INSURANCE

CHAPTER 242

HOUSE BILL NO. 1136

(Judiciary Committee)
(At the request of the Insurance Commissioner)

AN ACT to amend and reenact sections 26.1-01-07 and 26.1-01-08.1 of the North Dakota Century Code, relating to fees chargeable by the insurance commissioner.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[112] **SECTION 1. AMENDMENT.** Section 26.1-01-07 of the North Dakota Century Code is amended and reenacted 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, one hundred dollars and for renewal of certificate of authority, amendment to certificate of authority, or certified copy thereof, fifty 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, 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, 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.

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[112] Section 26.1-01-07 was also amended by section 1 of House Bill No. 1141, chapter 243, and section 1 of House Bill No. 1192, chapter 252.

9. For filing an annual statement, twenty-five dollars.

10. For filing the abstract of the annual statement of an insurance company for publication, thirty dollars.

11. For an official examination, the expenses of the examination at the rate adopted by the department. The rates must be reasonably related to the direct and indirect costs of the examination, including actual travel expenses, including hotel and other living expenses, compensation of the examiner and other persons making the examination, and necessary attendant administrative costs of the department directly related to the examination and must be paid by the examined insurer together with compensation upon presentation by the department to the insurer of a detailed account of the charges and expenses after a detailed statement has been filed by the examiner and approved by the department.

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, 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 must be paid to the testing service.

~~15.~~ 14. For issuing and each annual renewal of a surplus lines insurance producer's or insurance consultant's license, ten dollars.

~~16.~~ 15. For issuing an insurance producer's license, one hundred dollars.

~~17.~~ 16. For issuing a duplicate of any license or registration issued under this title, ten dollars.

~~18.~~ 17. For issuing and each annual renewal of a license to a resident agent for the attorney for a reciprocal exchange, ten dollars.

~~19.~~ 18. For filing of any miscellaneous documents or papers, including documents of admission and those filed annually upon license renewal, ten dollars each.

~~20.~~ 19. For a copy of any paper filed in the commissioner's office, twenty cents per folio.

~~21.~~ 20. For affixing the commissioner's official seal on a copy of any paper filed in the office and certifying the copy, ten dollars.

~~22.~~ 21. For each insurance company appointment and renewal of an appointment of an insurance producer, ten dollars.

~~23.~~ 22. For each company application for admission, five hundred dollars, except applications for admission for county mutual, fraternal benefit, and surplus lines companies must be one hundred dollars.

~~24.~~ 23. For issuing a license and each annual renewal of a license to an insurance premium finance company, one hundred dollars.

~~25.~~ 24. For examining or investigating an insurance premium finance company, the actual expense and per diem incurred; but the per diem charge may not exceed fifty dollars.

~~26.~~ 25. For issuing and each annual renewal of a license to an advisory organization, fifty 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, ~~16, 19, 20, and 21~~ 15, 18, 19, and 20.

However, the commissioner may, after public notice and hearing, increase the fees authorized by this section for any year if it is determined necessary to generate the revenue appropriated by the legislative assembly from the insurance regulatory trust fund to fund budgeted operations for the insurance department. The insurance commissioner may not implement a fee increase pursuant to this section to enhance or in any manner add funds to the legislative appropriation for the insurance department.

SECTION 2. AMENDMENT. Section 26.1-01-08.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-01-08.1. Electronic filings allowed.

1. Notwithstanding any other provision of this title, the commissioner may adopt rules that allow either an applicant or a licensee to file documents electronically with the commissioner or the commissioner's designee. The rules may contain procedures for the electronic filing of the following:

   a. Any document required as part of an application for a license under this title;

   b. Any document required to be filed by an applicant or licensee to maintain the license in good standing;

   c. Any fee required under this title; and

   d. Any other document required or permitted to be filed.

2. This section may not be interpreted to supersede any other provision of law that requires the electronic filing of a document or to require an applicant or licensee to make any other filing electronically. The commissioner or the commissioner's designee may charge a processing fee for electronic filing. A fee charged for the processing of an electronic filing is in addition to any other fee imposed for the filing. Processing fees charged for an electronic filing are limited to the lesser of twenty dollars per transaction or the actual cost of the electronic transaction

charged by the designee processing the filing. If the actual cost of processing an electronic filing exceeds twenty dollars per transaction the commissioner may adopt rules to increase an electronic processing fee not to exceed the actual cost charged by the designee.

Approved April 8, 2009
Filed April 9, 2009

CHAPTER 243

HOUSE BILL NO. 1141

(Industry, Business and Labor Committee)
(At the request of the Insurance Commissioner)

AN ACT to amend and reenact subsection 15 of section 26.1-01-07 of the North Dakota Century Code, relating to fees charged for issuing and renewing a surplus lines insurance producer's or insurance consultant's license.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[113] **SECTION 1. AMENDMENT.** Subsection 15 of section 26.1-01-07 of the North Dakota Century Code is amended and reenacted as follows:

15. For issuing ~~and~~ a surplus lines insurance producer's or insurance consultant's license, one hundred dollars. For each annual renewal of a surplus lines insurance producer's or insurance consultant's license, ~~ten~~ twenty-five dollars.

Approved March 19, 2009
Filed March 24, 2009

[113] Section 26.1-01-07 was also amended by section 1 of House Bill No. 1136, chapter 242, and section 1 of House Bill No. 1192, chapter 252.

CHAPTER 244

SENATE BILL NO. 2104

(Industry, Business and Labor Committee)
(At the request of the Insurance Commissioner)

AN ACT to create and enact a new subsection to section 26.1-04-03 of the North Dakota Century Code, relating to unfair compensation of insurance company employees.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new subsection to section 26.1-04-03 of the North Dakota Century Code is created and enacted as follows:

Unfair compensation. Basing the compensation, including performance bonuses or incentives, of claims employees or contracted claims personnel on the following:

a. The number of policies canceled.

b. The number of times coverage is denied.

c. Use of a quota limiting or restricting the number or volume of claims.

d. Use of an arbitrary quota or cap limiting or restricting the amount of claims payments without due consideration to the merits of the claim.

Approved March 19, 2009
Filed March 19, 2009

CHAPTER 245

SENATE BILL NO. 2181

(Senators Klein, Horne, Nodland)
(Representatives Kasper, Vigesaa)

AN ACT to amend and reenact subsection 1 of section 26.1-06.1-31 of the North Dakota Century Code, relating to contracts of reinsurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 1 of section 26.1-06.1-31 of the North Dakota Century Code is amended and reenacted as follows:

1. The amount recoverable by the liquidator from reinsurers may not be reduced as a result of the delinquency proceedings unless the reinsurance contract provides, in substance, that in the event of the insolvency of the ceding insurer, the reinsurance must be payable under one or more contracts reinsured by the assuming insurer on the basis of reported claims allowed by the liquidation court or proof of payment of the claim by a guaranty association without diminution because of the insolvency of the ceding insurer. The payments must be made directly to the ceding insurer or to the ceding insurer's domiciliary liquidator except if:

   a. The contract or other written agreement specifically provides another payee of such reinsurance in the event of the insolvency of the ceding insurer; or

   b. The assuming insurer, with the consent of the direct insured, has assumed such policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under the policies and in substitution for the obligations of the ceding insurer to such payees.

Approved April 8, 2009
Filed April 9, 2009

CHAPTER 246

SENATE BILL NO. 2214

(Senators J. Lee, Dever, Warner)
(Representatives N. Johnson, Kaldor, Weisz)

AN ACT to amend and reenact section 26.1-08-12 of the North Dakota Century Code, relating to comprehensive health association of North Dakota eligibility provisions.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-08-12 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-12. Eligibility.

1. The association must be open for enrollment by eligible individuals. Eligible individuals shall apply for enrollment in the association by submitting an application to the lead carrier. The application must~~:~~

   ~~a. Provide the name, address, and age of the applicant.~~

   ~~b. Provide the length of applicant's residence in this state.~~

   ~~c. Provide the name, address, and age of spouse and children, if any.~~

   ~~d. Provide a designation of coverage desired.~~

   ~~e. Be~~ be completed fully and accompanied by premium and evidence to prove eligibility.

2. Within thirty days of receipt of the application, the lead carrier shall either reject the application for failing to comply with the requirements of this section or forward the eligible individual a notice of acceptance and billing information.

3. At the option of the eligible individual, association coverage is effective:

   a. For an eligible individual applying under subsection 10 or 11, on the signature date of the application.

   b. For an eligible individual applying under subparagraph a of paragraph 1 of subdivision a of subsection 5 or under subparagraph a of paragraph 1 of subdivision c of subsection 5:

      (1) On the day following the date shown on the written evidence;

      (2) On the signature date of the application, if it is at least one day and less than one hundred eighty days following the date shown on the written evidence; or

(3) On any date after the signature date of the application if the date is at least one day and less than one hundred eighty days following the date shown on the written evidence.

c. For an eligible individual applying under subparagraph b or c of paragraph 1 of subdivision a of subsection 5 or under subparagraph b or c of paragraph 1 of subdivision c of subsection 5:

(1) On the signature date of the application; or

(2) On any date after the signature date of the application but less than one hundred eighty days following the date shown on the written evidence.

d. For an eligible individual applying under subparagraph d of paragraph 1 of subdivision a of subsection 5, on the date the lifetime maximum occurred if the application:

(1) Is submitted within ninety days after the date that lifetime maximum occurred; and

(2) Is accompanied with premium for coverage retroactive to the date that lifetime maximum occurred.

e. For an eligible individual applying under subdivision b or d of subsection 5:

(1) On the signature date of the application; or

(2) On any date after the signature date of the application, but less than sixty-four days following termination of previous coverage.

~~e.~~ f. For an eligible individual applying under subsection 6:

(1) On the signature date of the application; or

(2) On any date after the signature date of the application, but less than one hundred eighty days following the date shown on the written evidence from a medical professional.

4. An eligible individual may not purchase more than one policy from the association.

5. An individual may qualify to enroll in the association for benefit plan coverage as:

a. A traditional applicant:

(1) An individual who has been a resident of this state and continues to be a resident of the state who has received from at least one insurance carrier within one hundred eighty days of the date of application, one of the following:

(a) Written evidence of rejection or refusal to issue substantially similar insurance for health reasons by one insurer.

(b) Written evidence that a restrictive rider or a preexisting condition limitation, the effect of which is to reduce substantially, coverage from that received by an individual considered a standard risk, has been placed on the individual's policy.

(c) Written evidence that an insurer has offered to issue comparable insurance at a rate exceeding the association benefit rate.

(d) Written evidence that the applicant has reached the lifetime maximum coverage amount on the most recent health insurance coverage.

(2) Is not enrolled in health benefits with the state's medical assistance program.

b. A Health Insurance Portability and Accountability Act of 1996 applicant:

(1) An individual who meets the federally defined eligibility guidelines as follows:

(a) Has had eighteen months of qualifying previous coverage as defined in section 26.1-36.3-01~~, the most recent of which is covered under a group health plan, governmental plan, medicaid, or church plan~~;

(b) Has applied for coverage under this chapter within sixty-three days of the termination of the qualifying previous coverage;

(c) Is not eligible for coverage under medicare or a group health benefit plan as the term is defined in section 26.1-36.3-01;

(d) Does not have any other health insurance coverage;

(e) Has not had the most recent qualifying previous coverage described in subparagraph a terminated for nonpayment of premiums or fraud; and

(f) If offered under the option, has elected continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82], or under a similar state program, and that coverage has exhausted.

(2) Is and continues to be a resident of the state.

(3) Is not enrolled in health benefits with the state's medical assistance program.

c. An applicant age sixty-five and over or disabled:

(1) An individual who is eligible for medicare by reason of age or disability and has been a resident of this state and continues to be a resident of this state who has received from at least one insurance carrier within one hundred eighty days of the date of application, one of the following:

(a) Written evidence of rejection or refusal to issue substantially similar insurance for health reasons by one insurer.

(b) Written evidence that a restrictive rider or a preexisting condition limitation, the effect of which is to reduce substantially, coverage from that received by an individual considered a standard risk, has been placed on the individual's policy.

(c) Written evidence that an insurer has offered to issue comparable insurance at a rate exceeding the association benefit rate.

(2) Is not enrolled in health benefits with the state's medical assistance program.

d. A Trade Adjustment Assistance Reform Act of 2002 applicant:

(1) A trade adjustment assistance, pension benefit guarantee corporation individual applicant who:

(a) Has three or more months of qualifying previous health insurance coverage at the time of application;

(b) Has applied for coverage within sixty-three days of the termination of the individual's previous health insurance coverage;

(c) Is and continues to be a resident of the state;

(d) Is not enrolled in the state's medical assistance program;

(e) Is not imprisoned under federal, state, or local authority; and

(f) Does not have health insurance coverage through:

[1] The applicant's or spouse's employer if the coverage provides for employer contribution of fifty percent or more of the cost of coverage of the spouse, the eligible individual, and the dependents or the coverage is in lieu of an employer's cash or other benefit under a cafeteria plan.

[2] A state's children's health insurance program, as defined under section 50-29-01.

[3] A government plan.

[4] Chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care.

[5] Part A or part B of title XVIII of the federal Social Security Act [42 U.S.C. 1395 et seq.] relating to health insurance for the aged and disabled.

(2) Coverage under this subdivision may be provided to an individual who is eligible for health insurance coverage through the federal Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99-272; 100 Stat. 82]; a spouse's employer plan in which the employer contribution is less than fifty percent; or the individual marketplace, including continuation or guaranteed issue, but who elects to obtain coverage under this subdivision.

6. The board and lead carrier shall develop a list of medical or health conditions for which an individual must be eligible for association coverage without applying for health insurance coverage under subdivisions a and c of subsection 5. Individuals with written evidence of the existence or history of any medical or health conditions on the approved list may not be required to provide written evidence of rejection or refusal, a rate that exceeds the association rates, ~~or~~ substantially reduced coverage, or the lifetime maximum amount being reached.

7. A rejection or refusal by an insurer offering only stop-loss, excess of loss, or reinsurance coverage with respect to an applicant under subdivisions a and c of subsection ~~4~~ 5 is not sufficient evidence to qualify.

8. A traditional applicant, as specified under subdivision a of subsection 5, may have insurance coverage, other than the state's medical assistance program, with an additional commercial insurer; however, the association will reimburse eligible claim costs as payer of last resort.

9. An individual who is eligible for association coverage as specified under subdivision c of subsection 5 may not have more than one policy that is a supplement to part A or part B of medicare relating to health insurance for the aged and disabled. The individual may obtain association coverage as a traditional applicant as specified under subdivision a of subsection 5 which is concurrent with a supplement policy offered by a commercial carrier. However, the association will reimburse eligible claims as payer of last resort.

10. ~~Each resident dependent of an individual who is eligible for association coverage~~ If an individual is enrolled in association coverage, that individual's resident dependent is also eligible for association coverage.

11. ~~Each spouse of an individual who is eligible for association coverage with a preexisting maternity condition~~ If an individual is enrolled in association coverage, that individual's resident spouse is also eligible for association coverage.

12. A newly born child without health insurance coverage is covered through the mother's association benefit plan for the first thirty-one days following birth. Continued coverage through the association for the child will be provided if the association receives an application and the appropriate premium within thirty-one days following the birth. This coverage is not available to an applicant under subdivision c of subsection 5.

13. Preexisting conditions.

    a. Association coverage must exclude charges or expenses incurred during the first one hundred eighty days following the effective date of coverage for any condition for which medical advice, diagnosis, care, or treatment was recommended or received during the one hundred eighty days immediately preceding the signature date of the application.

    b. Association coverage must exclude charges or expenses incurred for maternity during the first two hundred seventy days following the effective date of coverage.

    c. Any individual with coverage through the association due to a catastrophic condition or major illness who is also pregnant at the time of application is eligible for maternity benefits after the first one hundred eighty days of coverage.

    d. A preexisting condition may not be imposed on an individual who is eligible under subparagraph d of paragraph 1 of subdivision a of subsection 5 or subdivision b or d of subsection 5.

14. Waiting periods do not apply ~~to an individual who~~:

    a. ~~Is receiving~~ To nonelective treatment or procedures for a congenital or genetic disease.

    b. ~~Has~~ To an individual who has obtained coverage as a federally eligible individual as defined in subdivision b of subsection 5.

    c. ~~Has~~ To an individual who has obtained coverage as an eligible person under subdivision a or c of subsection 5, allowing for a reduction in waiting period days by the aggregate period of qualifying previous coverage in the same manner as provided in subsection 3 of section 26.1-36.3-06 and provided the association application is made within sixty-three days of termination of the qualifying previous coverage.

    d. ~~Has~~ To an individual who has obtained coverage as an eligible individual under subdivision d of subsection 5.

e. To an individual who has obtained coverage as an eligible individual under subparagraph d of paragraph 1 of subdivision a of subsection 5.

15. An individual is not eligible for coverage through the association if:

a. The individual is enrolled in health benefits with the state's medical assistance program.

b. The individual has previously terminated association coverage unless twelve months have lapsed since such termination. This limitation does not apply to an applicant who is a federally defined eligible individual as defined under subparagraph d of paragraph 1 of subdivision a of subsection 5 or subdivision b of subsection 5.

c. The association has paid out one million dollars in benefits on behalf of the individual.

d. The individual is imprisoned under federal, state, or local authority. This limitation does not apply to an applicant who is a federally defined eligible individual as defined under subdivision b of subsection 5.

e. The individual's premiums are paid for or reimbursed under any government-sponsored program, government agency, health care provider, nonprofit charitable organization, or the individual's employer. However, this subdivision does not apply if the individual's premiums are paid for or reimbursed under a program established under the federal Trade Adjustment Assistance Reform Act of 2002 [Pub. L. 107-210; 116 Stat. 933].

16. A period of creditable coverage is not counted with respect to the enrollment of an individual who seeks coverage under this chapter if after such period and before the enrollment date, the individual experiences a significant break in coverage which is more than sixty-three days.

Approved April 8, 2009
Filed April 9, 2009

CHAPTER 247

SENATE BILL NO. 2318

(Senators Dever, Erbele, Heckaman, J. Lee)
(Representatives Kreidt, L. Meier)

AN ACT to create and enact section 26.1-18.1-03.1 of the North Dakota Century Code, relating to bond requirements for qualified programs of all-inclusive care for the elderly; and to amend and reenact section 26.1-18.1-01 of the North Dakota Century Code, relating to the regulation of qualified programs of all-inclusive care for the elderly.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-18.1-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-18.1-01. Definitions.

1. "Basic health care services" means the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory, and diagnostic and therapeutic radiological services.

2. "Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value, or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

3. "Carrier" means a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, or other entity responsible for the payment of benefits or provision of services under a group contract.

4. "Copayment" means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.

5. "Deductible" means the amount an enrollee is responsible to pay out of pocket before the health maintenance organization begins to pay the costs associated with treatment.

6. "Enrollee" means an individual who is covered by a health maintenance organization.

7. "Evidence of coverage" means a statement of the essential features and services of the health maintenance organization coverage which is given to the subscriber by the health maintenance organization or by the group contractholder.

8. "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee who is totally disabled on the date of termination.

9. "Grievance" means a written complaint submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee.

10. "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

11. "Group contractholder" means the person to which a group contract has been issued.

12. "Health maintenance organization" means any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both. However, a qualified program of all-inclusive care for the elderly is not a health maintenance organization.

13. "Health maintenance organization producer" means an insurance producer, as defined in section 26.1-26-02, who solicits, negotiates, effects, procures, delivers, renews, or continues a policy or contract for health maintenance organization membership, or who takes or transmits a membership fee or premium for such a policy or contract, other than for that person, or a person who advertises or otherwise holds out to the public as such.

14. "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber.

15. "Insolvent" or "insolvency" means that the organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.

16. "Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services.

17. "Net worth" means the excess of total admitted assets over total liabilities, but the liabilities do not include fully subordinated debt.

18. "Participating provider" means a provider as defined in subsection ~~20~~ 19 who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization.

19. ~~"Person" means any natural or artificial person including individuals, partnerships, associations, trusts, or corporations.~~

~~20.~~ "Provider" means any physician, hospital, or other person licensed or otherwise authorized to furnish health care services.

20. "Qualified program of all-inclusive care for the elderly" means a program that:

a. Is sponsored by a religious or charitable organization that is itself or is controlled by an entity organized under section 501(c)(3) of the Internal Revenue Code [26 U.S.C. 501(c)(3)];

b. Has been approved by the centers for medicare and medicaid services of the United States department of health and human services to operate, and is currently operating as, a program of all-inclusive care for the elderly; and

c. Has revenues from private pay sources which do not exceed ten percent of the program's total revenues.

21. "Replacement coverage" means the benefits provided by a succeeding carrier.

22. "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

23. "Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner.

SECTION 2. Section 26.1-18.1-03.1 of the North Dakota Century Code is created and enacted as follows:

26.1-18.1-03.1. Bond or insurance requirement. A qualified program of all-inclusive care for the elderly that operates in this state shall maintain a surety bond, in the amount of two hundred fifty thousand dollars. Any surety bond issued under this section must authorize recovery by the commissioner on behalf of any person in this state that sustained damages as the result of unfair practices, conviction of fraud, or failure by a qualified program of all-inclusive care for the elderly to perform a contractual obligation owed to the person.

Approved April 21, 2009
Filed April 22, 2009

CHAPTER 248

HOUSE BILL NO. 1294

(Representatives Wald, Monson)

AN ACT to create and enact section 26.1-21-24 of the North Dakota Century Code, relating to bond purchases by state agencies and political subdivisions; and to amend and reenact subsection 3 of section 26.1-01-07.1 and sections 26.1-21-07, 26.1-21-09, and 26.1-21-10 of the North Dakota Century Code, relating to the insurance regulatory trust fund and insurance provided to state agencies and political subdivisions under the state bonding fund.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 3 of section 26.1-01-07.1 of the North Dakota Century Code is amended and reenacted as follows:

3. Except as otherwise provided by law, ~~at~~ after the ~~end of each~~ fiscal year has been closed and all expenses relating to the fiscal year have been accounted for, the ~~state treasurer~~ office of management and budget shall transfer~~, after all fiscal year expenses have been paid,~~ any ~~cash~~ fund balance remaining in the insurance regulatory trust fund that exceeds one million dollars to the general fund.

[114] **SECTION 2. AMENDMENT.** Section 26.1-21-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-21-07. Coverage. The amount of coverage afforded to each state agency or political subdivision must be determined by the commissioner based upon the amount of money or property handled and the opportunity for defalcation. The coverage may be greater than but not less than the amount required by law or determined under law for a position. The coverage for a state legislative or judicial branch agency, however, may be determined by the legislative council or supreme court, respectively. Notwithstanding any other provision of law, the commissioner may issue bonds in such amounts as the commissioner determines necessary to carry out the purposes of the fund and, in determining the amount of coverage to be offered, the commissioner may consider the reserves necessary to pay the bonds and for all other necessary costs or expenses to carry out the purposes of the fund.

SECTION 3. AMENDMENT. Section 26.1-21-09 of the North Dakota Century Code is amended and reenacted as follows:

26.1-21-09. Premiums - Amount to whom paid - Minimum. The commissioner shall determine the premium for a blanket bond. Each state agency and political subdivision shall pay the premium in advance to the ~~state treasurer who shall keep~~ fund and the premiums collected must be kept in the fund. ~~The state treasurer shall issue receipts in triplicate. The treasurer shall file one of these receipts in the treasurer's office, shall mail one to the official making the payment,~~

[114] Section 26.1-21-07 was also amended by section 1 of Senate Bill No. 2300, chapter 249.

~~and shall mail one to the commissioner.~~ The minimum premium for each bond must be two dollars and fifty cents per public employee per year. Payments must be made for one year or for a longer term as prescribed by the commissioner. The premiums referred to in this section must be waived until the reserve fund of the state bonding fund has been depleted below the sum of two million dollars. The collection of premiums must be resumed on the bonds, at the rates provided under this section, whenever the reserve fund is depleted below the sum of two million dollars. The premiums must continue to be collected until the reserve fund reaches a total of three million dollars, at which time all premiums must again be waived until the reserve fund has been depleted below the sum of two million dollars.

SECTION 4. AMENDMENT. Section 26.1-21-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-21-10. Automatic insurance of state and political subdivisions.

1. Each state agency and each political subdivision shall apply to be bonded in the fund no less often than on a biennial basis or ~~if~~ when a change in coverage is requested, whichever occurs first. Unless an application is denied within sixty days from the date it is received by the commissioner, the application will be deemed approved and bond coverage in force. If a bond is in the discretion of the state agency or political subdivision and a bond is not requested, the state agency or political subdivision is exempt from this section.

2. The application must include a requested amount of bond coverage based on the amount of money and property handled and the opportunity for defalcation and any other condition imposed by law and list twenty-five percent of the money in control of the public officials or employees for which the bond is requested for the preceding year based on the total monthly balances. In addition, the application must include any information requested by the commissioner to determine the amount of money and property handled and the opportunity for defalcation, including the procedure used to determine the amount of bond requested, revenues for the last budget period by type, expenditures for the last budget period by type, the number of people that handle money, any portion of the last audit, and any financial procedures.

SECTION 5. Section 26.1-21-24 of the North Dakota Century Code is created and enacted as follows:

26.1-21-24. State agency or political subdivision may purchase bond in addition to fund bond. Nothing in this chapter prohibits a state agency or political subdivision from purchasing a bond issued by a duly authorized surety company in addition to the bond provided by the fund. A state agency or political subdivision that purchases an additional bond shall file evidence of that bond with the commissioner.

Approved April 8, 2009
Filed April 9, 2009

CHAPTER 249

SENATE BILL NO. 2300

(Senators Olafson, Anderson, Andrist)
(Representatives Belter, Headland, Kaldor)

AN ACT to amend and reenact section 26.1-21-07 of the North Dakota Century Code, relating to state bonding fund coverage.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[115] **SECTION 1. AMENDMENT.** Section 26.1-21-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-21-07. Coverage. The amount of coverage afforded to each state agency or political subdivision must be determined by the commissioner based upon the amount of money or property handled and the opportunity for defalcation but the amount must at least equal the amount of money or property actually handled or ten thousand dollars, whichever is less. The coverage may be greater than but not less than the amount required by law or determined under law for a position. The coverage for a state legislative or judicial branch agency, however, may be determined by the legislative council or supreme court, respectively.

Approved April 9, 2009
Filed April 13, 2009

[115] Section 26.1-21-07 was also amended by section 2 of House Bill No. 1294, chapter 248.

CHAPTER 250

SENATE BILL NO. 2144

(Political Subdivisions Committee)
(At the request of the State Auditor)

AN ACT to amend and reenact section 26.1-21-12 of the North Dakota Century Code, relating to claims against the bonding fund.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-21-12 of the North Dakota Century Code is amended and reenacted as follows:

26.1-21-12. Commissioner to notify state auditor of default of public employee or public official - Duty of state auditor. If any public employee or public official defaults or creates a liability against the fund, the commissioner shall notify the state auditor. The state auditor ~~immediately~~ shall investigate, or cause to be investigated, the accounts of the public employee or public official and file a report with the commissioner stating any amount due from the fund because of the default or wrongful act. For these services, the auditor or investigating firm must be paid out of the fund ~~the same fees as the auditor is paid for auditing the accounts of county officers~~ all reasonable costs incurred.

Approved March 19, 2009
Filed March 19, 2009

CHAPTER 251

SENATE BILL NO. 2109

(Industry, Business and Labor Committee)
(At the request of the Insurance Commissioner)

AN ACT to amend and reenact section 26.1-25.1-07 of the North Dakota Century Code, relating to insurance credit scores.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-25.1-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-25.1-07. Filing.

1. An insurer that uses insurance scores to underwrite or rate risks shall file the insurer's scoring models or other scoring processes with the insurance department. A third party may file scoring models on behalf of an insurer. A filing that includes insurance scoring must include loss experience justifying the use of credit information.

2. Any ~~filing relating to credit~~ scoring models, scoring processes, and information related to scoring models or processes filed by or on behalf of an insurer pursuant to subsection 1 is considered a trade secret ~~under chapter 47-25.1~~.

Approved April 8, 2009
Filed April 9, 2009

CHAPTER 252

HOUSE BILL NO. 1192

(Representative Wald)
(At the request of the Insurance Commissioner)

AN ACT to create and enact a new subsection to section 26.1-01-07 and a new section to chapter 26.1-26 of the North Dakota Century Code, relating to fees charged for insurance producer license continuation; to amend and reenact sections 26.1-26-20, 26.1-26-31, 26.1-26-31.1, and 26.1-26-50 of the North Dakota Century Code, relating to insurance producer continuing education requirements and penalties; to repeal sections 26.1-26-31.4 and 26.1-26-31.8 of the North Dakota Century Code, relating to insurance producer continuing education requirements; to provide a penalty; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[116] **SECTION 1.** A new subsection to section 26.1-01-07 of the North Dakota Century Code is created and enacted as follows:

For filing an individual insurance producer licensing continuation, twenty-five dollars.

SECTION 2. A new section to chapter 26.1-26 of the North Dakota Century Code is created and enacted as follows:

Biennial license continuation. A licensed individual insurance producer shall file a biennial license continuation in the form and manner prescribed by the commissioner and pay a fee of twenty-five dollars. The commissioner shall give a licensee not less than sixty days' notice of the biennial license continuation filing deadline.

SECTION 3. AMENDMENT. Section 26.1-26-20 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-20. Nonresident licensing.

1. Unless denied licensure pursuant to this chapter, the commissioner shall issue a nonresident person a nonresident insurance producer license if:

   a. The person is currently licensed as a resident and is in good standing in the person's home state;

   b. The person has submitted the proper request for licensure and has paid the fees required by section 26.1-01-07;

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[116] Section 26.1-01-07 was also amended by section 1 of House Bill No. 1136, chapter 242, and section 1 of House Bill No. 1141, chapter 243.

c. The person has submitted or transmitted to the commissioner either the person's home state application for licensure or a completed uniform application; and

d. The person's home state awards nonresident insurance producer licenses to residents of this state on the same basis.

2. The commissioner may verify the insurance producer's licensing status through the insurance producer data base maintained by the national association of insurance commissioners, its affiliates, or subsidiaries.

3. A nonresident insurance producer who moves from one state to another state or a resident insurance producer who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty days of the change of legal residence. A fee or license application is not required.

4. Notwithstanding any other provision of this chapter, a person licensed as a surplus lines insurance producer in the person's home state is entitled to receive a nonresident surplus lines insurance producer license pursuant to subsection 1. Except as to subsection 1, nothing in this section otherwise amends or supersedes any provision of chapter 26.1-44.

5. Notwithstanding any other provision of this chapter, a person licensed as a limited line credit insurance or other type of limited lines insurance producer in the person's home state is entitled to receive a nonresident insurance producer license, pursuant to subsection 1, granting the same scope of authority as granted under the license issued by the insurance producer's home state. For the purpose of this subsection, limited line insurance is any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to section 26.1-26-11.

~~6. A nonresident insurance producer shall pay a biennial continuation fee of twenty-five dollars.~~

SECTION 4. AMENDMENT. Section 26.1-26-31 of the North Dakota Century Code is amended and reenacted as follows:

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 business entity, 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 individual resident licensee fails to comply with continuing education requirements of this chapter;

6. The individual licensee fails to file the biennial continuation and pay the fee;

7. The surplus lines insurance producer has failed to maintain a resident or nonresident license as an insurance producer as required by section 26.1-26-17, or has failed to pay the annual renewal fee to the commissioner; or

~~6.~~ 8. The insurance consultant has failed to pay the annual renewal fee to the commissioner.

[117] **SECTION 5. AMENDMENT.** Section 26.1-26-31.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-31.1. Continuing education required - ~~Exceptions~~ Exception.

1. Except as otherwise provided in this chapter, any ~~person~~ individual licensed as ~~an~~ a resident insurance producer or resident insurance consultant shall provide the commissioner evidence, as required by the commissioner, that the ~~person~~ individual attended or participated in continuing education of not less than twenty-four hours of approved coursework, of which three hours must be in ethics. The commissioner may reduce or waive the minimum number of hours per year of approved coursework for any ~~person~~ individual having a license limited to a specific product type. Credit for courses attended in any one year over the minimum number of hours of coursework required, not to exceed twelve hours, 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~~ a two-year period ~~following licensure~~. The commissioner may provide a one-time extension of the two-year reporting requirement, not to exceed thirty-six months, if additional time is necessary in order to implement the transition to reporting continuing education by birth month. No continuing education is required of an insurance producer who is at least sixty-two years of age and who has a combined total years of continuous licensure as an insurance producer and years of age which equals eighty-five.

2. The commissioner shall by rule ~~divide the persons subject to this section into two equal segments for the purpose of reporting, as follows:~~

   ~~a. One-half of the persons shall file their report showing at least the minimum number of required hours of approved coursework for the previous two years within thirty days of January first of every odd-numbered year.~~

   ~~b. One-half of the persons shall file a report showing at least the minimum number of required hours of approved coursework for the previous two years within thirty days of January first of every even-numbered year.~~

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[117] Section 26.1-26-31.1 was also amended by section 1 of House Bill No. 1142, chapter 253.

~~3. All persons licensed after January 1, 1989, shall report within thirty days of the first day of January of the year following the second anniversary of the person's licensure~~ provide for reporting by birth month of compliance with the continuing education requirements of this section.

SECTION 6. AMENDMENT. Section 26.1-26-50 of the North Dakota Century Code is amended and reenacted as follows:

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~~ not to exceed ten thousand dollars for each violation. The fine may be collected and recovered in an action brought in the name of the state.

SECTION 7. REPEAL. Sections 26.1-26-31.4 and 26.1-26-31.8 of the North Dakota Century Code are repealed.

SECTION 8. EFFECTIVE DATE. This Act becomes effective on January 1, 2010.

Approved April 8, 2009
Filed April 9, 2009

CHAPTER 253

HOUSE BILL NO. 1142

(Industry, Business and Labor Committee)
(At the request of the Insurance Commissioner)

AN ACT to amend and reenact subsection 1 of section 26.1-26-31.1 of the North Dakota Century Code, relating to insurance producer continuing education requirements.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[118] **SECTION 1. AMENDMENT.** Subsection 1 of section 26.1-26-31.1 of the North Dakota Century Code is amended and reenacted as follows:

1. Except as otherwise provided in this chapter, any person licensed as an insurance producer or insurance consultant shall provide the commissioner evidence, as required by the commissioner, that the person attended or participated in continuing education of not less than twenty-four hours of approved coursework, of which three hours must be in ethics. The commissioner may reduce or waive the minimum number of hours per year of approved coursework for any person having a license limited to a specific product type. Credit for courses attended in any one year over the minimum number of hours of coursework required, not to exceed twelve hours, 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 two-year period following licensure. No continuing education is required of an insurance producer who, as of January 1, 2010, is at least sixty-two years of age and who has a combined total years of continuous licensure as an insurance producer and years of age which equals eighty-five.

Approved April 8, 2009
Filed April 9, 2009

[118] Section 26.1-26-31.1 was also amended by section 5 of House Bill No. 1192, chapter 252.

CHAPTER 254

HOUSE BILL NO. 1284

(Representatives Keiser, Wald)
(Senator Klein)

AN ACT to create and enact chapter 26.1-33.4 of the North Dakota Century Code, relating to the national conference of insurance legislators Life Settlements Model Act; to amend and reenact subsections 19 and 21 of section 10-04-02 of the North Dakota Century Code, relating to the definition of the terms viatical or life settlement contract and security; to repeal chapter 26.1-33.3 of the North Dakota Century Code, relating to viatical settlement contracts; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[119] **SECTION 1. AMENDMENT.** Subsections 19 and 21 of section 10-04-02 of the North Dakota Century Code are amended and reenacted as follows:

19. "Security" means any note; stock; treasury stock; bond; debenture; evidence of indebtedness; certificate of interest or participation in any profit-sharing agreement; certificate of interest or participation in an oil, gas, or mining title or lease or in payments out of production under such a title or lease; collateral trust certificate; preorganization certificate or subscription; transferable share; investment contract; viatical <u>or life</u> settlement contract or a fractionalized or pooled interest therein; program, contract, or other arrangement in which persons invest in a common enterprise the returns of which depend to any extent upon inducing other persons to participate or invest in the enterprise; investment of money or money's worth including goods furnished or services performed in the risk capital of a venture with the expectation of profit or some other form of benefit to the investor when the investor has no direct control over the investment or policy decisions of the venture; voting-trust certificate; certificate of deposit for a security; foreign currency commodity contract, as used in chapter 51-23; or beneficial interest in title to property, profits, or earnings; or, in general, any interest or instrument commonly known as a "security"; or any certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase, any of the foregoing.

21. "Viatical <u>or life</u> settlement contract" means an agreement for the purchase, sale, assignment, transfer, devise, or bequest of any portion of the death benefit or ownership of a life insurance policy or certificate, for consideration that is less than the expected death benefit of the life insurance policy or certificate. "Viatical <u>or life</u> settlement contract" does not include:

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[119] Section 10-04-02 was also amended by section 1 of House Bill No. 1100, chapter 107.

a. The assignment, transfer, sale, devise, or bequest of a death benefit, life insurance policy, or certificate of insurance by the ~~viator~~ owner to the ~~viatical~~ ~~settlement~~ provider pursuant to chapter ~~26.1-33.3~~ 26.1-33.4;

b. The assignment of a life insurance policy to a bank or depository institution; or

c. The exercise of accelerated benefits pursuant to the terms of a life insurance policy issued in accordance with the insurance laws of this state.

SECTION 2. Chapter 26.1-33.4 of the North Dakota Century Code is created and enacted as follows:

26.1-33.4-01. Definitions. As used in this chapter, unless the context requires otherwise:

1. "Advertisement" means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio; television; the internet; or similar communications media, including filmstrips, motion pictures, and videos; published, disseminated, circulated, or placed before the public, directly or indirectly, for the purpose of creating an interest in or inducing a person to purchase or sell, assign, devise, bequest, or transfer the death benefit or ownership of a life insurance policy or an interest in a life insurance policy pursuant to a life settlement contract.

2. "Broker" means an individual who, on behalf of an owner and for a fee, commission, or other valuable consideration, offers or attempts to negotiate life settlement contracts between an owner and providers. A broker represents only the owner and owes a fiduciary duty to the owner to act according to the owner's instructions, and in the best interest of the owner, notwithstanding the manner in which the broker is compensated. The term does not include an attorney, certified public accountant, or financial planner retained in the type of practice customarily performed in that individual's professional capacity to represent the owner whose compensation is not paid directly or indirectly by the provider or any other person, except the owner.

3. "Business of life settlements" includes an activity involved in offering to enter, soliciting, negotiating, procuring, effectuating, monitoring, or tracking of life settlement contracts.

4. "Chronically ill" means:

   a. Being unable to perform at least two activities of daily living, such as eating, toileting, transferring, bathing, dressing, or continence;

   b. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

   c. Having a level of disability similar to that described in subdivision a as determined by the United States secretary of health and human services.

5. "Financing entity" means an underwriter, a placement agent, a lender, a purchaser of securities, a purchaser of a policy or certificate from a provider, a credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a life settlement contract, but whose principal activity related to the transaction is providing funds to effect the life settlement contract or purchase of one or more policies, and who has an agreement in writing with one or more providers to finance the acquisition of life settlement contracts. The term does not include a nonaccredited investor or purchaser.

6. "Financing transaction" means a transaction in which a licensed provider obtains financing from a financing entity, including any secured or unsecured financing, any securitization transaction, or any securities offering which either is registered or exempt from registration under federal and state securities law.

7. "Fraudulent life settlement act" includes:

a. Any act or omission committed by any person that, knowingly and with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits or permits the person's employees or agents to engage in acts, including:

(1) Presenting, causing to be presented, or preparing with knowledge and belief that it will be presented to or by a provider, premium finance lender, broker, insurer, insurance producer, or any other person, false material information, or concealing material information, as part of, in support of, or concerning a fact material to one or more of the following:

(a) An application for the issuance of a life settlement contract or insurance policy;

(b) The underwriting of a life settlement contract or insurance policy;

(c) A claim for payment or benefit pursuant to a life settlement contract or insurance policy;

(d) Premiums paid on an insurance policy;

(e) Payments and changes in ownership or beneficiary made in accordance with the terms of a life settlement contract or insurance policy;

(f) The reinstatement or conversion of an insurance policy;

(g) In the solicitation, offer to enter, or effectuation of a life settlement contract or insurance policy;

(h) The issuance of written evidence of life settlement contracts or insurance;

(i) Any application for, the existence of, or any payments related to a loan secured directly or indirectly by any interest in a life insurance policy; or

(j) Enter into any practice or plan which involves stranger-originated life insurance;

(2) Failing to disclose to the insurer where the request for such disclosure has been asked for by the insurer that the prospective insured has undergone a life expectancy evaluation by any individual or entity other than the insurer or the insurer's authorized representatives in connection with the issuance of the policy.

(3) Employing any device, scheme, or artifice to defraud in the business of life settlements.

(4) In the solicitation, application, or issuance of a life insurance policy, employing any device, scheme, or artifice in violation of state insurable interest laws.

b. In the furtherance of a fraud or to prevent the detection of a fraud, any person commits or permits the person's employees or agents to:

(1) Remove, conceal, alter, destroy, or sequester from the commissioner the assets or records of a licensee or other person engaged in the business of life settlements;

(2) Misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person;

(3) Transact the business of life settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of life settlements;

(4) File with the commissioner or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise concealing information about a material fact from the commissioner;

(5) Engage in embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a provider, an insurer, an insured, an owner, an insurance, a policyowner, or any other person engaged in the business of life settlements or insurance;

(6) Knowingly and with intent to defraud, enter, broker, or otherwise deal in a life settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the owner or the owner's agent intended to defraud the policy's issuer;

(7) Attempt to commit, assist, aid, or abet in the commission of or conspiracy to commit the acts or omissions specified in this subsection; or

(8) Misrepresent the state of residence of an owner to be a state or jurisdiction that does not have a law substantially similar to this chapter for the purpose of evading or avoiding the provisions of this chapter.

8. "Insured" means the individual covered under the policy being considered for sale in a life settlement contract.

9. "Life expectancy" means the arithmetic mean of the number of months the insured under the life insurance policy to be settled can be expected to live as determined by a life expectancy company considering medical records and appropriate experiential data.

10. "Life insurance producer" means any person licensed in this state as a resident or nonresident insurance producer that has received qualification or authority for life insurance coverage or a life line of coverage pursuant to chapter 26.1-26.

11. "Life settlement contract" means a written agreement entered between a provider, or any affiliate of the provider, and an owner establishing the terms under which compensation or anything of value will be paid, which compensation or thing of value is less than the expected death benefit of the insurance policy or certificate, in return for the owner's present or future assignment, transfer, sale, devise, or bequest of the death benefit or ownership of any portion of an insurance policy or certificate of insurance for compensation; provided, however, that the minimum value for a life settlement contract must be greater than a cash surrender value or accelerated death benefit available at the time of an application for a life settlement contract. The term includes the transfer for compensation or value of ownership or beneficial interest in a trust or other entity that owns such policy if the trust or other entity was formed or availed of for the principal purpose of acquiring one or more life insurance contracts, which life insurance contract insures the life of an individual residing in this state.

a. "Life settlement contract" also includes:

(1) A written agreement for a loan or other lending transaction, secured primarily by an individual or group life insurance policy; or

(2) A premium finance loan made for a policy on or before the date of issuance of the policy when:

(a) The loan proceeds are not used solely to pay premiums for the policy and any costs or expenses incurred by the lender or the borrower in connection with the financing;

(b) The owner receives on the date of the premium finance loan a guarantee of the future life settlement value of the policy; or

(c) The owner agrees on the date of the premium finance loan to sell the policy or any portion of the policy's death benefit on any date following the issuance of the policy.

b. "Life settlement contract" does not include:

(1) A policy loan by a life insurance company pursuant to the terms of the life insurance policy or accelerated death benefits provisions contained in the life insurance policy, whether issued with the original policy or as a rider;

(2) A premium finance loan, as defined herein, or any loan made by a bank or other licensed financial institution, provided that neither default on such loan nor the transfer of the policy in connection with such default is pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this chapter;

(3) A collateral assignment of a life insurance policy by an owner;

(4) A loan made by a lender that does not violate chapter 26.1-20.1, provided the loan is not described in paragraph 1, and is not otherwise within the definition of life settlement contract;

(5) An agreement where all the parties:

(a) Are closely related to the insured by blood or law; or

(b) Have a lawful substantial economic interest in the continued life, health, and bodily safety of the individual insured, or are trusts established primarily for the benefit of such parties;

(6) Any designation, consent, or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee;

(7) A bona fide business succession planning arrangement:

(a) Between one or more shareholders in a corporation or between a corporation and one or more of the corporation's shareholders or one or more trusts established by the corporation's shareholders;

(b) Between one or more partners in a partnership or between a partnership and one or more of the partnership's partners or one or more trusts established by the partnership's partners; or

(c) Between one or more members in a limited liability company or between a limited liability company and one or more of the limited liability company's members

or one or more trusts established by the limited liability company's members;

(8) An agreement entered by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business; or

(9) Any other contract, transaction, or arrangement from the definition of life settlement contract that the commissioner determines is not of the type intended to be regulated by this chapter.

12. "Net death benefit" means the amount of the life insurance policy or certificate to be settled less any outstanding debt or lien.

13. "Owner" means the owner of a life insurance policy or a certificate holder under a group policy, with or without a terminal illness, who enters or seeks to enter a life settlement contract. For the purposes of this definition, an owner is not limited to an owner of a life insurance policy or a certificate holder under a group policy that insures the life of an individual with a terminal or chronic illness or condition except where specifically addressed. The term does not include:

a. Any provider or other licensee under this chapter;

b. A qualified institutional buyer as defined in rule 144A of the federal Securities Act of 1933, as amended [15 U.S.C. 77a et seq.];

c. A financing entity;

d. A special purpose entity; or

e. A related provider trust.

14. "Patient identifying information" means an insured's address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured.

15. "Policy" means an individual or group policy, group certificate, contract, or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state.

16. "Premium finance loan" means a loan made primarily for the purposes of making premium payments on a life insurance policy, which loan is secured by an interest in such life insurance policy.

17. "Provider" means a person, other than an owner, that enters or effectuates a life settlement contract with an owner. The term does not include:

a. Any bank, savings bank, savings and loan association, or credit union;

b. A licensed lending institution, creditor, or secured party pursuant to a premium finance loan agreement which takes an assignment of a life insurance policy or certificate issued pursuant to a group life insurance policy as collateral for a loan;

c. The insurer of a life insurance policy or rider to the extent of providing accelerated death benefits or riders or cash surrender value;

d. Any individual who enters or effectuates no more than one agreement in a calendar year for the transfer of a life insurance policy or certificate issued pursuant to a group life insurance policy, for compensation or anything of value less than the expected death benefit payable under the policy;

e. A purchaser;

f. Any authorized or eligible insurer that provides stop-loss coverage to a provider, purchaser, financing entity, special purpose entity, or related provider trust;

g. A financing entity;

h. A special purpose entity;

i. A related provider trust;

j. A broker; or

k. An accredited investor or qualified institutional buyer as defined respectively in regulation D, rule 501 or rule 144A of the federal Securities Act of 1933, as amended [15 U.S.C. 77a et seq.], that purchases a life settlement policy from a provider.

18. "Purchased policy" means a policy or group certificate that has been acquired by a provider pursuant to a life settlement contract.

19. "Purchaser" means a person that pays compensation or anything of value as consideration for a beneficial interest in a trust which is vested with, or for the assignment, transfer, or sale of, an ownership or other interest in a life insurance policy or a certificate issued pursuant to a group life insurance policy which has been the subject of a life settlement contract.

20. "Related provider trust" means a titling trust or other trust established by a licensed provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. In order to qualify as a related provider trust, the trust must have a written agreement with the licensed provider under which the licensed provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files relating to life settlement transactions available to the insurance department as if those records and files were maintained directly by the licensed provider.

21. "Settled policy" means a life insurance policy or certificate that has been acquired by a provider pursuant to a life settlement contract.

22. "Special purpose entity" means an organization formed solely to provide either directly or indirectly access to institutional capital markets for a financing entity or provider; or in connection with a transaction in which the securities in the special purpose entity are acquired by the owner or by a "qualified institutional buyer" as defined in rule 144 promulgated under the federal Securities Act of 1933, as amended [15 U.S.C. 77a et seq.]; or the securities pay a fixed rate of return commensurate with established a set-backed institutional capital markets.

23. "Stranger-originated life insurance" is a practice or plan to initiate a life insurance policy for the benefit of a third-party investor that at the time of policy origination has no insurable interest in the insured. Stranger-originated life insurance practices include cases in which life insurance is purchased with resources or guarantees from or through a person that at the time of policy inception could not lawfully initiate the policy on its own, and where at the time of inception there is an arrangement or agreement, whether verbal or written, to directly or indirectly transfer the ownership of the policy or the policy benefits or both to a third party. Trusts that are created to give the appearance of insurable interest, and are used to initiate policies for investors, violate insurable interest laws and the prohibition against wagering on life. Stranger-originated life insurance arrangements do not include those practices set forth in subdivision b of subsection 11.

24. "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death in twenty-four months or less.

26.1-33.4-02. Licensing and bonding requirements.

1. A person, wherever located, may not act as a provider or broker with an owner or multiple owners who is a resident of this state without first having obtained a license from the commissioner. If there is more than one owner on a single policy and the owners are residents of different states, the life settlement contract must be governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one owner agreed upon in writing by all owners.

2. Application for a provider or broker license must be made to the commissioner by the applicant on a form prescribed by the commissioner, and the application must be accompanied by a fee in an amount established by the commissioner; provided, however, that the license and renewal fees for a provider license must be reasonable and that the license and renewal fees for a broker license may not exceed those established for an insurance producer, as such fees are otherwise provided for in this title.

3. A life insurance producer who has been duly licensed as a resident insurance producer with a life line of authority in this state or the producer's home state for at least one year and is licensed as a nonresident producer in this state is deemed to meet the licensing requirements of this section and must be permitted to operate as a broker.

4. Not later than thirty days from the first day of operating as a broker, the life insurance producer shall notify the commissioner that the broker is acting as a broker on a form prescribed by the commissioner, and shall pay any applicable fee to be determined by the commissioner. Notification must include an acknowledgement by the life insurance producer that the broker will operate as a broker in accordance with this chapter.

5. The insurer that issued the policy that is the subject of a life settlement contract may not be responsible for any act or omission of a broker, provider, or purchaser arising out of or in connection with the life settlement transaction, unless the insurer receives compensation for the placement of a life settlement contract from the provider, purchaser, or broker in connection with the life settlement contract.

6. An individual licensed as an attorney, certified public accountant, or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the owner, whose compensation is not paid directly or indirectly by the provider or purchaser, may negotiate life settlement contracts on behalf of the owner without having to obtain a license as a broker.

7. Licenses may be renewed annually on the anniversary date upon payment of the periodic renewal fee. As specified in subsection 2, the renewal fee for a provider may not exceed a reasonable fee. Failure to pay the fee within the terms prescribed results in the automatic revocation of the license requiring periodic renewal.

8. The term of provider license must be equal to that of a domestic stock life insurance company and the term of a broker license must be equal to that of an insurance producer license. Licenses requiring periodic renewal may be renewed on their anniversary date upon payment of the periodic renewal fee as specified in subsection 2. Failure to pay the fees before the expiration of the renewal date results in expiration of the license.

9. The applicant shall provide such information as the commissioner may require on forms prepared by the commissioner. The commissioner, at any time, may require the applicant to fully disclose the identity of the applicant's stockholders (except stockholders owning fewer than ten percent of the shares of an applicant whose shares are publicly traded), partners, officers, and employees, and the commissioner may refuse to issue the license in the name of any person if not satisfied that any officer, employee, stockholder, or partner thereof who may materially influence the applicant's conduct meets the standards of this chapter.

10. A license issued to a partnership, corporation, or other entity authorizes all members, officers, and designated employees to act as a licensee under the license, if those individuals are named in the application and any supplements to the application.

11. Upon the filing of an application and the payment of the license fee, the commissioner shall make an investigation of each applicant and may issue a license if the commissioner finds that the applicant:

    a. If a provider, has provided a detailed plan of operation;

b. Is competent and trustworthy and intends to transact the applicant's business in good faith;

c. Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied;

d. If the applicant is a legal entity, is formed or organized pursuant to the laws of this state, or is a foreign legal entity authorized to transact business in this state, or provides a certificate of good standing from the state of its domicile;

e. Has provided to the commissioner an antifraud plan that meets the requirements of section 26.1-33.4-12 and includes:

(1) A description of the procedures for detecting and investigating possible fraudulent acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(2) A description of the procedures for reporting fraudulent insurance acts to the commissioner;

(3) A description of the plan for antifraud education and training of the applicant's underwriters and other personnel; and

(4) A written description or chart outlining the arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts and investigating unresolved material inconsistencies between medical records and insurance applications; and

f. If a provider or broker, has demonstrated evidence of financial responsibility in a format prescribed by the commissioner through a surety bond executed and issued by an insurer authorized to issue surety bonds in this state or through a deposit of cash, certificates of deposit, or securities or any combination thereof in the amount of one hundred fifty thousand dollars. The commissioner shall accept, as evidence of financial responsibility under this subdivision, proof that financial instruments in accordance with the requirements in this subdivision have been filed with one or more states in which the applicant is licensed as a provider or broker. The commissioner may ask for evidence of financial responsibility at any time the commissioner determines necessary. Any surety bond issued pursuant to this subdivision must specifically authorize recovery by the commissioner on behalf of any person in this state which sustained damages as the result of erroneous acts, failure to act, conviction of fraud, or conviction of unfair practices by the provider or broker.

12. The commissioner may not issue any license to any nonresident applicant unless a written designation of an agent for service of process is filed and maintained with the commissioner or unless the applicant has filed with the commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the commissioner.

13. Each licensee shall file with the commissioner before March first of each year an annual statement containing such information as the commissioner by rule may prescribe.

14. A provider may not use any person to perform the functions of a broker, as provided under this chapter, unless the person holds a current, valid license as a broker, and as provided in this section.

15. A broker may not use any person to perform the functions of a provider as defined in this chapter unless such person holds a current, valid license as a provider and as provided in this section.

16. A provider or broker shall provide to the commissioner new or revised information about officers, ten percent or more stockholders, partners, directors, members, or designated employees within thirty days of the change.

17. An individual licensed as a broker shall complete on a biennial basis fifteen hours of training related to life settlements and life settlement transactions as required by the commissioner; provided, however, that a life insurance producer who is operating as a broker pursuant to this section is not subject to the requirements of this subsection. Any person failing to meet the requirements of this subsection shall be subject to the penalties imposed by the commissioner.

26.1-33.4-03. License suspension, revocation, or refusal to renew.

1. The commissioner may suspend, revoke, or refuse to renew the license of any licensee if the commissioner finds that:

   a. There was any material misrepresentation in the application for the license;

   b. The licensee or any officer, partner, member, or director has been guilty of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent to act as a licensee;

   c. The provider demonstrates a pattern of unreasonably withholding payments to policyowners;

   d. The licensee no longer meets the requirements for initial licensure;

   e. The licensee or any officer, partner, member, or director has been convicted of a felony or of any misdemeanor of which criminal fraud is an element; or the licensee has pleaded guilty or nolo contendere with respect to any felony or any misdemeanor of which criminal fraud or moral turpitude is an element, regardless whether a judgment of conviction has been entered by the court;

   f. The provider has entered any life settlement contract that has not been approved pursuant to this chapter;

   g. The provider has failed to honor contractual obligations set out in a life settlement contract;

h. The provider has assigned, transferred, or pledged a settled policy to a person other than a provider licensed in this state, a purchaser, an accredited investor or qualified institutional buyer as defined respectively in regulation D, rule 501 or rule 144A of the federal Securities Act of 1933, as amended [15 U.S.C. 77a et seq.], financing entity, special purpose entity, or related provider trust; or

i. The licensee or any officer, partner, member, or key management personnel has violated any of the provisions of this chapter.

2. The commissioner may suspend, revoke, or refuse to renew the license of a broker if the commissioner finds that the broker has violated this chapter or has otherwise engaged in bad-faith conduct with one or more owners.

3. Before the commissioner denies a license application or suspends, revokes, or refuses to renew the license of any licensee under this chapter, the commissioner shall conduct a hearing.

26.1-33.4-04. Contract requirements.

1. A person may not use any form of life settlement contract in this state unless the contract has been filed with and approved, if required, by the commissioner in a manner that conforms with the filing procedures and any time restrictions or deeming provisions, if any, for life insurance forms, policies, and contracts.

2. An insurer may not require, as a condition of responding to a request for verification of coverage or in connection with the transfer of a policy pursuant to a life settlement contract, that the owner, insured, provider, or broker sign any form, disclosure, consent, waiver, or acknowledgment that has not been expressly approved by the commissioner for use in connection with life settlement contracts in this state.

3. A person may not use a life settlement contract form or provide to an owner a disclosure statement form in this state unless first filed with and approved by the commissioner. The commissioner shall disapprove a life settlement contract form or disclosure statement form if, in the commissioner's opinion, the contract or provisions contained therein fail to meet the requirements of sections 26.1-33.4-07, 26.1-33.4-08, and 26.1-33.4-10 and subsection 2 of section 26.1-33.4-14 or are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the owner. The commissioner may require the submission of advertising material.

26.1-33.4-05. Reporting requirements and privacy.

1. For any policy settled within five years of policy issuance, each provider shall file with the commissioner before March first of each year an annual statement containing such information as the commissioner may prescribe by regulation. In addition to any other requirements, the annual statement must specify the total number, aggregate face amount, and life settlement proceeds of policies settled during the immediately preceding calendar year, together with a breakdown of the information by policy issue year. The annual statement also must

include the names of the insurance companies whose policies have been settled and the brokers that have settled said policies.

a. Such information must be limited to only those transactions where the insured is a resident of this state and may not include individual transaction data regarding the business of life settlements or information that there is a reasonable basis to believe could be used to identify the owner or the insured.

b. Every provider that willfully fails to file an annual statement as required in this section, or willfully fails to reply within thirty days to a written inquiry by the commissioner in connection therewith, shall, in addition to other penalties provided by this chapter, be subject, upon due notice and opportunity to be heard, to a penalty of up to two hundred fifty dollars per day of delay, not to exceed twenty-five thousand dollars in the aggregate, for each such failure.

2. Except as otherwise allowed or required by law, a provider, broker, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, may not disclose the identity of an insured or information that there is a reasonable basis to believe could be used to identify the insured or the insured's financial or medical information to any other person unless the disclosure:

a. Is necessary to effect a life settlement contract between the owner and a provider and the owner and insured have provided prior written consent to the disclosure;

b. Is necessary to effectuate the sale of life settlement contracts, or interests therein, as investments, provided the sale is conducted in accordance with applicable state and federal securities law, and provided further that the owner and the insured have both provided prior written consent to the disclosure;

c. Is provided in response to an investigation or examination by the commissioner or any other governmental officer or agency or pursuant to the requirements of section 26.1-33.4-12;

d. Is a term or condition to the transfer of a policy by one provider to another provider, in which case the receiving provider shall comply with the confidentiality requirements of subsection 2 of section 26.1-33.4-05;

e. Is necessary to allow the provider or broker or its authorized representative to make contacts for the purpose of determining health status. For the purposes of this section, the term "authorized representative" does not include any person that has or may have any financial interest in the settlement contract other than a provider, licensed broker, financing entity, related provider trust, or special purpose entity; further, a provider or broker shall require its authorized representative to agree in writing to adhere to the privacy provisions of this chapter; or

f. Is required to purchase stop-loss coverage.

3. Nonpublic personal information solicited or obtained in connection with a proposed or actual life settlement contract is subject to the provisions applicable to financial institutions under the federal Gramm-Leach-Bliley Act [Pub. L. 106-102] and all other state and federal laws relating to confidentiality of nonpublic personal information.

26.1-33.4-06. Examination.

1. The commissioner, when the commissioner deems it reasonably necessary to protect the interests of the public, may examine the business and affairs of any licensee or applicant for a license. The commissioner may order any licensee or applicant to produce any records, books, files, or other information reasonably necessary to ascertain whether such licensee or applicant is acting or has acted in violation of the law or otherwise contrary to the interests of the public. The expenses incurred in conducting any examination must be paid by the licensee or applicant.

2. In lieu of an examination under this chapter of any foreign or alien licensee licensed in this state, the commissioner may, at the commissioner's discretion, accept an examination report on the licensee as prepared by the commissioner for the licensee's state of domicile or port-of-entry state.

3. Names of and individual identification data for all owners and insureds must be considered private and confidential information and may not be disclosed by the commissioner unless required by law.

4. Records of all consummated transactions and life settlement contracts must be maintained by the provider for three years after the death of the insured and must be available to the commissioner for inspection during reasonable business hours.

5. a. Upon determining that an examination should be conducted, the commissioner shall issue an examination warrant appointing one or more examiners to perform the examination and instructing the examiners as to the scope of the examination. In conducting the examination, the examiner shall use methods common to the examination of any life settlement licensee and should use those guidelines and procedures set forth in an examiners' handbook adopted by a national organization.

   b. Every licensee or person from whom information is sought, its officers, directors, and agents shall provide to the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets, and computer or other recordings relating to the property, assets, business, and affairs of the licensee being examined. The officers, directors, employees, and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the commissioner is grounds for suspension or refusal of, or nonrenewal of any license or authority held by the licensee to engage in the life settlement business or other business subject to the commissioner's

jurisdiction. Any proceedings for suspension, revocation, or refusal of any license or authority must be conducted pursuant to section 26.1-01-03.1.

c. The commissioner may issue subpoenas, administer oaths, and examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence.

d. When making an examination under this chapter, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the reasonable cost of which must be borne by the licensee that is the subject of the examination.

e. This chapter does not limit the commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination are prima facie evidence in any legal or regulatory action.

f. This chapter does not limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or licensee workpapers, or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the commissioner determines appropriate.

6. a. Examination reports must be composed of only facts appearing upon the books, from the testimony of its officers or agents, or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

b. No later than sixty days following completion of the examination, the examiner in charge shall file with the commissioner a verified written report of examination under oath. Upon receipt of the verified report, the commissioner shall transmit the report to the licensee examined, together with a notice that shall afford the licensee examined a reasonable opportunity of not more than thirty days to make a written submission or rebuttal with respect to any matters contained in the examination report and which shall become part of the report or to request a hearing on any matter in dispute.

c. If the commissioner determines that regulatory action is appropriate as a result of an examination, the commissioner may initiate any proceedings or actions provided by law.

7. a. Names and individual identification data for all owners, purchasers, and insureds must be considered private and confidential

information and may not be disclosed by the commissioner, unless the disclosure is to another regulator, is required under law, or is allowed under section 26.1-03-19.4.

b. Except as otherwise provided in this chapter, all examination reports, working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the commissioner or any other person in the course of an examination made under this chapter, or in the course of analysis or investigation by the commissioner of the financial condition or market conduct of a licensee must be confidential by law and privileged, is not subject to the state's open records laws, is not subject to subpoena, and is not subject to discovery or admissible in evidence in any private civil action. The commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties. The licensee being examined may have access to all documents used to make the report.

8. a. An examiner may not be appointed by the commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this chapter. This section may not be construed to automatically preclude an examiner from being:

(1) An owner;

(2) An insured in a life settlement contract or insurance policy; or

(3) A beneficiary in an insurance policy that is proposed for a life settlement contract.

b. Notwithstanding the requirements of this subsection, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under this chapter.

9. a. No cause of action arises nor may any liability be imposed against the commissioner, the commissioner's authorized representatives, or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out this chapter.

b. No cause of action arises, nor may any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this chapter, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This subdivision does not abrogate or modify in any way

any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subdivision a.

c. A person identified in subdivision a or b is entitled to an award of attorney's fees and costs if the person is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this chapter and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

10. The commissioner may investigate suspected fraudulent life settlement acts and persons engaged in the business of life settlements.

11. The commissioner may charge for examinations as provided for under section 26.1-01-07.

26.1-33.4-07. Advertising.

1. A broker or provider licensed pursuant to this chapter may conduct or participate in advertisements within this state. Advertisements must comply with all advertising and marketing laws or rules adopted by the commissioner which are applicable to life insurers or to brokers and providers licensed pursuant to this chapter.

2. Advertisements must be accurate and truthful, and may not be misleading in fact or by implication.

3. A person or trust may not:

a. Directly or indirectly, market, advertise, solicit, or otherwise promote the purchase of a policy for the sole purpose of or with an emphasis on settling the policy; or

b. Use the words "free" or "no cost" or words of similar import in the marketing, advertising, soliciting, or otherwise promoting of the purchase of a policy.

26.1-33.4-08. Disclosures to owners.

1. The provider shall provide in writing, in a separate document that is signed by the owner and provider, the following information to the owner no later than the date the life settlement contract is signed by all parties:

a. The fact that possible alternatives to life settlement contracts exist, including accelerated benefits offered by the issuer of the life insurance policy.

b. The fact that some or all of the proceeds of a life settlement contract may be taxable and that assistance should be sought from a professional tax adviser.

c. The fact that the proceeds from a life settlement contract could be subject to the claims of creditors.

d. The fact that receipt of proceeds from a life settlement contract may adversely affect the recipient's eligibility for public assistance or other government benefits or entitlements and that advice should be obtained from the appropriate agencies.

e. The fact the owner has the right to rescind a life settlement contract before the earlier of sixty calendar days after the date upon which the life settlement contract is executed by all parties or thirty calendar days after the life settlement proceeds have been delivered to the escrow agent by or on behalf of the provider as provided in subsection 11 of section 26.1-33.4-10. Rescission, if exercised by the owner, is effective only if both notice of the rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period. If the insured dies during the rescission period, the contract is deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider.

f. The fact that proceeds will be sent to the owner within three business days after the provider has received the insurer or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract.

g. The fact that entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits, that may exist under the policy or certificate of a group policy to be forfeited by the owner and that assistance should be sought from a professional financial adviser.

h. The amount and method of calculating the compensation paid or to be paid to the broker, or any other person acting for the owner in connection with the transaction, wherein the term compensation includes anything of value paid or given.

i. The date by which the funds will be available to the owner and the transmitter of the funds.

j. The fact that the commissioner shall require delivery of a buyer's guide or a similar consumer advisory package in the form prescribed by the commissioner to owners during the solicitation process.

k. The disclosure document must contain the following language:

> All medical, financial, or personal information solicited or obtained by a provider or broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the life settlement contract between the owner and provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or

provides funds for the purchase. You may be asked to renew your permission to share information every two years.

l. The fact that the commissioner shall require providers and brokers to print separate signed fraud warnings on their applications and on their life settlement contracts the following statement:

Any person that knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

m. The fact that the insured may be contacted by either the provider or broker or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address. This contact is limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less. This contact may be made only by a provider or broker licensed in the state in which the owner resided at the time of the settlement or by the authorized representative of such a provider or broker.

n. The affiliation, if any, between the provider and the issuer of the insurance policy to be settled.

o. That a broker represents exclusively the owner, and not the insurer or the provider or any other person, and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner.

p. The document must include the name, address, and telephone number of the provider.

q. The name, business address, and telephone number of the independent third-party escrow agent, and the fact that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

r. The fact that a change of ownership could in the future limit the insured's ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life.

s. If an insurance policy to be settled has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be settled, that the owner must be informed of the possible loss of coverage on the other lives under the policy and must be advised to consult with the owner's insurance producer or the insurer issuing the policy for advice on the proposed settlement.

t. The dollar amount of the current death benefit payable to the provider under the policy or certificate. If known, the provider also shall disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and

dismemberment benefits under the policy or certificate, and the extent to which the owner's interest in those benefits will be transferred as a result of the viatical settlement contract.

u. Any affiliations or contractual arrangements between the provider and the purchaser.

2. The written disclosures must be conspicuously displayed in any life settlement contract furnished to the owner by a provider, including any affiliations or contractual arrangements between the provider and the broker.

3. A broker shall provide the owner and the provider with at least the following disclosures no later than the date the life settlement contract is signed by all parties. The disclosures must be conspicuously displayed in the life settlement contract or in a separate document signed by the owner and provide the following information:

a. The name, business address, and telephone number of the broker.

b. A full, complete, and accurate description of all the offers, counteroffers, acceptances, and rejections relating to the proposed life settlement contract.

c. A written disclosure of any affiliations or contractual arrangements between the broker and any person making an offer in connection with the proposed life settlement contracts.

d. The name of each broker who receives compensation and the amount of compensation received by that broker, which compensation includes anything of value paid or given to the broker in connection with the life settlement contract.

e. A complete reconciliation of the gross offer or bid by the provider to the net amount of proceeds or value to be received by the owner. For the purpose of this section, gross offer or bid means the total amount or value offered by the provider for the purchase of one or more life insurance policies, inclusive of commissions and fees.

f. The failure to provide the disclosures or rights described in this section is deemed an unfair trade practice pursuant to section 26.1-33.4-16.

26.1-33.4-09. Disclosure to insurer. Without limiting the ability of an insurer from assessing the insurability of a policy applicant and determining whether to issue the policy, and in addition to other questions an insurance carrier may lawfully pose to a life insurance applicant, insurance carriers may inquire in the application for insurance whether the proposed owner intends to pay premiums with the assistance of financing from a lender that will use the policy as collateral to support the financing.

1. If, as described in subsection 11 of section 26.1-33.4-01, the loan provides funds that can be used for a purpose other than paying for the premiums, costs, and expenses associated with obtaining and maintaining the life insurance policy and loan, the application must be

rejected as a violation of the prohibited practices in section 26.1-33.4-12.

2. If the financing does not violate section 26.1-33.4-12 in this manner, the insurance carrier:

a. May make disclosures, such as the following, to the applicant and the insured, either on the application or an amendment to the application to be completed no later than the delivery of the policy: "If you have entered a loan arrangement where the policy is used as collateral, and the policy does change ownership at some point in the future in satisfaction of the loan, the following may be true:

(1) A change of ownership could lead to a stranger owning an interest in the insured's life;

(2) A change of ownership could in the future limit your ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life;

(3) Should there be a change of ownership and you wish to obtain more insurance coverage on the insured's life in the future, the insured's higher issue age, a change in health status, and other factors may reduce the ability to obtain coverage and may result in significantly higher premiums; and

(4) You should consult a professional adviser, since a change in ownership in satisfaction of the loan may result in tax consequences to the owner, depending on the structure of the loan;" and

b. May require certifications, such as the following, from the applicant or the insured or both:

I have entered into any agreement or arrangement providing for the future sale of this life insurance policy;

My loan arrangement for this policy provides funds sufficient to pay for some or all of the premiums, costs, and expenses associated with obtaining and maintaining my life insurance policy, but I have not entered into any agreement by which I am to receive consideration in exchange for procuring this policy; and

The borrower has an insurable interest in the insured.

26.1-33.4-10. General rules.

1. A provider entering a life settlement contract with any owner of a policy, wherein the insured is terminally or chronically ill, first shall obtain:

a. If the owner is the insured, a written statement from a licensed attending physician that the owner is of sound mind and under no

constraint or undue influence to enter into a settlement contract; and

b. A document in which the insured consents to the release of the insured's medical records to a provider, settlement broker, or insurance producer and, if the policy was issued less than two years from the date of application for a settlement contract, to the insurance company that issued the policy.

2. The insurer shall respond to a request for verification of coverage submitted by a provider, settlement broker, or life insurance producer not later than thirty calendar days from the date the request is received. The request for verification of coverage must be made on a form approved by the commissioner. The insurer shall complete and issue the verification of coverage or indicate in which respects it is unable to respond. In its response, the insurer shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract.

3. Before or at the time of execution of the settlement contract, the provider shall obtain a witnessed document in which the owner consents to the settlement contract, represents that the owner has a full and complete understanding of the settlement contract, that the owner has a full and complete understanding of the benefits of the policy, acknowledges that the owner is entering into the settlement contract freely and voluntarily, and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the policy was issued.

4. The insurer may not unreasonably delay effecting change of ownership or beneficiary with any life settlement contract lawfully entered in this state or with a resident of this state.

5. If a settlement broker or life insurance producer performs any of these activities required of the provider, the provider is deemed to have fulfilled the requirements of this section.

6. If a broker performs the verification of coverage activities required of the provider, the provider is deemed to have fulfilled the requirements of subsection 1 of section 26.1-33.4-08.

7. Within twenty days after an owner executes the life settlement contract, the provider shall give written notice to the insurer that issued that insurance policy that the policy has become subject to a life settlement contract. The notice must be accompanied by the documents required by subdivision b of subsection 1 of section 26.1-33.4-09.

8. All medical information solicited or obtained by any licensee must be subject to the applicable provision of state law relating to confidentiality of medical information if not otherwise provided in this chapter.

9. All life settlement contracts entered in this state must provide the owner with a right to rescind the contract before the earlier of sixty calendar days after the date upon which the life settlement contract is executed

by all parties or thirty calendar days after the life settlement proceeds have been sent to the escrow agent by or on behalf of the provider as provided in subsection 11. Rescission by the owner may be conditioned upon the owner giving notice and repaying to the provider within the rescission period all proceeds of the settlement and any premiums, loans, and loan interest paid by or on behalf of the provider in connection with or as a consequence of the life settlement. If the insured dies during the rescission period, the life settlement contract is deemed to have been rescinded, subject to repayment to the provider or purchaser of all life settlement proceeds and any premiums, loans, and loan interest that have been paid by the provider or purchaser, within sixty calendar days of the death of the insured. In the event of any rescission, if the provider has paid commissions or other compensation to a broker in connection with the rescinded transaction, the broker shall refund all the commissions and compensation to the provider within five business days following receipt of written demand from the provider, which demand must be accompanied by either the owner's notice of rescission if rescinded at the election of the owner or notice of the death of the insured if rescinded by reason of the death of the insured within the applicable rescission period.

10. Within three business days after receipt from the owner of documents to effect the transfer of the insurance policy, the provider shall pay the proceeds of the settlement to an escrow or trust account managed by a trustee or escrow agent in a state or federally chartered financial institution pending acknowledgment of the transfer by the issuer of the policy. The trustee or escrow agent must be required to transfer the proceeds due to the owner within three business days of the later to occur of the expiration of any then remaining rescission period or the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment, or designation of beneficiary from the insurance company.

11. Failure to tender the life settlement contract proceeds to the owner by the date disclosed to the owner renders the contract voidable by the owner for lack of consideration until the time the proceeds are tendered to and accepted by the owner. A failure to give written notice of the right of rescission tolls the right of rescission until sixty days after the written notice of the right of rescission has been given.

12. Any fee paid by a provider, party, individual, or an owner to a broker in exchange for services provided to the owner pertaining to a life settlement contract must be computed as a percentage of the offer obtained, not the face value of the policy. This section does not prohibit a broker from reducing such broker's fee below this percentage if the broker so chooses.

13. The broker shall disclose to the owner anything of value paid or given to a broker which relates to a life settlement contract.

14. It is a violation of this chapter for any person to enter a life settlement contract at any time before or at the time of the application for or issuance of a policy that is the subject of a life settlement contract or within a five-year period commencing with the date of issuance of the insurance policy or certificate unless the owner certifies to the provider

or the provider otherwise conclusively shows that one or more of the following conditions have been met within the five-year period:

a. The policy was issued upon the owner's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least sixty months. The time covered under a group policy must be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship;

b. The owner submitted independent evidence to the provider that one or more of the following conditions have been met within the five-year period:

(1) The owner or insured is terminally or chronically ill;

(2) The owner's spouse died or no remaining beneficiaries are then surviving;

(3) The owner retired from full-time employment; or

(4) The owner became physically or mentally disabled and a physician determined that the disability prevents the owner from maintaining full-time employment;

c. A final order, judgment, or decree has been entered by a court of competent jurisdiction, on the application of a creditor of the owner, adjudicating the owner in default, bankrupt, or insolvent, or approving a petition seeking reorganization of the owner or appointing a receiver, trustee, or liquidator to all or a substantial part of the owner's assets; or

d. The owner entered a life settlement contract more than two years after the date of issuance of a policy and, with respect to the policy, at all times before the date that is two years after policy issuance, the following conditions are met:

(1) Policy premiums have been funded exclusively with unencumbered assets, including an interest in the life insurance policy being financed only to the extent of the policy's net cash surrender value, provided by, or fully recourse liability incurred by, the insured or a person described in paragraph 5 of subdivision b of subsection 11 of section 26.1-33.4-01;

(2) There is no agreement or understanding with any other person to guarantee any such liability or to purchase, or stand ready to purchase, the policy, including through an assumption or forgiveness of the loan; and

(3) Neither the insured nor the policy has been evaluated for settlement in connection with the issuance of the policy.

15. Copies of the independent evidence described in subdivision b of subsection 14 and documents required by subsection 1, 2, 3, or 7 must

be submitted to the insurer when the provider submits a request to the insurer for verification of coverage. The copies must be accompanied by a letter of attestation from the provider that the copies are true and correct copies of the documents received by the provider.

16. If the provider submits to the insurer a copy of the owner's or insured's certification described in and the independent evidence required by subdivision b of subsection 14 when the provider submits a request to the insurer to effect the transfer of the policy or certificate to the provider, the copy is deemed to establish conclusively that the life settlement contract satisfies the requirements of this section and the insurer timely shall respond to the request.

26.1-33.4-11. Authority to adopt regulations - Conflict of laws.

1. The commissioner may adopt rules implementing this chapter and regulating the activities and relationships of providers, brokers, and insurers and their agents.

2. The commissioner may establish standards for evaluating reasonableness of a payment under a life settlement contract for an individual who is terminally or chronically ill. This authority includes regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a life insurance policy insuring the life of an individual who is chronically or terminally ill.

3. The commissioner may establish appropriate licensing requirements, fees, and standards for continued licensure for providers and brokers.

4. a. If there is more than one owner on a single policy and the owners are residents of different states, the life settlement contract must be governed by the law of the state in which the owner having the largest percentage ownership resides, or if the owners hold equal ownership, the state of residence of one owner agreed upon in writing by all of the owners. The law of the state of the insured governs if equal owners fail to agree in writing upon a state of residence for jurisdictional purposes.

   b. A provider from this state who enters a life settlement contract with an owner who is a resident of another state that has enacted statutes or adopted regulations governing life settlement contracts is governed in the effectuation of that life settlement contract by the statutes and regulations of the owner's state of residence. If the state in which the owner is a resident has not enacted statutes or regulations governing life settlement contracts, the provider shall give the owner notice that neither state regulates the transaction upon which the owner is entering. For transactions in those states, however, the provider is to maintain all records required if the transactions were executed in the state of residence. The forms used in those states need not be approved by the commissioner.

   c. If there is a conflict in the laws that apply to an owner and a purchaser in any individual transaction, the laws of the state that apply to the owner shall take precedence and the provider shall comply with those laws.

26.1-33.4-12. Prohibited practices.

1. It is unlawful for any person to:

   a. Enter a life settlement contract if such person knows or reasonably should have known that the life insurance policy was obtained by means of a false, deceptive, or misleading application for such policy;

   b. Engage in any transaction, practice, or course of business if such person knows or reasonably should have known that the intent was to avoid the notice requirements of this chapter;

   c. Engage in any fraudulent act or practice in connection with any transaction relating to any settlement involving an owner who is a resident of this state;

   d. Issue, solicit, market, or otherwise promote the purchase of an insurance policy for the purpose of or with an emphasis on settling the policy;

   e. Enter a premium finance agreement with any person or agency, or any person affiliated with such person or agency, pursuant to which such person shall receive any proceeds, fees, or other consideration, directly or indirectly, from the policy or owner of the policy or any other person with respect to the premium finance agreement or any settlement contract or other transaction related to such policy that are in addition to the amounts required to pay the principal, interest, and service charges related to policy premiums pursuant to the premium finance agreement or subsequent sale of such agreement; provided, further, that any payments, charges, fees, or other amounts in addition to the amounts required to pay the principal, interest, and service charges related to policy premiums paid under the premium finance agreement must be remitted to the original owner of the policy or to the original owner's estate if the original owner is not living at the time of the determination of the overpayment;

   f. With respect to any settlement contract or insurance policy and a broker, knowingly solicit an offer from, effectuate a life settlement contract with, or make a sale to any provider, financing entity, or related provider trust that is controlling, controlled by, or under common control with such broker;

   g. With respect to any life settlement contract or insurance policy and a provider, knowingly enter into a life settlement contract with an owner, if, in connection with such life settlement contract, anything of value will be paid to a broker that is controlling, controlled by, or under common control with such provider or the financing entity or related provider trust that is involved in such settlement contract;

   h. With respect to a provider, enter into a life settlement contract unless the life settlement promotional, advertising, and marketing materials, as may be prescribed by regulation, have been filed with the commissioner. In no event may any marketing materials expressly reference that the insurance is "free" for any period of

time. The inclusion of any reference in the marketing materials that would cause an owner to reasonably believe that the insurance is free for any period of time must be considered a violation of this chapter; or

i. With respect to any life insurance producer, insurance company, broker, or provider, make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

2. A violation of this section is deemed a fraudulent life settlement act.

26.1-33.4-13. Fraud prevention and control.

1. a. A person may not commit a fraudulent life settlement act.

b. A person may not knowingly and intentionally interfere with the enforcement of the provisions of this chapter or investigations of suspected or actual violations of this chapter.

c. A person in the business of life settlements may not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of life settlements.

2. a. Life settlement contracts and applications for life settlement contracts, regardless of the form of transmission, must contain the following statement or a substantially similar statement:

> Any person that knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

b. The lack of a statement as required in subdivision a does not constitute a defense in any prosecution for a fraudulent life settlement act.

3. a. Any person engaged in the business of life settlements having knowledge or a reasonable belief that a fraudulent life settlement act is being, will be, or has been committed shall provide to the commissioner the information required by and in a manner prescribed by the commissioner.

b. Any other person having knowledge or a reasonable belief that a fraudulent life settlement act is being, will be, or has been committed may provide to the commissioner the information required by and in a manner prescribed by the commissioner.

4. a. Civil liability may not be imposed on and no cause of action may arise from a person's furnishing information concerning suspected, anticipated, or completed fraudulent life settlement acts or suspected or completed fraudulent insurance acts if the information is provided to or received from:

(1) The commissioner or the commissioner's employees, agents, or representatives;

(2) Federal, state, or local law enforcement or regulatory officials or their employees, agents, or representatives;

(3) A person involved in the prevention and detection of fraudulent life settlement acts or that person's agents, employees, or representatives;

(4) Any regulatory body or its employees, agents, or representatives overseeing life insurance, life settlements, securities, or investment fraud;

(5) The life insurer that issued the life insurance policy covering the life of the insured; or

(6) The licensee and any agents, employees, or representatives.

b. Subdivision a does not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent life settlement act or a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that subdivision a does not apply because the person filing the report or furnishing the information did so with actual malice.

c. A person identified in subdivision a is entitled to an award of attorney's fees and costs if that person is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this chapter and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is "substantially justified" if the proceeding had a reasonable basis in law or fact at the time the proceeding was initiated.

d. This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in subdivision a.

5. a. The documents and evidence provided pursuant to subsection 4 or obtained by the commissioner in an investigation of suspected or actual fraudulent life settlement acts is privileged and confidential and may not be a public record and may not be subject to discovery or subpoena in a civil or criminal action.

b. Subdivision a does not prohibit release by the commissioner of documents and evidence obtained in an investigation of suspected or actual fraudulent life settlement acts:

(1) In administrative or judicial proceedings to enforce laws administered by the commissioner;

(2) To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of

detecting and preventing fraudulent life settlement acts, or to the national association of insurance commissioners; or

(3) At the discretion of the commissioner, to a person in the business of life settlements that is aggrieved by a fraudulent life settlement act.

c. Release of documents and evidence under subdivision b does not abrogate or modify the privilege granted in subdivision a.

6. This chapter does not:

a. Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

b. Preempt, supersede, or limit any provision of any state securities law or any rule, order, or notice issued thereunder;

c. Prevent or prohibit a person from disclosing voluntarily information concerning life settlement fraud to a law enforcement or regulatory agency other than the insurance department; or

d. Limit the powers granted elsewhere by the laws of this state to the commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

7. a. Providers and brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent life settlement acts. The commissioner may order, or a licensee may request and the commissioner may grant, such modifications of the following required initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this section. Antifraud initiatives include:

(1) Fraud investigators, who may be provider or broker employees or independent contractors; and

(2) An antifraud plan, which must be submitted to the commissioner. The antifraud plan must include:

(a) A description of the procedures for detecting and investigating possible fraudulent life settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(b) A description of the procedures for reporting possible fraudulent life settlement acts to the commissioner;

(c) A description of the plan for antifraud education and training of underwriters and other personnel; and

(d) A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent life settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

b. Antifraud plans submitted to the commissioner are privileged and confidential and are not a public record and may not be subject to discovery or subpoena in a civil or criminal action.

26.1-33.4-14. Injunctions - Civil remedies - Cease and desist.

1. In addition to the penalties and other enforcement provisions of this chapter, if any person violates this chapter or any rule implementing this chapter, the commissioner may seek an injunction in a court of competent jurisdiction in the county where the person resides or has a principal place of business and may apply for temporary and permanent orders that the commissioner determines necessary to restrain the person from further committing the violation.

2. Any person damaged by the acts of another person in violation of this chapter or any rule or regulation implementing this chapter may bring a civil action for damages against the person committing the violation in a court of competent jurisdiction.

3. The commissioner may issue a cease and desist order upon a person that violates any provision of this part, any rule or order adopted by the commissioner, or any written agreement entered into with the commissioner in accordance with chapter 28-32.

4. When the commissioner finds that such an action presents an immediate danger to the public and requires an immediate final order, the commissioner may issue an emergency cease and desist order reciting with particularity the facts underlying such findings. The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains effective for ninety days. If the commissioner begins nonemergency cease and desist proceedings under subsection 1, the emergency cease and desist order remains effective, absent an order by an appellate court of competent jurisdiction pursuant to chapter 28-32. In the event of a willful violation of this chapter, the trial court may award statutory damages in addition to actual damages in an additional amount up to three times the actual damage award. The provisions of this chapter may not be waived by agreement. A choice of law provision may not be utilized to prevent the application of this chapter to any settlement in which a party to the settlement is a resident of this state.

26.1-33.4-15. Penalties.

1. It is a violation of this chapter for any person, provider, broker, or any other party related to the business of life settlements to commit a fraudulent life settlement act.

2. For criminal liability purposes, a person that commits a fraudulent life settlement act is guilty of committing insurance fraud.

3. The commissioner may levy a civil penalty not exceeding fifty thousand dollars per violation and the amount of the claim for each violation upon any person, including those persons and their employees licensed pursuant to this chapter, who is found to have committed a fraudulent life settlement act or violated any other provision of this chapter.

4. The license of a person licensed under this chapter which commits a fraudulent life settlement act must be revoked.

26.1-33.4-16. Unfair trade practices. A violation of this chapter is considered an unfair trade practice pursuant to state law and subject to the penalties provided by state law.

SECTION 3. REPEAL. Chapter 26.1-33.3 of the North Dakota Century Code is repealed.

Approved April 21, 2009
Filed April 22, 2009

CHAPTER 255

SENATE BILL NO. 2380

(Senator Klein)
(Representative Kasper)

AN ACT to create and enact a new subsection to section 26.1-34.2-03 of the North Dakota Century Code, relating to annuity transactions; and to amend and reenact subsection 5 of section 26.1-34.2-03 of the North Dakota Century Code, relating to registered annuities.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[120] **SECTION 1. AMENDMENT.** Subsection 5 of section 26.1-34.2-03 of the North Dakota Century Code is amended and reenacted as follows:

5. Compliance with the ~~national association of securities dealers~~ financial industry regulatory authority conduct rules pertaining to suitability satisfies the requirements under this section for the recommendation of ~~variable~~ annuities registered under the Securities Act of 1933 [15 U.S.C. 77a et seq.] or rules or regulations adopted under that act. However, nothing in this subsection limits the insurance commissioner's ability to enforce the provisions of this chapter.

[121] **SECTION 2.** A new subsection to section 26.1-34.2-03 of the North Dakota Century Code is created and enacted as follows:

This chapter does not preempt, supersede, or limit any provision of any securities law of this state or any rule, order, or notice issued thereunder.

Approved April 8, 2009
Filed April 9, 2009

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[120] Section 26.1-34.2-03 was also amended by section 2 of Senate Bill No. 2380, chapter 255.

[121] Section 26.1-34.2-03 was also amended by section 1 of Senate Bill No. 2380, chapter 255.

CHAPTER 256

HOUSE BILL NO. 1204

(Representatives Keiser, Klemin, Weisz)
(Senator J. Lee)

AN ACT to create and enact subsection 15 to section 26.1-36-05, a new section to chapter 26.1-36, and a new section to chapter 54-52.1 of the North Dakota Century Code, relating to health insurance coverage for medical services related to intoxication; to amend and reenact subsection 2 of section 26.1-36-04 of the North Dakota Century Code, relating to individual health insurance coverage of injuries caused by intoxication or the use of narcotics or incurred in the commission of a crime; and to provide a statement of legislative intent.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 2 of section 26.1-36-04 of the North Dakota Century Code is amended and reenacted as follows:

2. Except as provided in subsection 3, ~~no~~ an accident and health insurance policy delivered or issued for delivery to any person in this state may not 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~~ before the occurrence of the loss for which the insurer is liable or ~~prior to~~ before 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~~ before the occurrence of the loss or ~~prior to~~ before 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~~ from the payment.

e. Subject to chapter 26.1-36.4, 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 after the loss-of-time benefit of the policy has been payable for ninety days, such benefit will be adjusted, as provided

~~below~~ under this subdivision, if the total amount of unadjusted loss-of-time benefits provided in all valid loss-of-time coverage upon the insured should exceed a percentage of the insured's earned income as provided 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 percentage 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 percentage provided.

(1) 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)~~ (a) the product of the insured's earned income and the original percent, or, if higher, the alternative percentage, bears to ~~(2)~~ (b) 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)~~ (a) and ~~(2)~~ (b) any amount of loss-of-time benefits payable under other valid loss-of-time coverage which does not contain an "overinsurance provision".

(2) 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.

(3) 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.

(4) The provision must provide that:

~~(1)~~ (a) "Earned income", except when 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)~~ (b) "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.

(5) This type of provision may be included only in a policy ~~which~~ that 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 workforce safety and insurance 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.

SECTION 2. Subsection 15 to section 26.1-36-05 of the North Dakota Century Code is created and enacted as follows:

15. A provision that except as otherwise provided under this subsection, the insurer is not liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a crime or to which a contributing cause was the insured's engagement in an illegal occupation. However, under this subsection the insurer is liable for a loss to the extent the crime committed was a misdemeanor violation of section 39-08-01.

SECTION 3. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Medical services related to intoxication. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver,

issue, execute, or renew any major medical expense policy on a group, individual, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any individual covered under the policy or contract for injury or illness resulting from any loss sustained or contracted in the consequence of the insured's being intoxicated or under the influence of any narcotic. The coverage required under this section may be subject to limitations under subdivision g of subsection 2 of section 26.1-36-04 or subsection 15 of section 26.1-36-05.

SECTION 4. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Insurance to cover medical services related to intoxication. The board shall provide medical benefits coverage under a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52-04.2 for medical services related to intoxication in the same manner as provided for under subsection 15 of section 26.1-36-05 and section 3 of this Act.

SECTION 5. LEGISLATIVE INTENT. This Act is not a mandate of health insurance coverage of services under section 54-03-28.

Approved April 21, 2009
Filed April 22, 2009

CHAPTER 257

SENATE BILL NO. 2274

(Senators J. Lee, Heckaman, Klein)
(Representatives Keiser, Thorpe, Weisz)

AN ACT to amend and reenact section 26.1-36-44 of the North Dakota Century Code, relating to health insurance independent external reviews requested by providers.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-36-44 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-44. Independent external review. Every insurance company, nonprofit health service corporation, and health maintenance organization that offers an accident and health line of insurance shall establish and implement an independent external review mechanism to review and determine whether medical care rendered under the line of insurance was medically necessary and appropriate to the claim as submitted by the provider. For purposes of this section, "independent external review" means a review conducted by the North Dakota health care review, inc., another peer review organization meeting the requirements of section 1152 of the Social Security Act, or any person designated by the commissioner to conduct an independent external review. A determination made by the independent external reviewer is binding on the parties. Costs associated with the independent external review are the responsibility of the nonprevailing party. A provider may not use an independent external review under this section unless the provider first has exhausted all internal appeal processes offered by the insurance company, nonprofit health service corporation, or health maintenance organization.

Approved April 8, 2009
Filed April 9, 2009

CHAPTER 258

HOUSE BILL NO. 1196

(Representatives Berg, Clark, Vigesaa)
(Senators Behm, Klein, Wanzek)

AN ACT to amend and reenact section 26.1-36.4-06 of the North Dakota Century Code, relating to elimination of the reporting requirement of modified community rating of insurance policies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[122] **SECTION 1. AMENDMENT.** Section 26.1-36.4-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.4-06. Modified community rating. Premium rates for individual policies are subject to the following:

1. For any class of individuals, the premium rates charged during a rating period to the individuals in that class for the same or similar coverage may not vary by a ratio of more than six to one after August 1, 1995, and by a ratio of more than five to one after August 1, 1996, when age, industry, gender, and duration of coverage of the individuals are considered. Gender and duration of coverage may not be used as a rating factor for policies issued after January 1, 1997.

2. An insurer, in addition to the factors set forth in subsection 1, may use geography, family composition, healthy lifestyles, and benefit variations to determine premium rates.

3. The commissioner shall design and adopt reporting forms to be used by an insurer to report information as to insurer's experience as to insurance provided under this chapter on a periodic basis to determine the impact of the reforms and implementation of modified community rating contained in this chapter ~~and the commissioner shall report to the legislative assembly or a committee designated by the legislative council the findings of the commissioner~~.

Approved April 8, 2009
Filed April 9, 2009

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[122] Section 26.1-36.4-06 was also amended by section 19 of House Bill No. 1436, chapter 482.

CHAPTER 259

HOUSE BILL NO. 1158

(Judiciary Committee)
(At the request of the Insurance Commissioner)

AN ACT to amend and reenact section 26.1-40-18 of the North Dakota Century Code, relating to automobile warranty contracts, automobile mechanical breakdown contracts, and automobile service contracts.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-40-18 of the North Dakota Century Code is amended and reenacted as follows:

26.1-40-18. Automobile warranties construed.

1. ~~An automobile dealer or a third-party administrator~~ A person who issues ~~an~~ a written automobile warranty contract, automobile mechanical breakdown contract, or automobile service contract shall maintain a policy of insurance which provides coverage for the ~~dealer's or administrator's~~ person's contractual obligation.

2. The policy must be issued by an insurer licensed, registered, or otherwise authorized to do business in this state. From the time the policy is filed with the commissioner:

   a. The insurer shall maintain surplus as to policyholders and paid-in capital of at least fifteen million dollars and annually file copies of the insurer's audited financial statements, the national association of insurance commissioners annual statement, and the actuarial certification required by and filed in the insurer's state of domicile; or

   b. The insurer shall maintain surplus as to policyholders and paid-in capital of between fifteen million dollars and ten million dollars, demonstrate to the satisfaction of the commissioner that the company maintains a ratio of net written premiums, wherever written, to surplus as to policyholders and paid-in capital of not greater than three to one, and annually file copies of the insurer's audited financial statements, the national association of insurance commissioners annual statement, and the actuarial certification required by and filed in the insurer's state of domicile.

3. This section does not apply to an original equipment manufacturer.

Approved April 24, 2009
Filed April 29, 2009

CHAPTER 260

HOUSE BILL NO. 1245

(Representatives Ruby, Keiser, Nathe)
(Senators Dever, Hogue, Miller)

AN ACT to amend and reenact section 26.1-41-03 of the North Dakota Century Code, relating to eliminating the need for a written request to suspend automobile coverage.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-41-03 of the North Dakota Century Code is amended and reenacted as follows:

26.1-41-03. Suspension of coverage - ~~Written~~ ~~request~~ Request by owner. Upon ~~receipt~~ notice 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.

Approved April 8, 2009
Filed April 9, 2009