3901-1-54 Unfair property/casualty claims settlement practices.

(A) Authority

This rule is issued pursuant to the authority vested in the superintendent under sections 3901.19 - 3901.26 of the Revised Code.

(B) Purpose

The purpose of this rule is to set forth uniform minimum standards for the investigation and disposition of property and casualty claims arising under insurance contracts or certificates issued to residents of ohio. It is not intended to cover claims involving workers' compensation, or fidelity, suretyship, and boiler and machinery insurance. The provisions of this rule are intended to define procedures and practices which constitute unfair claims practices. Nothing in this rule shall be construed to create or imply a private cause of action for violation of this rule.

(C) Definitions

As used in this rule:

(1) "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;

(2) "Claim file" means any retrievable electronic file, paper file, combination of both, or any other media;

(3) "Claimant" means a first party claimant, a third party claimant.

(4) "Contract" means any insurance policy or document containing the terms of the agreement wherein one party, the insurer, assumes certain obligations including financial obligations that arise as a result of a loss sustained by another party, the insured, or to any other party that has rights under the agreement.

(5) "Days" means calendar days. However, when the last day of a time limit stated in this rule falls on a Saturday, Sunday, or holiday, the time limit is extended to the next immediate following day that is not a Saturday, Sunday, or holiday.

(6) "Department" means the ohio department of insurance

(7) "Documentation" includes, but is not limited to, all communications, transactions, notes, work papers, claim forms, bills and explanation of benefits forms pertaining to the claim;

(8) "First party claimant" means any individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by the policy or contract;

(9) "Insurer" shall be defined as set forth in division (D) of section 3901.32 of the Revised Code;

(10) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liability under an insurance contract which is in effect or alleged to be in effect;

(11) "Like kind and quality part" means a salvage motor vehicle part equal to or better than the replaced part that is acquired from a licensed salvage motor dealer.

(12) "Notification of claim" means any notification, under the terms of an insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

(13) "Person" shall be defined as set forth in section 3901.19 of the Revised Code;

(14) "Practice" means a type of activity or conduct engaged in by an insurer with such frequency as to constitute a customary procedure or policy routinely followed in the settlement of insurance claims. A single act is not a business practice. However, an act that is malicious, deliberate, conscious and knowing may be the basis for corrective action ordered only by the superintendent without a showing that the conduct is a practice.

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

(16) "Superintendent" means the superintendent of insurance;

(17) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any other individual,

corporation, association, partnership or legal entity;

(18) "Written communications" includes any correspondence, regardless of source or type, that is materially related to a claim;

(19) "Proof of loss" means a document from the claimant that provides sufficient information from which the insurer can determine the existence and the amount of the claim.

(D) File and record documentation

An insurer's claim files are subject to examination by the superintendent of insurance or by the superintendent's duly appointed designees. To aid in such examination:

(1) An insurer shall maintain claim data that is accessible and retrievable for examination. Such data shall include number, line of coverage, date of loss and date of payment or date of denial or date when claim is closed without payment. The data for closed claims shall be kept for no less than three years or until the completion of the next financial examination conducted by the state of domicile, whichever is greater. Data for claims where the claims payment is less than $1000, or for towing, labor, glass or rental reimbursement may be kept in summary form.

(2) An insurer must be able to reconstruct its activities in regard to any claim, by documentation appropriate for the type and size of the claim. If the claim is closed, the time period for retention is set forth in subsection (1) above.

(3) If an insurer does not maintain hard copy files, claim files shall be accessible and be capable of duplication to hard copy.

(E) Misrepresentation of policy provisions

(1) An insurer shall fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance contract under which a claim is presented.

(2) No agent shall willfully conceal from first party claimants benefits, coverages or other provisions of any insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(3) No insurer shall deny a claim based on the first party claimant's failure to make

available for inspection the property which is the subject of the claim unless there is documentation of breach of the policy provisions in the claim file.

(4) No insurer shall deny a claim based upon the failure of a first party claimant to give written notice of loss within a specified time limit unless the notice is required by a policy condition, or a first party claimant's failure to give written notice after being requested to do so by the insurer is so unreasonable as to constitute a breach of the claimant's duty to cooperate with the insurer.

(5) No insurer shall indicate to a first party claimant on a payment draft, check or in any accompanying letter that the payment is final or a release of any claim unless the policy limit has been paid or the first party claimant and the insurer have agreed to a compromise settlement regarding coverage and the amount payable under the insurance contract.

(6) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage that contains language purporting to release the insurer or its insured from total liability.

(F) Response to acknowledge receipt of pertinent communications

(1) Notification of a claim given to an agent of an insurer shall be notification to the insurer.

(2) An insurer shall acknowledge the receipt of a claim within ten days of receiving such notification. An insurer may satisfy this requirement by making payment within this ten day period. An insurer may also satisfy this requirement by providing necessary claim forms and complete instructions to the claimant.

(3) An insurer shall respond within ten days to any communication from a claimant, when that communication suggests a response is appropriate. In the event that a complaint has been filed by a claimant in any court, an insurer is not obligated to respond within this time period and any communication between the claimant and the insurer will be subject to the appropriate rule of procedure for the court in which the lawsuit was filed.

(4) An insurer shall, within twenty-one days of receipt of an inquiry from the department regarding a claim, furnish the department with a reasonable response to the inquiry, in duplicate.

(G) General standards for settlement of claims

(1) An insurer shall within twenty-one days of the receipt of properly executed proof(s) of loss decide whether to accept or deny such claim(s). If more time is needed to investigate the claim than the twenty-one days allow, the insurer shall notify the claimant within the twenty-one day period, and provide an explanation of the need for more time. If an extension of time is needed, the insurer has a continuing obligation to notify the claimant in writing, at least every forty-five days of the status of the investigation and the continued time for the investigation.

If the form and execution of a proof of loss is material to an insurer, the insurer shall immediately provide the claimant with the specific documents and specific instructions so the claimant can submit the claim. An insurer shall not otherwise deny a claim solely on the basis the proof of loss is not on the insurer's usual form.

If an insurer reasonably believes, based upon information obtained and documented within the claim file, that a claimant has fraudulently caused or contributed to the loss as represented by a properly executed and documented proof of loss, such information shall be presented to the fraud division of the department within sixty days of receipt of the proof of loss. Any person making such report shall be afforded such immunity and the information submitted will be confidential as provided by sections 3901.44 and 3999.31 of the Revised Code.

(2) No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The claim file of the insurer shall contain documentation of the denial in accordance with section (D) of this rule.

(3) Except as otherwise provided by policy provisions, an insurer shall settle first party claims upon request by the insured with no consideration given to whether the responsibility for payment should be assumed by others.

(4) No insurer shall require an insured to submit to a polygraph examination unless authorized under the applicable insurance contract.

(5) Notice shall be given to claimants at least sixty days, before the expiration of any statute of limitation or contractual limit, where the insurer has not been advised that the claimant is represented by legal counsel.

(6) An insurer shall tender payment to a first party claimant no later than ten days after acceptance of a claim if the amount of the claim is determined and is not in dispute, unless the settlement involves a structured settlement, action by a

probate court, or other extraordinary circumstances as documented in the claim file.

(7) If a claim involves a non-negligent party's property loss and multiple liability insurers, the multiple liability insurers shall adjust the property loss within a reasonable time and pay the non-negligent party's loss in equal shares. After payment, the multiple liability insurers may then pursue available remedies to resolve the question of responsibility for the non-negligent party's loss.

(8) If a claim involves multiple coverages under any policy, no insurer shall withhold payment under any such coverage when the payment is known, the payment is not in dispute, and the payment would extinguish the insurer's liability under that coverage. No insurer shall withhold such payment for the purpose of forcing settlement on all other coverage to effect a single payment.

(9) An insurer must document the application of comparative negligence to any claim settlement. Such information shall be fully disclosed to the claimant upon the claimant's written request. An insurer shall not use pattern settlements as set forth in division (P) of section 3901.21 of the Revised Code.

(10) An insurer shall not use settlement practices that result in compelling first party claimants to litigate by offering substantially less than the amounts claimed compared to the amount ultimately recovered in actions brought by such claimants.

(H) Standards for prompt, fair and equitable settlements of automobile insurance claims

(1) When partial losses will be settled on the basis of a written estimate prepared by or for an insurer, the insurer shall supply the claimant a copy of the estimate upon which the proposed settlement is based. If the claimant subsequently claims that necessary repairs will exceed the written estimate, the insurer shall pay the difference between the written estimate and a higher estimate obtained by the claimant or promptly provide the claimant with the name of at least one repair shop that will make the repairs for the amount of the written estimate. If the insurer provides the name of only one repair shop, it shall ensure that the repairs are performed in a workmanlike manner. The insurer shall maintain documentation of all communications with the claimant pursuant to this subdivision.

(2) If an insurer reduces a claim amount because of betterment, depreciation or comparative negligence, it shall maintain all information pertaining to the reduction in the claim file. Such deductions shall be itemized and specified on

the written estimate as to dollar amount and shall be appropriate for the amount of deductions.

(3) An insurer may reduce a claim amount because of betterment deductions only if the deductions reflect a measurable decrease in market value due to the poorer condition of, or prior damage to, the vehicle; or reflects the general overall condition of the vehicle, considering its age; or the wear and tear or rust, and/or; missing parts, limited to no more of a deduction than the replacement costs of part or parts.

(4) When partial losses will be settled on the basis of a written estimate prepared by or for an insurer, the estimate must clearly indicate the use of the parts in compliance with section 1345.81 of the Ohio Revised Code. When "like kind and quality" parts are expected to be used in the repair, the estimate shall clearly indicate the location of the licensed salvage dealer where the "like kind and quality" parts are to be obtained.

(5) An insurer which elects to repair and designates a specific repair shop for automobile repairs shall cause the damaged automobile to be restored to its condition prior to the loss. The insurer shall assess no additional cost against the claimant other than as stated in the policy, and the repairs should be effected within a reasonable period of time.

(6) In settlement of claimants' automobile total losses on the basis of actual cash value or replacement of the automobile with another vehicle of like kind and quality, an insurer which elects to offer a replacement automobile shall:

(a) Provide an automobile by the same manufacturer, of the same or newer year, of similar body style, with similar options and mileage as the claimant's vehicle and in as good or better overall condition than the first party automobile prior to loss;

(b) Ensure that the automobile is available for inspection within a reasonable distance of the claimant's residence;

(c) Pay all applicable taxes, license fees, and other fees incident to transfer of evidence of ownership of the automobile at no cost to claimant other than any deductible provided in the policy; and

(d) Document the offer of the replacement automobile and any rejection of the offer in the claim file.

(7) In settlement of claimants' automobile total losses on the basis of actual cash value or replacement of the automobile with another of like kind and quality, an insurer which elects to offer a cash settlement to claimant, shall base the offer upon the actual cost to purchase a comparable automobile less any applicable deductible amount contained in the policy, and/or deduction for betterment as contained in paragraph (H)(2) of this rule. The settlement value may be derived from:

(a) The average cost of two or more comparable automobiles in the local market area if comparable automobiles are or were available to consumers within the last ninety ~~thirty~~ days; or

(b) The average cost of two or more comparable automobiles in areas proximate to the local market area, including the closest in-state or out-of-state major metropolitan areas. If comparable automobiles are or were available to consumers within the last ninety ~~thirty~~ days when comparable automobiles are not available pursuant to subsection (a) of this rule; or

(c) The average of two or more quotations obtained by the insurer from two or more licensed dealers located within the local market area if comparable automobiles are not available pursuant to subsections (a) and (b) of this rule; or

(d) The cost as determined from a generally recognized used motor vehicle industry source such as: ~~Any source for determining statistically valid fair market values that~~:

(i) An electronic database if the pertinent portions of the valuation documents generated by the database are provided by the insurer to the claimant upon request; or~~Gives primary consideration to the values of vehicles in the local market area and may consider data outside the area~~;

(ii) ~~Has a database which produces values for at least eighty-five per cent of all makes and models for the last fifteen model years taking into account the values of all major options for such vehicles; and~~A guidebook that is generally available to the general public if the insurer identifies the guidebook used as the basis for the cost to the claimant upon request; and

(iii) ~~Produces fair market values based on current data available from~~

~~the area surrounding the location where the claimant's vehicle was principally garaged except that parameters, including but not limited to time and area, may be expanded to assure statistical validity~~.to which appropriate adjustments for condition, mileage and major options are made and documented in the claim file.

(e) Any method or source chosen as specified in subsection (d) above shall be used consistently over a period of time by the insurer.

~~(e)~~(f) If within thirty days of receipt by the claimant of a cash settlement for the total loss of an automobile, the claimant purchases a replacement automobile, the insurer shall reimburse the claimant for the applicable sales taxes incurred on account of the claimant's purchase of the automobile, but not to exceed the amount that would have been payable by the claimant for sales taxes on the purchase of an automobile with a market value equal to the amount of the cash settlement. If the claimant purchase an automobile with a market value less than the amount of the cash settlement, the insurer shall reimburse only the actual amount of the applicable sales taxes on the purchased automobile. If the claimant cannot substantiate such purchase and the payment of such sales taxes by submission to the insurer of appropriate documentation within thirty-three days after receipt of the cash settlement, the insurer shall not be required to reimburse the claimant for such sales taxes. In lieu of reimbursement, the insurer may pay directly the applicable sales taxes to the claimant at the time of the cash settlement.

An insurer that settles a total loss on a cash settlement basis must maintain in the claim file the documentation used to determine the loss. Such information shall be provided to the first party claimant upon request. An insurer shall notify the first party claimant of any rights to renegotiate the settlement if a comparable vehicle is not available for purchase within thirty-five days of receipt of the settlement.

When an insurer elects to offer a replacement vehicle available to the claimant, the insurer shall provide all the details where such vehicle is available including the vehicle identification number.

(8) An insurer shall not require a claimant to travel an unreasonable distance to inspect a replacement automobile, to obtain a repair estimate, nor to have the automobile repaired at a specific repair shop.

(9) An insurer shall provide notice to a claimant prior to termination of payment for automobile storage charges. The insurer shall document all actions taken pursuant to this subdivision in accordance with paragraph (D) of this rule.

(10) An insurer shall include the first party claimant's deductible, if any, in subrogation demands. The insurer shall share any subrogations recovery received on a proportionate basis with the first party claimant, unless the first party claimant's deductible has been paid in advance or recovered. The insurer shall not deduct expenses from this amount except that an outside attorney or collection agency retained to collect such recovery may be paid a pro rata share of his expenses for collecting this amount.

(I) Standards for prompt, fair and equitable settlement of claims under fire and extended coverage insurance policies

(1) If a fire and extended coverage insurance policy provides for the adjustment and settlement of first party losses based on replacement cost, the following shall apply:

(a) When a loss requires replacement of an item or part, any consequential physical damages incurred in making such repair or replacement not otherwise excluded by the policy, shall be included in the loss.

(b) When an interior or exterior loss requires replacement of an item and the replaced item does not match the quality, color or size of the item suffering the loss, the insurer shall replace as much of the item as to result in a reasonably comparable appearance.

(c) When an insurer settles a loss that results in the insured paying a portion of the repair or replacement as betterment, the insurer shall maintain documentation of the basis for computing the betterment charge, and the insured's agreement to such charge prior to incurring the expense of the repair or replacement.

(2) If a fire and extended coverage insurance policy provides for the adjustment and settlement of losses on an actual cash value basis the following shall apply:

(a) The insurer shall determine actual cash value by determining the replacement cost of property at the time of loss, including sales tax, less any depreciation. Upon the insured's request, the insurer shall provide documentation detailing all depreciation deductions.

(b) If the insured's interest is limited because his property has nominal or no economic value, or a value disproportionate to replacement cost less depreciation, the insurer is not required to comply with subsection (2)(a) of this rule regarding the determination of actual cash value.

However, the insurer shall provide upon the insured's request, a written explanation of the basis for limiting the amount of recovery along with the amount payable under the policy.

(J) Severability

If any provision of this rule or the application of this rule is held invalid, such invalidity shall not affect any other provision or application of the rule which can be given effect without the invalid provision or application and to this end, the provisions of this rule are declared to be severable.

(K) Applicability of rule 3901-1-07 of the Administrative Code

If any provisions of any section of this rule conflicts with any of the provisions contained in rule 3901-1-07 of the ohio regulations of the department of insurance, the provisions of this rule will apply.

(L) Imposition of fine

Pursuant to 3901.22 of the Revised Code and a consent agreement with the insurer, the superintendent may recover the cost of an investigation under this rule and/or a penalty from the insurer.

~~(M) Effective date~~

~~This regulation shall be effective September 1, 1993.~~

Effective:

R.C. 119.032 review dates: 12/31/2006

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Certification

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Date

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