§ 1171.1. Short title

This act shall be known and may be cited as the "Unfair Insurance Practices Act."

§ 1171.2. Declaration of purpose

The purpose of this act is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the act of Congress of March 9, 1945 (Public Law 15, 79th Congress) [FN1], by defining or providing for the determination of all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

§ 1171.3. Definitions

As used in this act:

"Abuse" has the meaning given in 23 Pa.C.S. § 6102(a) (relating to definitions), notwithstanding the limited applicability provision in paragraph (5) of the definition of "abuse" in 23 Pa.C.S. § 6102(a). The term also means attempting to cause or intentionally, knowingly or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another person covered under 23 Pa.C.S. Ch. 61 (relating to protection from abuse).

"Commissioner" means the insurance commissioner of the Commonwealth of
Pennsylvania.

"Family or household members" has the meaning given in 23 Pa.C.S. § 6102(a) (relating to definitions).

"Insurance policy" or "Insurance Contract" means any contract of insurance, indemnity, health care, suretyship, title insurance, or annuity issued, proposed for issuance or intended for issuance by any person.

"Person" means any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds insurer, fraternal benefit society, beneficial association and any other legal entity engaged in the business of insurance, including agents, brokers and adjusters and also means health care plans. As defined in 40 Pa.C.S.A. Ch. 61 relating to hospital plan corporations [FN1], 40 Pa.C.S.A. Ch. 63 relating to professional health services plan corporations [FN2], 40 Pa.C.S.A. Ch. 65 relating to fraternal and beneficial societies [FN3] 40 Pa.C.S.A., Ch. 67 relating to beneficial societies [FN4] and the act of December 29, 1972 (P.L. 1701, No. 364), known as the "Voluntary Nonprofit Health Service Act of 1972." [FN5] For purposes of this act, health care plans, fraternal benefit societies and beneficial societies shall be deemed to be engaged in the business of insurance.

"Renewal" or "to renew" means the issuance and delivery by an insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer, such renewal policy to provide types and limits of coverage at least equal to those contained in the policy being superseded, or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term with types and limits of coverage at least equal to those contained in the policy being extended: Provided, however, That any policy with a policy period or term of less than twelve months or any period with no fixed expiration date shall for the purpose of this act be considered as if written for successive policy periods or terms of twelve months.

"Victim" means an individual who is or has been subjected to abuse.

"Victim of abuse" means an individual who is a victim or an individual who seeks or has sought medical or psychological treatment for abuse, protection from abuse or shelter from abuse.

§ 1171.4. Unfair methods of competition and unfair or deceptive acts or practices prohibited

No person shall engage in this state in any trade practice which is defined or determined to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance pursuant to this act.
§ 1171.5. Unfair methods of competition and unfair or deceptive acts or practices defined

(a) "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means:

(1) Making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which:

(i) Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

(ii) Misrepresents the premium overcharge commonly called dividends or share of the surplus to be received on any insurance policy;

(iii) Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy;

(iv) Is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any insurer operates;

(v) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;

(vi) Is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion or surrender of any insurance policy;

(vii) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

(viii) Misrepresents any insurance policy as being shares of stock.

(2) Making, issuing, publishing or circulating in any manner an advertisement, announcement or statement containing any representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business which is untrue, deceptive or misleading.

(3) Making, issuing, publishing or circulating any oral or written statement which is false or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure such person.
(4) Entering into any agreement to commit, or by any concerted action committing, any act or boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(5) Knowingly filing with any supervisory or other public official, or knowingly making, issuing, publishing or circulating any false material statement of fact as to the financial condition of a person, or knowingly making any false entry of a material fact in any book, report or statement of any person, or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

(6) Issuing or delivering or permitting agents, officers or employees to issue or deliver agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

(7) Unfairly discriminating by means of:

(i) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract; or

(ii) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy, fees or rates charged for any policy or contract of insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(iii) Making or permitting any unfair discrimination between individuals of the same class and essentially the same hazard with regard to underwriting standards and practices or eligibility requirements by reason of race, religion, nationality or ethnic group, age, sex, family size, occupation, place of residence or marital status. The terms "underwriting standards and practices" or "eligibility rules" do not include the promulgation of rates if made or promulgated in accordance with the appropriate rate regulatory act of this commonwealth and regulations promulgated by the commissioner pursuant to such act.

(8) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or paying or allowing, or giving or offering to pay, allow or give as inducement to such insurance, any rebate of premiums payable on the
contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration, inducement or anything of value whatsoever which is not specified in the contract.

(9) Cancelling any policy of insurance covering owner-occupied private residential properties or personal property of individuals that has been in force for sixty days or more or refusing to renew any such policy unless the policy was obtained through material misrepresentation, fraudulent statements, omissions or concealment of fact material to the acceptance of the risk or to the hazard assumed by the company; or there has been a substantial change or increase in hazard in the risk assumed by the company subsequent to the date the policy was issued; or there is a substantial increase in hazards insured against by reason of wilful or negligent acts or omissions by the insured; or the insured has failed to pay any premium when due whether such premium is payable directly to the company or its agent or indirectly under any premium finance plan or extension of credit; or for any other reasons approved by the commissioner pursuant to rules and regulations promulgated by the commissioner. No cancellation or refusal to renew by any person shall be effective unless a written notice of the cancellation or refusal to renew is received by the insured either at the address shown in the policy or at a forwarding address. Such notice shall:

(i) Be approved as to form by the insurance commissioner prior to use.

(ii) State the date, not less than thirty days after the date of delivery or mailing on which such cancellation or refusal to renew shall become effective.

(iii) State the specific reason or reasons of the insurer for cancellation or refusal to renew.

(iv) Advise the insured of his right to request, in writing, within ten days of the receipt of the notice of cancellation or intention not to renew that the insurance commissioner review the action of the insurer.


(vi) Advise the insured in a form commonly understandable of the provisions of subparagraphs (ii), (iii) and (iv) of this paragraph as they limit permissible time and reasons for cancellation.

(vii) Advise the insured of the procedures to be followed in prosecuting an appeal.
(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.

(i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

(v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

(vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.

(vii) Compelling persons to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts due and ultimately recovered in actions brought by such persons.

(viii) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(ix) Attempting to settle or compromise claims on the basis of an application which was altered without notice to or knowledge or consent of the insured of such alteration at the time such alteration was made.

(x) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made.

(xi) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants to induce or compel them to accept settlements or compromises less than the amount awarded in arbitration.

(xii) Delaying the investigation or payment of claims by requiring the insured,
claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(xiii) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage or under other policies of insurance.

(xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(xv) Refusing payment of a claim solely on the basis of an insured's request to do so unless:

(a) The insured claims sovereign, eleemosynary, diplomatic, military service, or other immunity from suit or liability with respect to such claim;

(b) The insured is granted the right under the policy of insurance to consent to settlement of claims; or

(c) The refusal of payment is based upon the insurer's independent evaluation of the insured's liability based upon all available information.

(11) Failure of any person to maintain a complete record of all the complaints which it has received during the preceding four years. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. For purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance.

(12) Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money or other benefit from any insurers, agent, broker or individual.

(13) Making, issuing, publishing or circulating in any manner an advertisement, announcement or statement offering permanent life insurance to persons fifty years of age or older without accompanying disclosures of any applicable reduction in the face amount payable and the period thereof.

(14) (i) Taking any of the following actions because the insured or applicant for an insurance policy or insurance contract is a victim of abuse:

(A) Denying, refusing to issue, refusing to renew, refusing to reissue or
cancelling or terminating an insurance policy or insurance contract or restricting coverage under an insurance policy or insurance contract.

(B) Adding a surcharge, applying a rating factor or using any other underwriting standard or practice which adversely takes into account a history or status of abuse.

(C) Excluding or limiting benefits or coverage under an insurance policy or insurance contract for losses incurred.

(D) With respect to a policy of a private passenger automobile, a policy covering owner-occupied private residential property or a policy covering personal property of individuals, refusing to pay an insured for losses arising out of abuse to that insured under a property and casualty insurance policy or contract to the extent of the insured's legal interest in the covered property if the loss is caused by the intentional act of another insured or using other exclusions or limitations which the commissioner has determined unreasonably restrict the ability of victims of abuse to be indemnified for such losses. When an insured submits a claim for losses pursuant to this subsection, the insurer shall provide to the insured a notice stating:

(I) that the insurer cannot refuse to pay a claim without conducting a reasonable investigation;

(II) that such investigation may include or result in contact with other insureds;

(III) that at the request of the insured, the insurer will not disclose the location of the insured to the other insureds or third parties as part of the investigation;

(IV) that the insurer will notify the insured at least fourteen days prior to instituting any legal action against the insured alleged to have caused the loss;

(V) that, after an insurer has paid a loss as a result of the claim, the insurer may nonrenew coverage or impose a surcharge as to the insured alleged to have caused the loss as long as the nonrenewal or surcharge imposition is not done prior to the later of six months following payment of the claim or the policy's renewal date; and

(VI) the national domestic violence hotline number.

(ii) Nothing in this paragraph shall be construed as:
(A) requiring that a person issue, renew or reissue an insurance policy or insurance contract solely because the insured or applicant is a victim of abuse; or

(B) requiring a person to provide benefits or coverage for losses incurred solely because the insured or applicant is a victim of abuse.

(ii.1) Payment of a claim pursuant to subparagraph (i)(D) shall constitute payment as to all other insureds under the policy.

(iii) A person shall not be in violation of this paragraph if any action taken is permissible by law and applies to the same extent to all applicants and insureds without regard to whether an applicant or insured is a victim of abuse.

(b) Nothing in subsection (a)(7) or (8) of this section shall be construed as including within the definition of discrimination or rebates any of the following practices:

(1) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums out of surplus accumulated from nonparticipating insurance if any such bonuses or abatement of premiums are fair and equitable to policyholders and for the best interests of the company and its policyholders;

(2) In the case of life insurance policies issued on the industrial or debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense; or

(3) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(c) Nothing in subsection (a)(9) of this section shall apply:

(1) If the insurer has manifested its willingness to renew by issuing or offering to issue a renewal policy, certificate or other evidence of renewal, including the mailing of a renewal premium notice to the insured not less than thirty days in advance of the expiration date of the policy.

(2) If the named insured has demonstrated by some overt action to the insurer or its agent other than mere nonpayment of premium that he wishes the policy to be cancelled or that he does not wish the policy to be renewed.
(3) To any policy of insurance which has been in effect less than sixty days, including any notice of termination period, unless it is a renewal policy. Any declination of coverage within the sixty-day period provided in this clause shall, for purposes of review by the insurance commissioner, be deemed a refusal to write and shall not be subject to the provisions of subsection (a)(9) of this section.

(4) Any insured may within ten days of the receipt by the insured of notice of cancellation or notice of intention not to renew, request in writing to the insurance commissioner that he review the action of the insurer in cancelling or refusing to renew the policy of such insured.

§ 1171.6. Non-liability for statements or information provided

There shall be no liability on the part of and no cause of action of any nature shall arise against the insurance commissioner, any insurer, the authorized representatives, agents and employees of either, or of any firm, person or corporation furnishing to the insurer information as to reasons for cancellation or refusal to renew for any statement made by them in complying with this act or for providing information pertaining thereto.

§ 1171.7. Power of Commissioner

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

§ 1171.8. Administrative hearing

(a) If, as a result of investigation, the Commissioner has good cause to believe that any person is violating any provision of this act, the Commissioner shall send notice of the violation by certified mail to the person believed to be in violation. The notice shall state the time and place for hearing which shall not be less than thirty days from the date of such notice.
(b) At the time and place fixed for the hearing in the notice, the person shall have an opportunity to be heard and to show cause why an order should not be made by the commissioner to cease and desist from acts constituting a violation of this act and why administrative penalties should not be assessed.

(c) Upon good cause shown, the Commissioner shall permit any person to intervene, appear and be heard at the hearing, either in person or by counsel.

(d) The Commissioner may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence and subpoena witnesses, compel their attendance and require the production of books, papers, records or other documents which he deems relevant to the hearing. The Commissioner shall cause a record of all evidence and all proceedings at the hearing to be kept.

(e) Following the hearing, the Commissioner shall issue a written order resolving the factual issues presented at the hearing and stating what remedial action, if any, is required of the person charged. The Commissioner shall send a copy of the order to those persons participating in the hearing.

§ 1171.9. Administrative penalty

Upon a determination by hearing that this act has been violated, the Commissioner may issue an order requiring the person to cease and desist from engaging in such violation or, if such violation is a method of competition, act or practice defined in section 5 of this act, [FN1] the Commissioner may suspend or revoke the person's license.

§ 1171.10. Injunction

If the alleged violator fails to comply with an order of the Commissioner following hearing to cease and desist from unfair methods of competition or an unfair or deceptive act or practice, the Commissioner may cause an action for injunction to be filed in the Commonwealth Court or the Court of Common Pleas of the county in which the violation occurred.

§ 1171.11. Civil penalties
In addition to any penalties imposed pursuant to this act, the court may, in an action filed by the Commissioner, impose the following civil penalties:

(1) For each method of competition, act or practice defined in section 5 of this act [FN1] and in violation of this act which the person knew or reasonably should have known was such a violation, a penalty of not more than five thousand dollars ($5,000) for each violation but not to exceed and aggregate penalty of fifty thousand dollars ($50,000) in any six month period;

(2) For each method of competition, act or practice defined in section 5 of this act and in violation of this act which the person did not know nor reasonably should have known was such a violation, a penalty of not more than one thousand dollars ($1,000) for each violation but not to exceed an aggregate penalty of ten thousand dollars ($10,000) in any six month period; and

(3) For each violation of an order issued by the Commissioner pursuant to section 9 of this act, [FN2] while such order is in effect, a penalty of not more than ten thousand dollars ($10,000).

§ 1171.13. Provisions of act additional to existing law

The powers vested in the Commissioner by this act are additional to any other powers to enforce any penalties, fines or forfeitures authorized by law with respect to the methods, acts and practices declared to be unfair and deceptive.

REGULATIONS:

CHAPTER 146. UNFAIR INSURANCE PRACTICES

Subchapter A. UNFAIR CLAIMS SETTLEMENT PRACTICES

§ 146.1. Scope.

This chapter defines certain minimum standards which, if violated with a frequency that indicates a general business practice, will be deemed to constitute unfair claims settlement practices. This chapter applies to persons and to insurance policies and insurance contracts except policies of workers’ compensation insurance and fidelity, surety and guaranty bonds. This chapter is not exclusive, and other acts, not herein specified, may also be deemed to be a violation of sections 4 and 5(10) of the Unfair Insurance Practices Act (40 P. S. §§ 1171.4 and 1171.5(10)).
§ 146.2. Definitions.

(a) The definitions of “person” and of “insurance policy or insurance contract” contained in section 2 of the Unfair Insurance Practices Act (40 P. S. § 1171.2) applies to this chapter.

(b) The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Agent—An individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim.

Claim—A demand for payment by a claimant and not an inquiry concerning coverage.

Claimant—Except as provided in § 146.10 (relating to written notice to claimants of payment of claim in third-party settlements), either a first-party claimant, a third-party claimant, or both, and including the claimant’s attorney and a member of the claimant’s immediate family designated by the claimant.

Commissioner—The Insurance Commissioner of the Commonwealth.

Department—The Insurance Department of the Commonwealth.

First-party claimant—An individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract.

Insured—A natural person, association, corporation, partnership or other legal entity who is insured under an insurance policy or insurance contract issued in this Commonwealth.

Insurer—A person licensed to issue or who issues an insurance policy or insurance contract in this Commonwealth.

Investigation—Activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract and settlement of claims or losses thereunder.

Notification of claim—A notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant or insured, which reasonably apprises the insurer of the facts pertinent to a claim.
Third-party claimant—An individual, corporation, association, partnership or other legal entity asserting a claim against an individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.

(c) The term “worker’s compensation,” in this chapter, includes but is not limited to Longshoremen’s and Harbor Worker’s Compensation.

§ 146.3. File and record documentation.

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed.

§ 146.4. Misrepresentation of policy provisions.

(a) An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(b) An insurer or agent may not fail to fully disclose to first-party claimants benefits, coverages or other provisions of an insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim.

(c) An insurer may not deny a claim for failure to exhibit the property without proof of demand and refusal by a claimant to do so.

(d) An insurer may not, except where there is a time limit specified in the policy, make statements—written or otherwise—requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if a time limit is not complied with unless the failure to comply with the time limit prejudices the rights of the insurer.

(e) An insurer may not request a first-party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(f) An insurer may not issue checks or drafts in partial settlement of a loss or claim under a specific coverage which checks or drafts contain language which expressly or impliedly releases the insurer or its insured from its total liability.
§ 146.5. Failure to acknowledge pertinent communications.

(a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

(b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant which reasonably suggest that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a).

§ 146.6. Standards for prompt investigation of claims.

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

§ 146.7. Standards for prompt, fair and equitable settlements applicable to insurers.

(a) Acceptance or denial of a claim shall comply with the following:

(1) Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be
given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(2) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority that the first-party claimant has fraudulently caused or contributed to the loss by arson or other illegal activity, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(b) If a claim is denied for reasons other than those described in subsection (a) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

(c) The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination:

(1) If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected.

(2) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority for suspecting that the first-party claimant has fraudulently caused or contributed to the loss by arson or other illegal activity, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(d) Insurers may not fail to settle first-party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(e) Insurers may not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the rights of the claimant may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the rights of the claimant. The notice shall be given to first-party claimants 30 days, and to third-party claimants 60 days, before the date on which the time limit may expire.
(f) An insurer may not make statements which indicate that the rights of a third-party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third-party claimant of the provision of a statute of limitations.

§ 146.8. Standards for prompt, fair and equitable settlements applicable to automobile insurance.

(a) Insurers may not recommend that third-party claimants make claim under their own policies solely to avoid paying claims under the insurer’s insurance policy or insurance contract.

(b) Insurers may not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at specific repair shops.

(c) Insurers shall, upon the request of the claimant, include the first-party claimant’s deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first-party claimant, unless the deductible amount has been otherwise recovered. A deduction for expenses can not be made from the deductible recovery unless an outside attorney is retained to collect the recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.

(d) If an insurer prepares an appraisal of the cost of automobile repairs, the appraisal shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the appraisal to the claimant and may furnish to the claimant, upon his unsolicited request, the names of two or more conveniently located repair shops.

(e) When the amount claimed is reduced because of betterment or depreciation information for the reduction shall be contained in the claim file. The deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

(f) When the insurer elects to repair in a first-party claim, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

(g) The insurer may not use as a basis for cash settlement with a first-party claimant an amount which is less than the amount which the insurer would pay if repairs were made, other than in total loss situations, unless the amount is
agreed to by the insured or provided by the insurance policy or insurance contract.

§ 146.9. Comparative negligence.

(a) Where comparative negligence is applied to a claim settlement offer or denial, insurers shall fully disclose to claimants the basis in fact or in applicable law for the offer or denial and settlement standards relating to the claims.

(b) Insurers may not use comparative negligence claim settlement standards which are inequitable and which result in compelling claimants to litigate by offering substantially less than the amount due and ultimately recovered in actions brought by the persons. Comparative negligence should not be applied to a claim settlement to reduce amounts claimants would otherwise be entitled to but for their negligence without reasonable evidence of the negligence and its relativity to the total negligence involved. A record of the evidence and the evaluation of its effect should be maintained in the claim file.

§ 146.10. Written notice to claimants of payment of claim in third-party settlements.

(a) Upon payment of $1,000 or more in settlement of a third-party liability claim, if the claimant is a natural person, the insurer shall cause written notice to be mailed to the claimant at the same time payment is made, by the insurer or its representative, including the insurer’s attorney, to the claimant’s attorney or other representative of the claimant by draft, check or otherwise.

(b) Nothing in this subsection will constitute a violation of this chapter if an insurer makes a good faith effort to comply with this section.

(c) A violation of this section will be deemed to occur if an insurer fails to provide the notice to claimants with a frequency that indicates that it is a general business practice.

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