules necessary in respect to the maintenance of the requirements.

26.1-41-03. Suspension of coverage - Written request by owner. Upon receipt from the owner of a secured motor vehicle, of a signed written request for suspension stating that the secured motor vehicle will not be operated on public roads or highways during a period of not less than thirty consecutive days, the basic no-fault insurer of the vehicle shall suspend on a pro rata basis or shall offer a similar credit, to the extent requested by the owner,

insurance coverage afforded under the policy providing the security for payment of basic no-fault benefits and the liabilities covered under the motor vehicle liability insurance for the secured motor vehicle until notified in writing by the owner that the coverage should be reinstated. The owner may not be required to surrender the number plates during the policy suspension period. During the period of suspension, subsections 1, 2, 4, 5, 6, and 7 of section 26.1-41-02 do not apply with respect to the secured motor vehicle, but if the secured motor vehicle is operated by or with the permission of the owner during the period of suspension, subsections 1, 2, 4, 5, and 7 of section 26.1-41-02 become applicable. This section does not apply to an owner of a secured motor vehicle for which proof of financial responsibility is required under the financial responsibility laws of this state.

26.1-41-04. Optional excess no-fault benefits. Each basic no-fault insurer of the owner of a secured motor vehicle shall also make available optional excess no-fault benefits for excess economic loss commencing upon the exhaustion of basic no-fault benefits, up to a total of forty thousand dollars in no-fault benefits for accidental bodily injury to any one person in any one accident. A basic no-fault insurer may also offer benefits and limits other than those prescribed in this section, and a basic no-fault insurer may incorporate in optional excess no-fault coverage the terms, conditions, and exclusions as may be consistent with the premiums charged. The amounts payable under optional excess no-fault benefits may be duplicative of benefits received from any collateral sources or may be written in excess of such collateral source benefits, or may provide for reasonable waiting period, deductibles, or coinsurance provisions. The optional excess no-fault benefits of a basic no-fault insurer may provide for subrogation to the injured person's right of recovery against any responsible third party.

26.1-41-05. Self-insurance - Liability policies - Authority of commissioner.

1. Self-insurance used as security required by this chapter may be provided by filing in satisfactory form all of the following:

   a. A continuing undertaking by the owner or other appropriate person to pay basic no-fault benefits and the liabilities covered by motor vehicle liability insurance and to perform all other obligations imposed by this chapter.

   b. Evidence that appropriate provision exists for the prompt and efficient administration of all claims, benefits, and obligations provided by this chapter.

   c. Evidence that reliable financial arrangements, deposits, or commitments exist providing assurance for payment of basic no-fault benefits and the liabilities covered by motor vehicle liability insurance and all

other obligations imposed by this chapter substantially equivalent to those afforded by an insurance policy that would comply with this chapter.

2. Every insurer authorized to transact the business of motor vehicle liability insurance in this state shall file with the commissioner as a condition of its continued transaction of business in this state a form declaring that its motor vehicle liability policies wherever issued are deemed to provide the security required by this chapter when the motor vehicle is operated in this state. Any nonadmitted insurer may file this form.

3. The commissioner may adopt necessary rules not inconsistent with this chapter. The commissioner may provide schedules of reasonable maximum benefits payments for specified medical services and rehabilitation expenses which basic no-fault insurers may incorporate into their policies of basic or optional excess coverages afforded pursuant to this chapter.

26.1-41-06. Persons entitled to basic no-fault benefits. Each basic no-fault insurer of a secured motor vehicle shall pay basic no-fault benefits without regard to fault for economic loss resulting from:

1. Accidental bodily injury sustained in the United States or its possessions or in Canada by the owner of the motor vehicle or any relative of the owner:

   a. While occupying any motor vehicle, or

   b. While a pedestrian as the result of being struck by a motor vehicle or motorcycle.

2. Accidental bodily injury sustained by any other person while occupying the secured motor vehicle if the accident occurs in the United States or its possessions or in Canada.

3. Accidental bodily injury sustained by any pedestrian in this state as a result of being struck by the secured motor vehicle.

26.1-41-07. Persons not entitled to benefits. Basic or optional excess no-fault benefits are not payable to or on behalf of any person while:

1. Occupying any motor vehicle without the expressed or implied consent of the owner or while not in lawful possession of the motor vehicle.

2. Occupying a motor vehicle owned by such person which is not insured for the benefits required by this chapter unless uninsured solely because the insurance company of

the owner has not filed a form pursuant to subsection 2 of section 26.1-41-05 to provide the basic no-fault benefits required by this chapter.

3. During a racing or speed contest, or in practicing or preparing for a racing or speed contest.

4. Intentionally causing or attempting to cause injury to oneself or another person.

26.1-41-08. Secured person exemption.

1. In any action against a secured person to recover damages because of accidental bodily injury arising out of the ownership or operation of a secured motor vehicle in this state, the secured person is exempt from liability to pay damages for:

   a. Noneconomic loss unless the injury is a serious injury.

   b. Economic loss to the extent of all basic no-fault benefits paid or to become payable for such injury under this chapter after subtracting the same elements of loss recoverable under any workmen's compensation law.

2. The exemption under subsection 1 does not apply unless the person who has sustained accidental bodily injury is a person who may qualify for basic no-fault benefits pursuant to section 26.1-41-06 and who is not excluded under section 26.1-41-07.

26.1-41-09. Payment of basic and optional excess no-fault benefits.

1. Basic and optional excess no-fault benefits are payable monthly for economic loss sustained by an injured person or dependent survivors or incurred on the injured person's behalf by the injured person's spouse, relatives, or guardian. A basic no-fault insurer may pay basic or optional excess no-fault benefits when due to the above persons who it believes have sustained or incurred the economic loss or at its option to the person rendering, for a charge, the services for which the benefits are payable. If the injured person dies, a basic no-fault insurer may pay the benefits due directly to those entitled to the benefits without the appointment of a personal representative and unless a court directs otherwise, may pay all benefits for survivors' income loss or replacement services loss to the surviving spouse for the use and benefit of all dependent survivors. A basic no-fault insurer's payments made in good faith in accordance with this chapter discharges its liability to the extent of the payments unless the basic no-fault

insurer has been notified in writing of the claim of some other person prior to the making of any of the payments.

2. Basic and optional excess no-fault benefits are overdue if not paid within thirty days after the basic no-fault insurer receives reasonable proof of the fact and the amount of loss sustained, except that the basic no-fault insurer may accumulate claims for periods not exceeding one month, and the benefits are not overdue if paid within twenty days after the period of accumulation. If reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within thirty days after the proof is received by the basic no-fault insurer. Any part or all of the remainder of the claim that is later supported by reasonable proof is overdue if not paid within thirty days after proof is received by the basic no-fault insurer. Payment is deemed made on the date of mailing. All overdue payments must bear interest at the rate of eighteen percent per annum.

26.1-41-10. Assignment of nonmedical benefits unenforceable - Exemption of benefits from process. An agreement for assignment of any right to nonmedical benefits payable in the future is unenforceable. Basic no-fault benefits are exempt from garnishment, attachment, execution, and any other process or claim to the extent that wages or earnings are exempt under any applicable law exempting wages or earnings from process or claims.

26.1-41-11. Mental and physical examinations. Whenever the mental or physical condition of a person is material to any claim that has been or may be made for past or future basic or optional excess no-fault benefits, the person shall submit to mental or physical examination by a physician designated by the basic no-fault insurer at a reasonably convenient location. Basic no-fault insurers are authorized to include reasonable provisions of this nature in policies providing basic or excess no-fault benefits.

26.1-41-12. Discovery of facts about an injured person.

1. Every employer or claimant shall, if a written request is made by a basic no-fault insurer against whom a claim has been made, furnish forthwith, in a form approved by the commissioner of insurance, a sworn statement of the earnings since the time of the accidental bodily injury and for a twelve-month period before the injury, of the person upon whose injury the claim is based.

2. Every physician, coroner or medical officer, hospital, clinic, or other medical institution providing, before or after an accidental bodily injury upon which a claim for basic or optional excess no-fault benefits is based, any products, services, or accommodations in relation to the injury, or in relation to a condition claimed to be connected with the injury, shall, if requested in writing

to do so by the basic no-fault insurer against whom the claim has been made:

a. Promptly furnish a written report of the history, condition, treatment, and dates and costs of treatment.

b. Permit the inspection and copying of its records regarding the history, condition, treatment, and dates and costs of treatment.

c. Promptly furnish autopsy reports.

3. In the event of any dispute regarding a basic no-fault insurer's right to discovery of facts about an injured person's earnings or about history, condition, treatment, and dates and costs of such treatment, a court of record may enter an order for such discovery as justice requires.

26.1-41-13. Priority of applicable security - Coordination of benefits.

1. A basic no-fault insurer has the primary obligation to make payment for economic loss because of accidental bodily injury arising out of the operation of a motor vehicle; provided, that the amount of all benefits a claimant recovered or is entitled to recover for the same elements of loss under any workmen's compensation law must be subtracted from the basic no-fault benefits otherwise payable for the injury.

2. As between applicable security basic no-fault benefits are payable as follows:

a. As to any person injured while occupying a secured motor vehicle, or injured as a pedestrian by a secured motor vehicle, the basic no-fault insurer of the secured motor vehicle shall pay the benefits.

b. As to any person who is injured while occupying an unsecured motor vehicle, or while being struck as a pedestrian by an unsecured motor vehicle, the basic no-fault insurer affording the benefits to the injured person shall pay the benefits.

c. As to any person injured while occupying a bus that is a secured motor vehicle, the basic no-fault insurer affording benefits to the injured person as the owner of a secured motor vehicle or as a relative of the owner of a secured motor vehicle shall pay the benefits; and, if there is no basic no-fault insurer affording benefits to the injured person, then the basic no-fault insurer of the bus shall pay the benefits.

d. As to any person injured while occupying a secured motor vehicle that is transporting persons under a ridesharing arrangement, as defined in section 8-02-07, the basic no-fault insurer affording benefits to the injured person as the owner of a secured motor vehicle or as a relative of the owner of a secured motor vehicle shall pay the benefits; and, if there is no basic no-fault insurer affording benefits to the injured person, then the basic no-fault insurer of the secured motor vehicle shall pay the benefits.

3. An insurer, health maintenance organization, or nonprofit health service corporation, other than a basic no-fault insurer, authorized to do business in this state may coordinate any benefits it is obligated to pay for economic loss incurred as a result of accidental bodily injury, with the first five thousand dollars of basic no-fault benefits. An insurer, health maintenance organization, or nonprofit health service corporation may not coordinate benefits unless it provides those persons who purchase benefits from it with an equitable reduction or savings in the direct or indirect cost of purchased benefits. The commissioner shall approve any coordination of benefits plan.

26.1-41-14. Stacking of basic no-fault benefits prohibited. When an injured person is provided basic no-fault benefits by an insurance policy issued in compliance with this chapter, the injured person is covered only to the extent of the basic no-fault benefits provided on the secured motor vehicle involved in the accident. If any person is injured while occupying an unsecured motor vehicle, basic no-fault benefits are only available to the extent of the applicable basic no-fault benefits provided to the injured person as the owner of a secured motor vehicle or as a relative of the owner of a secured motor vehicle. In either instance, basic no-fault benefits on any secured motor vehicle may not be added or stacked upon basic no-fault benefits available from any other source.

26.1-41-15. Motor vehicle liability insurance - Extraterritorial provision.

1. Motor vehicle liability insurance applies to the amounts which the owner is legally obligated to pay as damages because of accidental bodily injury and accidental property damage arising out of the ownership or operation of a motor vehicle, if the accident occurs in the United States or its possessions or in Canada. Motor vehicle liability insurance must afford limits of liability not less than those required under the financial responsibility laws of this state. Customary terms and conditions applicable to motor vehicle liability insurance apply.

2. If the accident occurs outside this state but in the United States or its possessions or in Canada:

a. If the limits of liability of the financial responsibility or compulsory insurance laws of the applicable jurisdiction exceed the limits of liability of the financial responsibility laws of North Dakota, the motor vehicle liability insurance is deemed to comply with the limits of liability of the laws of the applicable jurisdiction.

b. If the limits of no-fault benefits of the applicable jurisdiction exceed the limits provided under this chapter for no-fault benefits, the no-fault benefits are deemed to comply with the limits of the benefits of the laws of the applicable jurisdiction.

26.1-41-16. Insurer's right of subrogation. A basic no-fault insurer which has paid or may become obligated to pay basic no-fault benefits under this chapter is subrogated to the extent of its obligations to all of the rights of the injured person against any person other than a secured person. The subrogee has a lien to the extent of its obligations, and no release of rights is effective against the rights without the subrogee's consent.

26.1-41-17. Equitable allocation of losses among insurers. A basic no-fault insurer may recover basic no-fault benefits paid to or for the benefit of an injured person from the motor vehicle liability insurer of a secured person if:

1. The injured person has sustained a serious injury; or

2. The injury results from an accident involving two or more motor vehicles, at least one of which is a motor vehicle weighing more than six thousand five hundred pounds [2,948.35 kilograms] unloaded.

The right of recovery and the amount thereof must be determined on the basis of tort law without regard to section 26.1-41-08 by agreement between the basic no-fault insurers involved, or, if they fail to agree, by binding intercompany arbitration under procedures approved by the commissioner. The amount of recovery under this section may not exceed the limits of liability of the secured person's motor vehicle liability insurance policy or other security, reduced by the amount of the liability for tort claims against the secured person covered by the policy or other security.

26.1-41-18. Assigned claims plan.

1. Basic no-fault insurers authorized to provide basic no-fault benefits in this state shall organize, participate in, and maintain an assigned claims plan to provide that an injured person who suffers economic loss and is eligible for basic no-fault benefits under section 26.1-41-06, other than a person not entitled to benefits under section 26.1-41-07, may obtain basic no-fault benefits through the plan if:

a. Basic no-fault benefits are not applicable to the injury for some reason other than those specified in section 26.1-41-07; or

b. Basic no-fault benefits applicable to the injury are inadequate to provide the contracted-for benefits because of financial inability of a basic no-fault insurer to fulfill its obligations.

Payments made by the assigned claims plan pursuant to this subsection constitute covered claims under chapter 26.1-42.

2. If a claim qualifies for assignment under this section, the assigned claims plan or any basic no-fault insurer to whom the claim is assigned is subrogated to the rights of the claimant against any person liable, and against any basic no-fault insurer, its successor in interest, or substitute legally obligated to provide basic no-fault benefits to the claimant, for basic no-fault benefits provided by the assignment.

3. The assigned claims plan must contain any rules for the operation of the plan and for the equitable distribution of costs as may be approved by the commissioner. Any claim brought through the plan must be assigned to a basic no-fault insurer in accordance with the rules and the insurer, after assignment, has the rights and obligations it would have had if prior to the assignment it has issued security providing basic no-fault benefits applicable to the loss. Any person accepting benefits under this sections has the rights and obligations as that person would have had under security issued to that person providing basic no-fault benefits.

4. Any person who sustains accidental bodily injury while an occupant in or as a result of being struck by any motor vehicle is not eligible for benefits under the assigned claims plan if the person owned a motor vehicle on the date of loss and failed to provide continuous security for the motor vehicle as required by section 26.1-41-02.

5. Any person who requests suspension of coverage in accordance with section 26.1-41-03 is not ineligible for assigned claims plan benefits while the suspension is in effect if bodily injury is sustained while an occupant in or as a result of being struck by a motor vehicle not owned by that person.

26.1-41-19. Limitation of actions.

1. If no basic or optional excess no-fault benefits have been paid for loss, an action for the benefits may be commenced not later than two years after the injured person suffers

the loss and either knows, or in the exercise of reasonable diligence should know, that the loss was caused by the accident, or not later than four years after the accident, whichever is earlier. If basic or optional excess no-fault benefits have been paid for loss, an action for recovery of further benefits for the loss by either the same or another claimant, may be commenced not later than two years after the last payment of benefits.

2. If no basic or optional excess no-fault benefits have been paid to the decedent or dependent survivors, an action for benefits for survivors' income loss and replacement services loss and funeral and burial expenses may be commenced not later than one year after the death or four years after the accident from which death results, whichever is earlier. If survivors' income loss and replacement services loss benefits have been paid to any dependent survivor, an action for recovery of further survivors' income loss or replacement services loss benefits by either the same or another claimant may be commenced not later than two years after the last payment of benefits. If basic or optional excess no-fault benefits have been paid for loss suffered by an injured person before the injured person's death resulting from the injury, an action for recovery of survivors' income loss or replacement services loss benefits may be commenced not later than one year after the death or four years after the last payment of benefits, whichever is earlier.

3. Except as subsection 1 or 2 prescribes a longer period, an action by a claimant on an assigned claim which has been timely presented may be commenced not later than sixty days after the claimant received written notice of rejection of the claim by the basic no-fault insurer to which it was assigned.

4. The time period limitations prescribed in this section govern all actions for basic and optional excess no-fault benefits under this chapter notwithstanding any limitation prescribed elsewhere in the laws of this state.

SECTION 19. Chapter 26.1-42 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-42-01. Scope. This chapter applies to all kinds of direct insurance policies and contracts except life insurance policies, accident and health insurance policies, health service contracts, annuity contracts, contracts supplemental to life and accident and health insurance policies and annuity contracts, and any other policies and contracts within the application of section 26.1-38-01, title insurance policies, surety contracts, credit insurance policies and contracts, mortgage guaranty insurance policies and

contracts, and ocean marine insurance policies and contracts. This chapter must be liberally construed.

26.1-42-02. Definitions. As used in this chapter:

1. "Association" means the North Dakota insurance guaranty association.

2. "Board" means the board of directors of the association.

3. "Covered claim" means an unpaid claim, including one for unearned premiums, within the coverage of an insurance policy to which this chapter applies issued by an insurer if the insurer becomes insolvent after July 1, 1971. The claimant or insured must be a resident of this state at the time of the insured event or the insured property must be permanently located in this state. "Covered claim" does not include any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise.

4. "Insolvent insurer" means an insolvent insurer who has been issued a certificate of authority to transact insurance in this state either at the time the policy was issued or when the insured event occurred, and determined to be insolvent by a court of competent jurisdiction.

5. "Member insurer" means any person, except a county mutual insurance company, who writes any kind of insurance to which this chapter applies under section 26.1-42-01, including the exchange of reciprocal or interinsurance contracts, and is licensed to transact insurance in this state.

6. "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this chapter applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

26.1-42-03. Creation of the North Dakota insurance guaranty association. There is created a nonprofit unincorporated legal entity to be known as the North Dakota insurance guaranty association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under its plan of operation and shall exercise its powers through a board of directors.

26.1-42-04. Board of directors. The board of directors of the association must consist of no fewer than five nor more than nine persons serving terms as established in the plan of operation. The member insurers shall select the members of the board, subject to

the approval of the commissioner. Vacancies on the board must be filled for the remaining period of the term in the same manner as initial appointments. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented. Members of the board may be reimbursed from the assets of the association for expenses incurred by them as board members.

26.1-42-05. Powers, duties, and authority of the association.

1. The association shall:

   a. Be obligated to the extent of the covered claims of insolvent insurers existing (1) prior to the determination of insolvency and arising within thirty days after the determination of insolvency, or (2) before the policy expiration date if less than thirty days after the determination, or (3) before the insured replaces the policy or causes its cancellation, if the insured does so within thirty days of the determination. The obligation includes only that amount of each covered claim in excess of one hundred dollars and less than three hundred thousand dollars. The association may not be obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer.

   b. Be deemed the insolvent insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent.

   c. Assess member insurer's amounts necessary to pay the obligations of the association under subdivision a subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, the cost of examinations under section 26.1-42-10, and other expenses authorized by this chapter. Each member insurer assessment must be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year bears to the net direct written premiums of all member insurers for the preceding calendar year. Each member insurer must be notified of the assessment not later than thirty days before it is due. No member insurer may be assessed in any year an amount greater than two percent of that member insurer's net direct written premiums for the preceding calendar year. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available must be prorated and the unpaid portion must be paid as soon thereafter as funds become available. The

association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of the claims by the member insurer.

d. Investigate claims brought against the association and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation. The association shall deny all other claims and may review settlements, releases, and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which the settlements, releases, and judgments may be properly contested.

e. Notify such persons as the commissioner directs under subdivision a of subsection 2 of section 26.1-42-09.

f. Handle claims through its employees, through one or more insurers, or through other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner and may be declined by a member insurer.

g. Reimburse each servicing facility for association obligations it pays and for the expenses it incurs handling association claims. The association shall also pay the other expenses of the association authorized by this chapter.

2. The association may:

a. Employ or retain personnel to handle claims and perform its other duties.

b. Borrow funds necessary to effect this chapter in accord with the plan of operation.

c. Sue or be sued.

d. Negotiate and become a party to contracts necessary to carry out this chapter.

e. Refund to the member insurers in proportion to their contribution to the association that amount by which the assets of the association exceed the liabilities, if, at the end of any calendar year, the board finds

that the association's assets exceed the board's estimate of its liabilities for the coming year.

f. Perform other acts as are necessary or proper to effectuate this chapter.

26.1-42-06. Tax exemption. The association is exempt from payment of all fees and taxes levied by this state or any of its subdivisions except taxes levied on property.

26.1-42-07. Recognition of assessments in rates. The rates and premiums charged for insurance policies to which this chapter applies must include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association. These rates may not be determined to be excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurer.

26.1-42-08. Plan of operation.

1. The association shall submit to the commissioner a plan of operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments become effective upon approval in writing by the commissioner. If the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to effectuate this chapter. The rules continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

2. All member insurers shall comply with the plan of operation.

3. The plan of operation shall:

   a. Establish the procedures whereby all the powers and duties of the association under section 26.1-42-05 will be performed.

   b. Establish procedures for handling assets of the association.

   c. Establish the amount and method of reimbursing members of the board under section 26.1-42-04.

   d. Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer are deemed notice to the association or its agent. A list

of these claims must be periodically submitted to the association or similar organization in another state by the receiver or liquidator.

e. Establish regular places and times for meetings of the board.

f. Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board.

g. Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty days after the action or decision.

h. Establish the procedures whereby selections for the board will be submitted to the commissioner.

i. Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

4. The plan of operation may provide that any or all powers and duties of the association, except those under subdivision c of subsection 1 and subdivision b of subsection 2 of section 26.1-42-05, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of the association, or its equivalent, in two or more states. Such a corporation, association, or organization must be reimbursed as a servicing facility would be reimbursed and must be paid for its performance of any other association functions. A delegation under this subsection takes effect only with the approval of the board and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

26.1-42-09. Duties and powers of the commissioner.

1. The commissioner shall:

   a. Notify the association of the existence of an insolvent insurer not later than three days after the commissioner receives notice of the determination of the insolvency.

   b. Upon request of the board, provide the association with a statement of the net direct written premiums of each member insurer.

2. The commissioner may:

a. Require the association to notify insureds of the insolvent insurer and other interested parties of the determination of insolvency and of their rights under this chapter. The notification must be by mail at their last known address, where available. If sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation is sufficient.

b. Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any member insurer that fails to pay an assessment when due. The fine may not exceed five percent of the unpaid assessment per month, except that no fine may be less than one hundred dollars per month.

c. Revoke the designation of any servicing facility if the commissioner finds that claims are being handled unsatisfactorily.

26.1-42-10. Prevention of insolvencies. To aid in the detection and prevention of insurer insolvencies:

1. The board, upon majority vote, shall notify the commissioner of any information indicating any member insurer may be insolvent or in a financial condition hazardous to the policyholders or the public.

2. The board may, upon majority vote, request the commissioner to order an examination of any member insurer the board in good faith believes may be in a financial condition hazardous to the policyholders or the public. Within thirty days of the receipt of the request, the commissioner shall begin the examination. The examination may be conducted as a national association of insurance commissioners examination or by persons the commissioner designates. The association shall pay the cost of the examination, and the examination report must be treated as other examination reports. The examination report may not be released to the board prior to its release to the public, but this does not preclude the commissioner from complying with subsection 3. The commissioner shall notify the board when the examination is completed. The commissioner shall keep the request for an examination on file but the request is not open to public inspection prior to the release of the examination report to the public.

3. The commissioner shall report to the board when the commissioner has reasonable cause to believe that any

member insurer examined or being examined at the request of the board may be insolvent or in a financial condition hazardous to the policyholders or the public.

4. The board may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer. The reports and recommendations are not public documents.

5. The board may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

6. The board shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report on the history and causes of the insolvency, based on the information available to the association, and submit it to the commissioner.

26.1-42-11. Effect of paid claims.

1. Any person recovering under this chapter is deemed to have assigned that person's rights under the policy to the association to the extent of that person's recovery from the association. Every insured or claimant seeking the protection of this chapter shall cooperate with the association as if it were the insolvent insurer. The association has no claim for relief against the insured of the insolvent insurer for any sums the association has paid out except such causes of action as the insolvent insurer would have had. In the case of an insolvent insurer operating on a plan with assessment liability, payment of claims of the association does not operate to reduce the liability of insured's to the receiver, liquidator, or statutory successor for unpaid assessments.

2. The receiver, liquidator, or statutory successor of an insolvent insurer is bound by settlements of covered claims by the association or a similar organization in another state. A court having jurisdiction shall grant such claims priority equal to that to which the claimant would have been entitled, in the absence of this chapter, against the assets of the insolvent insurer. The expenses of the association or similar organization in handling claims must be accorded the same priority as the liquidator's expenses.

3. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which preserves the rights of the association against the assets of the insolvent insurer.

26.1-42-12. Nonduplication of recovery.

1. Any person having a claim against an insurer under any provision in an insurance policy other than a policy of an insolvent insurer which is also a covered claim, is required to exhaust first the right under the policy. Any amount payable on a covered claim under this chapter must be reduced by the amount of any recovery under the insurance policy.

2. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured. However, if it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. Any recovery under this chapter must be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

26.1-42-13. Stay of proceedings - Reopening default judgments. All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state must be stayed for sixty days from the date insolvency is determined to permit proper defense by the association of all pending claims for relief. As to any covered claim arising from a judgment under any decision, verdict, or finding based on the default of the insolvent insurer or its failure to defend an insured, the association, either on its own behalf or on behalf of the insured, may apply to have the judgment, order, decision, verdict, or finding set aside by the same court or administrator that made the judgment, order, decision, verdict, or finding, and must be permitted to defend against the claim on the merits.

26.1-42-14. Examination of the association - Annual report. The association is subject to examination and regulation by the commissioner. The board shall submit, not later than March first of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

26.1-42-15. Immunity. There is no liability on the part of and no claim for relief of any nature may arise against any member insurer, the association or its agents and employees, the board, or the commissioner or the commissioner's representatives for any action taken by them in the performance of their powers and duties under this chapter.

SECTION 20. Chapter 26.1-43 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-43-01. "Legal expense insurance" defined. Legal expense insurance, as authorized in this title, means insurance which involves the assumption of a contractual obligation to reimburse the

beneficiary against or on behalf of the beneficiary, all or a portion of the beneficiary's fees, cost, or expenses related to or arising out of services by or under the supervision of an attorney licensed to practice law in this state, regardless of whether the payment is made by the beneficiaries individually or by a third party for them.

26.1-43-02. What legal expense insurance does not include. Legal expense insurance does not include the provision of or reimbursement for legal services incidental to other insurance coverages.

26.1-43-03. Legal plans and contracts excepted from insurance code. Unless otherwise provided, this title does not apply to:

1. Plans licensed under chapter 26.1-19.

2. Retainer contracts made by attorneys with individual clients with fees based upon an estimate of the nature and amount of services to be provided to a specific client and similar contracts made with a group of clients involved in the same or closely related legal matters.

3. Employee welfare benefit plans as defined by the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829].

SECTION 21. Chapter 26.1-44 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-44-01. Surplus line insurance valid. Insurance contracts procured as surplus line coverage from unauthorized insurers in accordance with this chapter are valid and enforceable as to all parties, and must be given recognition in all matters and respects to the same effect as like contracts issued by authorized insurers.

26.1-44-02. Affidavit as prerequisite of insurance - Contents. A surplus lines insurance broker licensed under chapter 26.1-26 shall in every case execute and file with the commissioner within fifteen days of the effective date of any surplus line insurance policy, indemnity contract, or surety bond an affidavit in acceptable form that after a diligent search, an inability exists to procure the insurance, indemnity contract, or surety bond desired from an insurer authorized to do business in this state. There is a presumption that such inability exists and that a diligent search has been made if the insurance, indemnity contract, or surety bond provides coverage listed by the commissioner as an approved surplus lines coverage. If the commissioner concurs in the allegation in the affidavit, the commissioner may authorize the procuring of the insurance, indemnity contract or bond from an insurer not authorized to do business in this state.

26.1-44-03. Surplus lines in solvent insurers. A surplus lines insurance broker may not knowingly place surplus line insurance with an insurer that is financially unsound. The surplus lines insurance

broker shall ascertain the financial condition of the unauthorized insurer before placing insurance with the insurer. The surplus lines insurance broker may not so insure with:

1. Any insurer having less than five hundred thousand dollars of capital and five hundred thousand dollars in surplus, if a stock company, and five hundred thousand dollars in surplus, if a mutual company.

2. Any alien insurer that has not established an effective trust fund of at least one million dollars within the United States administered by a recognized financial institution and held for the benefit of all its policyholders in the United States or policyholders and creditors in the United States.

26.1-44-04. Service of process. Any insurer desiring to transact any business under this chapter, by any surplus lines insurance broker in this state, shall appoint in writing the commissioner as its true and lawful attorney, upon whom legal process in any action or proceeding against it must be served, and in the writing, shall agree that any legal process against it, which is served upon the attorney, is of the same legal force and validity as if served upon the insurer, and that the authority continues in force so long as any liability remains outstanding in this state. Copies of the appointment certified by the commissioner are sufficient evidence thereof and must be admitted in evidence with the same force and effect as the original. Legal process may not be served upon the insurer except as provided by this section. In any suit on a policy on behalf of the owner or holder of the policy, the service of process must be made as provided by this section, but the action must be prosecuted in the county of the policyholder's residence.

26.1-44-05. Endorsement of policy. Every policy issued under this chapter must be endorsed "THIS POLICY IS ISSUED PURSUANT TO THE NORTH DAKOTA SURPLUS LINES INSURANCE STATUTE UNDER SURPLUS LINES BROKER'S LICENSE NO. --------. THE INSURER IS A QUALIFIED SURPLUS LINES INSURER, BUT IS NOT OTHERWISE LICENSED BY THE STATE OF NORTH DAKOTA AND DOES NOT PARTICIPATE IN THE NORTH DAKOTA INSURANCE GUARANTY ASSOCIATION." The surplus lines insurance broker shall properly complete and sign the endorsement.

26.1-44-06. Record of business - Filing of statement - Content. Every surplus lines insurance broker shall keep a separate account of the business under the broker's license and on or before the first day of April in each year shall file with the commissioner a statement for the twelve months preceding, giving the name of the insured to whom a policy or indemnity contract granting unauthorized insurance has been issued, the name and home office of each insurer issuing the policy or contract, the amount of the insurance, the rates charged, the gross premiums charged, the date and term of the policy, and the amount of premium returned on each policy canceled or not taken, with such information and upon such form as required by the commissioner, and pay the commissioner an amount equal to the

taxes imposed by law on the premiums of authorized insurance companies. If a surplus line policy covers risks or exposures only partially in this state, the tax so payable must be computed upon the portion of the premium which is properly allocable to the risks or exposures located in this state.

26.1-44-07. Actions against insurers issuing insurance - Venue - Service of process - Time for answer. Every insurer making insurance under this chapter is deemed to be doing business in this state as an unlicensed concern and may be sued upon any claim for relief arising under any policy of insurance so issued and delivered by the insurer. The suit must be brought in the district court of the county in which the plaintiff resides. Service of summons and complaint in the suit must be made upon the commissioner in the manner provided by section 26.1-44-04.

26.1-44-08. Civil penalty for failure to file statement and pay tax - Action for recovery - Revocation of license - Conditions prerequisite to reissuance - Hearing procedure and judicial review. Every such surplus lines insurance broker who fails or refuses to make and file the annual statement, and to pay the taxes required to be paid prior to the first day of May after such tax is due, is liable for a fine of twenty-five dollars for each day of delinquence. The tax and fine may be recovered in an action to be instituted by the commissioner in the name of the state, the attorney general representing the commissioner, in any court of competent jurisdiction, and the fine, when so collected, must be paid to the state treasurer and placed to the credit of the general fund. The commissioner shall revoke the surplus lines insurance broker's license of the broker if any surplus lines insurance broker fails to make and file the annual statement and pay the taxes, or refuses to allow the commissioner to inspect and examine the broker's records of the business transacted by the broker pursuant to this chapter, or fails to keep the records in the manner required by the commissioner, or falsifies the affidavit referred to in section 26.1-44-02.

If the license of a surplus lines insurance broker is revoked, whether by the action of the commissioner or by judicial proceedings, another license may not be issued to that surplus lines insurance broker until two years have elapsed from the effective date of the revocation, nor until all taxes and fines are paid, nor until the commissioner is satisfied that full compliance with this chapter will be had.

26.1-44-09. Rulemaking authority. The commissioner may adopt reasonable rules to implement this chapter.

SECTION 22. REPEAL. Chapters 26-02, 26-03, 26-03.1, 26-03.2, 26-03.3, 26-05, 26-06, 26-09.2, 26-10, 26-10.1, 26-11.1, 26-17.1, 26-18, 26-31, 26-33, 26-34, 26-35, 26-36, 26-39, and 26-41 of the North Dakota Century Code, chapters 26-03.4, 26-03.5, 26-03.6, 26-17.2, and 26-36.1, and sections 26.1-17-13, 26.1-17-14, 26.1-17-15, 26.1-17-17, 26.1-18-15, and 26.1-18-16 of the 1983 Supplement to the North Dakota Century Code, sections 1 and 10 of

chapter 247, sections 1 and 12 of chapter 248, and section 1 of chapter 249 of the 1977 Session Laws, section 1 of chapter 303 of the 1981 Session Laws, and section 27 of chapter 332 of the 1983 Session Laws are hereby repealed.

SECTION 23. TRANSITION - APPLICATION TO EXISTING DOCUMENTS. Any agreement, application, certificate, complaint, contract, form, license, plan, policy, or schedule approved, delivered, filed, issued, or received under provisions of title 26 as it existed on June 30, 1985, is deemed to have been approved, delivered, filed, issued, or received under the appropriate provisions of title 26.1.

Approved March 27, 1985

CHAPTER 317

SENATE BILL NO. 2079
(Legislative Council)
(Interim Insurance Code Revision Committee)

INSURANCE CODE REVISION — HOUSEKEEPING

AN ACT to create and enact a new subsection to section 15-29-08 and a new subsection to section 58-06-01 of the North Dakota Century Code, relating to fire and tornado insurance coverage by school districts and townships; and to amend and reenact sections 2-02-09, 13-03.1-17, 26.1-02-02, subsections 6, 7, and 9 of section 26.1-02-05, subsection 5 of section 26.1-02-06, subsection 2 of section 26.1-02-23, subsections 1 and 2 of section 26.1-03-12, section 26.1-03-15, subsections 1 and 2 of section 26.1-03-17, subsection 1 of section 26.1-04-04, subsections 1 and 4 of section 26.1-04-05, sections 26.1-04-06, 26.1-05-04, 26.1-05-19, 26.1-05-27, 26.1-05-34, 26.1-07-14, subsection 5 of section 26.1-07-17, subsections 2, 6, and 9 of section 26.1-08-01, subsections 1 and 2 of section 26.1-08-03, subsection 1 of section 26.1-08-05, subsection 1 of section 26.1-08-06, subsection 4 of section 26.1-08-09, subsections 1, 2, and 3 of section 26.1-08-10, subsections 3 and 4 of section 26.1-08-11, subsection 1 of section 26.1-08-12, section 26.1-09-13, subsection 3 of section 26.1-10-01, subsection 9 of section 26.1-11-01, sections 26.1-11-07, 26.1-11-11, subsection 1 of section 26.1-11-12, sections 26.1-11-18, 26.1-11-19, 26.1-12-11, 26.1-12-12, 26.1-12-15, 26.1-13-16, 26.1-13-19, 26.1-14-15, 26.1-17-18, 26.1-17-23, 26.1-17-25, 26.1-17-26, 26.1-17-27, subsection 11 of section 26.1-18-03, sections 26.1-18-12, 26.1-18-14, subsection 3 of section 26.1-19-04, sections 26.1-19-08, 26.1-19-10, 26.1-22-20, 26.1-23-05, 26.1-23-11, 26.1-24-03, 26.1-24-05, 26.1-24-07, 26.1-25-16, 28-04-02, 31-12-06, 32-12.1-05, 32-12.1-06, subsection 1 of section 32-12.1-15, subsection 1 of section 39-01-08, subsection 7 of section 39-04-05, subsections 2, 3, and 4 of section 39-04-06, subsection 7 of section 39-05-20.3, subsection 2 of section 39-06-05, sections 39-16-05, 39-16-29, subsection 3 of section 39-16.1-04, section 39-16.1-20, subsection 7 of section 41-09-04, subsection 2 of section 43-10.1-01, sections 43-13-31, 49-18-33, subsection 2 of section 51-07-12, sections 54-30-24.1, 60-02-10.1, and 60-02-35.1 of the North Dakota Century Code, relating to

insurance policies, insurance contracts, and accident and health insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 2-02-09 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

2-02-09. Authorization for airport liability insurance - Exceptions. ~~From and after July 1~~ After June 30, 1967, any airport authority, county, city, township, or other political subdivision which operates an airport, is hereby authorized to carry liability insurance for its own protection and the protection of any employee from claim for loss or damage for bodily injury or property damage arising out of or by reason of its operation and maintenance of airport facilities in connection therewith or landing fields; provided, that any airport authority or political subdivision, and its agents, servants, and employees ~~shall~~ have full government immunity for any claims in excess of the limits afforded by such ~~policy or policies of~~ insurance policies or full governmental immunity in the event no insurance is carried~~; and further providing that the fact~~. The existence of insurance coverage ~~shall~~ may not be conveyed to the jury in the event of suits thereon, either directly or indirectly. If a dispute exists concerning the amount or nature of the insurance coverage, the dispute ~~shall~~ must be tried separately before the main trial determining the claims and damages of the claimant. This statute confers no right for a claimant to sue the insurer directly.

SECTION 2. AMENDMENT. Section 13-03.1-17 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

13-03.1-17. Insurance - ~~Policies of insurance~~ Insurance policies - Existing insurance.

1. The following types of insurance may be written in connection with loans made by licensees under this chapter:

   a. In the case of motor vehicles having a book value of more than five hundred dollars, fire, theft, and windstorm, and fifty dollars or more deductible collision; and in the case of all motor vehicles, bodily injury liability and property damage liability. If neither liability or property damage insurance is written, but other insurance is written covering a motor vehicle, the borrower shall sign the following statement: "This contract does not provide for motor vehicle liability and property insurance".

   b. Fire and extended coverage insurance upon property.

c. Life (on one or more borrowers) and accident and health ~~and accident~~ insurance or any of them may be written, upon or in connection with, any loan in any amount not exceeding the total amount to be repaid under the loan contract, and for a term not extending beyond the final maturity date of the loan contract; provided, that in the event of a renewal or prepayment of a contract or loan, this type of insurance ~~shall~~ must be canceled and a refund of the unearned premium ~~shall~~ must be credited or paid the borrower.

2. Notwithstanding any other provision of this chapter, any gain or advantage in the form of commission or otherwise, to the licensee or to any employee, affiliate, or associate of the licensee from such insurance or its sale ~~shall~~ is not ~~be~~ deemed to be an additional or further charge in connection with the contract of loan.

3. The insurance premium for such insurance may be collected from the borrower or included in the loan contract ~~of loan~~ at the time the loan is made. No insurance premiums or charges, other than for credit life and accident and health ~~and accident~~ insurance, may be included in a loan contract having a maturity of more than thirty-six months and fifteen days unless no charges are computed on such premiums or charges.

4. If a borrower procures insurance by or through a licensee, the licensee shall deliver to the borrower within fifteen days after the making of the loan an executed copy of the insurance policy or certificate of insurance. A borrower may procure insurance to secure a loan from any agent authorized to do business by the ~~insurance~~ commissioner of insurance. A licensee may require that such insurance be provided, including endorsements thereon, prior to any disbursement of loan proceeds, but charges ~~shall~~ will not accrue on any loan until the loan proceeds are disbursed. Nothing in this chapter ~~shall be so construed as to impair~~ impairs or ~~invalidate~~ invalidates the obligations of any ~~contract of~~ loan contract which was lawfully entered into prior to July 1, 1975.

SECTION 3. A new subsection to section 15-29-08 of the 1983 Supplement to the North Dakota Century Code is hereby created and enacted to read as follows:

To insure the school district's property which is not required to be insured against loss by fire or tornado by the state fire and tornado fund, in a stock or mutual fire insurance company or in the state fire and tornado fund.

SECTION 4. AMENDMENT. Section 26.1-02-02 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-02-02. Duty of commissioner before granting or renewing certificate of authority. The commissioner must be satisfied by examination and evidence that an insurance company is legally qualified to transact business in this state, including compliance with section 26.1-03-11, before granting a certificate of authority to the company to issue policies or make ~~contracts of~~ insurance contracts. A certificate of authority issued under this title remains in force in perpetuity if the required renewal fee is paid and the commissioner is satisfied that the documents required by section 26.1-03-11 have been filed, the statements and evidences of investment required of the company have been furnished, the required capital or surplus or both, securities, and investments remain secure, and all other requirements of law are met.

SECTION 5. AMENDMENT. Subsections 6, 7, and 9 of section 26.1-02-05 of the 1983 Supplement to the North Dakota Century Code are hereby amended and reenacted to read as follows:

6. Transactions involving group life, ~~sickness, and~~ accident, and health, or blanket ~~sickness and~~ accident and health insurance, or group annuities where the master policy of the group was lawfully issued and delivered in and pursuant to the laws of a state in which the insurance company was authorized to do an insurance business, to a group organized for purposes other than the procurement of insurance, and where the policyholder is domiciled or otherwise has a bona fide situs.

7. Transactions involving any ~~policy of~~ insurance policy or annuity contract issued before July 1, 1973.

9. Transactions involving ~~contracts of~~ insurance contracts issued to one or more industrial insureds; provided, that this does not relieve an industrial insured from taxation imposed upon independently procured insurance. An industrial insured is an insured:

   a. Which procures the insurance of any risk or risks other than life and annuity contracts by use of the services of a full-time employee acting as an insurance manager or buyer or the services of a regularly and continuously retained qualified insurance consultant;

   b. Whose aggregate annual premiums for insurance on all risks total at least twenty-five thousand dollars; and

   c. Which has at least twenty-five full-time employees.

SECTION 6. AMENDMENT. Subsection 5 of section 26.1-02-06 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

5. Issuing or delivering ~~a contract of~~ an insurance contract to residents of this state or to persons authorized to do business in this state.

SECTION 7. AMENDMENT. Subsection 2 of section 26.1-02-23 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

2. The company is practicing discrimination against individual risks in the issue or cancellation of policies, bonds, or other ~~contracts of~~ insurance contracts or corporate suretyship.

SECTION 8. AMENDMENT. Subsections 1 and 2 of section 26.1-03-12 of the 1983 Supplement to the North Dakota Century Code are hereby amended and reenacted to read as follows:

1. Any ~~policy of~~ insurance policy insuring only the insured's legal obligations arising from product liability or completed operations exposure of the insured.

2. Any other ~~policy of~~ insurance policy in which the premium computation includes a premium charge for product liability or completed operations exposure of the insured.

SECTION 9. AMENDMENT. Section 26.1-03-15 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-03-15. Limitation of liability. No liability, and no ~~cause of action~~ claim for relief of any nature, arises against any insurance company or its agents or employees, or the commissioner or the commissioner's employees, for any action taken by them pursuant to sections 26.1-03-13 and 26.1-03-14.

* **SECTION 10. AMENDMENT.** Subsections 1 and 2 of section 26.1-03-17 of the 1983 Supplement to the North Dakota Century Code are hereby amended and reenacted to read as follows:

1. Before issuing the annual certificate required by law, the commissioner shall collect from every stock and mutual insurance company, nonprofit health service corporation, health maintenance organization, and prepaid legal service organization, except a fraternal benefit society, doing business in this state, a tax on the gross amount of premiums, assessments, membership fees, subscriber fees, policy fees, and finance and service charges received in this state during the preceding calendar quarter, at the rate of two percent with respect to life insurance, one-half of one percent with respect to accident and ~~sickness~~ health insurance, and one percent with respect to all other lines of insurance. This tax does not apply to considerations for annuities. The tax is payable on or before the sixtieth day after the last day of the calendar

* NOTE: Section 26.1-03-17 was also amended by section 1 of Senate Bill No. 2142, chapter 318.

quarter and shall be deposited in the general fund in the state treasury.

2. An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for the amount of any assessment paid as a member of a comprehensive health association under subsection 4 of section 26.1-08-09 for which the member may be liable for the year in which the assessment was paid, a credit as provided under subsection 1 of section 26.1-38-08, a credit against the tax due for an amount equal to the examination fees paid to the commissioner under sections 26.1-01-07, 26.1-02-02, and 26.1-03-19 through 26.1-03-22, and a credit against the tax due for 1982, 1983, 1984, and 1985 for an amount equal to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this subsection ~~shall~~ must be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1.

SECTION 11. AMENDMENT. Subsection 1 of section 26.1-04-04 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

1. No person, engaged in selling ~~real or personal~~ property or in the business of financing the purchase of ~~real or personal~~ property or of lending money on the security of ~~real or personal~~ property and no trustee, director, officer, agent, or other employee of the person may require, as a condition precedent, concurrent, or subsequent to the sale or financing the purchase of the property or to lending money upon the security of a mortgage thereon or for the renewal or extension of any such loan or mortgage or for the performance of any other act in connection therewith, that the person purchasing the property or for whom the purchase is to be financed or to whom the money is to be loaned or for whom the extension, renewal, or other act is to be granted, or performed, negotiate any ~~policy of~~ insurance policy or renewal thereof covering the property through a particular insurance company, agent, solicitor, or broker.

SECTION 12. AMENDMENT. Subsections 1 and 4 of section 26.1-04-05 of the 1983 Supplement to the North Dakota Century Code are hereby amended and reenacted to read as follows:

1. Make any ~~contract of~~ insurance contract, or agreement with reference thereto, other than such as is expressed plainly in the policy issued thereon.

4. Offer, promise, allow, or give any paid employment or contract for services of any kind, or any other valuable inducement or consideration whatever not specified in the insurance policy or contract ~~of insurance~~.

SECTION 13. AMENDMENT. Section 26.1-04-06 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-04-06. Insured persons and applicants for insurance prohibited from accepting rebates. An insurance broker, limited insurance representative, or agent of any insurance or surety company, reciprocal, benevolent society, or any other insurance organization or association, however constituted or entitled, may not grant, and an insured person or party or applicant for insurance, either directly or indirectly, may not receive or accept, or agree to receive or accept, any rebate of premium or of any part thereof, or all or any part of any agent's, insurance broker's, limited insurance representative's, or solicitor's commission thereon, or any favor or advantage, or any share in any benefit to accrue under any ~~policy of~~ insurance policy, or any other valuable consideration or inducement other than such as may be specified in the policy, except as provided in an applicable filing which is in effect under the provisions of the laws regulating insurance rates.

SECTION 14. AMENDMENT. Section 26.1-05-04 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-05-04. Capital stock and surplus requirements upon organization of domestic stock company - Exceptions. A stock insurance company may not be incorporated under this chapter unless it has an authorized capital stock of at least five hundred thousand dollars and a surplus of at least five hundred thousand dollars. A domestic stock insurance company may not issue any ~~policy of~~ insurance policy until at least fifty percent of the required capital stock, and all of the required surplus, has been paid in, the residue of capital stock to be paid in within twelve months from the time of filing the articles of incorporation. The commissioner, for good cause shown, may extend the time of payment of the residue for the further period of one year. If the minimum capital stock and surplus requirements at the time a stock insurance company incorporated under this chapter were less than the minimum requirements provided by this section, the stock insurance company must maintain authorized capital stock and surplus which satisfies the capital stock and surplus requirements in effect at that time.

SECTION 15. AMENDMENT. Section 26.1-05-19 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-05-19. Authorized investment of funds of insurance companies. A domestic insurance company may invest any of its funds and accumulations in:

1. Securities or obligations made specifically eligible for such investment by law.

2. Bonds or other evidence of indebtedness issued, assumed, or guaranteed by the United States of America, the District of Columbia, or by any state, territory, or insular possession of the United States or by any county, city, township, school district, or other civil division of a state, including those payable from special revenues or earnings specifically pledged for the payment thereof, and those payable from special assessments, including rights to purchase or sell these securities or obligations if these rights are traded upon a contract market designated and regulated by a federal agency and purchased for legitimate hedging, nonspeculative purposes.

3. Bonds or other evidences of indebtedness issued, assumed, or guaranteed by any instrumentality or agency of the United States of America, including rights to purchase or sell these securities or obligations if these rights are traded upon a contract market designated and regulated by a federal agency and purchased for legitimate hedging, nonspeculative purposes.

4. Notes or bonds secured by mortgage or deed of trust insured by the federal housing administrator, debentures issued by the federal housing administrator, and securities issued by national mortgage associations.

5. Bonds issued by the industrial commission under chapter 4-36.

6. Bonds guaranteed by the economic development commission under chapter 6-09.2.

7. Bonds issued by the North Dakota municipal bond bank pursuant to chapter 6-09.4.

8. Bonds issued by the state board of higher education under chapter 15-55.

9. Revenue bonds issued by the state water commission.

10. Interim financing notes issued by the state water commission pursuant to chapter ~~16-02~~ 61-02.

11. Warrants issued by a city under chapter 40-24.

12. Bonds or notes issued pursuant to chapter 40-33.2.

13. Bonds or other obligations issued pursuant to chapter 40-58.

14. Bonds issued under chapter 40-61.

15. Bonds issued under chapter 54-30.

16. Notes or other evidences of indebtedness of the North Dakota life and health insurance guaranty association not in default.

17. Notes or other interest-bearing obligations of any state development corporation of which the company is a member, issued in accordance with chapter 10-30.

~~16.~~ 18. Bonds or other evidences of indebtedness issued, assumed, or guaranteed by the Dominion of Canada, or any province thereof, or by any municipality or district therein, provided that the obligations are valid and legally authorized and issued.

~~17.~~ 19. Mortgage bonds and debentures of any solvent railway company duly incorporated and authorized under the laws of this state or of any other state~~, territory,~~ or insular possession of the United States, or of the Dominion of Canada or of any province thereof.

~~18.~~ 20. Mortgage bonds and debentures of any solvent industrial public utility or financial corporation duly incorporated and authorized under the laws of the United States of America or of any state~~, territory,~~ or insular possession thereof, or of the Dominion of Canada or of any province thereof, including rights to purchase or sell these securities or obligations if these rights are traded upon a contract market designated and regulated by a federal agency and purchased for legitimate hedging, nonspeculative purposes.

~~19.~~ 21. Preferred stock, of, or common or preferred stock guaranteed as to dividends by, and common stock of, any corporation organized under the laws of the United States, any state~~, territory,~~ or possession of the United States, ~~the District of Columbia,~~ the Dominion of Canada, or any province of the Dominion of Canada, including rights to purchase or sell these securities or obligations if these rights are traded upon a contract market designated and regulated by a federal agency and purchased for legitimate hedging, nonspeculative purposes, subject to the following restrictions and limitations:

a. The company issuing the preferred stock or guaranteeing the dividends on the common stock must have earned an average amount per annum at least equal to five percent of the par value of its common and preferred stocks or in the case of stocks having no par value, of its issued or stated value outstanding at the date of purchase, over the period of seven fiscal years immediately preceding the date of purchase or which over such period earned an average

annual amount at least equal to two times the total of its annual interest charges, preferred dividends, and dividends guaranteed by it, determined with reference to the date of purchase.

b. The company issuing any common stock must have earned an average amount per annum at least equal to six percent of the par value of its capital stock, or in the case of stock having no par value of the issued or stated value of such stock, outstanding at the date of purchase over the period of seven fiscal years immediately preceding the date of purchase.

c. The company issuing or guaranteeing the stock has not been in arrears in the payment of dividends thereunder for a period of ninety days within the five-year period immediately preceding purchase of the stock.

d. Investments in preferred, guaranteed, and common stocks may not exceed in the aggregate twenty percent of the life insurance company's admitted assets.

~~20.~~ 22. Savings accounts, under certificates of deposit or in any other form, in solvent banks and trust companies which have qualified for federal deposit insurance corporation protection, shares and savings accounts, under certificates of deposit, investment certificates, or in any other form, in solvent savings and loan associations organized under federal law or state law of any state which have qualified for federal savings and loan insurance corporation protection, and shares and deposit accounts, under certificates of deposit or in any other form, in solvent state or federally chartered credit unions which are insured by the national credit union administration. Investments in the shares and accounts are not limited to, or by, the amount of any such insurance protection. Short-term or liquidity investments such as certificates of deposit, repurchase agreements, bankers' acceptances, commercial paper, money market mutual funds, or current interest accounts in solvent banks and trust companies, savings and loan associations, state or federally chartered credit unions, investment brokerage houses which are regulated by a federal agency, and such other types of investments as may be deemed appropriate and authorized by rule by the commissioner.

~~21.~~ 23. Loans made upon the security of its own policies, if a life insurance company, but no loan on any policy may exceed the reserve value thereof.

~~22.~~ 24. Notes secured by mortgages on improved unemcumbered real estate, including leaseholds substantially having and furnishing the rights and protection of a first real estate mortgage, within the United States of America or

any province of the Dominion of Canada. No loan may be made under this subsection unless at the date of acquisition the total indebtedness secured by such lien does not exceed seventy-five percent of the value of the property upon which it is a lien. The loan may be made in an amount exceeding seventy-five percent so long as any amount over seventy-five percent of the value of the property mortgaged is guaranteed or insured by the federal housing administration or guaranteed by the administrator of veterans affairs or is insured by private mortgage insurance through an insurance company authorized to do business in this state. Loans may be amortized on the basis of a final maturity not exceeding thirty years from the date of the loan with an actual maturity date of the loan at any time less than thirty years. A loan on a single-family dwelling where the loan is amortized on the basis of a final maturity twenty-five years or less from the date of the loan may be made in an amount not exceeding eighty percent of the value of the property mortgaged. The loan on a single-family dwelling may be made in an amount exceeding eighty percent so long as any amount over eighty percent of the value of the property mortgaged is insured by private mortgage insurance through an insurance company authorized to do business in this state. Buildings may not be included in the valuation of such property unless they are insured and the policies are made payable to the company as its interest may appear. A loan may not be made in excess of the amount of insurance carried on the buildings plus the value of the land. No insurance company may hold less than the entire loan represented by the bonds or notes described in this subsection except that a company may own part of an aggregate obligation if all other participants in the investment are insurance companies authorized to do business in North Dakota or banks whose depositors are insured by the federal deposit insurance corporation or savings and loan associations whose members are insured by the federal savings and loan insurance corporation or unless the security of the bonds or notes, as well as all collateral papers, including insurance policies, executed in connection therewith, are made to and held by a trustee which is a solvent bank or trust company having a paid-in capital of not less than two hundred fifty thousand dollars, except in case of banks or trust companies incorporated under the laws of the state of North Dakota, wherein a paid-in capital of not less than one hundred thousand dollars is required. In case of proper notification of default, the trustee, upon request of at least twenty-five percent of the holders of the bonds outstanding, and proper indemnification, shall proceed to protect the rights of the bondholders under the provisions of the trust indentures. An insurance company may acquire such an interest in real estate directly or as a joint venture or through a limited or general partnership in

which the insurance company is a partner. An insurance company acquiring such an interest in real estate on the basis of a joint venture or through a limited or general partnership may acquire such an interest so long as the company's interest does not exceed seventy-five percent of the value of the property.

~~23.~~ 25. First mortgage bonds on improved city real estate in any state, issued by a corporation duly incorporated under the laws of any state of the United States of America, if the loans on the real estate are made in accordance with the requirements as to first mortgage loans in subsection ~~22~~ 24.

~~24.~~ 26. Real estate for the production of income or for improvement or development for the production of income subject to the following provisions and limitations:

a. Real estate used primarily for farming or agriculture may not be acquired under this subsection.

b. Investments made by any company under this subsection may not at any time exceed ten percent of the admitted assets of the company.

c. An investment in any single parcel of real estate acquired under this subsection may not exceed two percent of the admitted assets of the company.

d. The real estate, including the cost of improvements, must be valued at cost and the improvements may be depreciated annually at an average rate of not less than two percent of the original cost.

e. An insurance company may acquire such real estate or an interest in such real estate directly or as a joint venture or through a limited or general partnership in which the insurance company is a partner.

~~25.~~ 27. Land and buildings used as home or regional offices, subject to the following provisions and limitations:

a. Land and buildings thereon in which it has its principal office and any other real estate including regional offices requisite for its convenient accommodation in the transaction of its business.

b. Investments or total commitment in the land and buildings may not aggregate more than ten percent of the company's admitted assets without the consent of the commissioner.

c. The real estate, including the cost of improvements, must be valued at cost and the improvements must be

depreciated annually at an average rate of not less than two percent of the original cost.

~~26.~~ 28. Investments by loans or otherwise, in the purchase of electric or mechanical machines, including software, constituting a data processing system. The company may hold the system as an admitted asset for use in connection with the business of the company if, (a) its aggregate cost does not exceed five percent of the admitted assets of the company; and (b) the cost of the components constituting the system is fully amortized over a period of not to exceed seven years. If a data processing system consists of separate components acquired at different times, then the cost of each component must be amortized over a period not to exceed seven years commencing with the date of acquisition of each component.

~~27.~~ 29. Promissory notes amply secured by the pledge of bonds or other evidences of indebtedness in which the company is authorized to invest its funds by the provisions of this section.

~~28.~~ 30. Loans, securities, or investments in addition to those permitted in this section, whether or not the loans, securities, or investments qualify or are permitted as legal investments under its charter, or under other provisions of this section or under other provisions of the laws of this state. The aggregate of such company's investments under this subsection may not exceed either five percent of the company's admitted assets, or the amount equal to the company's unassigned surplus, whichever is less.

The commissioner may adopt rules as to investments which are permissible for any domestic insurance company which may waive or increase any limitation on investments or authorize companies to invest their funds in investments which are not specifically mentioned in statutes relating to investments if ~~he~~ the commissioner finds, after notice and hearing, that such funds would be well invested and available for the payment of losses. The commissioner, in adopting such rules, ~~shall~~ may not be any more restrictive, or place any greater limitations on, any type of investment in which companies are authorized by statute to invest their funds.

This section does not prohibit a company from taking any action deemed necessary or expedient for the protection of investments made by it or from accepting in good faith, to protect its interests, securities, or property not mentioned in this section in payment or to secure debts due to it.

SECTION 16. AMENDMENT. Section 26.1-05-27 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-05-27. Certificate of compliance with security deposit law - Issuance - Renewal - Attachment to policies. The commissioner shall issue a certificate to a domestic life insurance company to the effect that the company does business under the compulsory reserve deposit law of North Dakota and maintains in the office of the commissioner a deposit of an amount in excess of the net value of all outstanding policies in stipulated and first-class securities deposited for the protection of the policyholders of the company when the company has:

1. Filed its annual statement; and

2. Deposited securities with the commissioner or filed a detailed list of securities held by the company in lieu of the deposit with the commissioner, the deposit and list to be renewed annually on or before March first.

The certificate expires on March thirty-first of the ensuing year and may be renewed annually upon the filing of a statement of renewal along with any additional physical deposit or additions to the statement of securities held by the company in lieu of a deposit and upon compliance with the other provisions of this section. A copy of the certificate may be attached to any ~~policy of~~ insurance policy issued by any domestic life insurance company after the certificate has been issued to it.

SECTION 17. AMENDMENT. Section 26.1-05-34 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-05-34. Reciprocal states - Restrictions on domestic companies - Exceptions. As used in this section, "reciprocal state" means a state the laws of which prohibit an insurance company domiciled therein from insuring the lives or persons of residents of, or property or operations located in, the state of North Dakota unless it holds a valid and subsisting certificate of authority issued by the commissioner of insurance of this state. The prohibition may be subject to the exceptions to this section.

A domestic insurance company may not enter into ~~a contract of~~ an insurance contract upon the life or person of a resident of, or property or operations located in, a reciprocal state unless it is authorized pursuant to the laws of that state to transact such insurance therein. The commissioner shall annually mail notice to every domestic insurance company, specifying the reciprocal states.

The exceptions to this section are:

1. Contracts entered into where the prospective insurant is personally present in the state in which the insurance company is authorized to transact insurance when the insurant signs the application.

2. The issuance of certificates under a lawfully transacted group life or group disability policy, where the master

policy was entered into a state in which the insurance company was then authorized to transact insurance.

3. The removal or continuance in force, with or without modification, of contracts otherwise lawful and which were not originally executed in violation of this section.

SECTION 18. AMENDMENT. Section 26.1-07-14 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-07-14. Court may order liquidation of company - Commissioner to direct liquidation - Procedure. If, after the institution of proceedings under sections 26.1-07-08 through 26.1-07-20 and after a full hearing on the order to show cause issued in connection therewith, the court orders a liquidation of the business of the company, the commissioner shall make and direct the liquidation. The commissioner may deal with the property and business of the company in the commissioner's own name as commissioner or in the name of the company, as the court may direct, and is vested by operation of law with title to all the property, contracts, and ~~rights of action~~ claims for relief of the company as of the date of the order directing liquidation. The filing or recording of the order in the office of a register of deeds imparts the same notice that the proper filing or recording of a deed, bill of sale, or other evidence of title by the company would impart. The order of liquidation, unless otherwise directed by the court, must provide that the dissolution of the company takes effect upon the entry of the order in the office of the clerk of the district court of the county wherein the company had its principal office for the transaction of business.

SECTION 19. AMENDMENT. Subsection 5 of section 26.1-07-17 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

5. Claims presented by the North Dakota insurance guaranty association and any similar organization in another state, which represent covered claims defined in section ~~26-36-05~~ 26.1-42-02.

SECTION 20. AMENDMENT. Subsections 2, 6, and 9 of section 26.1-08-01 of the 1983 Supplement to the North Dakota Century Code are hereby amended and reenacted to read as follows:

2. "Association plan" means ~~a policy of~~ insurance policy coverage offered by the association through the lead carrier.

6. "Insurance company" means a company operating pursuant to chapter ~~26-03.1 or~~ 26.1-17 or 26.1-36, and offering or selling ~~policies or contracts of~~ accident and ~~sickness~~ health insurance policies or contracts. Insurance company does not include a health maintenance organization.

9. "Policy" means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical, and medical care. Policy does not include coverage which is (a) limited to disability or income protection coverage, (b) automobile medical payment coverage, (c) supplemental to liability insurance, (d) designed solely to provide payment on a per diem basis, daily indemnity, or non-expense-incurred basis, or (e) credit accident and ~~sickness~~ health insurance.

SECTION 21. AMENDMENT. Subsections 1 and 2 of section 26.1-08-03 of the 1983 Supplement to the North Dakota Century Code are hereby amended and reenacted to read as follows:

1. There is established a comprehensive health association with participating membership consisting of those insurance companies, licensed or authorized to do business in this state, with an annual premium volume of accident and ~~sickness~~ health insurance contracts, derived from or on behalf of residents in the previous calendar year, of at least one hundred thousand dollars, as determined by the commissioner.

2. The board of directors of the association must consist of ten individuals, one from each of the ten participating member insurance companies of the association with the highest annual premium volumes of accident and ~~sickness~~ health insurance contracts as determined in subsection 1. Each board member is entitled to votes, in person or by proxy, based on the member's annual premium volume of accident and ~~sickness~~ health insurance contracts as determined in subsection 1, in accordance with the following schedule:

$ 100,000	- 4,999,999	1 vote
$ 5,000,000	- 9,999,999	2 votes
$10,000,000	- 14,999,999	3 votes
$15,000,000 or more		4 votes

Members of the board may be reimbursed from the moneys of the association for expenses incurred by them due to their service as board members, but may not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors must be borne by participating members of the association in accordance with subsection 4 of section 26.1-08-09.

SECTION 22. AMENDMENT. Subsection 1 of section 26.1-08-05 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

1. A plan of health coverage is a number three qualified plan A if it otherwise meets the requirements established by

chapter ~~26-03.1~~ 26.1-36, and other laws of the state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

a. The minimum benefits for covered individuals must, subject to this subdivision, be equal to at least eighty percent of the cost of covered services in excess of an annual deductible which does not exceed one hundred fifty dollars per person. The coverage must include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under this subsection. Coverage may be subject to a maximum lifetime benefit of not less than two hundred fifty thousand dollars.

b. Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician:

   (1) Hospital services.

   (2) Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than outpatient mental or dental, which are rendered by a physician or at a physician's direction.

   (3) Use of radium or other radioactive materials.

   (4) Oxygen.

   (5) Anesthetics.

   (6) Diagnostic x-rays and laboratory tests.

   (7) Services of a physical therapist.

   (8) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

c. Covered expenses must include, at the option of the eligible person, the usual and customary charges for professional services rendered by a chiropractor and for services and articles prescribed by a chiropractor for which an additional premium may be charged.

d. Covered expenses for the services or articles specified in this subsection do not include:

   (1) Drugs requiring a physician's prescription.

   (2) Services of a nursing home.

(3) Services of a home health agency.

(4) Home and office calls.

(5) Prostheses.

(6) Rental or purchase of durable medical equipment.

(7) The first twenty dollars of diagnostic x-ray and laboratory charges in each fourteen-day period.

(8) Oral surgery.

(9) Any charge for any care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent to self-insurance, or for which benefits are payable under another ~~policy of~~ accident and ~~sickness~~ health insurance policy or medicare.

(10) Any charge for treatment for cosmetic purposes other than for surgery for the repair of an injury or birth defect.

(11) Any charge for travel other than transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

(12) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician.

(13) That part of a charge for services or articles rendered or prescribed by a physician, dentist, chiropractor, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided.

(14) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(15) Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

(16) Any charge for organ transplants unless prior approval is received from the board of directors of the comprehensive health association.

SECTION 23. AMENDMENT. Subsection 1 of section 26.1-08-06 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

1. A plan of health coverage is a number three qualified plan B if it otherwise meets the requirements established by chapter ~~26-03.1~~ 26.1-36, and the other laws of the state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

   a. The minimum benefits for covered individuals must, subject to this subdivision, be equal to at least eighty percent of the cost of covered services in excess of an annual deductible which does not exceed one hundred fifty dollars per person. The coverage must include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under this subsection. The coverage may be subject to a maximum lifetime benefit of not less than two hundred fifty thousand dollars.

   b. Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician:

      (1) Hospital services.

      (2) Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than outpatient mental or dental, which are rendered by a physician or at a physician's direction.

      (3) Drugs requiring a physician's prescription.

      (4) Services of a nursing home for not more than one hundred twenty days in a year if the services commence within fourteen days following confinement of at least three days in a hospital for the same condition.

      (5) Service of a home health agency up to a maximum of one hundred eighty visits per year.

      (6) Use of radium or other radioactive materials.

      (7) Oxygen.

      (8) Anesthetics.

(9) Prostheses.

(10) Rental or purchase, as appropriate, of durable medical equipment.

(11) Diagnostic x-rays and laboratory tests.

(12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(13) Services of a physical therapist.

(14) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

c. Covered expenses must include, at the option of the eligible person, the usual and customary charges for professional services rendered by a chiropractor and for services and articles prescribed by a chiropractor for which an additional premium may be charged.

d. Covered expenses for the services or articles specified in this subsection do not include:

(1) Any charge for any care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance, or for which benefits are payable under another ~~policy of~~ accident and ~~sickness~~ health insurance policy or medicare.

(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect.

(3) Any charge for travel other than transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room,

unless the private room is prescribed as medically necessary by a physician.

(5) That part of any charge for services or articles rendered or prescribed by a physician, dentist, chiropractor, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided.

(6) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(7) Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

(8) Any charge for organ transplants unless prior approval is received from the board of directors of the comprehensive health association.

SECTION 24. AMENDMENT. Subsection 4 of section 26.1-08-09 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

4. Each participating member of the association which is liable for state income tax or state premium tax must share the losses due to claims expenses and meeting expenses under subsection 2 of section 26.1-08-03 of the association plan. The difference between the total claims expense of the association plan and the premium payments allocated to the payment of benefits is the liability of those association members that are liable for state income tax or state premium tax. Such association members must share in the excess costs of the association plan in an amount equal to the ratio of a member's total annual premium volume for accident and ~~sickness~~ health insurance charges, received from or on behalf of state residents, to the total accident and ~~sickness~~ health insurance premium contract charges received by association members that are liable for state income taxes or state premium taxes from or on behalf of state residents, as determined by the commissioner. Each member's liability may be determined retroactively and payment of the assessment is due within thirty days after notice of the assessment is given. Failure by a member to tender to the association the full amount assessed within thirty days of notification by the association is grounds for termination of membership.

SECTION 25. AMENDMENT. Subsections 1, 2, and 3 of section 26.1-08-10 of the 1983 Supplement to the North Dakota Century Code are hereby amended and reenacted to read as follows:

1. Any participating member of the association ~~may~~ shall submit to the commissioner the policies which are being proposed to serve as the association plan. The commissioner shall prescribe by rule the time and manner of the submission.

2. ~~Upon the commissioner's approval of the policy forms and contracts submitted, the~~ The association must select policies and contracts by a member or members of the association to be the association plan. The association must select one lead carrier to issue the qualified plans. The board of directors of the association shall prepare appropriate specifications and bid forms and may solicit bids from the members of the association for the purpose of selecting the lead carrier. The selection of the lead carrier must be based upon criteria established by the board.

3. The lead carrier shall perform all administrative and claims payment functions required by this section ~~upon the commissioner's approval of the policy forms and contracts submitted~~. The lead carrier shall provide these services for a period of at least three years, unless a request to terminate is approved by the association and the commissioner. The association and the commissioner shall approve or deny a request to terminate within ninety days of its receipt. A failure to make a final decision on a request to terminate within the specified period is deemed an approval. The association shall invite submissions of policy forms from members of the association, including the lead carrier, six months prior to the expiration of each three-year period. The association shall follow subsection 2 in selecting a lead carrier for the subsequent three-year period, or if a request to terminate is approved on or before the end of the three-year period.

SECTION 26. AMENDMENT. Subsections 3 and 4 of section 26.1-08-11 of the 1983 Supplement to the North Dakota Century Code are hereby amended and reenacted to read as follows:

3. All licensed accident and ~~sickness~~ health insurance agents may engage in the selling or marketing of qualified association plans. The lead carrier shall pay an agent's referral fee of twenty-five dollars to each licensed accident and ~~sickness~~ health insurance agent who refers an applicant to the association plan, if the applicant is accepted. The referral fees must be paid to the lead carrier from moneys received as premiums for the association plan.

4. Every insurance company which rejects or applies underwriting restrictions to an applicant for accident and ~~sickness~~ health insurance must notify the applicant of the

existence of the association plan, requirements for being accepted in it, and the procedure for applying to it.

* **SECTION 27. AMENDMENT.** Subsection 1 of section 26.1-08-12 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

1. The association plan must be open for enrollment by eligible persons. A person is eligible and may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

   a. The name, address, and age of the applicant, and length of applicant's residence in this state.

   b. The name, address, and age of spouse and children, if any, if they are to be insured.

   c. Written evidence that the applicant has been rejected for accident and ~~sickness~~ health insurance, or that restrictive riders or a preexisting conditions limitation, the effect of which is to reduce substantially coverage from that received by a person considered a standard risk, was required, by at least two insurance companies within six months of the date of the certificate.

   d. A designation of coverage desired.

SECTION 28. AMENDMENT. Section 26.1-09-13 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-09-13. Solicitation without certificate of authority - Limitation. For the purpose of organization, and upon the issuance of a permit by the commissioner, powers of attorney may be solicited without a license or certificate of authority, but an attorney, agent, or other person may not effect any ~~contract of~~ insurance contract under this chapter until compliance with this chapter.

SECTION 29. AMENDMENT. Subsection 3 of section 26.1-10-01 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

3. "Insurance company" means an insurer as described in section ~~26-02-02~~ 26.1-29-02, except that it does not include:

   a. Agencies, authorities, or instrumentalities of the United States~~,~~ and its possessions ~~and territories~~, the Commonwealth of Puerto Rico, ~~the District of Columbia,~~ or a state or political subdivision of a state.

* NOTE: Section 26.1-08-12 was also amended by section 2 of Senate Bill No. 2468, chapter 322.

b. Fraternal benefit societies.

c. Nonprofit ~~medical and hospital~~ health service ~~associations~~ corporations.

SECTION 30. AMENDMENT. Subsection 9 of section 26.1-11-01 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

9. Agreed to appoint, and will appoint, as its agents in this state only residents of this state except as otherwise provided in chapter ~~26-17.1~~ 26.1-26.

SECTION 31. AMENDMENT. Section 26.1-11-07 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-11-07. Countersignature requirement - Commissions - Reciprocity. Notwithstanding any other provision of this title or policy forms to the contrary, there may not be any requirement that an agent resident in this state sign or countersign ~~a policy of~~ an insurance policy covering a subject of insurance resident, located, or to be performed in this state. However, if the laws or rules of another state require a signature or countersignature by an agent resident in that state on ~~a policy of~~ an insurance policy written by a nonresident agent or nonresident broker of that state, then any ~~policy of~~ insurance policy written by an agent resident of that state licensed as a nonresident agent in this state covering a subject of insurance resident, located, or to be performed in this state must be signed or countersigned in writing by an agent resident in this state. ~~A policy of~~ An insurance policy may not be deemed invalid because of the absence of the required signature or countersignature. If the laws or rules of another state require an agent resident in that state to retain a portion of the commission paid on a like ~~policy of~~ insurance policy written, countersigned, or delivered by the agent in that state at the request of a nonresident agent or nonresident broker of that state, then the agent resident in this state who signed or countersigned ~~a policy of~~ an insurance policy written by a resident of that state licensed as a nonresident agent in this state covering a subject of insurance resident, located, or to be performed in this state shall retain an equal pro rata portion of any commission on the insurance policy ~~of insurance~~.

SECTION 32. AMENDMENT. Section 26.1-11-11 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-11-11. Consent to service of process - Unauthorized insurance company. Any of the following acts in this state, effected by mail or otherwise, by any unauthorized foreign or alien insurance company is equivalent to and constitutes an appointment by the company of the commissioner as its attorney upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of an insured or beneficiary arising out of any ~~contract of~~

insurance contract, and any such act signifies its agreement that the service of process is of the same legal force and validity as personal service in this state, upon such insurer:

1. The issuance or delivery of ~~contracts of~~ insurance contracts to residents of this state or to corporations authorized to do business in this state.

2. The solicitation of applications for such contracts.

3. The collection of premiums, membership fees, assessments, or other considerations for such contracts.

4. Any other transaction of insurance business.

SECTION 33. AMENDMENT. Subsection 1 of section 26.1-11-12 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

1. Service in any action, suit, or proceeding is, in addition to the manner provided in section 26.1-01-04, valid if served upon any person within this state who on behalf of the insurance company is:

   a. Soliciting insurance;

   b. Making, issuing, or delivering any ~~contract of~~ insurance contract; or

   c. Collecting or receiving any premium membership fee, assessment, or other consideration for insurance.

SECTION 34. AMENDMENT. Section 26.1-11-18 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-11-18. Attorney's fees. In any action against an unauthorized foreign or alien insurance company upon ~~a contract of~~ an insurance contract issued or delivered in this state to a resident of this state or to a corporation authorized to do business in this state, if the insurance company has failed for thirty days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract, and it appears to the court that refusal was vexatious and without reasonable cause, the court may allow to the plaintiff a reasonable attorney's fee and include the fee in any judgment that may be rendered in the action. The fee may not exceed twelve and one-half percent of the amount which the court or jury finds the plaintiff is entitled to recover against the insurance company, but the fee awarded may not be less than twenty-five dollars. Failure of an insurance company to defend any action is prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

SECTION 35. AMENDMENT. Section 26.1-11-19 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-11-19. Application. This chapter does not apply to any action, suit, or proceeding against any unauthorized foreign or alien insurance company arising out of any ~~contract of~~ reinsurance, ocean marine, aircraft, or railway insurance contract, insurance against legal liability arising out of the ownership, operation or maintenance of any property having a permanent situs outside this state, or insurance against loss of or damage to any property having a permanent situs outside this state, where the ~~contract of~~ insurance contract designates the commissioner or a bona fide resident of this state the attorney of the unauthorized insurance company upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of an insured or beneficiary arising out of the contract or where the insurance company enters a general appearance in the suit, action, or proceeding.

SECTION 36. AMENDMENT. Section 26.1-12-11 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-12-11. Authority to insure or reinsure - Kinds of insurance open to mutual company. Any mutual insurance company organized under this chapter may make ~~contracts of~~ insurance contracts, and may reinsure or accept reinsurance on any portion thereof, to the extent specified in its articles of incorporation, for the following kinds of insurance:

1. Fire, hail, lightning, tornado, and other insurance. Against loss or damage to property, and the loss of use and occupancy thereof, by fire, lightning, hail, tempest, flood, earthquake, frost or snow, explosion with fire ensuing, and explosion with no fire ensuing, except explosion by steam boilers or flywheels; against loss or damage by water caused by the breakage or leakage of sprinklers, pumps or other apparatus, water pipes, plumbing, or their fixtures, erected for extinguishing fires, and against accidental injury to the sprinklers, pumps or other apparatus, water pipes, plumbing, or fixtures; against the risks of inland transportation and navigation; upon automobiles, whether stationary or operated under their own power, against loss or damage by any of the causes or risks specified in this subsection, including also transportation, collision, liability for damage to property resulting from owning, maintaining, or using automobiles, and including burglary and theft, but not including loss or damage by reason of bodily injury to the person.

2. Liability insurance. Against loss, expense, or liability by reason of bodily injury or death by accident,

disability, sickness, or disease suffered by others for which the insured may be liable or may have assumed liability.

3. Disability insurance. Against bodily injury or death by accident and disability by sickness.

4. Automobile insurance. Against any or all loss, expense, and liability resulting from the ownership, maintenance, or use of any automobile or other vehicle. A policy may not be issued under this subsection against the hazard of fire alone.

5. Steam boiler insurance. Against loss or liability to persons or property resulting from explosions or accidents to boilers, containers, pipes, engines, flywheels, and elevators and machinery used in connection therewith, and against loss of use and occupancy caused thereby. If the company issues insurance under this subsection, it may make inspections and issue certificates of inspection.

6. Use and occupancy insurance. Against loss from interruption of trade or business which may be the result of any accident or casualty.

7. Miscellaneous insurance. Against loss or damage by any hazard upon any risk not provided for in this section which is not prohibited by statute or at common law from being the subject of insurance, except life insurance.

8. Legal expense insurance.

SECTION 37. AMENDMENT. Section 26.1-12-12 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-12-12. Compliance with general insurance laws - Provisions or conditions in policy. A mutual insurance company organized under this chapter must comply with the provisions of any law applicable to a stock insurance company effecting the same kind of insurance. A company may insert in any form of policy prescribed by the law of this state any provisions or conditions required by its plan of insurance which are not inconsistent or in conflict with the law of this state. The policy may conform to the ~~language and~~ form prescribed by the law, if the policy includes a provision or endorsement reciting that the policy is to be construed as if it were in the ~~language and~~ form prescribed by the law ~~and if a copy of the policy and endorsement, if any, first have been filed with, and not disapproved by, the commissioner~~.

SECTION 38. AMENDMENT. Section 26.1-12-15 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-12-15. Corporations, associations, boards, and estates may become member of mutual company - Rights and liabilities. Any public or private corporation, board, or association in this state or elsewhere may make applications and enter into agreements for, and hold, policies in any mutual insurance company organized under this chapter. Any officer, stockholder, trustee, or legal representative of the corporation, board, association, or the representative of an estate may be recognized as acting for or on its behalf for the purpose of the membership but is not liable personally upon the ~~contract of~~ insurance contract by reason of acting in the representative capacity. The right of any corporation organized under the laws of this state to participate as a member of any mutual insurance company is declared to be incidental to the purpose for which the corporation is organized and granted as fully as the rights and powers expressly conferred upon it.

SECTION 39. AMENDMENT. Section 26.1-13-16 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-13-16. Liability insurance contracts - Limitations. Any county mutual insurance company may make ~~contracts of~~ insurance contracts against loss, expense, or liability by reason of bodily injury or death by accident, disability, sickness, or disease suffered by others for which the insured may be liable or may have assumed liability, except no liability insurance contracts against any or all loss or expense resulting from the ownership, maintenance, or use of any motor vehicle normally operated, intended to be operated, or designed for use, upon any highway, road, or street in this state, may be made.

SECTION 40. AMENDMENT. Section 26.1-13-19 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-13-19. Reinsurance of excessive losses. Except as otherwise provided in sections 26.1-02-20 and 26.1-02-22, any county mutual insurance company may reinsure in a single contract, with other county mutual insurance companies, against excessive losses on all ~~contracts of~~ insurance contracts written. The reinsurance contracts may provide:

1. That whenever the total losses per dollar of insurance in force of any county mutual insurance company joining the contract exceeds the average total losses per dollar of insurance in force of all county mutual insurance companies joining the contract, the excessive loss or a portion thereof must be paid to the county mutual insurance company or companies suffering the excessive loss by the companies having a lower than average loss ratio; and

2. That the payments by individual companies suffering a lower than average loss ratio must be prorated according

to a formula based upon the total dollars of insurance in force of any participating company as compared to the total dollars of insurance in force of all participating companies suffering a lower than average loss ratio.

The payments by any single company may not be greater than that sum which would bring the loss ratio per dollar of insurance in force of the company up to the average loss per dollar of insurance in force of all participating companies.

SECTION 41. AMENDMENT. Section 26.1-14-15 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-14-15. Optional membership in insurance guaranty association. The company may not be a member insurer under chapter ~~26-36~~ 26.1-42 unless the board of directors by appropriate resolution, certified to and filed with the commissioner on or before December thirty-first following the issuance of its certificate of authority, elects to become a member. If there is an affirmative election, the company becomes a member of the insurance guaranty association effective July first of the following year. The election is irrevocable. In absence of a timely election, no policyholder, claimant, or creditor of the company may receive any payment by the insurance guaranty association.

SECTION 42. AMENDMENT. Section 26.1-17-18 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-17-18. Health service corporation contracts - Approval by commissioner. Contracts between a health service corporation and health service providers ~~and contracts between a health service corporation and subscribers for health service~~ at all times are subject to the approval of the commissioner. Contracts between health service corporations and subscribers for health service are subject to the applicable provisions of chapter 26.1-36 and are subject to the filing and approval requirements of chapter 26.1-30.

SECTION 43. AMENDMENT. Section 26.1-17-23 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-17-23. Licensing of sales representatives. The sales representatives of any health service corporation are subject to the laws pertaining to insurance agents as defined in chapter ~~26-17.1~~ 26.1-26. The commissioner shall prescribe the form for the license or certificate. The fee for a license or certificate is three dollars.

Sales representatives licensed to sell hospital service contracts may also sell all other health service contracts without further licensure.

SECTION 44. AMENDMENT. Section 26.1-17-25 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-17-25. ~~Rates, rating formulas, and rating systems subject to approval of commissioner~~ Rate requirements. ~~Rates charged subscribers, and rating formulas and rating systems used to determine rates, are at all times subject to the approval of the commissioner in the manner prescribed by this chapter.~~ Rates must cover reasonably anticipated claims, cover reasonable costs of operation and overhead expenses, and maintain contingency reserves at a proper level of not less than the sum of incurred claims and operating and overhead expenses for at least two months, but not more than four months. Rates may not be excessive, inadequate, or unfairly discriminatory.

SECTION 45. AMENDMENT. Section 26.1-17-26 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-17-26. ~~Rate~~ Procedure for submitting rate filings.

1. Each health service corporation must file with the commissioner every manual of classifications, rates, rating formulas, rating systems, and rules applicable thereto, and any modification of the foregoing which it proposes to use. Each filing must state the proposed effective date thereof and must indicate the character and extent of the coverage contemplated. Where a filing is not accompanied by supporting information, and the commissioner does not have sufficient information to determine whether the filing meets the requirements of this chapter, the commissioner shall require the corporation to furnish supporting information, and the waiting period will commence on the date the information is furnished. The information furnished in support of a filing must include (a) contract of benefits; (b) current rate structure; (c) claims experience for most recent period up to three years; (d) claims experience projection for next eighteen months; (e) letter of opinion from the corporation actuary; and (f) judgment of the corporation and its interpretation of the supporting data.

   A filing and any supporting information is open to public inspection after the filing becomes effective.

2. The commissioner shall review the filings ~~as soon as reasonably possible after they have been made and within the waiting period and the extension thereof, if any, in order~~ pursuant to sections 26.1-30-19 through 26.1-30-21 to determine whether they meet the requirements of this chapter.

~~3. Each filing shall be on file for a waiting period of thirty days before it becomes effective. The commissioner may extend the waiting period for an additional period not to exceed fifteen days if the commissioner gives written notice within the original waiting period to the filing health service corporation that the commissioner needs additional time to consider the filing.~~

Upon written application by the corporation, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof. ~~A filing shall be deemed to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or any extension thereof.~~

~~4.~~ 3. Under the rules the commissioner has adopted, the commissioner may, by written order, suspend or modify the requirements of filing as to any kind of contract for health services, subdivision thereof, or combination thereof, or as to any class of risks, the rates for which cannot practically be filed before they are used. The orders and rules must be made known to the health service corporation affected. The commissioner may make an examination as the commissioner deems advisable to ascertain whether any rates affected by an order meet the standards set forth in section 26.1-17-25.

SECTION 46. AMENDMENT. Section 26.1-17-27 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-17-27. Disapproval of rate filings.

1. If ~~within the waiting period or any extension thereof, as provided in subsection 3 of section 26.1-17-26,~~ the commissioner finds that a rate filing does not meet the requirements of this chapter, the commissioner shall ~~send to the health service corporation which made the filing written notice of disapproval of the filing, specifying in what respects the commissioner finds the filing fails to meet the requirements of this chapter and stating that the filing may not become effective~~ disapprove the rate filing pursuant to section 26.1-30-21.

2. If at any time subsequent to the applicable waiting period or extension thereof the commissioner finds that a rate filing does not meet the requirements of this chapter, the commissioner shall, pursuant to section 26.1-30-21, issue an order to that effect after a hearing ~~held upon not less than ten days' written notice specifying the matters to be considered at the hearing to every health service corporation which made the filing, issue an order specifying in what respects the commissioner finds that~~

~~the filings fail to meet the requirements of this chapter, and stating the date, within a reasonable period thereafter, as of which the filings are deemed to be no longer effective~~. Copies of the order must be sent to the corporation.

3. Any person or organization aggrieved with respect to any filing which is in effect, except the health service corporation which made the filing, may make written application to the commissioner for a hearing thereon. The application must specify the grounds relied upon by the applicant. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if the applicant's grounds were established, and that the grounds otherwise justify holding a hearing, the commissioner shall, within thirty days after receipt of the application, hold a hearing upon not less than ten days' written notice to the applicant and to each corporation which made the filing. If after a hearing the commissioner finds that the filing does not meet the requirements of this chapter, the commissioner shall issue an order ~~specifying the findings and stating the date, within a reasonable period thereafter, as of which the filing is deemed to be no longer effective~~ pursuant to section 26.1-30-21. Copies of this order must be sent to the applicant and to each corporation.

4. A manual of classifications, rules, rating plans, rating formulas, or modifications of any of the foregoing which establish standards for measuring variations in hazards or expense provisions, or both, and which has been filed pursuant to the requirements of section 26.1-17-26, may not be disapproved if the rates thereby produced meet the requirements of this chapter.

SECTION 47. AMENDMENT. Subsection 11 of section 26.1-18-03 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

11. A power of attorney duly executed by the applicant, if not domiciled in this state, appointing the commissioner and the commissioner's successors in office, and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all lawful process may be served in any legal action or proceeding against the health maintenance organization on a ~~cause of action~~ claim for relief arising in this state.

SECTION 48. AMENDMENT. Section 26.1-18-12 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-18-12. Evidence of coverage --~~Filing of forms and amendments~~ - Contents - Exception.

1. Every enrollee residing in this state is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation must issue the evidence of coverage. Otherwise, the health maintenance organization must issue the evidence of coverage.

~~An evidence of coverage, or amendment thereto, may not be issued or delivered to any person in this state until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the commissioner.~~

2. An evidence of coverage ~~must~~ may not contain:

~~1.~~ ~~No~~ any provision or statement which is unjust, unfair, inequitable, or which encourages misrepresentation, or which is untrue, misleading, or deceptive as defined in section 26.1-18-24.

3. An evidence of coverage must contain a

~~2.~~ A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of:

a. The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan.

b. Any limitations on the services, kinds of services, benefits, or kinds of benefits, to be provided, including any deductible or copayment feature.

c. Where and in what manner information is available as to how services may be obtained.

d. The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to an individual contract, and an indication whether the plan is contributory or noncontributory with respect to group contracts.

e. A clear and understandable description of the health maintenance organization's method of resolving enrollee complaints.

4. Any subsequent change may be evidenced in a separate document issued to the enrollee.

~~A copy of the form of evidence of coverage to be used in this state, and any amendment thereto, is subject to the filing and approval requirements of this section unless it is subject to the~~

~~jurisdiction of the commissioner under the laws governing health insurance companies or health service corporations in which event the filing and approval provisions of those laws apply. To the extent, however, that those provisions do not apply, the requirements in this section are applicable.~~

SECTION 49. AMENDMENT. Section 26.1-18-14 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-18-14. ~~Filing and approval of schedule~~ Schedule of charges. ~~A schedule of charges for enrollee coverage for health care services, or amendment thereto, may not be used in conjunction with any health care plan until a copy of the schedule, or amendment thereto, has been filed with and approved by the commissioner.~~

The charges for enrollee coverage for health care services must be established in accordance with actuarial principles for various categories of enrollees; provided, that charges applicable to an enrollee may not be individually determined and based on the status of the enrollee's health or physical disability. The charges may not be excessive, inadequate, or unfairly discriminatory. A certification, by a qualified actuary, to the appropriateness of the charges, based on reasonable assumptions, must accompany the filing with the commissioner along with adequate supporting information. For this purpose, a qualified actuary means a member of the American academy of actuaries or any other actuary who may be approved for this purpose by the commissioner.

SECTION 50. AMENDMENT. Subsection 3 of section 26.1-19-04 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

3. The application for a certificate of authority must be made in a form prescribed by the commissioner and be verified by an officer or authorized representative of the applicant and must set forth or be accompanied by:

   a. A copy of the basic organizational documents of the applicant, if any, including articles of incorporation, partnership agreements, trust agreements, or other applicable documents.

   b. A copy of the bylaws, regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant.

   c. A list of the names, addresses, and official capacities within the organization of all persons who are responsible for the conduct of the affairs of the applicant, including all members of the governing body, the officers and directors in the case of a corporation, the partners under a partnership, the

trustees under a trust agreement, and the members or owners under any other organizational form.

d. A statement generally describing the organization, its enrollment process, its administrative operations, any cost and quality control assurance mechanisms, its internal grievance procedure, the method it proposes to use to enroll members, the geographic area or areas to be served, the location of its office or offices, the number of providers to be utilized, and the recordkeeping system which will provide documentation of the utilization of plan benefits by enrolled participants.

e. A power of attorney duly executed by the applicant, if not domiciled in the state, appointing the commissioner and the commissioner's successors in office and duly authorized deputies as the true and lawful attorneys of the applicant in and for this state upon whom all lawful process may be served in any legal action or proceeding against the organization on a ~~cause of action~~ claim for relief arising in this state.

f. Copies of all contract forms the organization proposes to furnish to enrolled participants.

g. Copies of all contract forms the organization proposes to enter into with providers.

h. Copies of the forms evidencing coverage to be issued to enrolled participants.

i. Copies of the forms of group contracts, if any, which are to be issued to employers, unions, trustees, or other organizations.

j. A statement of the financial condition of the organization, including income statement, balance sheet, and sources of funds.

k. A description of the proposed marketing techniques and copies of any proposed advertising materials.

l. A schedule of rates with any available actuarial and other data.

m. Any other information the commissioner requires to make the determinations required under section 26.1-19-06.

SECTION 51. AMENDMENT. Section 26.1-19-08 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-19-08. Contract forms.

1. All contracts or other documents evidencing coverage issued by the prepaid legal services organization to participants and marketing documents purporting to describe the organization's prepaid legal services plan must contain:

   a. A complete description of the legal services to which the participant is entitled.

   b. The predetermined periodic rate of payment for legal services, if any, which the participant is obligated to pay.

   c. All exclusions and limitations on services to be provided including any deductible or copayment feature and all restrictions relating to preexisting conditions.

   d. All criteria by which a participant may be disenrolled or denied reenrollment.

2. A contract between a legal services organization authorized to do business under this chapter and any provider or any participant may not contain any provisions which require participants to guaranty payment, other than copayments and deductibles, to the provider in the event of nonpayment by the legal services organization for any covered services which have been performed under contracts between the participant and the legal services organization.

~~3. A contract form or amendment may not be issued unless it is approved by the commissioner. The contract form or amendment is deemed approved thirty-one days after its filing with the commissioner unless the commissioner finds during this period that the contract form or amendment does not comply with the requirements of section 26.1-19-06 or subsection 1 of this section.~~

SECTION 52. AMENDMENT. Section 26.1-19-10 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-19-10. Licensing of sales representatives. The sales representatives of a prepaid legal services organization are subject to the laws pertaining to insurance agents as defined in chapter ~~26-17.1~~ 26.1-26. The license ~~or certification~~ for the sales representatives must be issued on a form prescribed by the commissioner, and the fee ~~therefor~~ for a license is three dollars.

SECTION 53. AMENDMENT. Section 26.1-22-20 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-22-20. Replacement of policies. A An insurance policy ~~of insurance~~ in force on August 1, 1943, on property not ~~heretofore~~ required by law to be insured by the fund, may not be canceled by the commissioner, but all such risks, when the policy ~~covering the same~~ lapses, expires, or otherwise is canceled, ~~shall~~ must be insured in accordance with this chapter. The amount of the insurance carried by the fund ~~shall~~ must be increased or decreased from time to time so as to maintain at all times on the insured property the amount of insurance required by this chapter. All reinsurance policies taken or held by the fund ~~shall~~ must be canceled as of August 1, 1943, and all returned premiums ~~thereon shall~~ must be added to the reserve fund.

SECTION 54. AMENDMENT. Section 26.1-23-05 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-23-05. Recovery from fund when liability cannot be determined. When bodily injury to, or the death of, any person who is a resident of this state is occasioned by or arises out of an accident caused by the operation, maintenance, or use of a motor vehicle in this state and the identity of the person against whom an action might be brought for the recovery of damages for the bodily injury or death resulting from the accident cannot be ascertained, any person who would be entitled to bring the action to recover damages may bring an action in the district court of the county in which the accident occurred within six months from the date of the accident against the unsatisfied judgment fund, by service upon the commissioner and the attorney general, for the recovery of the damages from the fund, provided notice of the accident was given to some police officer immediately after the accident occurred and the name of the officer is alleged in the complaint. A payment may not be made from the fund in satisfaction of any judgment obtained in the action in excess of five thousand dollars, exclusive of costs, for bodily injury to, or the death of, any one person, nor in excess of ten thousand dollars for any one accident.

This section does not limit the liabilities or remedies of any person on the ~~cause of action,~~ claim for relief growing out of the accident for which suit was brought against the fund, but the fund is subrogated to the rights of any person who has obtained judgment under this section, to the extent that the fund has made payment in satisfaction thereof.

SECTION 55. AMENDMENT. Section 26.1-23-11 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-23-11. Order of payment from fund - Prorate distribution. If, at the time of the filing of the order, there is not sufficient moneys

in the unsatisfied judgment fund to satisfy the order, the order shall be registered by the state treasurer and shall be paid when the moneys are available in the fund and subsequent orders shall be paid in the order of registration. If more than two judgments are obtained against a judgment debtor upon ~~causes of action~~ claims for relief arising out of one accident and the aggregate amount due, after crediting any collections, exceeds twenty thousand dollars, the court in making its order shall direct that the state treasurer shall prorate the distribution from the fund in the proportion which each judgment or the balance unpaid thereon bears to the sum of twenty thousand dollars.

SECTION 56. AMENDMENT. Section 26.1-24-03 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-24-03. When insured entitled to return of premium. A person insured is entitled to a return of premium, including all policy fees in excess of two dollars, on any one policy, and all other sums of money paid in consideration of the ~~policy of~~ insurance policy, as follows:

1. To the whole premium, fee, or other sums if no part of the insured's interest in the thing insured is exposed to any of the perils insured against.

2. To the whole of the premium when the contract is voidable on account of the fraud or misrepresentation of the insurer or on account of facts of the existence of which the insured was ignorant without the insured's fault, or when by any default of the insured other than actual fraud, the insurer never incurred any liability under the policy.

3. Except as provided for in a policy form filed with and approved by the commissioner, when insurance other than life is made for a definite period of time and the insured surrenders the policy, to such proportion of the premium, fee, or other sum as corresponds with the unexpired time upon the amount of the policy remaining after deducting therefrom any claim for loss or damage under the policy which has accrued previously.

SECTION 57. AMENDMENT. Section 26.1-24-05 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-24-05. Surrender of fire ~~insurance~~ policy for cancellation - Return of premium - Short-term rates. The holder of any ~~policy of~~ insurance policy against loss or damage to property by fire or other casualty, notwithstanding any provision ~~thereof~~ of the policy or contract to the contrary, may surrender the policy for cancellation at any time. Upon surrender, the company issuing the policy shall retain or receive such proportion, and not more, of the premium paid or agreed

to be paid, including policy fees in excess of two dollars on any one policy and other sums of money paid or agreed to be paid in consideration of the ~~policy of~~ insurance policy, as corresponds with the usual short rates upon term policies as adopted and maintained by the organization which promulgates rates for fire insurance on property situated in this state for the time the policy remained in force.

SECTION 58. AMENDMENT. Section 26.1-24-07 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-24-07. Forfeiture of policy for nonpayment of premium - Notice required. A ~~policy of~~ An insurance policy may not be forfeited, suspended, or impaired, by virtue of any condition or provision ~~thereof~~ of the policy, for nonpayment of any note or obligation taken for the premium, or any part ~~thereof~~ of the premium, unless the insurer, not less than thirty days prior to the maturity of the premium, note, or obligation, mails, postage prepaid, to the insured at the insured's usual post-office address, a notice stating:

1. The date when the note or obligation will become due.
2. The amount of principal and interest that then will be due.
3. The effect of nonpayment upon the policy.
4. The right of the insured, at the insured's election, either to pay the premium in full and keep the policy in full force or to terminate the insurance by surrendering the policy and paying such part of the whole premium as it shall have earned.
5. The amount which the insured lawfully is required to pay or which, on account of previous payment, may be due the insured, in case of the insured's election to terminate the insurance on the day of the maturity of the premium, note, or obligation.

SECTION 59. AMENDMENT. Section 26.1-25-16 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-25-16. Rebates prohibited. No broker or agent may knowingly charge, demand, or receive a premium for any ~~policy of~~ insurance policy except in accordance with this chapter. No insurer or employee ~~thereof~~ of an insurer, and no broker or agent may pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, as an inducement to insurance, or after insurance has been effected, any rebate, discount, abatement, credit, or reduction of the premium named in ~~a policy of~~ an insurance policy, or any special favor or advantage in the dividends or other benefits to accrue ~~thereon~~ on the policy, or any valuable consideration or

inducement whatever, not specified in the ~~policy of~~ insurance policy, except to the extent provided for in applicable filing. No insured named in ~~a policy of~~ an insurance policy, nor any employee of ~~such~~ the insured, may knowingly receive or accept, directly or indirectly, any such rebate, discount, abatement, credit, or reduction of premium, or any such special favor or advantage or valuable consideration or inducement. This section does not prohibit the payment of commissions or other compensation to licensed agents or brokers, nor any insurer from allowing or returning to its participating policyholders, members, or subscribers, dividends, savings, or unabsorbed premium deposits. As used in this section ~~the word~~ "insurance" includes suretyship and ~~the word~~ "policy" includes bond.

SECTION 60. AMENDMENT. Section 28-04-02 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

28-04-02. Personal actions having venue where subject matter is located. An action for any ~~one~~ of the following causes ~~shall~~ must be tried in the county in which the subject of the action, or some part ~~thereof~~ of the subject, is situated, subject to the power of the court to change the place of trial in the cases provided by statute:

1. For the recovery of personal property distrained for any cause; and

2. For recovery on ~~a policy of~~ an insurance policy for loss or damage to the property insured, and such property at the time of its loss or damage ~~shall be~~ is deemed the subject matter of ~~such~~ the action.

SECTION 61. AMENDMENT. Section 31-12-06 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

31-12-06. Chapter does not apply if decedent provides otherwise. This chapter ~~shall~~ does not apply in the case of wills, living trusts, deeds, or ~~contracts of~~ insurance contracts, or any other situation where provision is made for distribution of property different from the provisions of this chapter, or where provision is made for a presumption as to survivorship which results in a distribution of property different from that here provided.

SECTION 62. AMENDMENT. Section 32-12.1-05 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

32-12.1-05. Liability insurance policy coverage. Except for punitive or exemplary damages for which a political subdivision may be held liable, ~~a policy or contract of~~ an insurance policy or insurance contract purchased by a political subdivision pursuant to ~~the provisions of~~ this chapter may provide coverage for liabilities established by this chapter and may provide such additional coverage as the governing body of the political subdivision determines to be appropriate. The insurer ~~shall~~ may not assert the defense of

governmental immunity, but this chapter confers no right upon a claimant to sue an insurer directly. If a dispute exists concerning the amount or nature of the required insurance coverage, the dispute ~~shall~~ must be tried separately. The insurance coverage authorized by this chapter may be in addition to any insurance coverage purchased by a political subdivision pursuant to any other provision of law.

SECTION 63. AMENDMENT. Section 32-12.1-06 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

32-12.1-06. Statement to ~~insurance~~ commissioner. The insurer under any ~~policy of~~ insurance policy purchased pursuant to this chapter shall certify to the commissioner that the policy is sufficient to provide coverage to the limitations established by this chapter. The statement of certification ~~shall~~ must be in a form prescribed by the commissioner, and the commissioner may require ~~policies of~~ insurance policies purchased by political subdivisions to meet ~~such~~ any other specifications ~~as~~ the commissioner determines ~~are~~ necessary to provide coverage to political subdivisions in the manner required by this chapter. If premium savings will result therefrom, ~~policies of~~ insurance policies may be written for a period which exceeds one year with the approval of the commissioner.

SECTION 64. AMENDMENT. Subsection 1 of section 32-12.1-15 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

1. The state or any state agency, bureau, or department may insure against liabilities provided by this chapter for its own protection and for the protection of any state employee. If a premium savings will result therefrom, the ~~policies of~~ insurance policies may be taken out for more than one year, but in no event beyond a period of five years.

SECTION 65. AMENDMENT. Subsection 1 of section 39-01-08 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

1. The state ~~of North Dakota~~ or any department, agency, or bureau, as well as any county, city, or other political subdivision including townships, school districts, and park districts using or operating motor vehicles and aircrafts, ~~are hereby authorized to~~ may carry insurance for their own protection and for the protection of any employees from claims for loss or damage arising out of or by reason of the use or operation of the motor vehicle or aircraft, whether the vehicle or aircraft at the time the loss or damage in question occurred was being operated in a governmental undertaking or otherwise. If a premium savings will result therefrom, the ~~policies of~~ insurance

policy may be taken out for more than one year, but in no event beyond a period of five years.

SECTION 66. AMENDMENT. Subsection 7 of section 39-04-05 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

7. For failure to maintain security for payment of basic no-fault benefits and the liabilities covered under motor vehicle liability insurance on a motor vehicle as required by chapter ~~26-41~~ 26.1-41.

* **SECTION 67. AMENDMENT.** Subsections 2, 3, and 4 of section 39-04-06 of the 1983 Supplement to the North Dakota Century Code are hereby amended and reenacted to read as follows:

2. ~~Whenever~~ When the person to whom the registration card or registration number plates have been issued makes or permits any unlawful use of the same or permits the use thereof by a person or on a vehicle not entitled thereto.

3. ~~Whenever~~ When the commissioner finds that a vehicle is registered in accordance with a reciprocity agreement, arrangement, or declaration and the vehicle is operated in violation of the agreement.

4. When the department determines that a motor vehicle is not covered by security for payment of basic no-fault benefits and the liabilities covered under motor vehicle liability insurance as required by chapter ~~26-41~~ 26.1-41.

SECTION 68. AMENDMENT. Subsection 7 of section 39-05-20.3 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

7. For failure to provide security for payment of basic no-fault benefits and the liabilities covered under motor vehicle liability insurance on a motor vehicle as required by chapter ~~26-41~~ 26.1-41.

SECTION 69. AMENDMENT. Subsection 2 of section 39-06-05 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

2. Any student who is enrolled in behind-the-wheel driver's training through a high school program approved by the superintendent of public instruction may operate a motor vehicle, under the supervision of a driver training instructor certified by the superintendent of public instruction, without a permit or license to operate a motor vehicle~~;~~ provided, that the school district sponsoring the driver's training program has ~~a policy of~~ an insurance policy covering any damage which may be done by any such student while operating the vehicle, and

* NOTE: Section 39-04-06 was also amended by section 1 of Senate Bill No. 2169, chapter 417.

provided further that proof of ~~such~~ coverage is filed with the ~~department~~ superintendent of public instruction by the school district's insurance carrier. The amount of the insurance coverage ~~shall~~ must be in the amount of ten thousand dollars because of bodily injury to or death of one person in any one accident, and, subject to ~~said~~ the limit for one person, in the amount of twenty thousand dollars because of bodily injury to or death of two or more persons in any one accident, and in the amount of five thousand dollars because of injury to or destruction of property of others in any one accident.

* **SECTION 70. AMENDMENT.** Section 39-16-05 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

39-16-05. Suspension of license and when not applicable. The commissioner, within sixty days after the receipt of a report of a motor vehicle accident within this state which has resulted in bodily injury or death, or damage to the property of any one person in excess of four hundred dollars, shall suspend the license of each driver of each vehicle in any manner involved in such accident, and if such driver is a nonresident, the commissioner shall suspend the driver's privilege of operating a motor vehicle within this state unless ~~such~~ the driver ~~shall deposit~~ deposits security as provided in sections 39-16-09 and 39-16-10 in a sum which ~~shall be~~ is sufficient in the judgment of the commissioner to satisfy any judgment or judgments for damages resulting from ~~such~~ the accident as may be recovered against such driver, provided that notice of ~~such~~ suspension and opportunity for hearing ~~shall~~ must be sent by the commissioner to ~~such~~ the driver not less than ten days prior to the effective date of ~~such~~ the suspension and ~~shall~~ must state the amount required as security. However, if a driver, either resident or nonresident, involved in ~~such~~ the accident purchases ~~a policy of~~ an insurance policy with at least the amount of coverage required by this section, and files proof and satisfies financial responsibility requirements thereof with the commissioner, that driver ~~shall be allowed to~~ may retain ~~his~~ the license or privilege until such time as the driver has accepted responsibility for the accident or agreed to a settlement of claims arising from the accident or until a court of this state has determined that the driver was negligent or responsible for the accident in whole or in part. If the driver is found negligent or responsible for the accident, in whole or in part, ~~his~~ the license or privilege ~~shall~~ must be suspended and ~~shall~~ will not be returned until the driver complies with ~~the provisions of~~ this chapter. This section ~~shall~~ does not apply under the conditions stated in section 39-16-06, or:

1. To a driver, if ~~he~~ the driver is the owner of the motor vehicle involved in the accident and had in effect at the time of such accident an automobile liability policy with respect to the motor vehicle involved in ~~such~~ the accident, affording substantially the same coverage as is required for proof of financial responsibility under chapter 39-16.1.

* NOTE: Section 39-16-05 was also amended by section 3 of House Bill No. 1331, chapter 435, and amended by section 1 of House Bill No. 1369, chapter 442.

2. To a driver, if not the owner of ~~such~~ the motor vehicle, if there was in effect at the time of ~~such~~ the accident an automobile liability policy or bond with respect to ~~his~~ the driver's operation of the motor vehicle, affording substantially the same coverage as required for proof of financial responsibility under chapter 39-16.1.

3. To a driver, if the liability of ~~such~~ the driver for damages resulting from ~~such~~ the accident is, in the judgment of the commissioner, covered by any other form of liability insurance policy or bond or certificate of self-insurance under section 39-16-32.

No such policy or bond ~~shall be~~ is effective under this section unless by an insurance carrier or surety company authorized to do business in this state, except that if ~~such~~ the motor vehicle was not registered in the state, or was a motor vehicle which was registered elsewhere than in this state at the effective date of the policy or bond, or the most recent renewal thereof, ~~such~~ the policy or bond ~~shall~~ is not ~~be~~ effective under this section unless the insurance carrier or surety company, if not authorized to do business in this state, shall execute a power of attorney authorizing the commissioner to accept service, on its behalf, of notice or process in any action upon ~~such~~ the policy or bond arising out of ~~such~~ the accident; provided, every such policy or bond is subject, if the accident has resulted in bodily injury or death, to a limit, exclusive of interest and costs, of not less than twenty-five thousand dollars because of bodily injury to or death of one person in any one accident and, subject to ~~said~~ the limit for one person, to a limit of not less than fifty thousand dollars because of bodily injury to or death of two or more persons in any one accident, and, if the accident has resulted in injury to or destruction of property to a limit of not less than ten thousand dollars because of injury to or destruction of property of others in any one accident. Upon receipt of notice of ~~such~~ the accident, the insurance carrier or surety company which issued ~~such~~ the policy or bond shall furnish for filing with the commissioner a written notice that ~~such~~ the policy or bond was in effect at the time of ~~such~~ the accident, or the department may rely upon the accuracy of the information and the required report of an accident as to the existence of insurance or a bond unless and until the department has reason to believe that the information is erroneous.

SECTION 71. AMENDMENT. Section 39-16-29 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

39-16-29. Seizure or return of ~~driver's~~ operator's license. Any person whose license is suspended as herein provided, or whose ~~policy of~~ insurance policy or bond, when required under this chapter, is canceled or terminated, or who neglects to furnish other proof upon request of the commissioner shall immediately return ~~his~~ that person's operator's license to the commissioner. If any person fails to return to the commissioner the license as ~~provided herein~~ required by this section, the commissioner shall forthwith direct

any peace officer to secure possession ~~thereof~~ of the license and return the ~~same~~ license to the commissioner.

SECTION 72. AMENDMENT. Subsection 3 of section 39-16.1-04 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

3. Any person whose license or nonresident's operating privilege has been suspended or is about to be suspended or ~~shall~~ will become subject to suspension under ~~the provisions of~~ this chapter may be relieved from the effect of ~~such~~ the judgment as ~~hereinbefore~~ prescribed in this chapter by filing with the commissioner an affidavit stating that at the time of the accident upon which ~~such~~ the judgment has been rendered the affiant was insured, that the insurer is liable to pay ~~such~~ the judgment, and the reason, if known, why ~~such insurance carrier~~ the insurer has not paid ~~such~~ the judgment. ~~Such~~ That person shall also file the original ~~policy~~ or a copy of the insurance ~~or a copy thereof~~ policy, if available, and ~~such~~ any other documents as the commissioner may require to show that the loss, injury, or damage for which ~~such~~ the judgment was rendered, was covered by ~~such policy of~~ the insurance policy. If the commissioner is satisfied from such papers that ~~such~~ the insurer was authorized to issue ~~such policy of~~ the insurance policy at the time and place of issuing ~~such~~ the policy and that ~~such~~ the insurer is liable to pay ~~such~~ the judgment, at least to the extent and for the amounts required in this chapter, the commissioner ~~shall~~ may not suspend ~~such~~ the license or nonresident's operating privilege, or if already suspended shall reinstate them.

SECTION 73. AMENDMENT. Section 39-16.1-20 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

39-16.1-20. Seizure or return of ~~driver's~~ operator's license. Any person whose operator's license is suspended as herein provided, or whose ~~policy of~~ insurance policy or bond, when required under this chapter, is canceled or terminated, or who neglects to furnish other proof upon request of the commissioner shall immediately return ~~his~~ the license to the commissioner. If any person fails to return to the commissioner the license as ~~provided herein~~ required by this section, the commissioner shall forthwith direct any peace officer to secure possession ~~thereof~~ of the license and return the ~~same~~ license to the commissioner.

SECTION 74. AMENDMENT. Subsection 7 of section 41-09-04 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

7. To a transfer of an interest or claim in or under any ~~policy of~~ insurance policy, except as provided with

respect to proceeds (section 41-09-27) and priorities in proceeds (section 41-09-33).

SECTION 75. AMENDMENT. Subsection 2 of section 43-10.1-01 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

2. "Pre-need funeral service contract" means any contract, other than ~~a contract of~~ an insurance contract, under which for a specified consideration paid in advance in a lump sum or by installments, a person promises, upon the death of a beneficiary named or implied in the contract, to furnish professional service or personal property to be used in funeral services, or to furnish cemetery merchandise.

SECTION 76. AMENDMENT. Section 43-13-31 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

43-13-31. Discrimination in optometric services prohibited. A person may not discriminate between licensed practitioners of optometry and physicians, or interfere with any individual's right to free choice of ocular practitioner, with respect to the providing of professional services within the scope of section 43-13-01. If a group health, accident or disability policy or ~~contract of~~ insurance contract, or any other type of employee group benefit or safety program specifically provides for the payment of optometric services within the scope of section 43-13-01, the payment must be made regardless of whether the service is performed by a physician or optometrist. This section does not apply to medical service contracts written by nonprofit health service corporations.

SECTION 77. AMENDMENT. Section 49-18-33 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

49-18-33. Insurance or bond required of common or contract carrier - Liability of insurer and surety - Trial. The commission in granting a certificate or permit to any common motor carrier or contract carrier shall require the owner or operator first to procure either liability and property damage insurance or a surety bond to be approved by the commission as to the form, sufficiency, and surety thereof and written by a company authorized to write such insurance in this state in an amount to be designated by the commission. The conditions of such liability insurance or surety bond ~~shall~~ must be such as to guaranty the payment of any loss or damage to property, or on account of the death of or injury to persons, resulting from the negligence of ~~such~~ the carrier. In any action for damages resulting from the negligence of such carrier, the insurer or surety ~~shall~~ may not be joined as a party defendant nor ~~shall~~ may the fact of the ultimate liability of such insurer or surety be disclosed or commented on to the jury. Upon final judgment the insurer or surety ~~shall become~~ is liable directly to the owner of ~~such~~ the judgment

for the full amount ~~thereof~~ of the judgment but not exceeding the amount of the ~~policy of~~ insurance policy or surety bond applicable to such loss. Each insurance policy or bond so required ~~shall~~ must be filed with the commission and ~~shall~~ must be kept in full force and effect, and upon the failure to do so the certificate or permit ~~shall~~ must be revoked and canceled; provided, that a certificate of any company authorized to write liability or property damage insurance in the state, in a form approved by the commission and certifying that there is in effect a liability insurance policy required by this section, may be filed in lieu of the policy itself. The commission also shall require the owner or operator first to procure a surety bond, written by a company authorized to write such bond in this state, in an amount to be designated by the commission, to guaranty the payment by the carrier to the shipper or its agent, of all cash or collect on delivery charges collected by said carrier in connection with the operation or conduct of his business as such common motor carrier or contract carrier.

SECTION 78. AMENDMENT. Subsection 2 of section 51-07-12 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

2. If the insurance required by any dealer, bank, or other finance agency or company does not provide insurance for bodily injury liability or property damage liability, then the ~~policy of~~ insurance policy or the certificate of insurance, if the policy is filed with the payee, ~~shall~~ must have imprinted or stamped ~~thereon~~ on the policy or certificate a notice that ~~such~~ the policy does not include bodily injury liability or property damage liability insurance. The imprinting or stamping of such notice ~~shall~~ must be in ~~such~~ the manner or form as may be approved by the commissioner of insurance.

SECTION 79. AMENDMENT. Section 54-30-24.1 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

54-30-24.1. Bonds as legal investments and security. Notwithstanding any restrictions contained in any other law, the state and all public officers, boards, and agencies, and political subdivisions and agencies thereof, all national banking associations, state banks, trust companies, savings banks and institutions, ~~building and loan associations,~~ savings and loan associations, investment companies, and other persons carrying on a banking business, ~~all insurance companies, insurance associations and other persons carrying on insurance business,~~ and all executors, administrators, guardians, trustees, and other fiduciaries, may legally invest any sinking funds, moneys, or other funds belonging to them or within their control in any bonds issued pursuant to this chapter, and ~~such~~ the bonds ~~shall be~~ are authorized security for ~~any and~~ all public deposits.

SECTION 80. A new subsection to section 58-06-01 of the North Dakota Century Code is hereby created and enacted to read as follows:

To insure the township's property which is not required to be insured against loss by fire or tornado by the state fire and tornado fund, in a stock or mutual fire insurance company or in the state fire and tornado fund.

* **SECTION 81. AMENDMENT.** Section 60-02-10.1 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

60-02-10.1. Revocation and suspension. The commission may suspend or revoke the license of any warehouseman for cause upon notice and hearing. Notwithstanding any other provisions of this chapter, the license of a warehouseman ~~shall~~ must automatically be suspended for failure at any time to have or to maintain either a bond or ~~policy of~~ insurance policy in the amount and type required.

SECTION 82. AMENDMENT. Section 60-02-35.1 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

60-02-35.1. Insurance - Cancellation - Suspension of license. Upon the existence of an effective ~~policy of~~ insurance policy as required in section 60-02-35, the insurance company involved shall give thirty days' advance notice to the commission and the insured by registered ~~or certified~~ mail return receipt requested of any cancellation of the policy. In the event of any insurance cancellation or expiration, the commission, without hearing, shall immediately suspend the license of ~~such~~ the warehouseman, and the suspension ~~shall~~ may not be removed until satisfactory evidence of the existence of an effective ~~policy of~~ insurance policy has been submitted to the commission.

Approved March 30, 1985

* NOTE: Section 60-02-10.1 was also amended by section 5 of House Bill No. 1202, chapter 661.

CHAPTER 318

SENATE BILL NO. 2142
(Committee on Industry, Business and Labor)
(At the request of the Commissioner of Insurance)

ESTIMATED INSURANCE PREMIUMS TAX

AN ACT to create and enact a new subsection to section 26.1-03-17 of the North Dakota Century Code, relating to the payment of estimated premium tax; and to amend and reenact subsections 1 and 2 of section 26.1-03-17 of the North Dakota Century Code, relating to premium tax, credits, and penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

* SECTION 1. AMENDMENT. Subsections 1 and 2 of section 26.1-03-17 of the 1983 Supplement to the North Dakota Century Code are hereby amended and reenacted to read as follows:

1. Before issuing the annual certificate required by law, the commissioner shall collect from every stock and mutual insurance company, nonprofit health service corporation, health maintenance organization, and prepaid legal service organization, except a fraternal benefit society, doing business in this state, a tax on the gross amount of premiums, assessments, membership fees, subscriber fees, policy fees, and finance and service charges received in this state during the preceding calendar ~~quarter~~ year, at the rate of two percent with respect to life insurance, one-half of one percent with respect to accident and sickness insurance, and one percent with respect to all other lines of insurance. This tax does not apply to considerations for annuities. The total tax is payable on or before ~~the sixtieth day after the last day of the calendar quarter~~ March first following the year for which the tax is assessable and shall be deposited in the general fund in the state treasury.

2. An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for the amount of any assessment paid as a member of a comprehensive health association under subsection 4 of

* NOTE: Section 26.1-03-17 was also amended by section 10 of Senate Bill No. 2079, chapter 317.

section 26.1-08-09 for which the member may be liable for the year in which the assessment was paid, a credit against the tax due for an amount equal to the examination fees paid to the commissioner under sections 26.1-01-07, 26.1-02-02, and 26.1-03-19 through 26.1-03-22 and a credit against the tax due ~~for 1982, 1983, 1984, and 1985~~ for an amount equal to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this subsection shall be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1.

SECTION 2. A new subsection to section 26.1-03-17 of the 1983 Supplement to the North Dakota Century Code is hereby created and enacted to read as follows:

Every stock and mutual insurance company, nonprofit health service corporation, health maintenance organization, and prepaid legal service organization, except a fraternal benefit society, doing business in this state required to pay premium taxes in this state shall make and file a statement of estimated premium taxes. The statement and payment shall be made on a quarterly basis as prescribed by the commissioner. Failure of a company to make payments of at least one-fourth of either the total tax paid during the previous calendar year, or eighty percent of the actual tax for the current calendar year, shall subject the company to the penalty and interest provided in subsection 3.

Approved March 22, 1985

CHAPTER 319

HOUSE BILL NO. 1507
(Representatives Whalen, Dorso, Payne)
(Senator Tallackson)

DOMESTIC INSURANCE COMPANY DIRECTORS

AN ACT to amend and reenact sections 26.1-05-05 and 26.1-05-31 of the North Dakota Century Code, relating to the qualifications of directors of insurance companies and deleting the requirement of stock ownership and to salaries, expenses, and pensions of officers and agents of domestic insurance companies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-05-05 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-05-05. Qualification of directors - Residence requirements of directors and executive officers. One-third of the directors and a majority of the executive officers of a domestic insurance company must be residents of this state~~, and each of the directors of the company, if it has capital stock, must be the owner in the director's own right of stock of the company of the par value of at least five hundred dollars~~.

SECTION 2. AMENDMENT. Section 26.1-05-31 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-05-31. Salaries and expenses of officers and agents of domestic life company - Restrictions. A domestic life insurance company may not:

1. Pay any salary, compensation, or emolument to any senior officer, trustee, or director thereof, ~~nor any salary, compensation, or emolument to any one person, firm, or corporation~~ amounting in any one year to more than ~~thirty~~ fifty thousand dollars, unless the payment thereof first is authorized by the board of directors of the company.

2. Grant any pension to any officer, director, or trustee thereof, or to any member of the officer's, director's, or trustee's family after death, except that it may provide a pension in pursuance of the terms of a retirement plan adopted by the board of directors and approved by the commissioner for any person who is or has been a salaried officer or employee of the corporation and who may retire by reason of age or disability.

Approved March 31, 1985

CHAPTER 320

HOUSE BILL NO. 1387
(Representatives DeMers, Wald, Haugland)
(Senators Heinrich, Stenehjem, Wenstrom)

INSURANCE BENEFITS FOR SERVICES PERFORMED BY NURSES

AN ACT to create and enact a new section to chapter 26-03 of the North Dakota Century Code, or in the alternative to create and enact a new subdivision to subsection 1 of section 26.1-36-04 and a new subsection to section 26.1-36-05 of the North Dakota Century Code as created by Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, a new section to chapter 26.1-17, and a new subsection to section 26.1-18-12 of the North Dakota Century Code, relating to benefits for services performed by registered nurses.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. If Senate Bill No. 2078 does not become effective, a new section to chapter 26-03 of the North Dakota Century Code is hereby created and enacted to read as follows:

Services performed by registered nurses - No exclusion of benefits. An insurer or nonprofit health service corporation may not deliver, issue, execute, or renew any individual or group accident and health insurance policy or health service contract that excludes benefits for health care services performed by a registered nurse licensed pursuant to chapter 43-12.1 if the following conditions are met:

1. The service performed is within the scope of the registered nurse's license;

2. The policy or contract currently provides benefits for identical services performed by a provider of health care licensed by this state;

3. The service is not performed while the registered nurse is employed within a hospital, skilled nursing facility, or intermediate care facility; and

4. The policy or contract does not offer, at the option of the individual with respect to an individual policy or contract or the employer or the group or association

representative with respect to a group policy or contract, coverage for services rendered by self-employed registered nurses licensed pursuant to chapter 43-12.1.

No lack of signature, referral, or employment by any other health care provider, and no provision of chapter 43-17 may be asserted to deny benefits under this section.

SECTION 2. A new subdivision to subsection 1 of section 26.1-36-04 of the North Dakota Century Code as created by Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, is hereby created and enacted to read as follows:

A provision that benefits under the policy may not be denied for any health care service performed by a registered nurse licensed pursuant to chapter 43-12.1 if the following conditions are met: (1) the service performed is within the scope of the registered nurse's license; (2) the policy currently provides benefits for identical services performed by a provider of health care licensed by this state; (3) the service is not performed while the registered nurse is employed within a hospital, skilled nursing facility, or intermediate care facility; and (4) the policy does not offer, at the option of the policyholder, coverage for services rendered by self-employed registered nurses licensed pursuant to chapter 43-12.1. No lack of signature, referral, or employment by any other health care provider, and no provision of chapter 43-17 may be asserted to deny benefits under this provision.

SECTION 3. A new subsection to section 26.1-36-05 of the North Dakota Century Code as created by Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, is hereby created and enacted to read as follows:

A provision that benefits under the policy may not be denied for any health care service performed by a registered nurse licensed pursuant to chapter 43-12.1 if the following conditions are met: (1) the service performed is within the scope of the registered nurse's license; (2) the policy currently provides benefits for identical services performed by a health care provider licensed by this state; (3) the service is not performed while the registered nurse is employed within a hospital, skilled nursing facility, or intermediate care facility; and (4) the policy does not offer, at the option of the employer, or the group or association representative, coverage for services rendered by self-employed registered nurses licensed pursuant to chapter 43-12.1. No lack of signature, referral, or employment by any other health care provider, and no provision of chapter 43-17 may be asserted to deny benefits under this provision.

SECTION 4. A new section to chapter 26.1-17 of the North Dakota Century Code is hereby created and enacted to read as follows:

Services of registered nurses - Denial of benefits prohibited. Every health service contract must contain a provision that benefits under the health service contract may not be denied for any health care service performed by a registered nurse licensed pursuant to chapter 43-12.1 if the following conditions are met: (1) the service performed is within the scope of the registered nurse's license; (2) the health service contract currently provides benefits for identical services performed by a health care provider licensed in this state; (3) the service is not performed while the registered nurse is employed within a hospital, skilled nursing facility, or intermediate care facility; and (4) the health service contract does not offer, at the option of the individual with respect to an individual contract or the employer or the group or association representative with respect to a group contract, coverage for services rendered by self-employed registered nurses licensed pursuant to chapter 43-12.1. No lack of signature, referral, or employment by any other health care provider, and no provision of chapter 43-17 may be asserted to deny benefits under this provision.

SECTION 5. A new subsection to section 26.1-18-12 of the 1983 Supplement to the North Dakota Century Code is hereby created and enacted to read as follows:

A provision that benefits under the evidence of coverage may not be denied for any health care service performed by a registered nurse licensed pursuant to chapter 43-12.1 if the following conditions are met: (a) the service performed is within the scope of the registered nurse's license; (b) the evidence of coverage currently provides benefits for identical services performed by a provider; (c) the service is not performed while the registered nurse is employed within a hospital, skilled nursing facility, or intermediate care facility; and (d) the evidence of coverage does not offer coverage, at the option of an individual with respect to an individual evidence of coverage or the employer or the group or association representative with respect to a group evidence of coverage, for services rendered by self-employed registered nurses licensed pursuant to chapter 43-12.1. No lack of signature, referral, or employment by any other provider, and no provision of chapter 43-17 may be asserted to deny benefits under this provision.

Approved March 22, 1985

CHAPTER 321

SENATE BILL NO. 2274
(Moore)

CONTINUING EDUCATION FOR INSURANCE AGENTS

AN ACT to create and enact nine new sections to chapter 26-17.1 of the North Dakota Century Code, or in the alternative to create and enact nine new sections to chapter 26.1-26 of the North Dakota Century Code as created in Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, relating to prelicensure and continuing education for insurance agents; and to provide an appropriation.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, a new section to chapter 26-17.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

Prelicensure education. Any applicant for licensure as an agent, broker, surplus lines broker or consultant shall file with the commissioner, in a form required by the commissioner, evidence that the person attended or participated in approved insurance education programs or courses of not less than eight hours of approved coursework for each major category of insurance for which licensure is sought. For the purpose of this section, the major categories of insurance are life insurance, accident and health insurance, property insurance, and casualty insurance. Coursework must have been completed within six months of the filing of the application for licensure and must have consisted entirely of classroom hours. An applicant is exempt from prelicensure requirements under this section for a major category of insurance if a national insurance designation that would exempt the applicant from written examination pursuant to section 26-17.1-35 has been obtained.

SECTION 2. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, a new section to chapter 26-17.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

Continuing education required.

1. Beginning January 1, 1987, any person licensed as an agent, broker, surplus lines broker or consultant shall provide the commissioner evidence, as required by the commissioner, that the person attended or participated in continuing education of not less than fifteen hours per year of approved coursework, of which seven and one-half hours per year must be classroom hours. The commissioner may waive requirement of seven and one-half hours per year of classroom work. The continuing education advisory task force may recommend granting up to fifteen hours continuing education credit for nationally recognized insurance education correspondence programs. The commissioner shall review the task force's recommendation, and the commissioner may approve up to fifteen hours of credit. Credit for courses attended in any one year over fifteen hours of coursework may be credited to the year next preceding the year in which they were earned or to the year next following the year in which they were earned. Reports of continuing education must be made at the end of each four-year period following licensure, except as provided in subsection 2.

2. On or before January 1, 1986, the commissioner shall by rule divide the persons subject to this section into four equal segments for the purpose of reporting, as follows:

   a. One-fourth of the persons shall file their report showing fifteen hours or more of approved coursework for the first year under this section within thirty days of January 31, 1987.

   b. One-fourth of the persons shall file a report showing thirty hours or more of approved coursework for the first two years under this section within thirty days of January 1, 1988.

   c. One-fourth of the persons shall file a report showing forty-five hours or more of approved coursework for the first three years under this section within thirty days of January 31, 1989.

   d. One-fourth of the persons shall file a report showing sixty hours or more of approved coursework for the first four years under this section within thirty days of January 31, 1990.

3. All persons licensed after January 1, 1987, shall report within thirty days of the first day of January of the year following the fourth anniversary of the person's licensure.

SECTION 3. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, a new section to

chapter 26-17.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

Continuing education advisory task force. The commissioner shall appoint a continuing education advisory task force consisting of nine members. The members must be representative, to the extent possible, of the various members of the insurance industry and of the several classes of insurance. Before making appointments to the advisory task force, the commissioner shall solicit nominations from the several professional organizations representing persons selling insurance in this state and from the organizations representing companies authorized to do business in this state. Members are entitled to expenses pursuant to sections 44-08-04 and 54-06-09. The advisory task force may recommend any rules to the commissioner which are necessary to fulfill its duties and powers.

SECTION 4. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, a new section to chapter 26-17.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

Accreditation of courses. The commissioner shall adopt by rule criteria for the accreditation of courses for continuing or prelicensure education. Applications for accreditation of any course offered in this state for continuing or prelicensure education must be submitted to the commissioner on forms prescribed by rule and with a fee of fifty dollars. Application must be made at least three months prior to the proposed date of the course. The advisory task force shall recommend to the commissioner whether any course satisfies the criteria for accreditation and the number of credit hours to be assigned to the course. The commissioner shall make a final determination as to accreditation and assignment of credit hours for courses.

SECTION 5. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, a new section to chapter 26-17.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

Report of compliance. Each person required to report under section 2 of this Act, shall file a written, sworn report of compliance with the commissioner in the form prescribed by rule, with a fee of twenty-five dollars, within thirty days after the close of the period for reporting the person's hours.

SECTION 6. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, a new section to chapter 26-17.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

Extension. The commissioner may grant an extension of time, not to exceed one year, for completion of the requirements imposed by section 2 of this Act.

SECTION 7. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, a new section to chapter 26-17.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

Credit for teaching. Any person teaching or lecturing at any approved continuing education course, seminar, or program qualifies for the same number of hours granted to a person enrolled in the approved course, seminar, or program.

SECTION 8. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, a new section to chapter 26-17.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

Credit for out-of-state courses. The commissioner may approve credit earned at any seminar, course, or program offered for prelicensure or continuing education in another state.

SECTION 9. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, a new section to chapter 26-17.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

License revocation.

1. The commissioner shall suspend the license of any person if after holding a hearing, the commissioner finds that the person failed to meet the requirements imposed by this Act. Any license suspended under this subsection must remain suspended until the person has demonstrated, to the satisfaction of the commissioner, compliance with the requirements of this Act and other applicable laws.

2. The commissioner shall, after holding a hearing, suspend the license of any person who has submitted a false or fraudulent certificate of compliance.

SECTION 10. If Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, becomes effective, a new section to chapter 26.1-26 of the North Dakota Century Code is hereby created and enacted to read as follows:

Prelicensure education. Any applicant for licensure as an agent, broker, surplus lines broker or consultant shall file with the commissioner, in a form required by the commissioner, evidence that the person attended or participated in approved insurance education programs or courses of not less than eight hours of approved coursework for each major category of insurance for which licensure is sought. For the purpose of this section, the major categories of insurance are life insurance, accident and health insurance, property insurance, and casualty insurance. Coursework must have been completed within six months of the filing of the application for licensure and must have consisted entirely of classroom hours.

An applicant is exempt from prelicensure requirements under this section for a major category of insurance if a national insurance designation that would exempt the applicant from written examination pursuant to section 26.1-26-25 has been obtained.

SECTION 11. If Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, becomes effective, a new section to chapter 26.1-26 of the North Dakota Century Code is hereby created and enacted to read as follows:

Continuing education required.

1. Beginning January 1, 1987, any person licensed as an agent, broker, surplus lines broker or consultant shall provide the commissioner evidence, as required by the commissioner, that the person attended or participated in continuing education of not less than fifteen hours per year of approved coursework, of which seven and one-half hours per year must be classroom hours. The commissioner may waive the requirement of seven and one-half hours per year of classroom work. The continuing education advisory task force may recommend granting up to fifteen hours continuing education credit for nationally recognized insurance education correspondence programs. The commissioner shall review the task force's recommendation, and the commissioner may approve up to fifteen hours of credit. Credit for courses attended in any one year over fifteen hours of coursework may be credited to the year next preceding the year in which they were earned or to the year next following the year in which they were earned. Reports of continuing education must be made at the end of each four-year period following licensure, except as provided in subsection 2.

2. On or before January 1, 1986, the commissioner shall by rule divide the persons subject to this section into four equal segments for the purpose of reporting, as follows:

   a. One-fourth of the persons shall file their report showing fifteen hours or more of approved coursework for the first year under this section within thirty days of January 1, 1987.

   b. One-fourth of the persons shall file a report showing thirty hours or more of approved coursework for the first two years under this section within thirty days of January 1, 1988.

   c. One-fourth of the persons shall file a report showing forty-five hours or more of approved coursework for the first three years under this section within thirty days of January 1, 1989.

d. One-fourth of the persons shall file a report showing sixty hours or more of approved coursework for the first four years under this section within thirty days of January 1, 1990.

3. All persons licensed after January 1, 1987, shall report within thirty days of the first day of January of the year following the fourth anniversary of the person's licensure.

SECTION 12. If Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, becomes effective, a new section to chapter 26.1-26 of the North Dakota Century Code is hereby created and enacted to read as follows:

Continuing education advisory task force. The commissioner shall appoint a continuing education advisory task force consisting of nine members. The members must be representative, to the extent possible, of the various members of the insurance industry and of the several classes of insurance. Before making appointments to the advisory task force, the commissioner shall solicit nominations from the several professional organizations representing persons selling insurance in this state and from the organizations representing companies authorized to do business in this state. Members are entitled to expenses pursuant to sections 44-08-04 and 54-06-09. The advisory task force may recommend any rules to the commissioner which are necessary to fulfill its duties and powers.

SECTION 13. If Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, becomes effective, a new section to chapter 26.1-26 of the North Dakota Century Code is hereby created and enacted to read as follows:

Accreditation of courses. The commissioner shall adopt by rule criteria for the accreditation of courses for continuing or prelicensure education. Applications for accreditation of any course offered in this state for continuing or prelicensure education must be submitted to the commissioner on forms prescribed by rule and with a fee of fifty dollars. Application must be made at least three months prior to the proposed date of the course. The advisory task force shall recommend to the commissioner whether any course satisfies the criteria for accreditation and the number of credit hours to be assigned to the course. The commissioner shall make a final determination as to accreditation and assignment of credit hours for courses.

SECTION 14. If Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, becomes effective, a new section to chapter 26.1-26 of the North Dakota Century Code is hereby created and enacted to read as follows:

Report of compliance. Each person required to report under section 11 of this Act, shall file a written, sworn report of compliance with the commissioner in the form prescribed by rule,

with a fee of twenty-five dollars, within thirty days after the close of the period for reporting the person's hours.

SECTION 15. If Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, becomes effective, a new section to chapter 26.1-26 of the North Dakota Century Code is hereby created and enacted to read as follows:

Extension. The commissioner may grant an extension of time, not to exceed one year, for completion of the requirements imposed by section 11 of this Act.

SECTION 16. If Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, becomes effective, a new section to chapter 26.1-26 of the North Dakota Century Code is hereby created and enacted to read as follows:

Credit for teaching. Any person teaching or lecturing at any approved continuing education course, seminar, or program qualifies for the same number of hours granted to a person enrolled in the approved course, seminar, or program.

SECTION 17. If Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, becomes effective, a new section to chapter 26.1-26 of the North Dakota Century Code is hereby created and enacted to read as follows:

Credit for out-of-state courses. The commissioner may approve credit earned at any seminar, course, or program offered for prelicensure or continuing education in another state.

SECTION 18. If Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, becomes effective, a new section to chapter 26.1-26 of the North Dakota Century Code is hereby created and enacted to read as follows:

License revocation.

1. The commissioner shall suspend the license of any person if after holding a hearing, the commissioner finds that the person failed to meet the requirements imposed by this Act. Any license suspended under this subsection must remain suspended until the person has demonstrated, to the satisfaction of the commissioner, compliance with the requirements of this Act and other applicable laws.

2. The commissioner shall, after holding a hearing, suspend the license of any person who has submitted a false or fraudulent certificate of compliance.

SECTION 19. APPROPRIATION. There is hereby appropriated out of any moneys in the bonding fund in the state treasury, not otherwise appropriated, the sum of $80,000, or so much thereof as may be necessary, to the commissioner of insurance to administer programs to require prelicensure and continuing insurance education, as provided in this Act, for the biennium beginning July 1, 1985, and ending June 30, 1987.

Approved April 4, 1985

CHAPTER 322

SENATE BILL NO. 2468
(Lips, Streibel)

COMPREHENSIVE HEALTH ASSOCIATION ELIGIBILITY

AN ACT to amend and reenact subsection 4 of section 26.1-08-01 and section 26.1-08-12 of the North Dakota Century Code, relating to eligibility qualifications and eligibility requirements for applicants for insurance coverage from the comprehensive health association of North Dakota.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 4 of section 26.1-08-01 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

4. "Eligible person" means an individual who ~~is~~ has been a resident of this state for a period of six months and meets the enrollment requirements of section 26.1-08-12.

* SECTION 2. AMENDMENT. Section 26.1-08-12 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-08-12. Enrollment by eligible person.

1. The association plan must be open for enrollment by eligible persons. A person is eligible and may enroll in the plan by submission of ~~a certificate of eligibility~~ an application to the lead carrier. The ~~certificate~~ application must provide:

   a. The name, address, and age of the applicant, and length of applicant's residence in this state.

   b. The name, address, and age of spouse and children, if any, if they are to be insured.

   c. Written evidence that the applicant has been rejected for accident and sickness insurance, or that restrictive riders or a preexisting conditions

* NOTE: Section 26.1-08-12 was also amended by section 27 of Senate Bill No. 2079, chapter 317.

limitation, the effect of which is to reduce substantially coverage from that received by a person considered a standard risk, was required, by at least ~~two insurance companies~~ one insurance company within six months of the date of the ~~certificate~~ application.

d. A designation of coverage desired.

2. Within thirty days of receipt of the ~~certificate of~~ application, the lead carrier shall either reject the application for failing to comply with the requirements of subsection 1 or forward the eligible person a notice of acceptance and billing information. Insurance is effective immediately upon receipt of the first month's association plan premium, and is retroactive to the date of the application, if the applicant otherwise complies with this chapter.

3. An eligible person may not purchase more than one policy from the association plan.

4. A person who obtains coverage pursuant to this section may not be covered for any preexisting condition during the first six months of coverage under the association plan if the person was diagnosed or treated for that condition during the ninety days immediately preceding the ~~filing of an~~ date of the application, except that coverage of a preexisting condition during the first six months must be provided upon the insured's payment of an additional premium set by the association and approved by the commissioner. This subsection does not apply to a person who has had continuous coverage under an individual, a family, or group policy ~~during~~ for the ~~year~~ twelve-month period immediately preceding the filing of an application for nonelective procedures or to a person who is treated by nonelective procedures for a congenital or genetic disease.

Approved April 4, 1985

CHAPTER 323

HOUSE BILL NO. 1113
(Committee on Industry, Business and Labor)
(At the request of the Commissioner of Insurance)

UNSATISFIED JUDGMENT FUND REPRESENTATION

AN ACT to amend and reenact section 26.1-23-06 of the North Dakota Century Code, relating to the unsatisfied judgment fund.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-23-06 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-23-06. Attorney general may appear. Section 26.1-23-04 does not apply in the case of any judgment entered by default, unless the commissioner and the attorney general have been given at least thirty days' notice prior to the entry of judgment, to which notice shall be attached a copy of the summons and complaint. Upon receipt of the notice, the attorney general may enter an appearance, file a defense, appear by counsel at the trial, or take any other action the attorney general deems appropriate on behalf of the fund and in the name of the defendant, and may thereupon, on behalf of the fund and in the name of the defendant, conduct a defense, and all acts done in accordance therewith shall be deemed to be acts of the defendant. The attorney general may appear and be heard on any application for payment from the fund and may show cause, if any, why the order applied for should not be made.

Approved March 14, 1985

CHAPTER 324

SENATE BILL NO. 2077
(Legislative Council)
(Interim Industry, Business and Labor Committee)

INSURANCE COMMISSIONER FEES

AN ACT to amend and reenact section 26-17.1-16 or in the alternative section 26.1-26-32 as created by Senate Bill No. 2078 as approved by the forty-ninth legislative assembly, and section 26.1-01-07 of the North Dakota Century Code, relating to fees charged by the commissioner of insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. If Senate Bill No. 2078 does not become effective, section 26-17.1-16 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-16. Fees - Failure to pay. All applications shall be accompanied by the applicable fees as provided in section 26.1-01-07. An appointment terminates upon failure to pay the prescribed annual renewal ~~fee~~ fees.

SECTION 2. AMENDMENT. Section 26.1-01-07 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-01-07. Fees chargeable by commissioner. The commissioner shall charge and collect the following fees:

1. For filing articles of incorporation, or copies, or amendments thereof, twenty-five dollars.

2. For each original certificate of authority issued upon admittance, fifty dollars and for renewal of certificate of authority, amendment to certificate of authority, or certified copy thereof, twenty-five dollars.

3. For issuing an annual reciprocal exchange license, the same fees as those applicable to the issuance of a certificate of authority in subsection 2.

4. For filing an annual report of a fraternal benefit society, and issuing a license or permit to the society, and for each renewal thereof, twenty-five dollars.

5. For filing bylaws or amendments thereof, ~~five~~ ten dollars.

6. For filing of articles of merger, or copies thereof, thirty dollars.

7. For receiving the service of process as attorney, whether the commissioner is served with the process or admits service thereon, ~~two~~ ten dollars.

8. For filing of power of attorney by nonadmitted insurer for conduct of business in compliance with surplus lines laws of this state, ten dollars.

9. For filing an annual statement, twenty-five dollars.

10. For each abstract of the annual statement of an insurance company for publication, ~~three~~ ten dollars.

11. For an official examination, the actual expense and per diem incurred; but the per diem charge may not exceed thirty-five dollars.

12. For issuing a certificate to a domestic insurance company showing a compliance with the compulsory reserve provisions of this title and the maintenance of proper security deposits, and for any renewal of the certificate, ~~five~~ ten dollars.

13. For a written licensee's examination administered by the office of the commissioner, with the examination not to exceed two lines of insurance at any one sitting, twenty dollars.

14. For a written licensee's examination not administered by the office of the commissioner under a contract with a testing service, the actual cost of the examination, subject to approval of the commissioner, which shall be paid to the testing service.

15. For issuing and each annual renewal of a resident insurance broker's, surplus lines insurance broker's and insurance consultant's license, or duplicate thereof, ten dollars.

16. For issuing and each annual renewal of a nonresident insurance broker's, surplus lines insurance broker's and insurance consultant's license, or duplicate thereof, fifteen dollars.

17. For issuing a license for a resident agent or limited insurance representative of a foreign insurance company, or duplicate, ~~three~~ ten dollars.

18. For issuing a nonresident insurance agent's or limited insurance representative's license, or duplicate, ten dollars.

19. For issuing a license for an agent or limited insurance representative of a domestic insurance company, county mutual insurance company, fraternal benefit society, or any other society, or duplicate, ~~three~~ ten dollars.

20. For issuing and each annual renewal of a license to a resident agent for the attorney for a reciprocal exchange, ~~three~~ ten dollars.

21. For filing of any miscellaneous documents or papers, including documents of admission and those filed annually upon license renewal, ~~one dollar~~ ten dollars each.

22. For a copy of any paper filed in the commissioner's office, twenty cents per folio.

23. For affixing the commissioner's official seal on a copy of any paper filed in the office and certifying the copy, ~~one dollar~~ ten dollars.

24. For each insurance company appointment and renewal of an appointment of an insurance agent or limited insurance representative, ten dollars.

Nonprofit health service corporations and health maintenance organizations are subject to the same fees as any other insurance company. County mutual insurance companies and benevolent societies are liable only for the fees mentioned in subsections 2, 10, 11, 13, 19, 22, ~~and~~ 23, and 24.

SECTION 3. AMENDMENT. Section 26.1-26-32 of the North Dakota Century Code as created by Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, is hereby amended and reenacted to read as follows:

26.1-26-32. Renewal of appointments and licenses - Annual fee. An appointment of an insurance agent or limited insurance representative and the license of an insurance broker, surplus lines insurance broker, or insurance consultant terminates upon failure to pay the prescribed annual renewal ~~fee~~ fees before May first.

Approved March 22, 1985

CHAPTER 325

HOUSE BILL NO. 1441
(Representatives Whalen, Wald)
(Senator Mutch)

GROUP INSURANCE POLICY REQUIREMENTS

AN ACT to amend and reenact section 26-03.1-04.1 of the North Dakota Century Code or in the alternative to amend and reenact section 26.1-36-06 of the North Dakota Century Code as amended by Senate Bill No. 2078, as approved by the forty-ninth legislative assembly relating to certain options required in group policies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. If Senate Bill No. 2078 does not become effective, section 26-03.1-04.1 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-03.1-04.1. Certain options required in group policies. No insurance company authorized to do business in this state shall deliver, issue, execute, or renew any policy of health insurance which includes coverage of medical benefits on a group, blanket, franchise, or association basis unless the insurer makes available, at the option of the ~~insured~~ policyholder, the following coverages for which an additional premium may be charged:

1. All drugs and medicines prescribed by the provider of health services.

2. Services rendered and care administered by chiropractors licensed under chapter 43-06.

SECTION 2. AMENDMENT. Section 26.1-36-06 of the North Dakota Century Code as created by Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, is hereby amended and reenacted to read as follows:

26.1-36-06. Group health policy and medical service contract options for drugs and chiropractic care. No insurance company or health service corporation may deliver, issue, execute, or renew any health insurance policy or medical service contract that includes coverage of medical benefits on a group, blanket, franchise, or association basis unless the insurer makes available, at the option of the ~~insured or subscriber~~ policyholder, the following coverages for which an additional premium may be charged:

1. All drugs and medicines prescribed by the provider of health services.

2. Services rendered and care administered by chiropractors licensed under chapter 43-06.

Approved March 27, 1985

CHAPTER 326

HOUSE BILL NO. 1211
(Committee on Social Services and Veterans Affairs)
(At the request of the Commissioner of Insurance)

ADDICTION AND SUBSTANCE ABUSE INSURANCE

AN ACT to create and enact section 26-39-03.1 of the North Dakota Century Code, relating to substance abuse benefits for human service centers; and to amend and reenact sections 26-39-01, 26-39-02, 26-39-03, and 26-39-05 of the North Dakota Century Code, relating to mental illness, addiction, and substance abuse insurance coverage; or in the alternative to amend and reenact sections 26.1-36-08 and 26.1-36-09 of the North Dakota Century Code as created by Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, relating to mental illness and addiction insurance coverage and substance abuse coverage.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, section 26-39-01 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-39-01. Definitions. As used in this chapter, unless the context or subject matter otherwise requires:

1. "Licensed treatment facility" means any hospital, as defined in subsection ~~29~~ 25 of section 52-01-01 and the state department of health rules and regulations pursuant thereto or as licensed under section 23-17.1-01, offering treatment for the prevention or cure of mental illness, alcoholism, drug addiction, or other related illness.

2. "Partial hospitalization" means that level and intensity of treatment that is greater than outpatient treatment, but less than inpatient treatment.

3. "Regional human service center" means a regional human service center licensed under section 50-06-05.2.

SECTION 2. AMENDMENT. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, section 26-39-02 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-39-02. Insurance companies and health maintenance organizations to comply with chapter. An insurance company ~~or~~, nonprofit health service corporation, or health maintenance organization, authorized to do business within this state may not deliver, issue, execute, or renew any policy of health insurance or health service contract on a group or blanket or franchise or association basis where more than fifty persons are covered or are to be covered by the policy and where the number of persons covered or to be covered represents more than seventy percent of all persons eligible for the coverage unless the policy conforms to the requirements of this chapter.

SECTION 3. AMENDMENT. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, section 26-39-03 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-39-03. Types of coverage required - Licensed treatment facility. Any policy or contract described in section 26-39-02 shall provide benefits, of the same type offered under such policy for other illnesses, for health services to any person covered under such policy, for the diagnosis, evaluation, and treatment of mental illness, alcoholism, drug addiction, or other related illness, in a licensed ~~hospital~~ treatment facility.

SECTION 4. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, section 26-39-03.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-39-03.1. Types of coverage required - Human service centers. Any policy or contract described in section 26-39-02 must provide benefits, of the same type offered under the policy or contract for other illnesses, for health services to any person covered by the policy or contract, for the diagnosis, evaluation, and treatment of alcoholism, drug addiction, or other related illness, at a regional human service center, at reimbursement rates that are reasonably similar to the charges for care provided by licensed treatment facilities.

SECTION 5. AMENDMENT. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, section 26-39-05 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-39-05. Other policies. This chapter does not prevent any insurance company, health maintenance organization, or nonprofit health service corporation from issuing, delivering, or renewing, at its option, any policy or contract containing provisions similar to

those required by this chapter, where the policy or contract is not subject to such provisions.

SECTION 6. AMENDMENT. If Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, becomes effective, section 26.1-36-08 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-36-08. Group health policy and health service contract substance abuse coverage.

1. An insurance company ~~or~~, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy or health service contract on a group or blanket or franchise or association basis where more than fifty persons are covered or are to be covered by the policy or contract and where the number of persons covered or to be covered represents more than seventy percent of all persons eligible for the coverage unless the policy or contract provides benefits, of the same type offered under the policy or contract for other illnesses, for health services to any person covered under the policy or contract, for the diagnosis, evaluation, and treatment of alcoholism, drug addiction, or other related illness, in a hospital, as defined in subsection 25 of section 52-01-01 and the state department of health's rules pursuant thereto or as licensed under section 23-17.1-01 or in a regional human resource center licensed under section 50-06-05.2, offering treatment for the prevention or cure of alcoholism, drug addiction, or other related illness. For health services provided in regional human service centers, reimbursement rates must be reasonably similar to the charges for care provided by hospitals as defined in this section.

2. The benefits may be provided for inpatient treatment and treatment by partial hospitalization:

   a. In the case of benefits provided for inpatient treatment, the benefits must be provided for a minimum of seventy days of services covered under this section and section 26.1-36-09 in any calendar year.

   b. In the case of benefits provided for partial hospitalization, the benefits must be provided for a minimum of one hundred forty days of services covered under this section and section 26.1-36-09 in any calendar year.

   c. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is

equivalent to two days of treatment by partial hospitalization.

"Partial hospitalization" means that level and intensity of treatment that is greater than outpatient treatment, but less than inpatient treatment.

3. This section does not prevent any insurance company ~~or~~, nonprofit health service corporation, or health maintenance organization from issuing, delivering, or renewing, at its option, any policy or contract containing provisions similar to those required by this section, where the policy or contract is not subject to such provisions.

SECTION 7. AMENDMENT. If Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, becomes effective, section 26.1-36-09 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-36-09. Group health policy and health service contract mental ~~illness~~ disorder coverage.

1. An insurance company ~~or~~, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy or health service contract on a group or blanket or franchise or association basis where more than fifty persons are covered or are to be covered by the policy or contract and where the number of persons covered or to be covered represents more than seventy percent of all persons eligible for the coverage unless the policy or contract provides benefits, of the same type offered under the policy or contract for other illnesses, for health services to any person covered under the policy or contract, for the diagnosis, evaluation, and treatment of mental ~~illness~~ disorder and other related illness in a hospital, as defined in subsection 25 of section 52-01-01 and the state department of health's rules pursuant thereto or as licensed under section 23-17.1-01, offering treatment for the prevention or cure of mental ~~illness~~ disorder and other related illness.

2. The benefits may be provided for inpatient treatment and treatment by partial hospitalization:

   a. In the case of benefits provided for inpatient treatment, the benefits must be provided for a minimum of seventy days of services covered under this section and section 26.1-36-08 in any calendar year.

   b. In the case of benefits provided for partial hospitalization, the benefits must be provided for a minimum of one hundred forty days of services covered

under this section and section 26.1-36-08 in any calendar year.

c. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is equivalent to two days of treatment by partial hospitalization.

"Partial hospitalization" means that level and intensity of treatment that is greater than outpatient treatment, but less than inpatient treatment.

3. This section does not prevent any insurance company ~~or~~, nonprofit health service corporation, or health maintenance organization from issuing, delivering, or renewing, at its option, any policy or contract containing provisions similar to those required by this section, where the policy or contract is not subject to such provisions.

Approved March 27, 1985

CHAPTER 327

SENATE BILL NO. 2395
(Reiten)

HEALTH INSURANCE CLAIM FORM

AN ACT to create and enact a new section to chapter 26-06, or in the alternative to create and enact a new section to chapter 26.1-36 as created by Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, and a new subdivision to subsection 9 of section 26.1-04-03 of the North Dakota Century Code, relating to a standard health insurance claim form, claim payment time limits, and unfair insurance practices.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. If Senate Bill No. 2078 is not approved by the forty-ninth legislative assembly or does not become effective, a new section to chapter 26-06 of the North Dakota Century Code is hereby created and enacted to read as follows:

Standard health insurance proof of loss form - Claim payment time limits. The commissioner shall prescribe by rule a standard health insurance proof of loss and claim form to be supplied by every insurer and health service corporation upon request for use in filing proof of loss and a claim. After receipt of a health insurance proof of loss form, the insurer shall, within fifteen business days, pay the claim, deny the claim, or request additional information. Within fifteen business days of the receipt of additional information, the insurer or health service corporation shall pay or deny the claim.

SECTION 2. A new subdivision to subsection 9 of section 26.1-04-03 of the 1983 Supplement to the North Dakota Century Code is hereby created and enacted to read as follows:

Failure to use the standard health insurance proof of loss and claim form or failure to pay a health insurance claim as required by this Act.

SECTION 3. If Senate Bill No. 2078 is approved by the forty-ninth legislative assembly and becomes effective, a new section to chapter 26.1-36 of the North Dakota Century Code is hereby created and enacted to read as follows:

Standard health insurance proof of loss form - Claim payment time limits. The commissioner shall prescribe by rule a standard health insurance proof of loss and claim form to be supplied by every insurer and health service corporation upon request for use in filing proof of loss and a claim. After receipt of a health insurance proof of loss form, the insurer shall, within fifteen business days, pay the claim, deny the claim, or request additional information. Within fifteen business days of the receipt of additional information, the insurer shall pay or deny the claim.

Approved March 28, 1985

CHAPTER 328

HOUSE BILL NO. 1167
(Committee on Social Services and Veterans Affairs)
(At the request of the Department of Human Services)

JUVENILE ACCIDENT AND SICKNESS INSURANCE

AN ACT to amend and reenact section 26-03.1-13 of the North Dakota Century Code, or in the alternative to amend and reenact section 26.1-36-20 of the North Dakota Century Code as created by Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, relating to conditions for the continuation of a juvenile's accident and sickness insurance coverage.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, then section 26-03.1-13 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-03.1-13. Juvenile's insurance coverage to continue - Conditions. Insurance companies licensed within this state shall continue coverage of a juvenile insured under a policy of accident and sickness insurance while the legal custody of the juvenile has been given by a court, under chapter 27-20, to any ~~state~~ public institution or agency, to the same extent as the general public is covered as long as the juvenile meets all the other usual qualifications for insurability and continues to pay the policy premiums. Under no circumstances shall a juvenile's incarceration be a basis for cancellation of his or her policy of accident and sickness insurance.

SECTION 2. AMENDMENT. Section 26.1-36-20 of the North Dakota Century Code as created by Senate Bill No. 2078 as approved by the forty-ninth legislative assembly is hereby amended and reenacted to read as follows:

26.1-36-20. Juvenile's accident and health coverage to continue - Conditions. Insurance companies and nonprofit health service corporations licensed in this state shall continue coverage of a juvenile insured under an accident and health insurance policy or a health service contract while the legal custody of the juvenile has been given by a court, under chapter 27-20, to any ~~state~~ public institution or agency, to the same extent as the general public is covered as long as the juvenile meets all the other usual qualifications for insurability and continues to pay the policy or contract premiums. A juvenile's incarceration may not be a basis for cancellation of the juvenile's accident and health insurance policy or health service contract.

Approved March 14, 1985

CHAPTER 329

SENATE BILL NO. 2359
(Lips)

FIRE INSURANCE POLICIES

AN ACT to amend and reenact sections 26-18-07 and 26-18-08 of the North Dakota Century Code, or in the alternative to amend and reenact sections 26.1-39-04 and 26.1-39-05 of the North Dakota Century Code as created and enacted by Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, relating to the measure of indemnity on fire insurance policies, the payment of the face value of an insurance policy on a loss, to nonapplication to personal property, the right of insurer to replace property in lieu of a cash payment, and the right of an insurer to offer a special endorsement.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. If Senate Bill No. 2078 does not become effective section 26-18-07 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-18-07. Measure of indemnity on fire insurance policy. If there is no valuation in the policy, the measure of indemnity in an insurance against fire is the full amount stated in the policy. If there is a valuation in the policy, such valuation is conclusive between the parties thereto in the adjustment either of a partial or a total loss if the insured has some interest at risk and there is no fraud on his part. In the event of a partial loss, the insurer is liable only for such proportion of the amount insured by it as the loss bears to the value of the whole interest of the insured in the property insured. A valuation fraudulent in fact, however, entitles the insurer to rescind the contract. The provisions of this section shall not be construed as a revocation of any of the rights of insurers delineated in section 26-18-08.

SECTION 2. AMENDMENT. If Senate Bill No. 2078 does not become effective section 26-18-08 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-18-08. Face of policy to be paid in case of loss by fire of insured real property.

1. This section does not apply as to personal property or any interest therein.

2. Whenever any policy of insurance shall be written to insure any real property in this state against loss by fire and the insured property shall be wholly destroyed by fire without fraud on the part of the insured or his assigns, the stated amount of the insurance written in such policy shall be taken conclusively to be the true value of the property insured.

SECTION 3. AMENDMENT. Section 26.1-39-04 of the North Dakota Century Code as created by Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, is hereby amended and reenacted to read as follows:

26.1-39-04. Measure of indemnity on fire policy. If there is no valuation in the policy, the measure of indemnity in an insurance against fire is the full amount stated in the policy. If there is a valuation in the policy, the valuation is conclusive between the parties in the adjustment either of a partial or a total loss if the insured has some interest at risk and there is no fraud on the insured's part. In the event of a partial loss, the insurer is liable only for the proportion of the amount insured as the loss bears to the value of the whole interest of the insured in the property insured. A valuation fraudulent in fact, however, entitles the insurer to rescind the contract. The provisions of this section shall not be construed as a revocation of any of the rights of insurers delineated in section 26.1-39-05.

* **SECTION 4. AMENDMENT.** Section 26.1-39-05 of the North Dakota Century Code as created by Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, is hereby amended and reenacted to read as follows:

26.1-39-05. Face of fire policy to be paid in case of loss of fire.

1. This section does not apply as to personal property or any interest therein.

2. Whenever any insurance policy is written to insure any real property in this state against loss by fire and the insured property is wholly destroyed by fire without fraud on the part of the insured or the insured's assigns, the stated amount of the insurance written in the policy is the true value of the property insured.

Approved March 28, 1985

* NOTE: Section 26.1-39-05 was also amended by section 3 of House Bill No. 1245, chapter 330.

CHAPTER 330

HOUSE BILL NO. 1245
(Dorso)

FIRE INSURANCE AND ARSON INVESTIGATIONS

AN ACT to amend and reenact subsections 3 and 7 of section 18-01-05.1, and section 26-18-08 or in the alternative section 26.1-39-05 as created by Senate Bill No. 2078 as approved by the forty-ninth legislative assembly, of the North Dakota Century Code, relating to fire insurance and arson investigations; and to repeal section 26-05-08 or in the alternative section 26.1-31-07 as created by Senate Bill No. 2078 as approved by the forty-ninth legislative assembly, of the North Dakota Century Code, relating to double fire insurance coverage.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsections 3 and 7 of section 18-01-05.1 of the 1983 Supplement to the North Dakota Century Code are hereby amended and reenacted to read as follows:

3. When an insurance company has reason to believe that a fire loss in which it has an interest may be of other than accidental cause, then, for the purpose of having such fire loss investigated by the state fire marshal, or a law enforcement officer as defined by section 12.1-01-04, the company ~~may~~ shall, in writing, notify the state fire marshal or law enforcement officer and provide ~~him with~~ any or all material developed from the company's inquiry into the fire loss.

7. The state fire marshal, any law enforcement officer, and any insurance company that ~~receive~~ receives any information furnished pursuant to this section shall hold the information in confidence until such time as its release is required pursuant to a criminal or civil proceeding. The state fire marshal and any law enforcement officer shall testify, if requested, in any litigation in which the insurance company at interest is named as a party.

SECTION 2. AMENDMENT. If Senate Bill No. 2078 is not approved by the forty-ninth legislative assembly or does not become effective, section 26-18-08 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-18-08. Face of policy to be paid in case of loss by fire or lightning of insured real property. Whenever any policy of insurance ~~shall be~~ is written or renewed to insure any real property in this state, including structures owned by persons other than the insured, against loss by fire or lightning and the insured property ~~shall be~~ is completely destroyed by fire without fraud on the part of the insured or his assigns, the ~~stated~~ amount of the insurance written in ~~such~~ the policy shall be taken conclusively to be the true value of the property insured and the true amount of loss and measure of damages, subject to the following conditions:

1. If the fire loss occurred within ninety days after the policy was issued or within ninety days after the policy limits were increased by twenty-five percent or more at the insured's request, the loss payable to the insured for fire loss incurred during the first ninety days shall be the full value of the policy, or the actual cash value or replacement cost of the property, whichever is less. This subsection does not apply to unchanged renewal policies or policies with inflation adjustment limits.

2. Builder risk policies of insurance covering property in the process of being constructed must be valued and settled according to the actual value of that portion of construction completed at the time of the fire or lightning loss.

3. In case of double fire insurance, each insurer must contribute proportionally towards the loss without regard to the dates of the insurance policies.

* **SECTION 3. AMENDMENT.** If Senate Bill No. 2078 is approved by the forty-ninth legislative assembly and does become effective, section 26.1-39-05 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-39-05. Face of fire policy to be paid in case of loss by fire or lightning. Whenever any insurance policy is written or renewed to insure any real property in this state including structures owned by persons other than the insured, against loss by fire or lightning and the insured property is completely or partially destroyed by fire without fraud on the part of the insured or the insured's assigns, the ~~stated~~ amount of the insurance written in the policy is the true value of the property insured and the true amount of loss and measure of damages, subject to the following conditions:

1. If the fire loss occurred within ninety days after the policy was issued or within ninety days after the policy limits were increased by twenty-five percent or more at

* NOTE: Section 26.1-39-05 was also amended by section 4 of Senate Bill No. 2359, chapter 329.

the insured's request, the loss payable to the insured for fire loss incurred during the first ninety days shall be the full value of the policy, or the actual cash value or replacement cost of the property, whichever is less. This subsection does not apply to unchanged renewal policies or policies with inflation adjustment limits.

2. Builder risk policies of insurance covering property in the process of being constructed must be valued and settled according to the actual value of that portion of construction completed at the time of the fire or lightning loss.

3. In case of double fire insurance, each insurer must contribute proportionally toward the loss without regard to the dates of the insurance policies.

SECTION 4. REPEAL. If Senate Bill No. 2078 is not approved by the forty-ninth legislative assembly or does not become effective, section 26-05-08 of the North Dakota Century Code is hereby repealed. If Senate Bill No. 2078 is approved by the forty-ninth legislative assembly and becomes effective, section 26.1-31-07 of the North Dakota Century Code is hereby repealed.

Approved March 14, 1985

CHAPTER 331

SENATE BILL NO. 2426
(Reiten)

MEDICAL AND LEGAL LIABILITY INSURANCE

AN ACT to amend and reenact subsection 3 of section 26-02-47 and subsection 1 of section 26-02-54 of the North Dakota Century Code, or in the alternative to amend and reenact subsection 3 of section 26.1-39-10 and subsection 1 of section 26.1-39-16 of the North Dakota Century Code as created in Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, relating to declination, cancellation, and nonrenewal of medical and legal liability insurance coverage.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. If Senate Bill No. 2078 is not approved by the forty-ninth legislative assembly or does not become effective, subsection 3 of section 26-02-47 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

3. Legal liability of the named insured arising out of bodily injury to or death of any persons or damage to property, except bodily injury, death, or property damage arising out of business pursuits ~~or the rendering or failure to render professional services~~ other than professional legal or medical services.

SECTION 2. AMENDMENT. If Senate Bill No. 2078 is not approved by the forty-ninth legislative assembly or does not become effective, subsection 1 of section 26-02-54 of the 1983 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

1. No insurer shall fail to renew a policy unless a written notice of nonrenewal is mailed or delivered to the named insured, at the last known address of the named insured, at least thirty days prior to the expiration date of the policy, except that where the policy provides professional liability coverage for legal or medical services, the nonrenewal notice must be mailed or delivered at least ninety days prior to the policy expiration date. A

post-office department certificate of mailing to the named insured at his last known address shall be conclusive proof of mailing and receipt on the third calendar day after the mailing.

SECTION 3. AMENDMENT. If Senate Bill No. 2078 is approved by the forty-ninth legislative assembly and becomes effective, subsection 3 of section 26.1-39-10 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

3. Legal liability of the named insured arising out of bodily injury to or death of any persons or damage to property, except bodily injury, death, or property damage arising out of business pursuits ~~or the rendering or failure to render professional services~~ other than professional legal or medical services.

SECTION 4. AMENDMENT. If Senate Bill No. 2078 is approved by the forty-ninth legislative assembly and becomes effective, subsection 1 of section 26.1-39-16 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

1. No insurer may fail to renew a property insurance policy unless a written notice of nonrenewal is mailed or delivered to the named insured, at the last known address of the named insured, at least thirty days prior to the expiration date of the policy, except that where the policy provides professional liability coverage for legal and medical services, the nonrenewal notice must be mailed or delivered at least ninety days prior to the policy expiration date. A postal service certificate of mailing to the named insured at the insured's last known address is conclusive proof of mailing and receipt on the third calendar day after the mailing.

Approved March 29, 1985

CHAPTER 332

HOUSE BILL NO. 1528
(Timm, Koland)

NO-FAULT INSURANCE COVERAGE

AN ACT to amend and reenact subsections 2 and 18 of section 26-41-03 and section 26-41-06 of the North Dakota Century Code, or in the alternative to amend and reenact subsections 2 and 21 of section 26.1-41-01 and section 26.1-41-04 of the North Dakota Century Code as created by Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, relating to levels of no-fault insurance coverage and the definition of serious injury.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, subsections 2 and 18 of section 26-41-03 of the 1983 Supplement to the North Dakota Century Code are hereby amended and reenacted to read as follows:

2. "Basic no-fault benefits" means benefits for economic loss resulting from accidental bodily injury. The maximum amount of basic no-fault benefits payable for all economic loss incurred and resulting from accidental bodily injury to any one person as the result of any one accident shall not exceed ~~fifteen~~ thirty thousand dollars, regardless of the number of persons entitled to such benefits or the number of basic no-fault insurers obligated to pay such benefits. Basic no-fault benefits payable shall not exceed one hundred fifty dollars per week per person prorated for any lesser period for work loss or survivors income loss, or one thousand dollars for funeral, cremation, and burial expenses.

18. "Serious injury" means an accidental bodily injury which results in death, dismemberment, serious and permanent disfigurement or disability beyond sixty days, or medical expenses in excess of ~~one~~ two thousand five hundred dollars. An injured person who is furnished the services in subsection 7 ~~of this section~~ without charge or at less

than the average reasonable charge therefor in this state shall be deemed to have sustained a serious injury if the court determines that the fair and reasonable value of such services exceeds ~~one~~ two thousand five hundred dollars.

SECTION 2. AMENDMENT. If Senate Bill No. 2078 of the forty-ninth legislative assembly does not become effective, section 26-41-06 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-41-06. Optional excess no-fault benefits. Each basic no-fault insurer of the owner of a secured motor vehicle shall also make available optional excess no-fault benefits for excess economic loss commencing upon the exhaustion of basic no-fault benefits, up to a total of ~~forty~~ eighty thousand dollars in no-fault benefits for accidental bodily injury to any one person in any one accident. Nothing contained herein shall prevent any basic no-fault insurer from also offering benefits and limits other than those prescribed herein, nor shall this section be construed as preventing any basic no-fault insurer from incorporating in such optional excess no-fault coverage such terms, conditions, and exclusions as may be consistent with the premiums charged. The amounts payable under optional excess no-fault benefits may be duplicative of benefits received from any collateral sources or may be written in excess of such collateral source benefits, or may provide for reasonable waiting period, deductibles, or coinsurance provisions. The optional excess no-fault benefits of a basic no-fault insurer may provide that it be subrogated to the injured person's right of recovery against any responsible third party.

SECTION 3. AMENDMENT. If Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, becomes effective, subsections 2 and 21 of section 26.1-41-01 of the North Dakota Century Code are hereby amended and reenacted to read as follows:

2. "Basic no-fault benefits" means benefits for economic loss resulting from accidental bodily injury. The maximum amount of basic no-fault benefits payable for all economic loss incurred and resulting from accidental bodily injury to any one person as the result of any one accident may not exceed ~~fifteen~~ thirty thousand dollars, regardless of the number of persons entitled to the benefits or the number of basic no-fault insurers obligated to pay the benefits. Basic no-fault benefits payable may not exceed one hundred fifty dollars per week per person prorated for any lesser period for work loss or survivors' income loss, or one thousand dollars for funeral, cremation, and burial expenses.

21. "Serious injury" means an accidental bodily injury which results in death, dismemberment, serious and permanent disfigurement or disability beyond sixty days, or medical expenses in excess of ~~one~~ two thousand five hundred

dollars. An injured person who is furnished the services in subsection 9 without charge or at less than the average reasonable charge for the service in this state is deemed to have sustained a serious injury if a court determines that the fair and reasonable value of the service exceeds ~~one~~ two thousand five hundred dollars.

SECTION 4. AMENDMENT. If Senate Bill No. 2078, as approved by the forty-ninth legislative assembly, becomes effective, section 26.1-41-04 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-41-04. Optional excess no-fault benefits. Each basic no-fault insurer of the owner of a secured motor vehicle shall also make available optional excess no-fault benefits for excess economic loss commencing upon the exhaustion of basic no-fault benefits, up to a total of ~~forty~~ eighty thousand dollars in no-fault benefits for accidental bodily injury to any one person in any one accident. A basic no-fault insurer may also offer benefits and limits other than those prescribed in this section, and a basic no-fault insurer may incorporate in optional excess no-fault coverage the terms, conditions, and exclusions as may be consistent with the premiums charged. The amounts payable under optional excess no-fault benefits may be duplicative of benefits received from any collateral sources or may be written in excess of such collateral source benefits, or may provide for reasonable waiting period, deductibles, or coinsurance provisions. The optional excess no-fault benefits of a basic no-fault insurer may provide for subrogation to the injured person's right of recovery against any responsible third party.

Approved April 15, 1985