§ 541.060. UNFAIR SETTLEMENT PRACTICES. (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to engage in the following unfair settlement practices with respect to a claim by an insured or beneficiary:

1. misrepresenting to a claimant a material fact or policy provision relating to coverage at issue;
2. failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of:
   A. a claim with respect to which the insurer's liability has become reasonably clear; or
   B. a claim under one portion of a policy with respect to which the insurer's liability has become reasonably clear to influence the claimant to settle another claim under another portion of the coverage unless payment under one portion of the coverage constitutes evidence of liability under another portion;
3. failing to promptly provide to a policyholder a reasonable explanation of the basis in the policy, in relation to the facts or applicable law, for the insurer's denial of a claim or offer of a compromise settlement of a claim;
4. failing within a reasonable time to:
   A. affirm or deny coverage of a claim to a policyholder; or
   B. submit a reservation of rights to a policyholder;
5. refusing, failing, or unreasonably delaying a settlement offer under applicable first-party coverage on the basis that other coverage may be available or that third parties are responsible for the damages suffered, except as may be specifically provided in the policy;
6. undertaking to enforce a full and final release of a claim from a policyholder when only a partial payment has been made, unless the payment is a compromise settlement of a doubtful or disputed claim;
7. refusing to pay a claim without conducting a reasonable investigation with respect to the claim;
8. with respect to a Texas personal automobile insurance policy, delaying or refusing settlement of a claim solely because there is other insurance of a different kind available to satisfy all or part of the loss forming the basis of that claim; or
9. requiring a claimant as a condition of settling a claim to produce the claimant's federal income tax returns for examination or investigation by the person unless:
   A. a court orders the claimant to produce those tax returns;
   B. the claim involves a fire loss; or
   C. the claim involves lost profits or income.

(b) Subsection (a) does not provide a cause of action to a third party asserting one or
more claims against an insured covered under a liability insurance policy.

§ 541.061. MISREPRESENTATION OF INSURANCE POLICY. It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to misrepresent an insurance policy by:

(1) making an untrue statement of material fact;
(2) failing to state a material fact necessary to make other statements made not misleading, considering the circumstances under which the statements were made;
(3) making a statement in a manner that would mislead a reasonably prudent person to a false conclusion of a material fact;
(4) making a material misstatement of law; or
(5) failing to disclose a matter required by law to be disclosed, including failing to make a disclosure in accordance with another provision of this code.

§ 541.107. DETERMINATION OF VIOLATION. After a hearing under this subchapter, the department shall determine whether:

(1) the method of competition or the act or practice considered in the hearing is defined as:
   (A) an unfair method of competition or deceptive act or practice under Subchapter B or a rule adopted under this chapter; or
   (B) a false, misleading, or deceptive act or practice under Section 17.46, Business & Commerce Code; and
(2) the person against whom the charges were made engaged in the method of competition or act or practice in violation of:
   (A) this chapter or a rule adopted under this chapter; or
   (B) Subchapter E, Chapter 17, Business & Commerce Code, as specified in Section 17.46, Business & Commerce Code.

§ 541.110. ADMINISTRATIVE PENALTY. (a) A person who violates a cease and desist order issued under Section 541.108 is subject to an administrative penalty under Chapter 84.

(b) In determining whether a person has violated a cease and desist order, the department shall consider the maintenance of procedures reasonably adapted to ensure compliance with the order.

(c) An administrative penalty imposed under this section may not exceed:
   (1) $1,000 for each violation; or
   (2) $5,000 for all violations.
(d) An order of the department imposing an administrative penalty under this section applies only to a violation of the cease and desist order committed before the date the order imposing the penalty is issued.

§ 541.111. CIVIL PENALTY FOR VIOLATION OF CEASE AND DESIST ORDER. (a) A person who is found by a court to have violated a cease and desist order issued under Section 541.108 is liable to the state for a penalty. The state may recover the penalty in a civil action.

(b) The penalty may not exceed $50 unless the court finds the violation to be wilful, in which case the penalty may not exceed $500.

SUBCHAPTER D. PRIVATE ACTION FOR DAMAGES

§ 541.151. PRIVATE ACTION FOR DAMAGES AUTHORIZED. A person who sustains actual damages may bring an action against another person for those damages caused by the other person engaging in an act or practice:

1. defined by Subchapter B to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance; or
2. specifically enumerated in Section 17.46(b), Business & Commerce Code, as an unlawful deceptive trade practice if the person bringing the action shows that the person relied on the act or practice to the person's detriment.

§ 541.152. DAMAGES, ATTORNEY'S FEES, AND OTHER RELIEF.

(a) A plaintiff who prevails in an action under this subchapter may obtain:
1. the amount of actual damages, plus court costs and reasonable and necessary attorney's fees;
2. an order enjoining the act or failure to act complained of; or
3. any other relief the court determines is proper.

(b) On a finding by the trier of fact that the defendant knowingly committed the act complained of, the trier of fact may award an amount not to exceed three times the amount of actual damages.

§ 541.153. FRIVOLOUS ACTION. A court shall award to the defendant court costs and reasonable and necessary attorney's fees if the court finds that an action under this subchapter is groundless and brought in bad faith or brought for the purpose of harassment.
§ 541.156. SETTLEMENT OFFER. (a) A person who receives notice provided under Section 541.154 may make a settlement offer during a period beginning on the date notice under Section 541.154 is received and ending on the 60th day after that date.

(b) In addition to the period described by Subsection (a), the person may make a settlement offer during a period:

(1) if mediation is not conducted under Section 541.161, beginning on the date an original answer is filed in the action and ending on the 90th day after that date; or

(2) if mediation is conducted under Section 541.161, beginning on the day after the date the mediation ends and ending on the 20th day after that date.

§ 541.157. CONTENTS OF SETTLEMENT OFFER. A settlement offer made by a person against whom a claim under this subchapter is pending must include an offer to pay the following amounts, separately stated:

(1) an amount of money or other consideration, reduced to its cash value, as settlement of the claim for damages; and

(2) an amount of money to compensate the claimant for the claimant's reasonable and necessary attorney's fees incurred as of the date of the offer.

§ 541.158. REJECTION OF SETTLEMENT OFFER. (a) A settlement offer is rejected unless both parts of the offer required under Section 541.157 are accepted by the claimant not later than the 30th day after the date the offer is made.

(b) A settlement offer made by a person against whom a claim under this subchapter is pending that complies with this subchapter and is rejected by the claimant may be filed with the court accompanied by an affidavit certifying the offer's rejection.

§ 541.159. LIMIT ON RECOVERY AFTER SETTLEMENT OFFER. (a) If the court finds that the amount stated in the settlement offer for damages under Section 541.157(1) is the same as, substantially the same as, or more than the amount of damages found by the trier of fact, the claimant may not recover as damages any amount in excess of the lesser of:

(1) the amount of damages stated in the offer; or

(2) the amount of damages found by the trier of fact.

(b) If the court makes the finding described by Subsection
(a), the court shall determine reasonable and necessary attorney's fees to compensate the claimant for attorney's fees incurred before the date and time the rejected settlement offer was made. If the court finds that the amount stated in the offer for attorney's fees under Section 541.157(2) is the same as, substantially the same as, or more than the amount of reasonable and necessary attorney's fees incurred by the claimant as of the date of the offer, the claimant may not recover any amount of attorney's fees in excess of the amount of fees stated in the offer.

(c) This section does not apply if the court finds that the offering party:
   (1) could not perform the offer at the time the offer was made; or
   (2) substantially misrepresented the cash value of the offer.

(d) The court shall award:
   (1) damages as required by Section 541.152 if Subsection (a) does not apply; and
   (2) attorney's fees as required by Section 541.152 if Subsection (b) does not apply.

§ 541.160. EFFECT OF SETTLEMENT OFFER. A settlement offer is not an admission of engaging in an act or practice defined by Subchapter B to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

§ 541.204. CIVIL PENALTY. In addition to requesting a temporary or permanent injunction under Section 541.201, the attorney general may request a civil penalty of not more than $10,000 for each violation on a finding by the court that the defendant has engaged in or is engaging in an act or practice defined as unlawful under:
   (1) this chapter or a rule adopted under this chapter; or
   (2) Section 17.46, Business & Commerce Code.

§ 541.205. COMPENSATION OR RESTORATION. The court may make an additional order or judgment as necessary to compensate an identifiable person for actual damages or for restoration of money or property that may have been acquired by means of an enjoined act or practice.

§ 541.206. CIVIL PENALTY FOR VIOLATION OF INJUNCTION.
(a) A person who violates an injunction issued under this subchapter is liable for and shall pay to the state a civil penalty of not more than $10,000 for each violation.
(b) The attorney general may, in the name of the state, petition the court for recovery of the civil penalty against the person who violates the injunction.

(c) The court shall consider the maintenance of procedures reasonably adapted to ensure compliance with the injunction in determining whether a person has violated an injunction.

(d) The court issuing the injunction retains jurisdiction and the cause is continued for the purpose of assessing a civil penalty under this section.

§ 541.207. REMEDIES NOT EXCLUSIVE. The remedies provided by this subchapter are:

(1) not exclusive; and

(2) in addition to any other remedy or procedure provided by another law or at common law.

§ 542.003. UNFAIR CLAIM SETTLEMENT PRACTICES PROHIBITED. (a) An insurer engaging in business in this state may not engage in an unfair claim settlement practice.

(b) Any of the following acts by an insurer constitutes unfair claim settlement practices:

(1) knowingly misrepresenting to a claimant pertinent facts or policy provisions relating to coverage at issue;

(2) failing to acknowledge with reasonable promptness pertinent communications relating to a claim arising under the insurer's policy;

(3) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under the insurer's policies;

(4) not attempting in good faith to effect a prompt, fair, and equitable settlement of a claim submitted in which liability has become reasonably clear;

(5) compelling a policyholder to institute a suit to recover an amount due under a policy by offering substantially less than the amount ultimately recovered in a suit brought by the policyholder;

(6) failing to maintain the information required by Section 542.005;

or

(7) committing another act the commissioner determines by rule constitutes an unfair claim settlement practice.

§ 542.004. EXAMINATION OF TAX RETURNS PROHIBITED.

(a) An insurer regulated under this code may not require a claimant, as a condition of settling a claim, to produce the claimant's federal income tax returns for examination or investigation by the insurer unless:

(1) the claimant is ordered to produce the tax returns by a court; or

(2) the claim involves:

(A) a fire loss; or
(B) a loss of profits or income.
(b) An insurer that violates this section commits:
   (1) a prohibited practice under this subchapter; and
   (2) a deceptive trade practice under Subchapter E, Chapter 17, Business & Commerce Code.
(c) A claimant affected by a violation of this section is entitled to remedies under Subchapter E, Chapter 17, Business & Commerce Code.

§ 542.005. RECORD OF COMPLAINTS. (a) In this section, "complaint" means any written communication primarily expressing a grievance.
   (b) An insurer shall maintain a complete record of all complaints received by the insurer during the preceding three years or since the date of the insurer's last examination by the department, whichever period is shorter. The record must indicate:
      (1) the total number of complaints;
      (2) the classification of complaints by line of insurance;
      (3) the nature of each complaint;
      (4) the disposition of the complaints; and
      (5) the time spent processing each complaint.

§ 542.006. PERIODIC REPORTING REQUIREMENT. (a) In this section, "claim" means a written claim filed by a resident of this state with an insurer engaging in business in this state.
   (b) If, based on complaints of unfair claim settlement practices under this subchapter, the department finds that an insurer should be subjected to closer supervision with respect to the insurer's claim settlement practices, the department may require the insurer to file periodic reports at intervals the department determines necessary.
   (c) The department shall devise a statistical plan for the periodic reports required under Subsection (b). The plan must contain at a minimum:
      (1) the following claims information for the preceding 12 months or from the date of the insurer's last periodic report, whichever period is shorter:
         (A) the total number of claims filed, including for each individual claim:
            (i) the original amount filed for by the insured; and
            (ii) the classification by line of insurance;
         (B) the total number of claims denied;
         (C) the total number of claims settled, including for each individual claim:
            (i) the original amount filed for by the insured;
            (ii) the amount settled; and
            (iii) the classification by line of insurance; and
(D) the total number of claims for which suits have been instituted against the insurer, including for each individual claim:
   (i) the original amount filed for by the insured;
   (ii) the amount of final adjudication;
   (iii) the reason for the suit; and
   (iv) the classification by line of insurance; and

(2) the information required to be maintained by the insurer under Section 542.005.

(d) If at any time the department determines that the requirement to file a periodic report is no longer necessary to accomplish the objectives of this subchapter, the department may rescind the reporting requirement.

§ 542.007. COMPARISON OF CERTAIN INSURERS TO MINIMUM STANDARD OF PERFORMANCE; INVESTIGATION.
(a) The department shall compile the information received from an insurer under Section 542.006 in a manner that enables the department to compare the insurer's performance to a minimum standard of performance adopted by the commissioner.

(b) If the department determines that the insurer does not meet the minimum standard of performance, the department shall investigate the insurer to determine the reason, if any, that the insurer does not meet the minimum standard.

§ 542.008. COMPLAINTS AGAINST INSURERS; INVESTIGATION. (a) The department shall establish a system for receiving and processing individual complaints alleging a violation of this subchapter by an insurer regardless of whether the insurer is required to file a periodic report under Section 542.006.

(b) The department shall investigate an insurer if the department determines that:
   (1) based on the number and type of complaints against an insurer, the insurer does not meet the minimum standard of performance adopted under Section 542.007; or
   (2) the number and type of complaints against the insurer are not proportionate to the number and type of complaints against other insurers writing similar lines of insurance.

§ 542.009. REVIEW OF INVESTIGATION RESULTS; HEARING. (a) On receiving the results of an investigation instituted under Section 542.007 or 542.008, the department shall review those results considering the standards of this subchapter to determine whether further action is necessary.
(b) If the department determines that further action is necessary, the department shall:
   (1) set a date for a hearing to review the alleged violations of this subchapter; and
   (2) notify the insurer of:
      (A) the date of the hearing; and
      (B) the nature of the charges.
(c) The department shall provide the notice required by Subsection (b)(2) not later than the 30th day before the date of the hearing.
(d) At a hearing under this section, the insurer may present the insurer’s case with the assistance of counsel.
(e) Evidence relating to the number and type of complaints or claims prepared by the department from information received or compiled under Section 542.006, 542.007, or 542.008 is admissible in evidence at:
   (1) the hearing; and
   (2) any related judicial proceeding.
(f) The hearing shall be conducted in accordance with this code and rules adopted by the commissioner.
(g) An insurer may not be found to be in violation of this subchapter solely because of the number and type of complaints or claims against the insurer.

§ 542.010. CEASE AND DESIST ORDER; ENFORCEMENT.
(a) If the department determines that an insurer has violated this subchapter, the department shall issue a cease and desist order to the insurer directing the insurer to stop the unlawful practice.
(b) If the insurer fails to comply with the cease and desist order, the department may:
   (1) revoke or suspend the insurer’s certificate of authority; or
   (2) limit, regulate, and control:
      (A) the insurer’s line of business;
      (B) the insurer’s writing of policy forms or other particular forms; and
      (C) the volume of the insurer’s:
         (i) line of business; or
         (ii) writing of policy forms or other particular forms.
(c) The department shall exercise authority under this section to the extent that the department determines is necessary to obtain the insurer’s compliance with the cease and desist order.
(d) At the request of the department, the attorney general shall assist the department in enforcing the cease and desist order.
§ 542.012. ATTORNEY’S FEES. The department is entitled to reasonable attorney’s fees if judicial action is necessary to enforce an order of the department under this subchapter.

§ 542.051. DEFINITIONS. In this subchapter:

1. "Business day" means a day other than a Saturday, Sunday, or holiday recognized by this state.

2. "Claim" means a first-party claim that:
   A. is made by an insured or policyholder under an insurance policy or contract or by a beneficiary named in the policy or contract; and
   B. must be paid by the insurer directly to the insured or beneficiary.

3. "Claimant" means a person making a claim.

4. "Notice of claim" means any written notification provided by a claimant to an insurer that reasonably apprises the insurer of the facts relating to the claim.

§ 542.054. LIBERAL CONSTRUCTION. This subchapter shall be liberally construed to promote the prompt payment of insurance claims.

§ 542.055. RECEIPT OF NOTICE OF CLAIM. (a) Not later than the 15th day or, if the insurer is an eligible surplus lines insurer, the 30th business day after the date an insurer receives notice of a claim, the insurer shall:

1. acknowledge receipt of the claim;
2. commence any investigation of the claim; and
3. request from the claimant all items, statements, and forms that the insurer reasonably believes, at that time, will be required from the claimant.

(b) An insurer may make additional requests for information if during the investigation of the claim the additional requests are necessary.

(c) If the acknowledgment of receipt of a claim is not made in writing, the insurer shall make a record of the date, manner, and content of the acknowledgment.

§ 542.056. NOTICE OF ACCEPTANCE OR REJECTION OF CLAIM. (a) Except as provided by Subsection (b) or (d), an insurer shall notify a claimant in writing of the acceptance or rejection of a claim not later than the 15th business day after the date the insurer receives all items, statements, and forms required by the insurer to secure final proof of loss.
If an insurer has a reasonable basis to believe that a loss resulted from arson, the insurer shall notify the claimant in writing of the acceptance or rejection of the claim not later than the 30th day after the date the insurer receives all items, statements, and forms required by the insurer.

If the insurer rejects the claim, the notice required by Subsection (a) or (b) must state the reasons for the rejection.

If the insurer is unable to accept or reject the claim within the period specified by Subsection (a) or (b), the insurer, within that same period, shall notify the claimant of the reasons that the insurer needs additional time. The insurer shall accept or reject the claim not later than the 45th day after the date the insurer notifies a claimant under this subsection.

§ 542.057. PAYMENT OF CLAIM. (a) Except as otherwise provided by this section, if an insurer notifies a claimant under Section 542.056 that the insurer will pay a claim or part of a claim, the insurer shall pay the claim not later than the fifth business day after the date notice is made.

(b) If payment of the claim or part of the claim is conditioned on the performance of an act by the claimant, the insurer shall pay the claim not later than the fifth business day after the date the act is performed.

(c) If the insurer is an eligible surplus lines insurer, the insurer shall pay the claim not later than the 20th business day after the notice or the date the act is performed, as applicable.

§ 542.058. DELAY IN PAYMENT OF CLAIM. (a) Except as otherwise provided, if an insurer, after receiving all items, statements, and forms reasonably requested and required under Section 542.055, delays payment of the claim for a period exceeding the period specified by other applicable statutes or, if other statutes do not specify a period, for more than 60 days, the insurer shall pay damages and other items as provided by Section 542.060.

(b) This section does not apply in a case in which it is found as a result of arbitration or litigation that a claim received by an insurer is invalid and should not be paid by the insurer.

§ 542.059. EXTENSION OF DEADLINES. (a) A court may grant a request by a guaranty association for an extension of the periods under this subchapter on a showing of good cause and after reasonable notice to policyholders.

(b) In the event of a weather-related catastrophe or major natural disaster, as defined by the commissioner, the claim-handling deadlines imposed under this subchapter are extended for an additional 15 days.
§ 542.060. LIABILITY FOR VIOLATION OF SUBCHAPTER. (a) If an insurer that is liable for a claim under an insurance policy is not in compliance with this subchapter, the insurer is liable to pay the holder of the policy or the beneficiary making the claim under the policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.

(b) If a suit is filed, the attorney's fees shall be taxed as part of the costs in the case.

§ 542.061. REMEDIES NOT EXCLUSIVE. The remedies provided by this subchapter are in addition to any other remedy or procedure provided by law or at common law.

SUBCHAPTER C. PROVIDING CERTAIN CLAIMS INFORMATION ON REQUEST

§ 542.101. REQUEST BY NAMED INSURED UNDER LIABILITY INSURANCE POLICY. (a) In this section, "liability insurance" means:

(1) general liability insurance;
(2) professional liability insurance, including medical professional liability insurance;
(3) commercial automobile liability insurance; and
(4) the liability portion of commercial multiperil insurance.

(b) On written request of a named insured under a liability insurance policy, the insurer that wrote the policy shall provide to the insured information relating to the disposition of a claim filed under the policy. The information must include:

(1) the name of each claimant;
(2) details relating to:
   (A) the amount paid on the claim;
   (B) settlement of the claim; or
   (C) judgment on the claim;
(3) details as to how the claim, settlement, or judgment is to be paid; and
(4) any other information required by rule of the commissioner that the commissioner considers necessary to adequately inform an insured with regard to any claim under a liability insurance policy.

(c) A request for information under this section must be transmitted to the insurer not later than six months after the date of disposition of the claim.
§ 542.102. REQUEST BY POLICYHOLDER UNDER PROPERTY AND CASUALTY INSURANCE POLICY. (a) On written request of a policyholder, an insurer that writes property and casualty insurance in this state shall provide the policyholder with a list of claims charged against the policy and payments made on each claim.
   (b) This section does not apply to a workers' compensation insurance policy subject to Article 5.65A.

§ 542.103. DEADLINE FOR PROVIDING REQUESTED INFORMATION. (a) An insurer shall provide the information requested under this subchapter in writing not later than the 30th day after the date the insurer receives the request for the information.
   (b) For purposes of this section, information is considered to be provided on the date the information is deposited with the United States Postal Service or is personally delivered.

§ 542.104. RULES. The commissioner may by rule prescribe forms for requesting information and for providing requested information under this subchapter.

SUBCHAPTER D. NOTICE OF SETTLEMENT OF CLAIM UNDER CASUALTY INSURANCE POLICY

§ 542.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to the settlement of a claim under a casualty insurance policy that is delivered, issued for delivery, or renewed in this state, including a policy written by:
   (1) a county mutual insurance company;
   (2) a Lloyd's plan;
   (3) an eligible surplus lines insurer; or
   (4) a reciprocal or interinsurance exchange.

§ 542.152. EXCEPTION. This subchapter does not apply to:
   (1) a casualty insurance policy that requires the insured's consent to settle a claim against the insured;
   (2) fidelity, surety, or guaranty bonds; or
   (3) marine insurance as defined by Article 5.53.

§ 542.153. NOTICE REQUIRED. (a) Not later than the 10th day after the date an initial offer to settle a claim against a named insured under a casualty
insurance policy issued to the insured is made, the insurer shall notify the insured in writing of the offer.

(b) Not later than the 30th day after the date a claim against a named insured under a casualty insurance policy issued to the insured is settled, the insurer shall notify the insured in writing of the settlement.

SUBCHAPTER E. RECOVERY OF DEDUCTIBLE FROM THIRD PARTIES UNDER CERTAIN AUTOMOBILE INSURANCE POLICIES

§ 542.201. PURPOSE. This subchapter is intended to encourage insurers to take appropriate and necessary steps to collect from third parties or the insurers of the third parties.

§ 542.202. DEFINITION. In this subchapter, "action" includes taking various actions such as reasonable and diligent collection efforts, mediation, arbitration, and litigation against a responsible third party or the third party's insurer.

§ 542.203. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any insurer that delivers, issues for delivery, or renews in this state a private passenger automobile insurance policy, including a reciprocal or interinsurance exchange, mutual insurance company, association, Lloyd's plan, or other insurer.

§ 542.204. ACTION TO RECOVER DEDUCTIBLE. (a) Notwithstanding any other provision of this code and except as provided by Subsection (b), if an insurer is liable to an insured for a claim that is subject to a deductible payable by the insured and a third party may be liable to the insurer or the insured for the amount of the deductible, the insurer shall:

(1) take action to recover the deductible against the third party not later than the first anniversary of the date the insured's claim is paid; or

(2) pay the amount of the deductible to the insured.

(b) An insurer is not required to take action or pay the amount of the deductible as required by Subsection (a) if, not later than the earlier of the first anniversary of the date the insured's claim is paid or the 90th day before the date the statute of limitations for a negligence action expires, the insurer:

(1) notifies the insured in writing that the insurer does not intend to take further collection actions against the third party; and

(2) authorizes the insured to take further collection actions.

(c) This section applies regardless of whether the third party who may be liable for the amount of the deductible is insured or uninsured.
§ 542.205. ENFORCEMENT; RULES. The commissioner may enforce this subchapter and adopt and enforce reasonable rules necessary to accomplish the purposes of this subchapter.

SUBCHAPTER G. INSURER’S RECOVERY FROM UNINSURED THIRD PARTY

§ 542.301. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any insurer that delivers, issues for delivery, or renews a private passenger automobile insurance policy in this state, including a county mutual, a reciprocal or interinsurance exchange, or a Lloyd's plan.

§ 542.302. RECOVERY IN SUIT OR OTHER ACTION. An insurer that brings suit or takes other action described by Section 542.202 against a responsible third party relating to a loss that is covered under a private passenger automobile insurance policy issued by the insurer and for which the responsible third party is uninsured is entitled to recover, in addition to payments made by the insurer or insured, the costs of bringing the suit or taking the action, including reasonable attorney's fees and court costs.

REGULATIONS:

Texas Administrative Code

TITLE 28       INSURANCE
PART 1          TEXAS DEPARTMENT OF INSURANCE
CHAPTER 21    TRADE PRACTICES

Subchapters

RULE §21.201  Short Title

These regulations shall be known as the "Unfair Claims Settlement Practices Rules."

RULE §21.202  Definitions

The following words or phrases, as used in these regulations, shall have the
meanings placed opposite them unless the explicit wording of a regulation shall otherwise direct.

(1) Business day--A day other than a Saturday, Sunday, or holiday recognized by this state.

(2) Claim--A request or demand reduced to writing and filed by a Texas resident with an insurer for payment of funds or the providing of services under the terms of a policy, certificate, or binder of insurance.

(3) Claimant--A person making or having made a claim.

(4) Complaint--Any written communication to an insurer, not solicited by such insurer, primarily expressing a grievance relating to an unfair claims settlement practice as defined in §21.203 of this title (relating to Unfair Claims Settlement Practices). For purposes of this subchapter, any written communication to an insurer by the same person which relates to the same claim, issue or question and requests or demands the same kind of relief and which arises out of the same transaction or transactions is considered to be part of the same complaint. A complaint is not a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding and/or supplying the appropriate information to the satisfaction of the person submitting the written communication, as applicable.

(5) First-party coverage--Benefits and other rights provided by an insurance contract to an insured.

(6) Insurer--Stock and mutual life, health, accident, fire, casualty, fire and casualty, hail, storm, title, and mortgage guarantee companies; mutual assessment companies; local mutual aid associations; local mutual burial associations; statewide mutual assessment companies; stipulated premium companies; fraternal benefit societies; group hospital service organizations; county mutual insurance companies; Lloyds; reciprocal or interinsurance exchanges; and farm mutual insurance companies.

(7) Policyholder--The owner of a policy, certificate, or binder of insurance, and any insured, named insured, or obligee under a bond.

(8) Third-party coverage--Benefits and other rights provided by an insurance contract to any person other than the insured.

(9) Written communication--Any communication that is documented by publication or otherwise being written onto a medium which is capable at the point of receipt of being viewed, stored, retrieved and reproduced by the recipient without any transcription. Such communication expressly includes, but is not limited to, facsimile transmissions and electronic mail transmissions.

RULE §21.203 Unfair Claim Settlement Practices

No insurer shall engage in unfair claim settlement practices. Unfair claim settlement practices means committing or performing any of the following:

(1) misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;
(2) failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies, provided that "pertinent communications" shall exclude written communications that are direct responses to specific inquiries made by the insurer after initial report of a claim. An acknowledgment within 15 business days is presumed to be reasonably prompt;

(3) failing to adopt and implement reasonable standards for prompt investigation of claims arising under its policies;

(4) not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear;

(5) compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

(6) failure of any insurer to maintain, in substantial compliance with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions), a complete record of all complaints, as that term is defined in §21.202(4) of this title (relating to Definitions), which it has received during the preceding three years or since the date of its most recent financial examination by the commissioner of insurance, whichever time is shorter. For purposes of this section, "substantial compliance" has the meaning set out in §21.2503 of this title (relating to Compliance Standard);

(7) failing to provide promptly, when provided for in the policy, claim forms when the insurer requires such forms as a prerequisite for a claim settlement;

(8) not attempting in good faith to settle promptly claims where liability has become reasonably clear under one portion of the policy in order to influence settlement under other portions of the policy coverage. (This provision does not apply to those situations where payment under one portion of coverage constitutes evidence of liability under another portion of coverage);

(9) failing to provide promptly to a policyholder 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;

(10) failing to affirm or deny coverage of a claim to a policyholder within a reasonable time. The reasonable submission of a reservation of rights letter by an insurer to a policyholder within a reasonable time is deemed compliance with the provisions of this paragraph;

(11) except as may be specifically provided in the policy, to refuse, fail, or unreasonably delay offer of settlement under applicable first-party coverage on the basis that other coverage may be available or third parties are responsible in law for damages suffered;

(12) attempting to settle a claim for less than the amount to which a reasonable person would have believed she/he was entitled by reference to an advertisement, as described in §21.102 of this title (relating to Scope), made by an insurer or person acting on behalf of an insurer;

(13) undertaking to enforce a full and final release from a policyholder when, in fact, only a partial payment has been made. (This provision shall not prevent or have application to the compromise settlement of doubtful or disputed claims);
(14) failing to establish a policy and proper controls to make certain that agents calculate and deliver to policyholders or their assignees funds due under policy provisions relative to cancellation of coverage within a reasonable time after such coverages are terminated;
(15) refusing to pay claims without conducting a reasonable investigation based upon all available information;
(16) failing to respond promptly to a request by a claimant for personal contact about or review of the claim;
(17) with respect to the Texas personal auto policy, to delay or refuse settlement of a claim solely because there is other insurance of a different type available to satisfy partially or entirely the loss forming the basis of that claim. The claimant who has a right to recover from either or both insurers is entitled to choose under which coverage and in what order payment is to be made;
(18) a violation of the Insurance Code, Article 21.55, by an insurer subject to its provisions;
(19) requiring a claimant, as a condition of settling a claim, to produce the claimant's federal income tax returns for examination or investigation by the insurer unless the claimant is ordered to produce those tax returns by a court of competent jurisdiction, the claim involves a fire loss, or the claim involves a loss of profits or income.

RULE §21.204 Special Claim Reports and Statistical Plan

If it should be found by the Texas Department of Insurance based on complaint or complaints of unfair claim settlement practices as described in §21.203 of this title (relating to Unfair Claims Settlement Practices), that an insurer should be subjected to closer supervision with respect to such practices, it may require such insurer to file a report at such periodic intervals as the department deems necessary. Such periodical reports shall contain the following information:

1. the total number of written claims filed, including the original amount filed for by the insured and the classification by line of insurance of each individual written claim, for the past 12-month period or from the date of the insurer's last periodic report, whichever time is shorter;
2. the total number of written claims denied for the past 12-month period or from the date of the insurer's last periodic report, whichever is shorter;
3. the total number of written claims settled, including the original amount filed for by the insured, the settled amount, and the classification of line of insurance of each individual settled claim, for the past 12-month period or from the date of the insurer's last periodic report, whichever time is shorter;
4. the total number of written claims for which lawsuits were instituted against the insurer, including the original amount filed for by the insured, the amount of final adjudication, the reason for the lawsuit, and the classification by line of insurance of each individual written claim, for the past 12-month period or from the date of the insurer's last periodic report, whichever time is shorter; and
(5) 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. Such periodic reports shall be filed with the State Board of Insurance and the commissioner of insurance.

RULE §21.205 Minimum Standard of Performance

All insurers shall maintain their affairs so that no unfair claims settlement practices are committed and the minimum standard of performance for all insurers (as that term is used in the Insurance Code, Article 21.21-2) is to comply with the provisions of §21.203 of this title (relating to Unfair Claims Settlement Practices).